NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 11 December 2025 at 9.00 am to 1.00 pm in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Verbal	Information	**09:00**
1.2	**Staff Charter and Values** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Attached	Information	
1.3	**Patient Story** Heather McNair, Interim Group Chief Nurse	Verbal	Assurance	**09:05**
1.4	**Questions from the Public and Governors** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Verbal	Discussion	**09:25**
1.5	**Declarations of Interest** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Attached	Assurance	**09:35**
1.6	**Minutes of the Meeting held on Thursday, 9 October 2025** Jane Hawkard, Non-Executive Director (Chair of Meeting)	BIC(25)215 Attached	Approval	
1.7	**Minutes of the HUTH Annual General Meeting (AGM) on Wednesday, 22 October 2025** Jane Hawkard, Non-Executive Director (Chair of Meeting)	BIC(25)216 Attached	Approval	
1.8	**Matters Arising** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Verbal	Assurance	
1.9	**Action Tracker** - **Public** Jane Hawkard, Non-Executive Director (Chair of Meeting)	BIC(25)217 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Interim Group Chair's Report** Jane Hawkard, Non-Executive Director (Chair of Meeting – presenting on behalf of Murray Macdonald, Interim Group Chair)	BIC(25)218 Attached	Assurance	**09:45**
2.2	**Interim Group Chief Executive's Briefing** Lyn Simpson, Interim Group Chief Executive	BIC(25)219 Attached	Assurance	**09:55**

3. STRATEGIC PROGRESS				
3.1	**Patients – Safety (including Assurance Committee update)** Dr Kate Wood, Group Chief Medical Officer & Heather McNair, Interim Group Chief Nurse	BIC(25)220 Attached	Assurance	**10:05**
3.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(25)221 Attached	Assurance	
3.1.2	**Maternity Reporting:** • **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** • **Maternity Safety: Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)** Heather McNair, Interim Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(25)222 Attached	Assurance	
BREAK – 10:45 – 11:00				
3.2	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Matt Powls, Interim Group Chief Delivery Officer	BIC(25)224 Attached	Assurance	**11:00**
3.3	**People (including Assurance Committee update)** Simon Nearney, Group Chief People Officer	BIC(25)225 Attached	Assurance	**11:15**
3.3.1	**Freedom to Speak Up Guardian (FTSUG) Quarter Two Report (NLaG & HUTH)** Liz Houchin & Fran Moverley, FTSUGs	BIC(25)226 Attached	Assurance	**11:25**
3.4	**Population** Heather McNair, Interim Group Chief Nurse	BIC(25)227 Attached	Assurance	**11:35**
3.5	**Public Purse (including Assurance Committee update)** Emma Sayner, Group Chief Financial Officer	BIC(25)228 Attached	Assurance	**11:40**
3.6	**Partnerships (including Assurance Committee Update)** Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	BIC(25)229 Attached	Assurance	**11:50**
4. OTHER ITEMS FOR ASSURANCE				
4.1	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(25)231 Attached	Assurance	**12:00**
5. OTHER ITEMS FOR APPROVAL				
5.1	**Emergency Preparedness, Resilience & Response (EPRR) Regulatory Report** Matt Powls, Interim Group Chief Delivery Officer	BIC(25)232 Attached	Approval	**12:15**

5.2	**Partnerships Strategy** Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	BIC(25)233 Attached	Approval	**12:25**
5.3	**Terms of Reference – Committees-in-Common** • **Performance, Estates & Finance** • **Quality & Safety** • **Workforce, Education & Culture** • **Strategic Programme & Partnerships** David Sharif, Group Director of Assurance	BIC(25)234 Attached	Approval	**12:35**
6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Jane Hawkard, Non-Executive Director (Chair of Meeting)	Verbal	Information / Assurance	
7.	**ANY OTHER URGENT BUSINESS**			
7.1	**Any Other Urgent Business** Jane Hawkard, Non-Executive Director (Chair of Meeting) / All	Verbal		**12:45**
8.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
8.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Jane Hawkard, Non-Executive Director (Chair of Meeting) / All	Verbal	Discussion	
9.	**DATE OF THE NEXT MEETING**			
9.1	**The next meeting of the Boards-in-Common will be held on Thursday, 12 February 2026 at 9.00 am**			

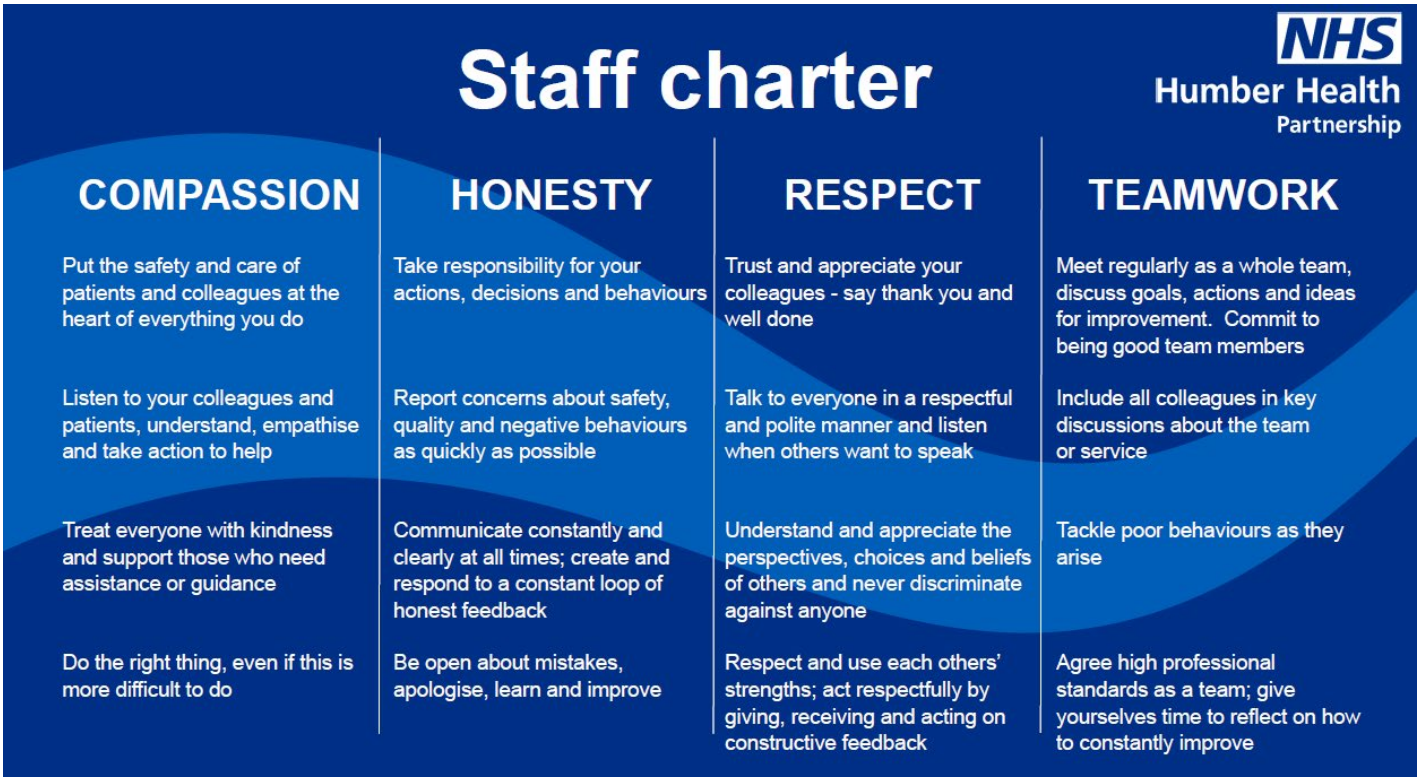
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – September 2025** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(25)235 Attached
6.1.2	**Safeguarding & Vulnerabilities Annual Report** Heather McNair, Interim Group Chief Nurse	BIC(25)236 Attached
6.1.3	**Patient Experience Annual Report** Heather McNair, Interim Group Chief Nurse	BIC(25)237 Attached
6.1.4	**PSIRF / Serious Incident Annual Report** Heather McNair, Interim Group Chief Nurse	BIC(25)238 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Performance, Estates & Finance Committees-in-Common Minutes – October & November 2025** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)239 Attached
6.2.2	**Finance Report – Month 7** Emma Sayner, Group Chief Financial Officer	BIC(25)240 Attached
6.3	**Workforce, Education & Culture Committees-in-Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – September & October 2025** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)241 Attached
6.3.2	**Guardian of Safe Working Hours – Quarter Two Report** Dr Kate Wood, Group Chief Medical Officer	BIC(25)242 Attached
6.4	**Audit, Risk & Governance Committees-in-Common**	
6.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – July 2025** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(25)243 Attached
6.5	**Capital & Major Projects Committees-in-Common**	
6.5.1	**Capital & Major Projects Committees-in-Common Minutes – June 2025** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)244 Attached
6.6	**Other**	
6.6.1	**Group Performance Report – NLaG and HUTH** Adam Creeggan, Group Director of Performance	BIC(25)245 Attached
6.6.2	**Trust Boards & Committees Meeting Cycle – 2026** David Sharif, Group Director of Assurance	BIC(25)246 Attached
6.6.3	**Board Assurance Framework (BAF)** David Sharif, Group Director of Assurance	BIC(25)247 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- Any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Group Chair, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Group Chair.
- Urgent business may be raised provided the Director wishing to raise such business has given notice to the Group Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- Directors / Board members should contact the Group Chair as soon as an actual or potential conflict is identified. Definition of interests – A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.
- When staff attend Board meetings to make presentations (having been advised of the time to arrive by the Board Secretary), it is intended to take their item next after completion of the item then being considered. This will avoid keeping such people waiting for long periods.



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

DRAFT
TRUST BOARDS-IN-COMMON MEETING IN PUBLIC
Minutes of the meeting held on Thursday, 9 October 2025 at 9.00 am
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Lyn Simpson	Interim Group Chief Executive
Emma Sayner	Group Chief Financial Officer
Amanda Stanford	Group Chief Nurse
Sarah Tedford	Interim Group Chief Delivery Officer
Dr Kate Wood	Group Chief Medical Officer
Murray Macdonald	Vice Chair (HUTH)
Julie Beilby	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG)
Gill Ponder	Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)
Prof Laura Treadgold	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Andy Haywood	Group Chief Strategy, Partnership & Digital Officer
Cameron Henser	XYLA Services (attending virtually)
Myles Howell	Group Director of Communications
Yvonne McGrath	Midwifery Director (For item 3.1.2)
Tracy Means	Nurse Director - Community, Frailty and Therapies Care Group (for item 1.3)
Simon Nearney	Group Chief People Officer
John Palmer	Trust Member
Ian Reekie	Lead Governor
David Sharif	Group Director of Assurance
Cllr Kevin Woolass	Member of the Public
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

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

1. CORE BUSINESS ITEMS

1.1 Welcome, Group Chair's Opening Remarks and Apologies for Absence

Sean Lyons welcomed Board members and observers to the meeting and declared it open at 9.07 am.

Sean Lyons thanked Sarah Tedford for all the hard work she had implemented and supported whilst at the Trust, it was noted that it was her last meeting due to her leaving the organisation at the end of October 2025.

There were no apologies for absence received for the meeting.

1.2 Staff Charter and Values

Sean Lyons reminded everyone of the Staff Charter shared at the meeting and highlighted that everyone should always adhere to this in terms of behaviours during the meeting.

1.3 Patient Story

Amanda Stanford introduced Tracy Means to Board members who would share the patient story.

Tracy Means shared the story of Mrs A who lived at home with her husband and three children near to Scunthorpe on behalf of Sarah Hart, District Nurse who had cared for this lady. Mrs A had sadly been diagnosed with Oesophageal cancer with liver metastasis. Tracy Means explained how the various community teams worked together for the family to have some time away together including linking in with the local GP Surgery of where they were staying in case of any support required in respect of her care. Tracy Means told of how Mrs A had unfortunately deteriorated when back at home in May. Discussions then had to take place with Mrs A and her husband in respect of the options they had in respect of her preferred place of care at end-of-life. This raised some queries from Mrs A and her husband which were resolved. Tracy Means explained how the family were supported during Mrs A's end-of-life care and what support was in place for them until she sadly passed away.

Tracy Means explained that the story reflected the essence of what community care could achieve in supporting patients and their families and what end-of-life care could be provided outside of a hospice setting. The lady's husband had said that people previously they had been made to feel that this could not be achieved at home, however, due to the work of the team they were pleased she was able to remain in her own home. She had received everything that she had wanted and that he could not be more grateful for this. It had shown that the team had not just delivered care but that they had honored their wishes and preserved a family's space and given her the gift of peace surrounded by the people who had loved her most. Finally, it reflected the compassion, co-ordination, and commitment that the community teams brought to families every day.

Amanda Stanford added that one of our quality priorities included end-of-life care and although it was recognised that within the hospital setting this was not always as it should be, this story had shown that in the community setting it was

done very well. She added that she had attended an end-of-life focus group the previous day and something that was hoped to be implemented as part of the quality priorities was “What matters to me”, and this story related to this.

Sean Lyons thanked Tracy Means for sharing the story of the family which must have been difficult. Dr Kate Wood also thanked Tracy Means for sharing the powerful story and asked her to thank the community colleagues; particularly for how they had co-ordinated the services to enable the lady to be at home.

Simon Parkes shared a personal story of a family member passing away whilst in hospital which had not been as positive. He felt this story showed how different this had been for this family in being respectful and supportive. It showed what could happen when patients were put front and centre during their care.

Tony Curry queried whether there was more that could be put in place for others in the same situation. Amanda Stanford advised that there was always more that could be put in place around end-of-life care and that there were certain areas that did not do this as well. She added that a badge had been developed for staff to say “Ask about Respect” to enable patients and families to ask questions. She noted that the community team had shown they were a leading light in the organisation for end-of-life care. It was recognised that families do not recover from a bad experience when family members passed away in hospital if it was not carried out in an appropriate and dignified way.

Sean Lyons highlighted that it had been a moving story and that all staff had gone out of their way including the services where the family had holidayed to ensure it was a positive experience for them.

1.4 **Declarations of Interest**

Sean Lyons sought declarations of interest from Board members, none were received.

1.5 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 14 August 2025 – BIC(25)171**

The minutes of the meetings held on the 14 August 2025 were accepted as a true and accurate record and would be duly signed by the Chair following the amendments listed below.

- Emma Sayner referred to page 16, item 3.5. It referred to unidentified Cost Improvement Plan (CIP) of just under £10 million, this should read £20 million.
- Simon Nearney referred to page 15, item 3.3. It referred to achieving 98% compliance with job planning by the end of October 2025, this should read 90%.
- Dr Kate Wood referred to page 2, item 1.3. It should refer to the NLaG Organ Donation Committee as she was the Chair of that particular Committee.

1.6 **Matters Arising**

Sean Lyons invited board members to raise any matters requiring discussion not captured on the agenda.

1.7 **Action Tracker – Public – BIC(25)172**

The following updates to the Action Tracker were noted:

- Item 4.2, 14 August 2025 – Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge – Internal Audit Recommendations. David Sharif explained that colleagues had been asked to close recommendations at the recent Group Risk & Assurance Committee and that KPMG had transitioned all the legacy internal audit recommendations successfully into the new system. Training had been undertaken with colleagues and the system now provided a good view of where they were including accessibility in terms of updates. Jane Hawkard had understood that the process would include low items being reviewed to identify whether they were still a priority, she queried whether that had also been undertaken. David Sharif advised that this had been undertaken as part of the communications and training by KPMG.
- Item 5.4, 14 August 2025 – Strategic Programmes & Partnerships Committees-in-Common Terms of Reference – clarification in respect of research. David Sharif advised a meeting had been held with the Non-Executive Director (NED) Chairs of the relevant Committees-in-Common. It had been agreed that clinical research should remain within the Quality & Safety Committees-in-Common, and that Terms of Reference would be updated to reflect this. The Capital & Major Projects Committees-in-Common was due to meet in October 2025, this meeting would then be closed down and the Strategic Programmes and Partnerships Committees-in-Common would start.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Chair's Report – BIC(25)173**

Sean Lyons referred to report and took it as read highlighting key points. He congratulated Murray Macdonald on his appointment as Interim Group Chair who would commence in the role on Monday, 13 October 2025. It was noted that Simon Parkes, Non-Executive Director (NED) would also be leaving the organisation at the end of December 2025. Sean Lyons wanted to recognise the service of three Governors, Jeremey Baskett and Rob Pickersgill who had served their maximum term as Governors and Diana Barnes, Public Governor who had also decided to step down from her role, he thanked them for their contribution at NLaG. Governor elections had just completed, there were still two vacancies where consideration would give given on next steps. Sean Lyons highlighted the incredible 62 years' service of Teresa Jackson; he had been delighted to have recently met her at her farewell presentation.

Sean Lyons thanked everyone for their support during his time as Group Chair, it was recognised it had been a journey but that he had been lucky to have worked with such a great team of staff.

2.2 **Group Chief Executive's Briefing – BIC(25)174**

Lyn Simpson referred to the report and highlighted key points. She explained that the improvement plan had been developed and that this had been put in place in response to the request from region, and nationally, to see sustained progress in improvement at the organisation. The plan had been developed to enable the organisation to make improvements in the short-term which would then include longer term developments over time. The longer-term included underpinning change in behaviours and attitudes. The Executives and Chief of Services had supported the development of the improvement plan to be submitted in November 2025. Discussions had also taken place with regional and national colleagues in respect of what support could be offered from them to accelerate improvement. Lyn Simpson explained that regional colleagues had asked what they could offer in respect of support. In response a request had been made in respect of the leadership level below the Executives as it was thought this would be helpful to develop their key demand and capacity skills. A response on this request was awaited. Secondly, a discussion had taken place with the national team on what they could offer, and although still in the infancy stages, they were reviewing who they could offer as support. Lyn Simpson explained that the plan was structured around three key points and that clinical ownership would be front and centre to the work and improvements.

Lyn Simpson referred to point two of the report and highlighted the expectations from NHS England. Lyn Simpson advised she had been asked to be the acute providers representative on the Integrated Care Board (ICB), she hoped this would be productive for the organisation. The first listening event had taken place to provide staff with the opportunity to share how they were feeling. This had been well attended and had identified themes which would be worked through on how they could be addressed.

Lyn Simpson explained she had visited the Hull University which had been an enjoyable meeting where she had met various professional groups from different organisations. This had been to establish an anchors leadership network which could prove helpful to identify what could be learned from in respect of retention and recruitment. A further meeting would take place before the end of the year, a workplan would also be developed from the group.

Lyn Simpson referred to the dashboard that was attached with the report and advised she would welcome feedback on what had been shared. It provided key points on where progress was being made.

Gill Ponder felt the dashboard had been helpful, she queried whether it could also include data around the current position of the finances and whether the position had improved or declined from the previous month. She added that it would be helpful to show the current position and improvements highlighting those that needed more attention and what was being put in place to resolve any issues. Lyn Simpson advised a quarterly update on those specific requests could be shared as a supplementary report. Tony Curry noted it was an excellent dashboard and queried whether it could also include issues around patient safety including complaints or safety incidents. It was agreed both finance updates and patient safety updates could be included as part of the dashboard.

Simon Parkes also welcomed the dashboard as it provided all the information on one page. He asked if there could be more focus on the narrative provided as that was important. One concern he had was in respect of the three elements of the improvement plan regarding what staff were additionally expected to undertake in respect of priorities. He queried whether this related to them or just the executives. Simon Parkes thought consideration should be given to the Committees-in-Common and Trust Boards-in-Common in respect of what issues were being discussed at meetings and how relevant that was to patient care, this could be shared through relevant chairs on how useful the meetings had been. Lyn Simpson noted the points made and felt that it was for the Committees-in-Common to have self-discipline on what issues where being considered and how productive the time spent on those issues were.

Helen Wright also welcomed the dashboard information being shared on one page and agreed it would be useful to highlight the finances on this too as some of the information shared in reports was difficult to understand due to lengthy reports. Emma Sayner noted the points made and explained that overall, it had showed that payment runs for non-pay had started to reduce significantly, linked to the run rate so there was a need to ensure grip and control continued. Helen Wright noted that in respect of finances there was transparency at the Committees-in-Common as to the current position.

Dr David Sulch queried whether widening of the arrows to highlight changes over several months was possible in respect of what had changed. Sue Liburd queried whether including the Chiefs of Service in the senior leadership team had been positive in respect of behaviours and accountability. Lyn Simpson explained that there seemed a greater clinical involvement with them. On a two weekly basis the Chiefs of Service were included in the executive team meetings, if they were unable to attend a representative would attend on their behalf. Two meetings had already taken place where discussions had been around performance, and reviewing what they would put in place. Five key points would be pursued to make a difference with subsequent meetings to ensure there was behavioural change. Following the meeting this week, communication had been sent to the Chiefs of Service to highlight what had been agreed, and be followed up to ensure progress was made in respect of holding to account. It was felt that the Chiefs of Service had left the meeting with a clear understanding of what they were accountable for.

Sean Lyons felt that the one page was a clear account of where the organisation was. Simon Parkes felt that better performance was achieved through accountability and those individuals being able to take control. Lyn Simpson agreed with the points made and explained that they had also been asked for ideas around any changes that may be required. Proposed changes had been made from the Chiefs of Services for the Emergency Department (ED) at both HUTH and NLaG, they were now working together to implement those improvements. There had also been a suggestion for the Chiefs of Service to advise executives on what they could support with in terms of “unblocking difficulties” that they may have.

Dr Kate Wood explained that there had been a meeting held the previous day with the Chiefs of Service where there had been measured positivity and more collective ownership of the challenges faced. It was noted that although ED was challenging there had been more positivity from those teams compared to the previous week.

Helen Wright championed the leading by example to ensure improvements were achieved as transformation started from the top down. She felt it was important to share this through communications to highlight what was being put in place. Sarah Tedford agreed and felt that transformation worked well with a single methodology with training provided for staff.

3. STRATEGIC PROGRESS

At this point it was agreed the sequence of the agenda would be changed.

3.1.2 Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH – BIC(25)177

Yvonne McGrath referred to the paper and advised that the Trusts were in a positive position in respect of the Clinical Negligence Scheme for Trusts (CNST) for safety action, one, two and three. In respect of safety action four, the paper showed details of the locum staffing audits which were compliant. It was noted that the results of consultant attendance in clinical situations had increased. The British Association of Perinatal Medicine (BAPM) standard had not been met at either Trust and it had been agreed that an action plan would be put in place to address this It would also be supported by the staffing paper due to be shared at the private Trust Boards-in-Common meeting that day for approval. It was noted that that the establishment paper also related to safety action five. Yvonne McGrath reported that the organisations were not compliant with the new birth rate plus.

In respect of safety action eight, Yvonne McGrath referred Board members to the action plan and progress report as there had been a commitment to train rotational medical staff that had commended on or after the 1 July 2025 to recover the position to 90% within six months of their start date.

In respect of safety action nine, Yvonne McGrath referred to the detail in the report of the perinatal deaths and noted the Maternity & Newborn Safety Investigations (MNSI) cases. The report also included the training compliance for that service. It was noted that the champion walkarounds were now in place and that feedback was being received from staff during the visits. She added that there had been no other concerns raised around external agencies. The Safety Champions for the Maternity Voices Partnership (MVP) and the perinatal leadership team had met within the Maternity Incentive Scheme (MIS) period. She further added that the Neonatal Culture Improvement Plan was being progressed, and work would commence on a dashboard for metrics on staff engagement and culture. The duty of candour was up to date and families had been notified as required.

In respect of safety action ten Yvonne McGrath reported that the positive overseas midwife experience continued. It was reported that although there had been 15.28 whole time equivalent (WTE) new midwives recruited, some had unfortunately not taken up those roles which had resulted in some gaps in establishment. It was noted that this was why the service did over recruit as this had occurred previously. There were also 16.5 WTE staff on maternity leave within maternity services. It was noted that NLaG was in a more positive position in terms of vacancies. It was reported that there had unfortunately been a spike in neonatal deaths and that a deep dive had, therefore, been undertaken with an action plan being put in place. Oversight for this would be through the Quality & Safety Committees-in-Common. Staff engagement continued with further developments on the staff intranet pages.

Yvonne McGrath advised that the pressure continued in neonatal services, however, matrons were working well in terms of moving patients and babies around as required. This did mean safety was maintained although it had been challenging for staff. Jane Hawkard queried whether any trends had been identified in respect of perinatal deaths. Yvonne McGrath explained there had been several babies born at 22 weeks and that some had congenital abnormalities; however, no trends had been identified.

Lyn Simpson explained that a meeting had been held with the Chief of Service in that area to provide assurance that there were no concerns that needed to be raised. A deep dive had also been held into each baby's death to provide explanation as to what had taken place around the birth and the after care. This had provided assurance that there had been openness and transparency around each case and that there had been no trends. It was recognised that there needed to be more understanding in respect of the did not attend (DNA) rates in ante-natal care as they had been high in the more deprived areas. Yvonne McGrath advised there was a tool available through the Royal College of Midwives (RCM) which would enable capturing grading levels of immobility that could support some of the work being undertaken. A review would also be undertaken on continuity models and looking at those women whose first language was not English, to provide additional support where required.

Jane Hawkard recognised that there had been concerns raised and some actions remained amber. She queried whether there was confidence that issues were being addressed. Yvonne McGrath explained that some of the actions had remained amber, however, some would be updated following the meeting today due to the update being provided to the Boards. She added that a meeting was held every Friday and that CNST actions were discussed during this time.

Amanda Stanford explained that training of medical colleagues remained a challenge; in some instances, clinical staff were registering attendance, however, they had not been staying for the full session. In those instances, this was being escalated and addressed. One option being considered was that when clinical staff rotated, they would be spoken to highlight what training they had to undertake to ensure they were compliant.

Yvonne McGrath referred to saving babies' lives and advised positive meetings had been held over the month, the guidance did detail that best endeavours must be put in place and that was what the teams had been doing, progress continued with this. Whilst 100% was not being achieved, it was being shown that there were best endeavours to reach full compliance.

Tony Curry queried whether there was confidence in respect of the service and the sustained improvements made on the journey so far. Yvonne McGrath explained that the service was fully staffed, however, there were gaps due to staff maternity leave. Further discussions would take place in respect of recruitment with the option of over-recruiting, as this would always be the case.

Lyn Simpson referred to the sickness absence on the neonatal unit as she felt this was something that could be supported; she queried what the proportion of sickness and maternity leave was in that area including recruitment figures. She noted that this was a responsibility of the Boards to manage this. Yvonne McGrath advised that there were a considerable number of staff on sickness policy

monitoring, it was noted this was 30%. Yvonne McGrath explained that a deep dive had been undertaken in respect of the high-level sickness absence and that this was being managed appropriately. It was recognised that there were several reasons for this, which were being reviewed to return staff to work more quickly.

It was noted that there were issues nationally in respect of limited beds for neonatal care, a senate was due to be undertaken to review the situation. Sue Liburd highlighted that there was also a higher level of sickness when there were neonatal deaths due to the pressures and how this affected staff's psychological impact. Yvonne McGrath highlighted that during those periods staff were supported as it was recognised it was difficult. Amanda Stanford added that those staff also received psychology support where required.

Sean Lyons referred to information that Yvonne McGrath had previously shared with him describing the trends in maternity attitudes. He felt that this would be useful for other Board members to have sight of this.

Action: Yvonne McGrath to share with Board members information on one page in respect of trends in maternity attitudes

Simon Nearney referred to the detail that had been shared in respect of 30% of staff being off sick from work. He noted that this did not mean 30% were off sick, it was those staff that had been identified and were receiving support for attendance. Yvonne McGrath explained that there was a more robust process in place for sickness absence than there had been previously. Simon Nearney advised that managers were following the sickness absence process which was working better than it had previously.

Sean Lyons thanked Yvonne McGrath for sharing the report.

Julie Beilby felt it was difficult for the Boards to say they were assured in respect of the information shared due to further discussion that would be undertaken in the private part of the meeting around staffing as the view could change in light of the outcome of discussions in that meeting. David Sharif noted the point made and explained that the Boards were receiving assurance form the Committees-in-Common in respect of the information presented. It was recognised further consideration would be needed in respect of assurance once the private item had been discussed. Julie Beilby felt that the assurance also included the resources and capacity in that service and that assurance should be provided on that point in totality. Jane Hawkard referred to the paper and noted that the paper did provide low assurance from the Committees-in-Common which could also improve if the staffing papers were approved.

3.1.1 **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(25)176**

Sue Liburd referred to the report and highlighted key points of escalation noting the learning lessons to provide a deeper level of assurance in respect of the cluster of neonatal deaths as previously discussed. In respect of the service user feedback, it was reported that despite levels of assurance and governance processes, the service user feedback had been positive. It was noted that considerable work had been undertaken in respect of the service including the MVP Leads which were now fully integrated to support feedback received. Issues had previously been

raised in respect of Bangladeshi patients in the community due to the language barrier, this had been responded to immediately in respect of the translation services that supported this.

Sue Liburd wanted to finally note that in respect of the staff experience and feedback, there had been discussion around the skills mix in terms of the level of experience. One issue identified was that units had several members of newly qualified inexperienced staff; she added that this was sometimes the issue of concern rather than how many staff were in particular areas.

Sue Liburd was pleased to report that the Maternity Support Workers (MSWs) had been positive on recent walkarounds following the recent dispute that had now been settled. Dr David Sulch explained that during walkarounds staff were raising concerns, however, they did also offer solutions for those raised but they were often unable to implement them. Concerns often raised were around space, it was felt that it was important that if changes were expected to be made then required support should be offered for those staff to enable them to share ideas.

Murray Macdonald felt that following discussions there was a risk in respect of some of the communities in terms of the demographics of some patients which could then be impacting on those ladies presenting with poorly babies. He queried whether this could be raised in the safety champion space to review options that could be considered to ensure improvements were made. Dr David Sulch explained that part of the visits had included the community teams and that those queries had been raised with them, it was felt that this could be explored further. Amanda Stanford advised that when she had worked at a previous Trust a health and equalities dashboard had been created that highlighted where the highest rates of DNAs where. She felt that accessing that kind of data would move this forward, as it did not appear to relate to issues in respect of distance for those patients not attending appointments.

Simon Parkes queried to what extent this related to patients having busy lives when required to attend appointments and whether that had been considered. Amanda Stanford explained she had previously worked in a place that had considered this and that a maternity circle had been implemented outside of the hospital in a community setting. This allowed engagement to be undertaken differently which had seen improvements. She added that implementation of this would require a system approach due to the investment required. Sue Liburd explained that there were good examples within this patch that could be learned from.

Sue Liburd added that the maternity report shared at the Boards would be reviewed and modified going forward as it was recognised it was a lengthy report.

At this point the meeting reverted back to the agenda sequence.

3.1 **Patients – Safety (including Assurance Committee Update) – BIC(25)175**

Amanda Stanford referred to the report and noted key points. She wanted to assure colleagues that issues had received scrutiny at the Quality & Safety Committees-in-Common. She advised that the report would be more streamlined going forward, and that as it evolved it would triangulate the data to provide more assurance to the Boards.

Amanda Stanford reported that there were some patterns in the metrics for pressure ulcers and falls, there would be a need to understand why this had occurred. Feedback would be provided through the Quality & Safety Committees-in-Common highlights. It had been noted that falls appeared to increase over the weekend period which would be reviewed further. Incident reporting had increased, and it was recognised that was positive for the Trusts to learn lessons. In respect of complaints, it was reported that they were slightly higher than previous years, this related to both organisations. There had been some issues around the quality of complaints which was being addressed with the teams. One improvement that had been noted in respect of complaints was that there had been a reduction in complaints being re-opened.

Amanda Stanford explained that work was being undertaken in respect of the safety culture of the organisations as this needed to improve with positive discussions taking place.

Gill Ponder referred to the points made around pressure ulcers and falls and queried how this triangulated between the risk of a fall and the avoidance of keeping those patients in bed to avoid pressure ulcers. Amanda Stanford advised this was a common risk, often as falls reduced pressure ulcers did increase. Work was being undertaken with the teams to identify how to address all of those issues. It was noted that there was a greater risk of patients having falls and pressure ulcers if they stayed in hospital for longer periods.

Dr Kate Wood referred to the never events over the last year as it was recognised there had been a high number of incidents which was unacceptable. She added that meetings were to be arranged over the next month with the multi-disciplinary teams to identify what could be done differently to support change whilst ensuring this was addressed. There would also be discussions at the next round as it was recognised that never events did not only occur during surgical procedures.

Dr Kate Wood requested that the wording in the Quality & Safety Committees-in-Common highlight report was changed. The report stated an external review of Transcatheter Aortic Valve Implantation (TAVI) had been commissioned. She highlighted that an external reviewer had been working with HUTH for the past 18 months. The report also referred to pathway compliance, she advised that this referred to a commission between the Trust and NHS England into a cardiology governance review and not in respect of pathway compliance. Dr Kate Wood asked if Sue Liburd and Dr David Sulch were happy for the amendments to be made. Sue Liburd agreed with the change to the highlight report, she added that the item had received significant assurance and that this had not been undertaken lightly.

Dr Kate Wood noted that it was important to keep visibility on Martha's Rule as the organisation went into the second pilot phase. It was noted that this was not yet rolled out across the organisation, it was recognised that publicly this may not be understood due to being in the pilot stages. A piece on communicating this to clinical staff would be shared to ensure that staff were aware of how to deal with this if it was requested by families.

Simon Parkes referred to the duty of candour and queried why this had been so poor as there were not many of them. Amanda Stanford explained this had been recognised and was being addressed with the teams due to issues within both

Trusts. She noted that all infections were reported as moderate harm which meant they then required a duty of candour. It was recognised that this was not necessarily a requirement around duty of candour and so needed further discussion. There was in place a trajectory and improvement plan and that on the Ulysses reporting system there was a mechanism around duty of candour for producing a response. It was reported that it was the follow up to the written apology that was the issue that needed to be resolved, this would have oversight through the Quality Improvement Group (QIG) and would then be reported back to the Quality & Safety Committees-in-Common. Lyn Simpson agreed with the point made as there was a need to ensure that the basics were correct, she was happy to support Amanda Stanford with the duty of candour.

Lyn Simpson queried why Martha's Rule had not been rolled out across the organisation as it had been in place for some time, she felt this should be adopted across the organisation. Dr Kate Wood advised this was due to ensuring appropriate members of staff had awareness of escalation routes, and that work was being undertaken around this. Lyn Simpson queried why that was the case as the Boards needed to understand and ensure that the organisation was acting in accordance with instructions. Dr Kate Wood explained that escalation routes were in place and that clinical teams were aware of that, however, the issues were around making sure that there was sufficient staff available in the delivery. In respect of paediatrics, the requirement was that there should be a second opinion option, the Trust did not currently have appropriate staff on a twenty-four seven-hour basis to make a second opinion. Lyn Simpson advised she would like the organisation to be in a position to adopt this further. It was agreed further discussion would be undertaken outside of the meeting with an update being provided to the Trust Boards-in-Common.

Action: Dr Kate Wood and Lyn Simpson to provide an update on adopting Martha's Rule across the organisation

Murray Macdonald queried what the position was in respect of infection prevention and control. Amanda Stanford explained that in respect of the Carbapenemase-producing Enterobacteriaceae (CPE) cases this was still ongoing on the South Bank and that there had been 180 cases since this had begun. A meeting was still being undertaken on a weekly basis to monitor this. There continued to be cases of Clostridioides Difficile (C. diff) at both Trusts, however, neither organisation was an outlier for this. She added that audits on cases still indicated that staff were not adhering to basic infection control at every level across the organisation. The Care Quality Commission (CQC) had fed back that in ED staff appeared to not see this as patient care during busy times by not always adhering to this. Amanda Stanford explained that two Practice Development Nurses had been appointed and that there had been changes of how the Care Groups worked in respect of IPC. It was noted that the Human Resources Policies were being developed to address non-adherence of staff not applying IPC. Amanda Stanford explained there was more work required in respect of this and that Dr David Sulch would also support some of the work being proposed.

Murray Macdonald felt that several of the issues being highlighted appeared to relate to our culture of safety. He therefore, queried whether this needed to be higher on the agenda to ensure it was addressed. Amanda Stanford agreed with the point made and advised this clearly needed to improve. It was felt that this related more to cultural issues as processes were in place to adhere to. It was

noted that staff did recognise when practice was not adhered to. However, they did not have the confidence to speak up and highlight this to particular staff which also linked to a psychological safety aspect. She added that the human factors training would support this change going forward.

Dr David Sulch noted that the mortality rates had improved. In respect of the patient safety report shared it had been recognised this was too lengthy. A time out session would review what should be included in the report, Dr David Sulch asked if board colleagues could feedback on what information they would also like included in the report.

Action: Board colleagues to feedback on what they would like included within the Patient Safety report going forward

Amanda Stanford explained that one of the best approaches to maintaining IPC was consistency which was a requirement of all staff, challenge was also key to addressing such issues in respect of staff entering clinical areas. Simon Parkes felt there needed to be a way of creating challenge for everyone when required to ensure improvements were made in respect of IPC.

Julie Beilby felt that too often the basics were not applied in respect of behaviours and this was not acceptable. She queried at what point people would accept personal accountability and whether there would be any consequence of the continuation of inappropriate behaviours. Sarah Tedford explained that issues were not often being escalated at the time which meant it was more difficult to address them. She added that staff speaking up needed to be done better. Helen Wright noted that meeting date referred to the 26 June and it had been the 25 September 2025.

3.2 **Patients – Performance (including Assurance Committee Update) – BIC(25)178**
Cancer / Urgent & Emergency Care / Referral to Treatment / Diagnostics

Sarah Tedford referred to the paper and noted key highlights. She reported that the Referral to Treatment (RTT) waiting lists had reduced due to treatments being undertaken and that validation continued, however, the reduction in long waits was not as expected. A request had been made for the intensive national support team to review what improvements could be put in place. It was noted that as the organisations had patients waiting over 18 and 52 weeks and that the organisation was in tier one. As a result meetings were being held with NHS England to review plans for oversight and progress. In respect of diagnostics, it was noted that the Group were an outlier for six week waits. One area of concern in respect of waiting lists was endoscopy. It was noted that the recent pay dispute at NLaG had significantly increased the waiting lists, and this had not reverted to where it should be.

Sarah Tedford reported on cancer performance and explained that the back log of patients was currently being addressed, this was across all specialties. In respect of the 62-day treatment there had been improvements from 48% to 55%, it was noted there still needed to be improvements in this area; however, this was moving in the right direction. Urgent & Emergency Care (UEC) was currently behind plan, due to increased attendances in that area, this also related to those being admitted staying for longer periods. It was reported that attendances had increased across

the country, however the organisation was an outlier on those being admitted and the length of stay. It had been agreed this needed more focus.

Sarah Tedford advised that the excellent work continued within the system on no criteria to reside (NCTR), and this had reduced from approximately 90 patients to 75 that week. Thanks were noted for colleagues that continued to progress with this. It was noted this needed to be sustained. Progress would continue with NHS England to ensure there was a programme of work to ensure this was reviewed weekly as improvements were still required. The continuous flow model was being worked through with NHS England, discussions were also due to take place with another organisation that had this in place.

Sarah Tedford reported that there had unfortunately been a patient waiting in ED for more than 50 hours which was unacceptable, and that this issue was being reviewed further. The director of the day continued in this area where improvements had been made to support the teams, this would be revisited to review whether any further improvements could be made. The Emergency Care Support team were now on both sites with enhanced support, they were reviewing what could be improved within ED. The concerns clinicians had raised related to not being able to improve the non-admittance position due to the number of patients lodged in the department. Two ED consultants that worked with NHS England were coming to support and review what could be put in place to ensure there were improvements. NHS England had been pleased with the changes at HRI in respect of the streaming of patients at the front door. The final area reviewed would be weekend discharge initiatives to ensure there were improvements in that area too, part of this would be enhanced discharge teams.

Tony Curry queried whether the Community Diagnostic Centres (CDCs) were working well and what the impact had been those being in place. Sarah Tedford explained that this had been working well, a dedicated manager had been introduced who was working with the specialties and GP partners to optimise those facilities. Sarah Tedford reported that she had recently attended the Health & Wellbeing Board on the South Bank and she had highlighted that facility there.

Simon Parkes referred to the patient that had waited 50 hours in ED and queried whether there had been consideration that having a senior member of staff attending that area whilst there were long waiters to ensure there were improvements with flow. Sarah Tedford advised she often visited the ED areas, however, on this occasion she had not been made aware of this. Had this been escalated, she would have addressed the issue at the time. She added that this was unfortunately being raised more often due to issues not being escalated at the time they occurred. She assured Board members that those aspects were being addressed. Lyn Simpson requested that Amanda Stanford and Sarah Tedford could share the WTE numbers of support staff for flow as that would show where further work was required, and to highlight what staff were in place in particular areas.

Helen Wright reported from the Performance, Estates & Finance Committees-in-Common perspective and advised that the reason for limited assurance was due to the level of performance being seen and that this could not be tolerated any further, the committees had not felt that transformation was occurring as it should be. Helen Wright thanked Sarah Tedford on behalf of the committees as there had been more clarity under her leadership than there had been previously. She noted

that seeing the trajectories on the Group Chief Executive dashboard would be welcomed.

3.3 **People (including Assurance Committee Update) – BIC(25)179**

Simon Nearney referred to the report and noted that the Workforce, Education & Cultures Committees-in-Common were sighted on the issues within the report. It was important to recognise that in respect of the People Strategy that those relevant reports were being shared at the committees.

In respect of cultural engagement, it was felt that there would be further improvements due to the plan in place and the key priorities being identified to progress this work.

Simon Nearney advised that the national staff survey had been launched, and currently the national average for completion was 14%. However, the organisation was just above this as 15% of staff at NLaG had completed this and that 19% had also completed this at HUTH. It was hoped that there would be an achievement of 60% for completion.

Simon Nearney explained that access to Bridget had improved with the relaunch and that 14,000 staff were now accessing this than the previous 9,000 staff. In respect of the flu vaccinations, 2,000 staff had received the vaccine in the first seven days which had been an improvement on previous years. A programme for staff to receive vaccines was in place across all five sites with reporting of this to the Executive meetings and Workforce, Education & Cultures Committees-in-Common. The completion of the staff survey was also being reported to the Chiefs of Service for their areas.

Simon Nearney highlighted further points from the report and advised that agency pay remained an issue and that this was behind plan. This was in respect of medical staff; the approvals process had been strengthened for anything that was over a week. In respect of nursing spend, the onboarding nurses due to join the organisation would address some of that overspend.

Simon Nearney reported that the Health Care Support (HCSW) terms had now been agreed, back pay would be received from the end of October 2025. The consultant NLaG dispute continued, however, a final offer had been made, and agreement was awaited of this. Simon Nearney referred to the report highlighting the current statistics around workforce and job planning. Although job planning was still not where it should be, discussions would be held with the Chiefs of Service to address this. It was noted that as of today this was at 57.9%.

Simon Nearney reported that the organisation development (OD) team were working with different teams across the organisation. In respect of mandatory training work continued, new staff to the organisation would now have their mandatory compliance moved across to their record from a previous trust when they joined the organisation. He added that the Trusts were also marshalling the local mandated training and role specific, groups would review what was required as role specific and what was mandatory.

Simon Nearney advised that a recent General Medical Council (GMC) survey for resident doctors had been poor. A programme for this would be implemented and discussions would be held with Chiefs of Service in respect of this.

Simon Parkes queried whether there was any evidence that linked job planning to performance and productivity as to whether this made a difference in practice. Simon Nearney explained that job plans could identify the direct clinical care undertaken including what support there was on each individual's activity in respect of what they could deliver. Simon Parkes noted the point made, however, queried whether it made a difference. Simon Nearney explained that overall most of those individuals had a job plan, however, this was out of date. It needed to be reviewed to ensure it was in line with the activity required for the organisation. Dr Kate Wood explained that job planning compliance had fallen, however, this was due to the system change on forming of the group. The company that was used would not allow for previous job plans to be moved across due to the licence regulations. It was noted that job planning provided a baseline for the capacity within the service. Operational colleagues did not always have data available to match capacity, this, therefore, supported that. It was hoped that this would be in place before the organisation went into planning for the next year. Dr David Sulch explained that job planning deployed the clinical resource where it was needed in terms of demand which did mean there would be improvements in productivity.

Julie Beilby reported that the Workforce, Education & Cultures Committees-in-Common felt that ensuring the basics were in place would support improvements. It was recognised that although some policies were still separate for the Group they should still be adhered to and focussed on. Sean Lyons referred to the medical education report and queried whether it had been anticipated that poor feedback would be received. Dr Kate Wood explained that early results had been shared with the committees in July 2025 and that the Guardian of Safe Working Hours had shared the position through regular reports. She added that to address this each Care Group would need to own its own action plans for their area. This should also include using information from the national training survey and the outcomes of improving resident doctors ten-point plan from NHS England.

Julie Beilby referred to the quarterly pulse survey and advised that there had been a challenging discussion around assurance, and that the reason for reasonable assurance was due to comparing our performance, that had not declined, compared to the declining national average.

Sue Liburd referred to the HCSW issue regarding re-banding and queried whether those that had not wanted to move to a band three would suffer detriment over time and still take on those roles. Simon Nearney advised all staff had been met with and that there were two clear job descriptions in place for the band two and band three roles. It had been agreed that if those band two staff wanted to progress to a three there would be an opportunity for this.

3.4 **Population – BIC(25)180**

Amanda Stanford referred to the report and took it as read. She explained that this referred to the health inequity data to apply to the services that were provided. Some services would need to be addressed sooner than others. Gill Ponder queried if there was any data on access to services and whether that would be shared. Amanda Stanford advised that this would be the case and that she had

previously undertaken some work that had shown some disadvantages. In the future this paper would highlight that data to support that work going forward in respect of systems and processes in place. Gill Ponder recognised that there was a high rate of DNAs which would link into productivity and finances, she felt that reviewing this would also address that. Amanda Stanford agreed with the point made and advised this would also be addressed.

3.5 **Public Purse (including Assurance Committee Update) – BIC(25)181**

Emma Sayner referred to the report and highlighted key points noting that the month 5 position was included within the papers for information. She advised that the run rate had stabilised, however, more improvements were still required. There was due to be some quarter three deficit support funding received and the organisations portion of this would be just under £6 million. At the recent NHS Chief Financial Officer session, there had been discussion in respect of grip and control and back to basics. There had been several speakers at the session which had been informative. There was expectations of a mid-year review where there would be key focus of what was being undertaken including workforce costs and agency spend.

Also referenced in the paper was the work around the deconstruction of the block contract. The national teams wanted more understanding on what was being undertaken in terms of that funding.

Murray Macdonald referred to the workforce plan as it detailed that agency spend was off target by £4.3 million and that this paper referred to agency being off by £0.3 million, he queried how that would be bridged together. Emma Sayner appreciated this needed to be undertaken better overall, the position forecast would be nearer the £45 million which would be supported by a triangulation piece of work. It was recognised that the WTE did not necessarily align to the finances which needed to improve.

Murray Macdonald explained he had attended a regional meeting the previous day where it had highlighted that the expectations around the H2 (half-year) review would be that board members needed to be able to explain overspend on agency. Emma Sayner agreed with the point made and added that the bank, agency and waiting list initiatives backed up core services which should not be the case, meaning that spend should be more aligned to substantive posts.

Dr David Sulch referred to the highlight report at point seven as it stated that the lack of weekend consultancy and senior cover was being referred to the Workforce, Education & Cultures Committees-in-Common, he queried what this referred to. Helen Wright explained this was in respect of performance as it seemed that the organisation operated a five-day service and that not enough staff were available through the night and over the weekend period. Emma Sayner added that there was also a financial aspect due to this as the organisation were paying premium costs with no significant output from those individuals on site which was also driving financial pressure.

Helen Wright reported that the Finance, Performance & Estates Committees-in-Common had reviewed month four and five and that improvements had been noted in respect of run rates. There were also some gaps closing in respect of the overall forecast. The gap had moved from £25 million to £15 million which highlighted

those improvements. It had been felt that although the organisation had signed up to reducing agency costs, it would not be practical to deliver on those numbers which was why the committees had given limited assurance. Helen Wright wanted to commend Emma Sayner, Ivan McConnell and the teams on the work being undertaken as more data was being provided than previously which had allowed more discussions.

Jane Hawkard referred to the implementation of LUNA ROVA as it had originally be advised that this would be implemented from December 2025, however, this was now due to be March 2026; she was concerned that this delay may mean it not having any impact on waiting lists. She felt that there should be discussions held to advise that this would not be tolerated in respect of the delay.

3.6 **Partnerships – BIC(25)182**

Andy Haywood referred to the report and noted key points advising that the Strategic Programmes & Partnerships Committees-in-Common would have oversight for this work going forward. Andy Haywood reported on the changes in various leadership roles within our region which may mean some challenge within the system. It was reported that within this there would be some opportunity for the organisation as it accounted for 42% of the allocated funds as we looked after four of the six Patient-Led Assessments of the Care Environment (PLACEs) in the Integrated Care System (ICS). Andy Haywood referred to the report and noted highlights. It was reported that governance processes were being reviewed in respect of how we employed stakeholders and who engaged with those people. Andy Haywood wanted to thank Moira Angel and Mark Graham from the Improvement Team for their work around this.

3.7 **Pioneering (including update on Electronic Patient Record (EPR)) – BIC(25)183**

Andy Haywood referred to the report and noted key highlights. It was reported that the full business for the EPR system would be shared with the Trust Boards-in-Common shortly, it was noted that the organisation had been successful in gaining an additional £15 million to support the implementation. There would be further discussion required in respect of the Business Case for Boards approval. He thanked staff members who were involved in the EPR for progressing this.

4. OTHER ITEMS FOR ASSURANCE

4.1 There were no items for assurance shared at the meeting.

5. OTHER ITEMS FOR APPROVAL

Sean Lyons sought approval of the items shared at the meeting, it was noted all papers had been discussed at the required Committees-in-Common meetings.

5.1 Workforce Disability Equality Standard (WDES) – BIC(25)185

The Trust Boards-in-Common approved the Workforce Disability Equality Standard.

5.2 Workforce Race Equality Standard – BIC(25)186

The Trust Boards-in-Common approved the Workforce Race Equality Standard.

5.3 Winter Plan – BIC(25)187

The Trust Boards-in-Common approved the Winter Plan.

5.4 Clinical Strategy – BIC(25)208

The Trust Boards-in-Common approved the Clinical Strategy.

5.5 Group Lottery Bank Account – BIC(25)209

Sean Lyons referred to the Group Lottery Bank Account approval and requested Boards approval. Julie Beilby had some concern regarding this suggestion as it would mean moving from two smaller charities to something under the Gambling Commission. She felt the organisation needed to be sure that there was sufficient capacity to run this due to the onerous task this would bring.

The Trust Boards-in-Common approved this in principal and there was agreement that the bank account would be opened.

Myles Howell agreed to provide a full paper on the proposal moving forward to be shared at the Workforce, Education & Cultures Committees-in-Common, the Trust Boards-in-Common agreed to the proposal.

Action: Myles Howell to provide a report on the proposals for the Group Lottery to the Workforce, Education & Cultures Committees-in-Common

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 **Items for Information / Supporting Papers**

The following items for information were shared.

- Quality & Safety CiC Minutes – July 2025
- Infection Control Annual Report
- Performance, Estates & Finance CiC Minutes – August & September 2025
- Finance Report – Month 5
- Fire Annual Report & Work Plan
- Group Annual Security Report
- Workforce, Education & Culture CiC Minutes – July & August 2025
- Guardian of Safe Working Hours – Quarter One Report
- Guardian of Safe Working Hours Annual Report
- Group Performance Report (GPR)
- Trust Boards & Committees Meeting Cycle 2025 & 2026
- Documents Signed Under Seal
- Board Assurance Framework (BAF)

7. ANY OTHER URGENT BUSINESS

Sean Lyons sought items of any urgent business from Board members. None were received.

Emma Sayner referred to the earlier query from Murray Macdonald in respect of the £4.3 million, she advised that this was comparing the actuals for 2024/25 to 2025/26 and the requirement to reduce by 30%, the £0.3 million was against budget.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from members of the public in attendance. It was noted that questions had been submitted prior to the meeting by John Palmer.

David Sharif referred to questions asked by John Palmer prior to the meeting. The first question was whether the decision to join NLaG and HUTH together was taken with the knowledge of the Hull Royal Infirmary (HRI) site and the issues that it currently had. David Sharif advised that the issue concerning the materials was first brought to the organisations attention in May 2025 following a classification change in materials that arose in 2024. At the time the Group was formed the risk profile around the tower had not changed. The organisation were already reviewing various areas of defect from the installation which had been ongoing since 2019; several issues had been raised with relevant parties. As these proceedings were live and submit to contractual discussions there could not be any further comment.

The second question raised was in respect of automated letters that were still being sent to patients with incorrect phone numbers on them. David Sharif advised that the governors' vigilance was appreciated and that this had enabled the organisation to take the information and correct those issues, he requested that, with appropriate permission from the individual, could the names of those patients including their date of birth, and either the NHS Number or hospital number be shared to allow further investigation.

The final question was in respect of Goole & District Hospital (GDH) and the access capacity for the dermatology service. David Sharif explained that the ICB had now concluded their engagement, the report following this would be produced by the end of October 2025. The key issues related to access of local services, travel and transport, delivery of services to best meet population health needs and the need for wider partnership working. The Programme team had mobilised several workstreams which would be developing comprehensive business cases over the next six months to meet those population health needs. It was reported that this was a comprehensive programme of work with multiple dependencies between workstreams and on other planned work within the local community. He added that the programme was governed through a Programme Board, supported by delivery workstreams and was also an integral partner in the wider ICB led Local Reference Group looking at population health needs.

A further query was raised in respect of the pathology forms used at the organisation, the forms had no mention of GDH on them. Sean Lyons requested that the information was shared to allow this to be reviewed. Secondly, it was advised that GDH produced 70% of its own electricity and yet it was still being under-utilised despite being an energy efficient hospital. It was queried why this

was being left to degrade as from a financial perspective this was not seen as looking after the finances. A request was made that the Boards considered this.

Murray Macdonald advised that as it was Sean Lyons final meeting, he wanted to thank him on behalf of colleagues. It was reported that he had been key in bringing the two separate Trusts together as a Group and that he had guided this through for which he should be commended. Murray Macdonald advised that staff had reflected on Sean Lyons as an individual and had commented on the fact that he was personally interested in colleagues as people and that he had spent time listening to what colleagues and patients had shared because he really did care. Murray Macdonald advised that the Boards would continue to do their best following his departure to build on his legacy of high standards.

Sean Lyons thanked Murray Macdonald for his kind comments, he wanted to thank everyone for their support for which he was grateful.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 There were no matters referred to the Committees-in-Common.

10. DATE AND TIME OF THE NEXT MEETING

10.1 **Date and Time of the next Boards in Common meeting:**

Thursday, 11 December 2025 at 9.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 12:58 hrs.

Cumulative Record of Board Director's Attendance 2025/26

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	4	4	Simon Parkes	4	4
Jonathan Lofthouse	0	0	Gill Ponder	4	4
Lyn Simpson	2	1	Emma Sayner	4	4
Julie Beilby	4	4	David Sharif	4	4
Tony Curry	4	3	Amanda Stanford	4	4
Linda Jackson	3	2	David Sulch	4	4
Jane Hawkard	4	4	Sarah Tedford	4	4
Sue Liburd	4	4	Laura Treadgold	4	2
Murray Macdonald	4	4	Clive Walsh	2	2
Ivan McConnell	2	2	Kate Wood	4	4
Heather McNair	1	1	Helen Wright	4	4
Simon Nearney	4	3			

JOINT NLaG COUNCIL OF GOVERNORS ANNUAL MEMBERS' MEETING & HUTH ANNUAL GENERAL MEETING

Minutes of the meeting held on Wednesday, 22 October 2025
at 14:30 to 17:00 hours via MS Teams Live

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Interim Group Chair
Ahmed Aftab	Staff Governor
Kevin Allen	Public Governor
Paula Ashcroft	Public Governor
Diana Barnes	Public Governor
Jeremy Baskett	Public Governor
Mike Bateson	Public Governor
Cllr Paul Henderson	Stakeholder Governor
Brent Huntington	Public Governor
David James	Public Governor
Corrin Manaley	Staff Governor
Rob Pickersgill	Deputy Lead Governor
Ian Reekie	Lead Governor
Dr Sandeep Saxena	Staff Governor
Dr Gorajala Vijay	Public Governor
Jackie Weavill	Staff Governor

Executive & Non-Executive Directors, Guest Speakers and Production:

Dr Faisel Baig	GP & Medical Director for Primary Care – NHS England - North East & Yorkshire
Adrian Beddow	Associate Director of Communications & Engagement
Julie Beilby	Non-Executive Director
Brian Clerkin	Director, Sumer AuditCo NI Ltd
James Collins	Director, Forvis-Mazars LLP
Tony Curry	Non-Executive Director
Cristhine De Castro	Deputy Ward Manager (Ward 5)
Tegan Grey	Clinical Sister (Ward 5)
Andy Haywood	Group Chief Strategy, Partnerships & Digital Officer
Myles Howell	Group Director of Communications
Alison Hurley	Deputy Director of Assurance
Veronica Moya Del Saz	Ward Manager (Ward 5)
Simon Nearney	Group Chief People Officer
Sue Liburd	Non-Executive Director
Debbie Lowther-Dand	Care Navigator (Ward 5)
Gill Ponder	Non-Executive Director
Emma Sayner	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Lyn Simpson	Interim Group Chief Executive
Rebecca Thompson	Deputy Director of Assurance

Dr Kate Wood	Group Chief Medical Officer
Simon Leonard	Communications Assistant (Teams Live Producer)
Suzanne Maclennan	Corporate Governance Officer (minutes)

Attendees:
Jennifer Allen, Rebecca Atkinson, Jennifer Clarke, David Cuckson, Marian Davison, Tega Eghagha, Adam Foster, David & Carol Hughes, Rachel Johnson, Jasmine Lee, John Palmer, Katrina Vorley, Mike Waites, Carol Wattam and Carl Wheatley.

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Interim Group Chair, Murray Macdonald, welcomed those present to the first joint NLaG Council of Governors (CoG) Annual Members' Meeting (AMM) and HUTH Annual General Meeting (AGM) which was held virtually via Microsoft Teams Live. Those present were advised the meeting would be recorded and available to view on the websites of both Trusts. Murray Macdonald paid tribute to Sean Lyons, the former Group Chair, who had recently resigned and expressed sincere thanks for his leadership and guidance through the formation of Humber Health Partnership (HHP). An overview of the agenda was provided which outlined the focus of the meeting and notable key speakers. The ability to submit questions via the question and answer (Q&A) facility was noted, with confirmation that these would be addressed during the meeting where possible. Any questions not provided with a response during the meeting would be followed up after the meeting and all questions and answers would be published on the websites following the meeting.

Alison Hurley provided details of apologies for absence for Public Governors' Wendy Lawtey and Clare Woodard and Stakeholder Governor, Cllr Linda Bayram.

Apologies were also received for Amanda Stanford (Group Chief Nurse), Sarah Tedford (Interim Group Chief Delivery Officer) and David Sulch (Non-Executive Director).

It was noted that Dr Faisel Baig would be joining the meeting at 16:30 hours for agenda item 3.2

1.2 Declarations of Interest

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

1.3 a - To receive the approved minutes of the previous NLaG Council of Governors (CoG) Annual Members' Meeting (AMM) held on 12 September 2024

The minutes of the NLaG CoG AMM held on the 12 September 2024 were received and accepted for information (previously approved at the CoG Business meeting on 31 October 2024).

b - To receive the approved minutes of the previous HUTH Annual General Meeting (AGM) held on 16 October 2024

The minutes of the HUTH AGM held on the 16 October 2024 were received and accepted for information (previously approved at the Trust Boards-in-Common meeting on 12 December 2024).

1.4 **Urgent Matters Arising**

No urgent matters arising were received.

2. ANNUAL REPORTS AND ACCOUNTS

2.1 **Overview of the Annual Reports 2024/25 and Priorities for the Future (for NLaG & HUTH)**

Lyn Simpson provided an overview of 2024/2025 and key priorities for 2025/2026. The presentation included a timeline of recent and current national events, the Secretary of State's key messages, national priorities for the NHS in the rest of 2025/26, a year of transition for NLaG and HUTH, Group performance and finances, the National Oversight Framework and the Group Strategy. The presentation concluded with key priorities for 2025/26 along with a summary of Lyn Simpson's reflections.

Lyn Simpson echoed the gratitude to the former Group Chair and additionally to Amanda Stanford, Group Chief Nurse, for acting as Group Chief Executive earlier in the year.

During the presentation Lyn Simpson reported and reiterated that the Group were committed to keeping Goole & District Hospital open.

Murray Macdonald agreed that the focus over the next six months was to listen to the patients and staff alongside working with clinicians to drive the required improvements to ensure that the best quality patient care was provided.

Questions were welcomed and none were received. Murray Macdonald encouraged those present to submit questions using the Q&A function.

2.2 **Financial Report for 2024/25 (for NLaG & HUTH)**

Emma Sayner highlighted that this section of the meeting would cover the statutory responsibility of the NLaG CoG AMM and HUTH AGM which was to report on the financial accounts for each Trust for 2024/25. It was confirmed that the review of each Trust would be delivered separately as they remained two sovereign organisations.

Emma Sayner's presentation covered the external auditors report, delivery of the financial control totals, financial regime, the source of funding, how the money was spent, investments, balance sheet strengths, borrowing position and looking ahead to 2025/26 which included the underlying financial position for each Trust. The presentation concluded with the key financial risks for HHP.

Murray Macdonald advised that an anonymous question had been submitted which enquired whether emails could be sent privately instead of raising a question in the meeting. It was suggested that any such questions be submitted to the Communications Teams via nlg-tr.comms@nhs.net.

Cllr Paul Henderson queried whether there was a risk of funding being diverted from HUTH to NLaG to cover the cost of the capital programme. Emma Sayner confirmed that the use of resources is specific to the Trust in which it was allocated and would not be within the regulations to transfer between Trusts. It was reported that NHS England (NHSE) operates the capital programme at a national level, and along with the Integrated Care Board (ICB) manage resources between organisations. The external audit companies for each Trust monitor the allocations and how it was spent.

Brent Huntington wondered when the funding for the Community Diagnostic Centres (CDC) was due to expire. Emma Sayner reported there were two funding streams for the CDCs, the capital allocation to purchase and build the assets and a revenue stream which had been confirmed for 2025/26. Confirmation of the settlement and allocation for 2026/27 onwards remained outstanding although it was anticipated it would remain the same as 2025/26.

2.2.1 **Annual External Audit Reports for 2024/25**

a) Sumer AuditCo NI Limited for NLaG

Murray Macdonald introduced Brian Clerkin, Director of Sumer AuditCo NI Limited to the meeting.

Brain Clerkin explained that this was the third year of Sumer AuditCo NI Limited auditing NLaG's financial statements. A summary of the audit report was provided and five key points were highlighted:

- The audit opinion issued on 24 June 2025 was in line with agreed timelines
- The audit process went well
- There was an unqualified audit opinion on the financial statements, which means that Sumer AuditCo NI Limited were happy the financial statements show a true and fair view of the expenditure and of the assets and liabilities at 31 March 2025
- The Value for Money (VFM) report had not identified any significant weaknesses
- It was not considered necessary to use their auditor powers to report on other matters.

Brian Clerkin expressed thanks to Emma Sayner and the Finance team for ensuring the process was well supported and effective.

b) Forvis Mazars for HUTH

James Collins, Director of Forvis Mazars was introduced to the meeting. A summary of the audit report was provided and four key points were highlighted:

- The audit opinion issued on 26 June 2025 was in line with agreed timelines

- An unqualified audit opinion was given on the financial statements
- In relation to Value for Money (VFM, significant weaknesses identified were:
  - financial sustainability in relation to the underlying deficit, Cost Improvement Plan (CIP), reliance on non-recurrent savings and deficit funding
  - Care Quality Commission (CQC) inspection was rated as inadequate for the criteria in relation to whether services were safe.

Murray Macdonald thanked both Brian Clerkin & James Collins for their reports and presentations and welcomed any questions. None were received.

2.3 **Governor Elections**

Alison Hurley provided an update regarding the current Governor annual elections and provided details of the seven seats available within the four public constituencies. It was reported that voting was open for Goole and Howdenshire and North Lincolnshire and would remain open until 17:00 hours on 13 November 2025. Results had been confirmed for North East Lincolnshire with an uncontested election where all three vacant seats had been filled. Unfortunately, there would be two vacant seats for East & West Lindsey as no nominations had been received. Alison Hurley confirmed the final results of the elections would be declared and published on 14 November 2025 when all new Governors terms of office would commence.

Murray Macdonald highlighted the importance of the Governor role and encouraged members to vote where applicable to ensure the Trust was well represented by its constituencies.

A break took place at 15:48 hours and the meeting resumed at 16:02 hours.

3. SERVICE DEVELOPMENTS

3.1 **Scunthorpe General Hospital (SGH): Ward 5 Flow Project**

Murray Macdonald introduced Veronica Moya Del Saz, Ward 5 Manager to the meeting.

Veronica Moya Del Saz highlighted that Ward 5 at SGH was an acute short stay ward and introduced the other team members who would be delivering the presentation, Cristhine De Castro the Deputy Ward Manager, Debbie Lowther-Dand the Care Navigator and Tegan Grey the Clinical Sister. The presentation covered how Ward 5 ensured timely patient flow was conducted by gathering patient information, pre-planning, prioritising, communication and supporting the team. It was highlighted that three Board rounds took place throughout each day and planning for these included completion of a Discharge to Access (D2A) social assessment for all patients on admission. The remainder of the presentation covered the Flow Campaign, the use of a safe discharge board and the SHOP model template (S – Sick patients, H – Home patient, O – Other patient & P – Plan) for patient flow. The team highlighted that all staff within Ward 5 contributed to ensure effective patient flow and they were very proud of their achievements.

Murray Macdonald thanked the team for their work and noted it was encouraging to see the excellent teamwork to deliver such great results and improve the process.

Marian Davison raised a query with regards to the re-admission numbers and whether the Occupational Therapy (OT) and Safeguarding teams were involved in the process. Veronica Moya Del Saz reported that from July 2024 there were only 18.4% of patients who had been re-admitted. It was confirmed that OT were included in the daily Board rounds where the need was identified and assessments were completed in advance before discharge. Similarly, the Safeguarding teams were involved where needed if concerns were raised, for example if a patient lived alone or repeatedly had falls.

Murray Macdonald commended the partnership working displayed and the learning opportunity available from the project.

Veronica Moya Del Saz, Cristhine De Castro, Debbie Lowther-Dand and Tegan Grey left the meeting and Dr Faisel Baig joined the meeting at 16:26 hours

Murray Macdonald reminded attendees that any questions not responded to during the meeting would be provided with an answer after the meeting.

Cllr Paul Henderson commented that the presentation from the SGH Ward 5 team was superb.

3.2 **Neighbourhood Health**

Murray Macdonald introduced, Dr Faisel Baig, GP & Medical Director for Primary Care, NHS England for North East & Yorkshire to the meeting.

Dr Faisel Baig delivered the Neighbourhood Health presentation which covered the following:

- 10 Year Health Plan for England including the three shifts:
  - Hospital to Community Care
  - Analogue to Digital Transformation
  - Sickness to Prevention Focus
- What is Neighbourhood Health and why Neighbourhood Health?
- Examples of Neighbourhood teams and projects from our region
- The National Neighbourhood Health Implementation Programme (NNHIP) – a large-scale change programme
- North East & Yorkshire Regional Governance
- Next steps
- Neighbourhood working
- A patient story about Francine and improving the life of our patients.

Murray Macdonald noted the very clear message that all patients want to be treated as an individual, as close to home as possible and receive the best quality of care available.

Murray Macdonald queried what the two Trusts working together as one partnership could do to move the Neighbourhood Health agenda forward. Dr

Faisel Baig highlighted the primary and secondary care interface, to free up capacity and ensure colleagues are able to lead interface forums. Some of this work was already underway although prioritisation was required. Job plans which moved people into their respective neighbourhoods together with building relationships between primary and secondary care to embrace a different way of care which affected everyone were key elements.

Murray Macdonald thanked Dr Faisel Baig.

4. OTHER

4.1 Questions to the Board of Directors

Questions were being submitted and responded to throughout the meeting for publication on the website of both Trusts.

4.2 Reflection of Format for Future Annual Members' Meetings

Murray Macdonald welcomed feedback on the first joint NLaG CoG AMM and HUTH AGM format using Microsoft Teams Live which had been utilised to allow easier access for members and the public to join the meeting. None were received. Any comments or suggestions following the meeting were requested to be directed to the Foundation Trust Office (nlg-tr.FoundationTrustOffice@nhs.net).

4.3 Items for Information / To Note

The Acronyms and Glossary of Terms were noted at Appendix A.

4.4 Any other Urgent Business

No items were raised within any other urgent business.

5. DATE AND TIME OF THE NEXT MEETING

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

The next CoG Business Meeting will be held on:

Wednesday, 5 November 2025 at 14:00 - 17:00 hours
In the Chamber, University Campus North Lincolnshire (UCNL), Ashby Road, Scunthorpe, DN16 1BU

The next Group Trust Boards-in-Common meeting will be held on:

Thursday, 11 December 2025 at 09:00 – 17:00 hours
In the Boardroom at Diana, Princess of Wales Hospital, Grimsby, DN33 2BA

The Interim Group Chair thanked the Foundation Trust Office and Communications Team for the event along with everyone for attending and closed the meeting at 16:51 hours.

NLaG CoG Cumulative Record of Governor's / Executive's and NED Attendance 2025/2026 - Public

Name	Possible	Actual	Name	Possible	Actual
Ahmed Aftab	4	3	Wendy Lawtey	4	3
Kevin Allen	4	4	Corrin Manaley	4	4
Paula Ashcroft	4	1	Emma Mundey	4	2
Diana Barnes	4	4	Rob Pickersgill	4	4
Jeremy Baskett	4	3	Ian Reekie	4	4
Mike Bateson	4	4	Caroline Ridgway	4	2
Cllr Linda Bayram	3	2	Dr Sandeep Saxena	4	3
Cllr Paul Henderson	4	2	Dr Gorajala Vijay	4	3
Cllr David Howard	1	0	Clare Woodard	4	3
Brent Huntington	4	4	Jackie Weavill	4	4
David James	4	4			

Name	Possible	Actual	Name	Possible	Actual
Andy Haywood	1	1	David Sharif	4	4
Jonathan Lofthouse	0	0	Lyn Simpson	2	2
Ivan McConnell	2	2	Amanda Stanford	3	1
Simon Nearney	3	3	Sarah Tedford	3	0
Emma Sayner	3	3	Dr Kate Wood	3	3

Name	Possible	Actual	Name	Possible	Actual
Julie Beilby	4	4	Sean Lyons	3	3
Tony Curry	1	1	Murray Macdonald	4	3
Linda Jackson	3	2	Simon Parkes	4	2
Sue Liburd	4	4	Gill Ponder	4	4

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(25)217

BOARDS-IN-COMMON - PUBLIC ACTION TRACKER

2025 / 26

ACTION TRACKER - CURRENT ACTIONS - 11 DECEMBER 2025

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
3.1.2	12.06.25	Maternity & Neonatal Safety Assurance Reports - Low fill rate for unregistered neonatal staff at HUTH		Yvonne McGrath to review the reason for the low fill rate for unregistered neonatal staff at HUTH	Yvonne McGrath	August 2025	Update to be shared at the August 2025 meeting.		August 2025 minutes
4.2	14.08.25	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge - Internal Audit Recommendations		David Sharif to progress the cleansing of internal audit recommendations that were low priority	David Sharif	October 2025	Update to be shared at the October 2025 meeting: advised at the September Executive Group Risk and Assurance meeting		KPMG internal audit action log
5.4	14.08.25	Strategic Programmes & Partnerships Committees-in-Common Terms of Reference - clarification in respect of research		David Sharif to arrange a chairs meeting to resolve research in the new Strategic Programmes & Partnerships Committees-in-Common terms of reference prior to Chair's action to approve.	David Sharif	October 2025	Update to be shared at the October 2025 meeting.		2 October 2025 meeting notes
3.1.2	09.10.25	Maternity & Neonatal Safety Assurance Reports - information in respect of trends in maternity attitudes		Yvonne McGrath to share with Board members information previously shared with Sean Lyons on trends in maternity attitudes	Yvonne McGrath	October 2025	Information circulated to Board members		
3.1	09.10.25	Patients - Safety - Implementation of Martha's Rule across the organisation		Dr Kate Wood and Lyn Simpson to provide an update on adopting Martha's Rule across the organisation following discussion outside of the meeting	Dr Kate Wood	December 2025	Further update to be provided at the December 2025 meeting.		
3.1	09.10.25	Patients - Safety - Improvements to the Patient Safety reporting		Board colleagues to feedback on what they would like included in patient safety reports in the future to Dr David Sulch and Sue Liburd on behalf of the committees	All Board Members	December 2025	Further update to be provided at the December 2025 meeting.		
5.5	09.10.25	Group Lottery Bank Account		Myles Howell to provide a report on the proposals for the Group Lottery to the Workforce, Education & Cultures Committees-in-Common following NED concern that integrating two small charities would become subject to heavier regulation from the Gambling Commission.	Myles Howell	November 2025	Myles Howell provided an email to NEDs that raised the query, confirming current arrangements, preparations and existing licence progress. With Workforce, Education & Culture Chairs and Interim Group Chair agreement, it was agreed this information closed the action.		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
3.1.3	13.02.25	Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports - Consideration for Maternity Sub-Board to be introduced		Consideration for Maternity Sub-Board to be introduced	Amanda Stanford	June 2025	Update to be shared at the June 2025 meeting.		June 2025 minutes
3.2	13.02.25	Performance, Estates & Finance Committees-in-Common Highlight Report - Audit, Risk & Governance Committees-in-Common to review risks		Simon Parkes and Jane Hawkard as NED Chairs of Audit, Risk & Governance Committees-in-Common to review that risks that related to performance were being referred through to the Quality & Safety Committees-in-Common appropriately	Simon Parkes / Jane Hawkard	April 2025	Update to be shared at the June 2025 meeting.		June 2025 minutes
3.5	12.06.25	Capital & Major Projects Committees-in-Common Highlight Report - BAF Risks against each Committees-in-Common		David Sharif to review this further in respect of the BAF risk against each Committees-in-Common	David Sharif	August 2025	Review complete with digital BAF Risk being assigned to Strategic, Programmes & Partnerships CiC.		Pioneer Board Item Update including BAF.
5.1	12.06.25	Green Plan - more detail to be added in respect of trajectories		Emma Sayner to add more detail within the report on what would be put in place including trajectories	Emma Sayner	August 2025	Subsequent discussions concluded that enhanced trajectories would be considered for future reports.		Discussions have taken place with the Finance & Estates team

Key:

Green	Completed - can be closed following meeting

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)218

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 December 2025**
Director Lead	Murray Macdonald, Interim Group Chair
Contact Officer / Author	Murray Macdonald, Interim Group Chair
Title of Report	Interim Group Chair's Report
Executive Summary	Report on Policy, Regulation and wider activities
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Interim Group Chair's Update

Introduction

In the short period that I have been in the role I have prioritised meetings with key internal stakeholders including the Interim Chief Executive (CEO), Lead Governor, Board Non-Executive Directors (NED) and Governors. I have also started to meet with each of the Care Group leadership teams. The insight that these individuals have provided has been most welcome along with their support.

In the wider system I have had the opportunity to meet with Fiona Edwards, Regional Director, Jason Stamp, the Chair of the Integrated Care Board (ICB), and Wendy Scott, who leads the Collaborative of Acute Providers (CAP), who have each helped me start to orientate myself in the wider system. Over the next few weeks, I expect to meet with the Chairs of our other NHS system partners as we collectively navigate the new NHS landscape.

In addition to NHS colleagues, I have met with several other partners and stakeholders. I am pleased to report that Lyn Simpson and I held two positive meetings firstly with the Save Goole Hospital group and the second with Sir David Davis MP. We agreed that there would be a number of follow up meetings, however, all those who attended agreed that we had begun the process of rebuilding trust and developing a productive relationship.

Finally, it is worth mentioning that I met with Carl Wheatley and Neil Gammon to understand more about our two Hospital Charities WISHH and The Health Tree Foundation.

Priority Areas

As the Interim Group Chair I have been tasked with specific areas of work to achieve over the next few months and in particular undertaking a review of our governance and implementation of the recommendations that follow.

I am pleased that ValueCircle consultancy have agreed to undertake the review and that they will be reporting their findings to enable implementation of any agreed changes by the new financial year. My thanks to Governors and NHS England (NHSE) for agreeing to not make any changes to the current Non-Executive Director positions during this period.

Performance Scrutiny

Board are well aware that NHSE have introduced a new framework for the assessment of provider performance (The NHS Oversight Framework) and that both Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust and Hull University Teaching Hospitals (HUTH) NHS Trust are in segment four.

Scrutiny of the Trusts is extensive although this has also included the provision of support from NHSE who have allocated national resources to the Trusts to help us accelerate our clinically led improvement journey. This support will focus on building capacity, strengthening systems, and supporting colleagues.

My first exposure to Performance Oversight was the Interim CEO and my attendance at the half year review meeting. The meeting was supportive of the Group and the focus that the Interim CEO was bringing to the improvement plan.

NHSE expect that Boards will ensure that safety is prioritised and that there is an active and positive learning culture across the organisation. They also expect the Boards to agree the detailed clinically led improvement plan which the Group is developing, with clear delivery targets which NHSE and the ICB will monitor.

Governance Changes

Boards

Sarah Tedford has left and been replaced by Matt Powls on an interim basis whilst the Trust await the arrival of Sam Peate who was recently appointed to the substantive position of Group Chief Delivery Officer.

Amanda Stanford has been successful in an application to join the ICB on secondment for the next six months. During Amanda Stanford's absence the Group Chief Nurse position will be undertaken by Heather McNair.

I am sure I speak for all of us in thanking Sarah Tedford for the work she did with us and wishing Amanda Stanford all the very best in her new position and the work she will be leading across the ICB system.

Earlier this year Simon Parkes indicated that he wished to step down from his role as NLaG NED at the end of the calendar year, however, in light of the governance review Simon Parkes has agreed to stay until the end of January 2026. My thanks to him for agreeing to this.

Governors

I am delighted to report that following the election process the following people have been appointed to the Council of Governors (CoG) for NLaG.

- Cheryl George – North East Lincolnshire
- Dietmar Harteveld – Goole and Howdenshire
- Marian Davison – North Lincolnshire

I am also pleased to report that Mike Bateson has been appointed as the Deputy Lead Governor.

Unfortunately, no nominations were received for the East and West Lindsey Constituency and these positions remain unfilled on the CoG.

Council of Governors' Annual Members' Meeting (AMM)

The annual Members meeting was held on the 22 October 2025 and for the first time the event contained both the CoG AMM and the HUTH Annual General Meeting (AGM). As well as conducting the statutory business of both meetings we enjoyed two excellent presentations, the first from the team who delivered the Flow Project at Scunthorpe General Hospital (SGH) and the second from Dr Faisal Baig, GP and Medical Director for Primary Care, NHS England – North East and Yorkshire.

This was the first time that the two events have been combined and the Governors' feedback would be welcome.

Golden Stars

I also had the pleasure of attending the Golden Stars Awards, along with Executive and NED colleagues, held at Scunthorpe Bath Halls. This was a very positive event celebrating the great work and dedication of individuals and teams across the Group.

The communication team are already planning next year's awards and I would be grateful for any feedback on this year's event to help us develop and improve for next year.

Murray Macdonald
Interim Group Chair

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)219

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	Lyn Simpson, Interim Group Chief Executive
Contact Officer / Author	Lyn Simpson, Interim Group Chief Executive
Title of Report	Interim Group Chief Executive's Update
Executive Summary	This report provides the Interim Group Chief Executive's update for the Public Boards-in-Common. Key points include: • Community Diagnostic Centre feedback • UKHCDO Peer Review feedback • CQC UEC assessment • GIRFT visit • NHSE Strategic Commissioning Framework and Medium-Term Planning Framework.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Assurance ☐ Information ☐ Other – please detail below:

Interim Group Chief Executive's Update

1. Clinically led improvement

The Partnership continues to progress a clinically led improvement programme shaped by our Senior Leadership Team (including Chiefs of Service) and the new Clinical Policy Group. This approach keeps safety, access and experience at the centre while we modernise models of care and strengthen delivery.

Clinical engagement continues to strengthen, with growing involvement of clinical leaders in shaping our improvement priorities and resource decisions. We are also working closely with local authority and ICB partners to advance shared priorities, improve patient flow, and support long-term service sustainability. This collaborative approach remains central to our direction and to improving outcomes for our patients and communities.

2. Community Diagnostic Centre (CDC)

Since phased opening, the Scunthorpe CDC has delivered more than 30,000 tests to date (at the time of this report's writing), with CT now running with contrast and MRI in final power-up/commissioning. Sir Nic Dakin MP (Scunthorpe) visited the CDC in October and fed back that the centre was clean and welcoming, with colleagues clearly enjoying their work.

3. Haemophilia service

Following a recent peer review, the UKHCDO has endorsed the change from interim to full Comprehensive Care Centre (CCC) status for Hull. Areas of good practice include the blood sample transport system and a buddying approach for transition; recommendations for further improvement focused on strengthening specialist nursing, physiotherapy and psychology provision, ED training and patient involvement in service design.

4. Urgent & Emergency Care

Following an inspection, The CQC has confirmed improvement in Urgent & Emergency Care at Hull Royal Infirmary - ratings for Safe, Effective, Responsive and Well-led moved up to Requires Improvement (from Inadequate), and Caring moved to Good. The overall HRI rating remains Requires Improvement, and the report sets out further work on environment, staffing, IPC, medicines, consent and outcomes.

5. Adult Social Care CQC Reports and Impact on Hospital Discharge

The Care Quality Commission has recently published assessments of adult social care provision in both Hull and the East Riding. Hull City Council's services were rated Requires Improvement, and East Riding of Yorkshire Council's services were rated Inadequate.

Both reports highlight pressures within local social care systems that can affect the timely discharge of people who are medically fit to leave hospital but require community, home-care or residential support to do so.

We continue to work closely with both local authority and with ICB partners to ensure people who need social care packages or placements before they can leave hospital, can access

these as quickly as possible. Our joint work remains focused on reducing delays, supporting independence and improving the experience of patients and families at the point of discharge.

6. Industrial action

Resident doctor colleagues undertook industrial action from 07:00 on Wednesday 14 November to 07:00 Wednesday19 November. As in previous rounds of industrial action, clinical teams and colleagues worked to minimise disruption for patients.

7. Elective recovery and outpatient transformation

National Clinical Improvement & Elective Recovery Director Professor Tim Briggs visited Castle Hill and Goole Hospital on Wednesday 12 November. Following his visits, Professor Briggs commended the rapid progress at Goole and asked clinical colleagues to replicate this pace at Castle Hill. This includes clinician-sponsored changes on outpatients (including PIFU), discharge and theatres to improve access, patient flow and productivity - reducing cancellations and unnecessary follow-ups.

8. Research, innovation and culture

We continue to scale challenge-led research with our universities and partners, increasing opportunities for patients and supporting recruitment and retention of high-calibre staff. Listening events with colleagues are shaping future planning, with a stronger clinical voice in resource decisions from 2026/27.

9. National context

NHS England published the Medium-Term Planning Framework (2026/27–2028/29) and Strategic Commissioning Framework in October and November respectively. Both documents set out the direction of travel for the NHS over the coming years: strengthening prevention, improving access to timely care, enhancing productivity, and working more effectively as integrated systems.

The Medium-Term Planning Framework provides greater stability by setting a multi-year outlook for financial planning, workforce, and service transformation. Its focus on system collaboration, workforce reform, digital innovation, and standardising high-impact improvement methods supports the work already underway across our Partnership, including our clinical redesign, outpatient transformation, flow improvements, and our developing research and innovation portfolio.

The Strategic Commissioning Framework reinforces the role of providers - working together in place and system partnerships - in shaping pathways, improving quality, and ensuring resources are used to best effect. This aligns strongly with our clinically led improvement programme and our commitment to making decisions as close to patients and services as possible.

Across both Trusts, we are ensuring that our priorities, operational plans and improvement programmes reflect this national direction, positioning Humber Health Partnership to contribute to system ambitions while delivering safe and sustainable care for our communities.

10. Internal engagement

I have continued to visit teams and departments across the Group and want to thank colleagues for their time and conversations about the day-to-day experience of colleagues and patients. In addition, we are developing a structured programme of listening and engagement, and in November I held dedicated listening events in Scunthorpe and Grimsby. These sessions brought together clinical and non-clinical colleagues to discuss improvement priorities, local challenges and opportunities.

11. External engagement

Over recent weeks I have continued meet with local Members of Parliament, including Sir David Davis MP in November at our Goole & District Hospital.

12. CEO Dashboard

Included with this report is the CEO dashboard. The dashboard, which will continue to be developed, encompassing key headlines around strategic updates, patient and staff experience, safety and quality priorities, operational performance, finance and workforce.

CEO DASHBOARD

December 2025 (linked to latest Board IPR)

NHS Humber Health Partnership

STRATEGIC UPDATE

2025-30 GOALS

- **Patients**
  Our Patients get the best care
- **People**
  Our People feel proud to work here
- **Population**
  Our Population live more years in good health

PROGRESS UPDATE

- **Patients**

The Partnership is advancing clinically led improvement, supported by strengthened SLT structures and the new Clinical Policy Group. UEC quality (HUTH) has improved following CQC inspection, and the Scunthorpe CDC is expanding diagnostic capacity. Elective GIRFT visits highlighted the need to replicate rapid outpatient and theatre gains across sites to enhance access, safety and experience.

- **People**

Clinical engagement is growing, with leaders increasingly shaping priorities, pathways and resource decisions. Peer review of specialist services emphasised good practice and development needs, while listening events reinforced the value of staff voice. CEO visits continue across the Group, recognising colleague commitment and supporting a culture focused on safety, improvement, collaboration and professional growth.

- **Population**

Engagement with system partners continues with the aim of are addressing social care pressures affecting discharge, working jointly to reduce delays and support independence.

MONTHLY TREND KEY

↑	Improvement on previous reported month
↓	Deterioration on previous reported month
↔	No change on previous reported month
↑↓	Trend vs previous period

SAFETY AND QUALITY PRIORITIES

- DP and Sepsis
- End of life
- Medication Safety
- Mental Capacity

OPERATIONAL PERFORMANCE (OCT 25)

IPR

NHS operating plan standards that cover a range of access points, including urgent and emergency care services (ED), planned and routine operations and cancer diagnostics and treatment.

HUTH

A&E 4hr wait (78% by March 2026)	**55.8%**	↓↑ 61.9% in Aug
62-day cancer (75% in March 2026)	***50.1.%**	↓↑ 55.3% in Aug
28-day FDS (80% in March 2026)	***59.8%**	↑↓ 50.8% in Aug
18-week RTT (65% in March 2026)	**56.5%**	↓↓ 56.7% in Aug
6 week wait (95% by March 2026)	**68.7%**	↑↓ 67.6% in Aug

*July 2025

NLAG

A&E 4hr wait (78% by March 2026)	**69.5%**	↓↓ 72.9% in Aug
62-day cancer (75% in March 2026)	***59.1%**	↑↑ 54.5% in Aug
28-day FDS (80% in March 2026)	***66.7%**	↑↑ 64.1% in Aug
18-week RTT (65% in March 2026)	**59.7%**	↑↓ 59.1% in Aug
6 week wait (95% by March 2026)	**61.6%**	↑↓ 61.3% in Aug

*July 2025

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- Friends and Family results remain strong across most areas: community 98.2%, inpatient 97.7%, outpatient 97.4%, postnatal community 100% and birth 100% all exceeded target. A&E scored 75.6% and antenatal 79.6%, both below target.
- High numbers of delayed discharges at HUTH continue to impact patient flow, contributing to A&E pressures and prolonged waits. Discharge delays are linked to patients awaiting social care support or community intermediate care services, highlighting the need for ongoing system collaboration to improve timely discharge and patient experience.

STAFF EXPERIENCE

- The Group is strengthening how clinical perspectives drive decision-making. Chiefs of Service now sit on the Senior Leadership Team, ensuring experienced clinicians shape priorities, resource use and day-to-day service delivery. This is increasingly important as differences in agency spend - 1.8% of total pay at HUTH compared with 4.2% at NLAG - reflect ongoing recruitment challenges in hard-to-recruit specialties.
- To reinforce this clinically led approach, the new Clinical Policy Group will bring senior clinicians together to make collective decisions on service design and resource allocation. This will keep safety, quality and clinical insight at the centre of strategy and operations, while supporting a stronger culture of learning and shared leadership..

PEOPLE (OCT 25)

IPR

Group sickness absence	**4.8%**	↔	4.8% in Aug
Core Mandatory Training	**87.4%**	↓	89% in Aug
Role Specific Training	**82.9%**	↑	80% in Aug
Appraisal rate (AfC)	**79.4%**	↓	81.0% in Aug
Turnover rate (12 months)	**7.4%**	↑	8% in Aug
Agency spend as % Total Pay	**2.8%**	↑	2.9% in Sept
Job planning	**77%**	↑	43% in Aug

GROUP FINANCIAL POSITION (M7)

Finance. rep

Indicator	£M
YTD I&E Performance	(£4.8m)
I&E Forecast Outturn	(0.0m)
Capital Expenditure	(£18.3m)
CIP YTD	(£12.1m)
Balance Sheet & Cash	£45.0m

DISCHARGE (NOV 25)

MH

HUTH

Bed occupancy classed as clinically ready for discharge (lower is better)
27.9% ↓↑ 27.5% in Oct

NLAG

Bed occupancy classed as clinically ready for discharge (lower is better)
18.5% ↓↓ 18.1% in Oct

THEATRE UTILISATION

IPR

HUTH touch-time capped utilisation (Elective 85% standard)	**79.4%**	↓↑	81.3% in Aug
NLAG touch-time capped utilisation (Elective 85% standard)	**79.4%**	↑↑	73.9% in Aug

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)220

Name of the Meeting	**Trust Boards-in-Common (Public)**
Date of the Meeting	11 December 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer Heather McNair, Interim Group Chief Nurse
Contact Officer/Author	Tracy Campbell, Patient Safety and Director of Quality Governance Richard Dickinson, Associate Director of Quality Governance Michela Littlewood, Associate Director of Quality Governance
Title of the Report	**Patients – Safety (including Assurance Committee update)**

Executive Summary	This report provides an overview of the work and actions being undertaken through the Quality Governance teams and reporting to the Quality and Safety Committees-in-Common. This includes:
	
	• Patient Safety (Incidents)
	  ○ PSIRF annual report is provided in the information paper section.
	  ○ Transition to Ulysses for HUTH has not impacted on overall incident reporting rates, with development of reporting and dashboards on this platform continuing.
	  ○ Never Events update provided in this report, including a Wrong implant (lens) incident in November 2025 totaling 17 cases since April 2024. Specific activities to support this work are detailed
	
	• Patient Experience, (Complaints, Patient Advise Liaison Service (PALS), Compliments, Patient Engagement)
	  ○ The annual report is provided in the information paper section.
	
	• CQC inspections:
	  ○ A CQC inspection of Urgent and Emergency care took place on the 16-17 September 2025 at Hull Royal Infirmary. The report was published on 19 November 2025.

UEC Core Service at HRI		
Domain	**2023 Rating**	**2025 Rating**
Safe	Inadequate	Requires Improvement
Effective	Inadequate	Requires Improvement
Caring	Requires Improvement	Good
Responsive	Inadequate	Requires Improvement
Well-led	Inadequate	Requires Improvement
Overall	Inadequate	Requires Improvement

        - The report is found at: https://www.cqc.org.uk/location/RWA01/reports.
        - Action plan development is underway

    - HUTH - Core Service: Medicine, inspection across HRI and CHH sites was undertaken on the 18-20 November 2025.
        - The initial feedback letter is provided appended to this report.
        - Information requests are being collated and on schedule for provision on 9 December 2025.
        - Action plans from the initial feedback are being developed.

- Quality Priorities
    - Deep dive of Mental Capacity Assessment and Deprivation of Liberty Standards was reported to QSCiC in October 2025.

Further activities are planned to support transformational improvement through the following:

- Development of the safety accreditation programme including theatres
- Development of the Learning and Improvement Academy inclusive of a safety hub
- Patient safety campaigns
- Revised quality and safety reports from the new year and on a quarterly basis thereafter
- Refreshed Integrated Performance Reporting

Background Information and/or Supporting Document(s) (if applicable)	Supporting papers from section 6 of the pack are:

	• The Quality section of the Integrated Performance Report for October • The Patient Experience Annual Report • The PSIRF Annual Report
Prior Approval Process	Quality Governance papers are presented at Quality & Safety Committees-in-Common (CiC) on a regular basis. The IPR is presented monthly and was taken to the October 2025 Quality & Safety CiC.
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Never Events Update

1.0 Aim

1.1 This report provides an update on the Never Event reporting and plans to address.

2.0 Background

2.1 In the last 12 months there have been 11 Never Events in the group, 6 in HUTH and 5 in NLAG. There have been 17 Never Events reported since moving to the HHP group model in April 2024, summarised in the table below:

Incident category from Never Event list	HUTH	NLAG	Total
1. Wrong Site Surgery	3	1	4
2. Wrong implant/prosthesis	2	2	4
3. Retained foreign object post procedure	5	2	6
6. Overdose of insulin due to abbreviations or incorrect device	0	1	1
13. Misplaced Nasogastric or Orogastric Tube	1	0	1
Total	**11**	**6**	**17**

Reference to the full list of Never Events can be found on NHSE website: 2018-Never-Events-List-updated-February-2021.pdf

2.2 During the period from October to November there has been one Never Event reported and declared.
HUTH – Wrong implant (Lens) during cataract surgery. The error was identified during the completion of operating notes at the end of the operation. The patient was informed, apology provided and returned to theatre for a lens exchange.

- Initial fact finding identified that the lens that was checked and prepared was not used, but that a lens prepared for the previous case had been used. This demonstrated a failure in clearing the unused equipment from the previous case and assumption that the correctly checked lens was being used.
- An immediate process change has been introduced by the Chief of Service for storage of the checked lens once checked and reinforcement of the clearance of the operating theatre equipment at the end of each case and a single lens in the theatre.
- The Never Event Immediate Response Meeting will include a facilitated After Action Review learning response with the team involved, which is scheduled for 4/12/2025.

3.0 Progress to date

- Never Event Immediate Response Meetings have been implemented across the group. The meetings have been productive in identifying actions to change practice where initial investigation has identified remediable actions.

- Surgical Safety and Interventions Group was introduced in June 2025, meeting monthly to focus.
- There have been investigations recently completed and going through sign off processes. 10 of the 17 cases are open investigations at various stages of report writing.
- Vignette of each of the Never Events has been compiled to brief all care groups and their local learning consideration.
- Presentations and engagement sessions through:
    - Grand Rounds
        - DPOW – 12/11/2025
        - SGH – 26/11/2025
        - HUTH – 28/11/2025

4.0 Next steps

- Development and update of the remaining NatSIPPS checklists for different procedures and settings continues with prioritisation of the Ophthalmology checklist for cataract surgery and interventional radiology.
- Seek wider engagement for monitoring and audit of compliance across all relevant environments.
- Simulation based training for theatre team leaders and team members.
- Training information and video recording has been updated and published for NatSSIPS2 compliance.
- Take the learning from each investigation and learning response outcome to ensure the range of training, simulation and orientation packages across the group are duly considered.
- Presentations and engagement sessions through:
    - Surgical specialties Governance meetings:
        - Group wide – 12/12.2025 at all 4 main sites.
    - Interventional Radiology – 5/1/2026
- Top 100 leaders safety briefing focus
- Quality Summit is planned for Q4.
- A structured forum for a panel discussion about the impact of Never Events on patients and staff.
- Continued Safer Surgery and Interventions Group is working collaboratively to coordinate the improvement work in addition to the actions being taken locally within care groups.

5.0 Conclusion

5.1 There are a series of measures being taken to monitor and develop engagement with clinical staff that are directly involved in providing care to patients, particularly when there are safety critical steps required, including NatSSIPs 2. The aim is to take forward their feedback and develop more reliably practice.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
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By email Lyn.Simpson7@nhs.net

Lyn Simpson
Interim Chief Executive Officer
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

20 November 2025

CQC Reference Number:
Hull Royal Infirmary – LAP01945
Castle Hill Hospital – LAP01927

Dear Lyn

Re: CQC inspection of Hull University Teaching Hospitals NHS Trust – Medical Services
Provider ID: RWA

Following your feedback meeting with Helena Lelew Operations Manager and Rachel Beynon Inspector on 20 November 2025, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to your colleagues at the feedback meeting.

This letter does not replace the draft report we will send to you but simply confirms what we fed-back on 20 November 2025 and provides you with a basis to start considering what action is needed.

Staff welcomed the inspection team and contributed to the inspection well at all sites. Please extend our thanks to them.

An overview of our feedback

The feedback to you was:

- We found instances of inappropriate patient placement, where patients were placed in unsuitable areas and for extended periods of time, for example patients on the short stay unit were staying beyond the 72-hour target and in the discharge lounge patients had stayed for several days and sometimes weeks. However, we were advised that a new discharge lounge was

scheduled to open in December. If implemented effectively, this should improve patient discharge efficiency.

- At Castle Hill, we found examples of when patients had been transferred to wards deemed as "medically fit", they did not have correct up to date handover information which impacted decision making. Staff looking after medical outlier patients found it difficult to contact consultants from the parent speciality.
- There were staffing concerns due to high patient acuity in some areas (e.g., on respiratory 5-6 patients with chest drains) this was causing pressure for staff to look after those patients. Staffing levels did not always account for boarded patients, leading to insufficient staff managing those patients. Staff were also often pulled to other areas, sometimes beyond their skill set, when staffing levels exceeded the norm.
- The feedback loop for learning from incidents was not consistently strong across all areas. Also, medical attendance at mortality and morbidity meetings in some specialties was low.
- Facilities Issues: AMU had ongoing issues with toilets being out of action for some time, providing limited facilities for 30 beds. Additionally, there are no en-suite facilities. The ventilation system in the treatment room was not working well, with ambient temperatures reaching 24.5°C.
- On both sites staff reported confusion about the leadership structure, the instability of interim posts and lack of clarity regarding roles and responsibilities within the care group.
- While matrons remained accessible and supportive, staff have expressed that leadership above the 8A level were less visible. This gap was making communication and engagement more challenging. Many staff members were unsure who the executive team was.
- The fragmented information systems were creating inefficiencies; and accessing multiple systems was confusing for staff, which could lead to delays and errors**.**
- Feedback from patients was positive. Patients reported that staff were kind, attentive, met their needs and maintained privacy and dignity throughout their care.
- We observed good multidisciplinary collaboration in all the areas we visited.
- Medicines Management: Storage and security was well-organized, with timely administration of critical medications such as insulin and Parkinson's treatments. We saw good compliance with the sepsis pathway regarding the one-hour antibiotic target.
- All areas we visited were clean and equipment checks were completed. Record Keeping was good with no gaps in care, and ReSPECT forms were being completed well.

A draft inspection report will be sent to you once we have completed our due processes, and you will have the opportunity to check the factual accuracy of the report.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection particularly during the challenges posed by the resident doctors' strike, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Helena Lelew
Operations Manager

cc. NHS England

CiC ESCALATION REPORT

QUALITY AND SAFETY COMMITTEES-IN-COMMON – 30 October 2025

NHS Humber Health Partnership

1.Matters for Reporting

A number of ED Risks will be triangulated with complaints and incidents through the Patient Safety Learning Group. Any harms will be reported to the Quality and Safety CIC for assurance. The Group is now harmonised with one risk system (Ulysses). The CIC were reasonably assured that there was a robust process in place, assurance regarding oversight regarding the mitigations and management of the risks was still required.

Never Events – There had been 1 case reported since the last meeting and the Investigation was underway. There are plans for sessions across the organisation, spanning multi-professional groups to raise awareness and discuss how best to improve this position.

The Group had 350 open complaints, and the teams were taking too long to respond, meaning that compliance against the standard was low. Communication was the key theme noted. Plans were in place to address the issues.

IPC Update – CPE screening was now taking place on admission and patients were being isolated immediately to avoid outbreaks. Antimicrobial stewardship ward rounds has been identified at DPOW and SGH. The actions in place had resulted in a reduction in cases.

2. Positive assurances

There was a sustained performance position at NLAG and HUTH for SHMI and HSMR.

3. Matters on which the committees have requested additional assurance

The **Mental Capacity Report** highlighted the digitalised forms which were being piloted. New training packages were in place which included mandatory practical and e-learning to improve compliance. Going Live across the North Bank would take place in November 2025. Clinical engagement and leadership support was required to ensure legal compliance.

4. Decisions made

The CIC agreed that the **EQIA Process** should receive limited assurance and further assurance was required.

The CIC gave limited assurance to the **Clinical Effectiveness report** and requested an improvement plan for assurance.

5. Escalation to Trust Boards

Maternity, Obstetrics and Neonatal staffing Business Cases were not approved at the Boards in Common in October. This poses risks for MIS year 7 and the lifting of the Section 31 notice. Revised business cases and plans to be presented to the Boards in Common in November 2025.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	N/a	N/a	Assurance	N/a
2	Risk Register Report Q1 and 2	N/a	N/a	Assurance	Reasonable
3	Never Events/Emerging Concerns	N/a	N/a	Assurance	N/a
4	Integrated Performance Report	N/a	N/a	Assurance	N/a
5	Quality Priorities – Mental Capacity	3	20	Assurance	● Reasonable
6	Maternity and Neonatal Assurance Report	3	20	Assurance	● Reasonable
7	EQIA	N/a	N/a	Assurance	● Limited
8	Infection, Prevention and Control Update	3	20	Review	N/a
9	Clinical Effectiveness Report	3	20	Assurance	● Limited

6. Comments on the effectiveness of the meeting

Members welcomed the discussion held in accordance with the Group's values.

7. Escalation to CiCs

8. Attendance record

Members / Attendees		A	M	J	J	A	S	O	N	D	J	F	M
Sue Liburd	Non-Executive Director (NLAG) Chair	✓	✓	✓	✓	-	✓	✓					
David Sulch	Non-Executive Director (HUTH) Chair	✓	✓	✓	✓	-	✓	✓					
Tony Curry	Non-Executive Director (HUTH)	x	✓	✓	✓	-	✓	✓					
Julie Beilby	Non-Executive Director (NLAG)	x	✓	✓	✓	-	✓	✓					
Kate Wood	Group Chief Medical Officer	✓	PS	✓	✓	-	PS	✓					
Sarah Tedford	Group Chief Delivery Officer	CW	CW	CW	✓	-	x	MP					
Amanda Stanford	Group Chief Nurse	✓	HMc	HMc	HMc	-	✓	✓					
David Sharif	Group Director of Assurance	✓	✓	✓	✓	-	RC	✓					
Richard Dickinson	Associate Director of Governance (NLAG)	✓	✓	✓	✓	-	✓	✓					
Michela Littlewood	Associate Director of Governance (HUTH)	✓	✓	✓	✓	-	x	✓					

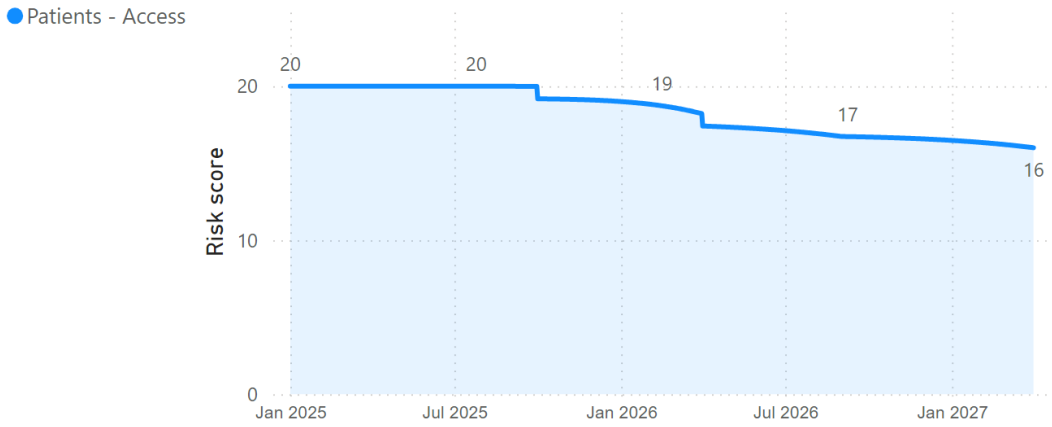
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Matt Powls, Interim Group Chief Delivery Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Patients - Access, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

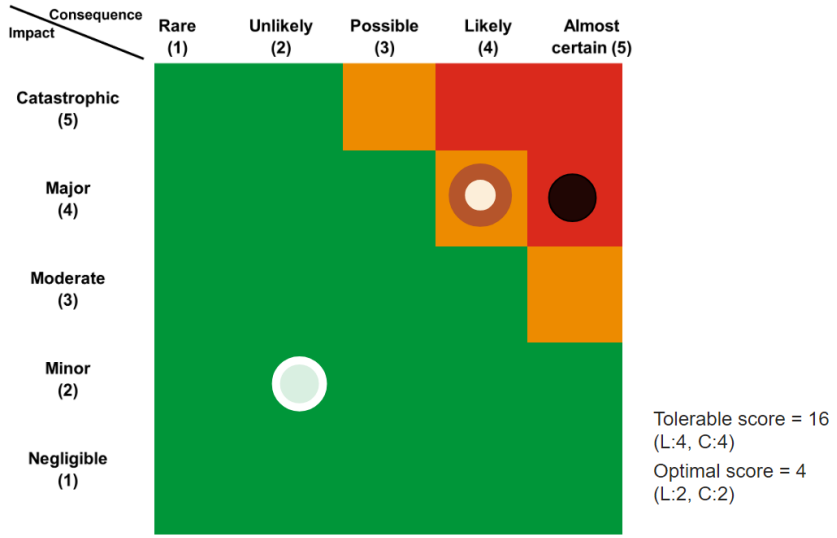
We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

2. Patients - Access

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Care Group Performance and Accountability	Limited
Financial Planning Improvement Board	Limited
Flow programme	Limited
National performance framework for support and scrutiny	Limited
Operating plan 2025-26	Limited
Planned Care Board	Reasonable
Tier 1 review processes - UEC and Cancer	Significant
Unplanned Care Board	Limited

Gaps in control (and Action ID)	21	31	37	41	53	Total
Challenge in resolving numerous national expectations / targets with available finance, degrading or overriding control			1			1
Data quality issues in supporting metrics		1				1
Lack of positive medical engagment in delivery	1					1
Lack of strong capabilities to identify and implement service improvement gains from exemplar sites or best practice	1					1
Lack of timely / realtime performance reporting (eg weekly dashboard)				1		1
Lack of trajectory setting to support robust performance management					1	1
Uncertainty over ICB role and function	1					1
Weak culture of improvement/change management and siloed working		1		1		2
Total	**3**	**1**	**1**	**2**	**1**	**1**	**9**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	
External	Acute Provider collaboration reports	
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Limited
External	ICU Network review	
Internal	Integrated Performance Report	Reasonable
External	NHS tiering arrangements and support or freedoms	
Internal	Planned Care Board reporting to Performance, Estates & Finance CiC	
Internal	Unplanned Care Board reporting to Performance, Estates & Finance CiC	

Assurance gaps (and Action ID)	20	31	42	53	Total
Absence of a comprehensive demand and capacity (bed) model that supports scenario analysis and planning	1			1	2
Absence of routine data quality monitoring and patient record validation		1	1		2
Inadequate coverage of performance metrics	1				1
Total	**1**	**1**	**1**	**1**	**1**	**5**

2. Patients - Access

NHS Humber Health Partnership

The table below details the 7 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
20	Strategic Bed Review (based on optimum LoS)	31/12/24	01/09/26	PA Consulting undertook a bed utilisation review (ahead of developing in-house modelling capacity). Work to be recalibrated in light of Improvement Plan Stabilise phase, demand and capacity at specialty level and Teletracking system implementation.	02/12/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Adam Creeggan, Group Director of Performance, Matt Powls, Interim Group Chief Delivery Officer	Limited
21	Embed QI Methodology	30/09/25	01/04/27			Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Heather McNair, Group Chief Nursing Officer	
31	Standing up revised organisational data quality governance		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
37	Developing skills and capability of Care Group leadership to tackle day-to-day challenges and lead on effective transformation programmes, intra-Care Group and cross-sites	31/03/26	01/04/26	Appointed Site Director of Operations and Transformation - due to start July-25	17/06/25	Simon Nearney, Group Chief People Officer, Matt Powls, Interim Group Chief Delivery Officer	Limited
41	Delivery of BI investment		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised	30/09/25	01/10/25	Internal exercise underway at present with plan to engage AI later	01/05/25	Adam Creeggan, Group Director of Performance	
53	Develop and embed Care Group integrated plans aligning expendture, activity and workforce	31/05/25	31/03/26	Set clear and individual objectives across four domains of finance, activity and workforce	01/05/25	Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	Significant

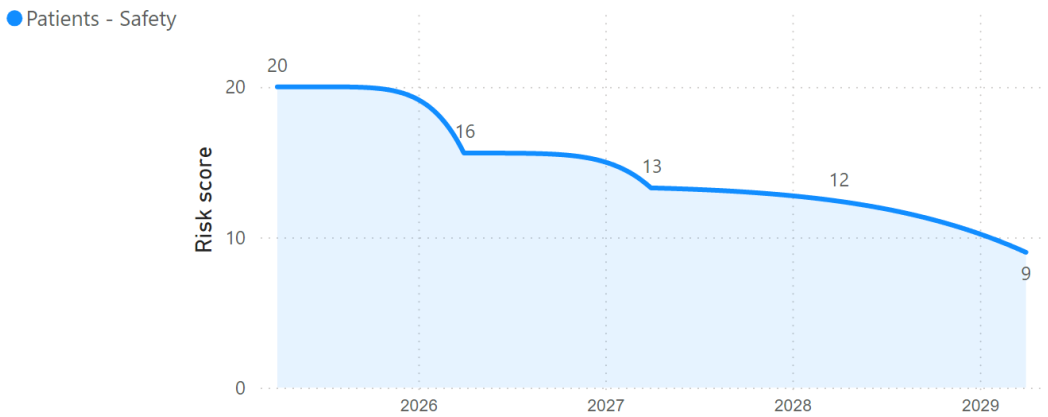
3. Patients - Safety

The strategic risk affecting our objective, 'Patients - Safety' is led by Kate Wood, Group Chief Medical Officer; Matt Powls, Interim Group Chief Delivery Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Patients - Safety, the risk's current score is 20 and its score last changed on 12/09/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

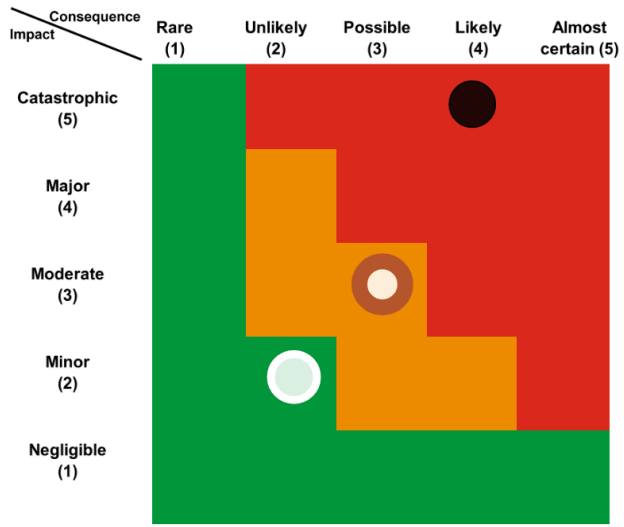
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Cautious). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Accreditation Frameworks	Limited
Care Group Performance and Accountability	Limited
Continuous Professional Development for all health professionals and mapped to Quality Priorities	
Freedom to Speak Up Guardian	Reasonable
Incident Reporting culture	Limited
Infection Control Committee	
Martha's Rule Compliance	Limited
Maternity and Neonatal Assurance Group	Reasonable
Mortality Improvement Group	Reasonable
National Best Practice for Audits	Reasonable
National NICE Guidance	Reasonable
Patient Experience and Learning	
Patient Safety and Learning Group	
Patient Safety Partners involvement	
Peer Review Process	
Quality and Safety Strategy	
Risk and Compliance Group	Limited
Safe Staffing Models	Reasonable
Statutory and Mandatory Training	Limited
Strategic Safeguarding Board	

Gaps in control (and Action ID)	12	13	14	15	52	54	Total
Comprehensive safety culture	1	1		1		1	**4**
Data quality issues in supporting metrics	1						**1**
Embedded awareness of requirement to fulfill EQIA process			1				**1**
Fully safe staffing levels (North)		1					**1**
Inconsistent evidence of embedded improved processes	1						**1**
Lack of consistent basic hygiene compliance				1			**1**
Lack of involvement in national quality audits					1		**1**
Lack of positive medical engagment in delivery						1	**1**
Martha's Rule compliance						1	**1**
Strong speak up and reporting culture				1			**1**
Total	**1**	**2**	**2**	**1**	**3**	**1**	**3**	**13**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Clinical audit outcomes	Reasonable
Internal	Complaint levels	Limited
Internal	CQC Action Plan	
External	External agency visit and inspection reports	Limited
Internal	Friends and Family Test reporting	Reasonable
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Limited
Internal	Incident reporting	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Maternity Neonatal Dashboard	
External	National Patient Survey	
Internal	Ouputs from QI Programme	Limited
Internal	Risk Management metrics	
Internal	Statutory and mandatory compliance levels	Limited
Internal	Ward accreditation metrics	

Assurance gaps (and Action ID)	12	13	15	Total
Absence of routine data quality monitoring and patient record validation	1			**1**
Manual triangulation of KPIs across Care Groups, Corporate and locations	1			**1**
Poor regulatory status		1	1	**2**
PSIRF Processes not fully embedded		1	1	**2**
Total	**2**	**2**	**1**	**1**	**6**

3. Patients - Safety

NHS Humber Health Partnership

The table below details the 8 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
12	Develop and publish Quality and Safety Strategy	01/06/25	31/03/26	Draft presented to 29 May Q&S with further draft planned for Sep copy following comments from CiC members	12/09/25	Heather McNair, Group Chief Nursing Officer	Reasonable
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25	31/03/29	1st Draft to NMB end of Jan	04/02/25	Heather McNair, Group Chief Nursing Officer	
14	Embed EQIA process (outlined in six-month finance report for 2024-25)	01/05/25	31/03/26	EQIA team well established within PMO. Completed full EQIA process as part of Winter Plan submission. Need to continually raise awareness among staff more broadly through FPIB.	12/09/25	Kate Wood, Group Chief Medical Officer, Heather McNair, Group Chief Nursing Officer	Limited
15	Develop and embed the Ward Accreditation programme	31/03/25	01/04/29	Action complete. 250 people to trained to date. SOPs agreed. Peer reviews set for next six months. Next iteration of reporting based on new programme.	04/02/25	Heather McNair, Group Chief Nursing Officer	Significant
52	Developing and implementing a robust clinical audit programme	31/03/26	31/03/27	Programme developed, now in process of implementation	12/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
54	Implementing programme of Martha's Rule actions (for pilot phase)	31/03/26	01/04/27	Piloting six wards, using feedback to inform rollout for organisation. Phase 2 in operation (to Mar 26). Patient Well Being questionnaire already implemented across the group - reporting to Q&S - except for staff gaps to enable paediatric second opinion	12/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
55	***** QS ***** Patient decision-making						
67	Implementation of Staffing business cases for maternity services	31/12/27	31/12/27		02/12/25	Heather McNair, Group Chief Nursing Officer	Reasonable

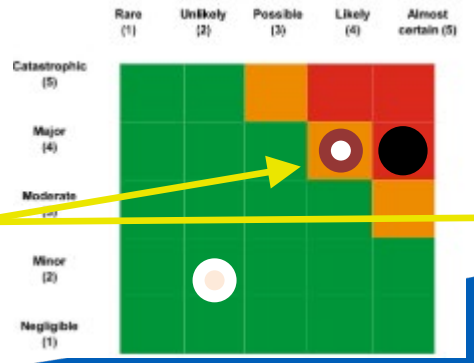
Appendix 1: Patient – Access

On 3 November 2025, the Group Executive Risk and Assurance Committee discussed the Patient Access risk and specifically the risk appetite giving rise to the small distance between the current score and maximum tolerable score (being 4 points). This one-page sets out the current risk, its appetite and proposed change.

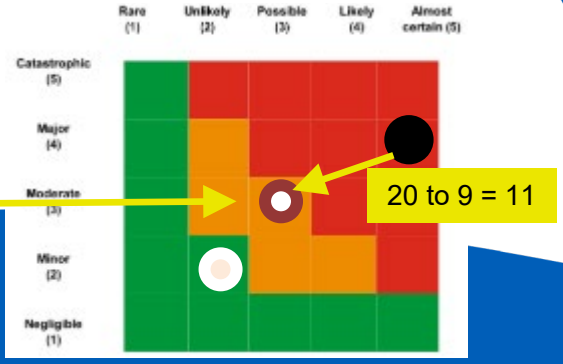
Patients – Access risk: We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

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

This change results in a greater distance from the current score to the tolerable score and therefore greater expectation on the actions to achieve this goal. The distance to tolerable changes from 4 to 11.



- **Proposed risk category - Clinical Quality and Safety**
- Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
- = CAUTIOUS risk appetite



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)221

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 December 2025
Director Lead	N/A
Contact Officer / Author	Sue Liburd, NED Maternity & Neonatal Safety Champion David Sulch, NED Maternity & Neonatal Safety Champion
Title of Report	Maternity & Neonatal Safety Champions Report
Executive Summary	The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are in place: • Delivery of high-quality clinical care across maternity & neonatal service & facilities. • Sufficient workforce numbers to deliver the maternity & neonatal services. • Timely and relevant learning and training systems. • Effective team working. • Authentic engagement mechanisms with service users and the collection of meaningful feedback. • Feedback is utilised to improve the delivery of quality care and services. This report has been developed to enable the Maternity & Neonatal Safety Champions for the two Trusts to report on and provide assurance to the relevant committees and boards in common. The report includes risks and concerns requiring escalation as well as good practice, improvement and innovation.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Maternity & Neonatal Safety Champion's Report
For the Month of December 2025

Executive summary:

The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are all in place:

- Delivery of high-quality clinical care across maternity & neonatal service & facilities.
- Sufficient workforce numbers to deliver the maternity & neonatal services.
- Timely and relevant learning and training systems.
- Effective team working.
- Authentic engagement mechanisms with service users and the collection of meaningful feedback.
- Feedback is utilised to improve the delivery of quality care and services.

This report has been developed to enable the Maternity & Neonatal Safety Champions for the two trusts to report on and provide assurance to the relevant committees and the boards in respect of the above areas. Where required, the report will include risks & concerns requiring escalation as well as good practice, improvement and innovation.

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between 01 September 2025 and 30 November 2025 have included a standard programme of walk rounds, meetings with service executive leads, plus attendance at maternity and neonatal assurance and service meetings as follows:

Hull University Teaching Hospitals (HUTH)

- 18 September — Maternity & Neonatal Assurance Group
- 25 September — Maternity Walkaround (DPOW)
- 16 October — Maternity & Neonatal Assurance Group
- 30 October — Maternity Walkaround (SGH)
- 19 November — LMNS Perinatal Quality Surveillance Group
- 20 November — Maternity & Neonatal Assurance Group

Northern Lincolnshire and Goole (NLaG)

- 02 September — MNVP – North & North East Lincs
- 18 September — Maternity & Neonatal Assurance Group
- 25 September — Maternity Walkaround (DPOW)
- 06 October — Maternity & Neonatal Leadership Review
- 09 October — NHSE Midlands Region NED Perinatal Safety Network
- 16 October — Maternity & Neonatal Assurance Group
- 28 October — Hull and NLaG Joint MNSI QRM
- 30 October — Maternity Walkaround (SGH)
- 20 November — Maternity & Neonatal Assurance Group

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
Data quality issues identified across BadgerNet, BSOTS, and Saving Babies Lives (SBL) reporting. Deep dives into areas of non-compliance alongside Maternity Documentation spot check audit underway across the Group.	Feedback remains positive, with users frequently highlighting compassionate staff, community midwifery, Ask-a-Midwife, and C-section care. Areas needing improvement: BadgerNet usability, communication and listening	Two actions raised through the Safety Mailbox, Shout Out Wednesday, or walkarounds have now been closed. Gynaecology ward (DPOW): In response to staff and service user

VTE assessments: remain low that target for assessing within 6 and 14 hours. Improvement actions underway. NLAG: Uterine Artery Doppler audit flagged low compliance with SBL intervention. Joint working underway with ultrasonography teams to formalise processes.	(particularly in relation to pre-term conversation, the possibility of transfer to another unit and IOL, discharge processes, and consistency in breastfeeding support. FFT: NLAG – 92% positive for maternity and 100% for neonatal care. Negative feedback predominantly relates to waiting times in the antenatal clinics.	concerns, the gynaecology ward has been relocated Key themes from walkarounds: concerns about triage timeliness, space constraints, support for newly qualified midwives and need for consistent medical presence.

Good practice, improvements & innovation to share:

- **Perinatal Mental Health:** A study day designed and hosted by our Perinatal Mental Health Midwives occurred in September with positive feedback
- **Nest & Nurture events**: Launched at NLAG with positive feedback.
- **Birth in Focus**: Midwifery Network Project launched in September.
- **Workforce Business Case (Group):** Maternity and neonatal workforce business case approved subject to annual business planning and review.
- **CNST (HUTH):** Training compliance for safety action 8 achieved.
- **Preceptorship:** Midwifery added to the Group's preceptorship policy. Work towards achieving the Preceptorship Kite Mark has begun.
- **Breast Feeding (HUTH):** Community Midwifery Support Workers are now visiting every new family in Hull and East Riding within three days of their baby's birth to help with breastfeeding.

Risks & concerns to escalate:

- **CNST (NLAG):** Strike action affected the mandatory training week at NLAG. Extra study days were provided, and staff were reassigned. One consultant missed fetal monitoring due to compassionate leave, resulting in 88% compliance at DPOW. Further discussions with NHS Resolution about compliance declaration are planned.
- **Neonatal cot capacity and infrastructure limitations:** The current volume of neonatal admissions has necessitated the transfer of infants across the system. Feedback from the MNVP has underscored the importance of initiating early discussions with parents and families regarding potential transfers.
- **Elevated ATAIN Rates (NLaG):** High rates of avoidable term admissions to neonatal units (ATAIN) are under review with thematic analysis in progress.
- **Staffing levels:** Maternity and neonatal departments are still facing staffing challenges because of staff illness, high rates of maternity leave, and newly qualified midwives and nurses who are completing their scheduled supernumerary periods.

Activities planned next month:

Safety Champions maintain active involvement across various sites and services, ensuring that concerns are addressed, innovation and advancements are acknowledged, and significant risks are escalated when required. Ongoing priorities will continue to be user experience - for both staff and service users, workplace culture, and access to digital resources in the months ahead. Next month's planned activities include:

- 02 December LMNS Delivery Board
- 18 December Maternity & Neonatal Assurance Group

Sue Liburd
Non-Executive Director
Maternity & Neonatal Safety Champion
Northern Lincolnshire & Goole NHS Foundation Trust

David Sulch
Non-Executive Director
Maternity & Neonatal Safety Champion
Hull University Teaching Hospitals Trust

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)222

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 December 2025
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath – Group Director of Midwifery
Title of Report	**Front sheet inclusive of** **1.) Maternity and Neonatal Assurance Report** **2.) Maternity Incentive Scheme Year 7 Progress Report** **3.) PMRT Quarterly Reports** **4.) Bi- Annual Midwifery and Neonatal Nursing Staffing Report inclusive of action plans** **5.) Updated Safety Action 4 Medical Action Plans**
Executive Summary	Executive Summary for Trust Boards in Common 1.) This report provides an overview of maternity and neonatal safety, quality, and workforce across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). It highlights progress, key achievements, and ongoing challenges aligned with the NHS England Maternity and Neonatal Three-Year Delivery Plan and NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 7 (MIS7). Key Achievements **Quality, Safety & Outcomes** · Perinatal deaths (Oct 2025): o HUTH: 1 antenatal stillbirth (26+3), 1 intrapartum stillbirth (37+6). o NLAG: 3 antenatal stillbirths, 1 neonatal death. · Reviews: Active PMRT and MNSI investigations highlight key themes: delayed induction decisions, documentation gaps, fetal monitoring concerns, incomplete pathways (e.g., Cherished Care), and DNA policy adherence. · Term admission rates: Mostly within the national <6% benchmark across all three units, with respiratory distress remaining a leading cause for separation. · The claims scores cards are included for both Trusts for discussion following the publication of the national results. · The Culture Survey has been updated and is included in the report. **Workforce & Staffing** · Vacancy rates: neonatal nursing pressures most notable at HUTH, with fill rates as low as 63–70% on some shifts. · Training compliance (SA8): o Midwives: generally >90% across most areas. o Medical staff: below the 90% target in several domains, particularly at NLAG.

- Red flags (Sept 2025):
  - HUTH: 53 (mostly induction delays)
  - NLAG: 14 (similar themes plus community staff redeployment to units).

Service User Experience

- Feedback remains positive, with users frequently highlighting compassionate staff, community midwifery, Ask-a-Midwife, and C-section care.
- Areas needing improvement: BadgerNet usability, communication and listening, discharge processes, and consistency in breastfeeding support.
- FFT: NLAG – 92% positive for maternity and 100% for neonatal care.

Operational Performance

- BSOTS compliance: Data quality issues identified at NLAG; adjusted October compliance 91%.
- Saving Babies' Lives v3: Both Trusts are progressing but remain below LMNS trajectories in several elements, particularly preterm birth interventions.
- VTE performance: Variable, with some sites requiring improvement at 6- and 14-hour assessment windows.

Culture, Leadership & Staff Voice

- Multiple initiatives underway including Tea Trolleys, Personalised Care Task & Finish Group, student support improvements, and culture workshops.
- Key themes from walkarounds: concerns about triage timeliness, space constraints, support for newly qualified midwives, and need for consistent medical presence.

Maternity Incentive Scheme Year 7

- **SA1**- fully compliant across the Group.
- **SA2**- fully compliant across the Group
- **SA3**- fully complaint across the Group
- **SA4**- Workforce Business Cases approved at November Board, therefore fully compliant once action plans uploads. Updated action plans following November Board are shared for this Board.
- **SA5**- Bi-annual Staffing Report shared for with this Board. Workforce Business Case approved at November Board. Updated action plan reflecting this approval are shared in these papers and therefore compliance with SA5 is achieved
- **SA6-** 'all best endeavours met' therefore compliant
- **SA7**- fully compliant across the Group
- **SA8**- fully compliant at HUTH. 1/8 Obstetric Consultant (88%) not compliant with Fetal Monitoring to discuss with NHSR as related unplanned absence. Due to low numbers of staff in the Consultant workforce to achieve greater than 90% all Consultants must attend training.
- **SA9**- fully compliant across the Group
- **SA10**- fully compliant across the Group

Perinatal Mortality Review Tool

	100% compliant for both trust for MIS Safety Action 1. The report details all deaths including reviews and consequent action plans.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**MNAG & QSCIC September 2025**
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**None**
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

November 2025

Contents

Item 1: Executive Summary 3
Item 2: Maternity Dashboard Overview 5
Item 3: Key highlights
3.1 CNST MIS Year 7: 10 Steps to Safety 8
3.2 Perinatal Quality Overview Model 10
Item 4: In month developments and updates 12
4.1 Maternity & Neonatal updates
122
Item 5: Training compliance 13
Item 6: Safe staffing 15
6.1 Fill rates – planned versus actual 15
6.2 Midwifery Staffing Vacancy Rates 16
6.3 Maternity Red Flags 16
Item 7: Learning lessons 17
7.1 HUTH Maternity & Newborn Safety Investigation cases 17
7.2 HUTH Detail of incidents graded moderate or above & rapid reviews 18
7.3 NLAG Maternity & Newborn Safety Investigation cases 19
7.4 NLAG Details of incidents graded moderate or above & rapid reviews 20
7.5 Top Risks on Maternity Risk Register 21
Item 8: Perinatal Mortality 22
8.1 Perinatal Mortality Summary for the period 22
8.2 National Perinatal Mortality Benchmarking 23
8.3 Details of PMRT Review Outcomes 24
Item 9: Listening to our staff 25
Item 10: Saving Babies Lives 27
Item 11: ATAIN 29
Item 12: Service User Feedback 30
Item 13: VTE Risk Assessment Performance 34
Item 14: Quality Improvement Projects (Group Update) 35
Item 15: Triangulation of Claims Scorecard 37
Item 16: BSOTS Performance 41
Item 17: MatNeo Three Year Delivery Plan – Progress update 42
Item 18: Progress with CQC Survey Action Plan 45
Item 19: Progress with Culture Improvement Plan 52
Item 20: Progress with Ockenden Actions 57
Appendix A: Learning from Deaths 60

1: Executive Summary & Highlight Report

Maternity and neonatal services across Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole (NLAG) continue to deliver safe care with positive user experience, while navigating ongoing workforce, training, and data quality challenges. Both organisations remain aligned to the NHS England Three-Year Delivery Plan, with key risks focused around workforce, CNST compliance, and implementation of core safety bundles.

Quality, Safety & Outcomes

- Perinatal deaths (Oct 2025):
  - HUTH: 1 antenatal stillbirth (26+3), 1 intrapartum stillbirth (37+6).
  - NLAG: 3 antenatal stillbirths, 1 neonatal death.
- Reviews: Active PMRT and MNSI investigations highlight key themes: delayed induction decisions, documentation gaps, fetal monitoring concerns, incomplete pathways (e.g., Cherished Care), and DNA policy adherence.
- Term admission rates: Mostly within the national <6% benchmark across all three units, with respiratory distress remaining a leading cause for separation.

CNST MIS Year 7 Compliance

- HUTH: 2 red and 8 amber across Safety Actions; key risks relate to workforce planning, SBL v3 compliance, and training (SA8).
- NLAG: 4 red, 5 amber and 1 blue; significant risks in midwifery workforce planning (SA5), SBLCB v3 implementation (SA6), and training (SA8).

Workforce & Staffing

- Vacancy rates: Midwifery ~7% across both organisations; neonatal nursing pressures most notable at HUTH, with fill rates as low as 63–70% on some shifts.
- Training compliance (SA8):
  - Midwives: generally >90% across most areas.
  - Medical staff: below the 90% target in several domains, particularly at NLAG.
- Red flags (Sept 2025):
  - HUTH: 53 (mostly induction delays)
  - NLAG: 14 (similar themes plus community staff redeployment to units).

Service User Experience

- Feedback remains positive, with users frequently highlighting compassionate staff, community midwifery, Ask-a-Midwife, and C-section care.
- Areas needing improvement: BadgerNet usability, communication and listening, discharge processes, and consistency in breastfeeding support.
- FFT: NLAG – 92% positive for maternity and 100% for neonatal care.

Operational Performance

- BSOTS compliance: Data quality issues identified at NLAG; adjusted October compliance 91%.
- Saving Babies' Lives v3: Both Trusts are progressing but remain below LMNS trajectories in several elements, particularly preterm birth interventions.
- VTE performance: Variable, with some sites requiring improvement at 6- and 14-hour assessment windows.

Culture, Leadership & Staff Voice

- Multiple initiatives underway including Tea Trolleys, Personalised Care Task & Finish Group, student support improvements, and culture workshops.
- Key themes from walkarounds: concerns about triage timeliness, space constraints, support for newly qualified midwives, and need for consistent medical presence.

Key Risks

- Workforce shortages and skill mix in maternity and neonatal units.
- Training compliance gaps affecting CNST readiness.
- Neonatal cot capacity and infrastructure limitations.
- Data quality issues across BadgerNet, BSOTS, and SBL reporting.
- Delays in time-critical care (notably induction processes).
- Inadequate estate for community midwifery teams (NLAG).

Overall Position

Despite significant pressures, both HUTH and NLAG demonstrate strong leadership commitment, positive culture shifts, and sustained improvements in many areas. However, workforce stabilisation, training compliance, data integrity, and delivery of CNST MIS standards remain the most urgent priorities to ensure safe, equitable and sustainable maternity and neonatal care across the Humber Health Partnership.

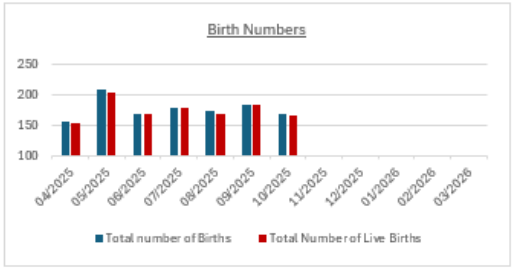
Item 2: Maternity Dashboard Overview

**The rolling stillbirth and neonatal death rates for DPOW and SGH are taken from Badgernet reporting from 1st October 2024 onwards.*

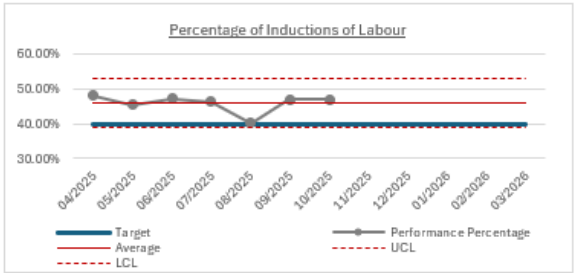
Maternity Overview - Diana Princess of Wales (DPOW)

Latest Month: October 2025

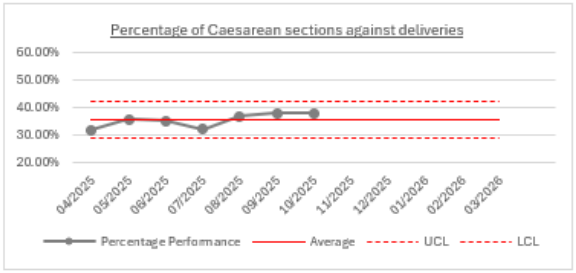
Number of Births / Live Births



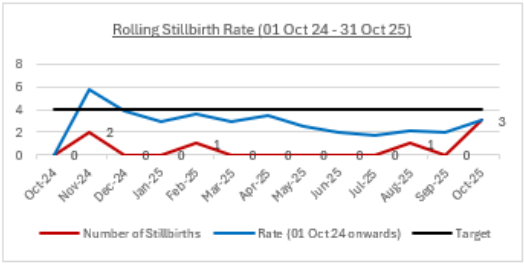
Induction of Labour Rate



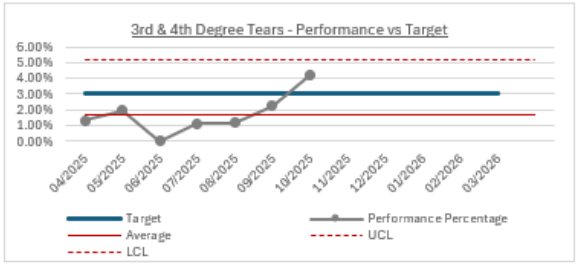
Caesarean Section Rate



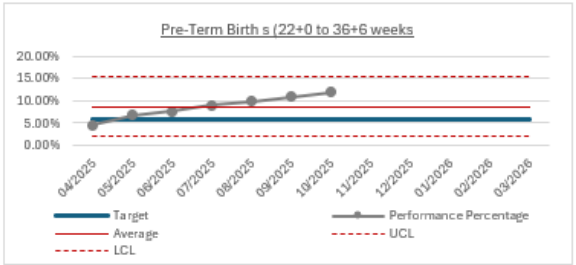
Rolling Stillbirth Rate (per 1000 births)



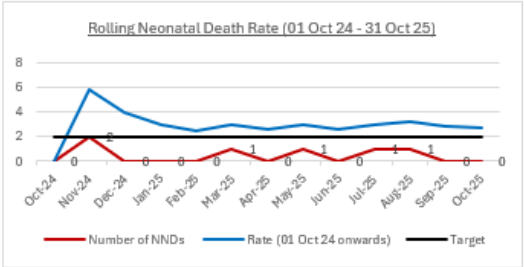
Third and Fourth Degree Tear Rate



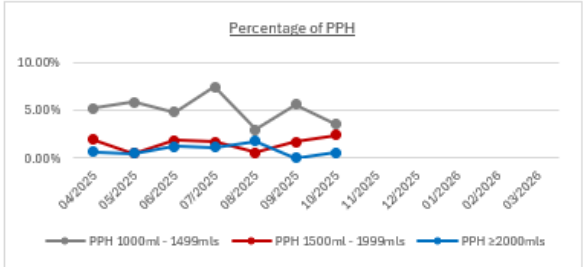
Preterm Birth Rate



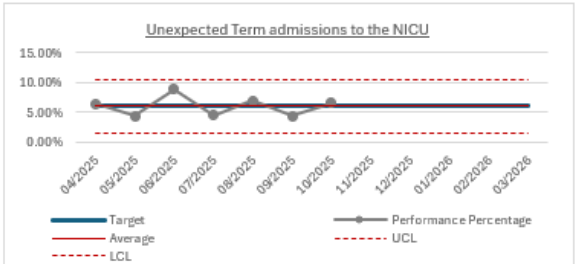
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



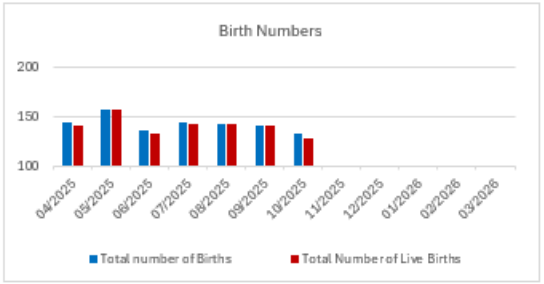
Unexpected Admission to NICU



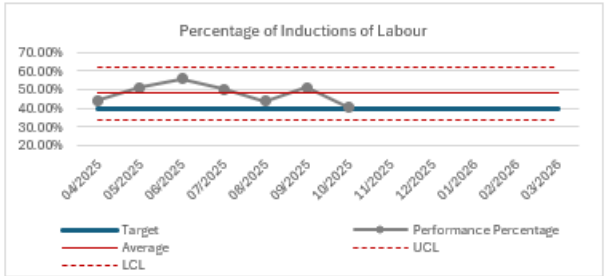
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: October 2025

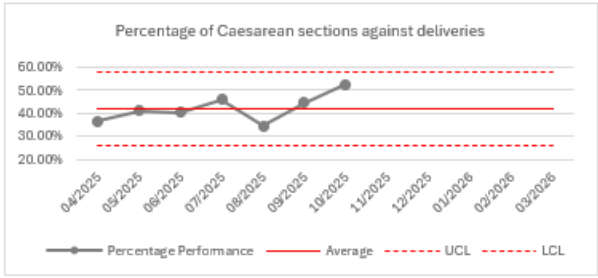
Number of Births / Live Births



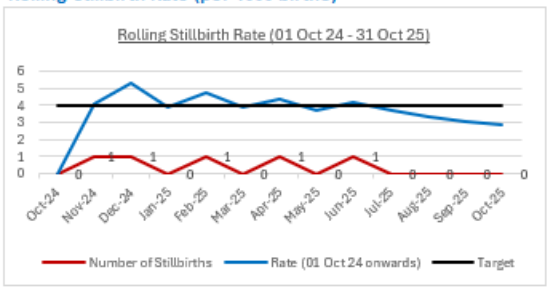
Induction of Labour Rate



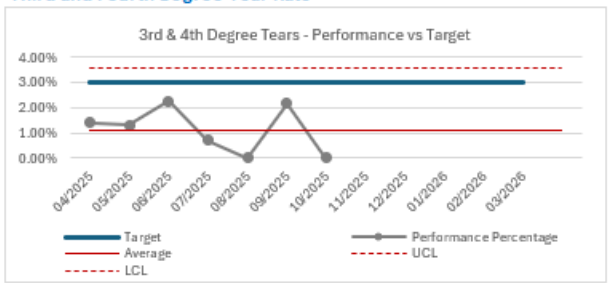
Caesarean Section Rate



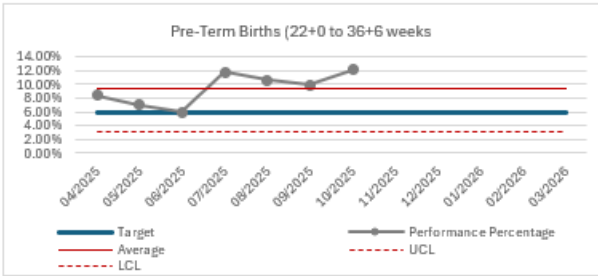
Rolling Stillbirth Rate (per 1000 births)



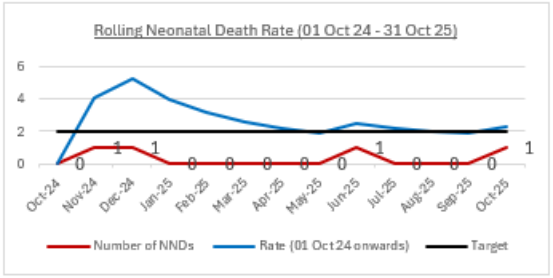
Third and Fourth Degree Tear Rate



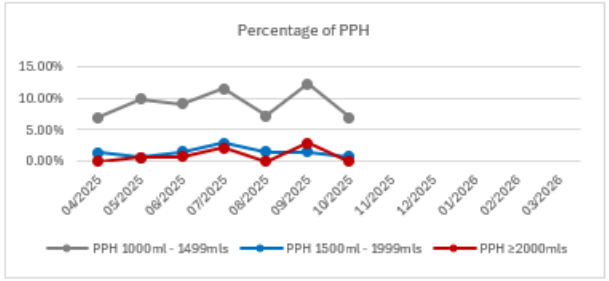
Preterm Birth Rate



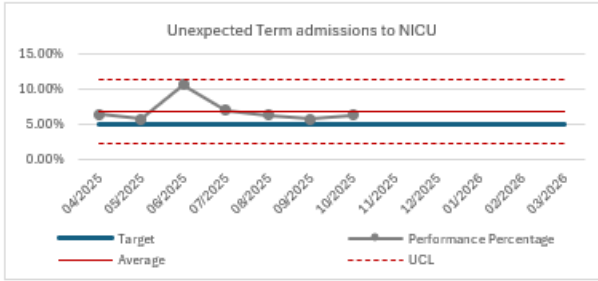
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU

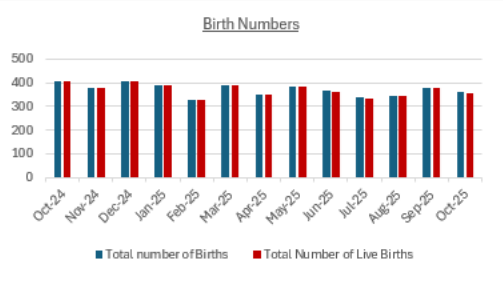


** The rolling stillbirth / neonatal death rates are based on data extracted from Badgernet. Issues noted in reporting when comparing to Power BI sourced data.*

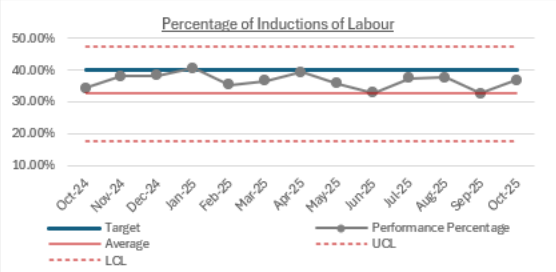
Maternity Overview - Hull University Teaching Hospitals (HUTH)

Latest Month: October 2025

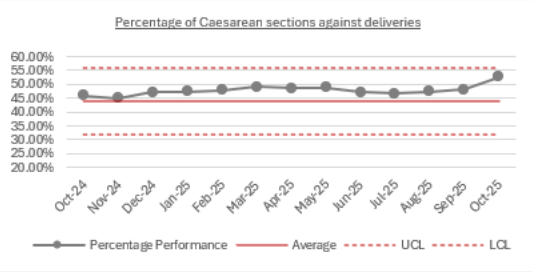
Number of Births / Live Births



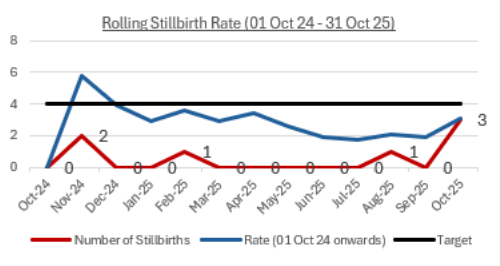
Induction of Labour Rate



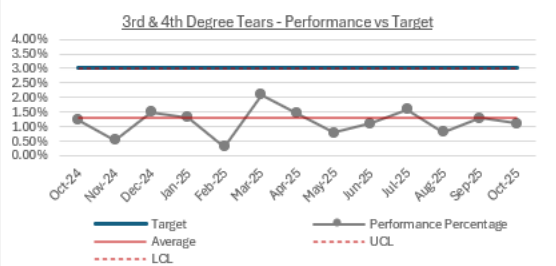
Caesarean Section Rate



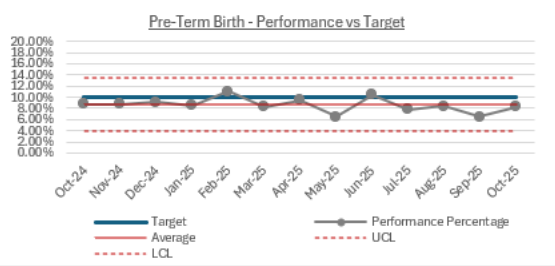
Rolling Stillbirth Rate (per 1000 births)



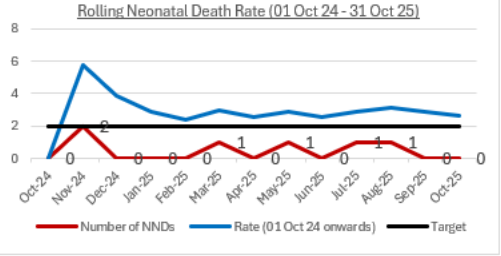
Third and Fourth Degree Tear Rate



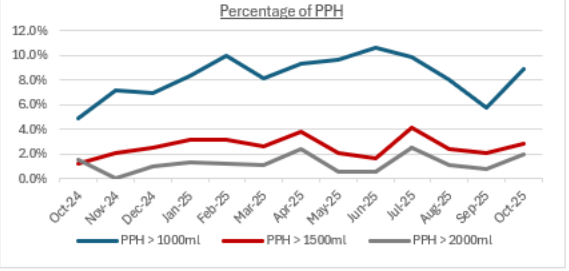
Preterm Birth Rate



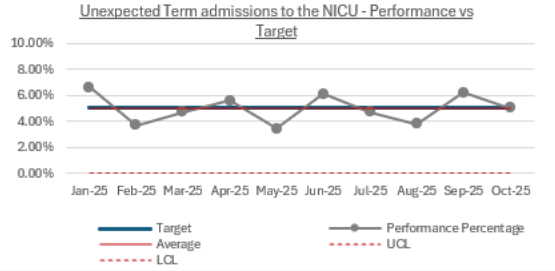
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU



Key Highlights 3.1 CNST MIS Year 7: 10 Steps to Safety

Hull University Teaching Hospitals NHS Trust

The Trust has utilised the NHS Resolution Audit tool during the year to track compliance with the standards.

Green - Completed
Amber - On Track for completion
Red - Not on track
Blue - Completed and evidenced

Safety action	Red	Amber	Green	Blue	
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					Trajectories for March 2026 set at 100% by LMNS for all elements. Difficult in achieving, particularly for pre-term birth standards due to the nature of presentation.
7 Service User Feedback / Co-produced Services					
8 Training					Outstanding staff members to book onto training.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**2**	**8**	**0**	**0**	

Northern Lincolnshire and Goole NHS Foundation Trust

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					Non-compliant with BAPM Medical & Nursing workforce requirements, progress against previous action plans required.
5 Midwifery Workforce Planning					Action plan to be developed and approved by Trust Board where establishment does not meet BirthRate Plus requirements.
6 SBLCB V3					Q1 25/26 (NLAG 81%), LMNS to determine if best endeavours have been made to achieve local trajectories to reach March 26 target.
7 Service User Feedback / Co-produced Services					MNVP team structure not in line with national requirements. Escalation as part of PQOM to Trust, ICB and Regional team undertaken.
8 Training Plan					Require staff to attend planned training sessions throughout November to achieve 90% target. Ongoing close surveillance.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**4**	**5**	**0**	**1**	

MIS Year seven guidance was published in April 2025. The MIS Delivery Group takes place monthly to discuss any risks identified with oversight from the Site Director of Nursing. The most significant risks are associated with Safety Action 5, Safety Action 6 and Safety Action 8.

2.3 Perinatal Quality Surveillance Model
Hull University Teaching Hospitals NHS Trust

CQC Maternity Ratings	Safe	Effective	Caring	Responsive	Well Led	Overall
	Inadequate	Requires improvement	Good	Requires Improvement	Inadequate	Inadequate
Maternity Support Programme	Yes					

Data measure	September 2025
Findings of reviews of all perinatal deaths using the real time data monitoring tool	Meeting occurred on the 24th September. External reviewers present. MNVP attendance. 99246 – 27+1 NND. HUTH care graded B/A. Delivered at Barnsley and bringing back in October for update regarding their CTG management and own review grading. 99518 – 30+6 AN SB. HUTH care graded B/B. Moved to report writing. 99594 – 32+ AN SB. HUTH care graded A/A. Congenital abnormality, at report writing.
Number of cases referred to MNSI/ENS	0 referred from HUTH but shared incident reported by NLAG. MI-045011 – term cooled baby. HUTH IOL transferred to NLAG for continuation of IOL. Not yet at interview stage.
Findings of review of all cases eligible for referral to MNSI	0
Number of incidents graded as moderate or above and what action is being taken	Please see 5.2
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report – item 4.
Service User Voice feedback	Please refer to body of report – item 9.
Staff feedback from frontline champions and walk-abouts	Personalised care T&F Group developed after discussions with community midwives. HUTH are also reviewing and devising an interim plan regarding Homebirths.
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10	Please refer to body of report – currently collating evidence. Main concerns: training compliance, SBL and midwifery staffing.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Place to work – 22% Receive treatment - 31%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)	91% - response rate 79% - within IQR

Northern Lincolnshire and Goole NHS Foundation Trust

CQC Maternity Ratings	Safe	Effective	Caring	Responsive	Well Led	Overall
DPOW	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Goole	Requires Improvement	Good	Good	Good	Good	Good
SGH	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity Support Programme	No					

Data measure	September 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	2 PMRT MDT meetings took place. External reviewers present at both. The following cases were reviewed: 98745 22+6 late fetal loss, care graded B/B. 98971: 36+4 antepartum stillbirth, care graded B/B. Themes identified include the non-completion of the Cherished Care Pathway in both cases.
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	Please refer to body of report for ongoing update of investigation.
Number of patient safety incidents logged and what actions are being taken	182 maternity (5 moderate – 3 linked to 1 birthing person). Incident 351572 now closed and will be included in a further MDT review. Further actions to be agreed once MDT review has taken place. Incidents being reviewed by Obstetric Governance Lead. Planned for discussion at Clinical Review.
Training compliance for all staff groups in maternity related to the core competency framework	Please refer to body of report
Service User Voice – themes	Please refer to body of report
Staff feedback from frontline champions and walk-abouts - themes	DPOW walkabout: Concerns raised about space utilisation and recommendations from midwifery teams regarding having an allocated doctor assigned to Triage to aid timely review.
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10 safety actions	Please refer to body of report
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Place to work – 47% Receive treatment - 58.6%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually) 2025	DPOW - 85% - response rate 54% - within IQR SGH – 84% - response rate 100% - within IQR

Item 4: In month developments and updates

4.1 Maternity and Neonatal updates

Positive News

- Maternity and neonatal workforce papers approved subject to annual business planning and review at private board.
- Nest & Nurture events launched at NLAG with positive feedback.
- Multiple Shining Lights for Maternity Staff across professions
- Majority of newly qualified midwives have started with us and now have their pins.
- Exceptional teamwork and communication noted in two recent rapid reviews at NLAG.
- Midwifery now on the on the Group's preceptorship policy and working towards achieving the Preceptorship Kite Mark
- Floating team pilot will commence at HUTH in April 2026.
- Pan-Group Personalised Care Task & Finish Group commenced
- Rotation Workshop outcome shared with staff at DPOW and will now proceed to consultation.
- Community Midwifery Support Workers are now visiting every new family in Hull and East Riding within three days of their baby's birth to help with breastfeeding. This is in addition to the wonderful support offered to Hull families by the Goodwin Baby Feeding Practitioners.
- Our first Culture Champion Jasmine Martin has done her first Positiv-tea Trolley at HUTH.



Areas of Concern

- Staffing across maternity and neonatal areas continues to be challenging due to sickness, high levels of maternity leave and newly qualified midwives and nurses continuing their planned supernumerary periods.

Item 5: Maternity Training Compliance

Safety action (SA8) identifies that 90% attendance in each relevant staff group should attend:

1. Fetal monitoring training
2. multi-professional maternity emergencies training
3. Neonatal Life Support Training

MIS - For rotational medical staff that commenced work on or after 1 July 2025 a lower training compliance will be accepted. Where applicable, confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.

Hull University Teaching Hospitals NHS Trust (October 2025)

	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	100%	N/A	95%	100% (prior 01/07) 64% (after 01/07)	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	94%	100%	83% (prior 01/07) 67% (after 01/07)	100%	92% (prior 01/07) 80% (after 01/07)	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	96%	N/A	N/A	N/A	N/A	N/A	92%	100%	86%	100%
NLS (4 year MIS)	N/A	N/A	N/A	N/A	N/A	N/A	94%		N/A	N/A

Northern Lincolnshire and Goole NHS Foundation Trust (October 2025)

	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetists (Consultants)	Anaesthetists (other doctors)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNPs
Fetal Monitoring (MIS)	96%	N/A	93%	58%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	94%	94%	100%	61%	96%	91%	N/A	N/A	N/A	N/A
Personalised Care (SBLCB)	88%	95%	80%	56%	N/A	N/A	N/A	N/A	N/A	N/A
Care during Labour & PN (SBLCB)	90%	N/A	73%	83%	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year) (MIS)	81%	N/A	N/A	N/A	N/A	N/A	94%	89%	88%	100%
NLS (4 year) (MIS)	N/A	N/A	N/A	N/A	N/A	N/A	94%	86%	N/A	N/A

Item 6: Safe Staffing
6.1 Fill rates – planned versus actual

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Sept 25	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	3204.3	3015.8	94.1%	3194.1	2915.5	91.3%	1620.0	1514.9	93.5%	1380.0	1384.0	100.3%
SGH	2484.3	2248.3	90.5%	2484.3	1986.9	80.0%	690.0	609.5	88.3%	915.0	777.3	84.9%

Month: Sept 25	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	3105.0	2631.9	84.8%	2760.0	2544.0	92.2%	1380.0	1026.3	74.4%	1035.0	926.7	89.5%
SGH	2070.0	1959.9	94.7%	1725.0	1706.2	98.9%	1605.0	1067.0	66.5%	1035.0	952.7	92.0%

Activity is based on inpatient areas only (Central Delivery Suite and Ward 26).

Hull University Teaching Hospitals (HUTH)

Month: Sept 25	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	8882.75	7910.17	89.1%	5439.5	4824.17	88.7%	3061.50	2703.83	88.3%	2644.00	2217.00	83.9%

Month: Sept 25	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	10349.00	6580.67	63.6%	6653.00	4682.58	70.4%	591.00	542.50	91.8%	330.00	144.00	43.6%

Activity is based on inpatient areas only (Maternity Triage, Labour ward, Rowan ward, Maple Ward and MLU)

6.2 Midwifery Staffing Vacancy Rates (September 2025)

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH	Vacancy rate NLAG	Vacancy rate adjusted NLAG
Midwifery	7.5%	4.2%	7.1%	-10.6%
Midwifery Support Workers	9.8%	8.7%	-7%	-13.6%

At NLAG the MSW's is in a deficit due to them not being coded accurately on ESR, there is different codes for those who meet the education element of the MSW framework and those who do not.

6.3 Red flags, Actions and Mitigations (September 2025)

The most recent data available is for September 2025. During the month HUTH reported 46 red flags and NLAG reported 14. The details are shown in the table below.

	HUTH	NLAG
Delayed or cancelled time critical activity	18 (34%)	7 (50%)
Delay between admission for induction and beginning of process	34 (64%)	2 (14%)
Delayed recognition of and action on abnormal vital signs	1 (2%)	-
Community staff have been called to work on the unit	-	5 (36%)
Total	**53**	**14**

Item 7: Learning lessons Hull University Teaching Hospitals NHS Trust

7.1 Maternity & Newborn Safety Investigation (MNSI) cases (ongoing)

MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN/referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-042322	White British – IMDD 9	Yes	Yes	Yes	Yes	Yes	Planned homebirth (transfer in for delivery) and cooled baby. Doula supporting family. Staff interview stage. MIRM review completed. ENS referral. DoC compliant. Awaiting draft report. UPDATE - Draft report received for FA. FA submitted and declining 1 safety action. Awaiting feedback expected after MNSI meeting 6th November.
MI-048159	White British – IMDD 1	No	Yes	Yes	Yes	Yes	(Term intrapartum still birth): MOH 5500ml and hysterectomy. Consent gained. Information being uploaded to Portal. MDT including anaesthetic and theatre MDT planned 07/11/2025. For uplift to LRP.
MI-048987	White British – IMDD 8	Yes	Yes	Yes	Yes	Yes	Baby born at term following a manual rotation and forceps assisted vaginal delivery. Required active cooling. MIRM complete. ENS referral. MNSI status: at initial contact and consent.

7.2 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
357973 - E. Coli Blood stream infection		Obstetric	Moderate – Matron and ward manager to review	This is awaiting ward manager review and matron review. Update requested 11/11/2025. This was graded moderate by IPC team.
357440 - Readmission for retained products of conception 18 days post C-section (Emergency) in Grimsby. Attended due to foul and yellow pv discharge.	WB/ IMDD 4	Obstetric	Moderate (assigned to NLAG)	Review assigned to NLAG. A joint review was proposed but this was declined. Surgical management of RPOC performed. NLAG to provide DoC.
356586 - PN transfer from Grimsby for a hysterectomy. ICU admission in Grimsby 14/10 Bakri balloon gradually deflated, further PPH, Balloon inserted again. Total EBL at this point 6 lt. patient was reluctant for hysterectomy. Transferred ITU to ITU due to interventional radiology. Obs handover provided. Bilateral UAE performed but continued to bleed. Decision for hysterectomy.	WB/IMDD 1	Obstetric	Severe Harm (MNSI – 048159)	Intrapartum IUD (MNSI threshold). Smoker. Declined cessation. BMI 41. Unemployed. G8 P7 -1. MoH and hysterectomy. Missed opportunity to induce in line with plan and local guidance. Staff and slots were not a factor. For PMRT and MNSI pathway. Planned MIRM review but no obstetric care other than hysterectomy performed at HUTH. This is being reviewed by the LRP (requested by NLAG).
355963 - 37+6 intrapartum still birth MOH 5770ml and hysterectomy. MNSI accepted. Grand-multiparous (G8 P7-1) Chronic hypertensive. BMI 41. Smoker (declined cessation). MIRM review identified. White British (IMDD1). Missed opportunity to induce at 37/40 (incorrect dates on the IOL proforma – offered IOL date 38+0) and available slots were present earlier in the week and staffing was not an issue. This is not an ongoing theme. The MOH and decision to perform the hysterectomy was well managed. She required ITU transfer due to hyperkalaemia	Asian (Pakistani) /IMDD 5	Obstetric	Severe Harm	16 DNA in pregnancy and DNA policy not followed. Personalised care and DNA policy being reviewed and working group created. This lady was non-compliant with her anti-hypertensive medication, LMWH and aspirin. Required multiple hospital admissions (x1 to general side for pneumonia with no documented obstetric/midwifery review). Reduced movements were not a factor. We asked the question if there were any delays in going to theatre, difficulty detecting FH upon initial admission without emergency buzzer use (ongoing QI) so in MIRM it was felt this may not have affected the outcome but was delayed in identifying an

(managed with calcium chloride infusion treatment) and AKI 2 (required hemofiltration).				emergency. This has been requested for review at the LRP 13/11/2025. Staff have been supported and continue to be so. Family engaging with bereavement services. NLAG to provide DoC provided.

7.3 Maternity & Newborn Safety Investigation cases (ongoing) Northern Lincolnshire and Goole NHS Foundation Trust

MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN/referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-045011	White British	Yes M25CT600/007	Yes	Yes	Yes	Yes	Baby required resuscitation and was transferred to Sheffield for active cooling. Discussed at Learning Response Panel and rapid review undertaken. Progressing through MNSI investigation, however local learning has been identified for both HUTH and NLAG. HUTH: Follow up growth scan not undertaken as per guidance, elevated BP not correctly investigated or reassessed at each contact and documentation did not include management plan prior to transfer to DPOW. NLAG: CTG misinterpreted, lack of recognitional of abnormal CT, lack of escalation of obstetric review, peer CTG and fetal monitoring reviews not documented in real time (undertaken following delivery).

							The Fetal Monitoring Lead Midwife continues to undertake a monthly audit and had recognised and escalated this concern for action. Delivery documentation not fully completed. Recommended equipment not used to secure ET tube, incomplete neonatal documentation.

7.4 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
351977	White British	Neonatal	Moderate	Incubators not able to reach required temperature or humidity required for extreme pre-term triplets. To be discussed at Learning Response Panel.
354591	Pakistani	Obstetric	Moderate	Preterm APH and PPH >2500mls and subsequently required a postnatal hysterectomy. Rapid review undertaken and due for discussion at Learning Response Panel 13/11/25. No immediate action taken – learning missed opportunity for earlier hysterectomy, potential missed opportunity for detecting placenta praevia and accreta, during second MoH clotting factors and fibrinogen not re-checked as per algorithm, MoH proforma not completed and medications, readily available in ITU and main theatres, running total of EBL not input on Badgernet, documentation over several platforms (written and Badgernet). No patient ID labels on CTGs and CTG not uploaded to Badger on Dopplex Centrale.
354592 (linked with above – same patient)				Transfer to ITU (investigation as per above detail).
354794 (linked with above – same patient)				PPH over 2400mls requiring blood transfusion (investigation as per above detail).

354612	White British	Obstetric	Moderate	36+5 weeks, delay in induction of labour due to NICU closure. Rapid review undertaken and has been to Learning Response Panel (06/11/25) who are happy with the learning identified and actions being taken. Learning identified: no offer of transfer to another unit, no SOP in place with regards to NICU cot unavailability and delay in IOLs, no documentation from the initial assessment by medical staff, delay in acting on abnormal antenatal CTG.
358674	Eastern European	Neonatal	Moderate	34+5 emergency LSCS for APH, baby dropped at delivery. Hot debrief undertaken with all staff involved. To be discussed at Learning Response Panel 06/11/25.

7.5 Top Risks on Maternity Risk Register

Hull University Teaching Hospitals NHS Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity / Obstetrics	Frequent unavailability of neonatal cots	High
Maternity / Obstetrics	Inability to provide dedicated overnight triage for birthing people – risk of missing urgent maternal risks	Moderate
Maternity / Obstetrics	Maternal Diabetic and Maternal medicine ANC capacity and staffing	Moderate
Neonatal	High risk of delayed diagnosis and management as patients are not being seen when we would wish them to	Moderate
Neonatal	Risk to patient safety due to guidelines not being updated on Bridget	Moderate
Neonatal	Risk of increased medication errors due to the lack of guardrails in place on neonates	Moderate

Northern Lincolnshire and Goole NHS Foundation Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity / Obstetrics	Inappropriate accommodation (community midwives)	High
Maternity / Obstetrics	Lack of compliance with BSOTS standards	Moderate
Maternity / Obstetrics	Maternity beds (last replaced in 2018, beds have a 5 year shelf life)	Moderate
Neonatal	Electricity supply failure in NICU	Moderate
Neonatal	CPAP drivers	Moderate
Neonatal	NICU incubators	Moderate

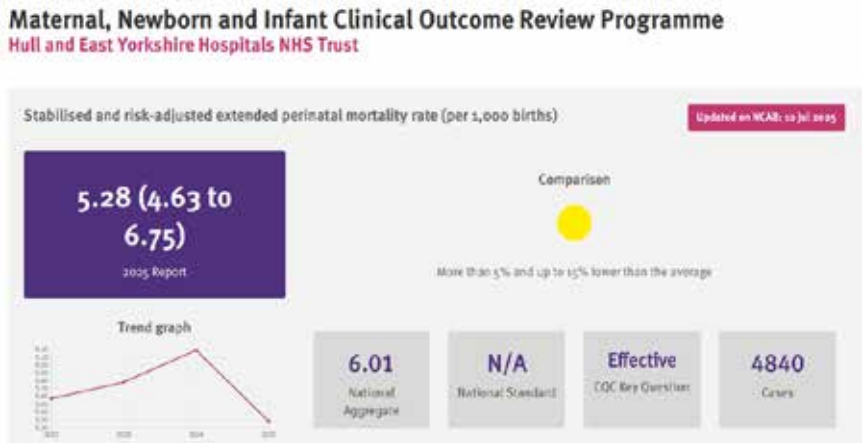
Item 8: Perinatal Mortality

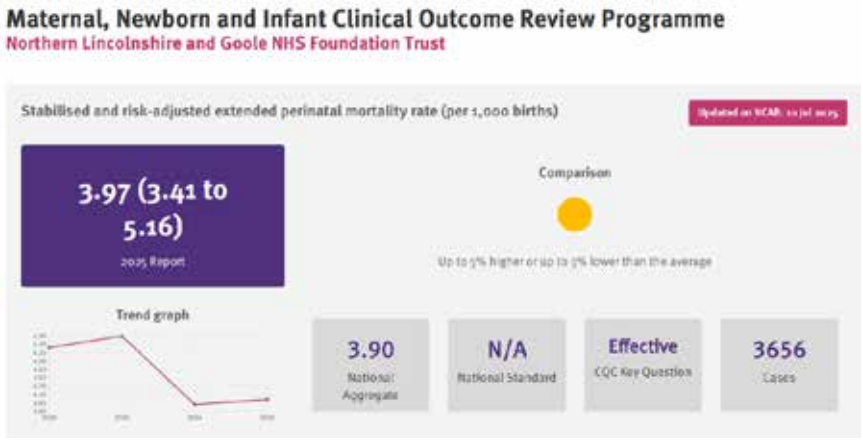
8.1 Perinatal Mortality Summary for the period

Perinatal deaths within month (October 2025)					
	Antenatal Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	1 (26+3)	0	1 (37+6)	0	0
NLAG	3 (27+2, 29+6, 28+0)	0	0	1 (35+0)	0

8.2 National Perinatal Mortality Benchmarking

The graphs below demonstrate how the Trust is performing against the national safety ambition.









8.3 Details of PMRT Review Outcomes (September 2025)

At the conclusion of the multidisciplinary review the team agree the grading of care, the categories are as follows:

Prior to the confirmation of the baby's death:
A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.

Following the confirmation of the baby's death:
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother.

Hull University Teaching Hospital NHS Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
99246	Barnsley to grade/B/A	N/A	N/A	Bringing back for Barnsley discussion of CTG and AN care grading (Barnsley)
99594	A/A	N/A	N/A	Congenital Abnormality. Moved to report writing.
99518	B/B	N/A	N/A	Moved to report writing.

Northern Lincolnshire and Goole NHS Foundation Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
98741	A / B	N/A	N/A	37+4 neonatal death (expected death due to fetal abnormalities). Rapid Review undertaken. Learning includes documentation issues with the non completion of the Cherished Care Pathway and not all postnatal investigations were completed.
99969	C / A	Yes	06/11/25	30+5 antepartum stillbirth. Rapid review undertaken. Discussed at LR panel and the group were satisfied with the agreed actions in place to address the learning identified.

Item 9: Listening to our staff

- **Safety Champion Walkaround at DPOW in September 2025. Feedback included:**
  - Staff pleased with the MNVP board in ANC reception and the information we had on display for the women.
  - **Triage:** women are not reviewed in timely manner due to ward rounds and ward workload. Recommendation for a designated doctor for ADU / Triage to allow women to be seen within BSOTS timeframes. **NED SC feedback / action:** Agreed it would be better practice to have a dedicated doctor and will speak to the team and look at rota's to see what can be arranged.
  - **Gynae ward:** Staff felt it would be much better back upstairs where it used to be so that it's easier for the doctors to come down and review the women, as the location has caused further delays. **NED SC feedback / action:** Discuss location with the team.
  - **Triage, Honeysuckle, Blueberry, Holly and Coordinators:** Staffing levels and concerns voiced about the amount of newly qualified midwives recruited and how much pressure this will have on the Band 6's. They felt that expectations are high to support NQMW's, students and run the ward and there are a number of Junior Band 6's feeling this pressure.
  - **Community:** Staff felt the Community Managers office is too small/cramped.

- **Space management NED SC discussion with staff:** Co-ordinators office was too large, handover times were very busy but felt these could be accommodated elsewhere or the room could be used in a better way. They felt the staff room was drab, uninviting and made the staff feel undervalued, it was also suggested about a 'floater' midwife that could cover midwives breaks to allow them to come off the ward and have a protected break.

- **Safety Champion Walkaround at SGH in October 2025. Feedback included:**
  - Management time
  - Staffing levels (suggestion of twilight MSW on CDS)
  - Not providing 1-1 care in labour or labour ward supernumerary status on occasion. *This was escalated to HoM for investigation and discussion with the Co-ordinator who raised the concern. Reassurance has been provided to those present on the walkabout and staff on the ward that they do occasionally have a postnatal patient or a non-labouring patient however this does not affect the supernumerary status according to MIS guidance and with regards to 1:1 care, there is sufficient evidence that on the occasion raised that 1:1 care in labour was achieved.*
  - Agency staff – not being prepared with Badgernet access etc
  - Time for signing off student midwives competencies

- Ask Me Anything continues by the Director of Midwifery continues monthly.

Item 10: Saving Babies' Lives Care Bundle (v3)

The new Saving Babies' Lives Care Bundle, version 3.2 was published in May 2025. The compliance for Q4/Q15 is based on the benchmarking against the new interventions.

Northern Lincolnshire and Goole NHS Foundation Trust

% of interventions fully Implemented					Current
Review quarter	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Assurance review date	19 Sept 24	11 Dec 24	14 Mar 25	06 Aug 25	07 Oct 25
Element 1: Smoking in pregnancy	90%	80%	80%	80%	90%
Element 2: Fetal growth restriction	85%	90%	90%	95%	90%
Element 3: Reduced fetal movements	100%	100%	100%	50%	50%
Element 4: Fetal monitoring in labour	100%	80%	100%	100%	100%
Element 5: Preterm birth	74%	74%	78%	67%	69%
Element 6: Diabetes	83%	83%	83%	83%	83%
TOTAL	**83%**	**81%**	**84%**	**80%**	**81%**

The table below provides the projected targets set by the LMNS.

	Mar-24	Interventions fully implemented	Quarterly review points		Mar-25	Progress required	Interventions fully implemented	Mar-26
Element 1	70%	7/10			90%	2	9/10	100%
Element 2	90%	18/20			95%	1	19/20	100%
Element 3	100%	2/2			100%		2/2	100%
Element 4	80%	4/5	June '24	Sept '24	100%	1	5/5	100%
Element 5	81%	22/27			92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Hull University Teaching Hospitals NHS Trust

% of interventions fully implemented					Current
Review quarter	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Assurance review date	18 Sept 24	11 Dec 24	12 Mar 25	30 Jul 25	06 Oct 25
Element 1: Smoking in pregnancy	70%	80%	90%	70%	70%
Element 2: Fetal growth restriction	100%	100%	100%	90%	90%
Element 3: Reduced fetal movements	50%	100%	100%	100%	100%
Element 4: Fetal monitoring in labour	40%	80%	60%	100%	100%
Element 5: Preterm birth	67%	89%	85%	77%	77%
Element 6: Diabetes	83%	100%	100%	67%	100%
TOTAL	**76%**	**91%**	**90%**	**81%**	**84%**

The table below provides the projected targets set by the LMNS.

	Mar-24	Interventions fully implemented	Quarterly review points		Mar-25	Progress required	Interventions fully implemented	Mar-26
Element 1	70%	7/10			90%	2	9/10	100%
Element 2	90%	18/20			95%	1	19/20	100%
Element 3	100%	2/2			100%		2/2	100%
Element 4	80%	4/5	June '24	Sept '24	100%	1	5/5	100%
Element 5	81%	22/27			92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Following the QA in October of Q1 2025/26 data, HUTH and NLAG are awaiting their final grading of interventions following discussions. The LMNS have requested a further submission of Q2 2025/26 data prior to the end of the MIS period (30/11/2025) to aid the decision regarding compliance for Safety Action 6. Data collection and reporting writing is currently taking place for Q2 data.

Item 11: Avoiding Term Admissions to NICU target <6%

Northern Lincolnshire and Goole NHS Foundation Trust

% of term babies that required admission to the NNU DPOW				
Month	Number of Births	Number of Births (≥37 weeks gestation	Number of Term Baby Admissions to NNU	%
Aug 2025	171	154	12	7.0%
Sep 2025	183	162	8	4.4%
Oct 2025	169	149	11	6.5%

% of term babies that required admission to the NNU SGH				
Month	Number of Births	Number of Births (≥37 weeks gestation	Number of Term Baby Admissions to NNU	%
Aug 2025	142	127	9	6.3%
Sep 2025	140	126	8	5.7%
Oct 2025	132	112	8	6.1%

Due to other incidents requiring prioritisation the quarter 2 ATAIN report is not yet available. It is not possible to determine any themes or trends at present.

Hull University Teaching Hospitals NHS Trust

% of term babies that required admission to the NNU HUTH				
Month	Number of Births	Number of Births (≥37 weeks gestation)	Number of Term Baby Admissions to NNU	%
Aug 2025	343	313	13	3.8%
Sep 2025	380	359	23	6.05%
Oct 2025	360	330	18	5.0%

The primary reason for separation of mother and baby in October are:

- RDS continues as the largest factor leading to admissions. This affected both vaginal and caesarean births.
- No hypothermic admissions
- Cord gasses being taken has improved in line with SOP
- Placenta's not following SOP – educational push commenced with labour ward and digital.
- Continued < 6% each quarter 2025/2026

Item 12: Service User Feedback

12.1 Complaints Received (October 2025)

Hull University Teaching Hospitals NHS Trust

	Complaints received – Maternity
Number received	**Claimant concern**
5	Concerns about the care received whilst undergoing an elective caesarean section (Anaesthetics). Concerns raised about midwifery care during the induction of labour process. Patient unhappy with birth experience which has left her traumatised and suffering from PTSD. Concerns raised about medication management / being assigned as consultant led care. Awaiting confirmation of questions – concern not yet known.

Northern Lincolnshire and Goole NHS Foundation Trust

	Complaints received – Maternity
Number received	**Claimant concern**
3 (DPOW) 0 (SGH)	Care during labour and failure to make reasonable adjustments due to ADHD while in labour. Part of placenta retained following birth. Concerns raised regarding whether this was adequately monitored. Delays in treatment due to delay in diagnosing pre-eclampsia.

12.2 Maternity and Neonatal Voices Partnership Feedback

Hull University Teaching Hospitals NHS Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production	
Going well • Caring midwives, going the extra mile • C-Sections (planned and emergency) • Community midwifery • IOL – communication and process • Golden hour on Rowan Ward and general experience • Parent education – carousel, classes *(project to improve further equitable offer)* • Ask a Midwife service • Breastfeeding support: Goodwin • MLU (if able to use) • ADU and Triage • Charitable partners support	**Not going so well** • Badger notes app • Feeling dismissed/not listened to • Rowan ward discharges • IOL – pressure to be induced • Breastfeeding support (East Riding) – new MSW support has commenced • More access to MLU or homebirth • Conflicting advice

Northern Lincolnshire and Goole NHS Foundation Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production
FEEDBACK: More partner facilities and involvement throughout the maternity journey is needed IN ACTION: Partner project was launched to look at more access/involvement for partners considering safety, estate & service user feedback. Resources are being designed and more facilities such as air beds and reclining chairs have been purchased. FEEDBACK: More information / awareness on Pelvic health issues is needed IN ACTION: Perinatal Pelvic Health Service fully running along with a self-referral process which is working well. Service user friendly coproduced leaflets and videos created also. FEEDBACK: More support and understanding of the needs of Neurodivergent (ND) service users is needed IN ACTION: ND in Maternity care working group set up to improve the experiences of these people and further educate the workforce. Service users also shared their stories at the LMNS Inclusion and Belonging conference in June. **Not going so well:** Badger notes app is inaccessible due to network issues, slow to load, not being used.

12.3 Friends and Family Test (October 2025)

Hull University Teaching Hospitals NHS Trust

HUTH's contract with Health Care Communications ended at the end of July and the patient experience team are now bringing F&F in-house. The patient experience team are in the process of implementing a new system and a new QR code. In the interim there are new simplified paper forms and posters for the wall. Current volunteers will support with FFT collection on tablets. Data was requested but unavailable at present.

Northern Lincolnshire and Goole NHS Foundation Trust

For October 2025 a total of 12 responses were received as part of the Friends and Family Test for NICU across the Trust. 100% of the feedback was positive.

For Maternity, 13 responses were received with 92% positive feedback. 1 service user rated their care as ‘poor’ which related to staff attitudes/communication at SGH.

NICU DPOW:
“The team have been amazing, making sure that we had all the up to date information and feeling happy with the care while we were off the ward”.

NICU SGH
“Absolutely amazing quality of care given. the staff go above and beyond for their patients. Its home away from home. Thank you to everyone, we'll miss you all.”.

Maternity DPOW:
All the midwives were amazing and could not help us anymore. They did round the clock care and engaged every step of the way. Thank you”.
Maternity SGH:
“We want to thank you for the incredible care and support during our baby’s birth. From the moment we arrived, every doctor, nurse, and staff member made us feel safe, comforted, and valued. Your professionalism, compassion, and warmth turned this special moment into a truly joyful experience. We’re deeply grateful for your dedication and
kindness — you made our baby’s arrival unforgettable!”

Item 13: VTE Risk Assessment Performance

Northern Lincolnshire and Goole NHS Foundation Trust

October 2025				
	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
SGH	36%	55%	65%	93%
DPOW	80%	85%	86%	85%
Goole	50%	50%	100%	N/A

Hull University Teaching Hospitals NHS Trusts

October 2025				
	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
HUTH	76.8%	86.2%	88.6%	100%

Item 14: Quality Improvement Projects (Group Update)

Improving Infant Feeding in Pregnant Diabetic Women / Birthing People

Background: ATAIN reviews at HUTH and NLAG highlighted that a number of term babies were being admitted to NICU with the primary reason being respiratory distress or infection. Upon further discussion it was felt that if the babies had received breastmilk, it may have prevented admission and separation of mother and baby. The ATAIN review group also felt that a number of babies admitted to the unit appeared to be born from mothers with diabetes, particularly around 37 weeks gestation by caesarean section.

The initial aim of the quality improvement project for MIS year 6 was to review all deliveries and improving the rates of breastfeeding at birth, however following further discussions and taking into account supporting information from ATAIN reviews, it was it was agreed for MIS year 7 to narrow the cohort and focus on birthing people who deliver with either pre-existing or gestational diabetes only. This decision was supported by the Diabetes Specialist Midwife who was working to improve antenatal education, promoting the benefits of breastmilk to pregnant women with diabetes with the aim of reducing term admission to NICU.

Progress (NLAG):

- In May 2024 Following the recognition of a lack of education / information provided to newly diagnosed pregnant women with gestational diabetes, weekly group antenatal education sessions were introduced across the Trust at the start of their pregnancy.
- The Infant feeding teams are now present in clinic to support the sessions at SGH and has been in place. At DPOW the Infant feeding team are not present in clinic, however, all women are referred to them and the peer support team if and when needed.
- Infant feeding education sessions have been introduced at NLAG (May/June 25) specifically for women who are Bengali speaking.
- For type 1 and type 2 women with diabetes, the education and support is provided by the Diabetes Specialist Nurses on a one to one basis rather than in a group setting. The Infant feeding team also support in the same manner but also on an individual basis.

Post intervention data for June 2025 data collection to commence.

Progress (HUTH):

- In April 2024, the Infant Feeding Specialist Midwife created presentation slides allowing the diabetes specialist midwives to share information at the group education sessions.
- At present, the diabetes team conduct group education on Tuesday afternoons mainly and led by the diabetes team. From the 1st September 2025 during the education sessions birthing people will be provided with harvesting packs rather than offered.

- For type 1 and type 2 women with diabetes, the education and support is provided by the Diabetes Specialist Nurses on a one-to-one basis rather than in a group setting (newly appointed Band 3 to support).
- The diabetes team is now fully established to allow greater focus on antenatal education.
- External support: In addition, Hull council funds Goodwin Breastfeeding practitioners to support birthing people in Hull the community, and any birthing people in the hospital. There are also a variety of breastfeeding support groups in community areas.

It is recognised that interventions have been put in place at a later date (compared to NLAG) but this is due to the QIP gaining more momentum with the diabetes team fully established. Whilst the Trusts are at different stages, the aim is to ensure pan-group consistency.

Item 15: Triangulation of Claims Scorecard Quarter 2 2025/26
15.1 Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 2

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

NHS Humber Health Partnership

Claims Scorecard 01 April 2015 – 31 March 2025 (55 claims)	
Top injuries by volume: Unnecessary pain (9) Fatality (8) Stillborn (5) Bladder damage (5) Psychiatric / psychological damage (4)	**Top injuries by value:** Brain damage (3) Cerebral palsy (2) Bladder damage (5) Fatality (8) Renal Damage / Failure (1)
Top causes by volume: Failure / delay in treatment (18) Failure / delay in diagnosis (8) Foreign body left in situ (3) Forceps delivery (3) Intra-operative problems (3)	**Top causes by value:** Failure / delay in treatment (18) Other (1) Intra-operative problems (3) Failure / Delay in diagnosis (8) Inadequate Nursing Care (3)

Claims Breakdown Q2 25/26

Unable to report due to the NHSR changing to a new system – data is not available to extract.

Incidents Q2 25/26

Top 5 incidents by volume:

- Documentation missing/not completed (23)
- Delay in treatment/procedure (22)
- Potential breach of confidentiality (20)
- Staffing levels affecting patients care/monitoring of patients (18)
- Temperature extremes – heat (18)

Number of incidents reported on Ulysses for Obstetrics / Maternity: **565**

Complaints Q2 25/26

There have been 7 new complaints received relating to the following categories:

- Clinical care and treatment (3)
- Poor communication (2)
- Injury sustained during treatment (1)
- Delay in investigations (1)

Clinical Audits Registered Q2 25/26

- MBRRACE Saving Lives Improving Mothers' Care / Confidential Enquiry
- MBRRACE Perinatal Mortality Surveillance
- National Pregnancy in Diabetes
- National Maternity and Neonatal Perinatal Audit
- National Perinatal Mortality Review Tool
- Seizures and Epilepsy in Pregnancy
- Bakri Balloon
- WHO Checklist

Deep Dive Reviews Q2 25/26

In progress:

Induction of labour (SGH / DPOW)

Postpartum Haemorrhage (>1000mls) following an increase in September 2025 (SGH).

Learning Q2 25/26
• Badgernet documentation for WHO Checklist not completed (SGH particularly) • Bereavement checklist to be completed in its entirety in order to prompt staff to undertake all postnatal observations • Woman assessed as high risk but aspirin not prescribed • GTT not undertaken for woman with history of PCOS • RFM's management not followed accordingly • Delay in Enoxoparin being commenced • Time delay in Triage for women being reviewed by obstetric team • Senior Paediatrician not in attendance at delivery for pre-term twins • Delay in documentation being written retrospectively of 72 hours • Neonatal resuscitation proforma not completed • Incident forms not being completed timely • Absconded patients policy not followed • Incorrect interpretation of intrapartum CTG

Themes Q2 25/26
• Women not asked about domestic violence at booking appointment • Not all postnatal investigations undertaken for bereaved mothers • Bereavement checklist not always completed in its entirety • Risk assessment not undertaken on attendance with RFM's • Delay in incident forms being completed • Poor documentation

Action Plan Q2 25/26	Not started / In progress / Complete	
Saving Babies' Lives newsletter / guidance for completing fetal monitoring (risk assessments, hourly fresh eyes) in Badgernet to be disseminated to all midwifery staff.	October 2025	
Discussions with individual staff members to take place regarding CO monitoring and the 'opt out' referral to the Tobacco Dependency Treatment Advisors for smoking in pregnancy.	October 2025	
Community Managers to discuss the requirement for domestic violence questions to be asked at booking appointment with community midwifery teams / reminder on PMRT newsletter	October 2025	
Current ongoing QI Project investigating scan capacity and growth scan appointment times	July 2026	
SOP to be produced to guide sonographers of the best strategies to take to obtain good scan images	November 2025	
Immediately adopt NEWTT 2 and update all EMC documentation	November 2025	
Individual staff training in fetal monitoring	November 2025	
Discussions with Theatre and Midwifery teams about using one system to record WHO checklist	December 2025	

15.2 Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 2 2025/26

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at Trust level (Board or directorate) quality meeting.

NHS Humber Health Partnership

Claims Scorecard 01 April 2015 – 31 March 2025 (84 claims)	
Top injuries by volume: Additional / unnecessary operation(s) (13) Stillborn (12) Fatality (8) Unnecessary pain (8) Bladder damage (7)	**Top injuries by value:** Cerebral Palsy (4) Brain damage (7) Stillborn (12) Fatality (8) Psychiatric / psychological damage (4)
Top causes by volume: Failure / delay in treatment (12) Failure / delay in diagnosis (8) Failure to monitor 1st stage of labour (7) Failure to act on abnormal test results (6) Inadequate nursing care (6)	**Top causes by value:** Failure / delay in treatment (12) Failure to monitor 1st stage of labour (7) Failure / delay in diagnosis (8) Failure to act on abnormal test results (6) Perineal tear – 1st/2nd/3rd degree (2)

Claims Breakdown Q2 25/26

Unable to report due to the NHSR changing to a new system – data is not available to extract.

Incidents Q2 25/26

Top 5 incident by volume:

- In-utero delay in IOL/NICU Cots **(67)**
- Term NNU admissions **(42)**
- Delay in >24 hours for ARM **(26)**
- Post partum haemorrhage (PPH) >1500mls **(19)**
- 3rd degree tear **(9)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **558**

Complaints Q2 25/26

There have been 8 new complaints received relating to the following

- Dissatisfied with care and treatment (6)
- Delayed treatment (1)
- Staff attitude communication (1)

Clinical Audits Registered Q2 25/26

- MBRRACE Saving Lives Improving Mothers' Care / Confidential Enquiry
- MBRRACE Perinatal Mortality Surveillance
- National Pregnancy in Diabetes
- National Maternity and Neonatal Perinatal Audit
- National Perinatal Mortality Review Tool
- Saving Babies' Lives Care Bundle Version 3.2 (Elements 1 – 6)
- Re-audit of External Cephalic Version

Deep Dive Reviews Q2 25/26

In progress: MDT thematic review in failed instrumental deliveries / Paralytic Ileus review.

Complete:

Induction of labour – *further deep dive conducted following the previous report in December 2024 to establish any changes in wait times, outcomes and any further actions are required. Task and Finish Group continues.*

Perinatal Loss <24/40 2022-2025 - *review completed due to perceived rise in early NND/late miscarriage in Jan-March 2025. 16 total cares reviews – 0.18% (national rate 0.7%). No further actions required. Presented at perinatal forum and MNIG October.*

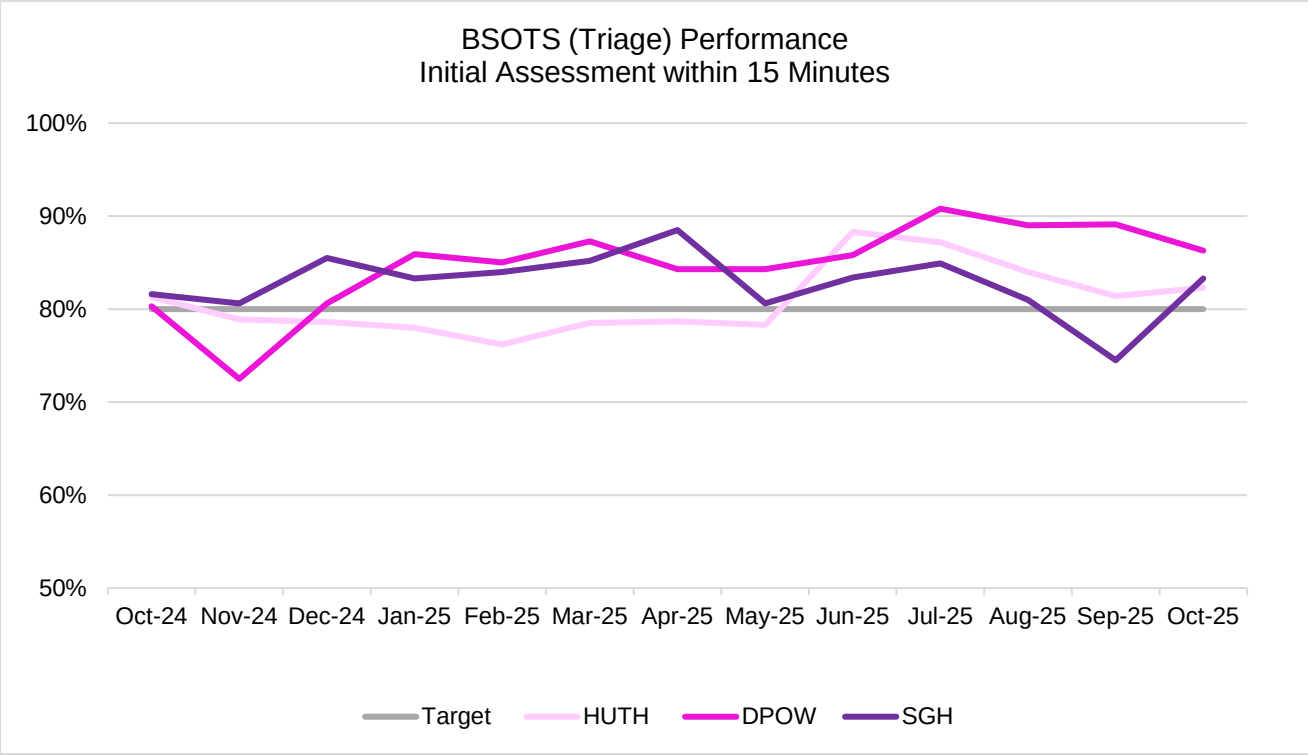
Postnatal readmission audit – *review completed due to Q1 increased in admissions. Action was to implement PICO dressing at HUTH. SOP in place and training continued.*

Learning Q2 25/26
• Steroid pathway review in ADU/ANC • Late pre-term admission rate (SA3) 0.6% • Well managed PPH>1500ml • Improved emergency buzzer use • Consultant escalation

Themes Q2 25/26
• ATAIN noted September spike but Q2 4.85% • Sustained in-utero transfer increase from Q1 • Increased NND rate • Improved use of translators • Documentation at operative vaginal deliveries below recommended standard

Action Plan Q1 25/26	Not started / In progress / Complete	
Induction of Labour Deep Dive	Aug 2025	
Explore the introduction of fetal monitoring champions on the wards and in community to support staff	Oct 2024	
Thematic review of postnatal readmissions	Sept 2025	

Item 16: BSOTS Performance



SGH & Goole
Following a dip in compliance in September a review was undertaken to identify any contributing factors. Upon reviewing the cases where assessment is reported on Badger after the 15 minute target, 28 were found to be compliant. Data quality issues have been identified whereby the time of assessment was recorded prior to the time of arrival on Badgernet and falsely reported as not meeting the target. Taking this in to account, October compliance for SGH and Goole is 91%.

2 women / birthing people attended triage and were categorised as ‘red’, both were assessed immediately upon arrival

Item 17: MatNeo Three Year Delivery Plan

Theme 1: Listening to and working with women and families with compassion

- Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.
- Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.
- Rolling out perinatal mental health services to improve the availability of this specialist care.
- Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.
- Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.
- Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support

Theme 2: Growing, retaining, and supporting our workforce

- NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.
- Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.
- Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.
- Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
- Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.

- Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Making care safer by consistently implementing best practice, including: • By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.
- In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.
- By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.
- Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Progress Update:

The table below provides an overview of the progress made in line with the 47 recommendations specified in the Three Year Delivery Plan as of the end of April 2025.

Key:

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales

Site	Blue	Green	Amber	Red
HUTH	21	20	3	3
NLAG	32	5	7	3

The actions that are RAG rated red are the same for both HUTH and NLAG:

Theme	Recommendation	Action Required	Updates / barriers
Theme 2	Grow our workforce at all levels.	Provide administrative support to free up pressured clinical time. Action: Explore admin support for all specialist roles within maternity.	Unlikely to invest in admin staff to support.
Theme 3	Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.	Review complaints process with MNVP lead.	Unable to agree process with central complaints team due to concerns about confidentiality. NF to contact Simon Treacher to discuss concerns.
Theme 4	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.	Implementation of national MEWS and NEWTT-2.	Updates required from Maternity and Neonatal Matrons.

Item 18: Progress with CQC Survey Action Plan

Following publication of the 2024 Maternity Care CQC Survey 18 actions were identified and incorporated into the MATNEOSIP tool for monitoring within the group.

NLAG & HUTH								
Action Number	**Issues**	**Outcome Aim**	**Actions**	**By whom**	**Comments**	**Target Date**	**RAG**	**Evidence/ Monitoring**
	Labour and the Birth of Baby							
C11	Not left alone when worried (during labour and birth).	All women and birthing people labour will have the confidence that a member of staff will be available.		HOM/DOM	All women have 1:1 care in labour. Compliance 100% pan-group over the last 6 months. Ongoing recruitment to recruit to vacant. Birthrate plus workforce complete 2025. 15/09 BR+ now received and paper written to go to October board for funding. Nov 25 – BR+ review completed 2025	Complete		
C19	Able to ask questions afterwards about labour and birth.	All questions are answered in a timely manner to prevent any concerns.	Documented evidence of questions and answers in the maternity records.	Matrons	Birth afterthoughts service now in progress- being arranged centrally via LMNS and carried out by senior midwife. Ask A Midwife service continuing for questions regarding pregnancy recently won national award.	Complete		

	Care In the ward after birth and feeding Baby							
Action Number	**Issues**	**Outcome Aim**	**Actions**	**By whom**	**Comments**	**Target Date**	**RAG**	**Evidence/ Monitoring**
D6	Found partner was able to stay with them as long as they wanted (in hospital after birth).	Relevant family who are involved in the birth are able to stay throughout the whole stay.	Clear evidence on discussions around partner being supported to stay.	HOM/Matrons/MNVP	Plan in place to introduce Golden Hour – Match 2025. Dad's champion involved via LMNS. July 25 – 'Golden Hour' implemented – positive feedback	Complete		
	Care After Birth							
F4	Saw the midwife as much as they wanted (postnatal).	A Midwife is available 24/7 during the stay.		HOM/Matron	Midwives available 24/7 in all inpatient areas, Recruitment to vacant posts in progress.	Complete		
F11	Given information about changes to mental health after having baby.	New Mum's are communicated to and are informed of what changes to be aware of relating to their mental health.	Documented evidence that conversations and any supporting information have been offered.	Community Manager	Mental Health Charity ' House of Light' well advertised for postnatal support. Maternal Mental Health Service reopened. PNMH midwives in post pan group. Community midwives direct women to these services. This information to be shared with community midwives and support services advertised widely. 15/09 audit needs to be completed to evidence this. November 25 - Discussed and documented at booking and at AN checks. House of light outside agency shared. Referrals made if needed to perinatal MH midwifery team	Complete		

F12	Told who to contact for advice about mental health after having baby.	New Mum's are informed of who to contact if they have concerns or want to discuss their mental health.	Evidence that contact information is given to new Mums.	Community Manager	November 25 - Discussed and documented at booking and at AN checks. House of light outside agency shared. Referrals made if needed to perinatal MH midwifery team			
F15	If needed it, received support or advice about feeding their baby during evenings, nights or weekends.	A Midwife is available 24/7 during the stay to support and advice as well as the baby feeding support staff.	Evidence that Parents have been introduced to the baby feeding support staff.	DOM/Infant Feeding Co-ordinator	Feeding support on the ward. All Hull women get day 3 visit from Goodwin. Previous inequity for women in East Riding overcome with change of guideline at HUTH - launched 01/09/2025.	May 2025		
HUTH								
	Care Whilst Pregnant							
B3	Offered a choice of where to have baby.	Parents are offered a choice on where to have their baby.	Evidence that choice has been offered in the pre-natal appointment.	Community Manager	Already in progress. To monitor choice of place of birth via Badgernet- community review ongoing. November 25 - Completed at booking and rediscussed at AN checks – share LMNS leaflet re this.	Complete		
B4	Given enough information about where to have baby.	Parents are well informed on where to have their baby.	Evidence that information has been given in the pre-natal appointment.	Community Manager	November 2025 - As above Poster regarding local hospitals with QR code directing to hospital tours recently launched via LMNS.	Complete		
B6	Felt midwives or doctor aware of medical history (antenatal)	Parents have the confidence that the team caring for them are aware of all their medical history.	Evidence on all medical history is captured in the maternity notes.	MNVP	Transitioned to Badgernet April 2024. To monitor via patient feedback to see if improvements as all notes now electronic.	Ongoing		

B10	Given enough support for mental health during pregnancy.	Where any mental health is identified during pregnancy support is available.	Evidence that any mental health concerns that are identified are actioned and support is offered.	Matrons	Mental Health Charity 'House of Light' well advertised for postnatal support. Maternal Mental Health Service reopened. PNMH midwives in post pan group. Community midwives direct women to these services. Information shared with community midwives and support services advertised widely.	Complete		
B17	Concern during your antenatal care taken seriously.	Parents have confidence that any concerns are listened to and support is offered and available.	Evidence that all concerns are captured in the maternity records and are acted upon appropriately.	HOM/DOM	All practitioners should be offering individualised and compassionate care. Individual feedback will be acted upon. Make Birth Better workshops complete Spring 2025. November 2025 – Personalised care task and finish groups commenced	Complete		
	Labour and the Birth of Baby							
C4	Given information / advice on risks of induced labour.	All risks on induced labour are fully explained and parents have the confidence when being induced.	Documented evidence that all risks have been clearly explained and that the parents fully understand.	HOM/DOM	IOL project ongoing. Information now given via Tommys leaflets and website documenting risks and benefits. IOL Task and Finish Group ongoing, met last in July 25. November 2025 – IOL group reinvigorated. Information given via Tommys leaflets and website documenting risks and benefits.	Complete		

	Care After Birth							
F5	Felt midwives aware of medical history (postnatal).	Parents have the confidence that the Midwifery team caring for them after delivery are aware of all their medical history.	Evidence on all medical history is captured in the maternity notes from prenatal through to post-natal.	HOM/DOM	All practitioners should be offering individualised and compassionate care. Individual feedback will be acted upon. Make Birth Better workshops complete Spring 2025. November 2025 – Personalised care task and finish groups commenced. Badgernet supports knowledge of history.	Complete		
F14	Received help and advice about feeding their baby (first four weeks after birth).	Parents know who to access for support, information and advice on feeding their baby.	Evidence on information regarding feeding baby is given to parents.	Infant Feeding Co-ordinator	Ongoing work towards BFI accreditation. New infant feeding midwife started post 6/1/25. Day 3 weights launched at HUTH for women in ER and Hull.	Complete		
NLAG								
	Labour and the Birth of Baby							
C12	Felt concerns were taken seriously (during labour and birth).	Women and birthing people have confidence that any concerns are listened to and support is offered during labour and birth.	Personalised care – ensure personalised care plans are used and plans of care made together with the woman, birthing person and /or birthing partner to ensure optimum support offered during labour and birth. To highlight to all providing intrapartum care.	Matrons	November 25 - Personalised care task and finish groups commenced.	May 2025		

	Care In the ward after birth and feeding Baby							
D7	Professionals did everything they could to help manage pain after birth.	Women and birthing people have confidence that their pain control will be managed well after giving birth.	1. Pain management is discussed and offered as required and is recorded on Badgernet to ensure that women and birthing people receive adequate analgesia. 2. To ensure that current antenatal education sessions include discussion on postnatal pain relief.	1. Ward Managers 2. Community Managers	Pain management included is Badgernet maternity records. November 25 – Postnatal analgesia was also highlighted by service users as a concern. Update required to ensure that current antenatal education sessions include discussion on postnatal pain relief.	May 2025 May 2025		
	Care after Birth							
F13	Given enough information about their own physical recovery.	Women and birthing people are well informed of how to support their own physical recovery.	Ensure antenatal education and discussions include expectations of physical recovery for the woman or birthing person.	1. Ward Managers 2. Community Managers	NHS Squeezy App free for pregnancy and up to 12 months PN commissioned by the LMNS awareness of pelvic health and abnormal signs and symptoms with link to self-referral form up to 18 months PN, staff education on mandatory training about pelvic health screening & referral and having in depth discussions prior to discharge on pelvic floor exercises, return to exercise, diet and hydration, bowel habits, core exercises, return to sex; POGP leaflets embedded onto Badgernet for discharge (can be given at any time also) - 'Fit for the Future'; suturing training to staff which	Complete		Completed by Pelvic health MW AN education covers recovery after birth

					covers misalignment, sexual function, evidence-based postnatal conversations on perineal care/recovery; comms work with ICB to promote taboo topic of pelvic health and raise awareness - using social media campaigns/blogs; working with MNVP to construct resources with service users In terms of AN education - OASI bundle includes implementing antenatal discussions re pelvic health / diet / hydration / bowel habits / safe exercise info on Badgernet and LMNS website available Squeezy app again Commencing antenatal 'carousels' for service users to access self-referral to PPHS Physios are constructing AN groups for PGP in terms of pregnancy, labour and birth and postnatal recovery with PIFUs if needed.			

Item 19: Progress with Culture Improvement Plan (Group)

The maternity culture improvement plan continues to be monitored as part of the MATNEOSIP tool within the division. The progress against open recommendations are detailed in the table below.

Recommendation	Action / Milestone	Expected Impact	Lead	Forecast Completion Date	Progress	RAG
NLAG						
Score Culture Survey or Maternity & Neonatal services	Survey active from 11/03/2024 and ran until 21/04/2024. Bi-weekly email reminders sent to all areas with the link and QR code to engage. Focus groups with QUAD following completion of survey, culture workshops to agree and implement changes. 18% of workforce for Maternity and Neonatal services trust wide responded, 73 people in total out of a possible 403.	Provide areas of focus based on the themes identified by the workforce to improve the culture across the division.	Nicola Foster/Yvonne McGrath	30/11/2025	Survey complete, awaiting results to be shared with QUAD (delayed due to the restructure of NLAG and HUTH). 14/07/2025 - Listening forums with external chair held. Decision made for Lucy Vere (Director of OD) to act as SRO for the Maternity Culture Improvement- planning meeting due to take place 19/9 to pull together ongoing actions and agree next steps. 20/08/2025 No update 05/11/2025 No update	
NMC Exception Report	Action plan in place, informing all workforce of current concerns raised by students, Having PMA support in place for students to access whilst on placement, continue students clinics, remind midwives of their role and responsibilities in the teaching and supervision of students, Matron walkarounds to continue on the wards to have conversations with students, Matrons to attend the universities to introduce themselves to students to promote the student clinics and feedback of concerns, Promote continuity for students with supervisor, production of a joint Charter with Midwives and Student Midwives of the expectations from both sides, Encourage staff to call out poor behaviour of other staff, Off duty to be produced in advance for students to know their roster requirements, Complete audits on all clinical areas.	Improved placement experience for all students. Feel psychologically safe and comfortable to call out poor behaviour, increase support available to students in clinical placement, re-educate midwives on their professional behaviours and responsibilities in relation to the NMC code.	DOM/HOM	Ongoing	5 actions remain in process, 7 actions complete. 14/07/2025 Will request update from Hull University, DOM and liaise with PLF for NALG. Aware of recent concerns raised following visit from NHSE 20/08/2025 No update 05/11/2025 Work has been ongoing within the trust. Students sent a feedback code to complete for their placement experience. This data was collected into site specific feedback and sent to SMT, Matrons and managers of the areas.	

Student support	Awareness of support available to students whilst on clinical placement. PLF in post 18.75 WTE across the trust. Pastoral Lead available to students to access. Student clinical site specific with Matrons to enhance SMT visibility and encourage escalation of concerns. PLF to send out emails to students with links for the clinics.	Students will feel supported in their clinical environment. Wide range of support options available to students.	Matrons	August 2023	20/08/2025 Recent visit from NHSE, will liaise with SMT and PLF's for outcomes of this visit and feedback received. 30/09/2025 No update, MS form created to obtain anonymous student feedback. Link sent to leads at both Hull and Lincoln to disseminate to students. 05/11/2025 Students sent a feedback code to complete for their placement experience. This data was collated into site specific feedbck and sent to SMT, Matrons and managers of the areas.	
Group Staff Experience Work Stream	Implementation of working group for improving staff experience at work. To include R&R leads as Staff Experience Leads, Staff Voice Champions from all areas and bandings to act as advocates at meetings. To include MDT working inc. PMA lead, QI lead, FTSU Guardian. To emulate shared decision making concept in making the working environment and staff experience the best it can be. Frequency of meetings TBC	Improved staff morale, inclusion of staff in decisions and actions involving improvements within their working area. Staff feeling of value and inclusion.	Yvonne McGrath DOM	TBC	**14/07/2025** Ongoing discussions with R&R leads and DOM around the implementation of the work stream. EOI forms sent out for staff voice champions (SVC). TOR written waiting for approval. **20/08/2025** waiting for clarification of safety champion role ?same as SVC. Once clarification provided will send out EOI for SVC group wide. (HS/JB) **30/09/2025** Still waiting for clarification **05/11/2025** No further update. To liaise with DOM and R&R lead at HUTH to clarify if still planning to implement.	
Maternity Incivility Reporting Tool	Poster to display in clinical areas with QR code for staff to report acts of incivility.	Provide staff with the tool to escalate incidents of incivility to SMT. Hope to encourage engagement from staff in reporting	Yvonne McGrath DOM	TBC	**14/07/2025** Poster created, waiting for confirmation to share and display in clinical areas across the group. ?who is responsible for checking the responses. **20/08/2025** No update, still waiting clarification (HS)	

		incidents to enable actions to be taken.			**30/09/2025** No update **05/11/2025** No update, will liaise with HUTH R&R lead as this was paused due to seeking clarity for who will be responsible for collecting and disseminating the data.	
Tea Trolley Walk rounds across both main sites	Plan monthly tea trolley at each main site as an opportunity to highlight specific services available to staff and provide staff with an opportunity to speak to pastoral midwife/PMA and guest facilitating the tea trolley that month.	Aim to improve visibility and awareness of support services available and bring about this support to the staff in the work environment. This will hopefully improve staff knowledge of what support the organisation offers and increase engagement in services	Jennie Buckley R&R, pastoral lead	30/11/2025	**05/11/2025** First tea trolley planned for DPOW 11/11/2025 & SGH 17/11/2025. The theme for November is MSW PDMW Role. The new PDMW will be speaking with our MSW team and providing them with information on their role, initiatives they are planning and gaining engagement in these projects. December and January themes planned and liaising with wellbeing services to assist in the future.	
Understanding cultural diversity workshop	The trust offers workshops by the EDI team. This workshop aims to explore cultural diversity, create an appreciation for its impact on team bonding. It aims to support team leaders in creating well-adjusted and thriving teams, exploiting the benefits of their cultural diversity.	Enhance staff knowledge on cultural diversity, unconscious bias and how our behaviours impact others.	EDI team	31/12/2025	Course is optional. Discussion with OD facilitators and HOM to potentially add to action plan following SCORE survey for all maternity staff to attend the session. OD facilitators will accommodate sessions. **14/07/2025 -** ? If still provided by the trust. Will check on ESR and discuss with DOM ? for possible action to be implemented as part of improvement plan. To form of the overarching strategy to be mapped on the 19/09.	

Recommendation	Action / Milestone	Expected Impact	Lead	Forecast Completion Date	Progress	RAG
HUTH						
Leadership 1-2-1 check and challenge meetings	Launch and everyone to have had a 1-2-1. 1 month Matron, next month HoM and Matron.		NF / CC	Nov-25	CC to find template	
Success profile: Learning Needs Analysis	What do staff need to carry out their roles? Self-assessment. Emerging themes as they go. Performance management culture and the positivity of this.	Understanding of what is needed from staff to fulfil their roles in each clinical area. An understanding of what is available to staff to support with growth and development	Managers	Ongoing		
Promote REACH	Tea trolley with Lynne Stothard and Facebook post. Introduce Helen to Lynne. Gather posters and arrange date for trolley. Posters to be laminated and displayed in staff areas after tea trolley. Ensure all managers are aware of how to access as well as staff. Facebook page post to highlight to those who miss trolley. Blog on Bridget for all of organisation awareness.		CC / HS / LS	Oct-25	Lynne has been contacted by staff requesting support	
Maternity flu vaccinations and staff survey	Tea trolley with Amy Stuart and Joanna Melia.		HS / AS / JM	Jan-26		
Community of Practice	Band 6 development. Group mentoring circles. Band 6's - ? With DoM. Talk about what's going and challenges they are facing as well as things they are excited about. Senior access and mentorship.		YM / NF	Ongoing		
Band 7's day	1pm - 4pm session for managers with Amy. Insights, restorative practice, team development exercises		HS / AS	Ongoing		
Band 8's day with T2	Outsourced to T2 for all matrons and some obstetricians, HUTH and NLAG, MATNEO. Insights, PRINT, attributes, restorative practice, team development exercises.		MS / NF / YM	Feb-26	2 days planned January and February 2026	

Career development, understanding and exposure to wider Group agenda	Scope for Growth. Training days for staff. Use PMA funding to encourage PMA's to go as well as managers		HS / YM / NF	Dec-26		
Culture dashboard	Matt Smith to write and share measures: Patient safety, Medication errors, PMA data Patient complaints, Staff survey, Sickness rate, Retention figures, Incivility tool figures, F2SU issues		MS	Oct-25	Not currently accessed by team	
PMA activity	£1000 for each site, Hull, Grimsby and Scunthorpe, to roll out PMA support for NQM and student midwives. Some PMA's have come forward to use some of the funding for hours. A report must be written detailing work done and outcome achieved by the end of March 2026. Poster Ask a PMA drop-in sessions RCS evaluation forms 24 hours after session - align with NLaG QI project	Tea trolley promoting awareness of team members and when to request RCS	HS / YM / NF / PMAs	Mar-26		
Braver than before course	Senior midwives to undertake course. Most managers have completed, now being rolled out to specialist midwives and junior sisters.		YM, HS	Ongoing	HS to remind staff to book on	
Maternity culture circle group meetings	Review of monthly incivility tool reports and discussion. OD, HoM, DoM, Recruitment and Retention, HRBP		MS, NF, YM, AS, HS, CC	Ongoing - monthly		
Tea trolleys for hot topics	2-hour trolley around maternity unit and follow up post in Facebook group.	Use guest speakers to promote support options within organisation and encourage engagement with messages. Themes, celebrations and links to services	HS	Twice monthly		

Item 20: Progress with Ockenden Actions

Northern Lincolnshire and Goole NHS Foundation Trust

The final Ockenden report was published in 2022 which identified 15 areas of care where there are opportunities for learning and improving the quality of care. The expectation was that all maternity services in all Trusts in England must implement the actions centred around: *Workforce Planning and Sustainability: financing a safe maternity workforce, Safe Staffing, Escalation and Accountability, Clinical Governance: Leadership, Clinical Governance: Incident Investigation and Complaints, Learning from Deaths, Multidisciplinary training, Complex Antenatal Care, Pre-term Birth, Labour and Birth, Obstetric Anaesthesia, Postnatal Care, Bereavement Care, Neonatal Care and Supporting Families.*
Under the 15 IEAs 92 sub actions are detailed within the report. Of those, 8 are the responsibility of national teams to implement and therefore no further action is required within NLaG. The remaining 84 have been assessed, the status of each sub action is detailed in the table below:

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales
Grey	Not Applicable

Immediate Essential Action No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
No. of actions	11	10	5	7	7	3	7	5	4	6	8	4	4	8	3	92
Blue	4	8	3	7	6	-	7	1	4	6	7	4	4	6	3	70
Green	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1
Amber	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Red	2	1	2	-	1	-	-	3	-	-	1	-	-	1	-	11
Grey (National/Regional)	3	1	-	-	-	3	-	-	-	-	-	-	-	1	-	8

Identified risks preventing completion of actions:
There is a risk to operational delivery of the national quality standards including Ockenden action plans due to insufficient consultant workforce capacity.

There has been a rise in complex patients who are at higher risk due to a change in guidelines, Induction policy changes and patient choice. The trust has approximately a 40% - 50% induction rate and caesarean section rate compared to 18% - 20% in 2018. Previously

the consultant on call would perform the on call as well as perform an elective caesarean list at the same time however as per immediate Ockenden actions trusts are advised to provide a dedicated consultant committed for on call only, this has put additional pressures on the consultant body.

In addition to the Ockenden requirement we have seen a significant increase in the demand of pregnant women being seen in the consultant led antenatal clinics e.g. smokers who were previously not consultant led now not only require to be reviewed in consultant led clinics. To fully meet IEA 8 regarding the provision of complex antenatal care the specialty must establish separate antenatal clinics for Hypertension, pre-pregnancy counselling, and pre-existing diabetes clinics, to establish these clinics there is a requirement to increase the consultant body.

With the introduction of new induction of labour guidelines and growth restriction guidelines there is a significant demand on our antenatal services which are currently unmet due to reduced capacity. The purpose of this case is to outline a proposal to address current risks to the operational delivery of quality standards within the Obstetrics & Gynaecology services as per the roles and responsibilities of an Obstetrics & Gynaecology Consultant document (July 2022), CNST and the Ockenden action delivery plan.

Ockenden have introduced several leadership posts i.e. PMRT lead, fetal monitoring lead, Obstetric MDT and Obstetric leads per unit. These additional responsibilities add to the current workload on our existing consult body and currently the average consultant is allocated 14 PAs within their job plan.

Currently for hot weeks and weekends the trust run a 1:6 rota for Obstetrics & Gynaecology for both Scunthorpe & Grimsby, this is not sustainable and there is evidence of burn out across the consultant workforce which is leading to an increasing sickness rate and a significant risk of delivering the Ockenden Immediate and essential actions along with a risk of the health and wellbeing of our consultant workforce. This has now been added to the divisional risk register as a significant risk.
These concerns were outlined in a paper to the Trust Executive Team and in the annual Obstetrics & Gynaecology Medical Workforce Business Plans.

Hull University Teaching Hospitals NHS Trust

The final Ockenden report was published in 2022 which identified 15 areas of care where there are opportunities for learning and improving the quality of care. The expectation was that all maternity services in all Trusts in England must implement the actions centred around: *Workforce Planning and Sustainability: financing a safe maternity workforce, Safe Staffing, Escalation and Accountability, Clinical Governance: Leadership, Clinical Governance: Incident Investigation and Complaints, Learning from Deaths, Multidisciplinary training, Complex Antenatal Care, Pre-term Birth, Labour and Birth, Obstetric Anaesthesia, Postnatal Care, Bereavement Care, Neonatal Care and Supporting Families.*
Under the 15 IEAs 92 sub actions are detailed within the report. Of those, 8 are the responsibility of national teams to implement and therefore no further action is required within HUTH. A refresh was commenced in 2025 and the remaining 84 have been assessed, the status of each sub action is detailed in the table below:

RAG RATING MATRIX	
Blue	Completed & embedded
Green	Completed & ongoing and / or not yet fully embedded
Amber	In progress / on track
Red	Not yet completed / significantly behind agreed timescales
Grey	Not Applicable

Immediate Essential Action No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
No. of actions	11	10	5	7	7	3	7	5	4	6	8	4	4	8	3	92
Blue	-	3	1	2	5	-	4	-	1	-	2	-	2	Awaiting update on actions	-	20
Green	3	2	2	4	1	-	3	2	3	2	2	-	2		2	28
Amber	4	4	2	1	-	-	-	3	-	4	3	4	-		1	26
Red	1	-	-	-	1	-	-	-	-	-	1	-	-		-	3
Grey (National/Regional)	3	1	-	-	-	3	-	-	-	-	-	-	-	1	-	8

Following the completion of the refresh exploring the EA and the final status for EA14, an update of the identified risks preventing completion of actions and actions which are not yet completed will be explored further in September MNAG.

Appendix 1: Learning from Deaths

The groupwide Mortality Improvement Group (MIG) takes place monthly with Family Services invited to attend every six months to provide an update and assurance of learning from deaths within the division. Risks are monitored outside of the meeting and if any concerns are identified the division will be requested to attend more frequently.

The slides below detail the update provided at the MIG meeting in June 2025, information relating to Gynaecology and Paediatrics has been removed.

	What does the data tell us? (Making data count principles, e.g. SPC, including Mortality PowerBI Dashboard source)	Care Group priorities and qualitative sources of information that contribute to mortality improvement e.g. learning from SJR, M&M, QI Projects, Audit, GIRFT, Complaints, Claims & Incidents.
Alert	**NLAG** - Increase in complaints and Ulysses incident forms regarding the poor bereavement care and lack of support they are receiving. **HUTH** – Neonatal alert process being reviewed an added onto the risk register. 1112 referrals being managed via maternity screening office.	NLAG - This has been escalated for discussion for possible mutual aid support
Advise	**NLAG's** overall perinatal death crude mortality rate is 5.2% and are in the over 5% higher category with 13 other Trusts in our peer group. 6 new cases reportable to MBRRACE for **PMRT** review: • 4 antepartum stillbirths • 1 is a late fetal loss • 1 is a neonatal death (expected due to fetal anomaly)	NLAG Key themes identified for learning following PMRT reviews are: • Interpreter not used at all appointments and family members used instead • domestic abuse questions not asked at booking or routinely throughout the pregnancy • 6 week postnatal investigation bloods not taken.

	MBRRACE national report: Comparatively 5% higher in excluded deaths due to congenital anomalies • Overall perinatal death crude mortality rate is 5.2% (over 5% higher category with 13 Trusts in peer group) • The stablised mortality rates is 3.97% (within 5% with 32 peer Trusts). **NLAG MNSI:** 1 new MNSI case – neonatal death (registerable by Manchester). SGH provided antenatal/intrapartum and postnatal care. This will also go through the PMRT process and Learning Response Panel. 1 existing MNSI - draft report just actioned. **HUTH PMRT:** · 8 current open (as of 20th June 2025) including 3 external reviews (NND but born at a different organisation) · 97853 29+6 SB – MIRM review completed. Awaiting PMRT. · 97484 22+6 NND – MIRM review completed. Awaiting PMRT. · 97620 NND >28days of age – MIRM review completed. CDOP pathway followed. Awaiting PMRT. · 98492 36+0 SB – MIRM review completed. Awaiting PMRT. · 98763 32+1 SB – MIRM review completed. Awaiting PMRT.	**HUTH** · Aspirin QI near completion · Recommended a <24/40 thematic review of perinatal losses (increased noted comparted to same period last year – SPC chart via MBRRACE utilised) · EDI and deprivation data captured for each review via MIRM, PMRT and MNSI. · Monthly audit of CNST criteria ongoing and action plan review · Actions identified at MIRM MDT meeting put in place prior to completion of PMRT and MNSI reviews · Actions tracked via DATIX and reviewed upon completion · Domestic abuse questions not always performed (often due to partners being in attendance – triage implementing a sticker system for prospective mothers to raise concerns that a private conversation is required) · Diabetic service overloaded with work but much improved trajectory of result reviews and continued MDT meetings in place.

	HUTH MNSI (Open) · MI- 040973. Perimortem caesarean section occurred following epidural placement. Baby cooled (No HIE) Mum alive and well. AAR completed and MNSI at interview stage. Family engagement with patient safety matron via translator in place. DoC Compliant. Shining light nominations for teams providing care. Staff supported. · MI-042322. Cooled term baby following transfer into the labour ward from a planned home birth. Mum alive and well. Baby discharged on anti-seizure medication (required control of hypertension and seizures. No HIE). Awaiting staff interviews. Family engagement with patient safety matron ongoing. DoC compliant. Staff supported.	
Assure	**NLAG** · PMRT cases are appropriately reported to MBRRACE and are all on target to be published well within the timeframes. · We are 100% for external representation at each of our PMRT reviews. · MBRRACE State of the Nation Report (published May 2025) · MBRRACE Perinatal Mortality Report (2023 births), published Feb 2025: · Stillbirth rate: 3.43 (2.96 to 4.06) · Neonatal death rate:1.96 (1.29 to 2.96) · Overall perinatal mortality rate: 5.28 (4.63 to 6.75)	**NLAG** · The stablised mortality rates is 3.97% and that is within 5% with 32 other Trusts. · NLaG's data has been benchmarked against the national MBRRACE-UK Reports. National recommendations assessed with an action plan in place. · MBRRACE PMRT reporting / monitoring as part of MIS year 7 · Learning from PMRT disseminated via emails, PMRT Newsletter and posters.

	HUTH · CNST full compliance MIS year 6 achieved. Year 7 TOR updating and continuation of process. · 2023 stabilised still birth rate 3.43 – continued downward trajectory (excluding abnormality) · 2023 Neonatal death rate 1.94 – continued downward trajectory (excluding abnormality).	**HUTH** · Robust MIRM learning process feeding into established external reporting pathways (PMRT,MNSI). · Board report for benchmarking GAP analysis submitted · Quarterly and Annual board reports submitted · Stabilised still birth and neonatal death rates 5-15% lower than comparable organisations. · MNVP attendance at PMRT and governance meetings · EDI teaching within maternity and obstetric MDT started 2025 (January) · Thematic review conducted 2025 of increase of term still births in Asian women with gestational diabetes.
New and emerging risks	**NLAG** - Issue has arisen around completion of Fresh Eyes. The Fetal Monitoring Leads have completed a systematic review and audited maternal records with issues identified at SGH. The Labour Ward Manager and Matron have undertaken a deep dive and have held discussions with individual staff members and coordinators. This will be reaudited monthly. **HUTH** – Return to theatre trend increasing morbidity (SPC chart now in use and thematic review presented).	
Learning from SJRs and M&Ms	**NLAG** • If the antenatal diagnosis of diaphragmatic hernia has been missed and the baby is struggling with breathing always try and listen to the heart, if the heart pulsation is on the right side, then suspect diaphragmatic hernia. • Importance of early escalation in unwell neonates with high CRP. • Antibiotic selection should include CNS coverage if meningitis is suspected • Early ID/Microbiology involvement aids decision-making • Distinguishing between NEC and feeding intolerance is crucial • Consistent follow-up is required for neonatal varicella management **HUTH:** · Wristband SOP approved for vaginal packs in maternity – to follow TACC and Gynaecology governance process (following retained vaginal pack – excluded from never event criteria) · Translation use inconsistent with global majority service users	

	· Improved CTG classification · Improved use of terbutaline.
Actions required and support needed	**NLAG** - We require interim bereavement support for our families whilst awaiting for our bereavement midwife to come into post. **HUTH** – Funding for bereavement support worker to continue ongoing work within bereavement MDT.

Humber Health Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Seven

HUTH & NLAG PROGRESS REPORT

December 2025

Yvonne McGrath – Group Director of Midwifery
Eloise Sims – HUTH Maternity Audit and Compliance Manager
Hayli Garrod – NLAG Maternity Audit and Compliance Manager

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

United by Compassion:
Driving for Excellence

Background

NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) applies to all acute trusts that deliver maternity services and are members of the CNST. Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund.

The Maternity Incentive Scheme Year 7 outlines a requirement for Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds. The Trust has submitted full compliance against the 10 safety actions for the preceding three years.

What is evident throughout the scheme is the need for the Trust Board and Integrated Care System (ICB) to be cited on the safety of maternity services and therefore we have compiled this report and will continue to do so on a quarterly basis to ensure the **Quality and Safety Committees in Common** (acting on behalf of the Trust Board) is sighted on the ongoing work and the future plans.

The purpose of this report is to provide an overview of the changes from year 6 and update on the progress made on the 10 safety actions in respect of Maternity Incentive Scheme – Year 7 highlighting key risks and the mitigating actions taken.

Weekly MIS Year 7 Delivery Group monitoring meetings are established to review progress and address risks identified.

Executive Summary

See below for an overview of the current compliance against the safety action requirements.

Green - Completed
Amber - On Track for completion
Red - Not on track
Blue - Completed and evidenced

HUTH

Safety action	Red	Amber	Green	Blue	
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					Awaiting confirmation from the LMNS to determine if best endeavours have been made to achieve local trajectories to reach March 26 target.
7 Service User Feedback / Co-produced Services					MNVP team structure not in line with national requirements. Escalation as part of PQOM to Trust, ICB and Regional team undertaken.
8 Training					Outstanding staff members to book onto training.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**2**	**8**	**0**	**0**	

NLAG

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					
2 Maternity Services Data Set (MSDS)					
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					Q2 25/26 (NLAG 83%), awaiting confirmation from the LMNS to determine if best endeavours have been made to achieve local trajectories to reach March 26 target.
7 Service User Feedback / Co-produced Services					MNVP team structure not in line with national requirements. Escalation as part of PQOM to Trust, ICB and Regional team undertaken.
8 Training Plan					Require staff to attend planned training sessions throughout November to achieve 90% target. Ongoing close surveillance.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**4**	**5**	**0**	**1**	

Steps for Sign Off:

Requirement	Date
Local Maternity and Neonatal System / Integrated Care Board evidence review	December 25
Trust Board to be sighted/approve outstanding evidence (submitted)	February 26
Trust Board evidence sign off	February 26
Submission of MIS year 7 declaration	By 03 Mar 26

Safety action 1:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?
Lead: Matthew Proctor (HUTH), Tracey Martin (NLAG).

Requirement		**HUTH Compliance**	**NLAG Compliance**
1.1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?		
1.2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?		
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.		
1.4	Were 75% of the reports published within 6 months of death? **Previously 60% in MIS year 6**		
1.5	**New standard:** For a minimum of 50% of the deaths reviewed was an external member present at the multidisciplinary review panel meeting and was this documented within PMRT? Applicable from 2 April 2025 onwards		
1.6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.		
1.7	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?		

Please refer to the tables below for a breakdown of qualifying cases/compliance as at the 24th November 2025.

Northern Lincolnshire and Goole NHS Foundation Trust						
MBRRACE-UK/PMRT standards for eligible babies following the PMRT process (N=9)	**%**	**Dec 24**	**Q4 Jan – Mar 25**	**Q1 Apr – Jun 25**	**Q2 Jul – Sep 25**	**Q3 Oct – 30 Nov 25**
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	2/2 (100%)	8/8 (100%)
Cases applicable for PMRT review are applicable to the following standards (n=14)						
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	1/1 (100%) 5 not yet met

Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	1/1 (100%) 5 not yet met
Multi-disciplinary reviews should be published within six months of the death.	**75%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	6 not yet met
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	1/1 (100%) 5 not yet met
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	Submitted Dec 25	To be submitted

Hull University Teaching Hospitals NHS Trust						
MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**%**	**Dec 24**	**Q4 Jan – Mar 25**	**Q1 Apr – Jun 25**	**Q2 Jul – Sep 25**	**Q3 Oct – 30 Nov 25**
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	4/4 (100%)	8/8 (100%)	5/5 (100%)	12/12 (100%)	3/3 (100%)
Cases applicable for PMRT review are applicable to the following standards.						
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	3/3 (100%)	8/8 (100%)	4/4 (100%)	9/10 (90% - 1 ongoing, joint case)	2/3 (66%% - 1 ongoing)
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	3/3 (100%)	8/8 (100%)	3/4 (75% - see comment below)	8/8 (100%)	2/3 (66%% - 1 ongoing)
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3/3 (100%)	8/8 (100%)	3/4 (75% - ongoing)	3/8 – ongoing.	0/3 - ongoing.
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**50%**	3/3 (100%)	8/8 (100%)	4/4 (100%)	5/8, ongoing.	0/3 – ongoing.
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	Submitted Oct 2025	To be submitted

N.B. Please note that cases applicable for PMRT review may change due to cases which are 'notification only' as per the MBRRACE reporting requirements. In Q2 for HUTH, there was a further change for reviews as both cases were reported by the Trust, but the baby was born in a different Trust and therefore they are required to lead the joint review process.

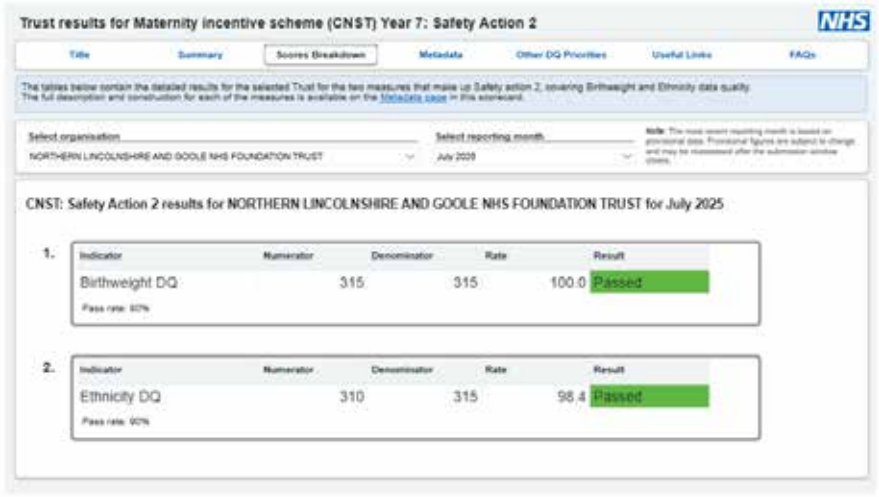
Regarding PMRT reviews commenced within two months of each death, the non-compliant case was inputted at the time, but date of birth was inputted as the date of identification. Surveillance therefore late but still reviewed through PMRT within timeframes. Compliance overall 22/23 and therefore 95.6%.

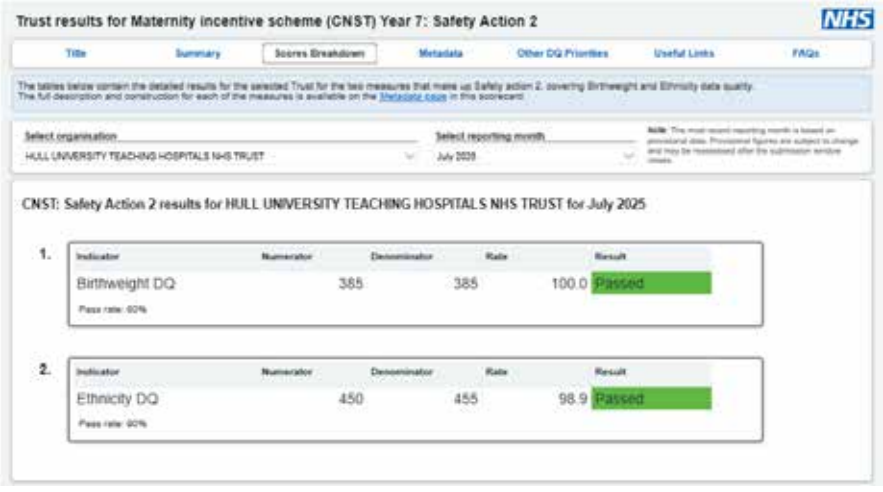
Action Required:
Quarter 2 2025/26 PMRT reports to be discussed at Trust Board and with the Safety Champions in December 2025.

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Lead: Mike Collins (HUTH), Carrie-Louise Dixon (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
2.1	**New Standard**: Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).		
2.2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)		

The MIS scorecard is published on a monthly basis by NHS England and can be accessed via the following link Microsoft Power BI. Finalised data for July 25 confirms both HUTH and NLAG have passed the data quality checks.





Safety action 3:
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Lead: Vesna Blair / Ellie Peirce (HUTH), Emma Spicer (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
3.1	Are the pathway(s) of care into transitional care in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice.		
3.2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice and has this been submitted to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.	N/A	N/A
Drawing on insights from themes identified from any term or late pre-term admissions to the NNU, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.			
For units commencing a new QI project:			
3.3	By 2 September 2025, register the Q1 project with local Trust quality/service improvement team.	N/A	N/A
3.4	By 30 November 2025, present an update to the LMNS and safety champions regarding development and any progress.	N/A	N/A
OR, for units continuing a QI project from the previous year:			
3.5	Demonstrate progress from the previous year within the first six months of the MIS reporting period and present an update to the LMNS and safety champions.		
3.6	By 30 November 2025 present a further update to the LMNS and safety champions regarding development and any progress at the end of the MIS reporting period.		

Quality Improvement Project – Progress Update:
Post intervention data collection to commence at NLAG in December 2025 and commence in February 2026 at HUTH.

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?
Lead: Uma Rajesh (HUTH), Preeti Gandhi / Lisa Pearce (NLAG)

Obstetric Workforce:

Requirement		**HUTH compliance**	**NLAG compliance**
4.1	Locum currently works in their unit on the tier 2 or 3 rota?		
4.2	OR they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)?		
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?		
4.4	Has the Trust implemented the RCOG guidance on engagement of long-term locums in full? Trusts should demonstrate full compliance through audit of any 6 month period from February 2025 to 30 November 2025.		
4.5	**NOT REPORTABLE IN MIS YEAR 7** Have you met or are you working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.		Action plan / SOP in place
4.6	Is the Trust compliant with consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. **New:** Trusts should demonstrate a minimum of **80%** compliance through audit of any 3 month period from February 2025 to 30 November 2025.		
4.7	Do you have evidence that the Trust position with the above has been shared with Trust Board?		
4.8	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?		
4.9	Do you have evidence that the Trust position with the above has been shared with the LMNS?		

Anaesthetic Workforce:

Requirement		HUTH compliance	NLAG compliance
4.10	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately.		

Progress update: Representative month rota from April 2025 onwards saved in the folders for both HUTH and NLAG (acceptable evidence).

Neonatal Medical Workforce:

Requirement		HUTH compliance	NLAG compliance
4.11	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Action plan in place	Action plan in place
4.12	Is this formally recorded in Trust Board minutes?		
4.13	If the requirements are not met, Trust Board should agree an action plan which updates on progress against any previous developed action plans. **New: This should be monitored via a risk register.**		
4.14	Was the above action plan shared with the LMNS?		
4.15	Was the above action plan shared with the neonatal ODN?		

Neonatal Nursing Workforce:

Requirement		HUTH compliance	NLAG compliance
4.16	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Action plan in place	Action plan in place
4.17	Is this formally recorded in Trust Board minutes?		
4.18	If the requirements are not met, Trust Board should agree an action plan which updates on progress against any previous developed action plans. **New: This should be monitored via a risk register.**		
4.19	Was the above action plan shared with the LMNS?		
4.20	Was the above action plan shared with the ODN?		

Progress update (medical and nursing workforce):
Awaiting Trust Board minutes from November 2025.

Safety action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Lead: Yvonne McGrath (HUTH and NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
5.1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (if this process has not been completed within three years due to measures outside of the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this).		
5.2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. Every report should include an update on all of the points below: · *Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall.* · *The midwife to birth ratio* · *Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift* · *Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour* · *A plan is in place for mitigation/escalation to cover any shortfalls in the two points above* · *It is recommended that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated.*		
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: · Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. · The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		
5.4	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.		
5.5	Where deficits in staffing levels have been identified must be shared with the local commissioners.		

Progress update:
Both Trusts demonstrate non-compliance with establishment levels, an action plan has been developed and submitted to Trust Board for approval. Awaiting November 2025 Trust Board minutes to evidence agreement.

Bi-annual staffing report to be submitted to Trust Board December 2025.

Safety action 6:
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?
Lead: Joanna Melia (HUTH), Samantha Sockett (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
6.1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory).		
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? *These meetings must include:* · *Initial agreement of a local improvement trajectory against these metrics for 25/26 and subsequently reviews of progress against the trajectory.* · *Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element* · *Evidence of sustained improvement where high levels of reliability have been achieved* · *Regular review of local themes and trends with regard to potential harms in each of the six elements.* · *Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.*		
6.3	Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?		
6.4	If the available implementation tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that SBLCB is fully / will be in place as agreed with the ICB.	N/A National implementation tool in place	

Progress update:
Saving babies' Lives Care Bundle version 3.2 was published in May 2025. The national expectation is that all Trusts should be fully compliant (100% in all elements) by March 2026. However, safety action 6 can be achieved if the LMNS are assured that all best endeavours have been made. Following quarter 2 assurance meetings the LMNS confirmed they are satisfied HUTH and NLAG have made best endeavours during the year to meet safety action 6.

Current compliance is shown in the tables below.

Northern Lincolnshire and Goole NHS Foundation Trust

For quarter 2 NLAG have achieved 83% (LMNS assessment).

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	90%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	69%	Partially implemented	69%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	81%	Partially Implemented	83%

Hull University Teaching Hospitals NHS Trust

For quarter 2 HUTH have achieved 90% (LMNS assessment).

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	70%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	90%	Partially implemented	90%

Safety action 7:
Listen to women, parents and families using maternity and neonatal services and co-produce services with users.
Lead: Yvonne McGrath / Rachael Thompson (HUTH) / Kimberley Boyd (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
7.1	Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge · Has progress on the coproduced action above been shared with Safety Champions? · Has progress on the coproduced action above been shared with the LMNS?		
7.2	Evidence of MNVP infrastructure being in place from your LMNS/ICB, including all of the following: · Job description for MNVP Lead · Contracts for service or grant agreements · Budget with allocated funds for IT, comms, engagement, training and administrative support · Local service user volunteer expenses policy including out of pocket expenses and childcare cost.	Infrastructure not in place, escalation route as per 7.3 followed.	
7.3	If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level. If evidence for 7.2 cannot be provided, then the escalation route must be followed as stated above. Evidence requirements for 7.4 and 7.5 are only required if evidence has been provided for 7.2 In this event, <u>as long as this escalation has taken place</u> the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action.		
7.4	**New**: Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a <u>quorate</u> member of trust governance, quality and safety meetings at speciality/divisional/directorate level including all of the following: *Safety champion meetings / Maternity business and governance / Neonatal business and governance / PMRT review meeting / Patient safety meeting / Guideline committee.*	N/A	N/A
7.5	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A	N/A

Progress update:

As per national requirements both Trusts do not have the required infrastructure in place. Guidance specifically states a band 8 MNVP lead should be in post. Escalation has taken place at Trust, regional and ICB level as per the technical guidance which allows both Trusts to declare compliance for this safety action.

Safety action 8:
Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?
Lead: Nichola Riggs (HUTH), / Zoe Saunders (NLAG) / Yvonne McGrath / Preeti Gandhi

Requirement		**HUTH compliance**	**NLAG compliance**
Fetal monitoring:			
8.1	90% of obstetric consultants		
8.2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)		
8.3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.4	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres		
Maternity emergencies and multiprofessional training:			
8.5	90% of obstetric consultants		
8.6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota		
8.7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives		
8.9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).		
8.10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors		
8.11	90% of all other obstetric anaesthetic doctors (commencing prior to 1 July 2025) including anaesthetists in training, SAS/LED doctors who contribute to the obstetric anaesthetic on-call rota.		
8.12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.		

Neonatal basic life support:			
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units		
8.16	90% of neonatal doctors (commencing with the organisation prior to 1 July 2025) who attend any births		
8.17	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		
8.18	90% of neonatal nurses (Band 5 and above who attend any births)		
8.19	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.	N/A	N/A
8.20	90% of advanced Neonatal Nurse Practitioner (ANNP)		
8.21	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)		
8.22	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.		

Progress update:
Risk identified with 1 consultant at NLAG who could not attend Fetal Monitoring training. At present a return to work date has not yet been confirmed and current compliance for DPOW is 88%.

Compliance for Rotational Medical Staff:
For rotational medical staff that commenced work on or after 1 July 2025 a lower training compliance will be accepted. Where applicable, confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.

Action Plan:

Action	Date of completion	RAG
HUTH and NLAG: Junior doctor rota supervisor (HUTH) and Rota Co-ordinator (NLAG) currently reviewing rotas to book all doctors into sessions for the above requirements. Both trusts have liaised with neighbouring trusts, ensuring up-to-date compliance dates for new staff members as per MIS guidance.	By 30/11/2025	
HUTH and NLAG: Close monitoring of attendance to continue by Practice Development Midwives and Maternity Audit and Compliance Managers to achieve compliance.	Ongoing	
HUTH: New full-time education admin support at interview stage. This will support with management of bookings and compliance in the future.	October 2025	
NLAG: Additional fetal monitoring sessions have been arranged in October and November 25 to ensure there is enough class capacity to accommodate.	By 30/11/2025	

Safety action 9:
Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
Lead: Yvonne McGrath (HUTH and NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) (including the following):		
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?		
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly and presented by a member of the perinatal leadership team to provide context.		
9.4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?		
9.5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.		
9.6	Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.		
9.7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?		
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) **and the MNVP lead** *(new)* (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.		
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.		

Safety action 10:
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?
Lead: Matthew Proctor (HUTH), Tracey Martin (NLAG)

Requirement		**HUTH compliance**	**NLAG compliance**
10.1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025.		
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025.		
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?		
10.4	For any occasions where it has not been possible to provide a format that is accessible for eligible families, has a SMART plan been developed to address this for the future.		
10.5	Has there has been compliance, where required, with Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		
10.6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.		
10.7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this.		
10.8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?		
10.9	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		

Progress update:

Qualifying cases that meet the reporting threshold to MNSI / EN are detailed in the monthly Maternity and Neonatal Assurance Report which is discussed at the Maternity and Neonatal Assurance Group, and Quality and Safety Committee in Common on a monthly basis. Reporting to Trust Board occurs on a bi-monthly basis (includes all cases within the MIS period, including DoC compliance and whether the appropriate information has been provided to families.

**Please note there have been a further 3 cases at HUTH and 1 at NLAG that qualified for reporting to MNSI and/or NHSR for Early Notification during the MIS period that have not been included in the November MNAG Assurance Report for Trust Board. All cases are in the very early

stages of reporting/investigation (reference numbers not yet known). These will be reported in the next Board Report in February 2026.

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 7, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 2 2025/26)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

October 2025

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Trust Board and Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 MBRRACE-UK reporting requirements and PMRT support:

Type of death	Eligible for reporting to MBRRACE-UK	Supported by the PMRT
Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Stillbirths – the baby is delivered from 24+0 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Early neonatal deaths – death of a live born baby occurring before 7 completed days after birth	**Yes** From 20+0 weeks gestation or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Late neonatal deaths – death of a live born baby occurring between 7 and 28 completed days after birth	**Yes** From 20+0 weeks gestation of pregnancy or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Post-neonatal deaths – death of a live born baby (born at 20+0 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring after 29 or more completed days after birth.	**No** Notification supported if death is to be reviewed with the PMRT.	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available. Baby must have received neonatal care.
Surviving sibling(s) in a multiple pregnancy – any live born baby who lives beyond 28 days, as part of a multiple pregnancy resulting in at least one late fetal loss, stillbirth or neonatal death.	**Yes** Notification only. Surveillance not required.	**No**
Terminations of pregnancy – Any registered stillbirth (from 24+0 weeks' gestation) or neonatal death (from 20+0 weeks' gestation) resulting from a termination of pregnancy should be notified. However, completion of the initial notification is only required. Completion of the full surveillance form is not required, and these deaths will not be supported for review using the PMRT.	**Yes** Notification only. Surveillance not required.	**No**

2. STANDARDS

A report has been produced for the Trust Executive Board each quarter from December 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b), c) and d) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**75%**
d) An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**50%**
e) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in MIS Year Seven (Appendix A)

There has been a total of **38** incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year seven period (01 December 2024 onwards):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive	Not eligible
December 2024	3	1	0	2 (post-neonatal)
Q4 (01 Jan – 31 Mar 25)	8	0	1	0
Q1 (01 Apr – 30 Jun 25)	3	1	1	1 (BW<200g)
Q2 (01 Jul – 30 Sept 25)	10	2	1	4 (post-neonatal)
Q3 (01 Oct – 31 Dec 25)	-	-	-	-
Total	**24**	**4**	**3**	**7**

24 cases are eligible for review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days. There are 4 notifications only which are due to reasons such as a MTOP, which meet the criteria as above. There are 3 babies that are not eligible because the baby is still alive due to a twin pregnancy, 1 baby whose birthweight was under 200g (excluded due to this) and 6 post-neonatal deaths that are not eligible. 0 cases met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

From 1st December 2024, please note there are 6 cases registered with MBRRACE where the deaths occurred at other Trusts and HUTH contributed to the care. It is the responsibility of the other Trusts to collaboratively complete the PMRT review. These cases do not appear on HUTH MIS year seven case list but are included in the yearly case list.

3.2 Summary of all incidents reviewed through PMRT in Quarter 2 2025/26 (Appendix B)

There have been **10** incidents reviewed through the PMRT process in quarter 2, and reports have been published for **4** of these. **2** are yet to receive final gradings following final review by the neonatal team.

When reviewing these cases, they are broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. It should be acknowledged that reporting relates to incidents that occurred earlier in the year due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

- 4 cases had no issues identified that would have had an impact on the outcome.
- 4 case had issues identified that would have had no impact on the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

- 8 cases had no issues identified that would have had an impact on the outcome.

2 cases yet to receive final gradings.

3.3 CNST Compliance as per MIS Year 7 Standards (Appendix C)

Following updated guidance from NHS Resolution and communications from MBRRACE-UK the Trust is on target to achieve full compliance. Please refer to Appendix C for further breakdown.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

3. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of eligible incidents reported (n=3)

		PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Dec24		**96445**	Neonatal death	27+2	13.10.24	11.12.24	650g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
		96455	Antepartum stillbirth	38+3	13.12.24	13.12.24	2810g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 11/06/25)	Yes – LMNS
		96467	Neonatal death	37+1	13.06.24	15.12.24	3096g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
		96528	Neonatal death	26+2	02.08.24	09.12.24	890g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
		96596	Antepartum stillbirth	39+4	23.12.24	23.12.24	2860g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 23/06/25)	Not yet discussed at PMRT
		96662	Neonatal death	23+2	25.12.24	27.12.24	360G	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 27/06/25)	MNVP
		96397	MTOP	21+2	06.12.24	06.12.24	410g	HUTH	HUTH	HUTH	NA	No	NA	NA	NA	NA

		PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q4 24/25		**96776**	Neonatal death	30+2	06.01.25	07.01.25	1500g	HUTH	LGI	LGI	LGI	No	Yes	Yes	LGI	Not yet discussed at PMRT
		97125	Neonatal death	22+1	22.01.25	29.01.25	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 29.07.25)	Not yet discussed at PMRT
		97208	Neonatal death	37+3	03.02.25	03.02.25	1455g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 03.08.25)	Not yet discussed at PMRT
		97208	Not eligible	37+3	03.02.25	Baby is still alive	2810g	HUTH	HUTH	HUTH	N/A	No	N/A	N/A	N/A	N/A
		97361	Antepartum Stillbirth	33+6	17.02.25	17.02.25	2285g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 17.08.25)	Not yet discussed at PMRT
		97393	Neonatal death	22+3	01.02.25	19.02.2025	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 19.08.25)	Not yet discussed at PMRT
		97484	Neonatal death	22+6	26.02.25	26.02.25	444g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 26.08.25)	Not yet discussed at PMRT
		97613	Stillbirth	23+0	03.03.25	03.03.25	1090g	Unbooked	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 03.09.25)	Not yet discussed at PMRT

	97620	Neonatal death	? <28 days	06.02.25	04.03.25	680g	Calderdale	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 04.09.25)	Not yet discussed at PMRT
	97853	Antepartum stillbirth	29+6	20.03.25	13.02.25	1615g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet published (deadline 20.09.25)	Not yet discussed at PMRT
Q1 25/26	98196	Antepartum stillbirth	23+2	16.04.25	16.04.25	553g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Review planned Q2	Review planned Q2
	98333	MTOP	22+0	26.04.25	26.04.25	440g	HUTH	HUTH	HUTH	N/A	No	Yes	N/A	N/A	N/A
	98492	Antepartum stillbirth	36+0	08.05.25	08.05.25	2495g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Review planned Q2	Review planned Q2
	98763	Antepartum stillbirth	32+1	27.05.25	27.05.25	1510g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Review planned Q2	Review planned Q2
	99180	Not eligible	25+5	27.06.25	02.04.2025	171g	HUTH	HUTH	HUTH	N/A	No	Yes	N/A	N/A	N/A
	99180	Not eligible	38+0	27.06.25	Baby still alive	3125g	HUTH	HUTH	HUTH	N/A	No	Yes	N/A	N/A	N/A

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q2 25/26	99246	Early NND	27+1	30.06.25	02.07.25	850g	Barnsley	Barnsley	HUTH	Yes	No	Yes	Yes	On track	Yes
	99247	MTOP	31+2	30.06.25	30.06.25	1950g	HUTH	HUTH	HUTH	N/A	N/A	Yes	N/A	N/A	N/A
	99338	Early NND	6 days	03.07.25	09.07.25	3215g	HUTH	HUTH	Martin house	Yes	No	Yes	Yes	On track	Yes
	99280	Intrapartum stillbirth	36+5	03.07.25	03.07.25	2090g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	99518	Antenatal stillbirth	31+0	22.07.25	22.07.25	1415g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	Yes
	99594	Antenatal stillbirth	32+3	26.07.25	26.07.25	1550g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	Yes
	99689	Antenatal Stillbirth	32+4	03.08.25	03.08.25	1500g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	October review
	100027	Early NND	22+6	27.08.25	28.08.25	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	October review
	100090	Late NND	103 days	15.05.25	26.08.25	1000g	HUTH	HUTH	Martin House	Yes	No	Yes	Yes	On track	October review

Q2 25/26	100143	Early NND	3 days	01.09.25	04.09.25	3302g	Rotherham	Rotherham	HUTH	Yes	Yes	Yes	Yes	On track	November planned
	100134	Late NND	54 days	12.07.25	04.09.25	480g	DPOW	DPOW	HUTH	Yes	No	Yes	Yes	On track	Planned November
	100192	Antenatal stillbirth	34+3 days	08.09.25	08.09.25	2300g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned November
	100249	Late NND	34 days	24.08.25	11.09.25	550g	Doncaster	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned December
	100360	Late NND	5 months	21.04.25	18.09.25	660g	Pinders	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned December
	100449	NND	21+2	26.09.25	26.09.25	410g	HUTH	HUTH	HUTH	N/A	No	Yes	‘Not suitable for R/V’	‘Not suitable for R/V’	‘Not suitable for R/V’
	100467	Late NND	66 days	28.07.25	27.09.25	2710g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	January Planned

Appendix B – Summary of all incidents reviewed through PMRT and reviews completed/moved to report writing in Q2 2025-2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
97853 (Q1)	Maternal assault and trauma to the placenta as a result of this.	A/B	The baby had to be transferred elsewhere for the post-mortem	Nil	Yes
98763 (Q1)	Undetermined	B/A	· This mother has a history of epilepsy requiring treatment with anti-convulsant, this was identified in a previous pregnancy, but she did not receive specialist periconceptional counselling/management · This mother was taking Anti-convulsant, this was identified in a previous pregnancy, but she did not receive specialist periconceptional counselling/management · The baby had to be transferred elsewhere for the post-mortem	Nil	Yes
97484	Sepsis, extreme pre-term gestation 22+6 gestation, Congenital abnormality - exomphalos, PPROM, preterm labour Twin pregnancy	A/A/A	During the move to the neonatal unit the baby's temperature was not maintained within an appropriate range	Improve Temperature management- new delivery resuscitation sheets created- to confirm highlight temperature management- will be introduced	Yes
98492	Placental Abruption	B/A	The baby had to be transferred elsewhere for the post-mortem	Known service provision at Sheffield.	Yes
97620	Sepsis, extreme prematurity, severe lung disease with candida	B/C/A	Nil	Nil – Neonatal care graded C and taken to Learning Response Panel	Yes
99280	Congenital abnormality - Acrania and Exencephaly	A/A	Nil	Nil	Yes
99072	Awaiting final neonatal grading and review. Planned delivery at LRI due to known cardiac abnormality.	B/-/-	Awaiting final neonatal review	Awaiting final neonatal review	Yes
99338	Awaiting final neonatal review and grading. Gastroschisis (rare presentation with apple peel bowel and single artery)	A/-/A	Awaiting final neonatal review	Awaiting final neonatal review	Yes
99246	Awaiting final review. Ex-utero transfer from Barnsley.	B/A	No issues from HUTH care identified	No issues from HUTH care identified	Yes

99518	Placental abruption	B/B	· This mother met the national guideline criteria for screening for gestational diabetes, screening was organised, but the results were not available · The baby was small for gestational age at birth, scans were indicated but had not been performed · This mother had a previous baby which was growth restricted/small for gestational age and her antenatal care was not appropriate given this history · This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the designated room/suite was already in use	· Diabetic leads ensuring re-booking of OGTT is performed when required (for review of education of pathway) · Delivered prior to 32/40 when planned USS were · SBLv3.2 identified as not requiring UtAd · Current charity drive to improve bereavement environment for families	Yes

Grading of care

Stillbirth:

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Neonatal death:

Grading of care of the mother and baby up to the point of birth of the baby:

- A - The review group concluded that there were no issues with care identified up the point that the baby was born
- B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

- A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

- A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
- B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Appendix C – Summary of CNST Compliance as per MIS Year 7 standards (01/12/24 – 30/11/25)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q4 Oct – Dec 25	Total
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	4/4 (100%)	8/8 (100%)	3/3 (1005)	10/10 (100%)	-	**25/25 (100%)**
Cases applicable for PMRT review are applicable to the following standards (n=23)							
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	3/3 (100%)	8/8 (100%)	3/3 (100%)	6/9 (66% - 3 ongoing)	-	**20/23 (87%)** **3 ongoing – no timeframe**
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	3/3 (100%)	8/8 (100%)	3/3 (100%)	7/8 (1 ongoing, 1 N/A as baby born in a different trust)	-	**21/22 (95%)** **1 ongoing**
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3/3 (100%)	8/8 (100%)	3/3 (100%)	0 applicable in timeframe	-	**On Target**
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT. (from 02/04/2025)	**50%**	N/A	Not yet discussed at PMRT.	3/3 (100%)	2 met (100%), all others after deadline		**100%**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted January 2025	Submitted April 2025	Submitted July 2025	Submitted October 2025	-	**100%**

Appendix D: Learning Points and Key Themes:

Key themes and/or learning identified from **Q2** cases PMRT or continued from previous quarterly reviews are as follows:

- Service pressure of diabetic service continues – on risk register and service improvements being supported
- Translation services at times inconsistent and family members used as translators in community settings
- Increased congenital/genetic abnormality with appropriate management

Appendix E: Summary of Saving Babies' Lives Interventions of cases which have gone through PMRT:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/10 (0%)	0/6 (0%)	0/10 (0%)		**0%**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/10 (0%)	0/6 (0%)	1/10 (10%)		**4%**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/10 (0%)	0/6 (0%)	0/10 (0%)		**0%**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/10 (0%)	1/6 (16.6%)	0/10 (0%)		**4%**

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 7, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 2 2025/26)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

October 2025

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Trust Board and Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 MBRRACE-UK reporting requirements and PMRT support:

Type of death	Eligible for reporting to MBRRACE-UK	Supported by the PMRT
Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Stillbirths – the baby is delivered from 24+0 weeks of gestation showing no signs of life, irrespective of when the death occurred	**Yes** From 400g where an accurate estimate of gestation is not available	**Yes** From 500g where an accurate estimate of gestation is not available
Early neonatal deaths – death of a live born baby occurring before 7 completed days after birth	**Yes** From 20+0 weeks gestation or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Late neonatal deaths – death of a live born baby occurring between 7 and 28 completed days after birth	**Yes** From 20+0 weeks gestation of pregnancy or 400g where an accurate estimate of gestation is not available	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available
Post-neonatal deaths – death of a live born baby (born at 20+0 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring after 29 or more completed days after birth.	**No** Notification supported if death is to be reviewed with the PMRT.	**Yes** From 22+0 weeks gestation or 500g where an accurate estimate of gestation is not available. Baby must have received neonatal care.
Surviving sibling(s) in a multiple pregnancy – any live born baby who lives beyond 28 days, as part of a multiple pregnancy resulting in at least one late fetal loss, stillbirth or neonatal death.	**Yes** Notification only. Surveillance not required.	**No**
Terminations of pregnancy – Any registered stillbirth (from 24+0 weeks' gestation) or neonatal death (from 20+0 weeks' gestation) resulting from a termination of pregnancy should be notified. However, completion of the initial notification is only required. Completion of the full surveillance form is not required, and these deaths will not be supported for review using the PMRT.	**Yes** Notification only. Surveillance not required.	**No**

2. STANDARDS

A report has been produced for the Trust Executive Board each quarter from December 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**75%**
d) An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**
e) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in MIS Year Seven (Appendix A)

There has been a total of 7 incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year seven period (01 December 2024 onwards):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2024	1	0	0
Q4 (01 Jan – 31 Mar 25)	2	0	0
Q1 (01 Apr – 30 Jun 25)	4	0	0
Q2 (01 Jul – 30 Sept 25)	1	1	0
Q3 (01 Oct – 31 Dec 25)	-	-	-
Total	**8**	**1**	**0**

1 case met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) and has been reported accordingly.

3.2 Summary of all incidents reviewed through PMRT in Quarter 2 2025/26 (Appendix B)

There have been 4 incidents reviewed through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to some incidents that occurred prior to the MIS year 7 timeframe.

In addition, please note there are 5 cases registered with MBRRACE where the death occurred at other Trusts and NLAG contributed to the care. It is the responsibility of the other Trusts to complete the PMRT process. These cases do not appear on NLAG MIS case list.

<u>Grading of care provided to the mother before the death of the baby</u>

- 0 cases had no issues identified that would have had an impact on the outcome.
- 3 cases had issues identified that would have had no impact on the outcome
- 1 case had issues that may have had a difference to the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

- 1 case had no issues identified that would have had an impact on the outcome
- 3 cases had issues identified that would not have had an impact on the outcome
- 0 cases had issues identified that may have had a difference to the outcome

<u>Grading of care of the baby from birth up to the death of the baby:</u>

- 0 cases had no issues identified that would have had an impact on the outcome.
- 0 cases had issues identified that would have had no impact on the outcome.

3.3 CNST Compliance as per MIS Year 7 Standards (Appendix C)

The Trust is on target to achieve full compliance. Please refer to Appendix C for further breakdown.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version 3.2 by the 01 March 2026. The care bundle was published in April 2025 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of eligible incidents reported

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Dec 24	96717	Intrapartum stillbirth	38+3	31/12/24	31/12/24	3130g	SGH	SGH	SGH	Yes	Yes (consent declined by family)	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q4 24/25	97389	Antepartum stillbirth	28+1	19/02/25	15/02/25	1080g	SGH	SGH	SGH	Yes	No	Yes	Yes	Yes	Yes
	97175	Antepartum stillbirth	38+6	02/02/25	02/02/25	2336g	DPOW	DPOW	DPOW	Yes	Yes	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q1 25/26	98971	Antepartum stillbirth	36+4	11/06/25	11/06/25	1990g	SGH	SGH	SGH	Not yet met	No	Yes	Yes	Yes	Yes
	98745	Late fetal loss	22+6	25/05/25	25/05/25	532g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Yes	Yes
	98741	Early neonatal death	37+4	23/05/25	23/05/25	1606g	DPOW	DPOW	DPOW	Not yet met	No	Yes	Yes	Not yet met	Not yet met
	98007	Antepartum stillbirth	38+2	01/04/25	01/04/25	2870g	SGH	SGH	SGH	Yes	No	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q2 25/26	99969	Antepartum stillbirth	30+5	26/08/25	26/08/25	1718g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met	Not yet met
	99819	Neonatal Death	21+4	13/08/25	13/08/25	422g	DPOW	DPOW	DPOW	*N/A	N/A	N/A	N/A	N/A	N/A

*Notification only required.

Appendix B – Summary of all incidents reviewed through PMRT in Q2 of 2025/2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?	Discussed at Learning Response Panel?
97389	Antepartum Stillbirth	B / A	No evidence in the notes that this mother was asked about domestic abuse at booking. This mother was assessed as high risk and in need of aspirin, but aspirin was not prescribed.	Reminder to al staff disseminated on the PMRT Newsletter. Reminder included on the Obstetric Huddle to assess and prescribe aspirin.	Yes	N/A
98007	Antepartum Stillbirth	C / B	Symphysis fundal height measurements were not performed at correct times/intervals. This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby, but serial scans were not planned. At first presentation with reduced fetal movements this mother was not appropriately risk assessed. This mother presented with reduced fetal movements but based on her scans and/or other investigations an appropriate management plan was not put in place. This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	Reminder to al staff disseminated on the PMRT Newsletter. Individual reflective supportive discussion with midwife regarding assessment of fetal movements. Discussion at Community Team Meeting regarding measuring symphysis fundal heights and carbon monoxide screening.	Yes	Yes

			NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened. This mother only had partial investigations for underlying metabolic and/or haematological abnormalities as per the local but not the national guideline.			
98745	Late Fetal Loss	B / B	Infection screening of the mother and baby was not carried out despite it being requested. It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home. It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital.	Reminder to al staff disseminated on the PMRT Newsletter. For Learning to be disseminated at Perinatal M&M meeting.	Yes	N/A
98971	Antepartum Stillbirth	B / B	At first presentation with reduced fetal movements this mother was not appropriately risk assessed. This mother presented with reduced fetal movements and scan was indicated but not carried out. This mother presented with reduced fetal movements, but management was not appropriate and was not in line with national guidance.	Reminder to al staff disseminated on the PMRT Newsletter. For Learning to be disseminated at Perinatal M&M meeting.	Yes	N/A

			This mother has a history of Coccyx manipulation surgery x2 and her antenatal care was not appropriate given this history. It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home. It is not possible to tell from the notes if the parents were provided with written information about practical issues following the death e.g. funeral options and benefits.			

Appendix C – Summary of CNST Compliance as per MIS Year 7 standards (01/12/24 – 30/11/25)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	2/2 (100%)	-
Cases applicable for PMRT review are applicable to the following standards (n=8)						
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	-
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	-
Multi-disciplinary reviews should be published within six months of the death.	**75%**	1/1 (100%)	2/2 (100%)	3/4 (75%) 1 not yet met (deadline 23/11/25)	Not yet met (deadline 26/02/26)	-
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**50%**	1/1 (100%)	2/2 (100%)	3/4 (75%) 1 not yet met	Not yet met	-
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	To be submitted Oct 2025	-

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q2** cases PMRT or continued from previous quarterly reviews are as follows:

- All postnatal bloods and investigations not being taken.
- Bereavement checklist not fully completed
- Not appropriately risk assessed when presenting with RFM's

The following key learning points from **Q2** PMRT reviews have been shared with staff via Safety Bulletins, PMRT Newsletter and Presentations at Perinatal M&M Meeting:

- All postnatal investigations required to gain full clinical picture
- Bereavement checklist must be fully completed
- Questions surrounding domestic abuse to be asked at booking
- Language Line to be used at all appointments

Action to be taken in response to the issues identified are detailed in appendix B.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/5 (20%)	1/5 (20%)	1 (25%)		
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	3/5 (60%)	0/5 (0%)	2/4 (50%)		
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/5 (20%)	0/5 (0%)	0/4 (0%)		
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	1/5 (20%)	0/5 (0%)	0/4 (0%)		

HUTH & NLaG Bi-Annual Midwifery & Neonatal Staffing Oversight Report

1. Introduction

This bi-annual report provides an overview of midwifery and neonatal workforce capacity, risks, and improvement actions across Humber Health Partnership (HHP), covering Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole (NLaG). The report fulfils the NHS England Three-Year Delivery Plan requirements, the National Quality Board (NQB) standards for safe staffing, and contributes to assurance for CNST Maternity Incentive Scheme (MIS) Year 7 Safety Actions.

The paper summarises:

- Birthrate Plus (BR+) findings and current midwifery staffing position
- Neonatal workforce compliance against BAPM standards
- Workforce risks and mitigations
- Progress on recruitment, retention, and skill mix development
- A summary of red flags, escalation, and acuity

2. Strategic Context

HHP continues to operate within a challenging maternity and neonatal staffing environment, with sustained demand, high acuity, and legacy workforce constraints at both HUTH and NLaG. National drivers remain focused on improving safety, continuity, and staffing compliance.

Key strategic influences include:

- NHS England Three-Year Maternity & Neonatal Delivery Plan
- Ockenden recommendations
- BAPM Neonatal Nurse Standards (2023)
- CNST MIS Year 7 requirements
- Regional and national workforce shortages

This report provides a consolidated view of current performance and the actions underway to ensure safe, sustainable staffing across maternity and neonatal services. The report is split into two parts, part one for Hull University Teaching Hospitals and part two for Northern Lincolnshire and Goole followed by a joint set of recommendations.

Hull University Teaching Hospitals Bi-Annual Midwifery & Neonatal Staffing Oversight Report

It is a requirement of the Maternity (and Perinatal) Incentive Scheme (MIS) that a midwifery staffing oversight report, covering staffing and safety issues, is submitted to the Trust Board every six months during Year 7.

Following the Care Quality Commission (CQC) inspection in March 2023, maternity services at HUTH were rated *Inadequate*. The inspection identified significant concerns regarding leadership, staff morale, staffing levels, and governance—issues that present a direct risk to the safety and wellbeing of mothers and babies and require immediate, sustained improvement.

HUTH has since entered the Maternity Safety Support Programme (MSSP) and received a detailed diagnostic report in June 2024. The findings highlight the urgent need for targeted investment to stabilise and strengthen midwifery services, particularly at HUTH. While initial measures—such as safety huddles, the

introduction of standard operating procedures, and focused recruitment—have been implemented, these actions alone are insufficient to address long-standing systemic challenges. Leadership gaps, moral injury among staff, and ongoing workforce shortages continue to undermine the service's ability to deliver consistently safe, high-quality care.

As NHS providers, it remains a core requirement that we have the right staff, with the right skills, in the right place at the right time, in line with National Quality Board (NQB) expectations for safe nursing and midwifery staffing. NICE (2017) guidance further emphasises that maternity services must maintain a systematic and evidence-based approach to setting midwifery establishments to ensure safe, continuous care for women and babies in all settings.

Maternity Services at Hull Royal Infirmary provide inclusive care to over 5,000 families each year across Hull and the East Riding of Yorkshire. The service operates a traditional model, with intrapartum care delivered at HRI, supported by a midwife-led birth centre and specialist fetal and neonatal services. Although birth rates have decreased nationally and locally, the complexity of women using the service continues to rise, with increasing numbers of safeguarding concerns, high BMI, diabetes, and smoking in pregnancy. The service therefore supports a diverse population with needs ranging from uncomplicated to highly complex care throughout pregnancy, labour, and the postnatal period.

Safe staffing reviews are undertaken six-monthly as part of the Trust establishment review process, supported by routine monitoring of actual versus planned staffing by area matrons. Daily LMNS-wide huddles assess system pressures, complemented by a Monday–Friday pan-group safety huddle to review staffing, acuity, and opportunities for mutual aid. Additional huddles occur as required throughout the day. The development of a specialty-specific on-call rota remains a priority to ensure appropriate clinical leadership out of hours, as current arrangements rely on the site team. The OPEL escalation framework is consistently applied, and work to implement a pan-group escalation tool is progressing.

Neonatal

Hull Neonatal Unit is a Level 3 tertiary unit with 33 cots (7 intensive care, 10 high dependency, 12 special care, and 4 transitional care). It is the only local Level 3 neonatal service and supports a population with significant deprivation and clinical complexity. As part of Humber Health Partnership, Level 3 activity has now been consolidated at Hull; previously, NLAG's Level 3 activity was aligned to Sheffield. The Level 3 designation requires delivery of at least 2,000 intensive care days per year. Following service realignment and cot expansion, Hull achieved this benchmark last year and is on track to reach approximately 2,300 intensive care days in the current financial year.

Neonatal workforce planning is informed by NHS England priorities, BAPM standards, and CNST MIS Year 7 requirements, and is subject to review at local, regional, and operational delivery network (ODN) levels. The NHS Long Term Plan highlights workforce as fundamental to improving neonatal outcomes. However, staffing growth has not kept pace with increasing acuity and complexity, creating the need for both establishment expansion and enhanced specialist training.

The BAPM (2017) framework sets out core safety standards, including:

- nurse-to-baby ratios of 1:1 (Intensive Care), 1:2 (High Dependency), and 1:4 (Special Care/Transitional Care)
- 70% of the nursing workforce trained in Qualification in Speciality (QIS)
- a supernumerary coordinator on every shift
- a 25% uplift to account for leave, training, and non-clinical requirements

Under CNST MIS Year 7, Trusts must either meet these standards or have a Board-approved plan in place to do so. Although the standards are not regulatory, they are referenced by the CQC and form a key benchmark for assessing safety, quality, and service resilience.

HUTH does not currently meet full BAPM compliance. However, there have been no incidents of patient harm or Patient Safety Incident Investigation (PSII) cases directly attributed to neonatal workforce gaps to date.

2. Midwifery Workforce: Birthrate Plus® Workforce Planning and 2025 Report

Birthrate Plus® (BR+) is the only nationally recognised workforce planning tool for maternity services and has been used across UK maternity units for many years. It provides an evidence-based framework to determine the total midwifery time required to safely care for women, underpinned by the principle of providing one-to-one midwifery care throughout established labour. Its methodology is consistent with NICE guidance on safe midwifery staffing and is endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG).

HUTH maternity services undertook a full BR+ assessment in 2024, with the refreshed report received in May 2025. The latest report identifies a total *clinical* establishment requirement of **217.95 WTE** registered midwives and Band 3/4 maternity support workers. The *overall* midwifery establishment required—including management roles and the non-clinical components of specialist posts—is **244.10 WTE**.

Specialist and leadership roles continue to develop in line with national recommendations and local service needs. Significant progress has been made over the past 12 months. The table below details the current funded posts:

Current leadership and specialist roles	WTE	Band	Notes
Director of Midwifery	0.5		Pan-Group
Head of Midwifery	1	8C	
Maternity Matron x 3	3.0	8A	
Quality & Safety Matron	1	8A	
Governance Midwife	1.8	7	
Bereavement Midwife	0.8	7	
Bereavement support midwife	0.8	6	0.47 WTE unfunded
Digital Lead Midwife	1	7	
Fetal Monitoring lead Midwife	1	7	
Infant Feeding Midwife	1	7	
Infant Feeding Support Midwife	0.5	6	
Public Health & Saving Babies Lives Lead Midwife	1	7	
Lead Midwife for Diabetes	0.85	7	
Diabetes Specialist Midwife	1.03	6	
Screening Midwife	1	7	
Deputy screening Midwife	0.88	6	
Perinatal Mental Health Midwife	1	7	
Practice educator Midwives	1	7	
Recruitment, Retention and Pastoral Lead	1	7	
Maternity Audit & Compliance Manager	1	7	

Midwifery Practice Leads for Ward Areas	7	7	
Pre-term Birth Lead Midwife	0.5	7	Pan-Group not recruited yet
Maternal Medicine Lead Midwife	0.5	7	Pan-Group not recruited yet

The Midwifery Business Case to achieve BR+ compliance and meet the Maternity Incentive Scheme (MIS) Safety Action 5 was approved by the Trust Board in November 2025. The business case outlines a phased approach to closing the identified gap of **21.47 WTE**, with the intention of achieving full BR+ compliance within an 18-month period. This timeline is essential to enable the Trust to undertake the next BR+ data collection in Quarter 2 of 2027 and receive the updated report by May 2028.

NICE (2017) guidance recommends that a Birthrate Plus® assessment is completed every three years, and that the midwifery staffing budget reflects the establishment identified. Where a Trust is not fully funded to the BR+ requirement, an action plan and clear timescale must be in place to address the shortfall, including mitigations to ensure safe care. This plan must also be shared with local commissioners.

See Appendix 1 for action plan

3. Neonatal Workforce and BAPM Standards

Qualified in Speciality

In view of the very specialist requirements of neonatal nursing, BAPM standards recommend that 70% of Neonatal Nurses have completed additional specialist training. As Hull Royal Infirmary is a Level 3 Neonatal Unit with high levels of activity and acuity, it is recommended that 85% of Neonatal Nurses are qualified in speciality. Completing this training is now an expectation at the point of recruitment whereas previously this was opt-out.

Trajectories

Current	55%
December 2026	70%
December	85%

The table below outlines the Leadership and Specialist Roles in place across Neonatal nursing at HUTH.

Leadership and Specialist Nurse Roles

Current leadership and specialist roles	WTE	Band	Notes
Nurse Director	0.5		
Deputy Nurse Director	0.5	8B	Pan-Group
Matron	1	8A	
Neonatal Governance Nurse	0.91	7	
Neonatal Unit Ward Manager	1	7	
Lead Neonatal Nurse Educator	1	7	
Clinical Neonatal Nurse Educator	2	1	

Lead Neonatal Bereavement Nurse	0.8	7	
Infant Feeding Lead	0.64	6	Role banding needs to be reviewed
Safeguarding and Discharge Lead Nurse	0.96	6	
Transitional Care and Outreach Lead	1	7	
Special Care Junior Sister	0.5	6	

An identified gap is for a Family Care Lead Nurse at a Band 7 1.0 WTE.

The Neonatal Nursing Business Case to achieve compliance with BAPM nursing standards and meet the requirements of the Maternity Incentive Scheme (MIS) Safety Action 4 was approved by the Trust Board in November 2025. The business case sets out a phased programme of investment to close the identified gaps in establishment, skill mix, and QIS-trained workforce. Quarterly meetings with the Neonatal Workforce Lead for the ODN are held to review staffing levels, numbers, and compliance with BAPM.

See Appendix 2 for action plan

4. Safe Staffing Oversight, Monitoring and Escalation

Robust mechanisms are in place across Humber Health Partnership (HHP) to provide ongoing oversight of maternity and neonatal staffing, acuity and safety. These systems ensure that workforce pressures are identified early and mitigated where possible, in line with NQB expectations for real-time staffing management.

4.1 Establishment Reviews and Six-Monthly Reporting

Formal safe staffing establishment reviews are undertaken every six months, as required by the National Quality Board and the Maternity Incentive Scheme (MIS) Year 7. These reviews incorporate:

- Birthrate Plus® and BAPM workforce modelling
- Acuity and dependency data
- Activity trends
- Red flag events
- Incidents, complaints and safety themes
- Workforce metrics, including vacancies, sickness and turnover

The outcome of each review is escalated to the Trust Board to ensure transparency, assurance and appropriate action planning.

4.2 Daily Operational Oversight

Daily real-time staffing oversight includes:

- LMNS-wide huddles: reviewing pressures and capacity across the regional footprint, facilitating mutual aid.
- Pan-group safety huddles (Monday–Friday): reviewing staffing, acuity, escalation status, theatre capacity, neonatal flow, and cross-site support opportunities.
- Ad-hoc huddles throughout the day in response to changes in acuity or staffing.

These processes enable rapid escalation, redistribution of staff and early identification of emerging risks.

4.3 Escalation Framework and On-Call Arrangements

The OPEL escalation framework is routinely used to identify and respond to staffing and activity pressures. Work is underway to implement a pan-group maternity escalation tool to ensure consistent decision-making and improved cross-site coordination.

A dedicated specialty-specific maternity on-call rota remains a priority. At present, out-of-hours operational and clinical escalation relies on the site team, which does not provide the specialist insight required for complex maternity decision-making. Development of an on-call model is essential to strengthen safety, governance and staff support.

4.4 Birthrate Plus® Live Acuity Tool

The Birthrate Plus® Live Acuity Tool is a real-time safe staffing tool used by midwives to assess workload based on the number of women requiring care and the clinical needs of each woman during admission, labour, birth, and the postnatal period. The tool measures acuity using clinical indicators aligned with the established Birthrate Plus® workforce planning framework.

Unlike retrospective assessments previously used, the BR+ Live Acuity Tool provides a prospective, predictive assessment of staffing requirements. The tool is completed every four hours by the Labour Ward Coordinator. It generates a real-time calculation of the number of midwives required to safely meet demand across each clinical area, based on:

- The requirement for 1:1 midwifery care in established labour
- The increased midwifery time required for women in higher-need categories
- Changes in clinical condition during labour, prompting movement into higher acuity categories

This approach supports compliance with the NICE (2017) Safe Midwifery Staffing for Maternity Settings guideline and is endorsed by NICE as an appropriate method for determining safe staffing levels in real time.

Use of the Acuity Tool to Support Safe Staffing

The BR+ Live Acuity Tool provides clear documentation of actions taken during periods of high acuity or staffing shortfalls and demonstrates the use of the Trust’s escalation policy. This evidence supports MIS Year 7 Safety Action 5 requirements regarding:

- Real-time monitoring of staffing
- Actions taken when staffing falls below required levels
- Use of escalation and mitigation

When staffing is below the required level or acuity increases, the following actions are taken in line with the escalation policy:

- Redeployment of midwives in specialist roles to work clinically
- Prioritisation of elective workload to maximise available staffing
- Band 7 and above managers providing clinical support
- Redistribution of staff to maintain 1:1 care in labour and protect the supernumerary Labour Ward Coordinator role
- Activation of community midwives via the on-call system
- Implementation of double-pay incentives to secure additional temporary staffing when required

These measures ensure that safety is maintained, and that midwifery staffing is responsive to fluctuations in acuity.

4.4.1 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following table outlines the compliance by month:

Month	Number of days per month	Number of shifts per month	Compliance
April 25	30	60	98%
May 25	31	62	100%
June 25	30	60	100%
July 25	31	62	100%
August 25	31	62	100%
September 25	30	60	100%

There was one red flag reported below where the Labour Ward Coordinator was unable to maintain supernumerary status but was NOT providing 1:1 care for a woman. This was recorded on the data reported at 00:00 on 01/04/2025 but then not declared on the next data input. This was investigated and was at a time of high acuity and was for a short period whilst the co-ordinator completed escalation, completing an initial triage. As per MIS guidance, this is accepted as it can be evidenced this is not a recurrent daily event from the Birth Rate + data.

4.4.2 One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour. If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance reported by the Birth Rate Plus acuity tool by Month:

Month	Number of days per month	Number of shifts per month	Compliance
April 25	30	60	100%
May 25	31	62	100%
June 25	30	60	100%
July 25	31	62	100%

August 25	31	62	100%
September 25	30	60	100%

4.4.3 Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE, 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool. The majority of red flags are related to delays in induction of labour. Following the updated Birthrate Plus report additional staffing will be available for Labour Ward which will support timely induction of labour. An induction of labour task and finish group is also ongoing to address these issues.

The following tables demonstrate red flag events:

1st April 2025 – 30th September 2025

Delivery Suite	APR	MAY	JUN	JUL	AUG	SEP	Total
Delayed or cancelled time critical activity	34	20	16	21	23	18	132
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	0	0	1	0	1
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes meds)	0	0	0	0	0	0	0
Delay in providing pain relief	0	0	0	0	0	0	0
Delay between presentation and triage	0	1	0	0	0	0	1
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0
Delay between admission for induction and beginning of process	25	48	29	25	33	34	194
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	1	1
Any occasion when 1 midwife is not able to provide continuous one-to-	0	0	0	0	0	0	0

one care and support to a woman during established labour							
Labour Ward Coordinator unable to maintain supernumerary status – providing 1:1 care for a woman	0	0	0	0	0	0	0
Labour Ward Coordinator unable to maintain supernumerary status – NOT providing 1:1 care for a woman	1	0	0	0	0	0	1
TOTAL	60	69	45	46	57	53	330

4.4.4 Neonatal Red flags

Neonatal red flags are currently being developed and will include supernumerary status of the NICU co-ordinator and compliance with BAPM nursing ratios.

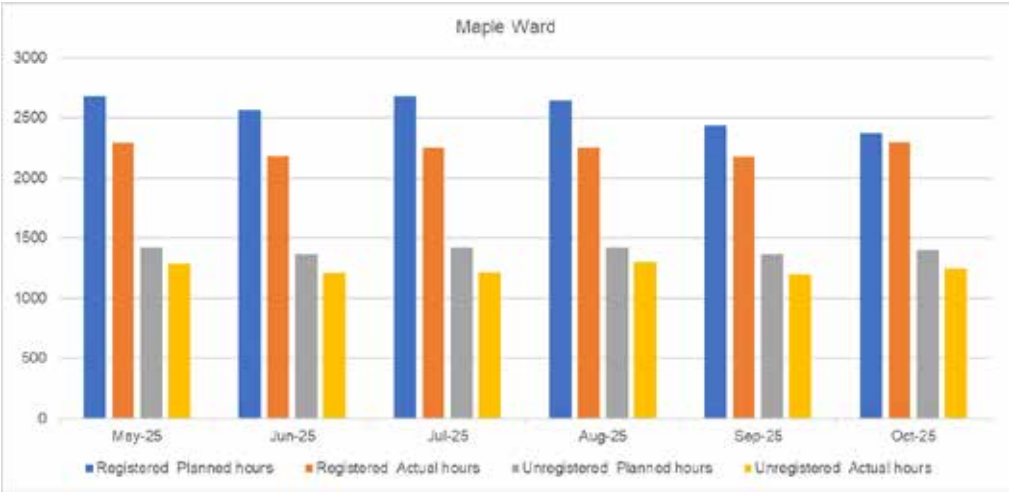
In the last 12 months despite very high levels of activity and acuity, the co-ordinator has only lost supernumerary status on 12 occasions. Future reports will develop these red flags as markers of point of escalation and action.

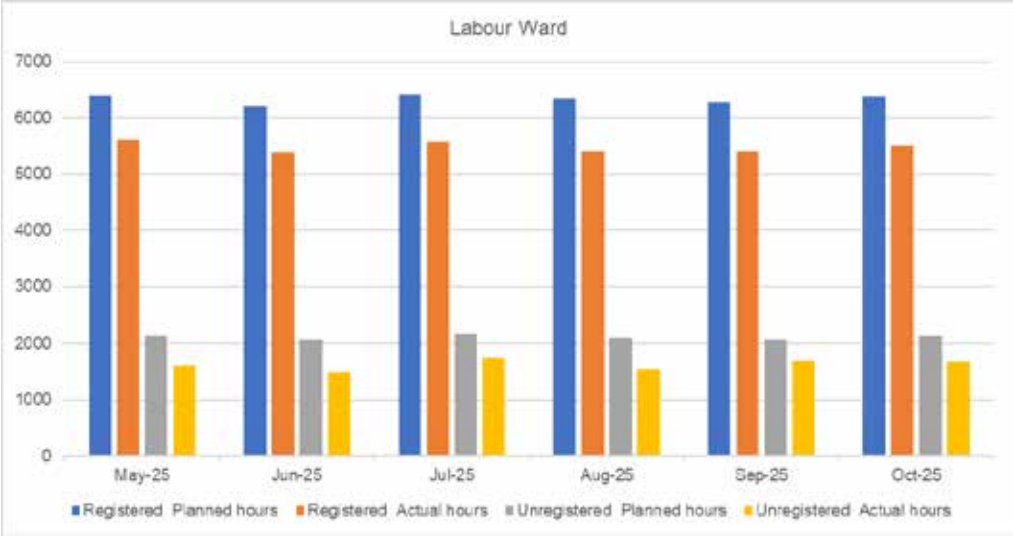
4.4.5 Monitoring of Actual vs Planned Staffing

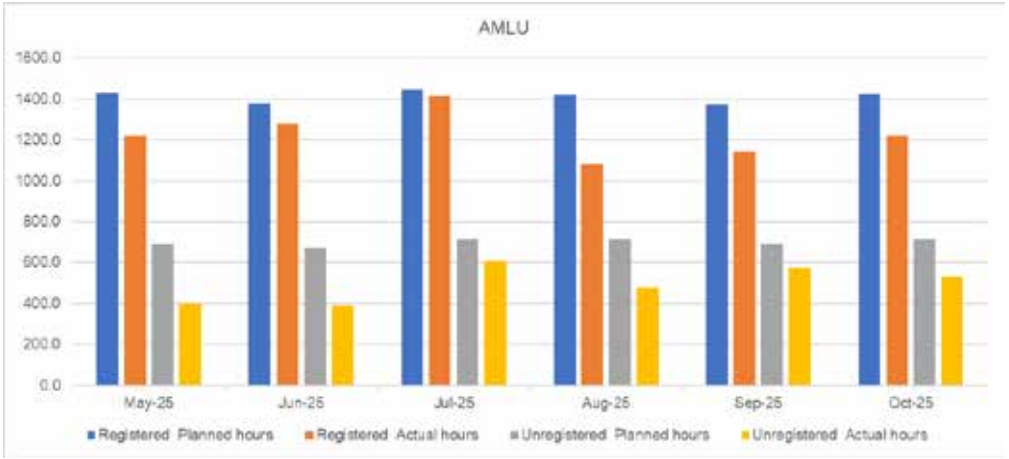
Matrons monitor actual versus planned staffing across all maternity areas each shift. Actions taken may include:

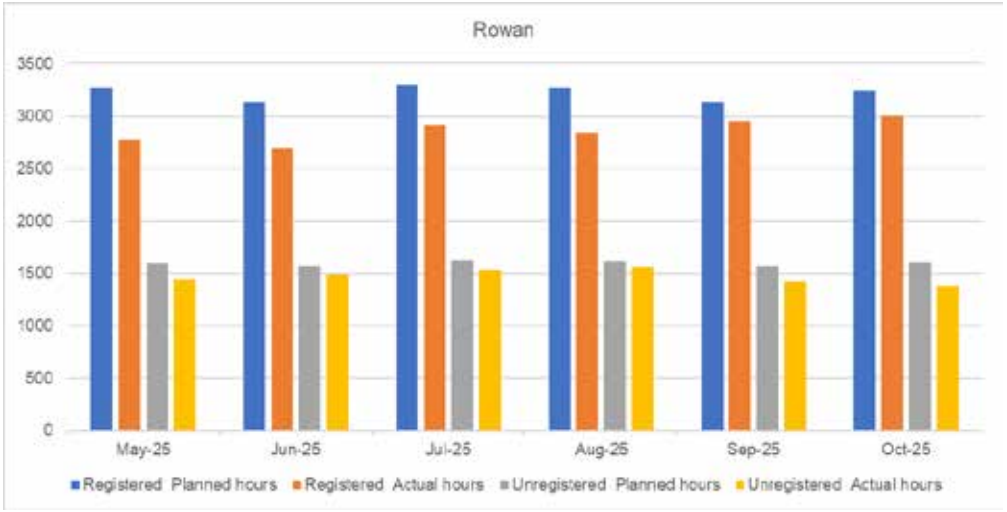
- Redeployment of staff between areas to maintain safe skill mix in bother maternity and neonates
- Prioritisation of 1:1 intrapartum care
- Pausing of non-essential activity where required
- Senior management escalation
- Use of bank, offering overtime and double pay incentive where appropriate

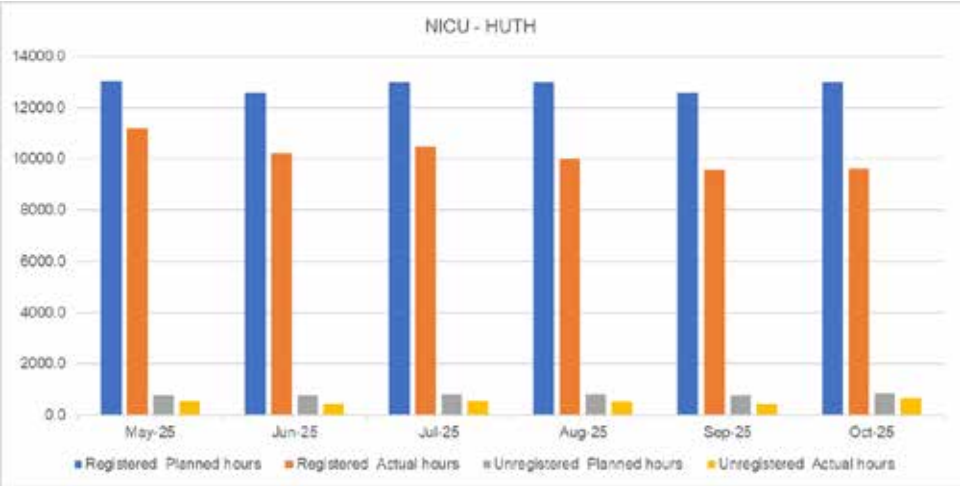
This continuous monitoring supports delivery of safe care and ensures a rapid response to fluctuations in activity or acuity.






AMLU
1600.0
1400.0
1200.0
1000.0
800.0
600.0
400.0
200.0
0.0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Rowan
3500
3000
2500
2000
1500
1000
500
0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours



4.4.6 Community Midwifery Caseloads

Community midwifery caseloads remain above the nationally recommended level. The current average caseload is 1:155, compared with the recommended 1:96 per whole-time equivalent (WTE) midwife. Reductions are expected as part of the midwifery workforce implementation plan. Increased rotation of midwives into community teams began in late 2025 and will continue throughout 2026

Current Caseload	1:155
By end of December	1:130
By end of February	1:110
By end of April	1:96

5. Current Midwifery & Neonatal staffing Issues and Risks

5.1 Midwifery

Recruitment and retention progress

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH
Midwifery	7.5%	4.2%
Midwifery Support Workers	9.8%	8.7%

Attrition

Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed. HUTH has retained all Internationally Recruited Midwives who have joined the Trust since first in late 2023.

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	5.0%	9.5	15.2	0.0	0.0%
Total	**5.0%**	**9.5**	**15.2**	**0.0**	**0.0%**

Turnover is 5.0% against a target of 10%

Maternity leave position

In October 2025, the maternity leave rate was 4.3%. This remains consistent for some time and Family Service Care Group are currently drafting a paper to seek agreement to backfill substantively to maternity leave at 75%.

Sickness absence rates from May 2025-October 2025:

Sickness levels remain stagnant over the last 6 months. The most common reason is mental health concerns.

Month	May	June	July	August	September	October
% of all midwives	5%	4.8%	4.7%	5.3%	5%	4.6%

The impact of sickness absence, maternity leave and the backfill from other areas for the triage service is affecting the quality of delivery in the following ways:

- Ability to provide a robust home birth service
- Cancellation of planned activity in community mainly booking appointments, potential to impact on targets for AN screening,
- Delay to induction of labour
- Delay to grade 3 caesarean sections
- Impact on service user experience.

Birth to Midwife Ratio from May 2025 – Oct 2025:

Month	May	June	July	August	September	October
Midwife to Birth	28.7	27.3	27.1	25.9	30.2	26.8

Actions taken to address attrition

- Shop-floor Culture Champions are in place, providing visible peer support to promote a positive working environment. Regular themed *"tea trolley"* wellbeing rounds are delivered to enhance morale and team connection.
- Restorative support sessions are offered to Midwifery Practice Leads in collaboration with Organisational Development, strengthening psychological safety and reflective practice.
- Induction and preceptorship programmes are being redesigned to ensure all new starters receive a personalised, supportive development plan throughout their first year. This includes Trust-wide work to achieve the Preceptorship Quality Mark.
- Close partnership working continues with Royal College of Midwives representatives, chaplaincy teams and the Trust Wellbeing Service, who are increasing their visibility within maternity areas to provide additional staff support.
- A dedicated HUTH Maternity Staff Communication closed Facebook group has been established to improve internal communication and celebrate new starters, achievements and upcoming events.
- Time-out days, including restorative practice sessions, are being provided to support staff wellbeing, reflection and team cohesion.

5.2 Neonatal

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	10.3%	10.0	3.9	3.8	37.9%
Total	**10.3%**	**10.0**	**3.9**	**3.8**	**37.9%**

10.3% against a KPI of 10%. Retention has been impacted by factors outside of the control of the care group, however, measures such as Clinical Psychologist to support staff are in place**.** Previously the Neonatal Unit was allocated early career nurses centrally, going forward the Neonatal will be involved in the recruitment processing and focusing recruitment on Registered Sick Children's Nursing rather than Adult Nurses that may not have had any exposure to a Neonatal Unit.

Maternity Leave position

In October 2025 the maternity leave rate was at 5.3%. This remains consistent for some time and Family Service Care Group are currently drafting a paper to seek agreement to backfill substantively to maternity leave at 75%.

Sickness absence rates April 2025 to October 2025

April- June	6.3WTE
July- September	1.6WTE

Sickness levels for October are 6.9% which are above the intended target of 4.0%. The most common reasons for mental health and stress. Neonatal services have been significant operational pressure for the 6 months which as increased burnout, stress levels and sickness for staff.

Vacancy rate

Rota tools have recently been reviewed and deficit in budget identified this has now been rectified and recruitment is progress to close that gap. Current vacancy rate is 4.06 and is currently out to advert.

6. Maternity and Neonatal Activity, Acuity and Complexity

6.1 Maternity Activity and Complexity

Although birth rates have declined both nationally and locally, the **complexity of women using HUTH maternity services continues to rise**. This reflects broader public health trends and local population characteristics. Key factors influencing acuity include:

- Increasing numbers of women requiring safeguarding support
- Rising prevalence of high BMI
- Higher rates of diabetes in pregnancy
- Continued smoking in pregnancy
- Growing proportion of women with multiple long-term conditions
- Increasing numbers of complex obstetric and fetal medicine cases

The service at Hull Royal Infirmary provides care for more than **5,000 families per year**, supporting women with both straightforward and highly complex pregnancies. The presence of a midwife-led birth centre, alongside specialist obstetric, fetal and neonatal services, ensures a full spectrum of intrapartum and perinatal care.

This increasing complexity places higher demands on midwifery staffing, skill mix, and leadership oversight, reinforcing the need for adequately funded establishments and robust escalation systems.

6.2 Neonatal Acuity and Dependency

Neonatal activity and acuity have also grown significantly, driven by:

- Increasing maternal complexity
- Higher survival rates of extremely preterm infants (from 22 weeks gestation)
- Expanded cot capacity
- Consolidation of all Level 3 activity within Hull
- Socioeconomic factors associated with poorer neonatal outcomes

Hull Neonatal Unit is a Level 3 tertiary neonatal unit comprising 33 cots**:** 7 Intensive Care (IC), 10 High Dependency (HD), 12 Special Care (SC), and 4 Transitional Care (TC). It is the only Level 3 unit in the local area and serves a population characterised by significant deprivation and clinical complexity.

As part of the Humber Health Partnership, all Level 3 neonatal activity is now consolidated at Hull**;** previously, NLAG's Level 3 activity was aligned to Sheffield. To maintain Level 3 tertiary designation, neonatal networks require services to deliver a minimum of 2,000 Intensive Care days per year**.**

Since realignment, combined with expansion of cot capacity, Hull Neonatal Unit achieved over 2,000 Intensive Care days **in** the last financial year and is on track to reach approximately 2,300 Intensive Care days **in** the current financial year.

Northern Lincolnshire and Goole Bi-Annual Midwifery & Neonatal Staffing Oversight Report

1. Introduction

It is a requirement of the Maternity (and Perinatal) Incentive Scheme (MIS) that each provider submits a midwifery staffing oversight report to the Trust Board every six months during Year 7. This section provides an overview of maternity and neonatal workforce and safety issues across Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), operating across Diana, Princess of Wales Hospital (DPOW) in Grimsby and Scunthorpe General Hospital (SGH).

Following national concerns surrounding maternity safety and workforce sustainability, NLaG has undertaken significant work to strengthen leadership, improve governance, and stabilise midwifery and neonatal staffing. While NLaG has not been subject to the same regulatory escalation as HUTH, both sites continue to experience considerable operational pressure, driven by staffing gaps, rising acuity, and persistent workforce challenges.

As NHS providers, NLaG must ensure that maternity and neonatal services are staffed with the right people, with the right skills, in the right place at the right time, in line with the National Quality Board (NQB) safe staffing principles and NICE (2017) guidance. Establishment reviews are undertaken six-monthly, underpinned by Birthrate Plus® modelling for maternity services and BAPM workforce standards for neonatal care.

Maternity services across NLaG provide care to a diverse and often high-need population. Despite stable birth numbers, the complexity of women accessing care continues to rise, linked to high levels of deprivation, increased safeguarding concerns, higher rates of smoking in pregnancy, rising BMI, and medical comorbidities. Community midwifery teams cover large rural and coastal geographies, adding further demands on caseload management and travel time.

Both DPOW and SGH operate alongside specialist fetal medicine pathways, obstetric services, and neonatal care provision. Each site is supported by daily monitoring of actual versus planned staffing, senior matron oversight, and morning LMNS-wide huddles to assess system pressures and enable cross-site mutual aid. Further work is underway to enhance escalation processes, strengthen clinical leadership out of hours, and improve resilience across both sites.

Neonatal

NLaG provides neonatal care across two Local Neonatal Units (LNUs), located at DPOW and SGH. These units support babies requiring special care and high dependency care, operating within the Yorkshire and Humber Operational Delivery Network.

Neonatal workforce planning at NLaG is shaped by NHS England priorities, BAPM (2017) standards, and CNST MIS Year 7 requirements. As with other providers, staffing growth has not kept pace with rising acuity, dependency, and the increased survival of preterm and medically complex infants.

The BAPM standards set the minimum requirements for safe neonatal staffing, including:

- nurse-to-baby ratios of 1:1 (Intensive Care, where applicable), 1:2 (High Dependency), and 1:4 (Special Care)
- at least 70% of nurses trained in Qualification in Specialty (QIS)
- a supernumerary shift coordinator on every shift
- a 25% uplift to support annual leave, sickness, training, and non-clinical duties

NLaG, in line with many LNU providers nationally, does not currently meet full BAPM compliance, particularly regarding QIS proportions and protection of shift leadership time. However, strong progress is being made through targeted recruitment, improved education capacity, and investment in neonatal nursing through the HHP-wide neonatal business case.

There have been no incidents of patient harm or PSIIs directly attributed to neonatal workforce gaps at NLaG, though the risk remains significant given the dependence on temporary staffing, the limited supply of QIS-trained nurses, and the increasing complexity of infants requiring care.

NLaG continues to work collaboratively with the Operational Delivery Network, HUTH colleagues, and the wider LMNS to strengthen neonatal workforce resilience, improve compliance with national standards, and ensure safe, high-quality care for babies and families across Northern Lincolnshire.

2. Midwifery Workforce: Birthrate Plus® Workforce Planning and 2025 Report

Birthrate Plus® (BR+) is the only nationally recognised and validated workforce planning tool for maternity services. It provides a robust framework for determining the midwifery establishment required to deliver safe, high-quality care and is based on an assessment of the total midwifery time needed to care for women, including the minimum requirement of 1:1 care in established labour. The BR+ methodology aligns with the NICE (2017) Safe Midwifery Staffing Guideline and is endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG).

NLaG maternity services completed a full BR+ assessment in 2024, with the final report received in July 2025. The assessment identified a required establishment of:

- 185.38 WTE clinical midwives, plus
- An uplift for specialist and management roles from 13.7 WTE to 22.92 WTE
- Resulting in a total BR+ requirement of 213.95 WTE

The current NLaG midwifery budget stands at 199.08 WTE, demonstrating a shortfall of 14.87 WTE across both maternity services when operating a predominantly traditional model of care.

To address this gap and ensure compliance with the Maternity Incentive Scheme (MIS) Safety Action 5, a Midwifery Workforce Business Case was approved by the Trust Board in November 2025. The business case sets out an 18-month phased plan to achieve full BR+ compliance. This trajectory is essential to support preparations for the next BR+ data collection in Quarter 2 of 2027 and to ensure the updated BR+ report is received by June 2028, in line with NICE recommendations that BR+ reviews be undertaken every three years.

Role	WTE	Band	Notes
Director of Midwifery	0.5		Pan-Group
Head of Midwifery	1	8C	
Maternity Matron x 2	3.0	8a	
Quality & Safety Matron	1	8a	Also cover Gynae, Neonates and Paediatrics
Consultant Midwife (Public Health)	1	8a	
Patient Safety Midwife	2	7	
Bereavement Midwife	1.5	7	
Digital Lead Midwife	1	7	
Fetal monitoring lead Midwife	1	7	

Infant feeding Midwife	1.6	7	
Public Health & Saving Babies Lives Specialist Midwife	1	7	
Lead Midwife for Diabetes	1	7	
Diabetes Specialist Midwife	1	6	
Screening Midwife	1	7	
Deputy screening Midwife	0.8	6	
Perinatal Mental Health Midwife	1	7	
Practice educator Midwives	1	7	
Recruitment, Retention and Pastoral Lead	1	7	
Perinatal Pelvic Health Lead Midwife	0.8	7	
Ward Managers	7	7	
Pre-term Birth Lead Midwife	0.5	7	Pan-Group not yet recruited
Maternal Medicine Lead Midwife	0.5	7	Pan-Group not yet recruited

The Midwifery Business Case to achieve BR+ compliance and meet the Maternity Incentive Scheme (MIS) Safety Action 5 was approved by the Trust Board in November 2025. The business case outlines a phased approach to closing the identified gap with the intention of achieving full BR+ compliance within an 18-month period. This timeline is essential to enable the Trust to undertake the next BR+ data collection in Quarter 2 of 2027 and receive the updated report by May 2028.

NICE (2017) guidance recommends that a Birthrate Plus® assessment is completed every three years, and that the midwifery staffing budget reflects the establishment identified. Where a Trust is not fully funded to the BR+ requirement, an action plan and clear timescale must be in place to address the shortfall, including mitigations to ensure safe care. This plan must also be shared with local commissioners.

See Appendix 2 for action plan

3. Neonatal Workforce and BAPM Standards

Qualified in Speciality

In view of the very specialist requirements of neonatal nursing, BAPM standards recommend that 70% of Neonatal Nurses have completed additional specialist training. Completing this training is now an expectation at the point of recruitment whereas previously this was opt-out.

Trajectories DPOW

Current	69%
March 2026	72.5

Trajectories SGH

Current	58%
June 2027	70%

The table below outlines the Leadership and Specialist Roles in place across Neonatal nursing at HUTH.

Leadership and Specialist Nurse Roles

Current leadership and specialist roles	WTE	Band	Notes
Nurse Director	0.5		
Deputy Nurse Director	0.5	8B	Pan-Group role
Matron	2	8A	Joint neonates/paediatrics- site based
Neonatal Governance Nurse	0.58	7	Commences in post 15th December
Neonatal Unit Ward Manager	2	7	X1 per site
Clinical Neonatal Nurse Educator	0.6	6	Will be up banded to B7
Deputy Ward Manager	0.7	6	Check hours

Following approval of the Workforce Business Cases specialist roles will be reviewed. The recommendation is for one Nurse Educator per 50 staff which equate to 1.0 WTE per site, currently there is a gap of 0.42 WTE per site.

The Neonatal Nursing Business Case to achieve compliance with BAPM nursing standards and meet the requirements of the Maternity Incentive Scheme (MIS) Safety Action 4 was approved by the Trust Board in November 2025. The business case sets out a phased programme of investment to close the identified gaps in establishment, skill mix, and QIS-trained workforce.

See Appendix 4 for action plan

4. Safe Staffing Oversight, Monitoring and Escalation

Robust mechanisms are in place across Humber Health Partnership (HHP) to provide ongoing oversight of maternity and neonatal staffing, acuity and safety. These systems ensure that workforce pressures are identified early and mitigated where possible, in line with NQB expectations for real-time staffing management.

4.1 Establishment Reviews and Six-Monthly Reporting

Formal safe staffing establishment reviews are undertaken every six months, as required by the National Quality Board and the Maternity Incentive Scheme (MIS) Year 7. These reviews incorporate:

- Birthrate Plus® and BAPM workforce modelling
- Acuity and dependency data
- Activity trends

- Red flag events
- Incidents, complaints and safety themes
- Workforce metrics, including vacancies, sickness and turnover

The outcome of each review is escalated to the Trust Board to ensure transparency, assurance and appropriate action planning.

4.2 Daily Operational Oversight

Daily real-time staffing oversight includes:

- LMNS-wide huddles: reviewing pressures and capacity across the regional footprint, facilitating mutual aid.
- Pan-group safety huddles (Monday–Friday): reviewing staffing, acuity, escalation status, theatre capacity, neonatal flow, and cross-site support opportunities.
- Ad-hoc huddles throughout the day in response to changes in acuity or staffing.

These processes enable rapid escalation, redistribution of staff and early identification of emerging risks.

4.3 Escalation Framework and On-Call Arrangements

The OPEL escalation framework is routinely used to identify and respond to staffing and activity pressures. Work is underway to implement a pan-group maternity escalation tool to ensure consistent decision-making and improved cross-site coordination.

A dedicated specialty-specific maternity on-call rota remains a priority. At present, out-of-hours operational and clinical escalation relies on the site team, which does not provide the specialist insight required for complex maternity decision-making. Development of an on-call model is essential to strengthen safety, governance and staff support.

4.4 Birthrate Plus® Live Acuity Tool

The Birthrate Plus® Live Acuity Tool is a real-time safe staffing tool used by midwives to assess workload based on the number of women requiring care and the clinical needs of each woman during admission, labour, birth, and the postnatal period. The tool measures acuity using clinical indicators aligned with the established Birthrate Plus® workforce planning framework.

Unlike retrospective assessments previously used, the BR+ Live Acuity Tool provides a prospective, predictive assessment of staffing requirements. The tool is completed every four hours by the Labour Ward Coordinator. It generates a real-time calculation of the number of midwives required to safely meet demand across each clinical area, based on:

- The requirement for 1:1 midwifery care in established labour
- The increased midwifery time required for women in higher-need categories
- Changes in clinical condition during labour, prompting movement into higher acuity categories

This approach supports compliance with the NICE (2017) Safe Midwifery Staffing for Maternity Settings guideline and is endorsed by NICE as an appropriate method for determining safe staffing levels in real time.

Use of the Acuity Tool to Support Safe Staffing

The BR+ Live Acuity Tool provides clear documentation of actions taken during periods of high acuity or staffing shortfalls and demonstrates the use of the Trust's escalation policy. This evidence supports MIS Year 7 Safety Action 5 requirements regarding:

- Real-time monitoring of staffing
- Actions taken when staffing falls below required levels
- Use of escalation and mitigation

When staffing is below the required level or acuity increases, the following actions are taken in line with the escalation policy:

- Redeployment of midwives in specialist roles to work clinically
- Prioritisation of elective workload to maximise available staffing
- Band 7 and above managers providing clinical support
- Redistribution of staff to maintain 1:1 care in labour and protect the supernumerary Labour Ward Coordinator role
- Activation of community midwives via the on-call system
- Implementation of double-pay incentives to secure additional temporary staffing when required

These measures ensure that safety is maintained, and that midwifery staffing is responsive to fluctuations in acuity.

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.
There have been 0 recorded incidents between April 2025 and September 2025 where the labour ward co-ordinator is not supernumerary.

Month	Number of days per month	Number of shifts per month	Compliance
April 25	30	60	100%
May 25	31	62	100%
June 25	30	60	100%
July 25	31	62	100%
August 25	31	62	100%
September 25	30	60	100%

One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken. The following table outlines compliance by Month.

Month	Number of days per month	Number of shifts per month	Compliance
April 25	30	60	99%
May 25	31	62	100%
June 25	30	60	100%
July 25	31	62	100%
August 25	31	62	100%
September 25	30	60	100%

There has been 1 recorded incident where 1 midwife was not able to provide continuous one-to-one care and support a woman during established labour. This was investigated and found to be a 'Born before Arrival' (BBA) and therefore not possible to provide it.

Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following table provides a breakdown of the red flag events from 1st April 2025 to 30 September 2025:

	Apr	May	Jun	Jul	Aug	Sept	Total
Delayed or cancelled time critical activity	-	-	-	3	1	7	11
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	-	1	-	-	-	2
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes meds)	-	-	1	-	-	-	1
Delay in providing pain relief	-	-	-	-	-	-	0
Delay between presentation and triage	-	-	-	-	-	-	0
Full clinical examination not carried out when presenting in labour	-	-	-	-	-	-	0
Delay of 2 hours or more between admission for induction and beginning of process	1	1		-	-	2	4
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	-	-	1	-	-	-	1
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	-	-	-	-	-	1

Community staff have been called in to work on the unit	1	1	1	1	1	5	10
TOTAL	4	2	4	4	2	14	30

Neonatal Red flags

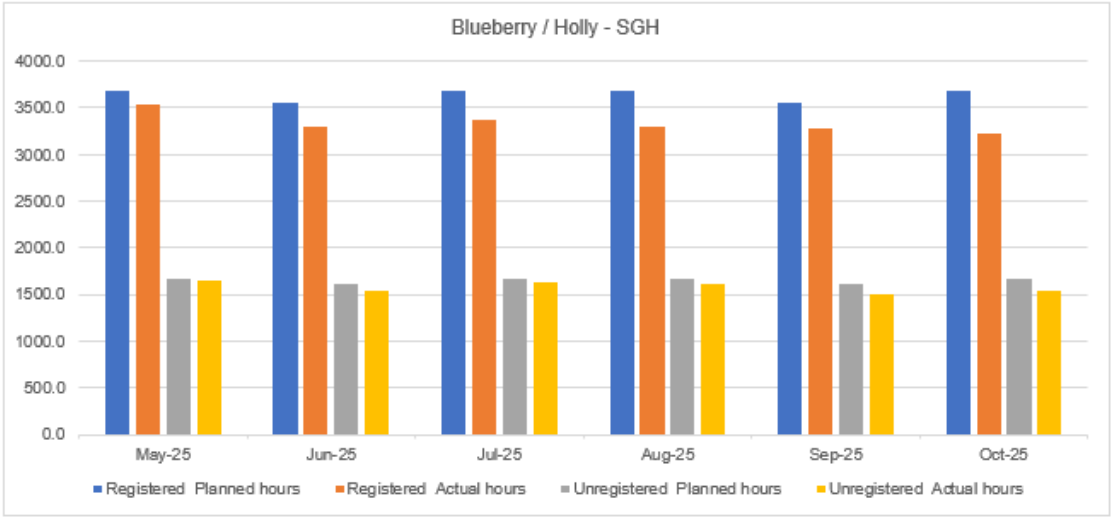
Neonatal red flags are currently being developed and will include supernumerary status of the NICU co-ordinator and compliance with BAPM nursing ratios.

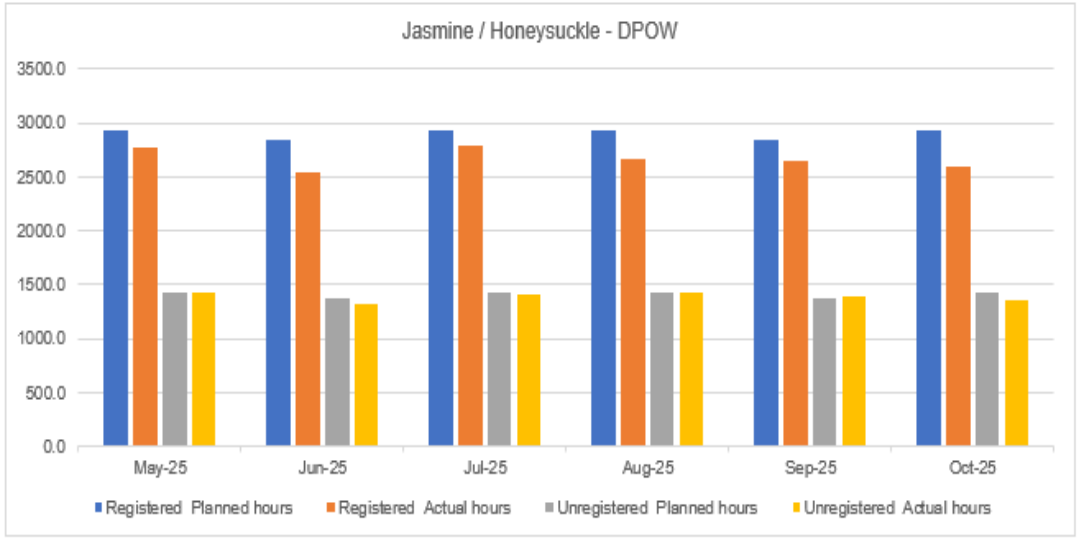
4.5 Monitoring of Actual vs Planned Staffing

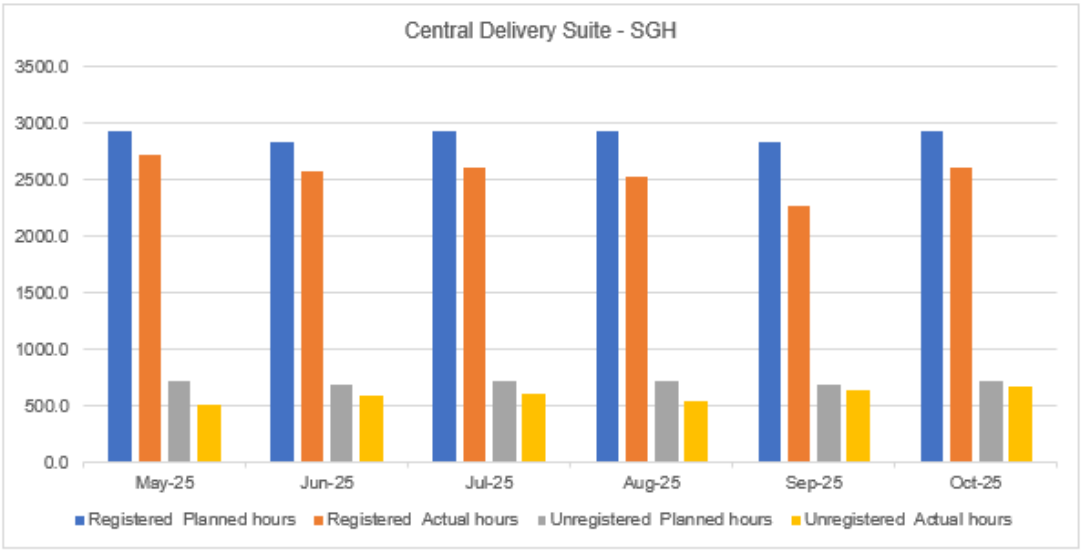
Matrons monitor actual versus planned staffing across all maternity areas each shift. Actions taken may include:

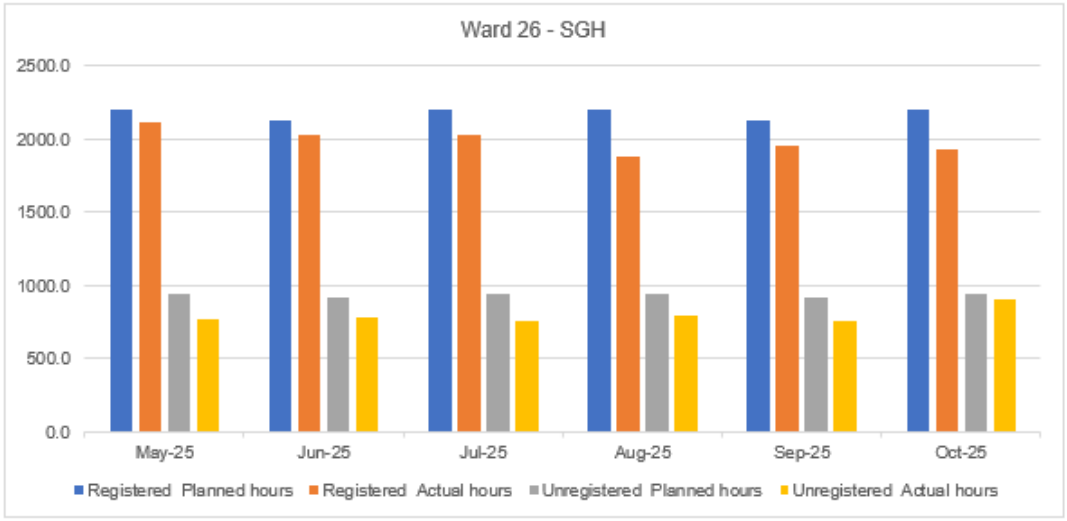
- Redeployment of staff between areas to maintain safe skill mix in bother maternity and neonates
- Prioritisation of 1:1 intrapartum care
- Pausing of non-essential activity where required
- Senior management escalation
- Use of bank, offering overtime and double pay incentive where appropriate

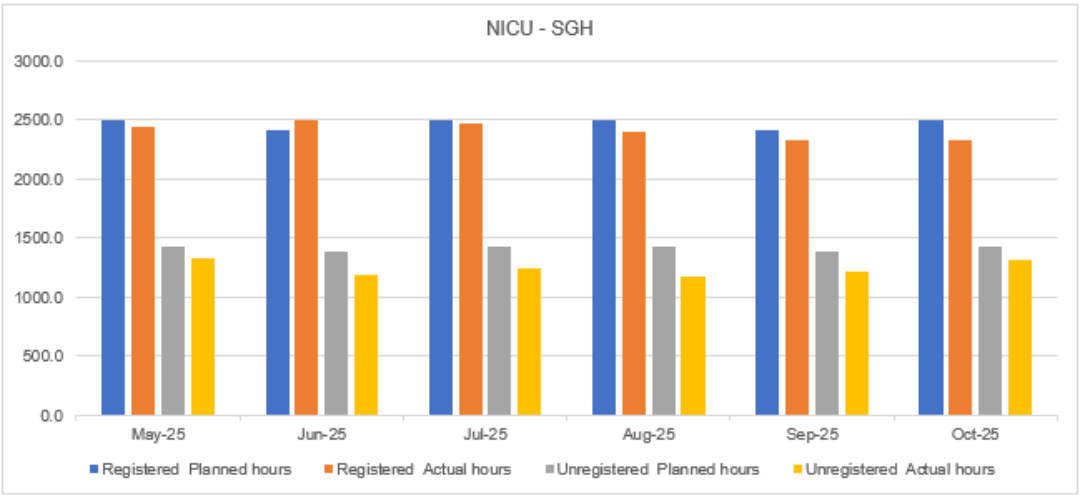
This continuous monitoring supports delivery of safe care and ensures a rapid response to fluctuations in activity or acuity.

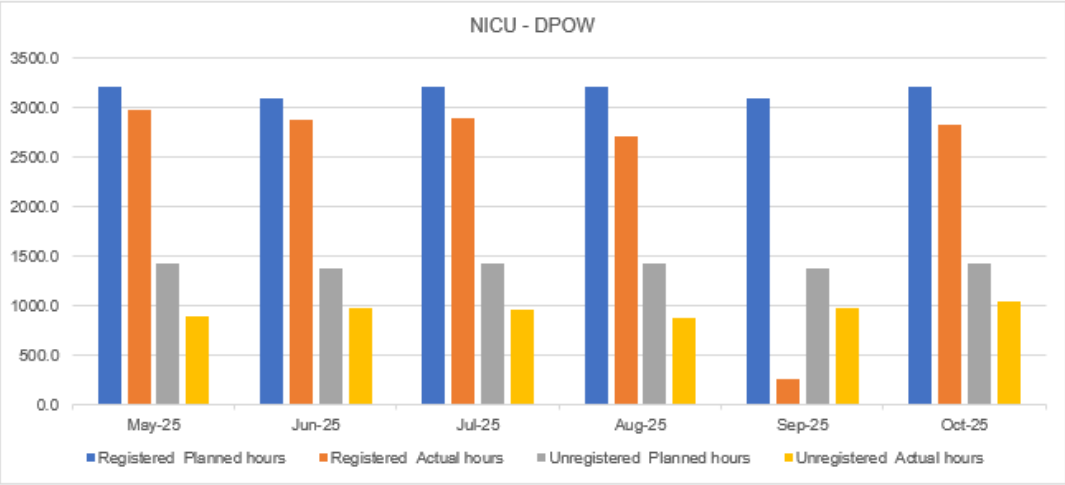



Jasmine / Honeysuckle - DPOW
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Central Delivery Suite - SGH
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Ward 26 - SGH
2500.0
2000.0
1500.0
1000.0
500.0
0.0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


NICU - SGH
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours



Fill rates are monitored daily, and staff redeployed based on the acuity. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

4.6 Community Midwifery Caseloads

Community caseload sizes have reduced over the last 18 months but remain above recommended caseload numbers. This is anticipated to reduce to the recommended 1:96 by the end of April 2026, due to increased rotation of midwives to community. Diana, Princess of Wales currently has a continuity of carer team which has been in place for the last 5 years based on a community and ward-based model.

	Annual recommended caseload	**Average current caseload November 2025**
Scunthorpe & Goole	1:96	1:78
Grimsby & Louth	1:96	1:85
Poppy	1:42	1:30

5.Current Midwifery & Neonatal staffing Issues and Risks

5.1 Midwifery

Recruitment and retention progress

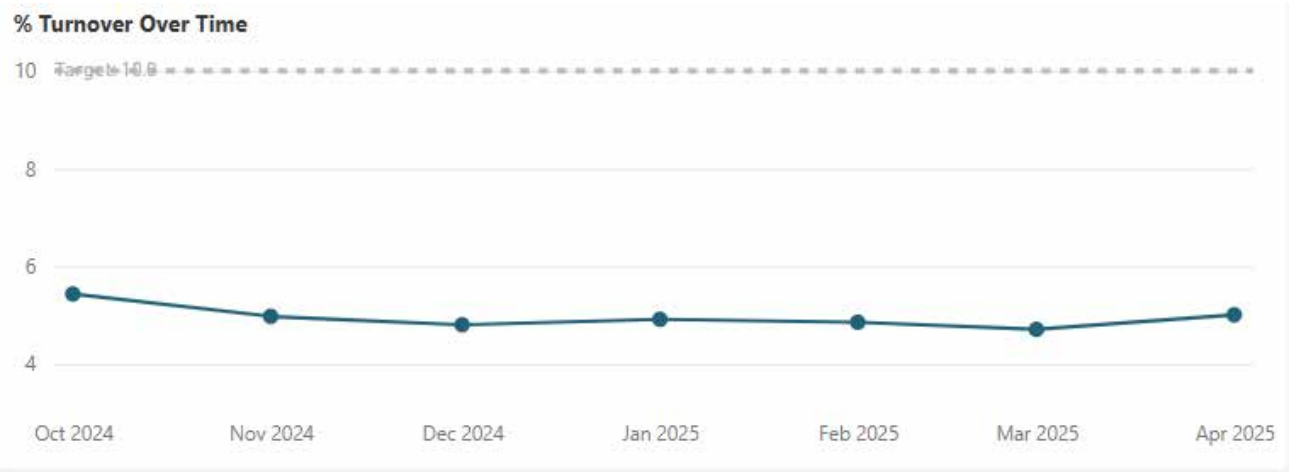
Only a small proportion of our workforce work full time. As at the 31st October 2025 the Trust had 17.02 WTE commencing or due to commence in post.

Attrition

Between May 2025 and October 2025 six midwives left. Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed.

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	5.3%	9.1	7.7	0.0	0.0%
Total	**5.3%**	**9.1**	**7.7**	**0.0**	**0.0%**



Pastoral support and Retention midwife role of supporting midwives (specifically early career and International Midwives) impacting positively on the service.

- Emotional support, following work related and personal situations impacting their mental wellbeing.
- Sign posting to other agencies for specialist support, such as counselling and mental health support through our internal services.
- Wellbeing support to staff off on long-term sick to enable them to return to work and remain at work.
- Listening to colleagues without the need of offering resolution (as this may not always be possible).

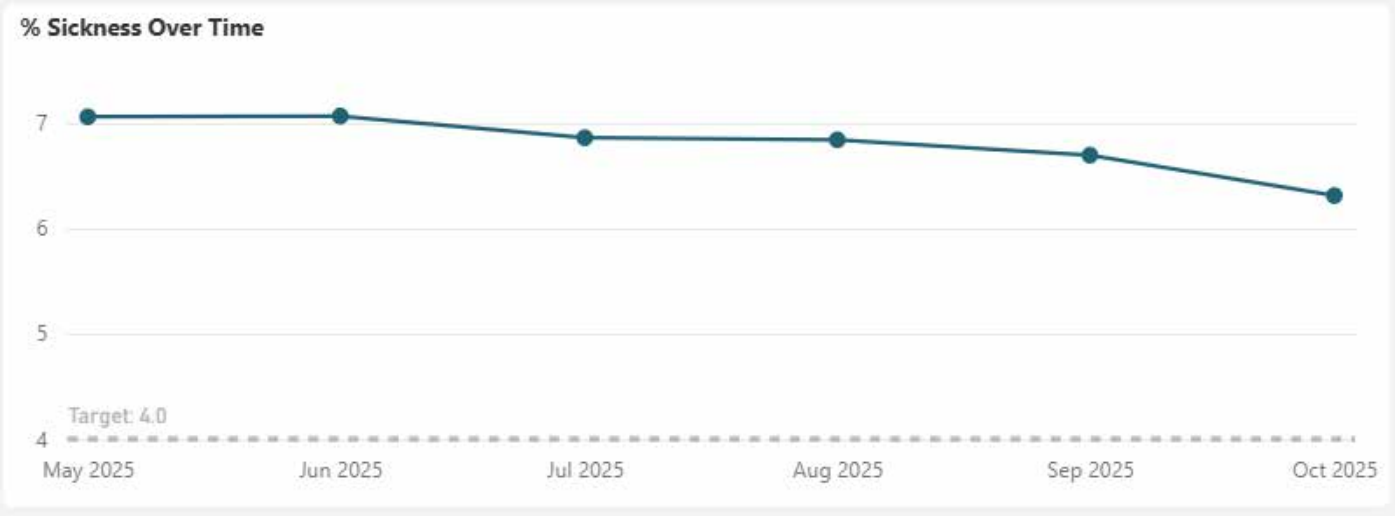
Maternity Leave position

in October 2025 6.04% of the Midwifery workforce (band 5, 6, 7 including specialist midwives) were on maternity leave. Midwifery Support Workers are at 2.7% and in total across the whole maternity workforce this was 5.04%. This remains consistent for some time and Family Service Care Group are currently drafting a paper to seek agreement to backfill substantively to maternity leave at 75%

Sickness absence rates May 2025 to October 2025:

Sickness levels for Nursing and Midwifery Registered staff (short-term and long-term) have remained around 6% during this period:

Month	May 25	June 25	July 25	August 25	September 25	October 25
% of all midwives	7.06	7.07	6.86	6.84	6.70	LTS: 4.8% STS: 2.1%



Birth to Midwife Ratio from May 2025 – Oct 2025:

Month	May	June	July	August	September	October
Midwife to Birth	29.3	25.5	24.4	24.8	26.0	24.4

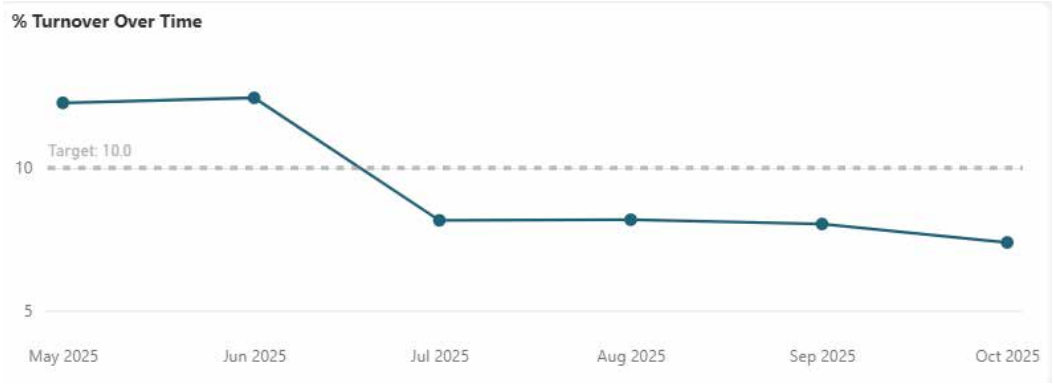
5.2 Neonatal

Recruitment and retention

Turnover for nurses is currently 7.4%, performing well against the KPI of 10%. Previously, early-career nurses were allocated to the Neonatal Unit through a central placement process. For the most recent intake, applicants applied directly to neonatal posts, resulting in a more self-selecting and motivated cohort. Some turnover reflects normal progression into specialist neonatal roles or movement into secondments, which is expected within a developing workforce.

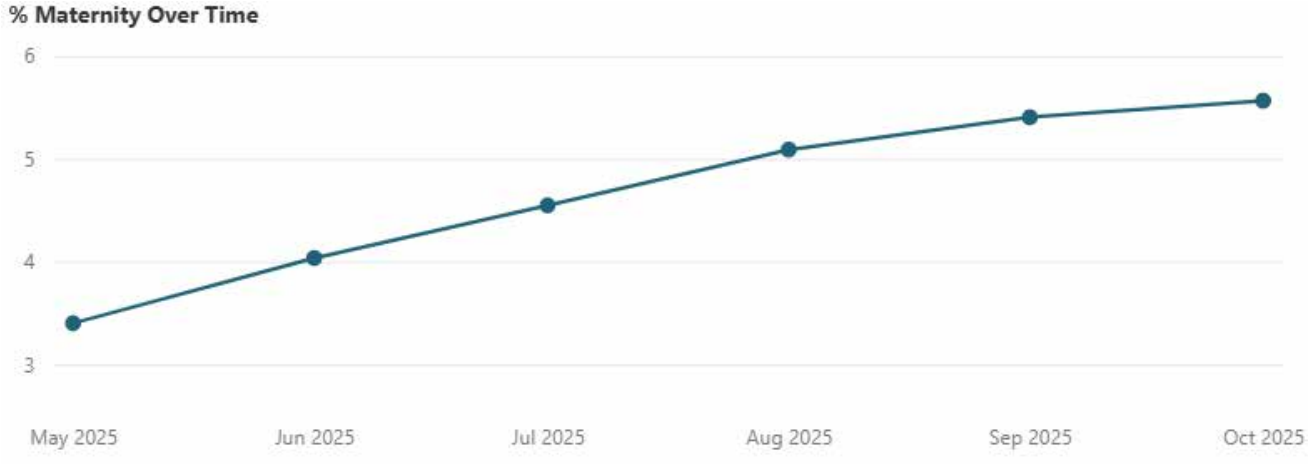
Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	7.4%	3.2	0.8	0.7	20.7%
Total	**7.4%**	**3.2**	**0.8**	**0.7**	**20.7%**



Maternity Leave

As of October 2025**,** maternity leave across the Neonatal Unit (including ward and outreach teams) is 5.6%**,** an increase from 4.8% in November 2024. This rate has remained broadly consistent at around 5%**,** and a business case is being drafted to substantively backfill 75% of all maternity leave to protect staffing resilience.



Vacancy Position

- DPOW: 0 WTE vacancy
- SGH: 0.6 WTE permanent vacancy, plus 0.8 WTE maternity leave cover (currently filled through bank arrangements)

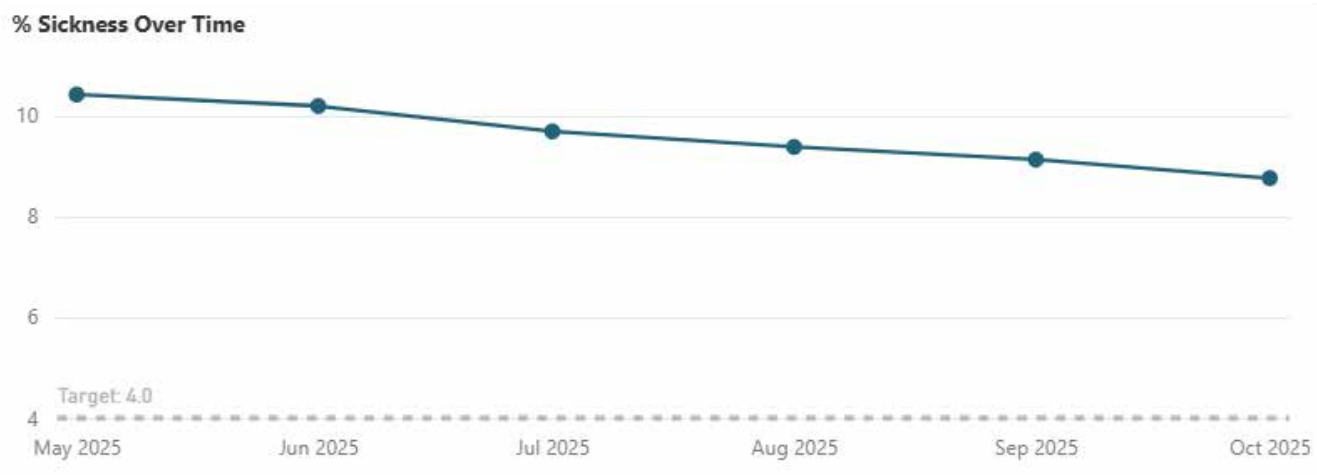
Vacancy levels remain low overall, but ongoing recruitment and retention remain essential to maintain safe staffing and meet BAPM standards.

Sickness Absence (May–October 2025)

Sickness absence for neonatal nursing staff has improved, reducing from 10.4% to 8.8% over the six-month period.
The primary reason for absence continues to be stress and mental health-related conditions. Maternity and neonatal teams are implementing a series of supportive measures, including:

- Access to CiC (Care in Confidence) support
- Increased visibility of Professional Nurse Advocates (PNAs)
- Early referral to Occupational Health
- Promotion of wellbeing initiatives

These interventions aim to reduce absence further and support staff wellbeing.



6. Maternity and Neonatal Activity, Acuity and Complexity – NLaG

6.1 Maternity Activity and Complexity

Although birth numbers across Northern Lincolnshire have remained broadly stable, the complexity of women accessing maternity services at NLaG continues to increase, reflecting both local population demographics and widening health inequalities across the region. Key contributors to rising acuity include:

- Higher proportions of women requiring safeguarding support
- Increasing rates of high BMI and obesity
- Elevated diabetes prevalence, including gestational and pre-existing diabetes
- One of the highest smoking-in-pregnancy rates regionally
- A growing number of women with multiple long-term conditions
- Rising numbers of complex obstetric, fetal medicine and high-risk pregnancies

Maternity care is delivered across two sites—Diana, Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH)—both of which support women with a wide spectrum of clinical need, from straightforward pregnancies to those requiring specialist obstetric input. Services are delivered within a geographical area that includes a mix of urban, rural and coastal communities, with significant pockets of deprivation, which adds to both demand and complexity. The increasing acuity of the maternity population places heightened pressure on midwifery staffing, skill mix, community capacity and clinical leadership oversight. This reinforces the importance of achieving Birthrate Plus® compliance, strengthening specialist roles, and maintaining robust escalation processes across both NLaG sites.

6.2 Neonatal Acuity and Dependency

Neonatal activity and acuity have also risen across NLaG's two Local Neonatal Units (LNUs), located at DPOW and SGH. Both units support babies requiring special care and high dependency care and are caring for an increasingly complex patient group. Key drivers of this increased dependency include:

- Rising maternal and pregnancy complexity
- Higher survival of preterm and medically fragile infants
- Sustained demand for high dependency care
- Socioeconomic deprivation, linked to poorer neonatal outcomes
- Increased numbers of infants requiring transitional care and enhanced postnatal support

Both LNUs operate within the Yorkshire and Humber Operational Delivery Network (ODN) and work closely with Hull as the regional Level 3 centre. Babies requiring intensive care continue to be transferred to Hull Neonatal Unit, while NLaG LNUs provide a high volume of special care and high dependency activity.

NLaG's neonatal services remain under sustained workforce and activity pressure, particularly due to challenges in achieving BAPM-compliant nurse-to-baby ratios and the required proportion of QIS-trained nurses. Increasing acuity and dependency also impact flow, increasing demand for Transitional Care across maternity wards and community outreach follow-up.
Despite these pressures, both DPOW and SGH continue to deliver safe neonatal care through daily senior oversight, cross-site escalation, LMNS huddles, and mutual aid with Hull where required. Workforce investment through the neonatal nursing business case is essential to strengthen resilience and meet BAPM standards across both units.

Recommendations across NHS Humber Health Partnership

1. Implement the Board-approved Midwifery Workforce Business Case
Proceed with the 18-month phased implementation plan to close the 21.47 WTE BR+ establishment gap and achieve full Birthrate Plus® compliance by Q2 2027.
2. Deliver the Neonatal Nursing Business Case to Achieve Full BAPM Compliance
Implement the phased programme to achieve required nurse-to-baby ratios, 70% QIS workforce, supernumerary coordinators and the 25% uplift, ensuring full compliance within 18 months.
3. Strengthen Leadership Capacity Across Maternity and Neonatal Services
Recruit to vacant leadership posts, protect supernumerary leadership time and invest in development programmes aligned with MSSP recommendations.
4. Improve Recruitment Pipelines and Retention
Enhance recruitment campaigns, strengthen preceptorship, provide flexible working options, expand pastoral support and protect professional midwifery and neonatal advocacy roles.
5. Continue to Reduce Community Midwifery Caseloads
Deliver the planned rotation model to achieve the recommended 1:96 community caseload ratio by April 2026 and monitor caseload acuity monthly.
6. Protect One-to-One Intrapartum Care and Supernumerary Coordinator Roles
Ensure 1:1 care in labour is prioritised during all periods of activity and maintain the supernumerary Labour Ward Coordinator and Neonatal Shift Coordinator roles in line with national standards.

7. Strengthen Real-Time Safe Staffing Oversight
Maintain and further embed the BR+ Live Acuity Tool, four-hourly coordinator reviews, LMNS and pan-group safety huddles, and improved documentation of escalation actions.
8. Develop and Implement a Specialty-Specific Maternity On-Call Rota
Replace reliance on generic site team escalation with a dedicated maternity on-call rota to ensure 24/7 clinical leadership and improved decision-making.
9. Improve Cross-Site and LMNS Mutual Aid Processes
Continue developing the pan-group escalation tool and strengthen operational links between HUTH and NLaG to manage activity, acuity and staffing pressures across the system.
10. Increase Transitional Care and Neonatal Community Outreach Team (NCOT) Capacity
Expand TC and NCOT workforce models to support patient flow, reduce unnecessary admissions and improve family-centred care.
11. Continue to Strengthen Staff Wellbeing, Culture and Restorative Practices
Support Culture Champions, restorative sessions, time-out days, enhanced OD support and improved internal communication to address moral injury and support a positive working environment.
12. Maintain Six-Monthly Safe Staffing Establishment Reviews
Ensure ongoing safe staffing reviews in line with NICE (2017), NQB requirements and MIS Year 7 standards, including Board-level visibility of risks, mitigations and progress against improvement plans.
13. Ensure Full CNST MIS Year 7 Compliance Monitoring
Monitor progress against all elements of Safety Action 5, address any emerging risks to compliance, and ensure commissioners and governance structures receive regular updates.
14. Align Workforce Planning with Future BR+ and BAPM Cycles
Prepare for the next BR+ data collection in Q2 2027 and the next BAPM workforce review cycle, ensuring ongoing investment, modelling accuracy and sustainability.
15. Develop a 3–5 Year Integrated Maternity and Neonatal Workforce Strategy
Produce a long-term, system-wide workforce plan encompassing recruitment, retention, skill mix, education, digital tools, culture, and leadership, aligned with NHSE and LMNS priorities.

Appendix 1: Midwifery action plan to reach Birth Rate Plus recommendation

Green - Completed (Audits - Minimum target reached)
Amber - On Track for completion
Red - Not on track, deadline passed (Audits - Not achieved)
Blue - Completed and evidenced (Audits - Stretch target achieved)

To reach Birthrate+ recommended budget

Director of Midwifery
Version 1.0
Update 28th November 2025

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	RAG Status	Actual Completion Date	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
1	As per MIS Year 7 requirements funded establishment for midwifery must match Birthrate+ recommendation	1. Review budgets and establishments with finance to confirm actual budget. 2. Finance paper/business case to be completed to request financial support to reach BR+ requirements 3. Discussed at private board in October 2025- decision to support business case not agreed. 4. For further discussion at private board on the 13th of November with recommendation for full support of the business case to acheive SA 5 compliance. 5. Workforce business cases approved at Private Board. Currently working closely with finance teams to achieve staffing required by end of Q1 2027 to enable BR+ data collection as required by MIS for the three yearly cycle of BR+ reviews	Enable recruitment to BR+ recommendations. Improved patient safety, staff and service User Experience	DoM	30/11/2025			1.Birthrate+ Report Received in June 2025. 2. Business case updated and shared at July Quality & Safety Committee. 3. Discussed at private board in October 2025- decision to support business case not agreed. 4. For further discussion at private board on the 13th of November with recommendation for full support of the business case to acheive SA 5 compliance.	
2	Bi-annual staffing paper to be shared with board including mitigation of any shortfalls.	1. Bi-annual reports shared at board, additional report shared at cabinet in Novemeber and will be shared at December board to align timing with Safer Staffing papers. This paper clearly lays out the remaining deficit to reach BR+ and requests that this funding is support. Previously the reported funded establishment was not accurate, the new Finance team is in place for the Care Group and the review described has now occured 2. Mitigation of shortfalls clearly described in staffing paper	Funding to BR+ recommendations o be agreed enabling recruitment, improved patient safety, staff and service user experience.	DoM	30/12/2025			1. QSC and Board minutes	
3	Share a plan to address deficits with local commissioners	1. LMNS well-sighted on staffing deficits and challenges, however this action plan will also be shared as per MIS guidance.	Ensure LMNS are sighted and enabled to support where possible	DoM	30/11/2025			1. Email reply confirming receipt of action plan	

Appendix 2: Neonatal nursing workforce BAPM recommendations and standards (HUTH)

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal standards.

If these are not met an action plan should be in place and agreed at Board level to meet these recommendations

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Neonatal Matron in post and works closely with the lead consultant in a MatNeo model of service delivery.	No further action required.	Deborah Bray, Nurse Director	N/A	Compliant	N/A
A minimum of 70% (special care) of the workforce should be registered A minimum of 80% (high dependency and intensive care) of the workforce should be registered.	**Current Position:** 95% Registered Nurses. 5% Unregistered Nurses (not included in baseline cot side nursing numbers). **Workforce Paper Opportunities:** Approval in principle to recruit to an establishment that is 100% capacity based and maintains the RN workforce requirements against standards.	Recruit to required WTE and uplift in banding required to enable the RN establishment to meet the requirement of the approved workforce paper phasing plan.	Deborah Bray, Nurse Director	N/A	Compliant – but further action required to meet revised workforce requirements	N/A
A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal	Current Position: **55%** (as of September 25). The next cohort of QIS training (5 RN's) will commence the programme in January 2026. HUTH are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and	Continue to execute current training plan, ensuring allocated staff attend the QIS programme (no more than 8 staff at any one time in the year).	Jenny Hemingway Neonatal Lead Educator	Dec 2026	Ongoing	Training compliance & Trajectories

care (qualified in specialty (QIS).	QIS Speciality, including meeting the 150 hours of supernumerary time. Additional funding received from the ODN to support QIS supernumerary training. As the QISF is now mostly online learning the ability to increase the number of staff released to 4 nurses twice yearly. Current trajectory to meet the 70% compliance rate is December 2026.					
Units have a minimum of two registered nurses/midwives on duty at all times, of which at least one is QIS.	Fully Compliant.	No further action required.	Deborah Bray, Nurse Director		Compliant	E-roster
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC: 1 RN 2 HD: 1 RN 4 SC: 1 RN 4 TC: 1 RN	**Current Position:** Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce. **Workforce Paper Opportunities:** Approval in principle to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses. Recruit to required WTE and progress uplift of Banding in line with agreed neonatal workforce phasing plan.	Deborah Bray, Nurse Director Francesca Matthews, Matron	April 2026 Recruitment Element	Compliant	Workforce Tool
There is a nursing co-ordinator on every shift in addition to those providing direct clinical care.	**Current Position:** Band 7 Nurse Co-ordinator established 24/7. Final WTE post being recruited to currently.	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified	Deborah Bray, Nurse Director		Compliant	Roster Incident & Red Flag Reports

	Mitigation in place to support shift leadership during escalation.	through Governance to be added to both Safecare and Ulysses.	Francesca Matthews, Matron			
Neonatal units providing surgical services have a nurse/midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery.	**Current Position:** No substantive Nurse/Midwife with surgical clinical leadership responsibility. **Current Mitigation**: Surgical Link Team in place with 1 x Band 7 Clinical Sister who has completed the specialist surgical course. **Workforce Paper Opportunities:** Surgical CNS post approved in principle within the Workforce Paper.	Recruit to post in line with agreed neonatal workforce phasing plans	Deborah Bray , Nurse Director Francesca Matthews, Matron	September 2026	Partially Compliant	Workforce Paper – Phasing Plan
Neonatal units providing surgical services have at least one nurse/midwife with neonatal surgical experience who has responsibility for co-ordinating transfer and discharge of babies pre- and post-surgery, liaising with primary and community services, and supporting parents and referring teams.	**Current Position/Mitigation:** Neonatal Band 7 Shift Co-ordinator is responsible for liaising with the necessary transport team required for transfer. Discharge Lead Nurse also supports the staff with liaising with community services for discharge. More complex babies are often transferred to Paediatrics Surgical Ward for on-going care once they reach 44 completed weeks. Close collaborative working with the Specialist Lead Nurse in Leeds in place and can reach out for support/advice if needed. **Workforce Paper Opportunities**: Surgical CNS post approved in principle within the Workforce Paper.	Recruit to CNS post in line with neonatal workforce paper phasing plans	Deborah Bray, Nurse Director Francesca Matthews, Matron	September 2026	Compliant	Workforce Paper – Phasing Plan

Appendix 3

Green - Completed (Audits - Minimum target reached)
Amber - On Track for completion
Red - Not on track, deadline passed (Audits - Not achieved)
Blue - Completed and evidenced (Audits - Stretch target achieved)

To reach Birthrate+ recommended budget

Director of Midwifery
Version 1.0
Update 28th November 2025

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Expected Impact	Strategic Lead	Forecast Completion Date	RAG Status	Actual Completion Date	Evidence / Validation of Completion	Ongoing Monitoring / Assurance
1	As per MIS Year 7 requirements funded establishment for midwifery must match Birthrate+ recommendation	1. Review budgets and establishments with finance to confirm actual budget. 2. Finance paper/business case to be completed to request financial support to reach BR+ requirements 3. Discussed at private board in October 2025- decision to support business case not agreed. 4. For further discussion at private board on the 13th of November with recommendation for full support of the business case to acheive SA 5 compliance. 5. Workforce business cases approved at Private Board. Currently working closely with finance teams to achieve staffing required by end of Q1 2027 to enable BR+ data collection as required by MIS for the three yearly cycle of BR+ reviews	Enable recruitment to BR+ recommendations. Improved patient safety, staff and service User Experience	DoM	30/11/2025			1.Birthrate+ Report Received in June 2025. 2. Business case updated and shared at July Quality & Safety Committee. 3. Discussed at private board in October 2025- decision to support business case not agreed. 4. For further discussion at private board on the 13th of November with recommendation for full support of the business case to acheive SA 5 compliance.	
2	Bi-annual staffing paper to be shared with board including mitigation of any shortfalls.	1. Bi-annual reports shared at board, additional report shared at cabinet in Novemeber and will be shared at December board to align timing with Safer Staffing papers. This paper clearly lays out the remaining deficit to reach BR+ and requests that this funding is support. Previously the reported funded establishment was not accurate, the new Finance team is in place for the Care Group and the review described has now occured 2. Mitigation of shortfalls clearly described in staffing paper	Funding to BR+ recommendations o be agreed enabling recruitment, improved patient safety, staff and service user experience.	DoM	30/12/2025			1. QSC and Board minutes	
3	Share a plan to address deficits with local commissioners	1. LMNS well-sighted on staffing deficits and challenges, however this action plan will also be shared as per MIS guidance.	Ensure LMNS are sighted and enabled to support where possible	DoM	30/11/2025			1. Email reply confirming receipt of action plan	

Appendix 4: Neonatal nursing workforce BAPM recommendations and standards (NLAG)

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal standards.

If these are not met an action plan should be in place and agreed at Board level to meet these recommendations

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Paediatric and Neonatal Matrons in post at DPOW and SGH who work closely with the lead consultant in a MatNeo model of service delivery. Support is also provided to the Band 7 Ward Managers.	No further action required.	Deborah Bray, Nurse Director	N/A	Compliant	Rosters
There should be a 1WTE Band 7 Lead nurse for Transitional Care Services who are Supernumerary 100% of the roster period	**Current Position:** Due to Band 7 Lead Nurse for the LNU's being supernumerary the oversight of the Transitional Care Service is incorporated into their role and responsibilities. **Workforce Paper Opportunities:** Approval in principle for 1wte Band 7 Lead Nurse for Transitional Care across NLAG. This will allow dedicated enhanced leadership of the Transitional Care Service.	Recruitment to post in line with agreed Neonatal Workforce Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley, Matrons	August 2026	Partially Compliant	Roster Job Description
A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Neonatal Matrons in post and works closely with the lead consultant neonatologists.	No further action required.	Deborah Bray, Nurse Director	-	Complete	Job descriptions

There must be a supernumerary Band 6 Shift lead 24/7	**Current Position:** Neither SGH or DPoW achieve 24/7 band 6 supernumerary status, however, consistently strive to achieve this when acuity and activity allows. **Workforce Paper Opportunities**: Approval in principle gained to recruit the required WTE to allow a Band 6 supernumerary shift lead to be in core baseline establishment	Recruitment to required posts in line with agreed Neonatal Workforce Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley, Matrons	April 2026		Workforce Phasing Plan Rosters
1 WTE Band 7 Nurse Educator required to work cross site	**Current position:** 2 x 0.63 WTE Band 6 Neonatal Nurse Educators in place (1 at each site). The ODN expectation is that the Neonatal Educators are Band 7 and have created a network job description for hospitals to work to. Additional funds have been received from the ODN to increase the Nurse Educator role with the expectation that there will be 2 x 0.6 WTE on each site at Band 7 – uplift in progress **Workforce Paper Opportunities:** Approval in principle gained to uplift the WTE to allow 1:50 ratio (1WTE Band 7 per site).	Recruitment to additional WTE in line with agreed Neonatal Workforce Phasing Plan.	Emma Spicer Matron	April 2026	Partially Compliant	Job Description Roster Workforce Phasing Plan
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC:1 RN		Approval in principle to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics. Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed			Compliant	Workforce Toolkit Roster

2 HD:1 RN 4 SC:1 RN 4 TC:1 RN **Current Position:** Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce. **Workforce Paper Opportunities:**			and ratified through Governance to be added to both Safecare and Ulysses. Recruit to required WTE and progress uplift of Banding in line with agreed neonatal workforce phasing plan. Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley Matrons April 2026 Recruitment Element			Escalation Plan
70% of the workforce should be Registered Nurses **Current Position:** **DPOW: 74%** **SGH: 63%**			**Workforce Paper Opportunities:** Approval in principle to move to a workforce split of 95/5% - with realignment of unregistered workforce to neonatal community-based roles in line with BAPM (2025) & BAPM (2021) guidance. HR Consultation and Implementation of a Rotational Unregistered Workforce Model between the Neonatal Unit and the NCOT Service required. Recruit to required WTE to enable the RN establishment to meet the requirement of the approved workforce paper phasing plan. Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley Matrons September 2026		Partially Compliant SGH	Rosters
30% of the workforce should be non-registered.		**DPOW: 26%** **SGH: 37%**			Compliant DPoW	
80% of registered nurse workforce should be QIS 70% compliance with QIS standard to be maintained 100% of the time.		**Current Position:** NLaG are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and QIS Speciality, including meeting the 150 hours of supernumerary time. DPOW: **69%** SGH: **56%**	Continue with training plan in place to support appropriate staff to access the relevant training and education modules to achieve the QIS. Trajectories to meet compliance metric, in place across the Trust. New starters without QIS to commence Foundation	Laura Parker & Rebecca Pearson, Neonatal Educators	SGH – Sept 2027 DPoW – March 2026	SGH DPoW	Training compliance rates

	Trajectory to meet 70%: DPoW– March 2026 SGH – September 2027	Programme after supernumerary preceptorship period completed.				
Neonatal Care Outreach Team (NCOT) must be available 7 days a week.	**Current Position:** SGH established to deliver a 5-day service DPoW established to deliver a 6-day service Ability to flex service provision to facilitate discharge across the 7 day period as required **Workforce Paper Opportunities:** Approval in principle to establish the NCOT service 7 days per week with a revised workforce model in line with BAPM standards for NCOT Services (2025).	Recruit to required WTE to enable the RN NCOT establishment to meet the requirement of the approved workforce paper phasing plan. Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jenny Copley, Matrons	September 2026	Partially Compliant	Roster
Non-registered workforce should complete a minimum of NVQ level 3 training.	**Workforce Paper Opportunities:** Workforce model for the cot side care (BAPM 2021) and the neonatal outreach service has been mapped against the BAPM NCOT Guidance (2025) and agreed in principle. The revised workforce model for the Unit based cot side care will see a reduction in the unregistered workforce. Approval in principle to develop and enhance the NCOT workforce to meet BPAM (2025). Workforce realignment from the current cot side workforce WTE will be required with support through an	Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan Develop an appropriate education and training programme to support role development across the community setting. No action required for current workforce configuration as all unregistered workforce have completed appropriate	Deborah Bray, Nurse Director Laura Parker & Rebecca Pearson Nurse Educator Emma Spicer & Jenny Copley, Matrons	September 2026	Partially Compliant	Roster Job Description Education & Training Programme

	appropriate programme of training and competency based education.	programme of study/competency.				

Humber Health Partnership

CNST MIS Year Seven - Neonatal Medical Workforce Benchmarking

Hull University Teaching Hospitals NHS Trust

Requirements for Safety Action 4:

1. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations.

BAPM standard requirement		MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
All tiers separate rota compliance	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff at all times.	Not compliant	Move under 1 year GP referrals to General Paediatrics. **Update 26/11/25:** Notice has been given to close the DOS for under 1 GP referrals into Neonatal Services from Dec 2025.	Dr Alia (Clinical Lead) Ms Theresa Bowen (Senior General Manager)	6 months	Proposal submitted to Quad & Paediatric Leads to formalise)	Quad paper submission Update from T Bowen
Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care.	Compliant Fully funded 9 person Tier 1 rota with a mix of Trainees & ANNP's.	No action required.	-	-	-	-
Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport).	Compliant Fully funded 12 person Tier 2 rota with a mix of Trainees & ANNP's.	No action required.	-	-	-	-

BAPM standard requirement		MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
Tier 3 separate rota compliance 24/7	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit.	Compliant 9 WTE funded consultant rota with 13 hour resident consultant presence & on call overnight.	No action required.	-	-	-	-
Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers).	Compliant 12 hour resident consultant presence job planned. 3 ward rounds/ day for ITU.	No further action required.	Dr Alia (Clinical Lead)	-	-	-
Tier 1 compliance more than 7000 deliveries per year	Two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care	Not applicable	No further action required.	Dr Alia (Clinical Lead)	-	-	-
Tier 2 compliance if more than 2500 IC (XA01Z) days per year	Two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.	Compliant Dedicated two tier 2 rota in place. Not currently applicable as HRG1 days delivered <2500.	For future proofing 12 WTE establishment in place but one used for trainee ANNP leaving a functional gap and reliance on locums. Update 26/11/25: The gap (Band 7 post) will be mitigated with increased budgeted establishment following the approval of the medical workforce business case as soon as this is implemented.	Dr Alia (Clinical Lead)	-	-	-

BAPM standard requirement		MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
Tier 3 compliance if more than 2500 IC days per year	Presence of at least two consultant led teams during normal daytime hours.	Compliant HUTH NICU already have consultant led teams 9am-5pm.	No further action required.	-	-	-	-
Tier 3 compliance if more than 4000 IC days per year	Consultant presence 24/7 in addition to Tier 2 staffing requirements	Not applicable	No action required.	-	-	-	-
Tier 3 compliance if more than 4000 IC days per year (daytime hours)	Three consultant led teams during normal daytime hours	Not applicable	No action required.	-	-	-	-
Minimum of 1 consultant with a designated lead interest in neonatology.		Compliant	No action required.	-	-	-	-
Tier 3 consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification / substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.		Compliant	No action required.	-	-	-	-
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).		Job plans have adequate SPA time to allow consultants to demonstrate expertise in neonatal care. Annual consultant neonatal update ran 13th Nov 2024 . (first year this has been run)	No action required.	-	-	-	-

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Optimal Arrangements for Neonatal Intensive Care Units in the UK: A BAPM Framework for Practice (2021) https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021

NHS
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CNST MIS Year Seven - Neonatal Medical Workforce Action Plan

Requirements for Safety Action 4:

1. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
2. If these are not met an action plan should be in place and agreed at Board level to meet these recommendations.

<table>
<tr><th>BAPM standard requirement</th><th>MIS Year 7 status</th><th>Action Required</th><th>Lead</th><th>Timescale</th><th>Status</th><th>Evidence</th></tr>
<tr><td rowspan="2">Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned.

BAPM junior medical staffing guidance for Local Neonatal Units:
<table>
<tr><th>LNU activity</th><th>Tier 1</th><th>Tier 2</th></tr>
<tr><td>>1000 Respiratory Care Days (RCD) or >400 Intensive Care days</td><td>>/= 1 resident, dedicated, 24/7 to ensure safety & quality</td><td>>/=1 resident, dedicated, 24/7 OR risk analysis if providing <24/7 separate cover</td></tr>
<tr><td colspan="3">Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.</td></tr>
<tr><td colspan="3">Tier 2: Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.</td></tr>
</table>
</td><td rowspan="2">DPOW: 802 RCD 2024-25No action required - dedicated Tier 1 and Tier 2 24/7 cover for paediatrics and neonates.

SGH: 911 RCD 2024-25
Dedicated Tier 1 and Tier 2 cover 09:00-17:00.

Tier 1 and Tier 2 shared cover for paediatrics and neonates 17:00-09:00.</td><td>Increase in SGH establishment is needed as they are closer to the 1000 RCD/year although numbers of individual babies are similar across both units.</td><td>Chief Nurse</td><td></td><td>Non-compliant</td><td>Approval for recruitment after presentation to board.</td></tr>
<tr><td>Increase in establishment or change in rotas required. Workforce review to be shared with Executive Team, action taken to be determined on Board Activity.</td><td>Chief Nurse</td><td>Workforce Review to be shared with Executive Team October 2025</td><td>Non-compliant</td><td>Approval for recruitment after presentation to board.</td></tr>
</table>

<table>
<tr><th>BAPM standard requirement</th><th>MIS Year 7 status</th><th>Action Required</th><th>Lead</th><th>Timescale</th><th>Status</th><th>Evidence</th></tr>
<tr><td colspan="7">BAPM consultant medical staffing guidance for Local Neonatal Units:</td></tr>
<tr><td>
<table>
<tr><th>LNU activity</th><th>Tier 3</th></tr>
<tr><td>>1000 Respiratory Care Days or >400 Intensive Care days</td><td>A minimum of 7 WTE neonatal paediatricians / neonatal consultants on the on-call rota**.</td></tr>
<tr><td colspan="2">**All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.</td></tr>
</table>
Source: The British Association of Perinatal Medicine
Service and Quality Standards for Provision of Neonatal Care in the UK (2022)
https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf
</td><td>8.75 x WTE at DPOW /
8 x WTE at SGH

Dedicated Tier 3 neonatal cover between 09:00-13:00.

Tier 3 shared cover for paediatrics and neonates 13:00 – 09:00.</td><td>Increase in establishment required. Workforce review to be shared with Executive Team, action taken to be determined on Board Activity.</td><td>Dr Manou (Clinical Director) / Ms Gandhi (Chief of Service) /Chief Nurse</td><td>Workforce Review to be shared with Executive Team October 2025</td><td>Compliant</td><td>Further discussion of workforce papers took place at private Trust Board Nov 25. Awaiting minutes to evidence outcome.</td></tr>
<tr><td>Minimum of 1 consultant with a designated lead interest in neonatology.</td><td>SGH: Locum Consultant in post with lead interest.

DPOW: Vacant post.</td><td>Recrutment of permanent consultants (DPOW and SGH) with a designated lead interest in neonatology.

Update 26/11/25:

DPOW: Neonatal interest consultant post out for advert, interviews 01/12/25

SGH: Job description review in progress with the aim to advertise in Dec 25.</td><td>Dr Manou (Clinical Director)</td><td>Recruitment in progress -</td><td>Non-compliant</td><td>Job plans / Permanent consultant posts appointed.</td></tr>
</table>

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
BAPM consultant medical staffing guidance for Local Neonatal Units:						
Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN.	Consultants do not have rotation / exposure to tertiary neonatal practice (not in job plans). SGH: Locum consultant (interest in neonatology) currently working towards CESR. Does not have CCT. DPOW: Vacant post (interest in neonatology)	Permanent Recruitment to neonatal lead posts across SGH (to replace locum) & DPOW (vacancy arising from resignation)	Dr Manou (Clinical Lead)	6 months	Non-compliant	DPOW recruitment in process; RCPCH Job Description approval being sought for SGH. Written confirmation from Clinical Lead (Dr Hebbar)
At least one LNU Tier 3 Consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training).	SGH: Does not have a CCT in neonatal medicine or neonatal SPIN module. DPOW: Vacant post.	To advertise both substantiative posts / appoint consultants into permanent posts who have a CCT or SPIN module.	Dr Manou (Clinical Lead)	6 months	Non-compliant	Qualification following appointment to posts / confirmation from Neonatal Clinical Lead
All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).	Trustwide: Unable to evidence as standard routine appraisal process does not include assessment of neonatal expertise.	Annual assessment package to be developed.	Dr Manou (Clinical Director)	01 January 2026	Non-compliant	Annual Assessment Package / Plan for consultant assessment.

Sources:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK (November, 2022) https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Staffing Request as per Business Case/Staffing Paper:
The Proposal to implement the BAPM recommendations will ensure dedicated resident doctor cover 24/7 for neonates both Tier1 and Tier2 level. The dedicated consultant cover form neonates will be extended for busy periods until 21.00 hours, and one consultant covering both paediatrics and neonates at night. The change in staffing and rota needs to happen only at one site as the recommendations is for one site to be a Level 2 unit (LNU) and the other site to be Level1 (SCU) as per the recommendations of the Y&H Neonatal Operational delivery network.

This proposal was based on BAPM Framework for Practice 2018:
LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs.https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/64/LNU_doc_Nov_2018.pdf

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)224

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	Matt Powls, Interim Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer/Author	Adam Creeggan, Group Director of Performance
Title of the Report	**Strategic update: Patients - Access**
Executive Summary	Key messages: • Significant challenges relating to patient access • Group Trusts are in national **Tier 1 oversight** for UEC, Cancer, Diagnostics and RTT (NLAG only) • An Operational Improvement Plan and associated in year recovery trajectories have been developed by the outgoing Interim Chief Delivery Officer, Sarah Tedford. • Delivery against both original 25/26 Operating Plan and in-year recovery trajectories for UEC and RTT are detailed in the paper. Summary Compliance:

DOMAIN		GROUP	HUTH Performance	NLAG Performance
RTT Long Waits		Oct-25	Oct-25	Oct-25
	104 Weeks	0	0	0
	78 Weeks	0	0	1
	65 Weeks	123	96	27
	52 Weeks	4165	3221	944
	% 52 Weeks *(target =<1.3% March '26)*	3.5%	4.0%	2.50%
Diagnostics (DM01)		Oct-25	Oct-25	Oct-25
	% greater than 6 weeks	35.30%	31.3%	38.4%
Cancer		Oct-25	Oct-25	Oct-25
	% FDS with 28 days	62.20%	59.8%	66.7%
	% Treated within 62 days	52.90%	50.1%	59.1%
UEC		Oct-25	Oct-25	Oct-25
	ED 4-hour standard *(target 78% March '26)*	63.2%	55.8%	69.5%
	ED 12-hour standard	17.1%	17.4%	16.8%

Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common Business Assurance Framework report included within this paper.
Prior Approval Process	
Financial implication(s) (if applicable)	Report references delivery of activity versus plan with inherent links to income generation via block contract or Elective Recovery Fund
Implications for equality, diversity and inclusion, including health inequalities	Report references the delivery of access targets, with inherent risks to equity of access across the Group's geography
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance below: ☐Information ☐Review ☐Other – please detail

Board Assurance Report – Patients

Key messages

Referral to Treatment (RTT)

Waiting list (PTL) growth has been arrested at NLAG and slowed considerably at HUTH, ending four years of c8% annual waiting list growth. This is a direct result of:

- Over delivery of RTT pathway completions versus plan.
- Lower that planned/historic referral levels in the latter part of 2024/25.
- The inception of the national 'Validation Sprint' programme in 2025/26.

At NLAG these actions have resulted a reduction in the total volume of patients waiting from 46,541 in April 2024 to 40,156 in October 2025 (-6,295 patients, -13.8%). At HUTH the waiting list of 81,279 reflects growth of 792 patients (+1.0%) in year.

Stabilisation of the waiting list has yet to translate into uniform improvement in RTT compliance i.e. the percentage of patients waiting <18 weeks on an RTT pathway. While NLAG is marginally ahead of the in-year recovery plan at 59.7% (plan 59.3%), HUTH is notably behind recovery expectation at 56.5% (plan 60.3%).

This relates to growth in long waiting patients with 3221 patients waiting more than 52 weeks at HUTH and 994 at NLAG. This is broadly double the volume of patients waiting >52 weeks in October 2024. In year recovery plans and associated in-year recover trajectories have been developed to reduce these volumes to 1108 and 411 respective by March 2026 to achieve the expectation that >52 weeks make up no more than 1% of the waiting list. As an interim step in the delivery of this expectation the Group is currently working to the elimination of >65 week waits by 31st December 2025.

Cancer Access

The Group is a negative national outlier for Cancer standards, with notable delays in outpatient and/or diagnostic stages of treatment in key tumour sites. The 28-day Faster Diagnosis Standard (FDS) is a critical determinant of the ability to deliver treatment with 62 days and has been significant challenged in the latter stages of 2024/25 and into 2025/26.

Extensive recovery actions have been introduced in year, through which compliance for 28-day FDS has improved from 56.5% in April 2025 to 70.4% at NLAG and 55.6% to 73.5% at HUTH in October 2025 (data is provisional). In turn this is driving improvement in completement of cancer treatment within 62 days, with NLAG achieving 65.1% versus 46.3% and HUTH improving to 57.7% from a low of 46.3%. These positions are ahead of agreed in-year recovery trajectories.

Improvement is set against significant demand growth above planned levels on both sites, up 5.8% HUTH and 5.3% NLAG over the last year. In contrast, the volume of conversions from referral with suspected malignancy to cancer treatment remains unchanged, thereby driving a lowering of our percentage conversion over time. Given the requirement to see cancer patients within a 14-day window and associated requirement for urgent diagnostic support, this change in referral profile has a higher associated resource absorption.

Diagnostic Access

The Group is a national outlier for Diagnostic 6-week waits, with October data showing deterioration on both sites to 31.3% at HUTH and 35.3% at NLAG. National expectation is no greater than 5% of patients waiting more than 6 weeks. In-year recovery trajectories shared with NHSE have committed to 5.0% delivery at NLAG and 11.0% delivery at HUTH by March 2026.

Compliance is set against significant demand above plan. The diagnostic activity plan has been exceeded in aggregation with total test volumes at HUTH being the second highest intra month on record during October 2025. However, increases in emergency, planned care and surveillance pathways are constricting waiting list (DM01) activity leading to associated waiting list growth.

Operational Improvement Plan launched creating enhanced capacity in key modalities such as Neurophysiology, Echocardiography, Sleep Studies, Imaging, etc. alongside utilisation efficacy to deliver year end commitments.

Unplanned & Emergency Care (UEC)

HUTH A&E 4 Hour standard (all types) was 55.8% in October 2025 (plan 72.9%). Type 1 performance of 40.9% was below the 25/26 operating plan target of 62.3%. Type 3 performance (HRI UTC) was 90.0% against the 95% target. Type 1 attendance volumes were above plan whilst Type 3 attendances were below planned levels.

NLAG combined type 1 and 3 performance was 69.5% against a target of 76.2%. Type 1 performance = 47.5% (Target 60.9%) and Type 3 performance = 99.2% (Target 99%). Type 1 attendances were lower than planned levels and Type 3 attendances were above planned levels for October 2025.

Critical Actions in place:

- HUTH: Working closely with Place partners aiming to increase UTC operating hours until 2am during winter to increase capacity.
- HUTH: Work ongoing with Yorkshire Ambulance Service to develop a falls care home pathway to avoid ED attendance where appropriate.
- HUTH: Plan to utilise H1 during winter pressures to reduce non admitted breaches, the unit will not be available until end of November / beginning of December.
- NLAG: Expanding CDU pathways to increase utilisation of area.
- NLAG: Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC.

The Group has reiterated its commitment to 78% delivery by March 2025 for both sites via the action programme agreed via national Tiering.

Regulatory oversight:

- **UEC** - remains in Tier 1 oversight for both Trusts.
- **RTT:** Tier 1 oversight for RTT for NLAG to be extended to include HUTH from December 2025
- **Cancer and Diagnostics:** remain in Tier 1 oversight for both Trusts.

CiC ESCALATION REPORT

Humber Health Partnership

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 4 November 2025

1. Matters for Reporting

The **Group finance** report at month 6 highlighted a deterioration of £0.3m to a YTD deficit of c£16m. Risks included delivery of the constitutional standards, unidentified CIP for the last part of the year, high cost drug expenditure increases and claw back of IPT referral income from the ICS. There is a risk to the deficit support funding in Q3 and Q4 from a revenue and cash perspective. Enhanced controls on spending are not yet delivering financial recovery trajectories and reductions in run rate.

Transformation progress highlighted a number of risks including workforce and Care Groups being behind plan and 100 projects with a £5m adjusted risk impact. This has resulted in the overall programme being £10m behind plan. Care Group support and challenge is now in place and monitored at the Senior Leadership Team meeting. All Care Groups have recovery plans in place. A review of Waiting List Initiatives was taking place and new criteria had been developed for additional contractual payments.

The CIC gave limited assurance due to deteriorating run rate and an overall gap to plan.

On **Performance**, the Group Performance report remained relatively unchanged and the planning for 2026/27 had commenced. Outpatient follow-ups were reducing and the Group had seen a 10% reduction overall. Bed-modelling, prioritising and level loading elective patients against non-elective patients was being progressed.

The CIC gave limited assurance as the Group was still on an improvement pathway with detailed plans in place. The CIC highlighted the need for more radical plans to address the long standing issues.

Estates Update – Work was ongoing regarding the Tower Block fire risk with Humber Fire and Rescue Service and comprehensive plans were being implemented in line with timescales.

The CIC gave significant assurance for the grip and control being displayed in this area.

2. Positive assurances

CQC Actions – actions for HUTH are now closed and NLAG actions are rated green.

Procurement Improvement Plan – Expired contracts had reduced from 208 last October 2024 to 88 in 2025.

3. Matters on which the committees have requested additional assurance

The CIC asked for further assurance relating to cancelled operations and Outpatient DNA numbers and the strategies being adopted to address.

4. Decisions made

Sterilisation Services (Decontamination) - The CIC approved the intent to explore option 5 and approved the direction of travel.

Contract approval, Cleaning Services – The CIC endorsed the decision to extend the OCS contract for a further 12 months and to go out to the market for the tender process.

Terms of Reference – The CIC approved the Terms of Reference with minor changes.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions Report	-	-	Assurance	
2	Group Finance Report – Month 6	6	16	Assurance	Limited
3	Update and transformation Programmes	2	20	Assurance	Limited
4	Group Performance Report	2	20	Assurance	Limited
5	Deep Dive: Elective Care	2	20	Assurance	Limited
6	Estates and Facilities and Development Update	6	16	Assurance	Significant
7	Sterilisation Services (Decontamination)	6	16	Approval	Approved
8	Procurement Improvement Plan and Expired Contracts	6	16	Assurance	Significant
9	Contract approval: Cleaning harmonisation (HUTH)	6	16	Approval	Approved

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 2 December 2025

Humber Health Partnership

1. Matters for Reporting

The CIC received a Theatres Utilisation deep dive and partial assurance was the rating of the KPMG audit. The CIC gave reasonable assurance due to the detailed action plan in place and actions remaining on track so far.

The **Group finance** report - at month 7 the Group is £4.8m away from plan, but that included £15.7m of non-recurrent Balance Sheet support. The CIC noted the worsening Financial position and the lack of improvements to the run rate and underlying position. CIP at M7 is £53m which is £12.1m behind plan and the year end forecast is £108m against a target of £130m. Actions were in place to limit bank and agency use, to maximise planned care activity and intensive support on the delivery of the Care Group Recovery action plans was in place. Converting non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target was being worked through. The CiC will determine what more can be done to hold Care Groups to account to deliver their financial plans. Limited assurance was given.

On **Performance**, the Operational Planning timetable and process was presented.

The Group Performance report provided limited assurance due to poor performance across most areas, in particular UEC, RTT and Diagnostics. There were however, improvements with Cancer waiting list reductions and the Faster Diagnosis Standard. Eliminating elective 65 week waits by 21-12-25 would not be achieved until mid-late January as increased urgent referrals and non-elective demand were absorbing diagnostic and outpatient capacity, leaving less for routine waiting list reduction. This revision had been agreed at Tier 1 support meetings.

Estates Update – The EPRR Team and Fire Safety Team had carried out a staged practical evacuation of the Tower Block, using various methods. The timings identified as part of the exercise will be included in the updated evacuation plan and risk assessment. The CIC are to receive the Humberside Fire and Rescue Service (HFRS) report from their recent site visit when it is available. The CIC gave significant assurance due to the grip and control being displayed across the Estates area in general but recognised the ongoing work with HFRS to quantify and reduce the risks identified until all the remedial works can be completed on the Tower Block.

2. Positive assurances

Additional grip and control had reduced the number of patients waiting more than 65 weeks.

3. Matters on which the committees have requested additional assurance

A report detailing additional actions the Group will take to close the financial gap against plan was requested by the CiC for Board consideration.

The CiC would dedicate time to agree ways to further improve effectiveness and improve financial and performance outcomes.

More detail regarding risk actions and how they are impacting on the BAF risk scores.

4. Decisions made

Cleaning harmonisation contract – The CIC endorsed the decision to extend the contract for a year, whilst a comprehensive market analysis of other potential suppliers took place. The CIC requested an action plan with milestones and accountability to ensure that the tender process was completed within the extension period. It was confirmed that a PMO was in place.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	-	-	Assurance	N/a
2	KPMG Audit: Theatres Utilisation	2	20	Assurance	Reasonable
3	Group Finance Report Month 7	6	16	Assurance	Limited
4	Transformation Programme update	6	16	Assurance	Limited
5	Operational Planning Update	2	20	Information	N/a
6	Group Performance Report	6	16	Assurance	Limited
7	Deep Dive – Outpatient Transformation	6	16	Information	N/a
8	Estates Facilities and Development Update	6	16	Assurance	Significant
9	Contract approval: Cleaning harmonisation (HUTH)	6	16	Endorse	Endorsed

5. Escalation to Trust Boards

Continued deterioration in financial performance and the need for a detailed plan to close the gap between planned and actual results to be agreed by the whole Board.

6. Comments on the effectiveness of the meeting

The annual Committee effectiveness review results were discussed. Whilst the results were positive, the CiC agreed to dedicate time to reviewing ideas for ways in which outcomes could be further improved.

7. Escalation to CiCs

N/a

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8. Attendance record

Members / Attendees		A	M	J	J	A	S	S	N	D	J	F	M
Gill Ponder	NED (Chair)	✓	✓	✓	x	✓	✓	✓	✓	✓			
Helen Wright	NED (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
David Sharif	Group Director of Assurance	✓	✓	RT	✓	✓	✓	✓	✓	✓			
Emma Sayner	Group Chief Finance Officer	✓	✓	✓	✓	✓	PR	✓	✓	✓			
Sarah Tedford	Group Chief Delivery Officer	✓	✓	AS	✓	✓	✓	✓	MP				
Philippa Russell	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Andy Haywood	Chief of Strategy, Partnerships and Digital	-	-	-	✓	x	x	x	x	x			
Tom Myers	Group Chief of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Simon Parkes	Non Executive Director	✓	✓	✓	✓	✓	x	✓	x	✓			
Jane Hawkard	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓			
Kate Wood	Group Chief Medical Officer	✓	✓	✓	✓	✓	✓	PS	✓	✓			

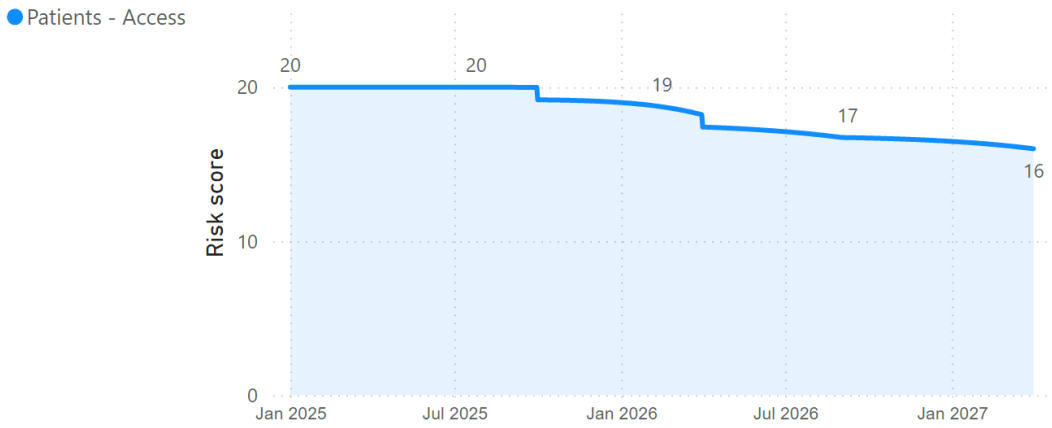
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Matt Powls, Interim Group Chief Delivery Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Patients - Access, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

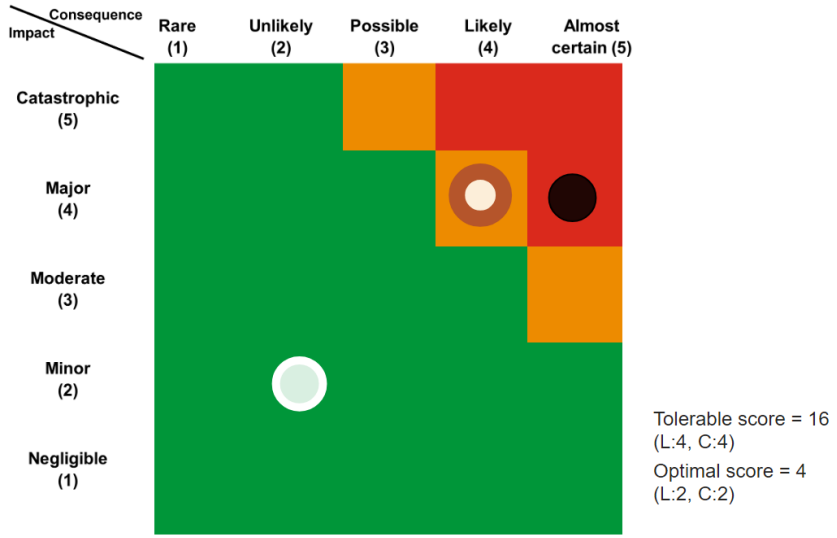
We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

2. Patients - Access

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Care Group Performance and Accountability	Limited
Financial Planning Improvement Board	Limited
Flow programme	Limited
National performance framework for support and scrutiny	Limited
Operating plan 2025-26	Limited
Planned Care Board	Reasonable
Tier 1 review processes - UEC and Cancer	Significant
Unplanned Care Board	Limited

Gaps in control (and Action ID)	21	31	37	41	53	Total
Challenge in resolving numerous national expectations / targets with available finance, degrading or overriding control			1			1
Data quality issues in supporting metrics		1				1
Lack of positive medical engagment in delivery	1					1
Lack of strong capabilities to identify and implement service improvement gains from exemplar sites or best practice	1					1
Lack of timely / realtime performance reporting (eg weekly dashboard)				1		1
Lack of trajectory setting to support robust performance management					1	1
Uncertainty over ICB role and function	1					1
Weak culture of improvement/change management and siloed working		1	1			2
Total	**3**	**1**	**1**	**2**	**1**	**1**	**9**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	
External	Acute Provider collaboration reports	
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Limited
External	ICU Network review	
Internal	Integrated Performance Report	Reasonable
External	NHS tiering arrangements and support or freedoms	
Internal	Planned Care Board reporting to Performance, Estates & Finance CiC	
Internal	Unplanned Care Board reporting to Performance, Estates & Finance CiC	

Assurance gaps (and Action ID)	20	31	42	53	Total
Absence of a comprehensive demand and capacity (bed) model that supports scenario analysis and planning	1			1	2
Absence of routine data quality monitoring and patient record validation		1	1		2
Inadequate coverage of performance metrics	1				1
Total	**1**	**1**	**1**	**1**	**1**	**5**

2. Patients - Access

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The table below details the 7 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
20	Strategic Bed Review (based on optimum LoS)	31/12/24	01/09/26	PA Consulting undertook a bed utilisation review (ahead of developing in-house modelling capacity). Work to be recalibrated in light of Improvement Plan Stabilise phase, demand and capacity at specialty level and Teletracking system implementation.	02/12/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Adam Creeggan, Group Director of Performance, Matt Powls, Interim Group Chief Delivery Officer	Limited
21	Embed QI Methodology	30/09/25	01/04/27			Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Heather McNair, Group Chief Nursing Officer	
31	Standing up revised organisational data quality governance		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
37	Developing skills and capability of Care Group leadership to tackle day-to-day challenges and lead on effective transformation programmes, intra-Care Group and cross-sites	31/03/26	01/04/26	Appointed Site Director of Operations and Transformation - due to start July-25	17/06/25	Simon Nearney, Group Chief People Officer, Matt Powls, Interim Group Chief Delivery Officer	Limited
41	Delivery of BI investment		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised	30/09/25	01/10/25	Internal exercise underway at present with plan to engage AI later	01/05/25	Adam Creeggan, Group Director of Performance	
53	Develop and embed Care Group integrated plans aligning expendture, activity and workforce	31/05/25	31/03/26	Set clear and individual objectives across four domains of finance, activity and workforce	01/05/25	Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	Significant

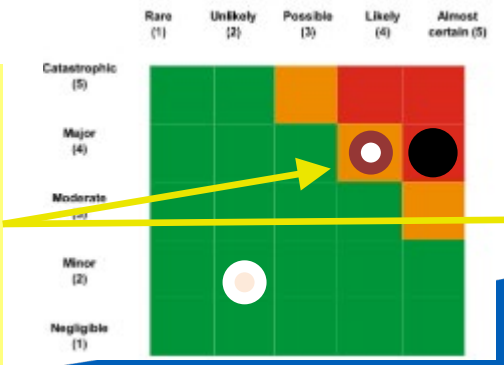
Appendix 1: Patient – Access

On 3 November 2025, the Group Executive Risk and Assurance Committee discussed the Patient Access risk and specifically the risk appetite giving rise to the small distance between the current score and maximum tolerable score (being 4 points). This one-page sets out the current risk, its appetite and proposed change.

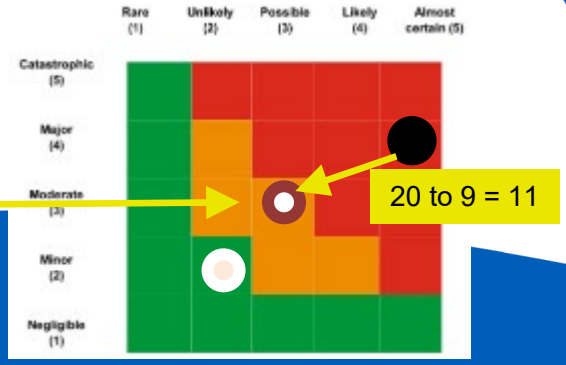
Patients – Access risk: We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

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

This change results in a greater distance from the current score to the tolerable score and therefore greater expectation on the actions to achieve this goal. The distance to tolerable changes from 4 to 11.



- **Proposed risk category - Clinical Quality and Safety**
- Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
- = CAUTIOUS risk appetite



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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)225

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	11th December, 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Simon Nearney, Group Chief People Officer
Title of Report	**Our People**
Executive Summary	This report provides an overview of the key People issues that have arisen since the last Boards-in-Common meeting and workforce matters discussed at Workforce, Education and Culture Committee-in-Common, which we are seeking to address and improve so our people feel engaged, valued and motivated to provide the best care possible to our patients.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce, Education and Culture Committees-in-Common October/November 2025 highlight report and People Board Assurance Framework are included with this report.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Humber Health Partnership

Trust Boards-in-Common

11th December 2025

Our People

1. Purpose

The purpose of this report is to provide an overview of the key People issues that have arisen since the last Boards-in-Common meeting and workforce matters discussed at Workforce, Education and Culture Committee, which we are seeking to address and improve so our people feel engaged, valued and motivated to provide the best care possible to our patients.

2. Background

NLaG and HUTH remain in the National Operating Framework (NOF) segment 4. The consequence of this is that we have less control over how we spend our money, and we are subject to a very high level of scrutiny from national teams and regulators. We have to make immediate improvements in our ED performance, reduce the size of our waiting lists and improve the timeliness of patients being diagnosed and if required, treated for cancer. Conversations are continuing with teams and individuals to focus our efforts on those key constitutional standards to make those improvements.

As well as patient access targets and financial performance, the NOF uses the national staff survey response and engagement scores to determine our position as well as sickness absence in the national league tables. This makes it even more important that managers and teams are having conversations about how we can improve the working environment; what we are doing and how we are doing it, to ensure our people enjoy coming to work, that their basic motivational needs are met, that staff are engaged and feel valued which is turn will improve performance and ultimately patient outcomes.

3. People Strategy 2025-28

The Group People Strategy (2025– 2028) was launched in April 2025 and aims to transform the workforce experience of our people through five strategic themes: People and Partnerships, Workforce Systems Transformation, Health and Wellbeing, Leadership, Learning and Talent Development, and Culture and Engagement. In the first year, the strategy will focus on foundational priorities, including workforce planning, digital tools, wellbeing initiatives, leadership development, and anti- discrimination frameworks. The work programme and deliverables are being presented to Workforce, Education and Culture Committees-in-Common at the end of each quarter. Quarter 3 will be presented in January 2026. The strategy is aligned with the NHS Long Term Workforce Plan and the NHS People Promise.

4. Culture & Engagement

4.1 Putting People First - Cultural Transformation Programme

The Putting People First programme continues throughout Quarter 3, with a focus on Reward and Recognition. Executive-led manager sessions are ongoing. These sessions encourage all attendees to consider how they can improve the ways in which they reward their teams.

The Q3 corporate offer has included a broad range of leadership development programmes, a new harmonized approach to Long Service, which will see an extension to the offers at both NLaG and HUTH currently, a home electronics salary sacrifice scheme for NLaG and a combined approach to staff recognition from simple ‘thank yous’ on Bridget to national awards.

4.2 National Staff Survey

The National Staff Survey closed on 28th November 2025. HUTH response rate was 46%, NLaG’s response rate was 40% and the national average was 47%. Corporate Services and Site Management and Discharge, both at NLaG, achieved a 60% response rate. Staff Survey communications began just before the survey was launched in September. Weekly meetings were held with HR and OD teams to discuss response rate and communications; it was discussed at

performance meetings with Care Groups and Corporate Services. Screensavers, posters and videos were also used in an attempt to reach an overall return rate of 60%. In addition, the weekly response rates for Care Groups were detailed on Bridget and an incentive was offered. The response rate is disappointing. A review will be undertaken to understand why more people did not engage.

4.3 Group Lottery

Plans for a group lottery are progressing and both the HUTH and NLaG staff lotteries will be ending at the end of this year. The final monthly draws will take place in December 2025. This is to make way for the launch of the Group lottery. "The Humber Health Jackpot". Our license application was submitted back in April, and we expect to have final authorisation this month.

4.4 Golden Stars

Due to clashes with other network conferences, we are proposing moving the Group Golden Stars awards ceremony from October to Friday 3rd July. This will also coincide with the NHS birthday. The Golden Stars Awards are funded entirely by the staff lotteries and external sponsorship. No NHS money is used to pay for the scheme. A number of key sponsors, including the Allam family have already expressed their desire to sponsor the event again in 2026. Last year almost 400 staff attended the event at Scunthorpe Baths Hall and we received over 450 entries to the Golden Stars from teams and individuals, some of whom went on to win national awards. This year we are looking at venues on the north bank.

5. Health & Wellbeing

5.1 Flu Vaccination

The HHP (HUTH and NLAG) staff influenza vaccination campaign commenced on the 1st of October. During October the group had static hubs one on each of the main sites open for staff to attend and have the vaccination. From November onwards the group moved to roving teams to attend specific areas across all hospital sites. Wards and services have been able to request a roving vaccinator to attend their team to administer vaccinations. Currently NLaG vaccination take up is 45%, HUTH is 44% which is similar to other size trusts. This has been a joint approach with Occupational Health, Corporate nursing and bank vaccinators. The communication programme continues, and the group continues to promote both individual and team-based incentives to improve take up. Vaccination teams are targeting departments with low uptake working alongside GC clinical teams to promote vaccination benefits to their teams.

6. People & Partnerships

6.1 Cancer Alliance service

Humber and North Yorkshire ICB have requested that HHP take on the employment and host the Cancer Alliance service with effect from 1st April 2026. There are circa 24 staff employed within the team and the cost is approximately £2m per annum. Due to national changes with NHSE and Integrated Care Boards, many ICB's are taking this approach to TUPE transfer the service to an acute provider. In West Yorkshire the ICB is seeking to transfer the service to Leeds Teaching Hospital. There are issues the group needs to work through and the Group Chief Executive and Chief People Officer will continue those discussions. Any transfer would be via a written agreement and any liabilities either current or in the future would be shared between the ICB and all providers within the Humber and North Yorkshire system.

6.2 Agency, Bank and Temporary Staffing

In the 24/25 financial year the Group reduced agency spend by £11.5m. For 25/26 NHSE have advised the Group is required to reduce agency spend by a further 30% as compared to agency usage in 24/25 i.e. £8.1m. For 25/26 the year to date spend at end Month 7 was £16.7m. At the end Month 7 agency spend is £5.4m off target. M7 agency usage reduced by £616k when compared to M6. M7 was £300k away from the in-month target, M6 was £923k away, demonstrating progress.

Executive Directors continue to approve all agency requests over 1 week. Care Group and Site Management Teams have the responsibility to approve less than 1 week as well as overtime, bank, locum and extra contractual payments. Care Groups are working hard to reduce variable pay

spend and standard placement contracts have reduced from 24 to 3 saving c20% VAT on each assignment.

Strategic workforce planning has commenced across the group to support the creation of the operational plan 26/27, with wider consideration of the next 5 years. A key focus of engagement is to live with our means and as such, exploring alternative and available workforce provision where possible to reduce reliance on variable spend.

6.3 Health Care Support Worker Band 2 / 3 and Nursing profiles band 4 to 9.
The joint collective agreement moving our Health Care Support Workers to band 3 was implemented in October 2025 and back-pay is being paid to staff over the next 12 months. The group is now working with HUTH and NLaG Staff Side representatives to consider and implement the new national job profiles for nursing and midwifery staff band 4, 5 and 6. As a group we are reviewing all those band job descriptions with a view to standardise and reduce the number of required job descriptions. The group is also working with York and Scarborough hospitals and Harrogate NHS Trust to try and ensure our approach is the same across the ICB for acute providers.

6.4 NLaG Pay Dispute (Consultants)
The Group Chief Medical Officer has successfully secured an agreement with the NLaG Local Negotiating Committee (LNC) on the additional on-call rate of pay for consultants. The new rate of pay has also been agreed with HUTH LNC, and the new group rate will be implemented effective from 1st December 2025. This ends the NLaG consultant dispute.

7. Workforce System Transformation

7.1 Key workforce metrics – current position

Metric	Group current Position	Target
Sickness	**4.8%**	**4%**
AFC Appraisals	**79.9%**	**85%**
Vacancy Rate	**4.3%**	**7%**
Turnover	**7.4%**	**10%**
Core Mandatory Training	**88.8%**	**85%**
Role Specific Training	**81.2%**	**85%**
Job Planning	**79.4%**	**100%**
Medical Appraisals	**84.3%**	**90%**

7.2 Non-clinical vacancy freeze
Given the group's current financial position, a non-clinical vacancy freeze is being considered for the remainder of the financial year. This is being discussed with Care Group leadership teams. Its not action

7.3 Resident Doctor 10 Point Plan
Resident Doctors play a vital role in delivering patient care while training across multiple sites and organisations. The dual responsibility creates challenges not typically faced by other staff groups. In August 2025, NHS England (NHSE) issued a letter outlining a 10-Point Plan on Getting Back to Basics for Resident Doctors which sets out national expectations and actions to tackle recurrent challenges experienced by Resident Doctors. The Group Chief People Officer is our Executive lead and we have a NLaG Resident Doctor lead and a Resident Doctor lead from HUTH. The 10 point action plan has been shared with the Workforce, Education and Culture Committee and the committee will receive monthly progress reports. Both trusts have a completed and submitted their baseline assessment to NHSE and progress is being made. This development will also be a standing item at the Resident Doctor Forums and NLaG and HUTH medical staff side meetings.

7.4 Resident Doctor Industrial Action

Participation in the last period of industrial action was **56.9%**. Further strike action is planned from 7am on 17th December to 7am on 22nd December 2025. In addition, the BMA is balloting resident doctors for further strike action during 2026.

8. Leadership, Learning & Talent Development

8.1 Learning, Improvement and Safety Academy

As part of the Improvement Plan for NHS Humber Health Partnership a Learning, Improvement and Safety Academy (LISA) will be created and will bring together clinical education, medical education and organisational development into one coherent improvement system. LISA will provide an integrated programme of leadership development, team effectiveness, safety training and improvement support across HHP, and will become the central place where teams access the skills, tools and support needed to deliver, high quality reliable care.

Key stakeholders from these relevant teams will come together and LISA will act as a coordinating hub, with the Group Director for Learning and OD working closely with the Improvement Team to build the programme and deploy the services based on the NHS HHP Improvement Plan Priorities. This programme will impact on how we deploy our services and use our capacity.

8.2 Organisational Development

The Organisational Development (OD) team have completed a full review of their activity since January 2025. They have created a Stepped Intervention Model, which is designed to understand varying levels of cultural and behavioural challenges across care groups. The model ranges from self-directed development (Minimal Support) to Intense Support for entrenched issues requiring executive sponsorship. Data from 84 requests since January 2025 indicates that moderate support is the most common intervention, reflecting a widespread need for structured leadership development and team upskilling. High and intense support requests are concentrated in areas such as Family Services and Cardiovascular, signalling deeply rooted challenges, while Corporate Nursing and specialist areas tend to engage with lighter-touch, self-directed interventions.

8.3 Workforce Culture Challenges and Targeted Approaches

The team is focusing capacity to improve workforce culture, particularly in maternity and cardiology services. In maternity, a systematic set change approach, has been adopted, focusing on assessment, mindset, skill set, tool set, coaching, and system set. Incivility reporting tools and staff surveys have identified key themes such as discrimination, intimidation, and disruptive communication, with key areas flagged so that we can provide additional focused leadership support.

Cardiology has transitioned from high intervention to high support, with persistent issues addressed through targeted OD interventions and the use of incivility tools. Staff feedback underscores the impact of some staff's behaviour on team morale and retention and with key areas now identified for the next phase of the workplan.

8.4 Measuring Impact and Aligning with Organisational Priorities

The OD team is committed to measuring the impact of interventions using the Kirkpatrick Model, focusing on behavioural change and outcomes at both team and organisational levels. The OD programme is closely aligned with organisational priorities, working in partnership with the Care Group and the new Improvement Team to ensure resources are allocated effectively and interventions support broader strategic goals such as leadership development, quality improvement, and team dynamics. This support will become even more robust when the Learning, Improvement and Safety Academy (LISA) is fully up and running.

8.5 Apprenticeship Levy

The NHS Humber Health Partnership has demonstrated significant investment in apprenticeship programmes, with total expenditure exceeding £1.8 million since March 2025, a 14% increase on the previous year. HUTH increased its levy spending by 17% and NLaG by 7%. The group's financial management has resulted in reduced expired levy funds and more efficient use of available budgets.

As of October 2025, HUTH's apprenticeship levy budget stood at £2.37m (with £1.01m spent in Q1–Q2), and NLaG's at £1.99m (with £0.84m spent in Q1–Q2). Projected spend for the remainder of the year is £2.02m across both trusts, with an overall predicted underspend of 11%.

There has been robust growth in apprenticeship activity across both trusts. HUTH enrolled 154 new apprentices between April and September 2025, bringing its total to 403 learners across 44 programmes. NLaG enrolled 108 new apprentices in the same period, with a total of 291 active apprenticeships spanning 45 standards. Notably, Level 7 apprenticeships (including Senior Leader programmes) accounted for 35% of new starts, reflecting a strategic push ahead of anticipated government funding changes. Both trusts have expanded into new areas such as engineering and healthcare science and have leveraged levy transfer funding to support regional health and social care partners.

8.4 GMC Medical Education Survey

Overview and Key Findings

The 2025 GMC National Training Survey has highlighted significant challenges requiring urgent action, particularly at Scunthorpe General Hospital (SGH), which reported 12 "red" outliers, compared to 7 at Diana Princess of Wales Hospital. The survey identified widespread concerns regarding patient safety across several specialties, including Gastroenterology, Cardiology, Respiratory, Anaesthetics, and Diabetes and Endocrinology, as well as broader cultural issues within the Trust.

Action Plans and Monitoring

Action plans addressing these concerns have been submitted to NHSE. Informal feedback indicates that Cardiology, Geriatric Medicine, and Gastroenterology are likely to be placed under Enhance Monitoring by the GMC, pending formal notification. Chiefs of Service are leading the implementation of these plans, with progress ongoing to meet required deadlines.

Targeted Interventions

Key interventions include:

- Reviewing medical rotas to ensure adequate staffing and supervision.
- Establishing a Medicine Steering Group.
- Providing weekly two-hour Self Development Time for Resident Doctors (initiated October 2025).
- Conducting facilitated listening sessions to gather feedback and address concerns.
- Updating supervision standards to guarantee every Resident Doctor has an Educational Supervisor.

Departmental Highlights

The Anaesthetics Department at NLaG recently received positive feedback from trainees during a School visit. However, the department still requires the appointment of a College Tutor. There is a proposal for a HUTH Consultant to take on this role, with the School supporting the arrangement provided the Tutor is present on site at least once a week.

Next Steps

The Site Medical Director has requested a review of Foundation Doctor allocations across medical specialties, as current placements do not reflect workload or the number of available Educational Supervisors. This review aims to ensure fair distribution and appropriate support for trainees.

The Trust is awaiting the results of the NHSE Education and Training survey, with the expectation that recent improvements will be recognised and reflected in the outcomes.

9. Recommendation

The Board-in-Common is requested to note the content of the report and provide any feedback. The Boards are also asked to provide a view on moving the date of the Golden Stars and progressing with the celebration evening in 2026.

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 28 October 2025

Humber Health Partnership

1. Matters for Reporting

The NLAG consultant dispute was still not resolved – a response from the NLAG consultants is still awaited.

The CIC heard about the 5-day, resident doctor industrial action and the comprehensive plans being developed to address the gaps**.**

The People Strategy Progress Report - There was a £5.1m overspend in agency costs. An executive intervention had taken place to increase governance, grip and control.

Job Planning compliance had improved and was at 68%. Reasonable assurance was given due to the processes in place and the improvements made.

2. Positive assurances

Potential charitable funding was available to refurbish staff rooms within the Group.

3. Matters on which the committees have requested additional assurance

CQC Actions– Improvements have been made been made in NLAG in the Children and Young people team, but further assurance was still required regarding mandatory training for medical staff. Limited assurance was given.

4. Decisions made

The NHSE Annual Self-Assessment relating to student placements was approved by the CIC. The Placement Tariff was discussed, and it was agreed that a review of where the funding was being used would take place.

The new EDI Steering Group Terms of Reference were approved by the CIC.

5. Escalation to Trust Boards

The PEF CIC had referred allocating resources over 7 day working to the WECC CIC. It was agreed that this should be managed by the Group Chief Delivery Officer.

The CIC had a challenging discussion regarding Operational Workforce Planning. The CIC gave reasonable assurance due to the actions that had been agreed by the Executive Team to recover the position .

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions Group Progress Report	N/a	N/a	Assurance	Limited
2	People Strategy Progress Report – Q2	1	20	Assurance	Reasonable
3	Operational Workforce Planning Summary	1	20	Assurance	Reasonable
4	Freedom to Speak Up Q2 HUTH	1	20	Assurance	Significant
5	Freedom to speak Up Q2 NLAG	1	20	Assurance	Significant
6	NHSE Annual Self-Assessment Return	N/a	N/a	Approval	Approved
7	Employee Relations Case Analysis – Focus on Timescales	1	20	Information	N/a
8	Job Planning	1	20	Assurance	Reasonable
9	EDI Steering Group Re-design	1	20	Approval	Approved
10	Terms of Reference review	1	20	Review	N/a

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 26 November 2025

Humber Health Partnership

1. Matters for Reporting

Resident Doctors Industrial Action –There were no issues due to consultants acting down and prompt clinical decisions. UEC performance and patient flow was better. A post learning review is being undertaken.

NLAG Doctor dispute – This issue had been settled and harmonised with the HUTH consultants. The new rate would be in place from 1st December 2025.

Guardian of Safe Working HUTH – A business case was in progress due to significant staffing issues and high fines in Paediatric Surgery. The CIC gave reasonable assurance.

Guardian of Safe Working NLAG – The CIC gave limited assurance due to a lack of confidence in the mitigations to address the issues raised..

Bands 4-9 Profile Review - The nationally mandated profile review of nursing and midwifery bands 4-9 had commenced**.** The CIC noted the risks related to the exercise, particularly the added costs involved.

2. Positive assurances

Apprenticeship Levy – Apprenticeship numbers had increased and external funding from NHSE was supporting a graduate engineering scheme at HUTH and level 6 construction skills at NLAG. The CIC gave reasonable assurance.

Medical and Dental Job Planning – The current compliance was 79.6% which had been an overall increase since the last meeting. The March 2026 target was 95%. A Focus on capacity and demand would be received at a future meeting.

3. Matters on which the committees have requested additional assurance

Work had commenced on the **Resident doctor 10-point plan** and this would be presented to the CIC on a regular basis. The initiative is in place to improve the working lives of resident doctors through health and wellbeing, rota and work schedules, payroll and expenses, rest areas, exception reporting etc.

Undergraduate Medical Education NLAG – The high number of students was causing pressure in the system and there was an issue highlighted regarding cancelled clinics which was impacting on students getting placements.

HUTH – Work was underway with clinical groups to determine how the Tariffs were spent across the Group.

The CIC gave reasonable assurance for the report but requested further information regarding cancelled clinics and tariff expenditure.

4. Decisions made

There were no decisions made by the CIC.

5. Escalation to Trust Boards

There were no concerns raised.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	BAF and Risk Register	N/a	N/a	Information	N/a
2	Resident Doctor 10 Point Plan	1	20	Information	N/a
3	Apprenticeship Levy Annuary Report 2024/25 (Progress)	1	20	Assurance	● Reasonable
4	Undergraduate Medical Education Annual Report	1	20	Assurance	● Reasonable
5	Guardian of Safe Working Hours – Q2 HUTH	1	20	Assurance	● Reasonable
6	Guardian of Safe Working Hours – Q2 NLAG	1	20	Assurance	● Limited
7	Medical and Dental Job Planning	1	20	Information	N/a
8	Organisational Development Update	1	20	Information	N/a
9	Nursing and Midwifery Bands 4-9 National Profile Review	1	20	Information	N/a
10	Safer Nurse Staffing Establishment Review	1	20	Endorse for BIC	Paper withdrawn

6. Comments on the effectiveness of the meeting

Members welcomed the discussion held in accordance with the Group's values.

7. Escalation to CiCs

N/a

8. Attendance record

Members / Attendees		A	M	J	J	A	S	O	N	D	J	F	M
Julie Beilby	Non-Executive Director (NLAG) Chair	✓	✓	✓	✓	✓	✓	✓	✓				
Tony Curry	Non-Executive Director (HUTH) Chair	x	✓	MMc	✓	✓	✓	✓	✓				
Simon Nearney	Group Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓				
Amanda Stanford	Group Chief Nurse	✓	HMc	HMc	HMc	JL	✓	JL	HMc				
Kate Wood	Group Chief Medical Officer	✓	PS	✓	✓	✓	PS	✓	AG				
David Sulch	Non-Executive Director (HUTH)	x	✓	✓	✓	✓	✓	✓	x				
Sue Liburd	Non-Executive Director (NLAG)	x	✓	✓	✓	✓	x	✓	✓				
Laura Treadgold	Non-Executive Director (HUTH)	✓	✓	✓	✓	x	x	✓	✓				
David Sharif	Group Director of Assurance	✓	✓	✓	✓	✓	✓	✓	✓				

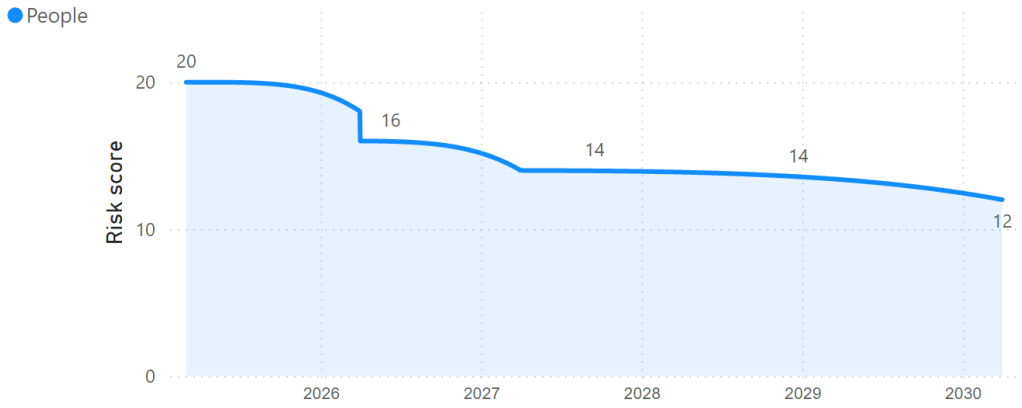
1. People

The strategic risk affecting our objective, 'People' is led by Simon Nearney, Group Chief People Officer and reported to the Workforce, Education and Culture Committees-in-Common. Under the risk category of People, the risk's current score is 20 and its score last changed on 23/09/2025. The actions were last reviewed on 23 September 2025. In full, the risk is:

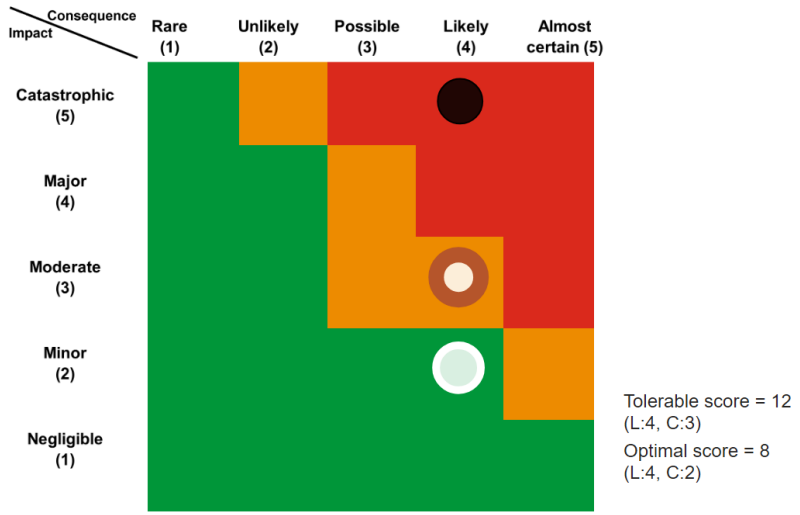
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Balanced)

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

1. People

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Annual Care Group Workforce plans	Limited
Care Group Performance and Accountability	Limited
CESR Programme	Significant
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Group Leadership Strategy (in development)	Limited
Group People Strategy 2025-28	Reasonable
Group Senior Management Team (was EMC)	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Limited
Talent management team for international recruitment	Limited
Workforce Transformation Committee	Reasonable
XXX - Resident Doctor 10 Point Plan Oversight Delivery Group	
XXX - Stability of Senior Leadership Team	Limited
XXX - Vacancy Control Panel	Reasonable

Gaps in control (and Action ID)	6	7	8	38	Total
Hard to recruit roles in medical specialities	1	1			2
Management and Leadership consistency in delivering the People Promise to staff			1	1	2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1		3
Total	**2**	**2**	**2**	**1**	**7**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable
External	XXX - External Safer Staffing report on application of model	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequent culture and staff experience measures	1	1
Lack of assurance re short term additional hours / overtime from Care Groups	1	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	1	1
Plans to address ageing workforce profile	1	1
Poor levels of mandatory training compliance	1	1
Total	**4**	**5**

1. People

NHS Humber Health Partnership

The table below details the 4 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
6	Recruitment drives using the Group values to attract high calibre candidates - focussed on medical staff and other key areas	31/03/26	01/04/26	Focus currently on medical staff.	23/09/25	Simon Nearney, Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	Care Groups / Corporates implementing actions plans. Some Corporate decisions are likely to have a detrimental impact on future engagement scores (e.g. car parking space / charges, food availability and prices)	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable
8	Group Leadership network and training programme - November 2024	30/12/25	01/04/27	New leadership programme for the Group launched (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable
38	Group Well-being platform live and being maintained	28/02/25	01/04/26	Went live with platform - now responding to requests from staff accessing the offer	23/09/25	Simon Nearney, Group Chief People Officer	Significant

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)226

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	11th December 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Elizabeth Houchin – NLAG Freedom to Speak Up Guardian Fran Moverley – HUTH Freedom to Speak Up Guardian
Title of Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 2) – NLAG** **Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 2) – HUTH**
Executive Summary	The Q2 FTSU reports present an overview of number of concerns raised, national and regional updates and the proactive work undertaken by the NLAG and HUTH FTSU Guardians, along with future plans for FTSU. **Key points to note for NLAG:** • Number of concerns received is similar to Q2 (94) in the previous reporting year (92). • Low number of anonymous concerns and below the national average for the size and type of organisation. • Common themes included worker safety, HR processes and inappropriate behaviours. **Key points to note for HUTH:** • 82 concerns were recorded; 21% increase since Q1 (2025/2026) and 52% increase compared to Q2 (2024/2025). • No concerns were raised anonymously to the FTSUG, whilst 30% of staff asked the FTSUG to protect their identity. • 5 workers reported potential negative impact. • The FTSUG was directly involved in the escalation of 51% concerns, an increase since Q1 (22%). • Concerns were mostly reported about Patient Services (16). • Individuals feedback had a positive experience of the FTSUG, but experience of speaking up to the wider Trust was mixed.
Background Information and/or Supporting Document(s) (if applicable)	This report is of routine nature and presented quarterly to the Workforce Transformation Group and the Workforce, Culture and Education Committees-in-Common. No supporting documents are applicable.
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 2 Report July to September 2025

Liz Houchin
14th October 2025

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 2 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 2 (Q2) of the 2025/2026 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper satisfies the Trust Strategic Objective of ‘Being a good employer’ and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at NLAG in place that allow staff to raise concerns, including, but not limited to:

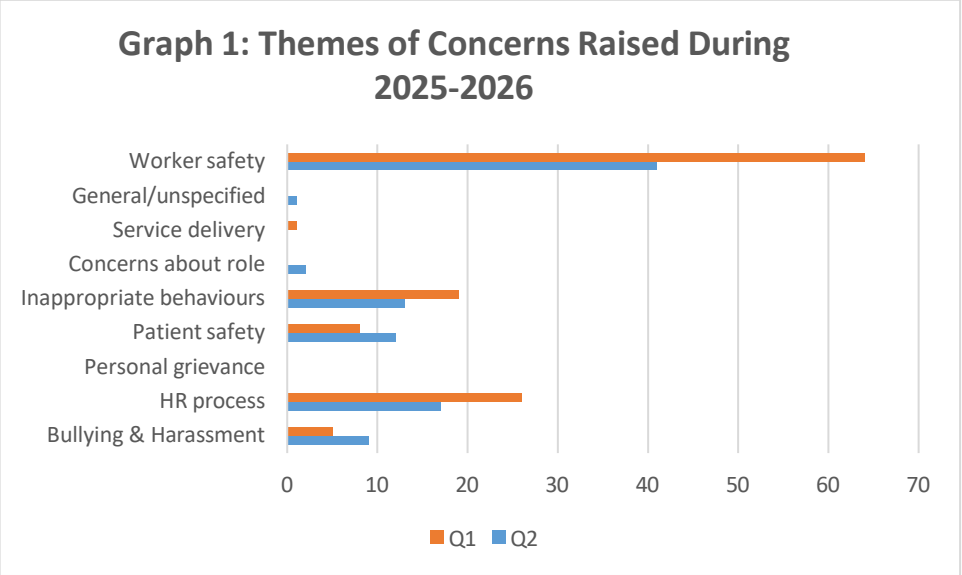
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Grievance Policy (DCP084)

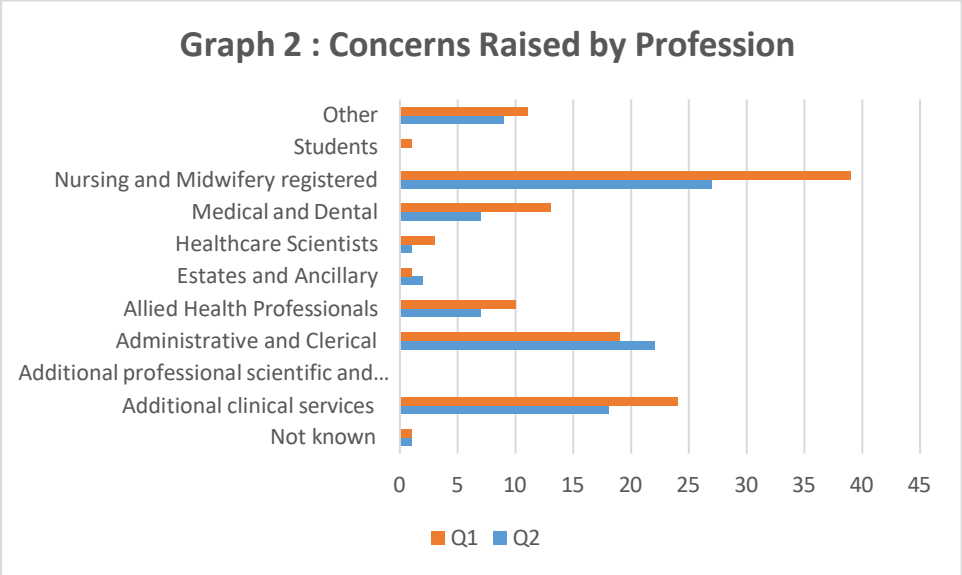
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st July 2025 to 30th September 2025 (Q2) – data, comments and assessment

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1 and 2 summarises the Q2 data:





4.3 In Q2 2024-25, 94 concerns were received. 9% of these were closed on the same day after giving advice or signposting.

- 2 concerns were raised anonymously in Q2 using the staff app. This is below the national average.
- In Q2 12 concerns involved an element of patient safety. This puts the Trust in the mid quartile nationally, figures accessed from Model Hospital. Latest data available is from Q4 2024/25.
- In Q2 42 concerns involved an element of worker safety which puts the Trust in the mid quartile nationally.

The Q2 figure of 94 is similar to Q2 in 2024-25 which was 92. The main themes raised were around worker safety, HR process and inappropriate behaviours. Looking at the worker safety concerns, 46% related to either not feeling psychologically safe to speak up, or the impact the working environment was having on wellbeing. 21% related to working conditions and 31% related to staffing levels.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q2	9	9

Data analysis of the completed evaluation forms indicate colleagues aged between 18-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds accessed the FTSUG in Q2.

Within the feedback received, the following are extracts of qualitative feedback received:

The FTSUG did her job professionally, she is a good listener

Liz was very helpful

The process has been too lengthy and taken too long to just receive little feedback, doesn't prove to me that the issues raised has been dealt with. (Due to staff confidentiality FTSUG could not share more).

Really easy to contact and kept me informed throughout, thank you.

Liz's quick response helped me get out of my black hole quicker.

4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

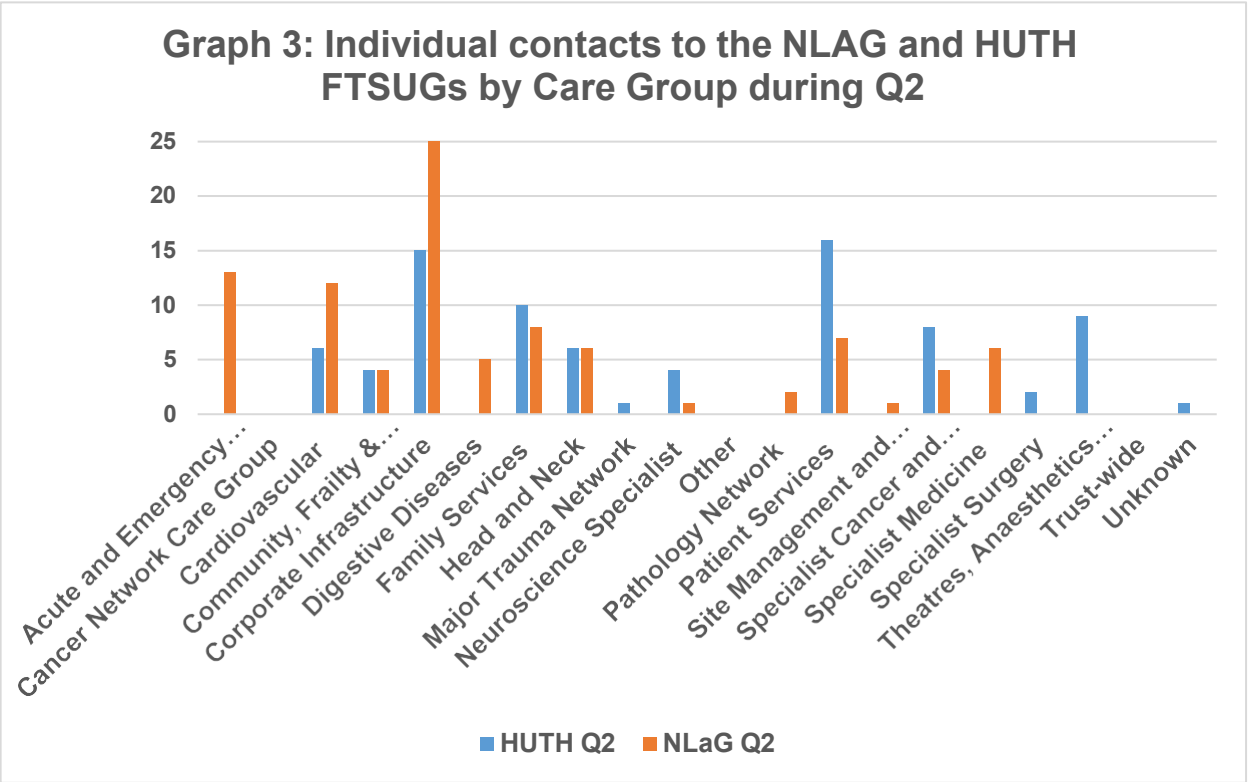
The FTSUG was contacted by managers who were supporting a colleague through the managing performance process. The managers' concerns included the length of time the process was taking, the impact this was having on both the wellbeing of the colleague and their own wellbeing, as well as the impact to service delivery, as the process was diverting time away from clinical care.

The FTSUG was also contacted by the colleague involved, who also raised concerns about the length of time and poor communication throughout the process, as well as the impact this was having on them.

The FTSUG contacted the Care Group management team and HR to raise these issues. Both provided responses and agreed that there was some learning points for the organisation and a review of the case will be completed on completion of the process.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 3 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.



5. FTSUG activities and proactive work during Q2

5.1 A high-level summary of the activities are detailed below:

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Trust inductions
- Attendance at Regional NGO meeting
- Board Self-Assessment Session
- Completion of Annual Refresher training by FTSUG
- Walk rounds with OD team

5.2 Future plans:

- Continue to work with HUTH FTSUG to deliver the FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- Attendance at all relevant meetings

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings to discuss and share best practice. During October 2025, the regional network will hold a virtual leadership conference with national speakers and opportunity for group working and networking.

6.2 National update

During Q2 the 'Review of patient safety across the health and care landscape (known as the Dash review) and the 10-year plan were published. The reviews confirmed that the National Guardian Office, the body overseeing FTSUGs will be closed, with their responsibilities transferring into NHSE after March 2026. FTSUGs will remain in post and are recognised as having integrated into the wider NHS system. The appointment of having a FTSUG will continue to be part of the standard NHS contract.

The National Guardian Office have launched a review into the speaking up experiences of bank and agency nurses and midwives. FTSUGs have been asked to promote this and the NLaG FTSUG has shared details with the Bank office team.

The National Guardian Office have released the annual 2024/2025 report Culture is a patient safety issue - a summary of speaking up to Freedom to Speak Up Guardians. The report provides insights into the speaking up landscape and culture across organisations, highlighting key trends, challenges, and areas for improvement.

The report also includes a number of recommendations for senior leaders and line managers, that can be read on the National Guardian Office website:

Culture is a patient safety issue - a summary of speaking up to Freedom to Speak Up Guardians

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Liz Houchin
14th October 2025

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 2 Report July to September 2025

Fran Moverley
October 2025

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 2 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during 1st July 2025 to 30th September 2025 - quarter 2 (Q2) of the 2025/2026 reporting year. The paper includes the details of the relevant regional and national updates for comparison and context. The collated Care Group data with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) within the NHS Humber Health Partnership (the Group), is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the 'Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts' published by NHS England and Improvement (NHSEI).

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current Group Strategic Objectives of 'Our People', 'We will look after the health and wellbeing of our people', 'Quality & Safety' and 'We will keep our patients safe and reduce avoidable harm'.

2.2 The report aims to provide assurance to the Group Trusts Boards-in-Common on promoting a 'speaking up' culture at HUTH for workers.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at HUTH in place that allow staff to raise concerns, including, but not limited to:

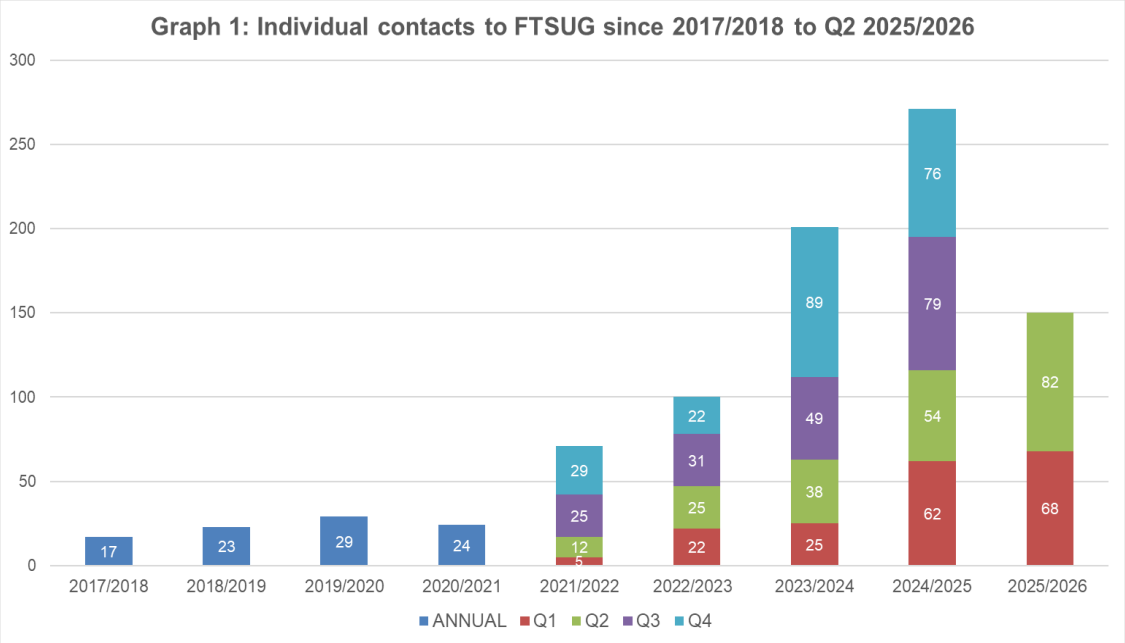
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Group Conflict Resolution Policy (GP026)
- Group Grievance Policy and Procedure (GP024)

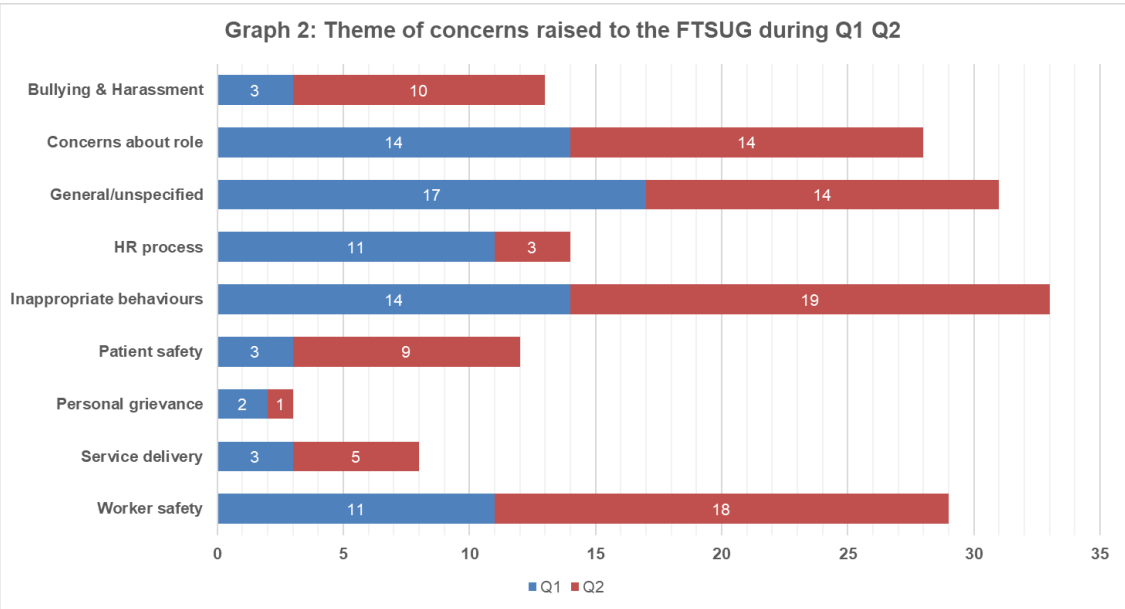
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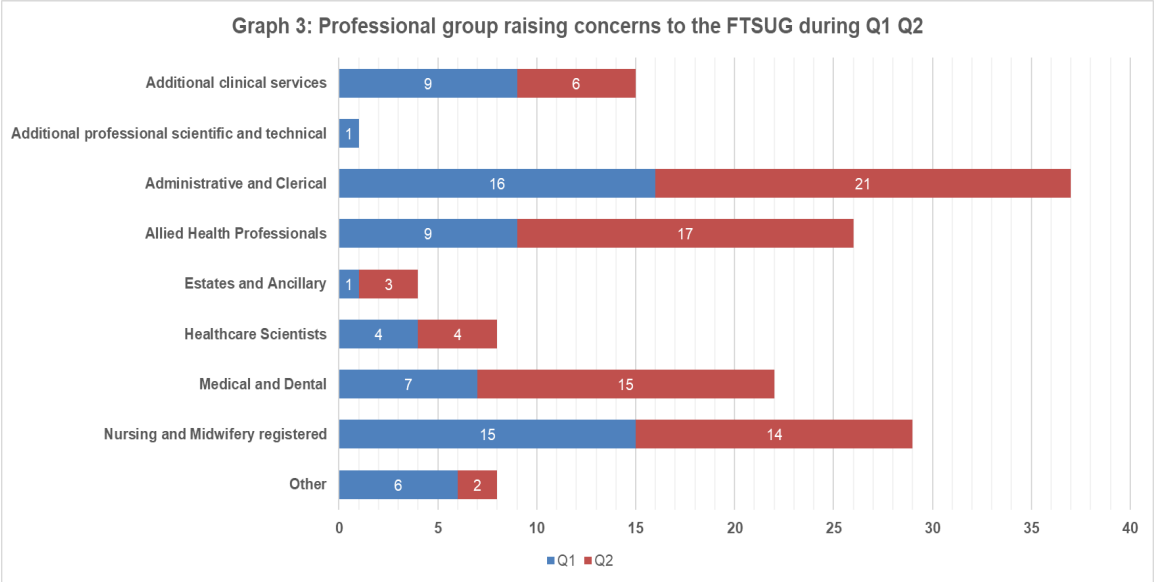
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1, 2 and 3 summarise the Q2 data:





NB. Please note some concerns may have more than one element



4.3 Observation and comments during Q2:

- During Q2 2025/2026, 82 individual concerns were received to the FTSUG (Graph 1) showing a 21% increase from the previous quarter (Q1 2025/2026) (76), and a 52% increase from the same reporting period (Q2) in 2024/2025 (54).
- No concerns continued to be raised anonymously (where the FTSUG did not know the identity of the individual). Nationally, 11.6% of cases raised to FTSUGs were reported anonymously (2024/2025 reporting year).
- 83% (68) of concerns were either within the remit of a line manager to be resolved or directly about the line manager, of which 69% (47) of individuals had already spoken up to their line manager, before approaching the FTSUG.
- During Q2, the FTSUG directly escalated 51% (42) of the concerns via an appropriate route, for example to a senior manager, an increase from 22% (15) during Q1 (2025/2026). Furthermore, 30% (25) of individuals asked the FTSUG to protect their identity throughout the speaking up process, an increase from 10% (7) of cases in Q1 (2025/2026). The FTSUG has observed an increase in staff expressing they did not feel able to raise their concerns themselves which is potentially concerning and will be monitored.
- Individuals were most likely to approach the FTSUG regarding concerns with an element of inappropriate behaviours (19), a slight increase from 14 concerns in Q1 (2025/2026). Inappropriate behaviours continue to be in the top 3 reasons for reporting since Q4 2023/2024. Examples have included staff feeling singled out, rudeness and being inappropriately challenged.
- Concerns with an element of worker safety (18) were the second most common reason discussed with the FTSUG and included physical health and safety and the psychological impact of concerns and situations in departments.

- During Q2 the most common professional groups raising concerns were administrative and clerical workers (21) followed by allied health professionals (17) and medical and dental (15). The number of concerns raised by both allied health professionals and medical and dental staff continues to increase from Q1.
- During Q2, 5 staff members reported being subject to potential negative impact as a result of speaking up. Each case was escalated through to senior management and reviews are ongoing.
- Two examples of key learning from speaking up include firstly, the value of the new REACH programme to support staff who requiring reasonable adjustments for a disability. During Q2 the FTSUG has been able to refer six staff to the REACH programme for support for themselves, and their line management. Secondly, key learning from a case was discussed (with consent) with the Staff Psychology team to assist in the development of a new management guide for supporting staff.

4.4 FTSU Guardian Feedback/Evaluation:

The FTSUG offers a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. The FTSUG is split into two parts – firstly the worker's experience of the HUTH FTSUG, and secondly, their experience of speaking up to the wider Trust. During Q2, 4 responses to the survey were received and the key results are detailed below.

	Very easy	**Fairly easy**	**Not easy**	**Difficult**
How easy was it to make contact with the FTSUG?	100% (4)	0%	0%	0%
	Excellent	**Good**	**Fair**	**Poor**
How was your experience of the FTSUG?	100% (4)	0%	0%	0%
	Yes	**No**	**Not sure**	
Did you feel supported when speaking up to the FTSUG?	100% (4)	0%	0%	
Given your experience, would you speak up again to the FTSUG?*	100% (4)	0%	0%	
Did you feel your concerns were listened to and taken seriously?	100% (4)	0%	0%	
	Highly likely	**Likely**	**Unlikely**	**Highly unlikely**
How likely are you to recommend to a work colleague to contact the FTSUG?	100% (4)	0%	0%	0%

Comments and observations:

- *The National Guardian Office guidance only requires one mandatory question to be included in the survey – '*Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'.* At HUTH, 100% of staff answered yes to this question and this figure will be reported back to the National Guardian Office as part of the quarterly reporting.

Examples of feedback about why the individual would speak up again and what went well with the FTSUG included:

- Feedback themes included that the FTSUG took the individuals serious,

was genuine, kind and listened.
- An example included: "*Fran was reliable and professional, always did what she said she was going to do and kept me updated".*

Examples of feedback to improve speaking up to the FTSUG included:
- One comment was received that included reassuring staff that the process is confidential and of value.

The second part of the surveys asked questions about the staff members' experience of speaking up to the wider Trust (for example to a line manager, senior manager, HR team etc):

	Yes	No	Not sure	I chose not to raise my concern	In part
Did you feel your concern was treated confidentially?	100% (2)	25% (1)	25% (1)	0%	
Did you feel your concerns were listened to and taken seriously?	50% (2)	50% (2)	0%	0%	
Given your experience, would you speak up again?	25% (1)	25% (1)	50% (2)		
Has your concern been addressed?	0%	50% (2)	0%	0%	50% (2)
Have you experienced any detriment, disadvantageous and/or demeaning treatment, or any negative impact, as a direct result of speaking up?	67% (2)	33% (1)			

Comments and observations:
- Staff stated they had gone onto speak up to their line manager, senior manager, manager outside of their own department or the Human Resources department.
- The National Guardian Office mandatory question was also asked in respect of the individual's experience of speaking up to the wider Trust – *'Give your experience, would you speak up again?'.* In comparison, this was lower with 25% (1) confirming they would. Comments received included that individuals will wait to see if their speaking up has made a difference and others would only speak up to the FTSUG in future.
- The responses were mixed whether the individual's concern had been fully addressed and whether the concern had been kept confidential or whether the individual had been listened to.
- An additional question has now been included in the feedback survey to establish if any individuals have received negative treatment or detriment as a result of speaking up. Two individuals stated they had, with one comment stating they were treated differently from other staff and excluded from conversations.

Examples of feedback about why the individual would speak up again and what went well with speaking up to the wider Trust, included:
- *"I have been able to proceed to the next stage in getting my issues resolved. This is still ongoing currently."*

Examples of feedback to improve speaking up to the wider Trust included:

- *"Could possibly improve the perception that staff have nowhere to go when line managers and senior managers are reluctant to listen to concerns".*
- *"In relation to my own experience, I cannot comment, as so far the Trust has not done what it said it was going to do. If it does do what it said it was going to do, that should make a difference to the issues raised".*

Planned action from the survey results:

- Managers specific session on FTSU to be offered during Speak Up awareness week in October.

4.5 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, learning for the Trust, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience. The below case study demonstrates a positive example of where a Trust senior manager has listened, feedback and continued to check in with a staff member:

The HUTH Freedom to Speak Up Guardian was initially contacted by a staff member who had several concerns including a poor culture in their department, lack of communication, low morale and staff feeling demoralised. The staff member discussed their concerns with the FTSUG and how they were fearful and did not feel psychologically safe to speak up.

The FTSUG discussed with the staff member the different options for speaking up, and helped to remove the barrier of fearing being identified by offering to escalate the concerns to a senior manager whilst protecting the individual's identity.

The FTSUG spoke with the senior manager for the Care Group, who offered a confidential conversation, which the staff member felt confident enough to progress. The senior manager listened, took action and at regular intervals contacted the staff member to monitor the situation and progress. The staff member commented that "Their handling of the issue was extremely supportive; they valued everything I discussed with them and they are making a difference".

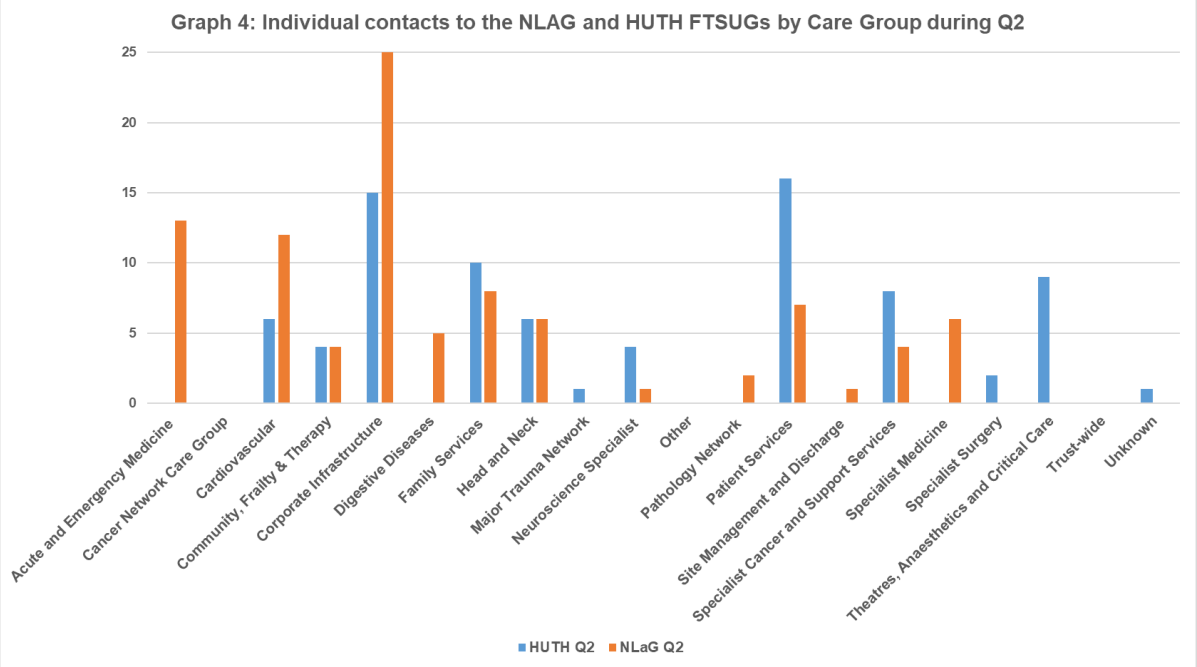
The staff member also fed back about the FTSUG "I can't tell you how much your support has helped. It has relieved an enormous amount of pressure in what was the worst experience in my entire working life".

This situation is a good example where the FTSUG was able to support through protecting the identity of the staff member, who then felt empowered and trusted the process to meet with the senior manager. Crucially, the senior manager listened, provided timely feedback and has continued to check in with the staff member since.

4.6 Care Groups – concerns combined

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised during Q2 to the sovereign HUTH and NLAG FTSUGs combined. At HUTH, the highest number of concerns were received about Patient Services followed by the Corporate Infrastructure and Family Services.

Graph 4 is sent to the Care Group Triumvirates and HR Business Partners quarterly to enable triangulation alongside other workforce metrics.



5. FTSUG activities and proactive work during Q2

5.1 A high level summary of the FTSUG activities are detailed below:

- Ongoing monthly face to face drop-in sessions at Hull Royal Infirmary and Castle Hill Hospital; and virtual drop ins on MS Teams. All monthly dates are planned and advertised for the remainder of 2025 to promote visibility and accessibility to the FTSUG. The Speak Up Champions have been assisting with promoting the drop ins within their teams.
- Continued departmental walkarounds jointly with the Organisational Development team or with a Patient Safety Matron; to promote speaking up and staff support available to the teams.
- A further 2 Speak Up Champions were trained. The HUTH Speak Up Champion Network now has total of 48.
- Attended the JLNC meeting to present the FTSU 2024/2025 annual report and key themes for learning.
- Guest panellist at the Building Allyship conference.
- Invited to present at team meetings – Cancer Network Nurses forum and the Pharmacy huddle.
- Presented to the new nursing apprentices and to all year 1 nursing students at Hull University to promote raising concerns to nurses early in their training.

- Supported the new F1, F2 and International Medical Graduates inductions with a market stall to promote speaking up.
- Obtained approval of the NHSE Board Self-reflection and associated improvement and strengths plan at the Group Boards-in-Common.
- Continued work on combining the national Freedom to Speak Up Policy in the NHS into a Group format.
- Introductory meeting with the new Acting Group Chief Executive.

5.2 Future plans:

- Partnership work with the NLAG FTSUG and Communications Officer to plan the national Speak Up Week awareness campaign.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and Northeast regional meetings to discuss best practice and contribute to active discussions. During October 2025 the region held a virtual leadership conference that included the opportunity to hear the outputs of research on the real-life experience of FTSUGs in roles.

6.2 National update

6.2.1. National Guardian Office changes

During Q2 the 'Review of patient safety across the health and care landscape' (known as the Dash review) and the NHS 10-year plan were published. The reviews confirmed that the National Guardian Office, the body overseeing FTSUGs will be closed, with their responsibilities transferring into NHS England after March 2026. FTSUGs will remain in post and are recognised as having integrated into the wider NHS system.

6.2.2. National review of bank and agency workers

The National Guardian Office have launched a national review into the speaking up experiences of bank and agency nurses and midwives. FTSUGs have been asked to promote the review and encourage staff who work as bank and agency registered nurses, nursing associates and midwives to participate in either a survey, focus groups or individual interviews. The HUTH FTSUG has worked with the Bank Workforce managers and the Communications team to promote the review to the teams.

6.2.3. National report 2024/2025

The National Guardian Office have released the annual 2024/2025 report Culture is a patient safety issue - a summary of speaking up to Freedom to Speak Up Guardians. The report aims to provide insights into the speaking up landscape and culture across organisations, highlighting key trends, challenges, and areas for improvement. Key information included:

- 2024/2025 saw the highest number of cases reporting to FTSUGs since the introduction of the role with 38,158 cases, an increase of 18.6% since 2023/2024 (in comparison in the same reporting period HUTH increased by 35%).
- Inappropriate behaviours and attitudes were the most commonly reported issue to all FTSUGs (39.7%). This was the same for concerns reported to the HUTH FTSUG (25%).
- Concerns related to worker safety and wellbeing significantly increased by 36.2% to 38.9%. The HUTH FTSUG also had an increase in cases with this element, but not as significant from 5.5% of cases to 14%.
- Nationally, the number of anonymous cases (where the FTSUG did not know the identity of the individual) increased to 11.6%. During the same reporting period, HUTH had 1.5% anonymous cases.
- Nurses and Midwives were the most likely professional group to speak up to FTSUGs (28.3%), followed by administrative and clerical workers (21%). Again, this mirrors the professional groups approaching the HUTH FTSUG (24% and 22.1% respectively).
- The annual report also summaries that whilst workers continue to express positive views about the FTSUG role, confidence in organisations to address concerns is in decline.

Furthermore the report includes a number of recommendations for senior leaders and line managers, that can be read on the National Guardian Office website: Culture is a patient safety issue - a summary of speaking up to Freedom to Speak Up Guardians

7. Conclusion

7.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up. Individuals at HUTH continue to contact the FTSUG for support in speaking up.

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The FTSUG role has been recognised as integrated into NHS Providers and will continue to operate despite changes to the national structure.

7.4 The HUTH and NLAG FTSUGs continue to work closely together to develop consistent reporting processes and recognition at national level as good practice.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's FTSUG arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the FTSUG role and speaking up arrangements in the Trust.

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)227

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 December 2025**
Director Lead	**Heather McNair, (Interim) Group Chief Nurse**
Contact Officer / Author	Linsay Cunningham, Group Director of Strategy and Partnerships
Title of Report	**Population**
Executive Summary	Key messages: • There are significant health inequalities in the population our hospitals serve. Poor underlying health of the population drives increased demand for healthcare services and often lead to poorer outcomes for those from more deprived communities for a variety of complex reasons. • Our Group Strategy sets out our commitment to doing more to tackle inequity and improve population health. • Following initial board discussion, an approach has been agreed to develop an action plan over the coming 9 to 12 months.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	None at this time
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	This work will support the Group to deliver our core strategic ambition – our Population live more years in good health.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Population

Key messages

There are significant health inequalities in the population our hospitals serve. Poor underlying health of the population drives increased demand for healthcare services and often lead to poorer outcomes for those from more deprived communities for a variety of complex reasons. Our Group Strategy sets out our commitment to doing more to tackle inequity and improve population health.

Following initial board discussion, an approach has been agreed to develop an action plan over the coming 9 to 12 months. In parallel, it was agreed that one or two discrete areas for action will be identified for immediate action to build confidence and demonstrate impact.

Health Inequity Action Plan Overview

Initial scoping work has been undertaken and an outline approach agreed to develop a Health Inequality Action Plan, involving a range of internal and external stakeholders. This will focus on three core strands of work, addressing different aspects of the population health agenda:

- Tackling inequity in care delivery
- Taking action on prevention
- Addressing wider determinants of health

Key developments

Work is now underway to address one of the discrete areas for improvement identified in the initial scoping work shared in November – missed appointments in Hull maternity services amongst service-users from the most deprived communities. Community midwifery teams, working with our local Maternity Voices Partnership and other key stakeholders are undertaking the work to understand the root causes of the issue identified and seek to co-design solutions with service-users. An update on the project will be provided in six months.

The Collaborative of Acute Providers (CAP) has established a Health Inequalities Community of Practice. Through the CoP, providers have committed to undertaking a self-assessment utilising the NHS Trust Health Inequalities Self-Assessment tool developed by NHS Providers. This will be undertaken over the coming weeks and used to identify priority areas for action for the Group. Where there are opportunities to share skills, learning and expertise across the CAP, these will be explored.

Key risks

The current organisational change process underway within the Integrated Care Board (ICB) may impact on the capacity of the ICB – either in the short or longer term – to support the Group in developing and implementing its Health Inequity Action Plan. It is unclear at this stage to what extent the current capabilities and functions within the ICB's population health team will be retained and what their work programme will look like from next year.

Additionally, the lack of dedicated resource internally to develop this work is continuing to impact on the speed at which plans can be developed and actions put into place.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)228

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Emma Sayner, Group Chief Financial Officer
Title of Report	**Public Purse (including Assurance Committee update)**
Executive Summary	The financial position for the Humber Health Partnership Group at Month 7 is included in detail for information at agenda 6.2.2 and has been discussed extensively through the most recent PEF on 2 December 2025. The group continues to be challenged in terms of the requirement to live within our means and are facing ongoing financial risk and expenditure that the measures implemented to date are not effectively and positively impacting on the run rate. These have included discretionary pay and non pay controls, vacancy panel arrangements as well as intensive support for financial recovery with the care groups. This is not a position that is unique to Humber Health Partnership the whole ICS across Humber and North Yorkshire is challenged and as a direct result of this, it has been confirmed that 1) the system will not receive the Q4 deficit support fund upfront which equates to c£7m for HHP (should financial performance recover this will subsequently flow) and 2) with effect from the beginning of December the organisations across HNY will be subject to double and (subsequently) triple lock arrangements with the ICB and Regional oversight. The loss of deficit support fund affects both revenue and cash and modelling is being done to understand what cash support may be required in the last quarter of the financial year. Further measures to recover the financial pressure have been discussed and agreed on 28 November and are being implemented with immediate effect. These include: **Vacancy Freeze**: Agreed that we need to move to a full vacancy freeze for Corporate and Administrative posts including Patient Administration, Estates and Facilities and Care Group admin teams. We will retain the Vacancy Control Panel as the route for teams to escalate any associated risk. Exceptions will be considered where the posts are considered to be essential for: the delivering of backlog recovery, income generation or to address critical safety concerns. Any requests will need to demonstrate that all other opportunities have already been considered (e.g. redeployment of existing staff, skill mix etc).

	Agency Controls: Whilst we do already review pre-booked agency requests, we agreed these controls needed to be strengthened further to ensure that all agency requests (including short notice requests) have the approval of the relevant Executive Lead (Group Chief Nurse, Group Chief Medical Officer or Chief Delivery Officer and the Group Chief Financial Officer. **Overtime / Bank Controls**: Agreed that all standard rate overtime requests and non-premium Bank should be approved by the relevant Care Group Tri. To be reviewed in 3 months to confirm effectiveness. Top 10 overtime payments for each Care Group to be reviewed every month. **Agency Plan**: need to strengthen existing plans to reduce Agency costs. This is currently being reviewed on a fortnightly basis through existing workforce efficiency meeting. **Rota controls:** rota's need to be scrutinised weekly by Care Group lead nurses on a prospective basis to ensure extra-contractual pay is minimised. Review effectiveness of the **no PO / no Pay policy**. Review and propose updated **Scheme of delegation** – consider whether Care Group Tri limits should be increased with emphasis on their accountability, but at the same time reducing the approval limits at Departmental level. Ensure **SOPs / policies** relating to the use of all extra-contractual pay are updated to reflect the above agreed actions. In terms of capital, the team have worked really hard on a multi-disciplinary basis and with system partners on a plan to manage the EPR allocation across 25/26 into 26/27. Expenditure is quite heavily backloaded to the end of the financial year and the estates and digital team are working hard to ensure we deliver the plan, there is risk linked to delivering the ground floor reconfiguration at HRI for which constitutional standards allocation has been received.
Background Information and/or Supporting Document(s) (if applicable)	BAF extract PEF Highlight Reports Month 5 Financial Position included for information at 6.2.2
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Financial considerations are an integral element of the update provided so no further updates in this section.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	It is important as we are considering changes and plans for the use of resources these considerations are taken into account through a robust EQIA process.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

CiC ESCALATION REPORT

Humber Health Partnership

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 4 November 2025

1. Matters for Reporting

The **Group finance** report at month 6 highlighted a deterioration of £0.3m to a YTD deficit of c£16m. Risks included delivery of the constitutional standards, unidentified CIP for the last part of the year, high cost drug expenditure increases and claw back of IPT referral income from the ICS. There is a risk to the deficit support funding in Q3 and Q4 from a revenue and cash perspective. Enhanced controls on spending are not yet delivering financial recovery trajectories and reductions in run rate.

Transformation progress highlighted a number of risks including workforce and Care Groups being behind plan and 100 projects with a £5m adjusted risk impact. This has resulted in the overall programme being £10m behind plan. Care Group support and challenge is now in place and monitored at the Senior Leadership Team meeting. All Care Groups have recovery plans in place. A review of Waiting List Initiatives was taking place and new criteria had been developed for additional contractual payments.

The CIC gave limited assurance due to deteriorating run rate and an overall gap to plan.

On **Performance**, the Group Performance report remained relatively unchanged and the planning for 2026/27 had commenced. Outpatient follow-ups were reducing and the Group had seen a 10% reduction overall. Bed-modelling, prioritising and level loading elective patients against non-elective patients was being progressed.

The CIC gave limited assurance as the Group was still on an improvement pathway with detailed plans in place. The CIC highlighted the need for more radical plans to address the long standing issues.

Estates Update – Work was ongoing regarding the Tower Block fire risk with Humber Fire and Rescue Service and comprehensive plans were being implemented in line with timescales.

The CIC gave significant assurance for the grip and control being displayed in this area.

2. Positive assurances

CQC Actions – actions for HUTH are now closed and NLAG actions are rated green.

Procurement Improvement Plan – Expired contracts had reduced from 208 last October 2024 to 88 in 2025.

3. Matters on which the committees have requested additional assurance

The CIC asked for further assurance relating to cancelled operations and Outpatient DNA numbers and the strategies being adopted to address.

4. Decisions made

Sterilisation Services (Decontamination) - The CIC approved the intent to explore option 5 and approved the direction of travel.

Contract approval, Cleaning Services – The CIC endorsed the decision to extend the OCS contract for a further 12 months and to go out to the market for the tender process.

Terms of Reference – The CIC approved the Terms of Reference with minor changes.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions Report	-	-	Assurance	
2	Group Finance Report – Month 6	6	16	Assurance	Limited
3	Update and transformation Programmes	2	20	Assurance	Limited
4	Group Performance Report	2	20	Assurance	Limited
5	Deep Dive: Elective Care	2	20	Assurance	Limited
6	Estates and Facilities and Development Update	6	16	Assurance	Significant
7	Sterilisation Services (Decontamination)	6	16	Approval	Approved
8	Procurement Improvement Plan and Expired Contracts	6	16	Assurance	Significant
9	Contract approval: Cleaning harmonisation (HUTH)	6	16	Approval	Approved

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 2 December 2025

Humber Health Partnership

1. Matters for Reporting

The CIC received a Theatres Utilisation deep dive and partial assurance was the rating of the KPMG audit. The CIC gave reasonable assurance due to the detailed action plan in place and actions remaining on track so far.

The **Group finance** report - at month 7 the Group is £4.8m away from plan, but that included £15.7m of non-recurrent Balance Sheet support. The CIC noted the worsening Financial position and the lack of improvements to the run rate and underlying position. CIP at M7 is £53m which is £12.1m behind plan and the year end forecast is £108m against a target of £130m. Actions were in place to limit bank and agency use, to maximise planned care activity and intensive support on the delivery of the Care Group Recovery action plans was in place. Converting non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target was being worked through. The CiC will determine what more can be done to hold Care Groups to account to deliver their financial plans. Limited assurance was given.

On **Performance**, the Operational Planning timetable and process was presented.

The Group Performance report provided limited assurance due to poor performance across most areas, in particular UEC, RTT and Diagnostics. There were however, improvements with Cancer waiting list reductions and the Faster Diagnosis Standard. Eliminating elective 65 week waits by 21-12-25 would not be achieved until mid-late January as increased urgent referrals and non-elective demand were absorbing diagnostic and outpatient capacity, leaving less for routine waiting list reduction. This revision had been agreed at Tier 1 support meetings.

Estates Update – The EPRR Team and Fire Safety Team had carried out a staged practical evacuation of the Tower Block, using various methods. The timings identified as part of the exercise will be included in the updated evacuation plan and risk assessment. The CIC are to receive the Humberside Fire and Rescue Service (HFRS) report from their recent site visit when it is available. The CIC gave significant assurance due to the grip and control being displayed across the Estates area in general but recognised the ongoing work with HFRS to quantify and reduce the risks identified until all the remedial works can be completed on the Tower Block.

2. Positive assurances

Additional grip and control had reduced the number of patients waiting more than 65 weeks.

3. Matters on which the committees have requested additional assurance

A report detailing additional actions the Group will take to close the financial gap against plan was requested by the CiC for Board consideration.

The CiC would dedicate time to agree ways to further improve effectiveness and improve financial and performance outcomes.

More detail regarding risk actions and how they are impacting on the BAF risk scores.

4. Decisions made

Cleaning harmonisation contract – The CIC endorsed the decision to extend the contract for a year, whilst a comprehensive market analysis of other potential suppliers took place. The CIC requested an action plan with milestones and accountability to ensure that the tender process was completed within the extension period. It was confirmed that a PMO was in place.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	-	-	Assurance	N/a
2	KPMG Audit: Theatres Utilisation	2	20	Assurance	Reasonable
3	Group Finance Report Month 7	6	16	Assurance	Limited
4	Transformation Programme update	6	16	Assurance	Limited
5	Operational Planning Update	2	20	Information	N/a
6	Group Performance Report	6	16	Assurance	Limited
7	Deep Dive – Outpatient Transformation	6	16	Information	N/a
8	Estates Facilities and Development Update	6	16	Assurance	Significant
9	Contract approval: Cleaning harmonisation (HUTH)	6	16	Endorse	Endorsed

5. Escalation to Trust Boards

Continued deterioration in financial performance and the need for a detailed plan to close the gap between planned and actual results to be agreed by the whole Board.

6. Comments on the effectiveness of the meeting

The annual Committee effectiveness review results were discussed. Whilst the results were positive, the CiC agreed to dedicate time to reviewing ideas for ways in which outcomes could be further improved.

7. Escalation to CiCs

N/a

Humber Health Partnership

8. Attendance record

Members / Attendees		A	M	J	J	A	S	S	N	D	J	F	M
Gill Ponder	NED (Chair)	✓	✓	✓	x	✓	✓	✓	✓	✓			
Helen Wright	NED (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓			
David Sharif	Group Director of Assurance	✓	✓	RT	✓	✓	✓	✓	✓	✓			
Emma Sayner	Group Chief Finance Officer	✓	✓	✓	✓	✓	PR	✓	✓	✓			
Sarah Tedford	Group Chief Delivery Officer	✓	✓	AS	✓	✓	✓	✓	MP				
Philippa Russell	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Andy Haywood	Chief of Strategy, Partnerships and Digital	-	-	-	✓	x	x	x	x	x			
Tom Myers	Group Chief of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Simon Parkes	Non Executive Director	✓	✓	✓	✓	✓	x	✓	x	✓			
Jane Hawkard	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓			
Kate Wood	Group Chief Medical Officer	✓	✓	✓	✓	✓	✓	PS	✓	✓			

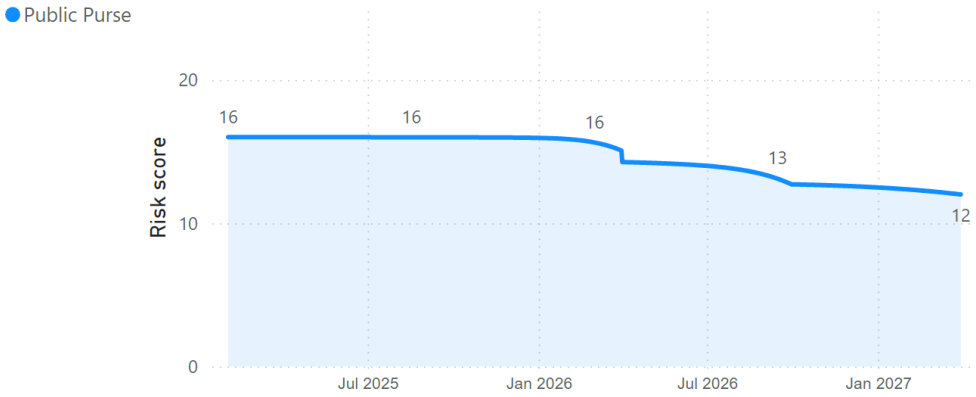
6. Public Purse

The strategic risk affecting our objective, 'Public purse' is led by Emma Sayner, Group Chief Financial Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Public Purse, the risk's current score is 16 and its score last changed on 04/02/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

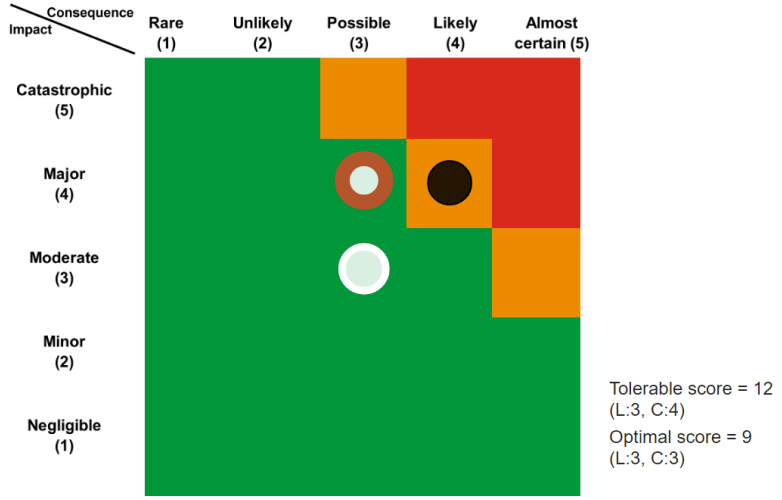
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

6. Public Purse

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Board capability and education	Reasonable
Budgetary control system	Reasonable
Business cases for investment / disinvestment decisions	Limited
Care Group Performance and Accountability	Limited
Cash management controls	Significant
Cost Improvement Programme	Reasonable
Financial management education for directors and budget holders	Reasonable
Financial Planning Improvement Board	Limited
Financial Strategy	Limited
High functioning Finance department advice and guidance	Reasonable
ICS finance model	Reasonable
Long term Financial Model	Limited

Gaps in control (and Action ID)	22	23	33	35	36	46	49	Total
Absence of comprehensive Estates Strategy / 10-year plan	1							1
Absence of Group Clinical Strategy	1							1
Absence of Group Finance Strategy founded on clinical and estates strategies		1	1					2
Interim officers in place	1							1
Lack of understanding of current financial pressure and need to live within means				1	1			2
Out of date Long Term Financial Model inc investments	1							1
Sustainable PMO / CIP Engine room capability to deliver transformation and financial savings	1							1
Weak culture of improvement/change management and siloed working				1	1	1	1	4
Total	**4**	**1**	**1**	**1**	**2**	**2**	**1**	**1**	**13**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	
Internal	Budget control reports	
Internal	Exception reporting on Standing Financial Instructions and Standing Orders compliance	
Internal	FPIB and PMO reporting on transformation and run-rate	
External	Internal audit review of key financial systems	
Internal	In-year operational plan progress	
External	NHSE external assurance reviews	
Internal	Service Line Reporting	
Internal	Vacancy control and Discretionary Spend Panel	
Internal	Workforce planning updates	

Assurance gaps (and Action ID)		Total
SLR not fully developed and embedded	1	1
Total	**1**	**1**

6. Public Purse

NHS Humber Health Partnership

The table below details the 9 actions underway to reduce the current risk score of 16. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
22	Develop a five-year long term financial model	31/10/25	31/03/27	Linked to Finance strategy development. Progress with meeting national model by Sep-25	06/08/25	Emma Sayner, Group Chief Financial Officer	Limited
23	Develop a comprehensive finance strategy	31/10/25	31/03/26	Draft financial strategy to PEF in Jul-25 and final planned for Sep-25	06/08/25	Emma Sayner, Group Chief Financial Officer	Reasonable
33	Business Case Review Group	31/01/25	30/09/26	Started w/c 20/1/25, now fully operational	23/06/25	Emma Sayner, Group Chief Financial Officer	Significant
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation	31/03/26	31/03/26		23/06/25	Matt Powls, Interim Group Chief Delivery Officer	Limited
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need value	31/03/26	30/09/26		23/06/25	Emma Sayner, Group Chief Financial Officer	Reasonable
46	Embedding a transformation plan / product with an external learning focus	31/03/26	01/04/26	to refresh each year	23/04/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	
49	Establish Group PMO approach with specialised transformation programme and resources	30/06/25	31/03/26		22/04/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	
62	Workforce pay and agency control programme	31/03/26	31/03/26	Lack of transformation impact on staffing and difficulties in medical recruitment, in certain specialties, and safer staffing requirements preventing further efficiencies.	23/09/25	Simon Nearney, Group Chief People Officer	Limited
63	Corporate services efficiency programme	31/03/26	31/03/26	Progress becoming more complex and lengthy. People Services reducing to staff (thereby giving leaders less capacity to transform)	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)229

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 December 2025**
Director Lead	**Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer**
Contact Officer / Author	Linsay Cunningham, Group Director of Strategy and Partnerships
Title of Report	**Partnerships (including Assurance Committee Update)**
Executive Summary	Key messages: • ICB consultation launched in November. Represents significant organisational change for one of our key partners – will put in place new working practices and new structure and remove a number of critical engagement roles and mechanisms, particularly at Place. • The pace and scale of change present a potential risk to delivery of our Partnerships Strategy. This risk is being mitigated through ongoing management of key relationships at system and at Place. • Development of Neighbourhood Health and healthcare delivery at place continues at pace – shift to provider leadership in a number of areas (particularly primary care). Update on BAF and mitigating actions: • Partnerships Strategy – included on the Board agenda for approval. Additional actions underway: • Stakeholder mapping review continues • Review of representation and internal feedback mechanisms • Review of group policy for clinical service change – to support delivery of Transformation plan for 2026/27 and beyond
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	None at this time
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None at this time
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Partnerships

Key messages

Uncertainty and change within our local health and care landscape presents a potential risk to delivery of our partnership strategy. Ongoing engagement through a range of forums will be critical to managing this risk over the coming months.

Good partnership working across the system is needed to underpin our group improvement journey and will be a core enabler to delivery of our transformation plan for 20206/27 and beyond.

Key developments – ICB Organisational Change

In line with national changes and implementation of the new operating model set out in the 10 Year Health Plan, our Integrated Care Board is undertaking organisational change to align to its new role and core function as a strategic commissioner.

Integrated Care Boards (ICBs) are required to reduce their operating costs to £18.76 per head of population. This reduction is part of a broader effort by NHS England to ensure that ICBs can operate efficiently and reduce duplication across the health and care system.

Humber and North Yorkshire ICB have launched their organisational change programme and this will continue through December and January, with an aim to implement by the end of the financial year.

This programme represents significant organisational change for our commissioners and key system partners. The changes – that are currently out to consultation and therefore subject to change – disestablish many of the convenor/facilitator and stakeholder engagement roles, particularly those embedded within each Place. Some of these functions may transition to providers or other partners within the health and care system, however, this is for local determination through existing collaborative arrangements and forums.

The pace and scale of change present a potential risk to delivery of our Partnerships Strategy. This risk is being mitigated through ongoing management of key relationships at system and at Place.

Key developments – Neighbourhood Health

Neighbourhood Health is a core component of the government's plan for the future of the NHS and is developing at pace across the country and in our geography. These changes are taking place in a complex ecosystem and the approaches being taken differ in each of the four places (and between different neighbourhoods within places).

This poses a key challenge for an organisation of our scale to ensure we have sufficient engagement to shape the models of delivery in each neighbourhood. As currently configured, there are 18 identified neighbourhoods across the Humber geography (8 in East Riding, 4 in Hull, 5 in North Lincolnshire and 1 for North East Lincolnshire). These are likely to shift over time as areas develop their approaches, reflecting national policy, which emphasises the role natural communities and aligning services to where people live.

Over the coming months, we will need to develop an approach for how our organisation and services interact with emerging models of neighbourhood delivery. Engagement of HHP clinicians in the development of new neighbourhood-based pathways and models of care will be critical to their success. This will be facilitated through the existing Outpatient Transformation programme so as to avoid duplication of effort and maximise clinical buy-in.

Update on BAF risks and actions

Risk description

We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

Key actions

A number of key actions are underway to mitigate this risk and ensure delivery of our partnership ambitions:

32. Develop and publish partnerships strategy

- The Strategy has been refined through ongoing engagement with key stakeholders and is presented now to Board for approval.

59. Align partnership reporting to governance arrangements

- Changes to Committees in Common – Strategic Partnerships and Programmes Committee in Common is now established with revised Terms of Reference to ensure greater visibility of partnerships working going forward. Updates on Neighbourhood Health implementation and partnership arrangements to be included in the forward plan for the CiC.

Update on other key work and actions underway:

- Clinical service change policy is being developed by a cross-organisational team (based on existing NLaG policy). This will include additional clinical engagement to ensure the policy is well understood and will support the organisation to meet its statutory duties in relation to service change in the changing policy landscape. This will ensure a consistent approach is followed across the Group, in particular, in our engagement with stakeholders and partners in local government.

- Review of representation on place and partnership forums continues, supported by work to strengthen internal feedback mechanisms, ensuring consistency of voice and impact of involvement is maximised.

- Internal governance for Neighbourhood Health implementation has been agreed – working through the Outpatient Transformation Board. This will ensure alignment and effective clinical involvement in shaping our input into neighbourhood delivery models.

CiC ESCALATION REPORT

Strategic Programmes and Partnerships (SPP) Committees-in-Common – 22 October 2025

Humber Health Partnership

1. Matters for Reporting

The Digital update highlighted the requirement for Board support to approve the Full Business Case for EPR within desired timescales. The case would be brought to the CiC before Board.

Specific project assurance was given for EPR, bed management system and patient led booking.

2. Positive assurances

The HASR programme was at the implementation stage. Regular performance updates would be presented to the CIC.

The CDCs (except ERCH) were now at the implementation stage. Regular performance updates would be presented to the CIC.

DrDoctor is now live in HUTH, which is an App that allows patients to manage their own appointments. The Group had seen a number of improvements, including a 20% drop in DNAs. 327,000 appointments had been managed via the App so far. Overall, the CiC had significant assurance on the implementation of the Digital strategy and programmes.

3. Matters on which the committees have requested additional assurance

Partnership Strategy – The CIC approved the first draft, however requested that the strategy be split into annual plans which would include programme leads and expected delivery timescales to enable the CiC to gain assurance on implementation of the strategy on behalf of the Board.

The CIC requested further information regarding the Luna Rover programme, why it had been delayed and what could be done to remove the barriers to recovering slippage.

There was a request to update the workplan to include all major transformation programmes.

A schedule of schemes requiring post project evaluation would be provided at the next meeting. This will include the CDCs, as there will be lessons learned around delays and whether the intended service change and benefits have been realised.

4. Decisions made

The CIC approved the Terms of Reference for the SPP CIC.

5. Escalation to Trust Boards

The Boards-in-Common are asked to note the closure of the Capital and Major Projects Committees-in-Common and receive the inaugural meeting report of the Strategic Programmes and Partnerships Committees-in-Common.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	-	-	Assurance	N/a
2	Risk Register Report Q1	-	-	Not received	N/a
3	Review and Evaluation of Business Cases	8	16	Not yet due	N/a
4	CDC Expansion – Albion Street	5	12	Information	N/A
5	Post Capital Project Evaluation	8	16	Information	N/a
6	Post Strategic Programme Completion Benefit Realisation Review	8	16	Not yet due	
7	Major Service Change/Transformation quarterly update	4	12	Information	N/a
8	Ground Floor HRI Programme	2	20	Not received	N/a
9	Draft Partnerships Strategy	5	12	Information	N/a
10	National Neighbourhood Health Implementation Programme	5	12	Information	N/a
11	Digital Plan Delivery – Quarterly Updates	4	12	Assurance	Significant
12	EPR	4	12	Assurance	Significant
13	Patient Led Booking (DrDoctor)	4	12	Assurance	Significant
14	Bed Management System	2	20	Assurance	Significant

6. Comments on the effectiveness of the meeting

The new Strategic Programmes and Partnerships CIC is evolving and will be developing its workplan, especially around partnerships and the benefits realisation schedule.

7. Escalation to CiCs

David Sharif to escalate the impact of the changes to the apprenticeship levy and the impact on attracting young people from disadvantaged backgrounds into training etc. and the challenge of sustaining finance for advanced practice roles. The CIC queried whether these changes require any amendments to the People Strategy.

8. Attendance record

Members / Attendees		A	M	J	J	A	S	O	N	D	J	F	M
Gill Ponder	Non-Executive Director (Chair)	Y		Y				Y					
Helen Wright	Non-Executive Director (Chair)	Y		Y				Y					
David Sharif	Group Director of Assurance	Y		Y				Y					
Emma Sayner	Group Chief Finance Officer	Y		Y				Y					
Sarah Tedford	Group Chief Delivery Officer	Y		Y				N					
Ivan McConnell	Group Chief of Strategy and Partnerships	Y		Y				Y					
Andy Haywood	Group Chief Digital Officer	Y		Y				Y					
Tom Myers	Group Chief of Estates and Facilities	Y		Y				N					
Simon Parkes	Non-Executive Director	Y		Y				Y					
Jane Hawkard	Non-Executive Director	Y		Y				N					

Gill Ponder, Chair of the Strategic Programmes and Partnerships Committees-in-Common
Helen Wright, Chair of the Strategic Programmes and Partnerships Committees-in-Common

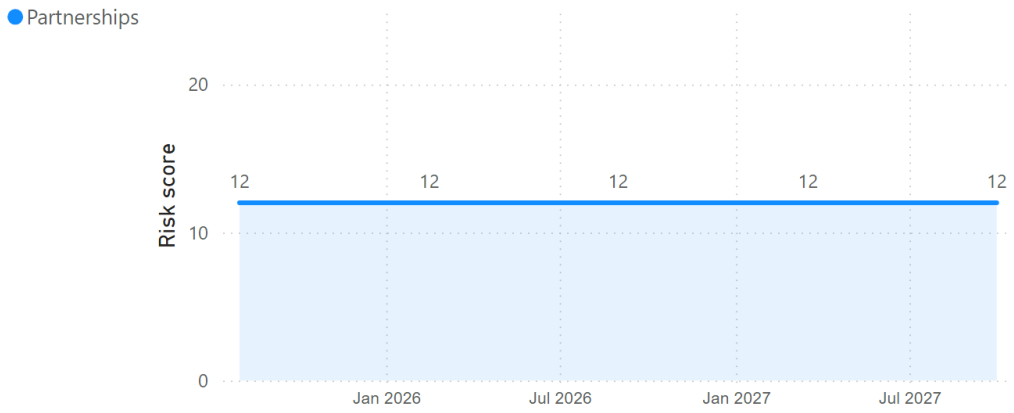
5. Partnerships

The strategic risk affecting our objective, 'Partners' is led by Lyn Simpson, Interim Group Chief Executive Officer; Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer and reported to the Strategic Programmes and Partnerships Committees-in-Common. Under the risk category of Partnerships, the risk's current score is 12 and its score last changed on 28/04/2025. The actions were last reviewed on 09 October 2025. In full, the risk is:

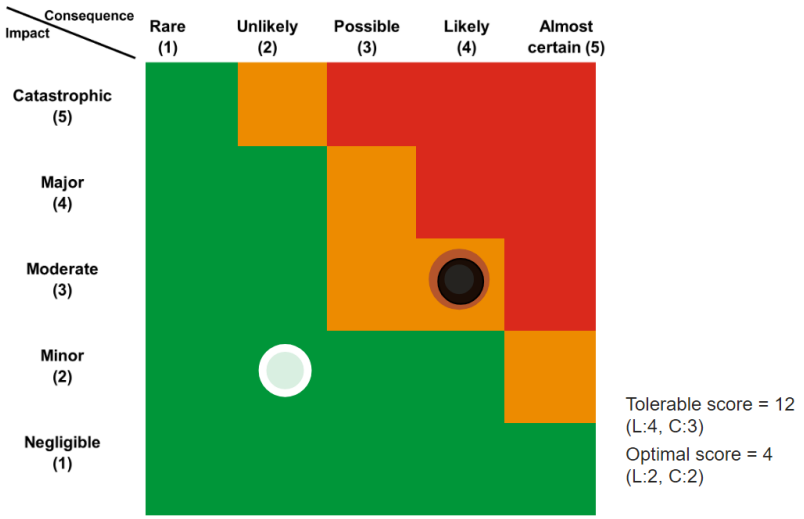
We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Balanced)

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

5. Partnerships

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Goole service review	Reasonable
Health and Overview Scrutiny Committees	Reasonable
Humber and North Yorkshire Collaboration of Acute Providers	Limited
Integrated Care Board	Limited
Place Boards	Limited

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	1	1
Lack of continuous leadership plus inconsistent engagement across region	1	1
Lack of ICB partnership strategy and identification of common opportunities and priorities	1	1
Lack of integrated CAP strategy despite workplan (limited progress)	1	1
Low system wide infrastructure to implement Goole plan	1	1
Variable quality of engagement with Place Boards	1	1
Total	**4**	**2**	**6**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
External	Establishment of operational CDC (vs strategic build) and financial delivery through PFIB	Reasonable
External	Positive Task and finish participation from Place Boards	Reasonable

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	1	1
Weak partnership approach embedded in Group strategies	1	1
Total	**2**	**2**

5. Partnerships

NHS Humber Health Partnership

The table below details the 2 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
32	Develop and publish partnership strategy	31/07/25	30/09/27	On course for completion, undergoing futher review to ensure alignment with the Ten Year Plan	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Significant
59	Align partership reporting to governance arrangements internally	30/09/25	31/03/26	Changes to Committees in Common, Capital and Major Projects to become Strategic Partnerships and Programmes - will ensure greater visibility of partnerships working going forward	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, David Sharif, Group Director of Assurance	Reasonable

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)231

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	11 December 2025
Director Lead	Simon Parkes, Non-Executive Director / NLaG Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Simon Parkes
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – November 2025 - Public**
Executive Summary	The attached highlight / escalation report summarise the key matters presented to and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting on 12 November 2025. The Trust Boards-in-Common are asked to: • Note the public highlight report from the November 2025 ARC CiC meeting and consider as necessary.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 12 November 2025
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Assurance ✓ Other – please detail below: For noting and consideration as necessary

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

Report for meeting of the Trust Boards to be held on:	11 December 2025 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	12 November 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 12 November 2025 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- NLAG & HUTH External Audit Routine Updates
- NLAG and HUTH External Auditor Annual Performance / Additional Fees
- Group Internal Audit Progress Report 2025/26 & Status of Management Actions
- Group LCFS Update
- Group Annual LCFS Report 2024/25
- Group EPRR Regulatory Report
- Group Procurement Update inc. Waving of Standing Orders
- Group Board Assurance Framework
- Group Risk Register
- Annual Review of Adequacy & Effectiveness of System for Management & Monitoring of Risk
- Annual Review of Risk Management Strategy
- Review of Group Losses and Compensations
- Review of Group Standards of Business Conduct Declarations
- Group Document Control Report
- Highlight Reports and Actions Logs from other Trust Board Sub-Committees-in-Common
- Group Data Protection and IG Report (Private Item)

*[*Items marked with an asterisk are on the boards' agenda as a standalone item in accordance with the board reporting framework – as applicable]*

3.0 Matters for reporting / escalation to the Trust Boards

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

a) **Group EPRR Regulatory Report** – The ARG CiC received the report and noted substantial progress made in terms of compliance with the NHS England (NHSE) Core Standards for Emergency Preparedness, Resilience and Response (EPRR) since the last annual report, particularly for HUTH. Compliance rates increased at NLAG from 90% to 94% and from 69% to 90% at HUTH, achieving these levels one year ahead of target. The focus will be on sustaining / improving these levels going forward. The Committees raised concerns around the risk of denial of access to systems, citing the critical incident being declared at another NHS Trust as a result of introducing their new Electronic Patient Record (EPR) system, and agreed that it needed continuing focus to ensure vigilance to the risks posed. Matt Overton, Group Operations Director (EPRR) shared details of work being done around this by the Group Digital team, and also in conjunction with the ICB and NHSE. The ARG CiC were assured on the responsiveness of the EPR processes, and also in relation to the work done on the HRI tower block to test evacuation and other processes for the building. The ARG CiC **endorsed the report** and recommended approval by the Boards-in-Common at its December 2025 meeting (which will be a specific agenda at the December Boards-in-Common meeting).

b) **Group Board Assurance (BAF) Framework** – Following discussion, the ARG CiC concluded that although the BAF was in a much better state they were not seeing the progress expected. It was suggested this may be due to not getting the level of necessary buy in and as a result the BAF was not driving things in the way that was needed. Therefore, the level of assurance around the effectiveness of the BAF process was agreed to be still **limited assurance**, and that the purpose of the BAF needed to be strengthened.

c) **Group Risk Register / Adequacy & Effectiveness of System for Management and Monitoring of Risks** – The Committees discussed their concerns with the Group Risk Register in detail, including high risks overdue for review, scoring of risks, missing or out of date narrative (e.g. comments from 2021), mitigated actions and mitigated risk scores and overall risk appetite. It was noted that key to the risk management process is Executive level buy in and ownership, as well as the need to focus on the Group's top key risks as the Committees considered there was too much in the Risk Register. Training on the new Ulysses system was raised, in that it was not sufficient to train people to use the system, but that training needed to be given on how to identify and manage risks. David Sharif, Group Director of Assurance advised that risk training is in two parts – the basics of good risk management and also the Ulysses system training. The ARG CiC concluded from its discussions that there was **no assurance**, as the process of risk management was not working in the way the Boards-in-Common needed it to work i.e. it is being used to report risks, not to actively manage them by driving actions and behaviours. The Committees agreed that this was a very significant issue which required escalating to the Boards-in-Common for discussion.

d) **Group Losses and Compensations Report** – The value of HUTH pharmacy stock write-offs (£233k for April to September 2025) was highlighted to the Committees. The ARG CiC were pleased to note the actions being taken to focus on the opportunities it presented, given the financial challenges of the Group. The Committees also discussed overseas visitors write-offs and requested assurance that the process was robust.

4.0 Matters on which the committees have requested additional assurance:

4.1 The ARG CiC requested additional assurance in relation to items as detailed above.

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

5.1 The ARG CiC received its routine item on the Board Assurance Framework (BAF). Please refer to section 3 for escalation regarding this.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to note the highlight report from the Audit, Risk and Governance Committees-in-Common.

Simon Parkes
NLAG ARG CiC Chair / NED
12 November 2025

(Apologies received from Jane Hawkard, HUTH ARG CiC Chair / NED)

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)232

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 December 2025**
Director Lead	Matt Powls, Interim Group Chief Delivery Officer
Contact Officer / Author	Matt Overton, Group Operations Director (EPRR)
Title of Report	**Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report 2025**
Executive Summary	The Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report is a combined report which encompasses the annual compliance report against the NHS England Core Standards for EPRR and the Annual Report for EPRR (detailing a summary of the planning, training, exercising and collaborative working that has taken place). This Regulatory Report covers the reporting period of 1st November 2024 to 31st October 2025 and the compliance statement for 2025/26 core standards to be approved by the Trust Boards in Common in December 2025. The 2025/26 NHS England Core Standards for EPRR self-assessment assurance process has been progressed in line with the national timeline and has included an ICB acute provider peer review process and ICB review of evidence submitted. This report includes the current compliance submission which will be taken to the final check and challenge step in the process at the HNY Local Health Resilience Partnership on 20th November 2025. The results for each Trust for 2025/26 are:

NLAG			
Self-Assessment Assurance Rating:	Substantially Compliant	Percentage Compliance:	94%
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	58	4	0

This is an increase for NLAG from last year's compliance of 90% to 94%.

HUTH			
Self-Assessment Assurance Rating:	Substantially Compliant	Percentage Compliance:	90%
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	56	6	0

	This is an increase for HUTH from last year's compliance of 69% to 90%. There are action plans in place for the partially compliant core standards for each Trust and the governance oversight of these are included in the report. All five of the EPRR Team objectives for 2025/26 have been achieved or are in progress and on track to be delivered by the end of March 2026. The report includes a breakdown of the progress made on meeting the training requirements within the NHS England Minimum Occupational Standards for EPRR over the three-year cycle and the collaborative working with multi-agency partners through training and exercising. During the reporting period there were two HHP declared incidents and 24 other incidents that didn't reach the threshold for HHP declaration but that did use EPRR mechanisms as part of the incident response. The Trust Boards-in-Common is asked to: • Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2025/26 (Appendix A) • Approve HUTH's Statement of Compliance for the NHS England Core Standards for EPRR 2025/26 (Appendix B)
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	• Presented to EPRR Board on 21st November 2025 and recommended for approval by the Trust Boards-in-Common. • Presented to Audit, Risk and Governance Committees-in-Common on 12th November 2025 and recommended for approval by the Trust Boards-in-Common.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

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Group Chief Delivery Officer

Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report 2025

Report Date:	3rd November 2025
Version:	1.1 (updated 25th November 2025)
Number of Pages:	29
Report Author:	Matt Overton, Group Operations Director (EPRR)
Executive:	Matt Powls, Interim Group Chief Delivery Officer (Accountable Emergency Officer) *Note:* NHS England Core Standards Submission signed off by Sarah Tedford, Interim Group Chief Delivery Officer (Accountable Emergency Officer)

1.0 Purpose of Report

The Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report is a combined report which encompasses the annual compliance report against the NHS England Core Standards for EPRR and the Annual Report for EPRR (detailing a summary of the planning, training, exercising and collaborative working that has taken place).

It includes both Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) detailing the specific core standards compliance for each Trust as they are required to be assessed separately as individual legal entities and submitted to the Integrated Care Board (ICB) and NHS England.

This Regulatory Report covers the reporting period of 1st November 2024 to 31st October 2025 and the compliance statement for 2025/26 core standards to be approved by the Trust Boards in Common in December 2025.

2.0 Background

The NHS needs to be able to plan for, and respond to, a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act for example. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Social Care Act 2022. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

HUTH and NLAG are both classed as Category One responders under the Civil Contingencies Act 2004. As a Category One responder there is a statuary duty for each organisation to:

- Assess risks
- Plan for emergencies
- Undertake business continuity management
- Warn, inform and advise the public
- Cooperate with partner agencies
- Share Information with partner agencies

2.0 NHS England Core Standards for EPRR

2.1 North East Region Approach to NHS England Core Standards for EPRR

NHS England has a responsibility to gain assurance on the preparedness of the NHS to respond to incidents and emergencies whilst maintaining the ability to remain resilient and continue to delivery critical services.

This is achieved through the EPRR Annual Assurance process which assesses each NHS provider's current compliance against the NHS England Core Standards for EPRR through a self-assessment and check and challenge process. NLAG and HUTH are required to submit separate submissions as they are individual legal entities.

Each year the NHS England Core Standards for EPRR are reviewed and revised by the national team prior to circulation to commence the assurance process. During 2023/24 there

was a significant change to the assurance process for the North East Region. Trusts were required to complete a self-assessment against the updated core standards for 2023/24, including an expanded set of additional compliance requirements provided in an 82-page pack.

The changed process for 2023/24 resulted in all Trusts within the North East Region reporting significantly lower compliance (HUTH 18% and NLAG 40%). For context, NLAG's 40% was the highest provider compliance rating against the new process within the ICB. Action plans were developed to improve compliance across all organisations, and a regional planning group was established by the ICB to support a collaborative approach to improvement and sharing of best practice.

Significant amounts of work have been progressed over the past 18 months to recover HUTH and NLAG's compliance with one of the EPRR Team's strategic objectives being for core standards to reach 'substantially compliant' rating at both Trusts by the 2026/27 annual compliance process.

2.2 2025/26 NHS England Core Standards for EPRR

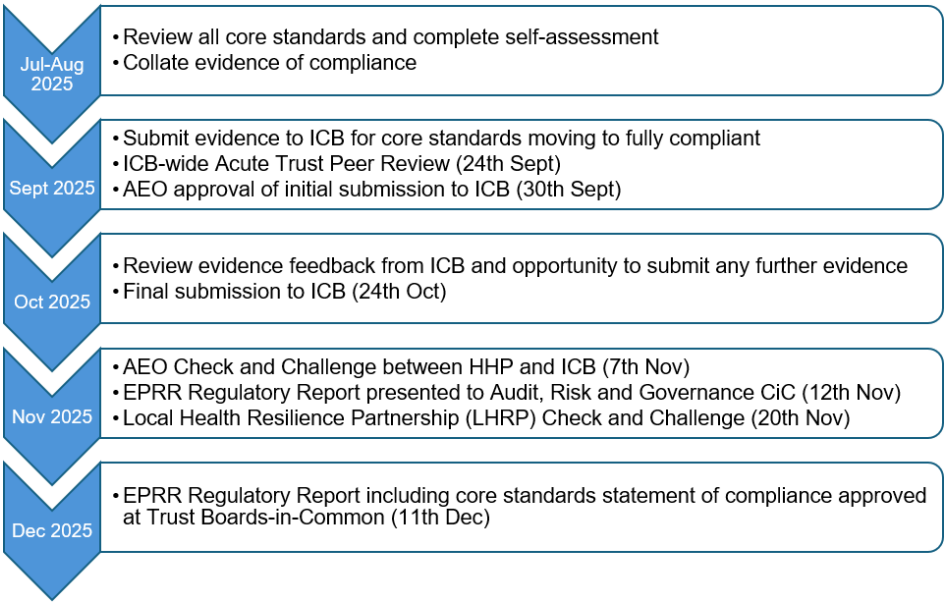
The NHS England Core Standards for EPRR 2025/26 assurance process commenced in July 2025 with the EPRR Team reviewing the 62 applicable core standards, collating evidence, and populating the self-assessment spreadsheet.

For 2025/26 NHE England and the HNY ICB agreed an evidence-based approach for this year with individual providers to submit evidence of work undertaken on their 20254/25 action plans for any core standards moving from non-compliant or partially compliant to fully compliant. The ICB EPRR Team then reviewed each piece of submitted evidence and provided feedback on whether they felt it was sufficient to move the core standard to fully compliant. This was then followed by each provider participating in a Peer Review Meeting to review evidence and self-assessments.

An initial self-assessment submission was provided to the ICB on 30th September 2025 after receiving approval by the Interim Group Chief Delivery Officer as Accountable Emergency Officer. This was followed by a final self-assessment submission provided to the ICB on 24th October 2025 and used for the Accountable Emergency Officer Core Standards Check and Challenge meeting on 7th November 2025 between HHP and the ICB prior to the final check and challenge on 20th November 2025 at the HNY Local Health Resilience Partnership (LHRP).

The annual assurance process concludes with the Trusts' compliance statements being approved at Trust Boards-in-Common in December 2025 through this EPRR Regulatory Report.

A visual timeline for this year's assurance cycle is displayed below, including the various check and challenge steps.



There are a total of 62 applicable core standards that HUTH and NLAG were assessed against. Each core standard was assessed against the requirements and rated as either 'Fully Compliant', 'Partially Compliant', or 'Non-Compliant'. Only core standards assessed as fully compliant contribute towards the Trust's overall compliance rating.

		Hull University Teaching Hospitals NHS Trust			Northern Lincolnshire and Goole NHS Foundation Trust		
Submission Year		**2023 – 2024**	**2024 – 2025**	**2025 – 2026**	**2023 – 2024**	**2024 – 2025**	**2025 – 2026**
No. Standards:	**Fully Compliant**	11	43	56	25	56	58
	Partially Compliant	51	19	6	37	6	4
	Non-Compliant	0	0	0	0	0	0
Overall Rating		Non-Compliant	Non-Complaint	Substantially Compliant	Non-Compliant	Substantially Compliant	Substantially Compliant
Compliance %		18%	69%	90%	40%	90%	94%

The assurance rating thresholds for the overall compliance rating are:

- Fully Compliant = 100%
- Substantially Compliant = 89-99%
- Partially Compliant = 77-88%
- Non-compliant = 76% or less

Although there were no core standards identified as non-compliant in either Trust, partially compliant core standards do not count towards the overall compliance rating. For this reason, NLAG received an overall compliance rating of 94% while HUTH received an overall compliance rating of 90%.

This is a significant improvement for HUTH compared to last year's overall compliance rating and exceeds the EPRR strategic objective to reach overall partial compliance for 2025/26. The

position for NLAG and HUTH are greater than other provider's within our ICB and the EPRR Team will continue to share our best practice with other providers in support of collaborative working.

The tables below show the breakdown of compliance by domain for each Trust.

HUTH - Core Standards 2025/26				
Domain	**No. Standards in Domain**	**No. Fully Compliant**	**No. Partially Compliant**	**No. Non-Compliant**
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	9	3	0
Total	62	56	6	0
Overall Rating	Substantially Compliant	90%	10%	0%

NLAG - Core Standards 2025/26				
Domain	**No. Standards in Domain**	**No. Fully Compliant**	**No. Partially Compliant**	**No. Non-Compliant**
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	11	1	0
Total	62	58	4	0
Overall Rating	Substantially Compliant	94%	6%	0%

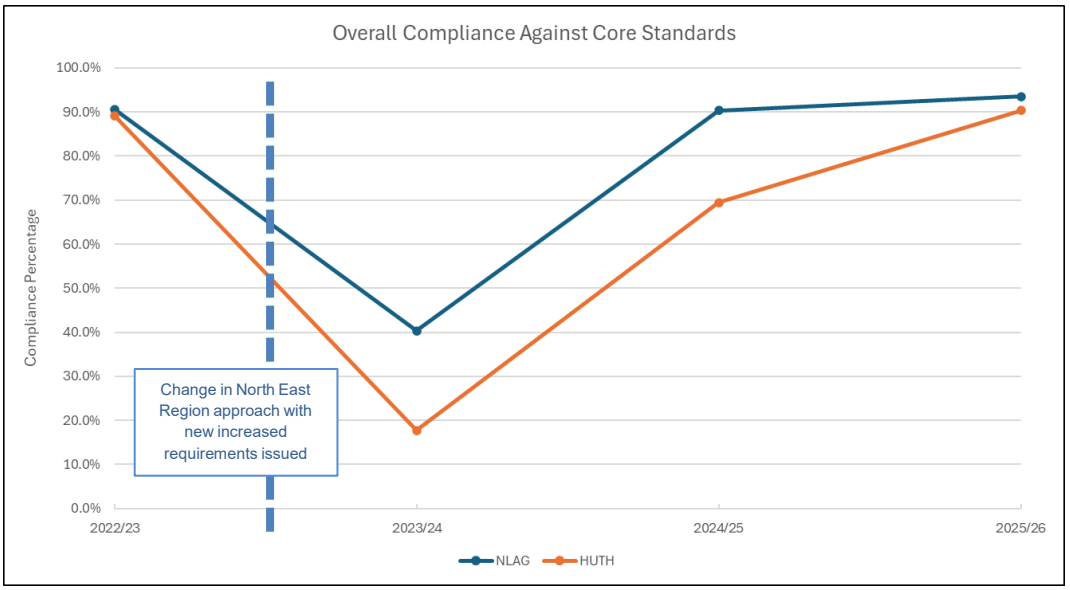
2.3 Maintaining and Improving Compliance

Each Trust has progressed a significant amount of work to maintain and improve compliance against the core standards.

This was achieved through the review and revision of multiple plans and policies, development of new Group-wide ways of working, and learning from exercises and incidents. This work included:

- Further improvements to the EPRR Work Programme as a central location for capturing action plans, lessons learned from exercises/incidents alongside the work plan and training schedule
- Development of a new EPRR Risk and Impact Assessments Procedure
- Development of a Group-wide Mass Casualty Plan
- Development of a Group-wide Business Continuity Policy
- EPRR Policy updated
- Incident Response Plan updated
- Incident Coordination Centre SOP updated
- EPRR Communications Plan updated
- Escalation and Surge Plans updated
- HUTH CBRN/HAZMAT Plan updated and new training schedule implemented for HRI
- Adverse Weather Plan updated
- Attendance and participation at multiple multi-agency exercises
- Launch of a Health Commander Training Prospectus
- Delivery of exercises and participation in multi-agency exercises
- Planning for, and responding to, multiple events and incidents throughout the year
- New process for capturing evidence of collaborative working and engagement with partner agencies for emergency plan development and consultation

The graphs below show the recovery of the compliance against the core standards over the past four years:



Overall Trust compliance against the core standards for the past four years

2.4 Oversight of Core Standards Action Plans

Any core standards assessed as partially compliant have an identified action to turn them compliant within the next 12 months. These required actions are included in the Core

Standards Action Plan for 2025/26 for each Trust (Appendix C for NLAG and Appendix D for HUTH).

The ICB established a provider collaborative working group last year that met throughout the year to focus on each domain of the core standards. These meetings were also used by the ICB as their progress review mechanism for oversight of progress being made against the submitted action plans. It is expected that the ICB will take the same approach for oversight of this year's provider action plans.

NLAG and HUTH have also benefited from the roll out of a joint EPRR Team as part of the new operational group structure which has enabled shared learning and joint development / review of plans.

The below table displays the governance oversight of the action plans.

Meeting	Oversight	Frequency
EPRR Group	Group-wide monthly meeting that has operational oversight of the detailed progress of the action plans	Bi-Monthly
EPRR Board	Group-wide meeting chaired by the Group Chief Delivery Officer with strategic oversight of the completion of the action plans	Quarterly
ICB Progress Review Meeting	ICB-chaired collaborative working group used to monitor progress against each provider's action plan	Monthly
Audit, Risk and Governance Committees-in-Common	A Regulatory Report submitted each year aligned to the national submission requirements, supported by a six-monthly progress report	Six Monthly

2.5 Deep Dive Subject for 2023/24 Core Standards

Each year alongside the main NHS England Core Standards for EPRR self-assessment process there is usually a national deep dive subject. This year NHS England decided not to conduct a deep dive subject.

2.6 Looking Ahead to 2026/27 Core Standards

In 2024 NHS England commenced a national review of the core standards with the intention to launch a completely new refreshed approach for the 2026/27 annual process. The message from the national team was that the new standards would be shared with all providers 12 months before they would come into action. This review was completed in 2025 but so far no update has been issued and no new standards shared.

There is a risk that if the new standards, replacing the current core standards, are not shared with providers in advance that there may not be enough time to incorporate any new requirements into our emergency plans, exercises, training or processes in time for the 2026/27 annual compliance process and could result in an overall drop in compliance ratings for providers. Any changes in requirements could lead to considerable work for update relevant plans and processes.

3.0 EPRR Audits

3.1 Annual CBRN Preparedness Audit

As part of the annual EPRR assurance cycle and in line with NHS England contractual standards to support the EPRR Framework, Ambulance Trusts conduct audits on Acute Trust's Chemical, Biological, Radiological and Nuclear (CBRN) preparedness. The audit encompasses emergency plans and procedures in place, specialist training provided by the Trust to staff, and maintenance of equipment.

East Midlands Ambulance Service (EMAS) conducted an on-site audit at DPOWH and SGH on 31st October 2024 with the report provided in December 2024. The report raised no concerns in planning or preparedness but did provide some recommendations to further strengthen the ED's CBRN preparedness. The report advised minor additions to the CBRN/HAZMAT Plan and a door seal missing on the decontamination room doors, which has subsequently been checked.

Yorkshire Ambulance Service (YAS) conducted an on-site audit at HRI on 21st October 2025 of which the report has not yet been received. Prior to this YAS have requested evidence of progress against last September 2024's report which raised multiple concerns regarding the ED's planning and preparedness against each of the CBRN core standards. As part of the new EPRR Team structure that went live in April 2025, one of the EPRR Manager's was assigned the CBRN domain as a lead across the Group to incorporate the best practice from NLAG. Progress has been made in Q1-Q2 2025/26 on an immediate review and revision of the HUTH CBRN/HAZMAT Plan (further full re-write and relaunch to follow), a full review of the CBRN training package delivered within the Trust and close working with the HRI ED CBRN Leads to develop a robust annual training schedule, equipment registers, and formal train the trainer courses from the ambulance service.

Further work is planned to strengthen the HRI ED CBRN preparedness including a full review of the training needs analysis for each role. These actions are part of the HUTH Core Standards action plan. The EPRR Team is building closer working relationships with YAS to support the identification of further improvements and reassurance on progress made.

3.2 Internal Audit of EPRR Arrangements

As part of a three yearly internal audit process, contracted external audit companies have completed the in-depth internal audit reviews at both NLAG and HUTH within the required timeframes and formal reports have been received providing the following assurance:

Trust	Audit	Assessor	Date of Last Audit Report	Assurance Rating
NLAG	EPRR Arrangements	Audit Yorkshire	October 2022	Significant Assurance
HUTH	Business Continuity and EPRR Arrangements	RSM UK Risk Assurance Services	October 2023	Substantial Assurance

At the time of this report the next NLAG audit had not commenced. An update on the outcome of this audit will be included in the next report to the Audit, Risk and Governance Committees-in-Common.

4.0 EPRR Strategic Objectives

The EPRR Team has a set of strategic objectives for each year which are aligned to the team's three year strategic strategy.

The EPRR Team objectives for 2025/26 are displayed below:

EPRR Team Objectives 2025/26

Strategic Intent
To develop, implement, promote and maintain plans, procedures, training and exercising in order to ensure compliance with the Trust's obligations under the Civil Contingencies Act 2004, NHS England, CQC and other performance management standards at local, regional and national levels.

NHS England Core Standards

To increase the overall compliance with the NHS England Core Standards for EPRR:

- NLAG to maintain 'substantially compliant' and increase overall percentage
- HUTH to achieve 'partially compliant' with increase in overall percentage

Training

To support and drive progression of Health Commander portfolio compliance through internal and external training to enable our Health Commanders to lead incident responses effectively, including design and roll out of Health Commander scenario training

Exercises

To participate in multi-agency exercises to test our emergency plans and contribute to shared learning. This includes:

- Delivering a live multi-agency exercise
- Achieving our exercises requirements as per the EPRR Framework and NHSE 7-year cycle

Collaborative Working

To implement a new HHP-wide EPRR risk assessment and impact process, aligned to the Humber LRF approach utilising risk assessments at national (NRR), regional (LHRP) and local levels (CRR) to identify impacts and realistic worse case scenario planning assumptions

Business Continuity

To support the organisation to maintain critical functions through transformational change, including:

- SGH energy project
- Community Diagnostic Centres
- Major IT system upgrades
- New SGH ICC

All five of the strategic objectives for this current financial year have been achieved or are in progress and on track to be delivered by the end of March 2026. Updates covering the five objectives are covered within this report.

5.0 EPRR Governance

As part of the transition to the new HHP group structure, the EPRR governance structure was fully reviewed and relaunched in 2024.

The current EPRR governance structure is displayed below:



The EPRR Group is responsible for the development, implementation, promotion and maintenance of plans, procedures, training and exercising to deliver the EPRR Work Programme. The EPRR Group will ensure that all relevant information is shared with Care Groups for inclusion in emergency plans, supplementary documents and business continuity plans. The EPRR Group is chaired by the Group Operations Director, meets bi-monthly and formally reports to the EPRR Board.

The EPRR Board provides oversight and assurance of the development, implementation, promotion and maintenance of plans, procedures, training and exercising in order to ensure compliance with each Trusts obligations. The EPRR Board is chaired by the Group Chief Delivery Officer (Accountable Emergency Officer), meets quarterly and formally reports to the Group Executive Meeting and for assurance to the Audit, Risk and Governance Committees-in-Common.

6.0 EPRR Team

As part of the transition to the new HPP Group structure, the NLAG EPRR Team and HUTH EPRR Team started to work more closely from December 2023. The Group Operations Director for Emergency Planning, Business Continuity, Discharge and Flow started to provide strategic leadership across both EPRR Teams reporting directly to the Group Chief Delivery Officer, who is the designated Accountable Emergency Officer for both Trusts.

An integration plan commenced to start bringing the working practices and planning approaches into line between both Trusts. A systematic review of each Trust's emergency plans has now been completed, with the core principle plans such as the EPRR Policy, the Incident Coordination Centre Standard Operating Procedures, and the Incident Response Plan all now embedded as Group-wide documents. Incident specific emergency plans have been reviewed and, where appropriate, have been relaunched as a single document with a Group-wide approach.

A formal consultation took place during October to December 2024 to restructure the EPRR Team into a new Group-wide structure that ensures a consistent level of experience and support across both North Bank and South Bank. The new structure went live from April 2025 and has already shown to reduce duplication, improve consistency, strengthen North and South Bank collaborative working and provide focus areas for individuals to lead of specific pieces of work Group-wide. One of the EPRR Managers left the team to pursue another role within the organisation and their replacement commenced in post from August 2025. The new appointee is an experienced emergency planner recruited from the Humber Local Resilience Forum.

All posts within the EPRR Team are substantively filled, however, there has been a significant period of long-term sickness within the team that has impacted on the team's capacity to deliver the challenging work programme at the same time as supporting the response to event planning and incidents.

As part of the EPRR Team's continuous professional development the team has engaged in a mix of training, workshops, and evaluating/observing partner agency exercises. The team regularly attends EPRR meetings at local, regional and national level, including engagement with the National Performance Advisory Group EPRR Network. Members of the team have completed formal qualifications in the past 12 months (e.g. One has completed the Diploma in Health EPRR and another has completed the Award in Health EPRR).

In addition to the above, the requirement for all EPRR Specialist Advisors to maintain a Portfolio of evidence to demonstrate compliance with the national Minimum Occupational Standards for EPRR has been progressed. This applies to three members of the EPRR Team

who undertake the role of EPRR Specialist Advisor during an incident. Current compliance is covered in section 7.3.

7.0 Exercising, Training and Collaborative Working

7.1 Exercises

As both Trusts are Category One responders, HHP must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agency plans.

The NHS EPRR Framework 2022 provides the minimum exercising requirements that NHS providers must adhere with to meet their obligations under the Civil Contingencies Act 2004 and associated guidance. The table below shows the exercise frequency requirement and the exercises undertaken by HHP. It should be noted that if an organisation activates its plan for response to a live incident, this replaces the need to run an exercise, providing lessons are identified and logged as part of a post-incident debrief.

Exercise Type	Required Frequency	Exercises (Lead Facilitator)	Compliance
Communications systems exercise (Test the organisation's ability to contact key staff and other NHS and partner organisations 24/7)	Every six months	• 12/12/2024 – Incident cascade test through NLAG switchboard • 31/12/2024 – Incident cascade test through HUTH switchboard • 05/06/2025 – Incident cascade test through NLAG switchboard • 09/09/2025 – Incident cascade test through HUTH switchboard **Note: Incident cascade is the same for both Trusts. We rotate between which switchboard we make the call through to support switchboard awareness. December 2024 tested both switchboards as it was a new Group-wide process*	Requirement Fully Met
Table top exercise (Bring together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a scenario and can help validate a new or revised plan	Every 12 months	• 14/11/2024 – Ex Zodiac – Mass Casualty Table Top Exercise (HHP) • 05/12/2024 – P66 Humber Refinery COMAH Exercise (LRF) • 13/12/2025 – Ex Golden Retriever – System-wide Mass Casualty Exercise (ICB) • 10/03/2025 – Grimsby and Immingham Port Health Table Top Exercise (UKHSA/LRF) • 23/04/2025 – Prax Lindsay Oil Refinery COMAH Exercise (LRF) • 30/04/2025 – Saltend Park COMHAH Exercise (LRF) • 23/05/2025 – Energy Resilience Workshop (NHSE) • 25/06/2025 – INEOS Manufacturing COMAH Exercise (LRF) • 01/07/2025 – Heatwave Table Top Exercise (HHP) • 03/10/2025 – BOC Scunthorpe	Requirement Fully Met

		COMAH Exercise (LRF) • 08/10/2025 – ABP Fertiliser Terminal COMAH Exercise (LRF) • 16/10/2025 – Ex Frostline – Adverse Weather Table Top Exercise (HHP)	
Live play exercise (Live test of arrangements and includes the operational and practical elements of an incident response: for example, simulated casualties being brought to an emergency department)	Every three years	• 18/05/2024 – Exercise Virgo: Live CBRN exercise at HRI ED (HHP) • 20/06/2024 – Live lockdown exercise of Family Services at DPOWH (HHP) • 26/09/2024 – Exercise Chile: Live HAZMAT exercise at SGH ED	Requirement Fully Met
Command post exercise (The command post exercise tests the operational element of command and control and requires the setting up of the incident coordination centre (ICC))	Every three years	• 13/03/2023 – Junior Doctor industrial action with physical ICC setup (4 days) • 11/04/2023 - Junior Doctor industrial action with physical ICC setup (5 days) • 14/06/2023 - Junior Doctor industrial action with physical ICC setup (3 days) • 18/05/2024 – Exercise Virgo: Live CBRN exercise at HRI ED (HHP) including physical ICC setup	Requirement Fully Met
ICC equipment test (The functionality of equipment used in an ICC must be tested)	Every three months	• 31/10/2024 – SGH ICC • 05/12/2024 – DPOWH ICC • 06/12/2024 – HRI ICC • 12/12/2024 – CHH ICC • 14/02/2025 – DPOWH ICC • 18/02/2025 – SGH ICC • 07/03/2025 – CHH ICC • 08/04/2025 – HRI ICC • 19/05/2025 – SGH ICC • 14/08/2025 – DPOWH ICC • 20/08/2025 – HRI ICC • 21/08/2025 – SGH ICC • 26/08/2025 – CHH ICC **Note: Regular checks have been completed on the ICCs, however, there are gaps in evidence of documented checklists so these haven't been included in the dates above.*	Requirement Partially Met

The new Incident Coordination Centre (ICC) for SGH became operational from July 2025 onwards as part of the newly refurbished Ward 10 floor. The ICC room is located next to the SGH Operations Centre and is an improvement on the previous ICC, including multiple large wall-mounted screens, the ability to have live TV news feed, and pre-set locations for each key member of the Incident Management Team (IMT) with dedicated mitel phones. The new ICC meets the guidance requirements including being connected to essential power through a back-up generator so it can continue to function during a power outage.



New Incident Coordination Centre (ICC) at SGH became operational in July 2025

As well as delivery and participation in formal exercises, the EPRR Team has taken part in live testing of planning assumptions and equipment. An example of this is the practical testing of evacuation equipment in conjunction with the Fire Safety Team including timing of vertical patient evacuations through multiple methods (e.g. patient assisted via stairs, non-ambulant patients on beds via lifts, ski-pads and evac chairs via stairs). This practical testing is used to inform emergency plans and provide decision makers with additional information when considering options during an incident.



Evacuation Ski-Pad being used to test evacuation timings at HRI Tower Block



Evac-Chair being used to test evacuation timings at HRI Tower Block

7.2 Collaborative Working with Partner Agencies

A critical part of the EPRR Team's work programme is the engagement in collaborative working with partner agencies, both NHS and wider, in the development of plans, training and exercising.

HHP is represented by the EPRR Team at the Humber Local Resilience Forum (LRF) and the HNY Local Health Resilience Partnership (LHRP), as well as associated sub-groups. HHP participates in joint planning and testing of regional plans and regularly attends multi-agency

exercises to evaluate response plans and identify lessons to be learned that can be incorporated into internal and external plans.

As part of the close working relationship with the Humber LRF, a series of training sessions have been made available for HHP's Strategic Health Commanders, Tactical Health Commanders, and EPRR Team to attend including Joint Emergency Services Interoperability Principles (JESIP) training, LRF Strategic/Tactical Coordinating Group training, Regional multi-agency capabilities events, and evaluator/observer slots on LRF partner live exercises. HHP has participated in many COMAH exercises (Control of Major Accident Hazard) over the past year to not only contribute to the review and testing of off-site plans but also as a training opportunity.



Live multi-agency exercise at Craven Park to test CBRN response ahead of the Coldplay Concerts (16th July 2025)

7.3 Principles of Health Command Training

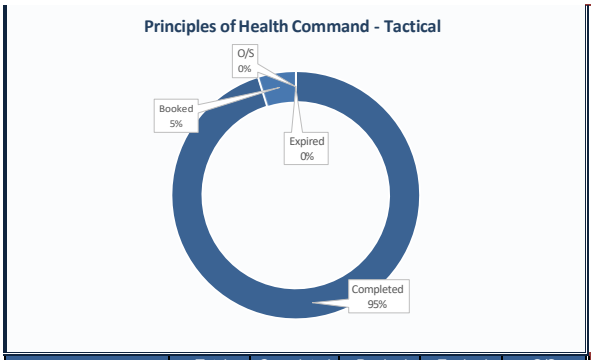
The NHS England Minimum Occupational Standards for EPRR mandates set minimum competencies that all leaders and managers involved in leading an incident response, or part of the decision-making process, must achieve and maintain. These roles are referred to as Strategic Health Commanders, Tactical Health Commanders, Operational Health Commanders, and EPRR Specialist Advisors. It should be noted that the national team has still not yet launched the Operational Health Commander elements as the national decision was taken to focus on the Strategic and Tactical implementation first.

The two mandated elements include:

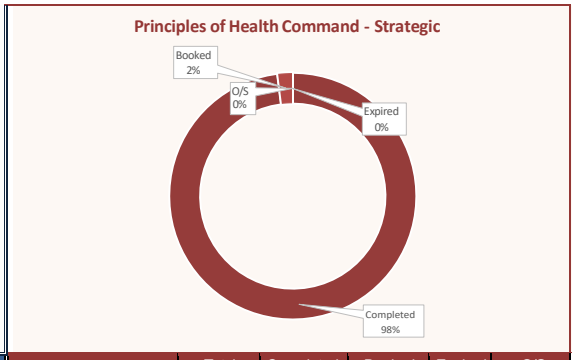
- All Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists must attend the relevant national Principles of Health Command Course at their relevant level (e.g. Strategic On-Call rota participants must attend the strategic level)
- All Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists must maintain a Personal Development Plan (PDP) portfolio with evidence of their continuous professional development to meeting the National Occupational Standards (NOS) for their role. NHS North East Region issued portfolios to all providers that details the mandatory training required to meet and evidence these competencies

There are currently 50 individuals who are required to undertake Strategic Health Commander training and maintain a portfolio, 41 individuals who are required to undertake Tactical Health Commander training and maintain a portfolio, and three individuals who are required to undertake EPRR Specialist training and maintain a portfolio.

The first element above (Principles of Health Command) was launched ahead of the portfolios and there is a locally agreed target with the ICB to achieve 80%+ compliance with both Strategic and Tactical levels. The charts below show that at the end of October 2025 the current compliance is 98% of Strategic Health Commanders have completed the training with the remaining 2% booked to attend a course before the end of December 2025. For Tactical Health Commanders, 95% have completed the training with the remaining 5% booked to attend a course before the end of December 2025.



	Total	Completed	Booked	Expired	O/S
Principles of Health Command - Tactical	41	39	2	0	0



	Total	Completed	Booked	Expired	O/S
Principles of Health Command - Strategic	50	49	1	0	0

The second element is the Personal Development Plan (PDP) portfolio. The portfolio was developed by NHS England North and was launched within HHP in July 2024 to all Strategic and Tactical Health Commander and EPRR Specialists.

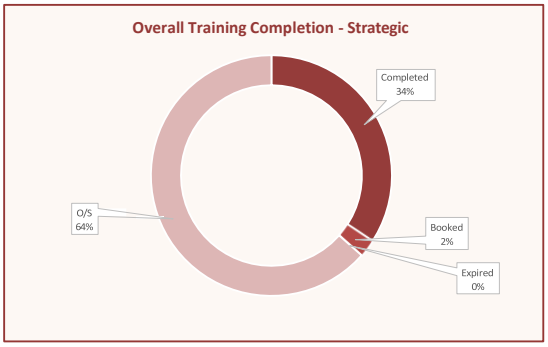
The portfolios are part of a three year cycle and the compliance and assurance will be reported through the EPRR Group, with oversight from the EPRR Board, and externally through the North of England Commander Portfolio Oversight Board (CPOB). As of October 2025, the CPOB has not been established by NHS England, however, the Trust's compliance and progress is reported regularly to the ICB with oversight from the HNY LHRP.

The training requirements within the portfolios include new training which most providers had not previously incorporated into their training programmes (e.g. media training). The estimated time commitment to complete and maintain the portfolio over a three year period is 21 hours for Tactical Health Commanders, 33 hours for Strategic Health Commanders, and 204 hours for EPRR Specialist Advisors.

The charts below show the current compliance of required training as recorded centrally at the end of October 2025. All Health Commanders are completing the portfolios and training within their individual portfolios. These charts are expected to increase in compliance as portfolios are reviewed throughout the three year cycle.

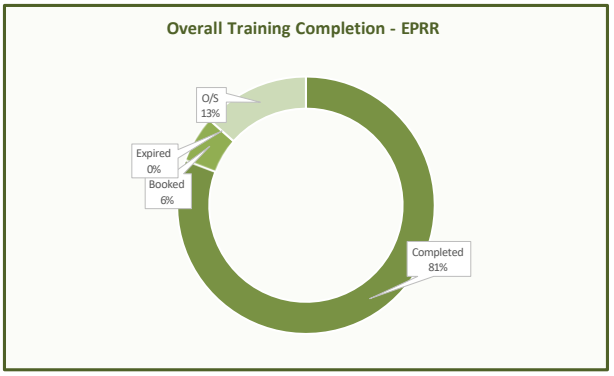


	Total	Completed	Booked	Expired	O/S
Overall Training Completion - Tactical	41	88	11	0	270



	Total	Completed	Booked	Expired	O/S
Overall Training Completion - Strategic	50	188	13	0	349

The chart below shows the current compliance of required training for the EPRR Specialists at the end of October 2025. All EPRR Specialists are completing their individual portfolios as part of the three year cycle. The overall compliance has dropped due to a new member of the team joining from August 2025 who is progressing well through the various training courses and is currently at 44% completion after three months. The other two members of the team are at 100% and 89% completion.



	Total	Completed	Booked	Expired	O/S
Overall Training Completion - EPRR	3	42	3	0	7

The training that is mandated or recommended as part of the portfolio compliance is delivered through a mix of formal external training courses, internal training sessions and exercises. An example of the 2025 training schedule is displayed below:

EPRR Training Schedule for 2025

January	February	March	April	May	June	July	August	September	October	November	December
Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions	Corporate Inductions
	EPRR Media Training	EPRR Media Training			Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation	Incident Response Plan / Command and Control Familiarisation
CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training	CBRN/HAZMAT Training
	Humber LRF Risk Workshop	UKHSA Adverse Weather Webinar	Saltend Park COMAH Exercise	NEY Energy Resilience Workshop	INEOS Manufacturing COMAH Exercise	Heatwave Exercise		Exercise Pegasus (Tier 1Infectious Outbreak)	Scenario Based Health Commander Training	Scenario Based Health Commander Training	Scenario Based Health Commander Training
	Phillips66 COMAH Exercise	Grimsby and Immingham Port Health Exercise	Prax Lindsay Oil Refinery COMAH Exercise		Communications Cascade Test			Communications Cascade Test	ABP Fertiliser Terminal COMAH Exercise	Exolum Storage COMAH Exercise	Centrica Storage COMAH Exercise
			Martyn's Law Webinar						Exercise Pegasus (Tier 1Infectious Outbreak)	Exercise Pegasus (Tier 1Infectious Outbreak)	Communications Cascade Test
			Preparing for Public Inquiries Training						Exercise Frotsline Adverse Weather		
Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)	Principles of Health Command (Strategic)
Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)	Principles of Health Command (Tactical)
Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness	Defence Awareness
EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness	EPRR Communications Awareness
Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness	Joint Decision-Making Model Awareness
JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness	JESIP Awareness
	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness	LRF Awareness
Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness	Specialist Asset Awareness
On-Call Training (As Required)											
Health Commander Portfolio Awareness (As Required)											

EPRR Training Schedule for 2025

To improve completion of the Health Commander portfolios the EPRR Team has introduced a number of supporting mechanisms during 2025:

- An MS Teams Channel has been created for Health Commander Portfolios. Each Health Commander has their own individual folder where their portfolio (PowerPoint file) is stored. This should be the master copy and updated directly through MS Teams

going forward. Individual access permissions are in place so only the EPRR Team and the individual themselves will be able to access their portfolio folder

- A training prospectus of internal and external training available with booking links and a table showing the mandatory and optional training for Strategic and Tactical was launched to make it easier to find and book on training
- Internal training offering of a one hour virtual session covering the Incident Response Plan and Command and Control Familiarisation
- Rapid 15 minute 1:1 meetings available with the EPRR Team to go through the mandatory training requirements and book sessions into the diary
- A Strategic and Tactical Health Commander is identified to attend each multi-agency exercise to widen the opportunities for multi-agency exercising and learning
- Providing 1:1 support meetings for those Health Commanders who request one to support with completion of portfolios

As all NHS providers are now mandated to ensure their Strategic Health Commanders, Tactical Health Commanders and EPRR Specialists achieve, evidence and maintain compliance with the minimum occupational standards it should be noted that there is not yet enough capacity across all the required training to meet the demand. The EPRR Team are working collaboratively across the ICB to try and secure suitable training opportunities for our leaders.



HHP Heatwave table top exercise (1st July 2025)



HHP Adverse Weather table top exercise (16th October 2025)

8.0 Business Continuity Management System

Both Trusts have a well embedded Business Continuity Management Strategy which includes a policy, guidance and service-level plans which have now been brought into a Group-wide policy and approach. Each plan identifies critical and non-critical functions within each service that would be required to be maintained during an incident, or that can be stood down to support critical functions. Each plan is required to be reviewed on an annual basis by the nominated service lead with compliance monitored through the EPRR Group. Plans can get reviewed and updated more regularly if required when new threats or risks are identified. Internal audits have been carried out on both Trusts' business continuity managements systems providing substantial assurance (see section 3.2).

As part of the harmonisation across the HHP Group, Directorate and service-level BCPs have been re-aligned to reflect the new Care Group structure including a review of the nominated owners for each plan. During the HHP restructure to the Care Groups, the compliance rating with service-level BCP reviews reduced significantly and has been slow to recover. A Business

Continuity Working Group has been established to provide focus and support for BCP authors and service leads.

Local Requirement	Target	Current Position	Compliance
Group-wide BCP in place	BCP in place	BCP in place	Requirement Fully Met
Group-wide BCP within review schedule	Reviewed within last 12 months	Reviewed 20/08/2025	Requirement Fully Met
Service-level BCPs in place	BCPs in place	All current BCPs in place on Trust intranets	Requirement Fully Met
Service-level within review schedule	90% or more reviewed within last 12 months	88% reviewed within the last 12 months (12% overdue)	Requirement not met
Service-level BCPs tested or activated for live response	90% or more tested or activated within last 12 months	BCPs implemented for real for: • Industrial action (November 2024) • HUTH switchboard outage (March 2025) • PACS failure (April 2025) • ePMA outage (June/July 2025) • CHH Switchboard outage (July 2025) • Family Services lift failure (July 2025) • Industrial action (July 2025)	Requirement Fully Met

Service-level BCPs have been implemented over the last year as part of the industrial action response and several plans were also implemented as part of specific incidents, such as switchboard outages, system failures, and infrastructure failures. Any lessons to be learned from the exercise/incident are captured as part of the exercise/incident debrief and included in an action plan.

The focus throughout 2025 has been to get clarity on BCP ownership across the Directorates and Care Groups and to get a consolidated register of up-to-date reviewed BCPs. The next step is to focus on the quality and usefulness of the content within the BCPs, ensuring learning from incidents are incorporated into the BCPs in a timely manner and shared with frontline staff.

At present there is no formal process for the testing of individual service-level BCPs, as these are tested during EPRR training or exercises (e.g. table top, multi-agency exercises). This means the reliance of testing and validation of BCPs has been their use during real incidents. The BC Working Group will be reviewing the BCP template and revision process for effectiveness and introducing a best practice checklist. This checklist will include annual testing of BCPs by the service lead and feeding back lessons learned and interdependencies through the BC Working Group.

9.0 EPRR Work Programme

The EPRR Work Programme provides a central location for the EPRR Team to record work undertaken, in progress and scheduled. The EPRR Work Programme captures:

- Emergency plans, SOP and policy review schedules
- EPRR training schedule
- EPRR exercise schedule
- EPRR incidents log
- Action tracker for post-incident and post-exercise action plans
- BCP review and testing monitoring
- External EPRR actions

All documents have a set review schedule but often plans are reviewed more regularly due to activation of the plan (to incorporate learning from the incident or exercise) or to incorporate the latest national guidance or organisational developments.

10.0 EPRR Top Risks

The EPRR Team, in conjunction with external EPRR Leads from the ICB and partner agencies, use the nationally and locally identified risks to inform the focus of scenarios for the training and exercising schedules. The National Risk Register feeds into the local Humber Community Risk Register, developed and maintained through the Humber Local Resilience Forum (LRF). The Local Health Resilience Partnership (LHRP) maintains an ICB-wide EPRR Risk Register which focuses on health specific risks linked with both LRF and LHRP planning.

The HNY LHRP completed a detailed multi-provider review in June 2025 to identify and agree the following top five risks:

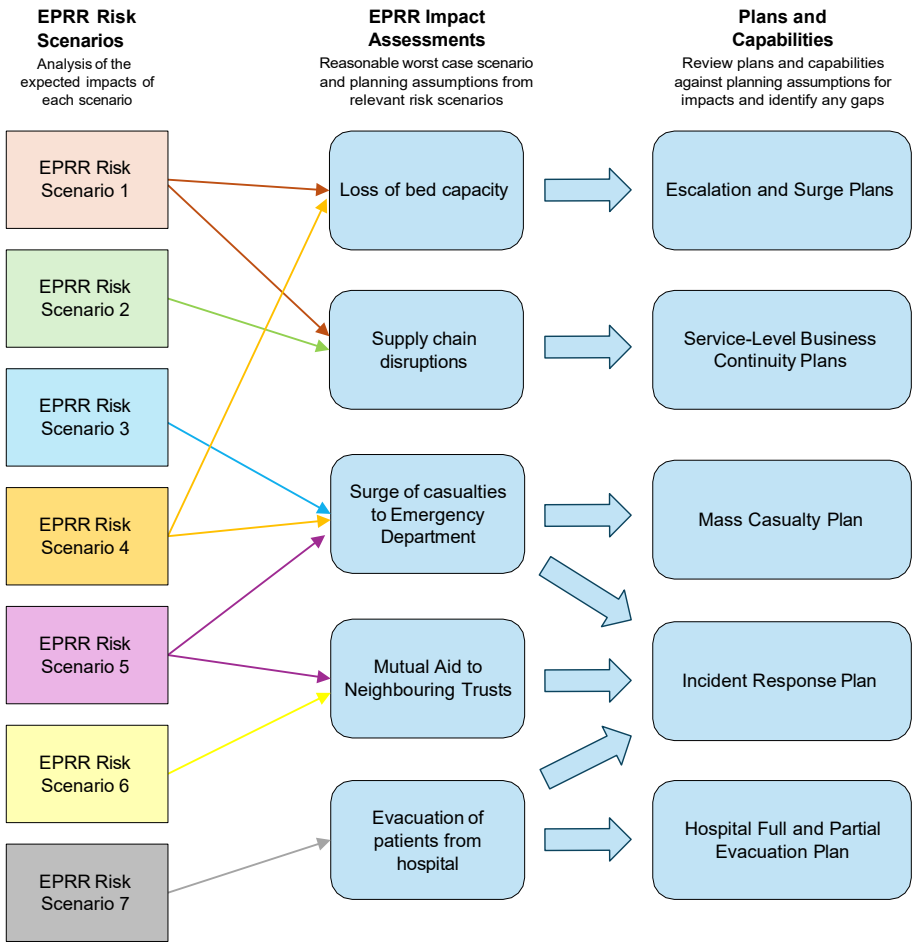
Risk Scenario	Highest Score on Humber or North Yorkshire LRF Community Risk Register	First Glance Impacts for Planning Focus and Capability Analysis
Denial of Access to Systems	• Telecoms **(16 High)** • Health and Social Care Systems **(15 High - NYorks)**	• Loss of digital capabilities • Loss of critical services and reliance on business continuity plans
Adverse Weather – Extreme hot, cold and flooding	• Cold Weather **(16 Very High - Humber)** • Hot Weather **(12 Very High - Humber)** • Flooding - Coastal **(12 Very High)** • Flooding – Surface / Fluvial **(12 Very High - Humber)**	• Excess deaths • Mass casualties • Surge in attendance/increase in demand for health services
Infectious Diseases and Pandemics	• Pandemic **(20 Very High)** • Outbreak of an emerging infectious disease **(16 Very High)**	• Excess deaths • Mass Casualties • Surge attendance/increase in demand for health services
Energy Supply Failure including loss of utilities and telecommunications	• Electricity **(15 Very High)** • Gas **(12 Very High)**	• Excess deaths • Mass Casualties • Surge attendance/increase in demand for health services

		• Loss of staffing
COMAH Site Release or Explosion/Malicious Attack Resulting in Contaminated Casualties	• COMAH **(3 Medium)** • Terrorist or malicious incidents / chemical attacks - Various **(20 Very High)**	• Mass Casualties • Mass Fatalities • Surge attendance/increase in demand for health services • Mobilisation of specialist CBRN Resources

During 2025 a full review was undertaken of both Trusts approach to EPRR risks and a new Group-wide EPRR Risks and Impacts Assessment Process was developed and introduced.

The new procedure follows a consequence based planning approach rather than planning for each individual risk. Each EPRR Risk Scenario is reviewed to identify the potential EPRR impact on HHP should an EPRR Risk Scenario occur. There are many different EPRR Risk Scenarios (currently 126 identified) but many of these result in similar impacts to HHP and the ability for the organisation to delivery its services and keep its patients and staff safe.

The diagram below displays an example of how the process links from EPRR Risk Scenarios to EPRR Impact Assessments to plans and capabilities:



Consequence based planning generally involves planning for the largest scale or longest duration impact that can be reasonably expected from any given risk and is considered to be a more efficient and versatile approach. The methodology involves reviewing individual risks, identifying the potential impacts from the overall register, and using the reasonable worst case scenario (RWCS) as the planning assumption for each impact.

Building capabilities and plans for the most severe manifestation of consequences that be reasonably expected from any assessed risk means that HHP should be well prepared for the impacts from emergencies.

All 126 EPRR Risk Scenarios have been reviewed and the HHP relevant EPRR Impacts identified. The EPRR Team will now progress with detailed assessments of each EPRR Impact to identify any planning or capability gaps which will be discussed at the EPRR Group. Any identified gaps that can't be mitigated will be added to the work programme and to the Trust Corporate Risk Register.

11.0 Live Incidents / Response

11.1 Declared Incidents during Reporting Period

During the reporting period of 1st November 2024 to 31st October 2025 there were two declared incidents. These were both business continuity incidents. Both Trusts did respond to incidents declared by other agencies but there was not the need for our Trust(s) to declare an incident to support the response to these.

Date	Incident	Trusts Involved	Incident Coordination	Trust Declared EPRR Incident
18/07/2025	Family Services lift failure at DPOWH	NLAG	Virtual ICC established	Yes – Business Continuity
14/10/2025	Water failure in Renal Unit at HRI	HUTH	Multi-health coordination meetings established with ICB support	Yes – Business Continuity

Family Services lift failure at DPOWH

On 18th July 2025 a business continuity incident was declared following the failure of both lifts within the Family Services Building at DPOWH which resulted in the inability to move patents in or out of units on the top floor of the building.

This resulted in a number of coordination meetings being established to identify options for dealing with the outage and to minimise the impacts on patient care.

A contingency plan was created that saw one lift brought back into action, however, the fix could not be guaranteed, and a permanent remedy would not be able to be sought until after the weekend. As such, use of the lift was considered as 'emergency use' only. Plans were established to support the affected services over the weekend until the other lift could be fixed the following week.

A full debrief and post-incident report was completed and identified many areas of good practice. The lessons to be learned from the incident were compiled into an action plan which is being reported through the EPRR Group for oversight of completion and shared learning.

Water failure in Renal Unit at HRI

On 13th October 2025 the water treatment in the main dialysis unit failed its morning quality checks for water quality within the Renal Unit based at Hull Royal Infirmary. The Renal Unit is a fully managed service delivered by Fresenius and the property is managed by NHS Property Services.

Once the water quality check had failed this was escalated by Fresenius to the Clinical Lead as per their escalation plan. The unit was unable to offer any dialysis until the water quality was resolved. An engineer arrived onsite and identified the problem requiring a part that needed to be delivered from Germany at the end of the week. The decision was taken by the unit to redirect patients to alternative suitable dialysis sites.

The need to divert dialysis patients to alternative units resulted in an impact on other dialysis units taking additional patients and for YAS to coordinate the changes in patient transport service (PTS) routes and bookings. The HNY ICB EPRR Team and HHP EPRR Team were then notified of the issue and impacts and an initial coordination meeting took place followed by a business continuity incident being declared on 14th October 2025.

The water quality issue was fixed on 16th October 2025 and the Renal Unit returned back to normal operations from 17th October 2025 when the incident was stood down. At the time of this report a hot debrief has taken place but the cold debrief and post-incident report have not yet been undertaken.

11.2 Live Incidents / Reponses during Reporting Period

Although not requiring formal declaration as incidents, the following internal or external incidents/events were responded to by HHP. The EPRR Framework principles were applied to varying degrees in response to these incidents/events, which range from on-call Health Commander structures, response through normal operational mechanisms or utilising EPRR principles of command and control establishing a physical or virtual Incident Coordination Centre (ICC). Any lessons learned from these incidents were captured as part of post-incident debriefs where applicable.

Date	Incident	Trusts Involved	Incident Coordination	Trust Declared EPRR Incident
11/11/2024	Midwifery Support Worker industrial action	NLAG	IA Planning Group established. Virtual ICC in place during strike	No
03/12/2024	Hull contaminated spice incidents	HUTH	Multi-agency response with TCG	No
05/12/2024	Ward C1 water outage	HUTH	IPC, Estates	No
01/01/2025	Severe road traffic collision in Hull	HUTH	YAS, ED, Major Trauma	No
06/01/2025	EMAS declared critical incident due to operational pressures	NLAG	Multi-agency response	No
22/01/2025	Road traffic collision between school bus and tractor (police declared major incident)	HUTH	Multi-agency response	No
30/01/2025	Op Elysian – Lord Prescott funeral	HUTH	Multi-agency response with SCG/TCG	No
18/02/2025	Lockdown of St Stephens shopping centre due to suspicious package	HUTH	Multi-agency response	No
07/03/2025	HUTH switchboard server outage	HUTH	Facilities, Site, All wards	No
10/03/2025	Op Poetry – North Sea tanker collisions	NLAG	Multi-agency response with SCG/TCG	No
07/04/2025	Fire in Estates workshop at DPOWH	NLAG	Estates, F&RS	No
16/04/2025	PAC system failure	HUTH	Digital, All wards	No
09/05/2025	HRI Maternity and NICU pressures	HUTH	Family Services	No
10/06/2025	ePMA outage	NLAG	Pharmacy, Digital, All wards	No

20/06/2025	ePMA outage	NLAG	Pharmacy, Digital, All wards	No
04/07/2025	CHH switchboard phones outage	HUTH	Facilities, Site, All wards	No
08/07/2025	ePMA outage	NLAG	Pharmacy, Digital, All wards	No
25/07/2025	BMA Resident Doctors industrial action	HUTH & NLAG	IA Planning Group established. Virtual ICC in place during strike	No
16/08/2025	Planned protest march past HRI	HUTH	Multi-agency response	No
27/08/2025	Op Leste – National anti-immigration protests	HUTH & NLAG	Multi-agency response	No
01/09/2025	Planned go live of new SHYPS LIMS system	HUTH	Y&SH, HUTH	No
07/10/2025	Fire in Doctors Accommodation at SGH	NLAG	Estates, Site	No
07/10/2025	Gas leak near the Renal Unit at SGH	NLAG	Estates, Site	No
22/10/2025	MRI and CT Scanner failure at SGH	NLAG	SS&SC, Estates	No

Both Trusts have responded to a high number of internal and external incidents as listed above. Through planning and response arrangements both Trusts have managed to maintain critical services throughout these periods by the implementation of service-level BCPs and/or coordination through EPRR command and control principles.

11.3 Medical Oxygen Delivery Systems and Monitoring

There has been no change to the arrangements in place for the monitoring of medical oxygen delivery systems since last year's EPRR Regulatory Report. The information below was provided last year and included this year for reference.

On 7th November 2020 there was an incident declared at NLAG to respond to a potential risk of Trust's oxygen supply infrastructure being unable to meet the patient demand for piped oxygen. As part of the post-incident investigation a series of operational plans and assurance checks were put in place to ensure the potential risk is routinely monitored and managed.

The Audit, Risk and Governance Committees-in-Common asked for the ongoing assurance that the measures and procedures put in place remain effective. NLAG has a number of operational and emergency plans that are used to prevent and respond to an oxygen delivery incident. These include the Oxygen Provision Monitoring and Alarm Activation Plan (DCM488), flow rates and WebV information, and the Estates Emergency On-Call Manual.

In addition to the operational plans the monitoring of the oxygen delivery flow rate to ward areas is monitored by the NLAG Operation Centres to ensure that ward areas that are pulling a higher demand are highlighted at the earliest opportunity and can be reviewed to ensure the pull on the ring is not exceeding the maximum flow rate. If it is noticed that the oxygen flow rate is exceeding the stated flow rate for an area, this is raised with department staff to check for accuracy and then escalated to Estates.

The NLAG Operations Centre have access to the flow meters live teleweb on the Hub which allows live data feedback. If flow rates were to cause an issue within a ring, then the early warning local alarms would sound to alert staff in the area of a potential issue. Designated Nursing Officer (DNO) training was expended to include all Site Matrons to provide further resilience 24/7 onsite within Operations.

The Medical Gas Committee has a standing agenda item for Medical Oxygen which includes national and BOC supplier information, project updates, oxygen demand and capacity review,

equipment update, training update, alerts, risks and incidents. All works relating to the Medical Gas Pipeline System and changes involving medical gas cylinders are brought to the meeting for discussion and to ensure compliance with Health Technical Memorandum 02-01: Medical Gas Pipeline Systems (Part A and Part B) and NHS C0871 Performance of Healthcare Cryogenic Liquid Oxygen Systems Nov 2021. Any derogations from the above are discussed and, where supported, are raised with the Quality and Safety Committee for consideration. Where derogations are not supported assurance is sought that changes are made to ensure compliance. A Quality Control Assessment is undertaken as part of commissioning and works sign off.

12.0 Trust Boards in Common Action Required

The Trust Boards in Common are asked to:

- Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2025/26 (**Appendix A**)
- Approve HUTH's Statement of Compliance for the NHS England Core Standards for EPRR 2025/26 (**Appendix B**)

Appendix A

North East and Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2025-26

STATEMENT OF COMPLIANCE

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, NLAG will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer
Sarah Tedford, Interim Group Chief Delivery Officer

Date signed: 17/10/2025

11/12/2025	11/12/2025	Will be included in 2025/26
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

North East and Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2025-26

STATEMENT OF COMPLIANCE

Hull University Teaching Hospitals NHS Trust (HUTH) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, HUTH will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer
Sarah Tedford, Interim Group Chief Delivery Officer

Date signed: 17/10/2025



11/12/2025	11/12/2025	Will be included in 2025/26
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix C

NLAG Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
Domain 3 - Duty to maintain Plans									
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	NLAG has several policies and SOP that cover how the organisation will respond and deal with infectious diseases including the national infection prevention and control manual. Work has progressed on ensuring HCID arrangements are clear and embedded with IPC plans in the process of being updated.	Partially compliant	Review existing infectious diseases policies and plans, updating terminology and ensuirng HCID arrangements are clear and embedded	Wendy Millard, Deputy Director of Infectioon Prevention and Control	31/12/2025
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NLAG does not have a stand alone policy in repsonse to new and emerging pandemics but has several policies that covers the response actions. A new and emerging pandemics plan is being developed.	Partially compliant	Development of a new and emerging pandemics plan to be produced as a HHP Group-wide approach	Wendy Millard, Deputy Director of Infectioon Prevention and Control	31/03/2026
Domain 9 - Business Continuity									
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Approaching standards with an improvement plan in place. This is due to changes in move from DPST which NLAG was fully compliant with in 2024 to the new CAF (Cyber Assurance Framework) Toolkit with the toolkit including different elements to the DPST which NLAG does not fully meet yet	Partially compliant	Work through the actions within the CAF improvement plan ahead of 2026 submission	Sue Meakin, Group Data Protection Officer / Tony Deal, Group Chief Technology Officer	31/07/2026
Domain 10 - CBRN									
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	The Trust has suitable access to both wet and dry decontamination equipment 24/7 at both EDs. Staff have adequate access to FFP3 24/7 and are provided with the relevant fit testing through the Infection Control and Prevention Team and trained cascade trainers. FFP3's are disposable equipment and are supplied to ward/department areas, there is no inventory maintained of their issue. Additional FFP3's are delivered to wards/departments when required on request to replenish disposed masks. There is currently not enough FFP3 fit tested staff across NLAG for this standard to be fully compliant.	Partially compliant	FFP3 fit testing training to be increased to ensure adequate number of staff FIT tested across key departments involved in FFP3 PPE response	Wendy Millard, Deputy Director of Infectioon Prevention and Control	31/05/2026

Appendix D

HUTH Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
Domain 3 - Duty to maintain Plans									
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	HUTH has several policies and SOP that cover how the organisation will respond and deal with infectious diseases including the national infection prevention and control manual. Work has progressed on ensuring HCID arrangements are clear and embedded with IPC plans in the process of being updated.	Partially compliant	Review existing infectious diseases policies and plans, updating terminology and ensuirng HCID arrangements are clear and embedded	Wendy Millard, Deputy Director of Infectioon Prevention and Control	31/12/2025
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	HUTH does not have a stand alone policy in repsonse to new and emerging pandemics but has several policies that covers the response actions. A new and emerging pandemics plan is being developed.	Partially compliant	Development of a new and emerging pandemics plan to be produced as a HHP Group-wide approach	Wendy Millard, Deputy Director of Infectioon Prevention and Control	31/03/2026
Domain 9 - Business Continuity									
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Approaching standards with an improvement plan in place. This is due to changes in move from DPST to the new CAF (Cyber Assurance Framework) Toolkit with the toolkit including different elements to the DPST which HUTH does not fully meet yet	Partially compliant	Work through the actions within the CAF improvement plan ahead of 2026 submission	Sue Meakin, Group Data Protection Officer / Tony Deal, Group Chief Technology Officer	31/07/2026
Domain 10 - CBRN									
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the	Documented roles for people forming the decontamination team including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Equipment is available and able to be deployed 24/7, however we currently only have 21 PRPS trained members of ED staff who are able to undertake wet decontamination, and this not enough to provide a 24/7 cover. A review of training availability is taking place and training days are being released to train more staff over the coming months.	Partially compliant	HRI ED to increase trained CBRN PRPS staff to enable robust coverage across rotas 24/7 to provide adequate decontamination cover	Loraine Laws, Operations Director / Wendy Page, Nurse Director / Ben Raynor, Chief of Service	31/07/2026

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	CBRN element within the EPRR TNA. A recent review of training material has been completed. Which is now a group-wide aligned training package. There are multiple trainers within HUTH, but with the group structure we can utilise mutual aid trainers from NLAG as required.	Partially compliant	A further review of the TNA to be developed to include areas that are at a greater risk of self presenters attending to seek help	Ashley Leggott, EPRR Manager / Lauren Beardshaw, HRI ED Lead	31/12/2025
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Training sessions are delivered through the year for staff within the ED, however there have been limited sessions in 2024/25, and the requirment to update with the latest IOR principles remains outstanding. Training material has been updated with latest IOR principles and incorporates a theoretical assessment along with practical observation. A training schedule has now been established for the next 12 months.	Partially compliant	A further review of the TNA to be developed to include areas that are at a greater risk of self presenters attending to seek help and for those identified posts to be incorproated into the training schedule. This will also provide staff competency records as evidence	Ashley Leggott, EPRR Manager / Lauren Beardshaw, HRI ED Lead	28/02/2026

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)233

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	Andy Haywood – Group Chief Strategy, Partnerships and Digital Officer
Contact Officer / Author	Linsay Cunningham – Group Director of Strategy and Partnerships
Title of Report	**Partnerships Strategy**
Executive Summary	An extensive process of engagement was undertaken to inform the development of the Partnerships Strategy. It is a key enabling strategy and describes *how* the organisation will work with partners to deliver the overarching ambitions within the Group Strategy (approved August 2025) and *how* we will deliver our Group Strategy commitment: "We will work well with others, build trust and develop ambitious partnerships for the future." The purpose of the Partnerships Strategy is to: • prioritise energy and resources into the areas that will have the biggest impact • signal to current and potential future partners that our organisation is 'open for business' The Partnerships Strategy sets out how we will deliver our ambitions through four key areas of focus: 1. Our health and care system 2. Our education and learning partners 3. Our local economy 4. Our people and communities In each of these spheres, we will take positive action to ensure we have the infrastructure and relationships in place to deliver the best care for our patients in services that our people are proud to work in and support our population to live healthier lives. The Strategy provides a three-year road map and a summary set of metrics to measure delivery and impact. The Board is asked to: • formally approve the Partnerships Strategy
Background Information and/or Supporting Document(s) (if applicable)	• Group Strategy • Embedding the Strategy (slidepack)
Prior Approval Process	Strategic Programmes and Partnerships Committee in Common (22/10/25)
Financial Implication(s) (if applicable)	No direct implications

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The Partnerships Strategy will support delivery of the Group Strategy ambition to support our population to live more years in good health and narrow the gap in access for those from our most deprived communities.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS Humber Health Partnership

Partnerships Strategy

2025-2028

Contents

Foreword 3
Who we are – NHS Humber Health Partnership (HHP) 4
Where we are now 5
Our track record of collaboration 5
Our population 5
Where we are trying to get to – Our Ambition 7
Our Strategic Goals 7
Our Partnership Ambition 7
How we will get there – Our Action Plan 8
Our Health and Care System 9
Education and Learning Partnerships 13
Local Economy 16
Local Communities 20
How will we know we are successful 24
Our roadmap for delivery 26

Foreword

The publication of the government's 10 Year Health Plan reinforces the vital role of partnerships in delivering healthcare in the future. We cannot succeed in delivering what our population needs without strong collaborative relationships across our health and care system and beyond.

As our lives become ever more connected so too must our healthcare provision – we need services that work flexibly around people rather than expecting people and their health needs to fit neatly into organisational boxes. The only way to deliver joined-up care is for us as healthcare providers to join up and work together: to talk to one another, to share information, to trust one another and to hold each other to account, ensuring that in all we do we put the needs of our patients first.

Amongst our most important partnerships are those with the roughly one million people who live in our region and rely on the services we provide. As our population changes and health needs become increasingly complex, it is more important than ever that we work together with our population and take collective responsibility for our health and wellbeing.

By working together with our population, our people and our partners in the public, private, voluntary and community sectors, we can position the Humber at the forefront of the innovations that will change health and healthcare in our country.

There are so many great assets on our doorstep. This strategy sets out where we will focus and how we aim to work together to maximise the benefit of these assets and deliver the three core ambitions in our Group Strategy:

- Our patients get the best care
- Our people feel proud to work here
- Our population lives more years in good health

Andy Haywood

Group Chief Strategy, Partnerships and Digital Officer

Who we are – NHS Humber Health Partnership (HHP)

The NHS Humber Health Partnership (HHP) is a group of two providers of acute, specialist and community healthcare services – Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Formed in August 2023, the Partnership brings together the strengths of both organisations, pooling resources and driving value through scale across a large region.

Our vision is: **United by Compassion, Driving for Excellence**.

The hospitals on either side of the Humber have been working ever more closely together over the last 25 years, ever since Castle Hill Hospital first started providing radiotherapy and other specialist cancer services for patients from Northern Lincolnshire.

Over the past two decades our collaborative journey has continued and now under our Group leadership model, we are operating with single leadership teams for all our clinical services across both banks of the Humber, helping to ensure we have sustainable models of care and patients across the region have equitable access to the best possible care.

Our organisation in numbers…

19,500 staff

600 volunteers

5,000 patient contacts every day

1,500,000 population served

We have developed this Partnerships Strategy to give clear direction to leaders across our organisation, ensuring energy and resources are targeted appropriately. It provides a roadmap of the key actions we will take to solidify existing partnerships and build the new and ambitious collaborations we need as to deliver our overarching ambition to be one of the leading hospital groups in the UK, delivering **safe**, **sustainable** and **inclusive** healthcare services. It also provides clarity for our external partners and stakeholders on our priorities and key areas of focus over the coming years.

Where we are now

Our track record of collaboration

This Partnerships Strategy builds upon a strong track record of collaboration and partnership working both within and beyond the Humber Health Partnership (HHP).

Despite operating under different systems of governance, our two member trusts increased their levels of cooperation and collaboration significantly over recent years, laying strong foundations for the formation of the group. The group model leverages the strengths of NLaG's position as a Foundation Trust and HUTH's standing as a University Teaching Hospital and tertiary centre, harnessing different strengths and clinical expertise across the respective organisations. The diversity within the group provides a strong platform upon which to build, enabling teams to rapidly adopt "best in class" models to develop stronger, more sustainable services across the sub-region.

Increasing collaboration is also evident across the wider health and care sector within the Humber and North Yorkshire region. Improved joint working between primary, secondary, community, mental health and social care provides a strong foundation on which to build a new neighbourhood model of care, in which services are better integrated and designed around the needs of patients and service-users.

Over recent years, both NLaG and HUTH have developed partnerships with organisations from a range of sectors. These key partnership relationships need to be strengthened and expanded as the group operating model becomes fully embedded – moving from multiple bilateral relationships to group-wide relationships that will drive increased value for our population.

Our population

Around 1 million people live in the Humber region, which is a diverse mix of industrial, urban, rural and coastal areas. Our population can expect to live shorter and less healthy lives than those living in other parts of England. Not only do people within the Humber have a lower life expectancy when compared to the England average but they are spending an increasing proportion of their lives living with serious health conditions.

The conditions in which people live and work, combined with the impact of deprivation, mean that a greater proportion of the Humber population have one or more long-term health condition.[1] The life chances of people vary significantly across the Humber with many individuals and communities disproportionately affected by ill-health and premature death.

This puts a significant burden on healthcare services, with those living in the most deprived communities twice as likely to attend an Emergency Department as those living in the most affluent communities,[2] increasingly likely to have multiple health conditions, more likely to deteriorate while waiting for surgery and least likely to be able to use digital solutions.[3]

We have both a moral and an economic imperative to do what we can to improve the underlying health of our population. Access to healthcare services accounts for only a small proportion of an individual's health outcomes, with wider socio-economic factors playing a far

[1] NHS Digital (2020) *Quality and Outcomes Framework 2019-20* QOF Report

[2] NHS Digital (2020) *Hospital Accident & Emergency Activity 2019-20* A&E Activity 2019-20

[3] GiRFT (2022) *Design and layout of elective surgical hubs – a guide for NHS systems and regions to support planning of effective surgical hubs* GiRFT Report p.6

greater role.[4] We must therefore work in partnership with and support our patients, our people and our population to deliver on this health improvement agenda together.

[4] David Buck, Alex Baylis, Durka Dougall and Ruth Robertson (2018) *A vision for population health: Towards a healthier future* The Kings Fund A Vision For Population Health | The King's Fund

Where we are trying to get to – Our Ambition

Our Strategic Goals

Our Partnerships Strategy is an enabling strategy that supports us to deliver our wider Group strategic goals, which are:

- Our patients get the best care
- Our people feel proud to work here
- Our population lives more years in good health

Our patients get the best care

Delivering effective healthcare services that meet the diverse needs of our population cannot be done in isolation from other health and care organisations, local government, voluntary, community and social enterprise (VCSE) sector bodies, individuals, families, and carers. As care increasingly shifts from hospital to community, we need effective partnerships with organisations across the health and care system to deliver integrated services that are effective now and fit for the future.

Our people feel proud to work here

Our people are our biggest asset and key to ensuring we deliver the best care for our patients. Working in partnership with our people, giving ownership, accountability and earned autonomy will ensure our services are the best they can be and our people are proud to call HHP their place of work. We also need strong and wide-reaching partnerships with education, training and skills providers, research, industry, and commercial bodies to deliver the workforce, innovation, and infrastructure we require to deliver excellent care in the future.

Our population lives more years in good health

Many of the factors that impact on individuals and communities' health and wellbeing (their conditions of living or wider determinants of health) sit outside of our direct control as a provider of healthcare services. Nevertheless, as a large public sector body, a major employer, health and care sector leader, and a trusted voice within local communities our sphere of influence is significant. We have an important role to play in shaping decisions and advocating for better health for our people and communities. We can make a difference to the health of our population by leveraging our partnerships to maximise the impact we can have on the lives and life chances of our patients, our people, and our population.

Our Partnership Ambition

To achieve these ambitions, we will strive to be good partners in all we do. We will work well with others, build trust and develop ambitious partnerships for the future.

Our aim is to be genuinely collaborative in all that we do, embedding a culture of shared ownership, shared risk, and collective reward.

We will be an organisation that responds to challenges by asking: "how do we solve this problem together?" rather than attempting to pass the responsibility onto someone else. We will be trusted by our partners to deliver on their behalf and have a reputation as an innovative, exciting organisation that is "open for business".

How we will get there – Our Action Plan

To achieve our Partnerships ambition, we will embed the strong foundations we have in place by continuing to play an active role in our health and care system, cementing existing partnerships belonging to each of our constituent organisations. We will build on these foundations by leveraging the strength of the group, expanding our influence, and building new collaborative arrangements across a range of areas.

Our Commitment

We will work well with others, build trust and develop ambitious partnerships for the future

We will deliver our partnerships ambitions in four key areas:

1. Our health and care system
2. Our education and learning partners
3. Our local economy
4. Our people and communities

In each of these spheres, we will take positive action to ensure we have the infrastructure and relationships in place to deliver the best care for our patients in services that our people are proud to work in and support our population to live healthier lives.

Health and Care System

Strategic Action:

We will play a leading role in local health and care partnerships

The Humber is served by a complex and diverse health and care economy. This diversity creates opportunities to deliver services differently, leveraging the different assets of our social enterprises, voluntary sector organisations and wider health partners, with the potential to create new vehicles to deliver neighbourhood health services. It also creates challenges, particularly for an organisation as big as Humber Health Partnership (HHP), in identifying where best to invest energy and resources on collaborative arrangements.

Working in partnership with organisations across the health and care system is vital to the future sustainability of our services. Instead of passing patients back and forth between services and providers, increasing costs to the system and delivering poorer outcomes for patients, our clinical teams must work as part of an integrated system where care is organised around the person rather than organisational boundaries.

By working together we can:

- ✓ improve the quality and safety of healthcare services we deliver and improve access for our patients – helping more patients to get to the right care, first time.
- ✓ improve peoples' experience of care – by providing greater continuity through more joined-up care.
- ✓ deliver better outcomes for patients – by bringing together different clinical expertise to support patients in the best way.
- ✓ deliver better value for money – by reducing duplication and wasted effort and helping to ensure the right patients are being looked after in the right setting.

To deliver the government's vision for a Neighbourhood Health Service,[5] these existing partnerships will become ever more important, providing the foundations upon which new service models can be built. As funding and resources shift from hospital into communities, it will be ever more important to have the right infrastructure in place within each of our neighbourhoods and communities to ensure specialist expertise are deployed into neighbourhood services in the most effective and efficient way possible. A key priority of this strategy is to work with stakeholders in each of our localities to actively shape our response to the 10 Year Health Plan and ensure we design the right partnerships and contractual arrangements to deliver neighbourhood care effectively in our geography.

Our Aim is:

to be a trusted partner in our health and care system, sharing risk and leading transformational change.

This will help to deliver:

more effective services that better meet the needs of our populations and reduce health inequity.

[5] 10 Year Health Plan Fit for the future: 10 Year Health Plan for England - executive summary - GOV.UK

To deliver this aim, we will focus our efforts on the following **key actions**:

Actions:

1. We will be good system leaders
2. We will increase day-to-day collaboration
3. We will give our teams permission and tools to collaborate by default

1. Be good system leaders

The Humber and North Yorkshire health and care economy has a complex system architecture, encompassing multiple sets of collaborative arrangements across multiple geographies and sectors. This system architecture has developed over time and will continue to change in response to local and national policy changes, particularly the reforms set out within the 10 Year Health Plan.

At the current time, there are a number of key collaborative arrangements in which Humber Health Partnership (HHP) takes a leading role, including:

- The Humber and North Yorkshire Integrated Care System (ICS)
- Sector collaborative arrangements:
    - Humber and North Yorkshire Collaborative of Acute Providers (CAP)
    - Humber and North Yorkshire Community Collaborative
- Health and Care Partnership arrangements in each of the four local authority areas served by HHP
    - North East Lincolnshire Health and Care Partnership
    - North Lincolnshire Place Partnership
    - Hull Health and Care Partnership
    - East Riding Place Health and Care Committee
- Health and Wellbeing Boards in the four main local authority areas served by HHP
- Working groups responsible for overseeing the implementation of Neighbourhood Health across each of our places
- Humber Local Resilience Forum (LRF)
- A wide range of operational and tactical health and care system leadership groups

We are committed to playing a full and active role across our system architecture and will respond to changes as they emerge. We will deploy leadership resource to actively participate and play our part in joint decision-making and strategic leadership. We will build trust and credibility with our partners so that together we can take risks to deliver the type of radical change we need. We will ensure that all senior leaders are equipped and supported to work as system leaders – focusing on what is best for patients and the population and looking beyond their own organisational boundaries.

At the same time, we will ensure that such collaborative arrangements drive value for all partners, by reducing transactional costs and removing barriers to collaboration within frontline service delivery. Where collaborative arrangements lead to inefficiencies and duplication of effort or get in the way of delivering improved outcomes for patients and the population, we will be hold ourselves and our partners to account and reduce or remove any structures or processes that do not add value to our system.

Our priority area of focus will be working with local authority, social care and community services partners to unlock capacity in the system and ensure, wherever possible, patients are treated in the right place at the right time. Working together we will address the challenges we see every day of patients staying too long in hospital when they would do

better at home with wrap-around support. We recognise these are difficult challenges to solve and will work closely with partners to move resources around the system to ensure we are doing everything we can to avoid people coming to hospital when they don't need to or staying any longer than is absolutely necessary when they do come.

2. Increase day-to-day collaboration

Effective engagement in system leadership is important for unlocking barriers and creating the operating environment for collaboration. However, the biggest impact of partnership working comes from ensuring strong links are in place at an operational level.

We will do more to facilitate partnership working on a day-to-day basis between frontline teams, encouraging joint ownership and collaborative problem-solving and working to unblock barriers and challenge cultures that are organisationally focused and do not support integration.

This will include actions such as:

- Looking at where we can physically bring teams together. Developing more joint working spaces so professionals from different organisations can work alongside and learn from one another on a day-to-day basis.
- Making it easier for staff and volunteers to move between organisations or work across the whole patient pathway without having to change employer.[6]
- Making it easier to move money between organisations and different parts of the system where it supports more effective patient care and reduces overall costs within the system. This will include taking swift action to shift resources (both people and money) to work alongside primary and community colleagues to deliver services in a different way, supporting the transition to neighbourhood care.[7]
- Identifying clinical, operational and back-office functions that could be delivered in a more joined-up way across organisations to support integration and improved productivity across the system.

By enabling more health and care professionals from different sectors with different employers to work alongside one another on a day-to-day basis, we will unlock ideas and enable multidisciplinary teams to solve problems and challenges together leading to better outcomes for patients and more efficient and effective healthcare provision.

3. Upskilling for collaboration

Within our current health and care system there are a range of bureaucratic, behavioural and cultural barriers that prevent healthcare professionals from working together and putting in place more joined-up care. As we work together to unblock technical and administrative barriers, we will also seek to change behaviours by actively promoting collaboration and showcasing examples of the positive impact of joint working in our system.

We will provide opportunities for training and professional development to ensure our staff have the skills they need for working collaboratively across systems, as appropriate within their roles. This will include looking at how we deliver training jointly with other provider partners so teams from different parts of the system can learn and develop skills together.

[6] Further details are provided in the People Strategy

[7] Further details will be provided in our Finance Strategy

We will deliver these changes through actions such as:

- Expanding the reach of the Humber Generalist School, diversifying the range of courses and learning methods offered to reach a wider cohort of staff
- Incorporating appropriate partnership working and collaboration goals as a core element within career development plans as these are introduced for all staff across the organisation
- Developing toolkits, training and practical support through our Transformation Academy to enable teams to work more effectively and confidently across organisational boundaries
- Providing training and support – in new business models, entrepreneurship, contract development – to our current and future leaders to build the skills and knowledge they will need to work differently in the future

By giving our staff the permission and the tools they need to work across organisational boundaries, we will increase collaboration in frontline service delivery, leading to reduced duplication, handovers and delays and contributing to the delivery of better outcomes for patients.

Education and Learning Partnerships

Strategic Action:

We will develop strong and diverse partnerships with education providers to grow the flexible, adaptable and resilient workforce we need for tomorrow

The health and care workforce of the future will look very different to the workforce today as service models change and we begin to fully exploit the potential of new innovations such as genomics and AI. In coming years, a smaller proportion of healthcare professionals will see their primary place of work as a hospital ward or clinic, instead our workforce will increasingly fulfil some or all of their role from neighbourhood health centres, call centres, telehealth hubs and in peoples' own homes.

To enable this shift, we need to fundamentally shift how we recruit, train and keep our workforce. Strong and mutually supportive partnerships with a diverse range of education and learning providers will be critical to our success. Our size and geographic spread offers greater opportunities to shape the market and ensure our current and future workforce can access the type of training and development that will meet the needs of our services in the future.

Working collaboratively will unlock a number of key benefits, including:

- ✓ Providing more diverse learning experiences for students and learners at all levels
- ✓ Increasing our ability to shape the curriculum to ensure our future healthcare professionals are equipped to deliver services differently
- ✓ Additional economic and societal benefits through increasing access into employment and training through collaborative efforts on widening participation
- ✓ Increasing the return on our collective investment
- ✓ Unlocking potential new funding streams through innovative partnerships and commercial joint ventures

Our people are our greatest asset; we need to work with them to transform what we do and how we do it.

Our Aim is:

to have strong and effective partnerships with education, learning and skills providers

This will help to deliver:

effective learning and development opportunities for teams today and the flexible, adaptable and resilient workforce we need for tomorrow.

To deliver this aim, we will focus our efforts on the following **key actions**:

Actions:

1. We will build the innovative and forward-thinking partnerships we need to train our future workforce to meet the organisation's changing needs.
2. We will create inclusive opportunities for people in our communities, supporting local talent to flourish.

1. Re-shape how we train and develop our workforce

As the way in which we deliver care changes, so too must the way we train and develop our workforce. This includes ensuring our workforce is fully digitally-literate, able to take advantage of the opportunities and productivity improvements that new technologies will unlock. It also means enabling our professionals to work in an increasingly multi-disciplinary way, working across organisational and geographical boundaries.

To do this we need to solidify and deepen the relationships we have with our Further and Higher Education partners, leveraging our strength as University Teaching Hospitals and ensuring we are making the most of opportunities to shape curricula and implement innovative new approaches to teaching and learning. We must also seek out new partnership opportunities in areas where we need to make more rapid change and upskill staff.

Some key areas for action include:

- Working with our education partners to increase opportunities for interprofessional learning to break down professional boundaries and foster collaboration.
- Co-producing – with our education partners – innovative approaches to undergraduate and postgraduate learning, such as student-led clinics and other experiential learning techniques, to improve the learning experience for students and support clinical services to develop and improve.
- Developing pathway-based learning opportunities that enable students to undertake placements across multiple organisations and increase learning opportunities within community and neighbourhood teams.
- Building the digital literacy and capability of our workforce by, for example, ensuring adequate provision is made within supplier contracts for training and onboarding of new technologies.
- Undertaking comprehensive workforce planning at service and organisational level to inform future workforce training needs and enable informed discussions with current and potential future training suppliers.
- Developing a clear vision for advanced practice across the organisation, ensuring consistency in job titles and definitions and identifying a sustainable funding model for future development of advanced practice roles in light of changes to the apprenticeship levy.

By working with a broad range of partners to diversify our approach to education and learning, we can ensure our teams are able to constantly adapt and deliver healthcare services that are fit for the future.

2. Grow our own local talent

Across the NHS Humber Health Partnership, we employ over 19,000 people in a wide range of roles and professions, however, barriers exist that prevent some within our local communities from accessing the career development opportunities we can offer. Educational attainment rates in the Humber region are below national average and there are skills gaps within the local workforce.[8]

[8] R. Sarrakh, J. Heyes, S. Killick, K. Penney (2025) *Productivity, Training and Skills in Yorkshire, the Humber and the North East*, Productivity Insights Paper No. 048, The Productivity Institute Productivity, Training and Skills in Yorkshire, the Humber and the North East

As we develop our future workforce pipelines, we will support more inclusive growth through a targeted approach to training and workforce development, focused on widening participation and access. We will work in partnership with our education providers to establish a range of flexible routes into training and employment that will enable every one of our people to reach their full potential.

Our People Strategy sets out in more detail how we will achieve this. Some key areas for action include:

- Working with schools and colleges to promote careers in health and care, removing barriers to entry and raising aspirations of our young people.
- Embedding and ensuring the long-term sustainability of our Careers Ambassadors network.
- Working with partners, such as the cornerstone employer network to engage with the local community and provide inclusive career opportunities for young people and job seekers.
- Prioritising widening participation in our partnerships with further and higher education providers and use of the reformed apprenticeship (skills) levy to ensure young people from disadvantaged communities have the best possible access to training and development opportunities.
- Working closely with regional educational partners to co-create career pathways with local student enrolments aligned to workforce demand.
- Offering flexible career pathways and training routes that enable people at all stages of life to reach their full potential.
- Tackling discrimination, encouraging diversity and creating a sense of belonging. Ensuring that all staff, regardless of background, have equal access to career and job opportunities.

Partnership-working is vital to delivering our goals for widening participation and ensuring those living within the most deprived communities in the Humber have the same opportunities to develop rewarding careers within our health and care system as those living in the most affluent communities.

Local Economy

Strategic Action:

We will use our size and scale to bring national and international attention to the Humber region

The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there.[9] Our size and scale as a group enables us to do more to leverage this influence and maximise the benefits to the Humber.

As a major employer, and source of high-skilled jobs, we contribute significant value to the local economy. We are one of the largest employers in the region with over 19,000 members of staff. In the last five years we have generated circa £35 million inward investment into the system for clinical trials and research and secured a total of £68 million of external funding for decarbonisation schemes, helping to deliver our ambitious Net Zero targets.

Working collaboratively with a broader range of partners can leverage significant benefits to our organisation and to the region's economy, including:

- ✓ Driving inward investment into the region – by attracting investment into clinical research, innovation and infrastructure projects.
- ✓ Supporting delivery of our NetZero commitments – by leveraging research and infrastructure investment to identify opportunities for delivering sustainable healthcare for the future.
- ✓ Attracting and retaining top talent – by increasing opportunities for our workforce to lead and participate in world-class research and innovation.
- ✓ Building the reputation of the region – by bringing high-profile research and development opportunities into the organisation.
- ✓ Supporting local businesses and working with local suppliers to build resilience.

Working together as a group we have a significant asset base within the Humber's local economy. We will utilise these assets to drive good growth in our local economy, building and retaining talent within our region and supporting broader health improvements for our population.[10]

Our Aim is:

to play a more prominent role in supporting inclusive and sustainable growth in the Humber economy.

This will help to deliver:

improvements in the conditions of living (wider determinants of health) in our most deprived communities and high aspirations for our people and our population.

[9] The Health Foundation (2019) *Building healthier communities: the role of the NHS as an anchor institution* Building Healthier Communities

[10] Stubbs, R, Husbands, C, Dickson, N (2020) *Levelling Up the Yorkshire and Humber: health as the new wealth post-COVID*, NHS Confederation and Yorkshire Universities Levelling-Up Yorkshire and Humber Report

Over the coming three years, we will cement our relationships with key partners and develop new and ambitious collaborations to support inclusive growth and drive improvements to the health and social wellbeing of our population, working with our Combined Mayoral Authorities and other local government partners. We will leverage the influence we have as a group to forge new relationships with wider academic and industry partners, to advocate for our region and its people and attract investment and increased attention into our area.

To deliver this aim, we will focus our efforts on the following key actions:

Actions:

1. We will increase inward investment into the Humber for health and life science innovation.
2. We will leverage industry partnerships and expertise in carbon reduction to deliver our ambitious Net Zero targets and cement our role as leaders in the delivery of sustainable healthcare.
3. We will forge closer links with other like-minded organisations and influential institutions in the North of England, so that together we can have a stronger voice to advocate for our populations.

1. Research and innovation

The Humber region has a strong asset base within the health technology, pharmaceutical and life sciences sector.[11] As an organisation, HHP is in a strong position to attract further investment into the region for collaborative research and innovation, driving improved outcomes for our population. Our strong relationships with local universities, coupled with the availability of advanced manufacturing capabilities on our doorstep provides a platform on which to make the region a national hub for innovation that generates cutting edge solutions to our healthcare challenges.

The demography of the Humber region, with its diverse population, mix of rural, urban and coastal communities and levels of morbidity and mortality within the population, presents a unique opportunity to work differently with academic institutions and industry innovators to develop new technologies and innovative approaches to healthcare delivery.

Some of the actions we will take include:

- Developing innovation hubs to support collaboration with academic institutions and industry partners, enabling resource sharing and scaling of innovations.
- Supporting the growth of healthcare-related local start-ups by facilitating access to our research facilities, mentorship, and expertise.
- Supporting cross-sector research initiatives that bring together the scientific expertise of academic researchers with the technological and financial resources of industry partners for the benefit of the population.
- Forging new large-scale commercial partnerships to deliver innovative solutions to our big population health challenges – looking nationally and internationally to find the right partners with the ambition and expertise to deliver what we need.
- Expanding our research programmes for clinicians, nurses, midwives and allied health professionals, so that we can attract, develop and retain skilled professionals and researchers to the Humber region.

[11] Updating the Northern Powerhouse Independent Economic Review: Capabilities, scenario planning and narrative Area profiles

- Hosting regional and national research conferences to raise the profile of HHP and the Humber region as a leader in healthcare research innovation, attracting new investment and fostering wider economic regeneration.

Collaboration sits at the heart of our Research and Innovation Strategy, which sets out in more detail how we will deliver these actions.

2. Build sustainably and inclusively

Climate change is the greatest threat to human health in the 21st century, impacting everything from the types and numbers of cases we see to how and where we provide patient care. As healthcare providers, we have a responsibility to take action and lead by example in delivering care sustainably.

Our goal is to be recognised as the leading NHS organisation in the country in our journey to achieving net zero emissions and fostering climate resilience. We will focus on delivering future models of healthcare that are more sustainable and have a lower impact on the world around us. We will work towards rapid decarbonisation of our services and ways of working, foster greater resilience and adaptation in our buildings and service models and enable an inclusive transition that reduces inequalities and leaves no one and nowhere behind.

Key actions we will take include:

- Working with academic partners, local schools and staff to encourage innovation and ideas which contribute to delivering our Net Zero goals.
- Collaborating and sharing best practice on carbon reduction and achieving Net Zero goals with local businesses (SMEs).
- Working with partners across local government and the private sector to support patients, visitors, staff and contractors to travel in more sustainable ways.
- Working with sustainable, ethical, and local suppliers to meet our Net Zero targets.
- Ensuring the right partnerships are in place to build sustainability into all new facilities and improve the climate resilience of our sites and services.
- Working with Local Resilience Forum (LRF) partners to ensure co-ordinated emergency and climate change adaptation planning is in place.
- Supporting partners in the voluntary and community sector to plant trees, encourage biodiversity and improve the health of local people by providing access to our green spaces for green social prescribing.

Collaboration is essential to delivering these goals. Partnership working with academic institutions and research organisations will allow us to access research funding and identify actions we can take to reduce our impact on the environment. As set out in our Green Plan, Partnerships with local industry and leaders in the renewable energy sector will ensure we continue to be at the forefront of NHS organisations in our carbon reduction and delivery of Net Zero.

3. Leading voice for the North

The North of England economy produced £386 billion Gross Value Added (GVA) in 2021, equivalent to almost 19% of the overall UK economy.[12] Health innovation is one of the prime capabilities of the north of England's economy (as identified by the Northern Powerhouse

[12] Transforming Economic Performance | Transport for the North - Transport for the North

Independent Economic Review).[13] Achieving the untapped potential of the North requires working together at scale across the whole region to shape policy decisions, resource allocation and wide-scale change. Even as a group across the Humber, we are not big enough to fully exploit these opportunities.

There is a role for organisations in the North to work together to influence policy-making on health and wider areas that impact on health. There are significant similarities between the health needs of populations in Grimsby and Blackpool or Hull and Liverpool. By collaborating across the North, we can raise the profile of the distinct challenges and the innovative solutions our communities and partners are developing.

Key actions we will take include:

- Continue to build and strengthen our regional networks through the Collaborative of Acute Providers (CAP) and neighbouring acute collaboratives (e.g., WYAAT).
- Develop our clinical networks across Yorkshire and Humber and seek opportunities to grow these further across the North.
- Ensure we are playing a full part in (and getting full benefit from our membership of) Health Innovation Yorkshire and Humber (and the Health Innovation North network) to leverage investment into health and life sciences into our organisation/region.
- Explore opportunities to work with neighbouring tertiary providers on policy and influencing within and beyond the health sector.

[13] NPIER-2023-Summary-Report-For-Final-Publication.pdf

People and Communities

Strategic Action:

We will define a new relationship with our communities

Within the communities we serve, people are increasingly living with one or more long-term health conditions. The combined impacts of deprivation and ageing are putting increasing pressure on hospital services, with emergency admissions and demand for planned care both continuing to grow.

To deliver sustainable healthcare services in the future, we must reshape what we do and how we do it. We need a new, more collaborative, relationship with our patients where our services enable individuals to have more control over their own health and how they interact with us as a provider. The digital transformation within the NHS will support this shift by putting more power in the hands of patients who will increasingly interact with our services through the NHS App. We must adapt our culture and ways of working to support this change and work with partners to tackle barriers such as digital exclusion, so no one is left behind.

Working in partnership with our patients and service-users will deliver a number of benefits over time, including:

- ✓ Better clinical outcomes – through increased prevention and earlier intervention.
- ✓ Reduction in demand for urgent and emergency care – through better management of long-term conditions, helping us to cope better with anticipated increases in demand driven by population changes.
- ✓ Reduction of health inequity – through better identification of unmet needs and improved services for people living in the most deprived areas and other inclusion health groups.
- ✓ Delivering better value – by implementing shared decision making and what matters most to individual patients.
- ✓ A healthier population – by encouraging and supporting local people to make small changes in their own lives that can improve their overall health and wellbeing.

Re-defining our relationship with our patients and our population will require us to redesign our clinical models to enable more supported self-management of conditions, more responsive interventions and more preventative care.

Our Aim is:

to change the dynamic of our relationship with local people from one that is characterised by dependence and paternalism to one of collaboration and co-ownership.

This will help to deliver:

a more active, engaged, health-improving population.

Working with our partners in the NHS, local government, the voluntary, community and social enterprise (VCSE) sector, education and industry, we will support our populations to be actively engaged in their own health and wellbeing.

We will do achieve this aim by undertaking **key actions** in the following areas:

Actions:

1. We will build trust and confidence by listening and learning
2. We will reshape our models of care so that they support and enable more effective self-management
3. We will support our frontline staff to equip their patients to make small but impactful changes to their health and wellbeing
4. We will support our partners to equip communities to positively engage in improving their own health and wellbeing

1. Build trust and confidence by listening and learning

For our work in this area to be impactful, we need to be a trusted voice in our local communities. We will achieve this through demonstrating that we are listening, learning and open to challenge.

We will take time to listen to our communities and to really understand their needs, wants and aspirations. We will put in place effective systems, at both an individual and a corporate level, to actively listen to patients, their loved ones and wider communities and ensure we are constantly learning from the feedback we receive. We will actively share learning from when things have not gone well and demonstrate how we are listening and learning.

We will work with our patients, loved ones, staff and wider communities to design services and seek to involve our communities in making difficult decisions about how to use scare resources within our system.

How we will achieve this will be addressed through a refreshed patient experience and involvement action plan. This will include actions such as:

- Ensuring that simple and effective mechanisms are in place for patients and loved ones to share concerns, complaints and compliments and that an effective process for learning from complaints and feedback is also in place.
- Ensuring that simple and effective mechanisms are in place for staff to identify areas of concern and that an effective process for learning is also in place.[14]
- Provide training and tools to staff to enable them to use co-design within their services. Work with teams to embed engagement and involvement as a cultural norm and the way we undertake work across our hospitals.
- Actively promote and communicate how and where things have changed based on feedback. Build trust with communities by closing the feedback loop, explaining why it has not been possible to take on board suggestions as well as highlighting when changes have been made.

2. Reshape our models of care

Over the coming years, we will transform our services, enabling our patients to take greater control over when and how they interact with our services, book appointments and communicate with their healthcare team. This will include looking at how we support our patients and service users to manage their own health conditions and access the support they need in a more timely and responsive manner.

[14] How we will achieve this is set out in our Freedom to Speak Up Strategy

To do this, we will need to change the way in which clinical services are organised, how and when professionals are deployed and the systems we use to interact with our patients. These changes are set out in more detail in our Clinical Strategy, but will include actions such as:

- Turning our approach to outpatient services on its head so that hospital-based outpatient appointments become the exception rather than the norm.
- Increasing our use of virtual and remote monitoring and ensuing our services are geared up to maximise the potential of wearables and smart devices for our patients – this will include working with partners and leveraging external funding to address digital poverty within our communities.
- Changing our approach to booking and scheduling of appointments and reviewing access routes into services

As we redesign how and where we provide clinical services, we will put patient choice and control at the centre of service design, re-enforcing the shift from paternalistic to collaborative in every interaction.

3. Make Every Contact Count

Every day upwards of 15,000-20,000 people come through the doors of our organisation – this includes patients, staff, visitors, loved ones, suppliers, contractors, students and volunteers. This means that every single day we have a captive audience almost equivalent to a full MKM Stadium, which presents a huge opportunity to make a positive difference.

Over the period of this strategy, we will develop a robust and structured approach to making every contact count within our organisation. We will work with our teams to build their confidence, skills and expertise so that they can make more of an impact through their daily interactions to provide patients with the tools and the knowledge they need, and the encouragement of a trusted healthcare professional, to make small but impactful changes to their health and wellbeing.

This will include actions such as:

- Working with partners to ensure effective support services are in place and are easy to access/refer into for patients and frontline staff (e.g., tobacco dependency service, mental health liaison teams).
- Partnering with public health colleagues within local government to develop simple tools and campaigns for staff to engage in health promotion conversations with colleagues, patients and visitors.
- Partnering with Local Authority colleagues to provide training and development opportunities in Making Every Contact Count (MECC) for clinical and non-clinical staff, recognising the importance of the interactions our porters, catering and facilities teams have every day with patients, families and loved ones.

4. Support our population to live well

We need our patients and wider communities to be engaged and active in wanting to improve their health and quality of life. We will play our part in this by supporting our partners in local government, industry and the VCSE sector to ensure that health promotion and health improvement campaigns are as effective as possible, targeting the right populations and tackling the right issues. We will use our scale, reach and connections to support initiatives that are ambitious and transformative for our population. We will support our

partners in efforts to improve health literacy and digital inclusion, helping to tackle key drivers of health inequity.

This will include actions such as:

- Providing clinical input and expertise to increase effectiveness of campaigns.
- Providing data and insight to shape priorities for campaigns (identifying factors impacting on poor health outcomes and key target audiences).
- Providing appropriate access to patients, staff and other target audiences to undertake engagement exercises.
- Amplifying campaigns using our voice and reach through a range of channels.
- Working with a range of partners including charities, voluntary groups and private sector bodies to provide expert advice and support to health promotion and behaviour change.

How will we know we are successful

The Partnerships Strategy is an enabling strategy and designed to support delivery of wider strategic objectives of the organisation:

- Our patients get the best care
- Our people feel proud to work here
- Our population live more years in good health

We will therefore measure the success of this strategy through a range of direct measures, which demonstrate we are taking the required actions identified in this strategy and indirect or impact measures, which demonstrate that these actions (alongside other actions being undertaken by the organisation) are delivering our strategic goals.

These measures are summarised in the table below and will be reviewed and refreshed as required over the lifetime of this strategy.

Our Aim is…	**This will help to deliver…**	**Some of the key measures we will use to demonstrate delivery include…**
Health and Care System		

To be a trusted partner in our health and care system, sharing risk and leading transformational change.	More effective services that better meet the needs of our populations and reduce health inequity.	• Feedback from partners and strategic stakeholders (360° review)
		• Number of programmes HHP is undertaking a leadership role (%age change on previous year)
		• Performance/impact metrics:
		  ○ Average number of days from discharge ready date and actual discharge date
		  ○ Readmission rate band
		  ○ Percentage of people waiting over 6 weeks for a diagnostic procedure or test

Education and Learning Partners		

To have strong and effective partnerships with education, learning and skills providers	Effective learning and development opportunities for today and the flexible, adaptable and resilient workforce we need for tomorrow.	• Feedback from partners and strategic stakeholders (360° review)
		• Utilisation of Growth and Skills Levy within the organisation
		• Fill-rate of trainee-grade posts (across all disciplines/professions)
		• Performance/impact metrics:
		  ○ National Education and Training Survey overall satisfaction score
		  ○ NHS staff survey education and training theme score

Local Economy		

To play a more prominent role in supporting inclusive and sustainable growth in the Humber economy.	Improvements in the conditions of living (wider determinants of health) in our most deprived communities.	• Feedback from partners and strategic stakeholders (360° review)
		• Direct investment for R&D (change over time)
		• Number of research collaborations
		• Percentage of staff who are research-active
		• Direct investment to support carbon reduction and delivery of Green Plan
		• Indirect/impact measures:
		  ○ Investment in life sciences in the Humber region (change over time)
		  ○ Regional GDP/head

People and Communities		

To change the dynamic of our relationship with local people from one that is characterised by dependence and paternalism to one of collaboration and co-ownership.	A more active, engaged, health-improving population.	• Number of complaints (reduction over time)
		• Patient experience measures including:
		  ○ National surveys
		  ○ Friends and Family Test
		• Percentage of patients on PIFU pathways
		• Number of staff trained in MECC
		• Performance/impact metrics:
		  ○ Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit stop smoking

Our roadmap for delivery

This is an ambitious strategy, and it is not possible to deliver all the actions at once. The delivery plan below sets out the key priorities to be undertaken in each year of the strategy.

Year 1

- Continue to contribute to key forums within the Humber and North Yorkshire system and work to ensure HHP plays a lead role in re-shaping the local system architecture in response to the 10 Year Health Plan.
- Work with partners across health and care to develop plans to rapidly improve our NCTR (no criteria to reside) position across the region.
- Undertake comprehensive stakeholder mapping, streamline communication mechanisms and embed an effective stakeholder engagement approach.
- Identify priority areas for development of new strategic partnerships, to deliver other group strategies (e.g. Research and Innovation Strategy, Digital Strategy, Green Plan).
- Develop toolkits, training and practical support to enable frontline teams to collaborate more effectively.
- Co-produce a new patient experience and involvement action plan that will support a shift in the relationship our organisation has with our communities.

Year 2

- Refresh stakeholder mapping and engagement approach.
- Pursue new strategic partnerships in identified priority areas.
- Develop and expand our partnerships with key strategic stakeholders across the region to increase influence and impact locally, nationally and globally.
- Develop a core offer to support implementation of Neighbourhood Health models of care across the Humber region, working in partnership with primary care and other partners within and across each of our four Places.
- In line with implementation of the Group Clinical Strategy, design and implement new models of care that support collaboration and patients as active partners in their health and care.
- Develop a comprehensive future workforce plan, aligned to the group Clinical Strategy, including a clear strategy for advanced practice across the group, to drive the development of education and learning partnerships for the future.
- Identify opportunities, in line with our emerging estates strategy, to co-locate teams from multiple organisations to support greater collaboration.
- Begin to implement strategic action plans developed in year 1.

Year 3

- Refresh stakeholder mapping and engagement approach.
- Continue to deliver strategic action plans
- Evaluate success of strategic partnership development work and identify new areas of focus.
- Refresh Partnerships Strategy

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)234

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 December 2025**
Director Lead	**David Sharif, Group Director of Assurance**
Contact Officer / Author	**David Sharif, Group Director of Assurance**
Title of Report	**Terms of Reference (Committees-in-Common)**
Executive Summary	Attached are Terms of Reference for the following Committees-in-Common • Quality and Safety (endorsed 25.09.25) • Strategic Programmes and Partnerships (endorsed 22.10.25) • Workforce, Education and Culture (endorsed 29.10.25) • Performance Estates and Finance (endorsed 04.11.25)
Background Information and/or Supporting Document(s) (if applicable)	Terms of Reference are attached.
Prior Approval Process	Committees-in-Common
Financial Implication(s) (if applicable)	N/a
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/a
Recommended action(s) required	✓ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

QUALITY & SAFETY COMMITTEE-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	DCT305
Version:	1.0
This version issued:	
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	December 2026
Owner:	Committee Chair
Document type:	Terms of Reference
Number of pages:	9 (including front sheet)
Author / Contact:	Group Chief Nurse / Group Director of Assurance

1.0 Purpose

1.1. The purpose of the Quality & Safety Committee-in-Common is to provide oversight of and assurance to the trust board on the effectiveness of the quality governance arrangements in place across the clinical activities of the organisation in support of the provision of safe, effective and high-quality care and patient experience and / or to escalate risks to the achievement of that objective.

1.2. The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Patient - Safety and Population objectives.

1.3. The Committee-in-Common will work closely with the Strategic Programme and Partnerships Committees-in-Common, and together monitor progress towards the Group's Pioneer objective.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Quality & Safety Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Quality & Safety Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Quality & Safety Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Quality & Safety Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Quality & Safety Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the 'Trust Scheme of Delegation and Powers Reserved for the Trust Board' are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Quality & Safety Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Quality & Safety Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

3.3 The **Quality & Safety Committee-in-Common** will receive a routine report from the sub-groups that report into it.

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's quality strategy, priorities and key performance indicators (KPIs).

4.2 To provide oversight of the development and monitor delivery of other relevant strategies as delegated by the Trust Board to the committee.

4.3 To provide oversight of the development of the Trust's Annual Quality Report / Account in readiness for approval by the Trust Board and ensure that shared learning from the previous years' activities is disseminated throughout the trust and wider group.

4.4 To monitor and provide assurance to the Trust Board that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. [Whilst the committee's remit covers all the trust's services, the committee has a specific oversight role in respect of the quality & safety of the Trust's maternity & neonatal services.]

4.5 To assure the Trust Board that, where there are risks and issues that might jeopardise the Trust's ability to deliver excellent quality care, these risks and issues are being managed in a controlled and timely way.

4.6 To receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality and safety.

4.7 To maintain an overview of safe staffing and its impact on quality & safety.

4.8 To monitor information from adverse incidents, claims and concerns / complaints and other feedback received from patients / service users to demonstrate that the Trust is learning and making improvements.

4.9 To assure the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety and is responding appropriately to and learning from national and national reviews and other sources e.g. CQC, NHSE, royal colleges, NHS resolution, internal and external audit, Coroner etc.

4.10 To review and monitor clinical outcomes including but not limited to review of:

- clinical audit outcomes (and to approve the annual clinical audit programme);
- compliance with NICE guidance (and to approve any deviations from NICE guidance);
- outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths.

4.11 To understand themes/trends presenting in respect of patient safety and quality risks and to seek assurance on the control of those risks.

4.12 To utilise intelligence to identify where there are gaps in controls i.e. CQC Key Lines of Enquiry or Business Intelligence Software.

4.13 To initiate corrective action where gaps in the control of patient safety and quality risks are identified and monitor delivery of the agreed improvements. This will include requests for 'deep dives' and / or referral to another board committee for consideration.

4.14 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.15 To ensure that the trust continues to fulfil any requirements as determined by the CQC and other regulators and to provide assurance to the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety.

4.16 To have oversight of progress against delivery of the Research and Innovation strategy.

4.17 To review and approve annual reports, policies, procedures, guidelines and other documents (and any subsequent changes to those documents) which are applicable to the Trust's quality, patient safety and patient safety agenda and / or recommend their approval to the Trust Board.

4.18 To receive reports and/or minutes from the relevant reporting groups and meetings for monitoring and assurance purposes; ensuring action or decisions are made as and when identified.

4.19 To agree an annual work plan and monitor its delivery.

4.20 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Nurse

5.1.3 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Patient Safety and Clinical Governance

5.2.2 Group Director of Assurance or deputy

5.2.3 Governor Observer

5.2.4 ICB Observer Representative(s)

5.2.5 Patient Participation / Service User Voice Representative(s)

5.2.6 CQC (open invitation)

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Group Chief Delivery Officer

5.3.2 Other senior officers of the Trust

5.3.3 Other Non-Executive Directors

5.3.4 Care Group Triumvirates

5.3.5 Research & Development Managers

5.3.6 The Chair & Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.2 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.Chairperson

6.2.1 The Non-Executive Director members of the committee will be the chair of the **Quality & Safety Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective Quality & Safety Committees-in-Common will alternate at each monthly meeting. Both NED chairs will attend the agenda setting meetings

with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Quality & Safety Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the four core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within two working days of the meeting.

6.7.3 The ‘action tracker’ of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action ‘lead’ and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire and Goole NHS Foundation Trust

Appendix A

Decisions Delegated to the Quality & Safety Committee-in-Common (NLaG)

Type of Decision	**Delegated to the Quality & Safety Committee-in-Common (NLaG)**	**Reserved for NLaG Board of Directors**
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Quality Strategy & Priorities	Approval of Quality Strategy & Priorities Approval of Annual Quality Account
	Monitor the development and delivery of other relevant strategies	Approval of: Clinical Strategy Mental Health Strategy Quality Improvement Strategy Research, Development & Innovation Strategy
Quality & Safety / Patient Experience / Clinical Outcomes	Monitor and provide assurance that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated	Approval of Changes to the CQC Statement of Purpose
	Monitor and provide assurance on the safety of the Trust's services including Maternity & Neonatal Services	Assurance in respect of the safety of the Trust's Maternity & Neonatal Services Approval of CNST Maternity Improvement

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
		Scheme (MIS) Submission
	Monitor and provide assurance in respect of safe staffing and the impact on quality & safety	Approval of the recommendations from the Safe Staffing Review
	Approval of relevant quality & safety annual reports e.g. safeguarding, infection control, medicines management	
	Monitor Learning from Deaths	

Hull University Teaching Hospitals NHS Trust

QUALITY & SAFETY COMMITTEE-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	DCT305HU
Version:	2.0
This version issued:	Result
of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Group Trust Board
Date for review:	December 2026
Owner:	Committee Chair
Document type:	Terms of Reference
Number of pages:	9 (including front sheet)
Author / Contact:	Group Chief Nurse / Group Director of Assurance

1.0 Purpose

1.1 The purpose of the **Quality & Safety Committee-in-Common** is to provide oversight of and assurance to the trust board on the effectiveness of the quality governance arrangements in place across the clinical activities of the organisation in support of the provision of safe, effective and high-quality care and patient experience and / or to escalate risks to the achievement of that objective.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Patient - Safety and Population objectives.

1.3 The Committee-in-Common will work closely with the Strategic Programme and Partnerships Committees-in-Common, and together monitor progress towards the Group's Pioneer objective.

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Quality & Safety Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Quality & Safety Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Quality & Safety Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Quality & Safety Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Quality & Safety Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the 'Trust Scheme of Delegation' are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Quality & Safety Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Quality & Safety Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

3.3 The **Quality & Safety Committee-in-Common** will receive a routine report from the sub-groups that report into it.

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's quality strategy, priorities and key performance indicators (KPIs).

4.2 To provide oversight of the development and monitor delivery of other relevant strategies as delegated by the Trust Board to the committee.

4.3 To provide oversight of the development of the Trust's Annual Quality Report / Account in readiness for approval by the Trust Board and ensure that shared learning from the previous years' activities is disseminated throughout the trust and wider group.

4.4 To monitor and provide assurance to the Trust Board that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. [Whilst the committee's remit covers all the trust's services, the committee has a specific oversight role in respect of the quality & safety of the Trust's maternity & neonatal services.]

4.5 To assure the Trust Board that, where there are risks and issues that might jeopardise the Trust's ability to deliver excellent quality care, these risks and issues are being managed in a controlled and timely way.

4.6 To receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality and safety.

4.7 To maintain an overview of safe staffing and its impact on quality & safety.

4.8 To monitor information from adverse incidents, claims and concerns / complaints and other feedback received from patients / service users to demonstrate that the Trust is learning and making improvements.

4.9 To assure the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety and is responding appropriately to and learning from national and national reviews and other sources e.g. CQC, NHSE, royal colleges, NHS resolution, internal and external audit, Coroner etc.

4.10 To review and monitor clinical outcomes including but not limited to review of:

- clinical audit outcomes (and to approve the annual clinical audit programme);

- compliance with NICE guidance (and to approve any deviations from NICE guidance);
- outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths.

4.11 To understand themes/trends presenting in respect of patient safety and quality risks and to seek assurance on the control of those risks.

4.12 To utilise intelligence to identify where there are gaps in controls i.e. CQC Key Lines of Enquiry or Business Intelligence Software.

4.13 To initiate corrective action where gaps in the control of patient safety and quality risks are identified and monitor delivery of the agreed improvements. This will include requests for 'deep dives' and / or referral to another board committee for consideration.

4.14 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.15 To ensure that the trust continues to fulfil any requirements as determined by the CQC and other regulators and to provide assurance to the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety.

4.16 To have oversight of progress against delivery of the Research and Innovation strategy.

4.17 To review and approve annual reports, policies, procedures, guidelines and other documents (and any subsequent changes to those documents) which are applicable to the Trust's quality, patient safety and patient safety agenda and / or recommend their approval to the Trust Board.

4.18 To receive reports and/or minutes from the relevant reporting groups and meetings for monitoring and assurance purposes; ensuring action or decisions are made as and when identified.

4.19 To agree an annual work plan and monitor its delivery.

4.20 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Nurse

5.1.3 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Patient Safety and Clinical Governance

5.2.2 Group Director of Assurance or deputy

5.2.3 ICB Observer Representative(s)

5.2.4 Patient participation / service user voice representative

5.2.5 CQC (open invitation)

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Group Chief Delivery Officer

5.3.2 Other senior officers of the trust

5.3.3 Other Non-Executive / Associate Non-Executive Directors

5.3.4 Care Group Triumvirates

5.3.5 Research & Development Managers

5.3.6 The Chair & Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 There will be 10 meetings throughout the year, apart from August, plus a time out session in December. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Quality & Safety Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective Quality & Safety Committees-in-Common will alternate at each monthly meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second

Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Quality & Safety Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the four core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within two working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Hull University Teaching Hospitals NHS Trust

Appendix A

Decisions Delegated to the Quality & Safety Committee-in-Common (HUTH)

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Quality Strategy & Priorities	Approval of Quality Strategy & Priorities Approval of Annual Quality Account
	Monitor the development and delivery of other relevant strategies	Approval of: Clinical Strategy Mental Health Strategy Quality Improvement Strategy Research, Development & Innovation Strategy
Quality & Safety / Patient Experience / Clinical Outcomes	Monitor and provide assurance that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated	Approval of Changes to the CQC Statement of Purpose
	Monitor and provide assurance on the safety of the Trust's services including Maternity & Neonatal Services	Assurance in respect of the safety of the Trust's Maternity & Neonatal Services

		Approval of CNST Maternity Improvement Scheme (MIS) Submission
	Monitor and provide assurance in respect of safe staffing and the impact on quality & safety	Approval of the recommendations from the Safe Staffing Review
	Approval of relevant quality & safety annual reports e.g. safeguarding, infection control, medicines management	
	Learning from Deaths	

STRATEGIC PROGRAMMES AND PARTNERSHIPS COMMITTEE-IN-COMMON (HUTH)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	10 October 2025
Date approved:	
Approving body:	Trust Board (Group Chair)
Date for review:	October 2026
Owner:	Committee Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Strategy, Partnerships and Digital Officer / Group Director of Assurance

1.0 Purpose

1.1 The **Strategic Programmes and Partnerships Committee-in-Common** is responsible for providing assurance to the Trust Board that major programmes, significant projects and major service changes (involving capital and / or revenue) align to the strategic objectives for the Group and that they are being effectively identified, resourced, managed, and delivered on time with the intended benefits. The committee will also have oversight of post-project benefit realisation reviews and make recommendations for how capital resource is prioritised and allocated.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Pioneer objective.

1.3 The Committee-in-Common will work closely with the:

- Performance, Estates & Finance Committees-in-Common, which will monitor delivery of the annual capital programme (i.e. expenditure against plan); and
- Quality and Safety Committees-in-Common, to monitor progress towards the Group's Pioneer objective.

1.4 The Strategic Programme and Partnerships Committee-in-Common is also responsible for providing assurance to the Trust Board that its approaches to strategic partnerships are well-defined, planned and progressing in line with expectations and intended benefits.

2.0 Authority

2.1 In accordance with the NHS Trust's Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Strategic Programmes and Partnerships Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Strategic Programmes and Partnerships Committee-in-Common** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Strategic Programmes and Partnerships Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Strategic Programmes and Partnerships Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Strategic Programmes and Partnerships Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Strategic Programmes and Partnerships Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Strategic Programmes and Partnerships Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting advising of the risks faced.

4.0 Responsibilities

4.1 To review the Trust's Capital Plan, ensuring that major capital investment schemes are in line with and support the agreed strategy and objectives of the Trust and wider group.

4.2 To scrutinise and evaluate all significant business cases (including the review of outline and full business cases) for proposed capital investment that require either Strategic Programmes and Partnerships Committee-in-Common or Trust Board approval, ensuring that outcomes and benefits are clearly defined and are measurable.

4.3 To approve investment (and dis-investment) proposals and business cases within delegated limits and / or to make recommendations to the Trust Board for approval of business cases above the committee's delegated limits.

4.4 To monitor the pace, progress and effectiveness of delivery of major capital projects ensuring that emerging risks are being appropriately managed and mitigated.

4.5 To undertake post-project implementation evaluations to determine whether the intended outcomes and benefits have been realised and / or to determine any lessons to be learned for future programmes and major projects.

4.6 To have oversight of and receive assurance on the pace and progress of delivery of agreed areas of major service change / transformation including those being delivered jointly with external partners.

4.7 To have oversight of delivery of the Digital Strategy and plan including major IT investment programmes and enablers.

4.8 To agree an annual work plan for the Committee and monitor its delivery.

4.9 In summary, to cover the following areas of scope:

- Significant Capital Investment and Business Cases
- Capital Planning
- Digital
- Joint Strategic Capital Development Plans

4.11 To review at a high-level, the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise the specific assurances it highlights.

4.12 To monitor on an ongoing basis, the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.13 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.14 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board or other groups within HUTH, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Strategy, Partnerships and Digital Officer

5.1.4 Group Chief Delivery Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Transformation

5.2.3 Group Director of Assurance or deputy

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.2 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above including from the Care Group Triumvirates.

5.3.3 Group Chief Medical Officer

5.3.4 The Group Chair and Group Chief Executive* have a right of attendance and speaking rights

*In the absence of the Group Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held quarterly. Where required and in agreement with the committee chair and Group Chief Financial Officer for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Strategic Programmes and Partnerships Committee-in-Common.** In line with agreed CiC principles agreed between HUTH and NLaG, the Non-Executive Director chairs of the respective Strategic Programmes and Partnerships Committee-in-Common will alternate at each meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the Strategic Programmes and Partnerships Committee-in-Common will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the six core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum. Associate NEDs do not count towards quoracy.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the Trust Board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting, action tracker and escalation report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers).

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, NHSE Board Capability Assessment, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Strategic Programmes and Partnerships Committee-in-Common (HUTH)

Type of Decision	Delegated to the Strategic Programmes and Partnerships Committee-in-Common (HUTH)	Reserved for HUTH Trust Board
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.	
	Investigating or having investigated and / or seeking further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.	
Significant operational transformation programmes and major service changes	Consideration of the design and oversight of proposed major service change	Decisions on major service change
	Consideration of the design and oversight of the delivery of key workstreams within the HASR programme	
	Consideration of the design and oversight of the delivery of large-scale strategic projects or enablers	Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation
Capital	Consideration and approval of investment (and disinvestment) decisions and the development of capital investment plans	Approval of Capital Plan Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation

Type of Decision	Delegated to the Strategic Programmes and Partnerships Committee-in-Common (HUTH)	Reserved for HUTH Trust Board
Partnership	Consideration and approval of investment (and disinvestment) decisions and approaches to the work with strategic partners.	Approval of Partnership strategy
Strategy	Monitor the development and delivery of other relevant strategies	Digital Strategy

STRATEGIC PROGRAMMES AND PARTNERSHIPS COMMITTEE-IN-COMMON (NLAG)

Membership and Terms of Reference

Reference:	Reference?
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Date approved by owner (if applicable):	10 October 2025
Date approved:	
Approving body:	Trust Board
Date for review:	October 2026
Owner:	Committee Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Strategy, Partnerships and Digital Officer / Group Director of Assurance

1.0 Purpose

1.1 The **Strategic Programmes and Partnerships Committee-in-Common** is responsible for providing assurance to the Trust Board that major programmes, significant projects and major service changes (involving capital and / or revenue) align to the strategic objectives for the Group and that they are being effectively identified, resourced, managed, and delivered on time with the intended benefits. The committee will also have oversight of post-project benefit realisation reviews and make recommendations for how capital resource is prioritised and allocated.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Pioneer objective.

1.3 The Committee-in-Common will work closely with the:

- Performance, Estates & Finance Committees-in-Common, which will monitor delivery of the annual capital programme (i.e. expenditure against plan); and
- Quality and Safety Committees-in-Common, to monitor progress towards the Group's Pioneer objective.

1.4 The Strategic Programme and Partnerships Committee-in-Common is also responsible for providing assurance to the Trust Board that its approaches to strategic partnerships are well-defined, planned and progressing in line with expectations and intended benefits.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Strategic Programmes and Partnerships Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Strategic Programmes and Partnerships Committee-in-Common** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Strategic Programmes and Partnerships Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Strategic Programmes and Partnerships Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated

and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Strategic Programmes and Partnerships Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the *'Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Strategic Programmes and Partnerships Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Strategic Programmes and Partnerships Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting advising of the risks faced.

4.0 Responsibilities

4.1 To review the Trust's Capital Plan, ensuring that major capital investment schemes are in line with and support the agreed strategy and objectives of the Trust and wider group.

4.2 To scrutinise and evaluate all significant business cases (including the review of outline and full business cases) for proposed capital investment that require either Strategic Programmes and Partnerships Committee-in-Common or Trust Board approval, ensuring that outcomes and benefits are clearly defined and are measurable.

4.3 To approve investment (and dis-investment) proposals and business cases within delegated limits and / or to make recommendations to the Trust Board for approval of business cases above the committee's delegated limits.

4.4 To monitor the pace, progress and effectiveness of delivery of major capital projects ensuring that emerging risks are being appropriately managed and mitigated.

4.5 To undertake post-project implementation evaluations to determine whether the intended outcomes and benefits have been realised and / or to determine any lessons to be learned for future programmes and major projects.

4.6 To have oversight of and receive assurance on the pace and progress of delivery of agreed areas of major service change / transformation including those being delivered jointly with external partners.

4.7 To have oversight of delivery of the Digital Strategy and plan including major IT investment programmes and enablers.

4.8 To agree an annual work plan for the Committee and monitor its delivery.

4.9 In summary, to cover the following areas of scope:

- Significant Capital Investment and Business Cases
- Capital Planning
- Digital
- Joint Strategic Capital Development Plans

4.11 To review at a high-level, the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise the specific assurances it highlights.

4.12 To monitor on an ongoing basis, the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.13 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.14 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board or other groups within NLaG, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Strategy, Partnerships and Digital Officer

5.1.4 Group Chief Delivery Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Transformation

5.2.3 Group Director of Assurance or deputy

5.2.4 Governor observer

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.2 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above including from the Care Group Triumvirates.

5.3.3 Group Chief Medical Officer

5.3.4 The Group Chair and Group Chief Executive* have a right of attendance and speaking rights

*In the absence of the Group Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held quarterly. Where required and in agreement with the committee chair and Group Chief Financial Officer for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Strategic Programmes and Partnerships Committee-in-Common.** In line with agreed CiC principles agreed between HUTH and NLaG, the Non-Executive Director chairs of the respective Strategic Programmes and Partnerships Committee-in-Common will alternate at each meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the Strategic Programmes and Partnerships Committee-in-Common will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the six core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum. Associate NEDs do not count towards quoracy.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the Trust Board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting, action tracker and escalation report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers).

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, NHSE Board Capability Assessment, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Strategic Programmes and Partnerships Committee-in-Common (NLaG)

Type of Decision	Delegated to the Strategic Programmes and Partnerships Committee-in-Common (NLaG)	Reserved for NLaG Trust Board
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.	
	Investigating or having investigated and / or seeking further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.	
Significant operational transformation programmes and major service changes	Consideration of the design and oversight of proposed major service change	Decisions on major service change
	Consideration of the design and oversight of the delivery of key workstreams within the HASR programme	
	Consideration of the design and oversight of the delivery of large-scale strategic projects or enablers	Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation
Capital	Consideration and approval of investment (and disinvestment) decisions and the development of capital investment plans	Approval of Capital Plan Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation

Type of Decision	Delegated to the Strategic Programmes and Partnerships Committee-in-Common (NLaG)	Reserved for NLaG Trust Board
Partnership	Consideration and approval of investment (and disinvestment) decisions and approaches to the work with strategic partners.	Approval of Partnership strategy
Strategy	Monitor the development and delivery of other relevant strategies	Digital Strategy

Hull University Teaching Hospitals NHS Trust

WORKFORCE, EDUCATION & CULTURE COMMITTEE-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	DCT307HU
Version:	1.0
This version issued:	
Result of last review:	N/A
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Date for review:	December, 2026
Owner:	Group Chair
Document type:	Terms of Reference
Number of pages:	8 (including front sheet)
Author / Contact:	Simon Nearney, Group Chief People Officer / David Sharif, Group Director of Assurance

1.0 Purpose

1.1 The **Workforce, Education & Culture Committee-in-Common** is responsible for oversight of risks to the delivery of the Trust's People Strategy, associated plans and priorities which may impact on the health and wellbeing of the workforce and / or on the quality of care, for providing assurance to the trust board as to the effectiveness of the arrangements in place and / or for escalating risks to delivery.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its People objective.

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Workforce, Education & Culture Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Workforce, Education & Culture Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Workforce, Education & Culture Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Workforce, Education & Culture Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Workforce, Education & Culture Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Workforce, Education & Culture Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Workforce, Education & Culture Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

3.3 The **Workforce, Education & Culture Committee-in-Common** will receive a routine report from the sub-groups that report into it (as detailed within the work plan).

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's People Strategy and priorities and ensure that the People Strategy is aligned with the agreed strategic direction, culture, vision and values of the trust and wider group.

4.2 To provide input into and monitor delivery of the recruitment, retention, leadership, talent management & succession planning, training & organisational development and culture work programmes for the trust and wider group.

4.3 To monitor and provide assurance to the Trust Board that workforce risks which threaten the achievement of the strategic objectives of the trust and wider group and / or which may impact on the quality of care, are being identified and appropriately mitigated and / or to escalate concerns, as appropriate.

4.4 To monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements including but not limited to:

- Workforce Key Performance Indicators (KPIs)
  - Vacancies
  - Turnover
  - Sickness Absence
  - Mandatory Training
  - Appraisal
  - Temporary staffing / agency spend
  - Employee Relations / HR cases (e.g. disciplinaries, exclusions etc.)
- Staff Survey (local and national)

- Occupational Health & Wellbeing
- Staff Vaccination
- Registered Nurse & Midwifery Staffing
- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Guardian of Safe Working
- Job Planning
- Medical Revalidation
- Gender Pay Gap
- WRES
- WDES
- Modern Slavery

4.5 To monitor education, training and learning activities ensuring that they comply with the required legal and mandated standards and support service development / transformation and evidence-based practice.

4.6 To ensure that statutory workforce reporting requirements are met including escalation to the Trust Board for approval, as appropriate.

4.7 To support the development of emerging innovative roles.

4.8 To understand the workforce implications of service transformation and provide oversight of delivery of the agreed implementation plans.

4.9 To provide oversight of progress against the Trust's Research & Innovation Strategy and priorities.

4.10 To provide oversight of the Trust's arrangements for and monitor the progress of plans to improve staff engagement, communication and recognition.

4.17 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.11 To agree an annual work plan for the committee and monitor its delivery.

4.12 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief People Officer

5.1.3 Group Chief Medical Officer

5.1.4 Group Chief Nurse

5.2 In Attendance (all meetings)

5.2.1 Group Director of Assurance or deputy

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 North & South Bank Managing Directors

5.3.2 Other senior officers of the People Directorate & Trust

5.3.3 Others Non-Executive Directors

5.3.4 Director of Post Graduate Medical Education

5.3.5 Director of Undergraduate Medical Education

5.3.6 Guardian of Safe Working

5.3.7 Freedom to Speak Up Guardian

5.3.8 Other Topic & Network Leads

5.3.9 The Chair & Chief Executive* and have a right of attendance and speaking rights

*In their absence, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Workforce, Education & Culture Committee-in-Common.** In line with

agreed CiC principles agreed between NLaG and HUTH, the NED chairs of the respective **Workforce, Education & Culture Committees-in-Common** will alternate at each monthly meeting. Both NED chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second NED member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Workforce, Education & Culture Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive / Associate Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting and escalation / highlight report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Hull University Teaching Hospitals NHS Trust

Appendix A

Decisions Delegated to the Workforce, Education & Culture

Committee-in-Common

(HUTH)

Type of Decision	Delegated to the Workforce, Education & Culture Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the People Strategy, Delivery Plan & Priorities	Approval of People Strategy & Priorities
People / Workforce	Monitor and provide assurance that workforce risks which threaten the achievement of the trust' strategic objectives are being identified and appropriately mitigated	Approval of: Gender Pay Gap Report Modern Slavery Statement WDES Submission WRES Submission
	Monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements	

Northern Lincolnshire and Goole NHS Foundation Trust

WORKFORCE, EDUCATION & CULTURE COMMITTEE-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	DCT307
Version:	1.0
This version issued:	
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Group Trust Board
Date for review:	December, 2026
Owner:	Group Chair
Document type:	Terms of Reference
Number of pages:	8 (including front sheet)
Author / Contact:	Simon Nearney, Group Chief People Officer / David, Sharif, Group Director of Assurance

1.0 Purpose

1.1 The Workforce, Education & Culture Committee-in-Common is responsible for oversight of risks to the delivery of the Trust's People Strategy, associated plans and priorities which may impact on the health and wellbeing of the workforce and / or on the quality of care, for providing assurance to the trust board as to the effectiveness of the arrangements in place and / or for escalating risks to delivery.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its People objective.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Workforce, Education & Culture Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Workforce, Education & Culture Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Workforce, Education & Culture Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Workforce, Education & Culture Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Workforce, Education & Culture Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the 'Trust Scheme of Delegation and Powers Reserved for the Trust Board' are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Workforce, Education & Culture Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Workforce, Education & Culture Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

3.3 The **Workforce, Education & Culture Committee-in-Common** will receive a routine report from the sub-groups that report into it (as detailed within the work plan).

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's People Strategy and priorities and ensure that the People Strategy is aligned with the agreed strategic direction, culture, vision and values of the trust and wider group.

4.2 To provide input into and monitor delivery of the recruitment, retention, leadership, talent management & succession planning, training & organisational development and culture work programmes for the trust and wider group.

4.3 To monitor and provide assurance to the Trust Board that workforce risks which threaten the achievement of the strategic objectives of the trust and wider group and / or which may impact on the quality of care, are being identified and appropriately mitigated and / or to escalate concerns, as appropriate.

4.4 To monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements including but not limited to:

- Workforce Key Performance Indicators (KPIs)
  - Vacancies
  - Turnover
  - Sickness Absence
  - Mandatory Training
  - Appraisal
  - Temporary staffing / agency spend
  - Employee Relations / HR cases (e.g. disciplinaries, exclusions etc.)
- Staff Survey (local and national)
- Occupational Health & Wellbeing
- Staff Vaccination
- Registered Nurse & Midwifery Staffing

- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Guardian of Safe Working
- Job Planning
- Medical Revalidation
- Gender Pay Gap
- WRES
- WDES
- Modern Slavery

4.5 To monitor education, training and learning activities ensuring that they comply with the required legal and mandated standards and support service development / transformation and evidence based practice.

4.6 To ensure that statutory workforce reporting requirements are met including escalation to the Trust Board for approval, as appropriate.

4.7 To support the development of emerging innovative roles.

4.8 To understand the workforce implications of service transformation and provide oversight of delivery of the agreed implementation plans.

4.9 To provide oversight of progress against the Trust's Research & Innovation Strategy and priorities.

4.10 To provide oversight of the Trust's arrangements for and monitor the progress of plans to improve staff engagement, communication and recognition.

4.11 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.12 To agree an annual work plan for the committee and monitor its delivery.

4.13 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief People Officer (lead group executive)

5.1.3 Group Chief Medical Officer (voting member)

5.1.4 Group Chief Nurse (voting member)

5.2 In Attendance (all meetings)

5.2.1 Group Director of Assurance or deputy

5.2.2 Governor Observer

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 North & South Bank Managing Directors

5.3.2 Other senior officers of the trust

5.3.3 Others Non-Executive / Associate Non-Executive Directors

5.3.4 Director of Post Graduate Medical Education

5.3.5 Director of Undergraduate Medical Education

5.3.6 Guardian of Safe Working

5.3.7 Freedom to Speak Up Guardian

5.3.8 Other Topic & Network Leads

5.3.9 The Chair & Chief Executive* and have a right of attendance and speaking rights

*In their absence, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 The Non-Executive Director member of the committee will be the chair of the **Workforce, Education & Culture Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the NED chairs of the respective **Workforce, Education & Culture Committees-in-Common** will alternate at each monthly meeting. Both NED chairs will attend the agenda

setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second NED member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Workforce, Education & Culture Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one (voting) Non-Executive Director and two (voting) group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, voting members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No later papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting and any escalation / highlight report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire and Goole NHS Foundation Trust

Appendix A

Decisions Delegated to the Workforce, Education & Culture

Committee-in-Common

(NLaG)

Type of Decision	Delegated to the Workforce, Education & Culture Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the People Strategy, Delivery Plan & Priorities	Approval of People Strategy & Priorities
People / Workforce	Monitor and provide assurance that workforce risks which threaten the achievement of the trust' strategic objectives are being identified and appropriately mitigated	Approval of: Gender Pay Gap Report Modern Slavery Statement WDES Submission WRES Submission
	Monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements	

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE, ESTATES & FINANCE COMMITTEE-IN-COMMON (NLAG)

Membership and Terms of Reference

Reference:	DCT304
Version:	1.1
This version issued:	
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Group Trust Board
Date for review:	December 2026
Owner:	Group Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1 Purpose

1.1 The committee is responsible for oversight of risks to the delivery of financial and operational performance and estates & facilities targets and priorities and for providing assurance to the trust board as to the effectiveness and sustainability of the arrangements in place and / or for escalating risks to delivery.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Patient - Access and Public Purse objectives.

2 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Performance, Estates & Finance Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Performance, Estates & Finance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Performance, Estates & Finance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Performance, Estates & Finance Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Performance, Estates & Finance Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the '*Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3 Accountability & Reporting Arrangements

3.1 The Performance, Estates & Finance Committee-in-Common is accountable to the NLaG Trust Board.

3.2 The Performance, Estates & Finance Committee-in-Common will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

4 Responsibilities

4.1 Strategy

4.1.1 To provide oversight of the development and monitor delivery of the Trust's financial strategy.

4.2 Financial and Operational Performance (NHS Constitutional Standards)

4.2.1 To review and challenge construction of operational and financial plans for the planning period as defined by the regulator.

4.2.2 To seek assurance that the organisation has in place robust and effective operational planning arrangements (including capacity & demand planning) to deliver contract levels of activity.

4.2.3 To review, challenge and monitor in-year financial and operational performance including but not limited to the delivery of access targets.

4.2.4 To oversee the development and delivery of any corrective improvement plans where performance may deviate from agreed trajectories and advise the Trust Board accordingly on these plans and any risks to delivery.

4.2.5 To review the plans for winter and make recommendations to the Trust Board. To monitor delivery of the agreed plans.

4.2.6 To review and support the development of operational performance and finance key performance indicators (KPIs), and associated reporting and escalation to inform the organisation and assure the Trust Board.

4.2.7 To consider loan applications prior to referral to the Trust Board for approval.

4.2.8 To refer issues to other committees for consideration, as appropriate, including where matters for which the committee has oversight have the potential to adversely impact on other areas of trust business e.g. quality & safety, workforce etc.

4.3 Business Planning

4.3.1 To approve the annual business planning timetable.

4.4 Procurement

4.4.1 To provide oversight and assurance on procurement processes and performance.

4.5 Estates, Facilities and Sustainability

4.5.1 To review the delivery of the Trust's estates strategy & priorities.

4.5.2 To consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

4.5.3 To receive and consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan.

4.5.4 To receive an annual update on the Trust's sustainability measures to achieve the Governments Net Zero target.

4.6 Cost Improvement Plans

4.6.1 To oversee the development and delivery of the Trust's cost improvement plans and associated efficiency and productivity programmes.

4.7 CQC Improvement Actions

4.7.1 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.8 Risk & Assurance

4.8.1 To monitor and provide assurance to the Trust Board that financial & operational performance and estates risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. To recommend appropriate responses and mitigation for such risks.

4.8.2 To review and approve policies and other documents relevant to the work of the committee and / or endorse such documents for approval by the Trust Board.

4.8.3 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.8.4 To agree an annual work plan and monitor its delivery.

4.8.5 In summary, to cover the following areas of scope:

- Budgetary Management
- Contract management
- Cost Efficiency & Improvement
- Debt Management
- Estates, Facilities & Sustainability including Green, Carbon & Travel Plans
- Financial & Operational Performance
- Financial Planning
- Financial Strategy

- Fire Safety
- Health & Safety (Estates related)
- Operational Planning
- Procurement (Strategy & Improvement Plan)
- Revenue Business Cases
- Security Management
- Winter Planning

4.8.6 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.8.7 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.8.8 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at Appendix A.

5 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Performance

5.2.3 Group Director of Assurance or deputy

5.2.4 Deputy Director of Finance

5.2.5 Operational Director of Finance

5.2.6 Governor Observer

5.3 In Attendance (as required / the agenda dictates)

5.3.1 Group Director of Transformation

5.3.2 Group Chief Strategy & Partnerships Officer

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive / Associate Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6 Procedural Issues

6.1.1 Frequency of Meetings

6.1.2 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Performance, Estates & Finance Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective **Performance, Estates & Finance Committees-in-Common** will alternate at each meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Performance, Estates & Finance Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted on the day of the meeting without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting and any escalation or highlight report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers).

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

Decisions Delegated to the Performance,
Estates & Finance Committee-in Common NLaG

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Financial Strategy & Priorities	Approval of Financial Strategy & Priorities
	Monitor the development and delivery of the Estates Strategy, Priorities & Associated Plans	Approval of Estates Strategy & Priorities Approval of Green Carbon & Travel Plans
Estates & Facilities	Monitor and provide assurance that estates & facilities risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated – includes risks associated with the ageing estate	Approval of Premises Assurance Model Submission & Improvement Plan
	Consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan	
Financial & Operational Performance	Approve the annual business planning timetable Monitor and provide assurance to the Trust Board that financial & operational performance risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. Recommend appropriate responses and mitigation for such risks	Approval of Annual Plan: Operational & Financial Plan Approval of Winter Plan

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
Procurement	Monitor and approve procurement contracts and contract extensions in accordance with the limits set out in the Scheme of Delegation (and / or endorse for Trust Board approval) and receive assurance in respect of procurement processes, improvements and performance / KPIs.	Approval of Contracts & Contract Extensions in accordance with the limits set out in the Scheme of Delegation

Hull University Teaching Hospitals NHS Trust

PERFORMANCE, ESTATES & FINANCE COMMITTEE-IN-COMMON (HUTH)

Membership and Terms of Reference

Reference:	DCT304HU
Version:	1.1
This version issued:	
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Group Trust Board
Date for review:	August, 2026
Owner:	Group Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1 Purpose

1.1 The committee is responsible for oversight of risks to the delivery of financial and operational performance and estates & facilities targets and priorities and for providing assurance to the trust board as to the effectiveness and sustainability of the arrangements in place and / or for escalating risks to delivery.

1.2 The Committee-in-Common is responsible for providing assurance to the Trust Board regarding progress towards its Patient - Access and Public Purse objectives.

2 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Performance, Estates & Finance Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Performance, Estates & Finance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Performance, Estates & Finance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Performance, Estates & Finance Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Performance, Estates & Finance Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3 Accountability & Reporting Arrangements

3.1 The Performance, Estates & Finance Committee-in-Common is accountable to the HUTH Trust Board.

3.2 The Performance, Estates & Finance Committee-in-Common will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

4 Responsibilities

4.1 Strategy

4.1.1 To provide oversight of the development and monitor delivery of the Trust's financial strategy.

4.2 Financial and Operational Performance (NHS Constitutional Standards)

4.2.1 To review and challenge construction of operational and financial plans for the planning period as defined by the regulator.

4.2.2 To seek assurance that the organisation has in place robust and effective operational planning arrangements (including capacity & demand planning) to delivery contract levels of activity.

4.2.3 To review, challenge and monitor in-year financial and operational performance including but not limited to the delivery of access targets.

4.2.4 To oversee the development and delivery of any corrective improvement plans where performance may deviate from agreed trajectories and advise the Trust Board accordingly on these plans and any risks to delivery.

4.2.5 To review the plans for winter and make recommendations to the Trust Board. To monitor delivery of the agreed plans.

4.2.6 To review and support the development of operational performance and finance key performance indicators (KPIs), and associated reporting and escalation to inform the organisation and assure the Trust Board.

4.2.7 To consider loan applications prior to referral to the Trust Board for approval.

4.2.8 To refer issues to other committees for consideration, as appropriate, including where matters for which the committee has oversight have the potential to adversely impact on other areas of trust business e.g. quality & safety, workforce etc.

4.3 Business Planning

4.3.1 To approve the annual business planning timetable.

4.4 Procurement

4.4.1 To provide oversight and assurance on procurement processes and performance.

4.5 Estates, Facilities and Sustainability

4.5.1 To review the delivery of the Trust's estates strategy & priorities.

4.5.2 To consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

4.5.3 To receive and consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan.

4.5.4 To receive an annual update on the Trust's sustainability measures to achieve the Governments Net Zero target.

4.6 Cost Improvement Plans

4.6.1 To oversee the development and delivery of the Trust's cost improvement plans and associated efficiency and productivity programmes.

4.7 CQC Improvement Actions

4.7.1 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.8 Risk & Assurance

4.8.1 To monitor and provide assurance to the Trust Board that financial & operational performance and estates risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. To recommend appropriate responses and mitigation for such risks.

4.8.2 To review and approve policies and other documents relevant to the work of the committee and / or endorse such documents for approval by the Trust Board.

4.8.3 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.8.4 To agree an annual work plan and monitor its delivery.

4.8.5 In summary, to cover the following areas of scope:

- Budgetary Management
- Contract management
- Cost Efficiency & Improvement
- Debt Management
- Estates, Facilities & Sustainability including Green, Carbon & Travel Plans
- Financial & Operational Performance
- Financial Planning
- Financial Strategy
- Fire Safety

- Health & Safety (Estates related)
- Operational Planning
- Procurement (Strategy & Improvement Plan)
- Revenue Business Cases
- Security Management
- Winter Planning

4.9 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.10 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.11 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at **Appendix A.**

5 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Performance

5.2.3 Group Director of Assurance or deputy

5.2.4 Deputy Director of Finance

5.2.5 Operational Director of Finance

5.3 In Attendance (as required / the agenda dictates)

5.3.1 Group Director of Transformation

5.3.2 Group Chief Strategy & Partnerships Officer

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive Directors / Associate Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Performance, Estates & Finance Committee-in-Common.** In line with agreed CiC principles agreed between HUTH and NLaG, the Non-Executive Director chairs of the respective **Performance, Estates & Finance Committees-in-Common** will alternate at each meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Performance, Estates & Finance Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting and any escalation or highlight report will be shared with the committee chair for approval within five working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Hull University Teaching Hospitals NHS Trust

APPENDIX A

Decisions Delegated to the Performance, Estates & Finance Committee-in-Common (HUTH)

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Financial Strategy & Priorities	Approval of Financial Strategy & Priorities
	Monitor the development and delivery of the Estates Strategy, Priorities & Associated Plans	Approval of Estates Strategy & Priorities Approval of Green Carbon & Travel Plans
Estates & Facilities	Monitor and provide assurance that estates & facilities risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated – includes risks associated with the ageing estate	Approval of Premises Assurance Model Submission & Improvement Plan
	Consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan	
Financial & Operational Performance	Approve the annual business planning timetable Monitor and provide assurance to the Trust Board that financial & operational performance risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. Recommend appropriate responses and mitigation for such risks.	Approval of Annual Plan: Operational & Financial Plan Approval of Winter Plan

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
Procurement	Monitor and approve procurement contracts and contract extensions in accordance with the limits set out in the Scheme of Delegation (and / or endorse for Trust Board approval) and receive assurance in respect of procurement processes, improvement and performance / KPIs.	Approval of Contracts and Contract Extensions in accordance with the limits set out in the Scheme of Delegation

V2

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)235

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 December 2025
Director Lead	Sue Liburd, Committee Chair of Quality & Safety CIC David Sulch, Committee Chair of Quality & Safety CIC
Contact Officer / Author	Sue Liburd, Committee Chair of Quality & Safety CIC David Sulch, Committee Chair of Quality & Safety CIC
Title of Report	~~Quality & Safety Committees in Common Minutes – September 2025~~
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 25/9/25
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 30/10/25
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 25 September 2025 at 9.00am to 12.30pm in the Boardroom, DPoW or via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director (NLaG) - Chair
David Sulch	Non-Executive Director (HUTH)
Amanda Stanford	Group Chief Nurse
Dr Pete Sedman	Deputy Group Chief Medical Officer
Tony Curry	Non-Executive Director (HUTH)
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Rebecca Thompson	Group Deputy Director of Assurance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Yvonne McGrath	Group Director of Midwifery
Tracy Campbell	Director of Nursing (HUTH)
Wendy Millard	Assistant Chief Nurse/Deputy Director of IP&C
Vicky Thersby	Group Head of Safeguarding
Linsay Cunningham	Deputy Director of Strategy and Partnerships
Simon Thackray	Consultant Cardiologist and Chief of Service Cardiovascular Care Group
Kevin Allen	Governor (NLaG)
Jo Palmer	PA (Minute taker)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Ahead of his departure from the Group, Sean Lyons joined the meeting briefly to thank the committees for the way in which the two organisations worked together and supported each other, whilst retaining their individual identity. He acknowledged the good work undertaken to date and wished them every success in the future.

The committee Chair welcomed those present to the meeting and apologized for the late availability of papers and explained that the agenda had been adjusted and streamlined to remain focused on current key quality priorities. She acknowledged there may be some items which could not be assured due to the

short time scale in reading the papers.

Apologies for absence were noted from Dr Kate Wood, Group Chief Medical Officer, Michela Littlewood, Associate Director of Quality Governance (HUTH) and Sarah Tedford, Interim Group Chief Delivery Officer.

1.2 **Staff Charter and Values**

The Chair reminded attendees the meeting was to be conducted in line with the above, with particular consideration to teamwork and respect.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meetings held on 24 July 2025**

The minutes of the meetings held on 24 July 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.6 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

Item 1.7 29/5/25 – item closed
Item 2 – Dr Pete Sedman updated that a revised offer had been made to the NLaG consultants, and the result of the vote was awaited
Item 3.2 – item closed as on today's agenda
Item 4.5.1 – item closed as on today's agenda
Item 3.1c 26/6/25 – item closed. Amanda Stanford updated that the framework had been created, and consideration needed to be given on how to engage. The IPC risk was due to be reviewed at the next IPC strategic committee
Item 4.6 – item to be closed as on today's agenda
Item 7.1 – Richard Dickinson updated that there was interest from current volunteers in the patient representative role and conversations were being had on attendance at PSLG and QSC. Amanda Stanford asked that from an Information Governance perspective, this was covered off in their role using the national template
Item 4.3 – item closed as on today's agenda
Item 4.6 – for review at the timeout session in November
Item 6.1 - no further update and to discuss at the next meeting
Item 6.3 – Richard Dickinson updated that this had been presented at the Audit, Risk & Governance CiC and had been well received, although there was no appetite currently. Julie Beilby added that at a recent development event for NEDs, there was discussion on the need to ensure that learning is embedded and to carry out checks to ensure this is working. She felt it reinforced the need for spot checking. Amanda Stanford stated there was opportunity within the Group for a

change in how learning was taken forward and to be more proactive. Tracy Campbell agreed.
Item 7.2 – Tracy Campbell updated that she had spoken with Annie Laverty, Chief Experience Officer at Newcastle Hospitals Foundation Trust, who had created a process in her organisation using real-time patient feedback. This could be shared to the Group for 12 months at a one-off cost of circa £100K, to support with coaching and business analysis. She had also shared her bid for charitable funds at Newcastle. Amanda Stanford advised that she was fully supportive of this, and work would commence on creating a business case. Julie Beilby reflected that it would be an example of an 'investment to transform project'.

The CiC was happy to support the business case and Sue Liburd suggested as this was related to patient safety, an approach be made to The Health Tree Foundation with a bid for charitable funding.

1.7

Operational Pressures Update, including:

- Neonatal care

Amanda Stanford updated the meeting that the Group was already under pressure at all sites, but following her recent on-call, noted that SGH was facing an increased amount. She advised that conveyancing rates were increased site-wide and she was aware of inappropriate use of ambulances and low discharge rates during her on-call period. There had been reports of patients in the corridor on the HUTH site and there had been significant issues with neonatal care, in line with concerns nationally. Staff were being affected due to the added pressure and recent deaths and in mitigation, agency staff had been approved to assist with staffing pressures.

There had been a water leak within orthopaedic theatres which had affected service. Amanda advised that she had raised with the ICB that if some Estates & Facilities (E&F) issues could be improved, this would have a positive operational impact on patient safety.

Initial feedback from the recent unannounced CQC visit to HUTH ED was positive, and although corridor care was not acceptable, the current use was impressive and worthy as an example. The department was seen to be holding too much risk. Tracy Campbell added that the visit had increased staff morale as the hard work by staff had been recognized. Tracy also noted the early onset of operational pressures.

David Sulch asked if the CQC had also visited the wards, to which Amanda replied they had not. David considered this then perhaps did not give a true position. Amanda acknowledged that the Group was not maximizing the virtual wards or the 200 community beds and work needed to be done to change this.

- CPE update

Amanda Stanford confirmed that there were 179 cases of CPE with issues around consistent screening and adherence to basic IPC principles was a continuing problem, now necessitating a need to be included as a HR policy. E&F involvement was needed to improve the sinks and drainage.

Terms of Reference

1.8 It was agreed for nine meetings to be held throughout the year; no meeting in January or August plus the timeout recently agreed to be moved from December to November.

Rebecca Thompson had also noted that the 5.3.1 reference to the Site CEOs needed amending to the Group Chief Delivery Officer.

David Sulch noted that the reference to Research, Development and Innovation (R,D & I) had been removed but this was due to be confirmed at a forthcoming meeting to discuss where this was best sited. He also referred to the Quoracy and that it should read core members 3 of 4 and not 3 of 5.

Sue Liburd asked for these amendments to be made and brought back for approval at the November timeout session.

ACTION: ToR amendments to be made and document to be approved at the November timeout session

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported that there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF) Q1, including high level risks

Rebecca Thompson advised that the document had been updated and the score of 20 relating to patient safety was unchanged. Meetings had been held with Dr Kate Wood and were to be arranged with Amanda Stanford and the relevant actions updated accordingly. Assurance ratings were now visible on controls and actions.

The running order of the meeting was adjusted to enable item 3.2 to be discussed later in the meeting along with item 6.1

3.3 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report & recommendations to note.

3.4 Review of Relevant External Report, Recommendations & Assurances

There were no external reports, recommendations or assurances to note.

3.5 Never Events/Emerging Concerns

Richard Dickinson advised there had been fifteen Never Events since the formation of the Group and twelve were still active. There was due concern around

the recurrence of some events, particularly in surgical safety and interventions, such as wrong-site surgery and retained swabs. Immediate response meetings were being held and there had been good engagement.

There had been an increase in the reporting of near misses which was viewed as a positive change in culture, however some staff were reluctant to speak up for fear of recrimination. Sue Liburd stated it was important that staff teams felt empowered to intervene and uphold safety protocols.

The CiC discussed the variability in checklist compliance, and it was reported that signature checklists were well completed, but observational compliance was inconsistent and often only improved when staff knew they were being monitored and there needed to be a shift in this behaviour. Dr Pete Sedman spoke of the move to digitising the process within EPR which would hopefully improve compliance. He informed the CiC that Never Events had increased nationally but locally were much higher.

Cultural change was considered the biggest challenge and work would be ongoing to explore themes and encourage speaking up.

Amanda Stanford believed there was a need to understand what the safety metrics were, as in performance against standards. Richard Dickinson spoke of activity within teams to observe behaviour and Sue Liburd was pleased to see an increase in reporting and noted the good processes put in place but emphasised that the culture needed to change so that good compliance was standard, and not just when there was scrutiny. It was important to set new standards and inform and support staff.

David Sulch made a point about the correct usage of checklists, rather than a reliance on assumption and that it was important to look at whether there were any themes which would explain poor compliance.

Tracy Campbell agreed that it was important to put processes in place that would empower staff to speak up and she was indeed receiving feedback from certain areas of poor behaviour. Amanda Stanford emphasised the importance of good reporting and making this normal behaviour, which would then enable work around changing culture.

Tony Curry asked the question of who was considered in charge in a theatre setting to ensure that the correct processes were being followed. Amanda Stanford considered that the person in charge is the surgeon, but the team needed to be confident in speaking out. Psychological safety and the whole team should be empowered. Dr Pete Sedman considered that the surgeon is accountable but works as part of a team and relies on other members of the team to do their role correctly.

David Sulch did wonder whether increased theatre productivity was resulting in staff not fully complying with what was important. Dr Pete Sedman believed there were several reasons for the occurrence of a Never Event and Amanda Stanford added that there was work to be done around when a theatre list was finalised, work to be done in pre-assessment and didn’t think it was related to productivity but indeed a cultural issue.

Sue Liburd clarified that despite the actions taken to date and an increase in reporting, this continued to be a cultural issue and therefore asked that it remain on the agenda until the year end.

ACTION: Jo Palmer to include on the agenda for the remainder of the year

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Quality & Safety

4.1 Quality Priorities Q1 –

- **Deep Dive on Deteriorating Patient & Sepsis**

Tracy Campbell thanked Austin Smithies, Associate CMO, for his work on Deteriorating Patient and Sepsis, Julia Elstob from the Quality Improvement team and the sepsis team for their input. She advised that there were seven workstreams focussing on education, Martha's Rule, patient engagement, RESPECT documentation, infection prevention (catheter-associated infections), delirium screening and sepsis.

Sue Liburd asked that thanks be passed on to the sepsis team from the CiC in relation to their ongoing efforts with the screening and the new dashboard.

Amanda Stanford was of the view that the Quality Priorities paper needed to be mapped around the IPR matrix and a reference added relating to the metrics that were being used. This would then clearly demonstrate impact, particularly around complaints and patient experience.

Assurance was noted as reasonable.

4.2 CQC Improvement Plan

Amanda Stanford highlighted the significant progress on this, particularly for NLaG, in consolidating the actions down to five key areas; medical staffing training, medical staff record keeping, medicines reconciliation in ED, 62-day cancer waiting times and oxygen prescribing. 62-day cancer waiting times continued to be challenging and would not be marked as complete until the national standards were met. There was an expectation that oxygen prescribing, medical staff mandatory training and medical staff record keeping would start to show evidence of an improvement.

David Sulch considered that mandatory training still held a lot of focus, to which Amanda Stanford agreed, and it was perhaps time for it to be regarded as Business as Usual and Care Groups held to account through the Performance & Accountability meetings.

Julie Beilby agreed and also referred to the cancer target and the fact that the organisation's submitted plan was below the national requirement. She was strongly of the opinion that the current level of 'red' on the improvement plan could not be amended to 'green', considering the level of scrutiny the organisation was currently under.

Sue Liburd asked when the Children & Young People's Board would be stood up and Amanda Stanford confirmed that she would chair the first meeting hopefully in October 2025. She also recognised that the Care Groups had made some improvements, but some areas remained a focus.

Assurance was noted as reasonable.

The running order of the meeting was again adjusted to allow Yvonne McGrath time to join and present Item 4.3

4.4

Children & Young People Assurance

This paper was deferred but the formation of the CYP Board was acknowledged and the first meeting planned for October 2025.

4.5

Quarterly Quality Theme Triangulation, Learning and Improvement Report (including Patient Safety themes and analysis, including PSII, PSIRF and legal) Q1

Richard Dickinson presented the report, which tracked all patient safety and experience activity and highlighted that progress had been made in patient experience, communication and safety themes.

There was ongoing work around auditing and improving responses to missed results, particularly in outpatient settings with a focus on electronic solutions and prioritisation. Strategic action plans were being developed around pressures ulcers and falls.

David Sulch questioned how the organisation ensures that teaching and learning is happening and looking at the IPR, there seemed to be an increase in occurrence of pressure ulcers, with some PSIIs having been listed for a long time. Richard Dickinson responded that there was work ongoing to reduce the backlog and improve timeliness. David highlighted that the process around missed results did need to be reviewed if the Group moved towards a Patient Initiated Follow up (PIF) practice. Richard Dickinson agreed and was of the view that the use of more electronic mechanisms could be the answer.

Tracy Campbell advised all Care Groups had been approached on their overdue data and there was a planned focussed event on 7 November 2025, chaired by Dr Kate Wood and Amanda Stanford, where Care Groups will individually present their data. This had also promoted enquiries for other work to be covered off on the day. She reminded the CiC that HUTH would move over from Datix to the incident reporting system currently used by NLaG called Ulysses on 1 October 2025.

Assurance was noted as reasonable, recognising a good understanding of the challenges and noting active improvement plans.

Yvonne McGrath joined the meeting at 10.47am

4.3 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)**

Yvonne McGrath advised the CiC that despite efforts to over-recruit, there was still a slight shortfall due to high levels of maternity leave, but projections indicated a better position by the Spring for the South bank. The Workforce paper was due to be presented to Board in October.

There were ongoing risks relating to medical staffing, training and compliance with safety actions, particularly 4, 5, 6 and 8.

There were reported discrepancies between data sources for VTE and work was ongoing to resolve this.

There had been an increase in neonatal deaths, particularly around 22 weeks or with genetic disorders and this was causing significant pressure and trauma for staff. Psychological support and learning from other units were being considered.

There was an emphasis on supporting families and a deep dive had been performed. There were many non-English speaking families who required improved interpretation services, rather than reliance on family members and also staff who needed support. There was a new neonatal bereavement lead now in post. Some new e-learning guidance was to be introduced for all staff and Amanda Stanford added that there needed to be a conversation at Board on the service across all three sites, as there was a clear need to review the service model across the sites, particularly around the best use of beds.

Sue Liburd asked for an update on the “Ask me Anything” initiative, which had been launched to gain staff feedback and Yvonne responded that most of the responses had come from DPoW.

Sue also advised the CiC that at a recent meeting she had had with civic leaders from the Bangladeshi community, it was apparent that language and interpretation was an issue. Amanda Stanford added that this concern had come to light following the neonatal review. Yvonne McGrath added that GPs were now not prescribing for women with Gestational Diabetes Mellitus (GDM), which would have a huge impact.

Tony Curry left the meeting

Assurance was noted as reasonable.

ACTION: Amanda Stanford to advise ICB that GPs are no longer prescribing for GDM women

There was a break at 11am for ten minutes

4.6 **Learning from Deaths Quarterly Report Q1**

Dr Pete Sedman advised the CiC that there had been an improvement in mortality rates, but recognised challenges with sepsis and secondary malignancies. It had also been highlighted that completion of the RESPECT forms needed to be better, as well as the declaration of palliative intent, which was lower than the national average. The fact that there were no palliative nurses on the South bank may be a factor. The Medical Examiner service was being scrutinised across the Group, focussing on the slight delay in having the death certificates stamped. It was also noted that there needed to be more input to support resident doctors.

David Sulch noted the continued excellent mortality rates on the South bank despite the current concerns relating to patient safety. Palliative care coding was very low on the South bank and it was expected that if the coding was higher, then the expected mortality would be higher. Richard Dickinson accepted this point and advised that there would be a workstream looking at trying to improve the coding when only palliative care was involved.

The CiC recognised the importance of the actual learning being embedded into normal practice with the suggestion of spot checks to confirm implementation. The triangulation of data from claims, inquests and feedback would assist learning and ensure timely sharing of lessons learned. This in turn would progress to behavioural change. There was a need for a redesign of the process of reporting Learning from Deaths.

Assurance was noted as reasonable.

4.7 **Equality and Quality Impact Assessment (EQIA)**

There was none to note.

4.8 **Safeguarding including MCA & DOLS**

Amanda Stanford advised that there had been an increase in the requirement to participate in reviews, and she also advised that the transition service had been shortlisted for an award at the HSJ awards in London. There were some disparities with student nurse processes across the Group and the need for funding and process alignment.

Vicky Thersby joined the meeting at 11.19am

Vicky Thersby advised that an ICB review was underway, looking at potential ICB funding to stop the disparity across the Group, as HUTH did not have the Sudit nurse that NLaG had.

She also highlighted that there had been improvements in the initial health assessments for children looked after. There was now in post a named nurse for children looked after in NE Lincolnshire. Staffing was improving but it was notable that sickness absence was still causing an impact, and mitigations were in place to maintain service cover.

The service was also still awaiting the Domestic Abuse Co-ordinator business case outcome for x2 Band 4 WTE posts across the Group and if this was not improved, it would have a detrimental impact and risk on both teams given their size.

The ED navigator role on the North bank was working well, with the South bank being commissioned slightly differently and there were close links with the Blue Door initiative locally to get this up and running.

Sue Liburd questioned the North and South bank DOLS and whether there was a reason behind the increase and Vicky Thersby agreed to investigate this.

ACTION: Vicky Thersby to investigate the increase in DOLS across the Group

Julie Beilby referred to the Domestic Abuse position and asked whether any opportunities had been explored for external funding, as suggested at a previous meeting, from either the police and crime commissioners, or the elected mayors. Vicky Thersby replied that there had not as the outcome from the business case was awaited. Julie was of the view that it could be beneficial to the business case to demonstrate that there was potential outside opportunity and offered her support in conversations around this as she had experience of this working elsewhere.

ACTION: Amanda Stanford to liaise with Vicky Thersby on potential external funding opportunities

Sue Liburd encouraged Amanda and Vicky to accept Julie's offer of support.

Assurance was noted as reasonable, as opposed to significant due to the concern around long-term funding and capacity.

Vicky Thersby left the meeting

Simon Thackray joined the meeting at 11.30am

4.9 **TAVI**

Dr Pete Sedman introduced the paper and Dr Simon Thackray began his presentation by thanking Richard Dickinson for his work and involvement in the report. Simon updated that there had been a lot of work ongoing within cardiology, which had resulted in an improvement in culture, with better feedback from trainees, reduced reports of incivility via the tool and positive input from the Freedom to Speak Up Guardian. He considered, along with colleagues, that the department was a transformed place. There had been a change in clinical leadership which had brought several positive changes, policies had been audited, and the anticoagulation protocol had been amended to provide medication up to 24 hours before a procedure to reduce the risk of stroke. There were now frequent meetings with the staff every few months to see how they were doing, how they were feeling and annual pathway audits would be undertaken to maintain the current standards. Overall, the culture had improved but it would continue to be work in progress.

Simon advised the CiC that an audit of ten patients had recently been undertaken which showed that all were well aligned with best practice pathways. In addition, an external audit specialist from James Cook, Doogie Mirror, reviewed recent mortalities and graded them positively also, apart from one case which was rated inadequate due to possible technical issues with a specific TAVI platform which had since been discontinued.

Sue Liburd asked whether the support from James Cook was for a limited time, but Simon was pleased to advise that it would continue indefinitely, which would provide great benefit to the TAVI team.

David Sulch thanked Simon Thackray and the team for their work in improving the service and was of the view that it set a good example to others in how to transform a service. Pressures had been noted but he was pleased to see evidence of ongoing governance improvements.

Julie Beilby also thanked Simon for the very clear presentation and noted that the colour coded governance arrangements were helpful and gave a high level of assurance.

Sue Liburd agreed with Julie's comments, thanked Simon and was of the view that it clearly demonstrated what actions were being taken and how learning was being embedded into the culture of the department.

ACTION: A further update on TAVI to be provided in March 2026

Assurance was noted as significant.

Amanda Stanford updated the CiC that she would shortly be undertaking a piece of safeguarding work with Vicky Thersby around the deaths that were under investigation, and this would be available for presentation in the March update.

Simon Thackray left the meeting at 11.44am

Dr Pete Sedman updated the CiC regarding an incident relating to an echocardiographer with American accreditation, but not English accreditation, who had been suspended for amending the echocardiogram reports of a colleague, amounting to at least 150 cases. The department mandates that a staff member must have the English accreditation to cross-cover.

Sue Liburd questioned whether there was any potential impact on patients, to which Dr Pete Sedman replied that it was currently unknown how many patients would need to have their medication adjusted because of incorrect reporting.

Sue also asked what the review process would entail, to which Amanda Stanford replied that Human Resources was involved, but there was an issue around the post not being regulated and therefore the individual could still take up a post elsewhere. A prompt investigation was envisaged, with police involvement and fact finding, but clinically, a full review of the patients affected, including Duty of Candour.

ACTION: Echocardiogram incident for ongoing update to the CiC

Richard Dickinson asked if there could be any other staff groups that were not registered and at risk of a similar incident. Amanda Stanford agreed that this needed attention and would raise with the Regional Chief Nurse. Richard was of the view that a process could be put into place locally even if it was not adopted nationally.

4.10 **Integrated Performance Report (IPR): Quality & Safety metrics**

Richard Dickinson outlined the paper, highlighting improvements in mortality rates and consistency in other areas. Infection Control presented as a challenge with ongoing efforts to improve VTE compliance and finalise safety closure on beds.

Duty of Candour compliance for NLaG was improved but not quite at the expected standard and at HUTH there was clearly still work to do. Data quality issues were also being addressed.

Amanda Stanford highlighted some formatting issues on the dashboard which would need amending before submission to CQC and Richard agreed to look at this.

Amanda also noted that regarding Duty of Candour, at the recent Quality Improvement Group (QIG) it was reported that HUTH was not performing as well as NLaG, but on looking at the presented figures, it appeared to be performing better than NLaG. Richard responded that this in fact was inaccurate and related to the reporting mechanism used. Amanda advised that an update would be brought to the next meeting to assure the committee on Duty of Candour, due to the challenge from the QIG.

ACTION: Amanda Stanford to update the CiC at the October meeting regarding Duty of Candour performance

ACTION: Richard Dickinson to circulate the IPR report in Power Point format to the CiC

<u>Patient Experience</u>

4.11 **Patient Experience Report (including learning from complaints) Q1**

Amanda Stanford outlined the main concerns were around the complaints process, which was part of the improvement plan. There were still too many complaints and a clear need for a more continuous improvement approach. There was work underway to improve the PALS response time and the team were embedding the Northumbrian approach into their processes. The organisation was aware of the themes and trends through the complaints and the quality of the responses was being closed monitored, which in turn was contributing to a delay.

Despite the number of complaints, the oversight framework indicated positive results for both the North and South banks on patient experience, and it was unclear why this was. Tracy Campbell agreed to investigate this but added that there was strong engagement in learning from complaints sessions and staff were very happy to be involved in efforts to improve care.

Julie Beilby was encouraged to hear of the work underway on complaints and the use of the Northumbrian approach but advised that she had been unable to read the whole report due to the time constraint.

The CiC agreed that it was inappropriate to give a level of assurance due to the time constraints, therefore the paper was taken for information only.

Linsay Cunningham joined the meeting at 12.05pm.

5. STRATEGY

5.1 Clinical Strategy (final draft)

Dr Pete Sedman introduced and thanked Linsay Cunningham for her work and engagement with all the Care Groups and clinical leads in creating the strategy document.

Linsay Cunningham proceeded to share a slide summary of the paper.

The Strategy aligns with the ten-year health plan and is a framework defining a clinical model with tertiary/specialist services, with a core hospital and a focus on community/virtual hospital integration.

Sue Liburd referred to the design principle of care only taking place in a hospital setting if necessary and asked how this would be enforced if a patient or the family chose otherwise. Linsay Cunningham responded that this came down to a need to shape expectation and evidence the 'new normal'. Dr Pete Sedman agreed that it was important to encourage alternative options before hospital treatment was agreed upon.

Sue Liburd considered that there was a lot of work to do in educating the public on their alternative options and Amanda Stanford added that there needed to be a lot of work on what community care will look like so that the public have a clear understanding of what would be available. Staff would also need to adapt to this new way of working and there would be a need for close links with the local council to attract the public and provide a funding opportunity.

Julie Beilby reflected that it was difficult to put such plans into action and was important to bring to fruition the promises of funding, by working with multiple agencies. Health was everyone's business and should be embedded into the culture of local authority work, as it relates to the local community and is affected by deprivation and poor education.

Sue Liburd agreed with Julie that Board is not well sighted on discussions around 'place' and it was considered that the organisation's move from the Capital & Major Projects Committee to the Strategic Programmes and Partnerships Committee would help with this.

Sue Liburd acknowledged Kevin Allen's comment within the meeting chat requesting the Clinical Strategy being presented to the NLaG Governors.

ACTION: A presentation of the Clinical Strategy to be provided to the NLaG Governors

The CiC endorsed the Clinical Strategy for Trust Board approval.

Linsay Cunningham left the meeting.

Wendy Millard joined the meeting at 12.28pm.

The running order was slightly adjusted to include the deferred Item 3.2

3.2 **IPC BAF Q1**

Wendy Millard advised the CiC that work was underway to align the Infection Control team and policies across the Group. HUTH were currently 61% fully compliant, 37% partially compliant and 2% non-compliant with the BAF, whereas NLaG were 37% compliant, 51% partially compliant and 4% non-compliant. Interviews had taken place for two practice development matrons to work across the Group and their role will be to improve compliance and deliver the IPC framework to all staff as well as enacting the recommendations detailed within the annual report. Wendy was confident that a continuing improvement will be seen and acknowledged that since the formation of the Group, a stronger IPC team had emerged.

Assurance was agreed as limited.

6. ANNUAL REPORTS

6.1 **Infection Control Annual Report & Workplan**

Wendy Millard was of the view that the restructure of the IPC team and the service was a major improvement, and the team were very enthusiastic to start making a difference. Antimicrobial stewardship (AMS) continued to be a concern, with only one AMS lead in post, and the organisation presented as an outlier in national audits. A business case was being developed to receive more support with this, but currently the new practice development matrons were picking up some work and going out to wards to educate staff and consultants.

There were apparent anomalies with data alignment at NLaG on surgical site infections, but this had been rectified and a workplan was in place to address increased infections in hips and knees at Goole Hospital.

The main recommendations within the annual report related to reducing gram-negative bloodstream infections, improving hydration and enhancing AMS through education and clinical champions and the team were also actively looking for nurse champions. There was a five-year sepsis strategy in place and work ongoing with E&F, particularly on the South bank with an old and challenging estate, and mitigating work was underway.

Sue Liburd thanked Wendy Millard and commended her for an outstanding, excellent report.

Wendy Millard left the meeting.

The CiC approved the annual report and workplan.

7. HIGHLIGHT REPORTS

7.1 **Patient Safety and Learning Group**

7.2 **Patient Experience Group**

7.3 **Maternity and Neonatal Assurance Group**

7.4 **Risk and Compliance**

The highlight reports were noted.

8. ITEMS FOR INFORMATION

8.1 **Draft Workplan**

This item was deferred, due to discussion at a separate meeting on 24 October 2025.

9. ANY OTHER URGENT BUSINESS

9.1 **Any Other Urgent Business**

Richard Dickinson referred to the Risk Register Report, which was due to have been discussed under Item 3.1. The paper was taken as read and it was agreed to bring a refreshed report to the next meeting.

ACTION: Risk Register to be presented at the October meeting

10. MATTERS TO BE REFERRED BY THE COMMITTEES

10.1 **Matters to be referred to other Board Committees**

There were no matters for referral to any of the other board committees.

10.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

It was agreed that the following matters required escalation to the Trust Board in the Committees' highlight report:

- Deep dive into neonatal deaths
- CPE cases
- Positive initial feedback following the HUTH CQC visit
- Martha's Rule and sepsis screening tool being used and good results seen
- Culture around Never Events
- CQC action plan
- Echocardiogram investigation to be updated to the CiC until further notice
- Assurance around Duty of Candour to be brought to the CiC in October 2025
- The Group Clinical Strategy was endorsed and approved for Board and a presentation is to be made to NLaG Governors
- SHIMH scores were now acceptable and positive
- Significant assurance received on TAVI

11. DATE AND TIME OF THE NEXT MEETING

11.1 **Date and Time of the next Quality & Safety CiC meeting:**

The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 30 October 2025 at 9.00am to 12.30pm, in The Nightingale Room, Education Centre, SGH.

The committee Chair closed the meeting at 12.42 hours.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2025/2026

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Name	Title	2025 / 2026											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y		Y						
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y		Y						
Tony Curry	Non-Executive Director (HUTH)	N	Y	Y	Y		Y						
Julie Beilby	Non-Executive Director (NLaG)	N	Y	Y	Y		Y						
Dr Kate Wood	Group Chief Medical Director	Y	D	Y	Y		D						
Heather McNair	Interim Group Chief Nurse	N	Y	D	Y								
Amanda Stanford	Group Chief Nurse						Y						
Clive Walsh	Interim Chief Executive (North)	Y	N	D									
Sarah Tedford	Interim Chief Executive (South)	N	N	D	Y		N						
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y		N						
Yvonne McGrath	Care Group Midwifery Director	N	N	Y	Y		Y						
Rebecca Thompson	Group Deputy Director of Assurance	Y	Y	Y	Y		Y						
Murray MacDonald	Non-Executive Director of Assurance	N	N	Y	N		N						
Richard Dickinson	Associate Director of Governance (NLaG)	Y	Y	Y	Y		Y						
Michela Littlewood	Associate Director of Governance (HUTH)	Y	Y	Y	Y		N						
Kevin Allen	Governor Observer			Y	Y		Y						

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)236

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11th December
Director Lead	Heather McNair
Contact Officer / Author	Victoria Thersby
Title of Report	Safeguarding and Vulnerabilities Annual Report (2024-2025)
Executive Summary	The Trust Boards -in- Common is asked to receive and approve the Safeguarding and Vulnerabilities Annual Report (2024-2025). This has been approved virtually at both the Strategic Safeguarding Board and Quality & Safety Committee - in - Common. It provides an overview of the national and local context of safeguarding and vulnerabilities and associated agendas relating to adult and children safeguarding, and vulnerability agendas. This provides assurance that both Hull Teaching Hospital Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) are meeting their statutory, contractual and commissioning requirements. These reports highlight and explain the key performance activity of the teams and informs the Trust Boards - in - Common of how its statutory responsibilities are being met, any significant issues or risks, and how these are being mitigated and addressed, and provides plans for the forthcoming year (2025-2026). This report indicates good and effective multi-agency partnership working across Hull, East Riding, North and Northeast Lincolnshire with established and embedded site-based safeguarding/ vulnerabilities teams at Hull Royal Infirmary, Scunthorpe General Hospital and Diana Princess of Wales Hospital. A significant number of priorities were achieved this year, and some were re-prioritised due to competing priorities and reviewing other ways of implementing them. This report consolidates and describes the work undertaken across the year and provides the first Humber Health Partnership (HHP) Safeguarding and Vulnerabilities Report. Notwithstanding the collaboration of the teams and the work and support ongoing, some non-uniformity of the data and systems and processes which are not aligned due to differing operating models results in different data captures. Work is underway to drive conformity into a HHP model, and in preparation for our new digital system implementation. Some of our key achievements are: • A review of the governance arrangements and commissioning of a HHP Strategic Safeguarding Board with three operational groups. • Collaborated Vulnerabilities Team (South Bank) /Enhanced

	Care Team (North Bank) model with leadership from the Lead Nurse Vulnerabilities supporting the Trusts strategic objectives to reduce health inequalities. • Consistent support to deliver HHP induction training delivering key safeguarding messages. • Launched the Vulnerabilities and Enhanced Care Assessment Tool (VENA); proactively identifying vulnerable patients and oversight of the team. • There has been a marked improvement in compliance on the wards who are taking part in the QUiP (MCA-DoLS). North Bank are now involved in this. • HUTH and NLaG have introduce A&E Navigators on both North and South Banks through a pilot project. Funding was extended for 2025-2026. • The Anlaby Suite was awarded the Trusts Golden Star Award in the category of Excellence In Partnership Working. • An extensive review of safeguarding children supervision arrangement (North Bank) and successful roll out of a cascade supervision model was implemented. • The forensic SARC service was under review with all SARC's required by 2nd October to have obtained accreditation to meet Forensic Science Regulator Standards; this has continued into 2025-2026. • The SUDIC Nurse role has now moved into paediatrics. • The Hope Box Project is now well-embedded within maternity services North and South Bank, aiming to minimise trauma through birth separation and providing kindness and empathy to families. • Successful implementation of Sexual Safety in Health Care and promotion of this HHP wide. • Short Term funding through STADA enabled a Domestic Abuse Co-Ordinator (South Bank) to review and successfully implement responses, pathways, training and support.
Background Information and/or Supporting Document(s) (if applicable)	Annual Report attached
Prior Approval Process	Strategic Safeguarding Board/ Quality & Safety Committee -in-Common
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

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Partnership

Humber Health Partnership

Safeguarding & Vulnerabilities Annual Report

2024-2025



Foreword

Safeguarding is a statutory responsibility of all NHS organisations. In order to uphold this responsibility we must work with our staff, our patients, and their families and our external partners.

Our 2024-2025 Safeguarding and Vulnerabilities annual report highlights our achievements and plans in preparation for the coming year.

Our vision: to be a safe organisation that ensures safeguarding is everyone's business, by working holistically together to safeguard the most vulnerable in society.

Our mission: to provide an exceptional service in our 'think family' approach to safeguarding by working with our colleagues, our patients, and our safeguarding partners.



Amanda Stanford – Group Chief Nurse

Contents

Foreword …… 2

Introduction..…… 4

Purpose …… 4

Governance …… 5

Workforce/ team structure …… 6

Workforce Risks ……..6

Promotions and Campaigns …… 7

Prevent ……8

Adult Safeguarding …… 8

Mental Capacity Act & Deprivation of Liberty Safeguards ……..12

Safeguarding Children ……..18

Child Sexual Assault Service (CSAAS) ……..24

Sudden Unexpected Death in Childhood ……...26

Midwifery …… 27

Female Genital Mutilation …… 33

Training, Safeguarding Supervision and Development …….. 35

Serious Violence Duty …….. 38

A&E Navigators…… 38

Sexual Safety in the NHS ……39

Domestic Abuse …… 40

Allegations Against Staff ……...44

Transition (South Bank) …… 45

Vulnerabilities …… 46

Children Looked After North/ Northeast Lincolnshire …….. 51

Mental Health …… 55

Safeguarding Partnerships …….. 56

Conclusion …….. 57

Priorities 2025-2026 …….. 58

Acknowledgments/ Contributions…… 64

Introduction

Safeguarding is an integral part of Humber Health Partnerships core business and is a shared responsibility with our staff. We work together with multi-agency partners across the districts of Hull, North Lincolnshire, North East Lincolnshire and East Riding to improve lives and protect the most vulnerable in our society from harm.

Our safeguarding work is underpinned by the Trust's core values by demonstrating our behaviours of compassion, honesty, respect and team work.

As part of our annual planning, we will review our Trust priorities for the year. Our approach to safeguarding is based on the 6 principles of safeguarding.

- Empowerment
- Working in partnership
- Being accountable and transparent
- A culture of prevention
- Proportionality
- Protection

Throughout this report we have highlighted our key areas of responsibility and achievements and plans for the forthcoming year.

Purpose of Report

This annual report consolidates and describes the work undertaken across the year (2024-2025) and provides the first Humber Health Partnership (HHP) Safeguarding and Vulnerabilities Annual Report combining the work of Hull Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Notwithstanding the collaboration of the teams and the work and support ongoing, some non-uniformity of the data and systems and processes which are not aligned due to differing operating models results in different data captures. Work is underway to drive conformity into a HHP model.

This report informs and provides the Trust Board members of assurance that the Organisations are discharging their statutory responsibilities for safeguarding adults, children and vulnerabilities incorporating other associated agendas including Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS), and Children Looked After in relation to:

- The Mental Health Act (1983)
- The Children Act (1989)
- The Sexual Offences Act (2003)
- Female Genital Mutilation Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11
- Domestic Violence and Victims Act (2004)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Registration standards, Health, and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- The Equality Act (2010)
- The Human Rights Act (1988)

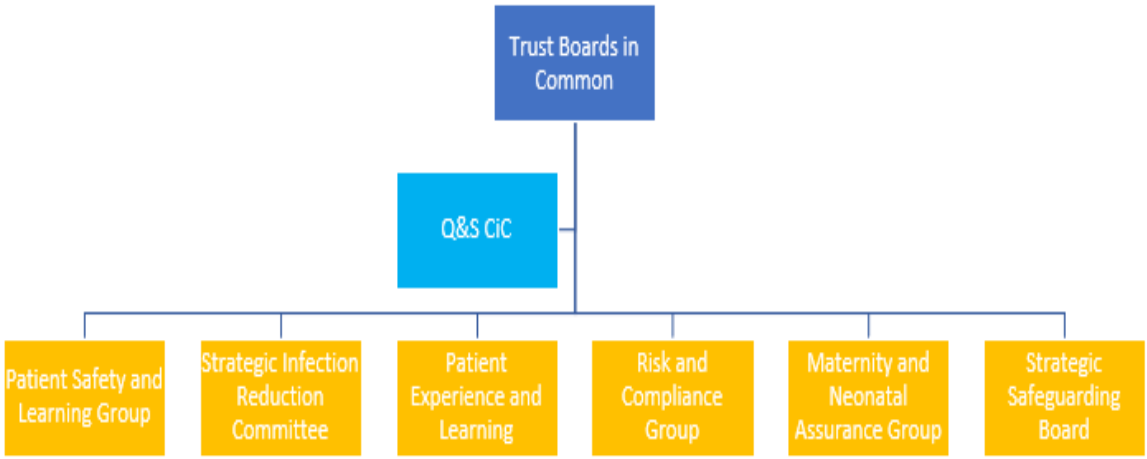
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- The Care Act (2014)
- Counter- Terrorism and Security Act (2015)
- Modern Slavery and Human Trafficking Act 2015
- Working Together to Safeguard Children (2023)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (First Edition: August 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Fourth edition: January 2019)
- Domestic Abuse Act 2021
- Health and Social Care Act 2022
- Safeguarding Accountability and Assurance framework (NHSE,2024)
- NHS Standard Contract 2024-2025

Governance Arrangements

A Safeguarding Board was identified and commissioned last year with Safeguarding, Midwifery, and Vulnerabilities Operational Groups reporting into this Board. This has been re-reviewed, and subgroups of this meeting combined with new terms of reference approved.

Both safeguarding and vulnerability teams support statutory Safeguarding Children Partnership and Adult Safeguarding Boards across Northeast and North Lincolnshire (NEL, NL), Hull and East Riding. Attendance at Partnerships, Boards and their sub-groups is carried out by members of the team.

Assurance via quarterly assurance meetings is held with Designated Nurses for Hull, East Riding, NEL and NL and by the completion of joint section 11 audits, and the NHS England Safeguarding Commissioning Assurance Toolkit (SCAT), Children Looked After Data Collection and Prevent Training Data Collection quarterly.





Workforce and Team Structure

The Executive Lead for Safeguarding Children and Adults is the Chief Nurse; this responsibility is delegated to the Deputy Chief Nurse. The Safeguarding and Vulnerabilities Team/Enhanced Care Team have collaborated since July 2024 and restructured to form the HHP Safeguarding and Vulnerability Team led by a Group Head of Safeguarding and Deputy Heads of Safeguarding on the North and South Banks. The Group Head of Safeguarding reports directly to the Deputy Chief Nurse. There were changes to leadership North Bank with the interim Head of Safeguarding in place whilst formal re-structure was agreed which resulted in the lead dementia post being vacant since October 2023. This has since been recruited to and the risk removed from the risk register.

In line with contractual arrangements (NHS Contract 2024-25), there are Named Nurses for Children, Adults, Midwifery and MCA DoLS. Named Doctors for Safeguarding Children are employed North and South Banks, including those Paediatricians with Designated Safeguarding roles in the organisation for Children and Children Looked After across NEL, NL, Hull and East Riding. Gaps within the Hull Children Looked After Designated portfolio include the Designated Doctor for Children Looked After of which the ICB are aware.

Workforce Risks

- No planning for succession in specialist roles. Number of Named Nurses have indicated they will retire within 12-18 months.
- Designated Doctor for Death in Childhood (North Bank) retirement next year and planning with ICB for succession planning and mitigation of a SUDIC key worker role.
- Escalation of the disparity in workforce arrangements impacting on North Bank Key Named Nurse roles (Children and Midwifery).
- Escalation of the disparity in workforce arrangements impacting on the North Bank Safeguarding Adults team including MCA deputy role, Domestic Abuse Coordinator and Specialist Mental Health Nurse.
- Absence of child death key worker role for HUTH.
- Absence of Transitions Nurse for HUTH

1. Promotions and Campaigns

- National Stalking Awareness Month (April) - including how to spot, respond and keep safe.
- Mental Health Awareness Week (May) - Indicators of mental health and DA including support offered by local DA services
- 'What does pride mean to the safeguarding team' including quotes from our team
- Newsletter for Disability Pride Month - Barriers for those experiencing DA with Disabilities. Newsletter for Honour Based Abuse 14th July 'Those lost to honour based abuse'.
- Newsletter for Intersectionality
- September World Deaf Day Newsletter
- October Domestic Abuse (DA) Awareness month. Newsletter. DA Stand at SGH and DPoW restaurants.
- White Ribbon Campaign 16 days of activism 16 posts on social media (November).
- Hosted Domestic Abuse Event – 'A Call to Action' across the Group to close the 16th day of activism
- Full promotion of 'Call to Action' DA campaign on Bridget via our comms team, including this being promoted on HEY 247 main page
- White Ribbon campaign stands at both Hull Royal Infirmary and Castlehill Hospital with collaborative attendance/representation from children's and adults safeguarding team, occupational health, Trust IDVA and a DA champion
- FGM Awareness newsletter & FGM Safe lives Webinar shared
- 'UK says no more' 2nd - 8th March week. Safeguarding and DA Champions say no more to...
- Autism awareness day – raised on social media
- Dementia Action week – raised on social media, attendance at LA dementia conference
- Carers week - raised on social media
- LD awareness week – joint events with community LD teams to promote personal safety and health equality
- Delirium awareness day – visits to wards at both DPoW and SGH promoting the use of the delirium care pathway
- Downs syndrome awareness day - raised on social media
- Violence against Women and Girls (VAWG) survey promoted at the Anlaby Suite for young people to complete as part of the child safeguarding week
- The 'Tell Someone Campaign' was promoted in respect of a survivor of sexual abuse
- A group of young people from North Lincolnshire attended the Anlaby Suite's CSAAS to undertake the '15 steps challenge'
- The Deputy member of the Youth Parliament attended the Anlaby Suite. She represents the local area on a national scale to ensure young people's voices are heard on issues affecting them
- 'Anyone, Anywhere' campaign promoted as part of the Child Sexual Assault Assessment Service (CSAAS)
- Safeguarding children and adult team participated in the 'Shine a Light Walk' as part of 'Sexual Abuse and Sexual Violence' week.

2. Prevent

The Prevent Duty under the Counter terrorism and Security Act (2015) requires that we work in partnership to prevent people being drawn into terrorism. To comply with this and fulfil our responsibilities we follow our Prevent Strategy Implementation Policy. This supports and safeguards those most at risk of radicalisation which is a form of exploitation.

The Humber Health Partnership (HHP) has met its statutory responsibilities in relation to ensuring prevent training is delivered in line with the NHS Prevent Training and Competencies Framework (2022). Prevent leads are in place in the Trust and collaboratively link with our partnership and local arrangements and subsequent meetings.

Achievements

- Completed NHS England Prevent returns on time
- 100% Attendance at local Prevent awareness events
- Active member of Channel in both North East Lincolnshire and North Lincolnshire with 100% attendance
- Supported staff with Prevent referrals and awareness raising of the importance of identifying people who may be at risk of radicalization
- Maintained above target compliance in training
- Reviewed the Prevent Competencies for staff on the North Bank and aligned training to be mandatory for all staff and volunteers. Plan in place to increase compliance North Bank

3. Adult Safeguarding

Following the introduction of the Care Act (2014) implemented in April 2015; adult safeguarding has been on a statutory footing. The HHP is a safeguarding partner and in line with our Local authority partners in Hull, East Riding (ER), NEL and NL, work in partnership to safeguard and protect adults with care and support needs from abuse neglect.

The Care Act (2014) provides a comprehensive legal framework for protecting adults at risk of abuse or neglect. This statutory function is the responsibility of the local authority, but all agencies must collaborate and support these arrangements. As a partner agency the HHP fulfils our statutory, regulatory, and contractual duties, providing assurance to the Safeguarding Adults Boards (Hull, ER, NL and NEL), the Integrated Care Board (ICB), and NHS England (NHSE).

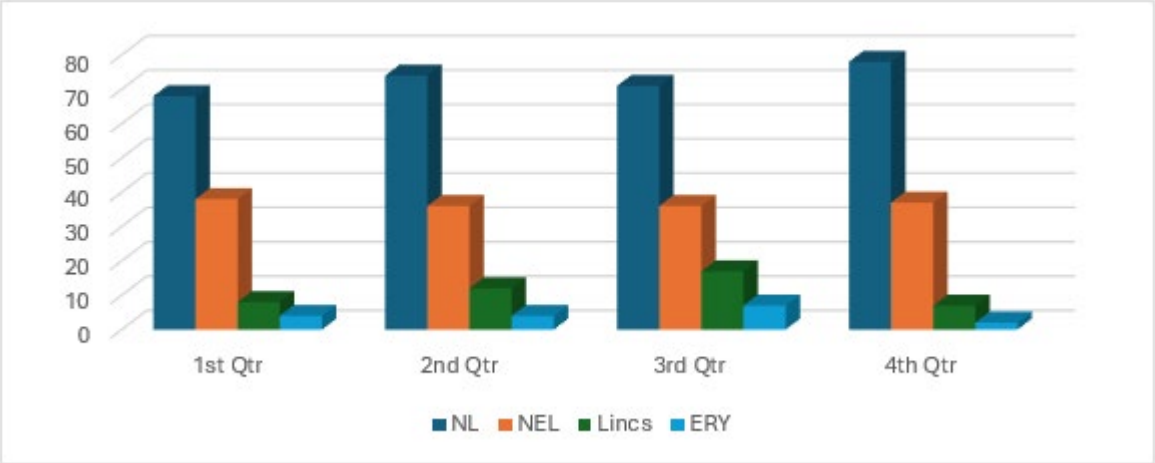
Assurance

- Strong governance arrangements and reporting to the Safeguarding Operational Group and Safeguarding Board in place.
- Adult Safeguarding policies and procedures and in place and safeguarding activity is recorded and reported at the Safeguarding Operational Group (bi- monthly).
- Training is provided at Levels 1-3 (Adult Intercollegiate Document, 2024).
- Complaints with a safeguarding element are reviewed by the teams.
- Providing specialist advice and support and supervision to staff.

- Delivered bespoke training sessions and updated safeguarding training in line with local/ national learning
- Sharing information with other safeguarding partners
- Undertake and supported safeguarding investigations (Section 42 Care Act) and contributed to Safeguarding Adult Reviews ensuring actions from learning lessons are implemented and embedded.
- Develop and undertake audits as required.
- Provide leadership and visibility on Safeguarding Adults.
- Continued partnership working with the Local Authorities and Safeguarding Adult Boards.
- Attendance at MAPPA (Multi-Agency Public Protection Arrangements), Multi Agency Cuckooing Advisory Panel (MACAP)

a) South Bank Adult Safeguarding Referrals

There is a consistent number of referrals made over the past 12 months across all Local Authorities.



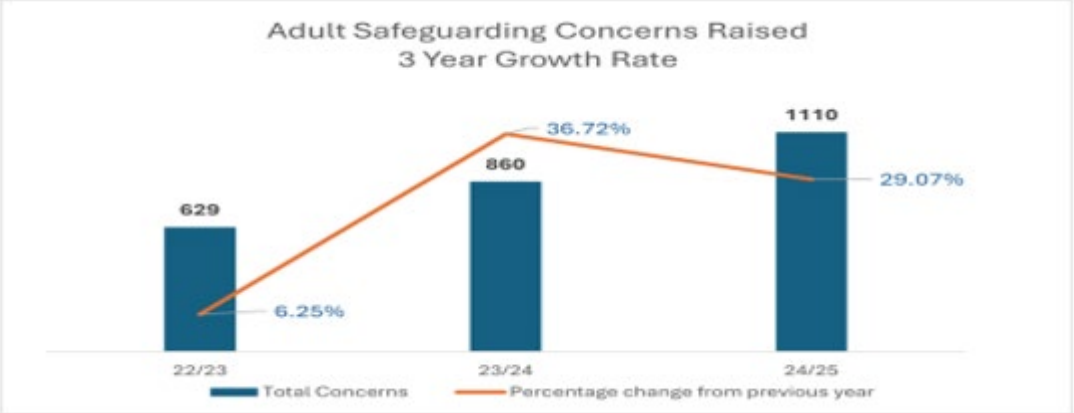
Over the past year there has been 499 Section 42 Care Act referrals sent to the Local Authorities, consistently across Q1-Q4. These are sent directly by staff in areas through WebV electronic patient record. Compared to last year there was 467 referrals, this shows an increase of 7%.

There were 929 contacts made into the team for advice and support. This is a new data capture for this year. Contacts into the team identify that neglect, domestic abuse, self-neglect and financial abuse are dominant factors. The team can also direct staff to more suitable support if the concerns doesn't meet the 3-stage criteria of the Care Act.

There were 7 requests for information for Line of Sight/ Safeguarding Adult reviews: 5 progressed. There was no specific learning identified for South Bank however more generally this was in relation to the understanding of mental capacity and legal literacy.

b) North Bank Safeguarding referrals

There have been 1057 adult referrals sent to the Local Authority following internal quality assurance checks by the safeguarding team; these are then forwarded on. Self-neglect, neglect and domestic abuse were the most prevalent. A weekly meeting is held with Hull Safeguarding Adults team. This indicates a 29% increase from 2023-2024.



The Trust has participated in 18 Safeguarding Adult Reviews (SAR); 13 in Hull and 5 in East Riding, all at various stages from potential to confirmed reviews. All learning identified is shared within the North bank Briefing Paper presented to the Safeguarding Operational Group for any learning identified for implementation by clinical leads/care groups. The significant increase in numbers and requests for information and chronologies, particularly by Hull Safeguarding Adults Board has been escalated to the Designated Nurse (ICB) to advise that set deadlines are difficult to achieve due to short deadlines sent and number of requests received. This is being monitored at the safeguarding operational group. Learning identified on one SAR related to the frequency of pain assessments, and the development of a pathway with the homeless team. The reviews also showed evidence of good communication, timely interventions for physical and mental health and good evidence of appropriate care and treatment during admission.

Key Achievements

- Attended Local Authority Safeguarding Adults Board and sub-group meetings.
- Oversight of all safeguarding adults referrals sent to the local authority
- Continued contribution to the Safeguarding Adults Review processes. Named Nurse is the Vice Chair for the SAR Panel in NEL.
- Named Nurse was a speaker at the NL Safeguarding Adults Conference in February and delivered a talk about professional curiosity in health care.
- Safeguarding representation at the falls SWARMS to give a safeguarding perspective and to co-ordinate referrals to the local authority if appropriate.
- Authoring of the Group Sexual Safety policy collaboratively with HUTH and NLaG. This has been approved and now available to the organisation.
- Facilitation of the safeguarding adults level 3 training via teams or face to face.
- Recruitment to the vacant Band 7 Specialist Nurse post (South Bank).

- Involved in the Forensic Project led by the Named Doctor for Adult Safeguarding at the East Riding and North Lincolnshire (ICB) HCP (suspected non-accidental injuries adults) North Bank.
- Named Nurse presented training to the Falls team and falls link nurses to improve safeguarding referrals quality
- Named Nurse presented training to HUTH Tissue Viability Nurse link nurses and Safer Skin committee incorporating DOH Safeguarding adult's protocol: pressure ulcers and raising a safeguarding concern

HHP Achievements

- The induction training package for Safeguarding is aligned across the group following collaboration North and South Bank Safeguarding teams (delivered twice a month).
- Adult and Children Safeguarding team members consistently support every Trust induction session presenting on key safeguarding messages and priorities.

Priorities for 2025-26

- Share the results of the Making Safeguarding Personal: A Review of the Effectiveness of Safeguarding Referrals audit and address actions arising from this (South Bank)
- Progress and seek agreement from a HHP perspective regarding compliance with the Intercollegiate Document for SG Adults (2024) and delivery of Level 3 Adult training Aligned across North and South
- To explore aligning data collection across Safeguarding Adults teams
- Improve Level 3 Adult safeguarding training compliance.
- Review the pilot project (North Bank) of adults 'Not brought to appointments' in line with the Was not brought Policy- not completed (2024-25) due to team absence and acuity.
- Promote closer working with the complaints team to ensure that any complaints making reference to abuse or neglect are reviewed by the safeguarding team.
- Develop a Was Not Brought Group Policy and audit the quality of the concerns raised
- Establish a consistent s42 process across the partnership by integrating the best aspects from each bank to create a stronger, unified process.

4. Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 as part of the Mental Capacity Act ([MCA],2005). It is designed to protect an individual's rights if, care or treatment received in hospital, or a care home may deprive them of their liberty and if they lack the mental capacity to consent to those arrangements. Both North and South banks clinical teams have a responsibility to identify patients who may be detained for treatment or care, who lack mental capacity and are unable to agree to their stay in hospital.

Achievements South Bank:

- All MCA 2005 documentation is completed electronically.
- Robust oversight of electronic data on for Capacity Assessments, Best Interest documentation and Deprivation of Liberty Safeguards Applications.
- Ongoing review of mandatory training offers taking into account the new Trust Group.
- Continue to deliver bespoke training sessions, supervision and Bitesize training.
- Continued to work with wider Vulnerabilities Team and other speciality staff implementing the MCA.
- Bespoke training is delivered the Resident Doctors (Junior Doctors)
- MCA monthly message 7-minute briefing posted on Trust page.
- Improvements within the legal literacy of the MCA as a result of the focused training and supervision informed by the QI Audit.
- Achieved 83% Mandatory training compliance.

Achievements North Bank:

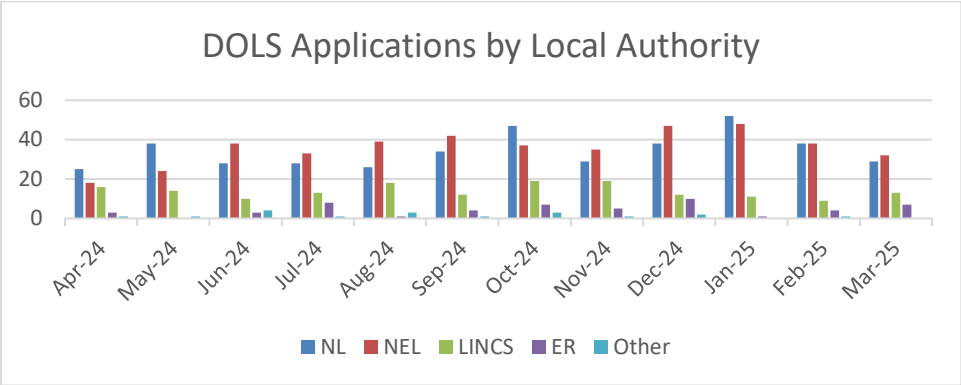
- All DoLS applications submitted to Local authorities had an associated capacity assessment
- Quarterly DoLS and associated capacity/best interest audit shows an improving picture for both numbers of submission and quality.
- Launch of Vulnerabilities and Enhanced Care Assessment Tool (VENA) Sept 24 – this supports the MCA lead to identify where potential restraint and restriction is happening and where MCA/DoLS advice and support is required. Proactive rather than reactive

Priorities 2025-2026

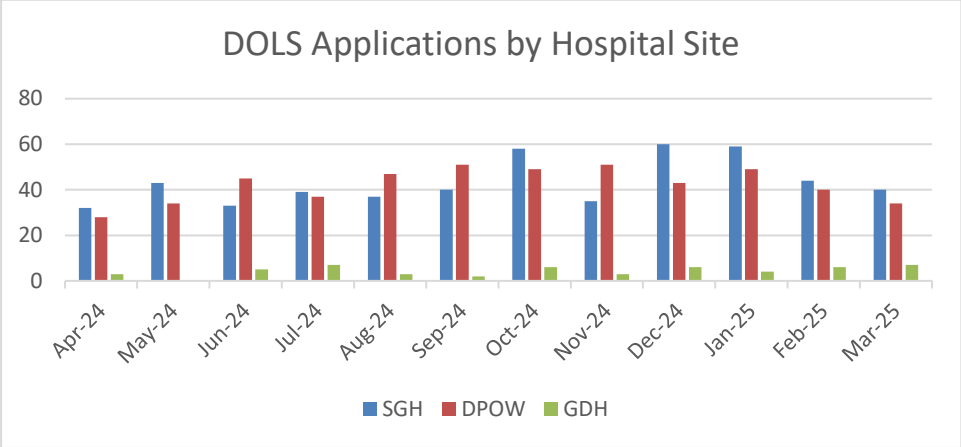
- Finalise missing and absconded patient policy
- Co-produce the joint MCA/ DOLS HHP policy
- Review the Quality Improvement work and development actions
- Bridging the gap between MCA knowledge and practice
- Digitisation of DOL application using Lorenzo platform launching Nov 25 (North Bank).
- Improve reporting on mental capacity and best interest prevalence
- Targeted audits with specialist provision e.g. Dementia/ Fractured Neck of Femur (NOF) surgical pathway
- Explore data capture of IMCA referrals South Bank.

a) Data South Bank Deprivation of Liberty Safeguards

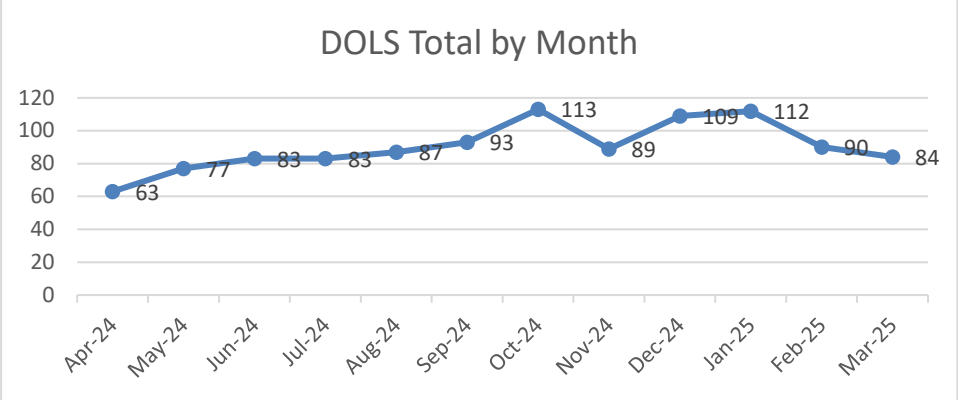
DoLS applications are sent electronically by organisational staff directly to the appropriate local authorities. Data is obtained from WebV patient record system.



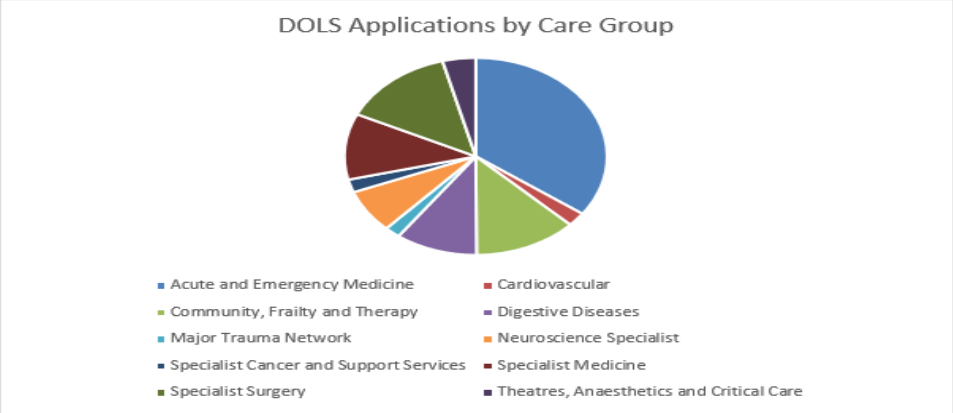
** The majority of DOLS applications are submitted to North East Lincolnshire or North Lincolnshire Local Authority DOLS Teams. A smaller percentage are submitted to East Riding DOLS teams.*



**there were similar numbers of applications from SGH and from DPOW and 52 from Goole Hospital.*

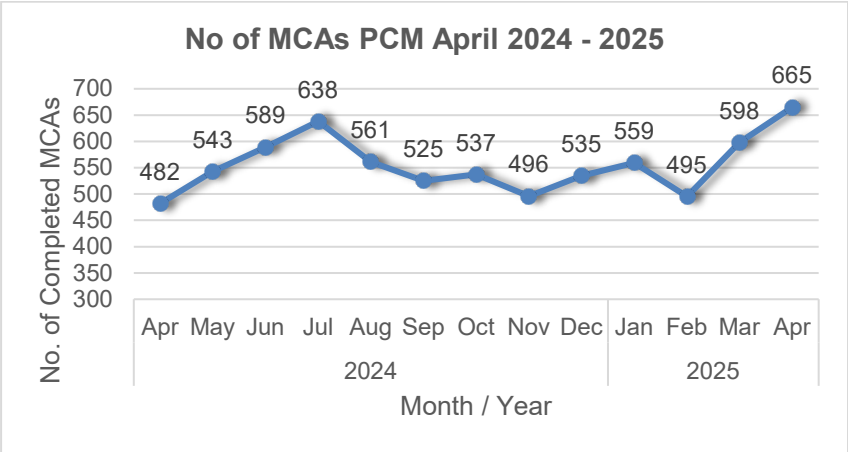


**a total of 1080 for year 2024-2025 (672 for 2023-24). This is an increase of 61%*

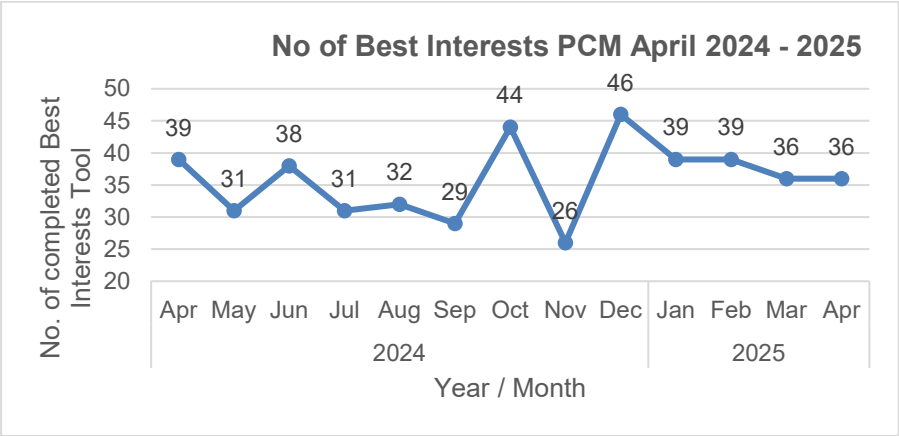


**acute and emergency medicine had the most applications. 30% of DoLS applications were made by Surgery, compared to Medicine who applied for 70% of all DoLS applications.*

Mental Capacity and Best Interest Decisions



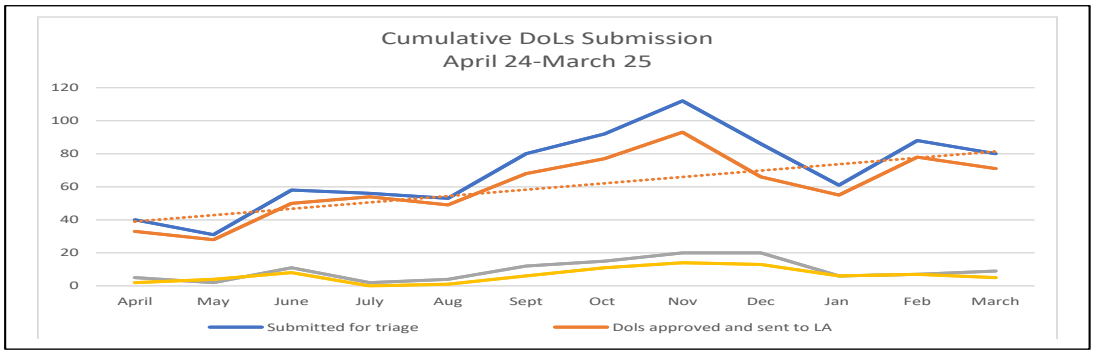
** Note this data shows the number of Mental Capacity Assessments completed on WebV April 2024 to April 2025. This does not reflect any capacity assessments that may have been documented within the clinical notes. An average of 546 assessments are undertaken monthly. This monthly average has increased from 486 2023-24.*



** Best Interest documentation on WebV continues at a fairly constant level and audit shows an increased in quality within this documentation.*

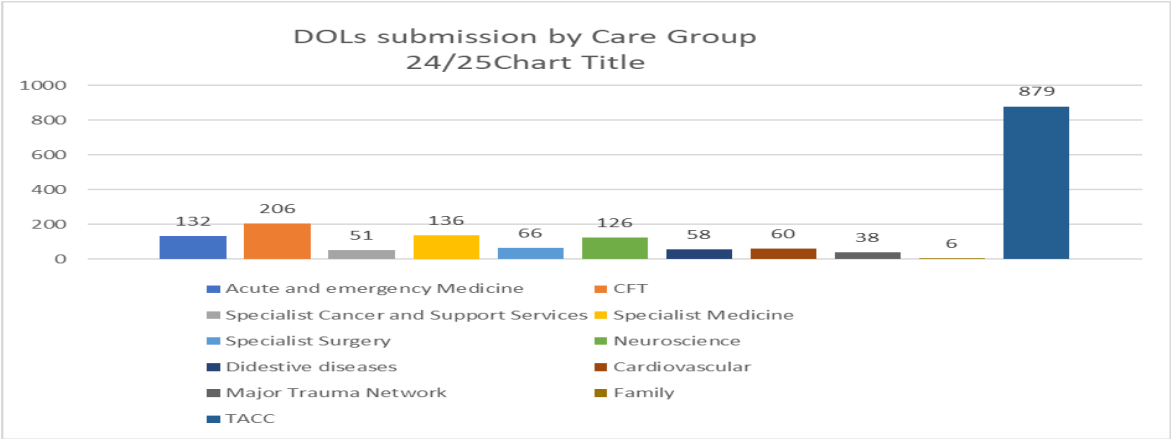
b) Data North Bank

Deprivation of Liberty Safeguards

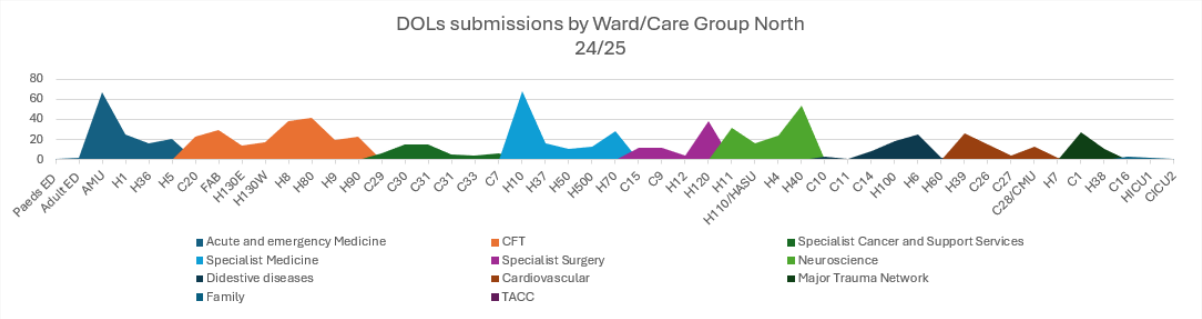


**there were 879 applications made 718 met threshold and were sent to the relevant local authority. Audit identified failures were due to incomplete and low-quality applications. Over the reporting year there has been a continued increase in the number of deprivation requests reaching thresholds showing improvements in the quality.*

	Apr-24	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Submitted for triage	40	31	58	56	53	80	92	112	86	61	88	80
Dols approved and sent to LA	33	28	50	54	49	68	77	93	66	55	78	71
Dols not approved	5	2	11	2	4	12	15	20	20	6	7	9
DATIX submitted	2	4	8	0	1	6	11	14	13	6	7	5



** acute and emergency medicine had the most applications.*



** There are concerns that wards with similar pt groups have such a difference in DOL applications. However, it is hoped the quip and introducing a new way of learning and focussing on knowledge into practice will address these gaps. But there will be fluctuations year on year*

Mental Capacity and Best Interest Decisions

There is no data available as all MCA are paper based. All DoLS applications submitted to the local authorities do however have an associated capacity assessment which gives assurance that DoLS are applied to patients who lack capacity.

A quarterly DOLS audit and associated MCA /BI is undertaken with the objectives;

- To understand the quality of documents on first submission – would they meet the legal threshold.
- To identify education and knowledge gaps that impact on completion and inform MCA QuIP digital solution.
- Identify areas of good practice
- Understand numbers of potential illegal detainments

The findings have been vital in the development and objectives for the QuIP which will be:

- Using forced fields in the digitisation development will support compliance on first submission, therefore safeguarding patients and staff
- Reduce the administrative burden and streamline the process.
- Inform the education/learning agenda.

Court of Protection (COP)

There were a number of potential COP applications discussed but avoided through reasonable adjustments and proportionate response.

Independent Mental Capacity Advocate (IMCA)

North - 31 referrals 24/25, compared to 33 referrals 23/24

South- not captured.

Quality Improvement South Bank

The Mental Capacity Act is one of the Trust's key priorities for 2023 – 25. Our project goal is to improve the quality and compliance with the MCA across the Trust. The MCA DOLS team continue to audit key wards on a monthly basis rating capacity assessments and best interest documentation for legal literacy, this then informs training needs which could be

Mandatory MCA DOLS Training, bespoke training, Bitesize training or supervision. A marked improvement in compliance has been shown on the wards that are taking part in the QuIP.

Project	Number of audits	Current compliance
MCA/DoLS	1	R 57.8%

Audit overview

Audit	Frequency	Compliance over last 6 periods						Current
Mental Capacity Assessment (from June 24)	M	N/A	50.7%	58.1%	62.9%	59.5%	61.7%	57.8%

** shows compliance with the MCA 2005 in terms of robust narrative within documentation over a 6-month period in 2024. The Quality audit showed an improvement in the ward areas of 50.7% to 61.7%.*

Project	Number of audits	Current compliance
MCA/DoLS	1	R 62.1%

Audit overview

Audit	Frequency	Compliance over last 6 periods						Current
Mental Capacity Assessment (from June 24)	M	60.3%	58.9%	55.9%	51.2%	45.8%	55.1%	62.1%

** shows the last 3 months of the 2024 Audit (60.3%, 58.9%, 55.9%). The MCA QuIP rolled out to 4 new wards for 2025, audit was followed by training and supervision (51.2% in April 2025 improved to 62.1% in July 2025).*

North Bank

HUTH has joined forces with the South QUiP. A prevalence audit for pilot areas completed, indicating little or no evidence of MCA use in decision making for such issues as end of life (EOL), respect, discharge planning or serious medical treatment decisions (SMT). 88 sets of notes have been reviewed. 57 (65%) had a record impairment in the functioning of the mind or brain. Of these 42 had complex decisions made such as EOL, nasogastric insertion, discharge planning, only 5 (12%) demonstrated adherence to the MCA process. This outcome along with other measures forms the baseline to address the application of knowledge into practice and how to develop changes in the training and education currently offered. A repeat of the audit will take place once changes to training and development has commenced.

Mental Capacity Act (Amendment Bill)

In April 2023 the Government announced the indefinite delay in the implementation of Liberty Protection Safeguards. A current challenge is in the Supreme Court in relation to the Cheshire West case. The team are closely monitoring this.

5. Safeguarding Children

HHP is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children (2023), the Children Act (1989/2004) and to work with both NL, NEL, Hull and East Riding Safeguarding Children Partnerships and neighbouring local authorities.

Our policies are linked and aligned with multi-agency policies and procedures and our safeguarding responsibilities are effectively discharged by the provision of day-to-day advice, supervision, support, identification of harm, making safeguarding referrals, attendance at strategy meetings/ child protection conferences, statement writing, attending court and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and safeguarding children practice reviews/learning lessons reviews and lines of sight processes for learning.

Key Achievements South Bank

- Mock Joint Targeted Agency Inspection Domestic Abuse (JTAI) NL. This identified gaps in collating the information by agencies should a JTAI Inspection be announced. The impact of this on the Safeguarding Team regarding capacity to respond to information requests would be impacted, however no organisational learning was identified
- The introduction of ED Navigators at both DPOW and SGH
- The embedding of Hollie Guard app within the trust
- The establishment of multi-agency self-harm meetings
- Development of the liaison risk stratification for reviewing attendances of children/young people in the ED.
- Roll out of routine enquiry (domestic abuse) in Early Pregnancy Unit and Gynaecology
- Continue to be active participants at Safeguarding Children Partnership meetings
- Established star of the month in ED for excellent safeguarding practice.
- Monthly safeguarding children team development meetings
- The use of baby maps for babies in NICU ratified
- Development to capture Early Help (EH) data in Web V and SystmOne.
- Safeguarding notice boards within ED.
- Embedding of electronic feedback forms at safeguarding children training
- Positive safeguarding children training audit undertaken identifying that it met the objectives set and applied into practice.
- Worked with multiagency partners to step back from Multi-agency Risk Assessment Conferences (MARAC) meetings
- Two MARAC audits completed which identified that the introduction of a WebV referral form improved the evidence of the level of risk.
- Supported the Anlaby Suite with nursing cover for child protection/ forensic medicals
- Embedding of the review of 16 / 17yrs olds and offering of support to the adult wards
- On going work with HUTH colleagues to review policies and documents and align if possible
- Daily support to the children's wards and ED at DPOW and SGH
- Active multi agency partner at Pre MACE and MACE meetings
- A flagging system is also in place to alert staff to children who have been highlighted as at risk of CCE /CSE.

- Developed a risk stratification to ensure oversight of children/young people ED attendances is maintained with support from community health partners NL/NEL.

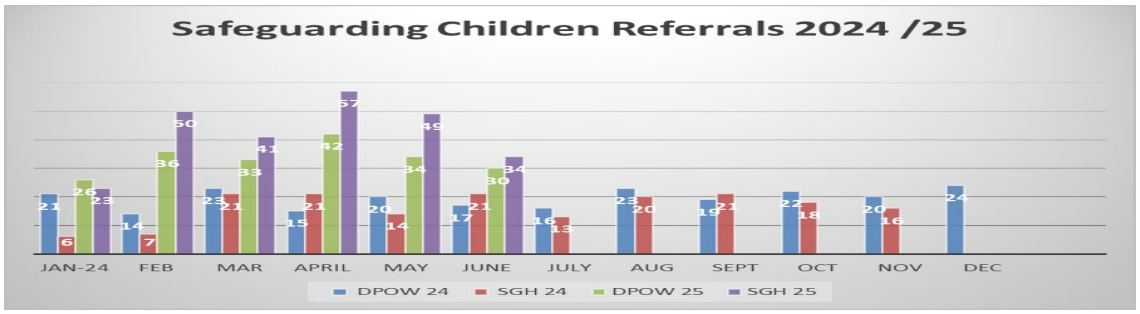
Key Achievements North Bank

- Attendance at strategy meetings (216) in relation to child sexual abuse as part of the CSAAS (North Bank). A disparity between the conversion rates to attending for medical appointments following a recommendation at the strategy meeting has been addressed through a task and finish group with the Hull Safeguarding Children Partnership and the three statutory agencies resulting in targeted training and amended paperwork with oversight of the Named Nurse (Children), Hull Safeguarding Children Partnership.
- Data regarding the number of referrals made relating to CCE/CSE is collected evidencing awareness amongst staff.
- Participated in the 15 Steps Challenge by North Lincs Youth Council - "you said/we did". Children and young people feedback positively regarding staff; however the aesthetics of the building were noted not to be as welcoming. All comments are being addressed to ensure a more child friendly environment.
- All children (Anlaby Suite attendees) are provided with a dental hygiene kit. Hygiene Packs are provided to promote hygiene and provide short term help.
- Mobile Video Interpreting Device has improved service user experience and accessibility to an interpreter.
- Attending Hull and East Riding Safeguarding Partnership subgroups to identify learning opportunities.
- Supported the implementation and role if of the new ED Navigator Service providing safeguarding support for complex child sexual exploitation/child criminal exploitation cases.
- Working collaboratively with the Independent Sexual Violence Advocates (Blue Door) to promote and identify outstanding health needs of those who do not attend appointments within maternity.
- Established regular regional Sexual Assault Referral Centre Meetings (SARC)
- Attending Police Audit Meeting – Rape and Serious Offences Security Panel Meetings (RASSO) to identify any learning opportunities.
- LADO training undertaken by Named Nurse Children and Named Midwife
- Collaborated with Hull Safeguarding Partnership in ensuring compliance with Working Together 2023.
- Promoted and collaborated with Humberside Police regarding multi-agency training for attendance at strategy discussions.
- Ensuring resilience in the medical team through appropriate level training for forensic medical examinations.
- The Anlaby Suite was awarded the Trusts Golden Star Award in the category of Excellence in Partnership Working
- Named Nurse has presented at South Yorkshire Police Board Meeting regarding the Child Sexual Assault Assessment Service.
- Supported and promoted Modern Day Slavery awareness and multi-agency partnership working
- Extensive review of safeguarding children supervision arrangements (North Bank) and successful roll out of a cascade supervision model.

- Trained 59 midwives as safeguarding supervisors to assist in the delivery the supervision model
- Daily attendances in children/ adult ED regarding any issues relating to children and families and review of business intelligence report of attendances enabling information to be shared with 0-19 service by safeguarding practitioners.

Data South Bank

Chart (a)



**The number of safeguarding referrals for children and young people has risen at both sites compared to numbers of referrals during 2024 This may be due to implementation of the electronic referral form that has now been embedded within Web V.*

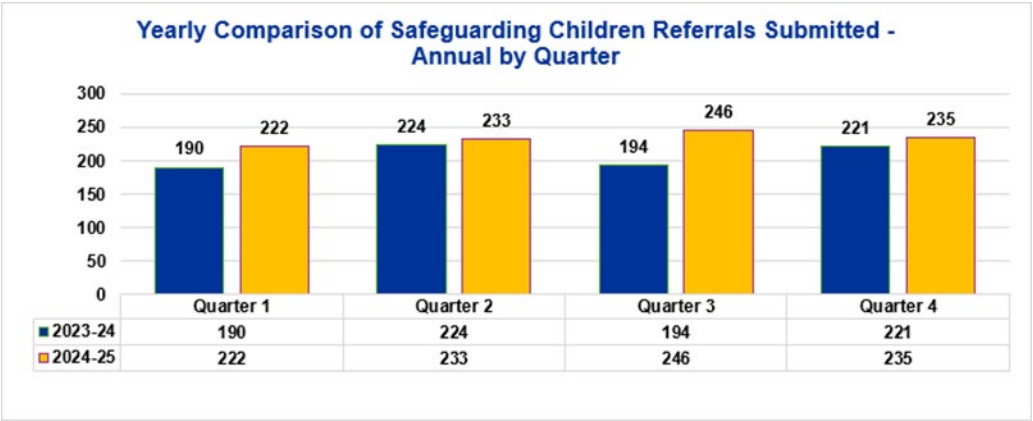
Chart (b)



** The number of requests for safeguarding children medicals is unpredictable and responsive to the requests from children's social care. The number requested to both sites have not increased and DPOW average 6 a month. The months where the numbers are high are when large sibling groups are presented for medicals. Most children and young people are presented for safeguarding medicals when actual or suspected physical harm has occurred.*

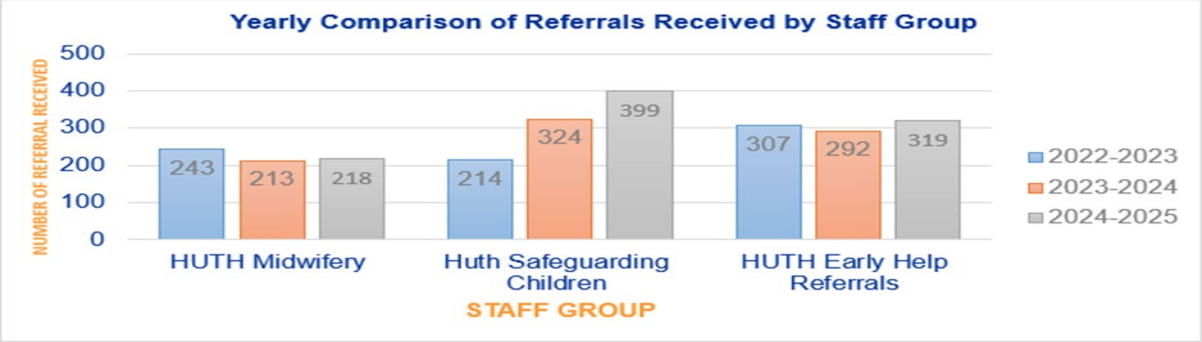
Data North Bank

Chart (a)



**936 Children Social Car referrals were received into the safeguarding children team and forwarded on to the relevant local authorities. These referrals are for all categories of harm and all different levels of service, including children young people and unborn babies. This is compared to 829 that were received in 2023-2024, which is an increase of 107 referrals. This increase is evidenced across all quarters for this reporting period.*

Chart (b) Early Help referrals



**Referrals for maternity have remained static over 3 years with children referrals rising significantly year on year. Around 80% of all early help referrals are from maternity services; this shows positive application of the threshold of need.*

Priorities 2025-2026

- South Bank – to analyse the number of referrals that led to safeguarding investigations as well as the quality of the information provided
- Embed CPIS Phase 2
- Align DPOW and SGH liaison data to ensure accurate data recording
- Review and align safeguarding children activity across HHP
- To review learning from audit and multiagency learning reviews, collaborating with the Care Groups and Governance to ensure learning is embedded into practice.
- Secure a Band 7 deputy for the North Bank Named Nurse to increase resilience, succession planning and support for safeguarding team. In addition this would mirror and align with the safeguarding children team at NLaG

- Seacure a Band 7 deputy for the North Bank Named Midwife to increase resilience, succession planning and support within midwifery. In addition this would mirror and align with the safeguarding midwifery team at NLaG
- Develop the threshold of need presentation to enable staff to access via the Big Blue Button, at a time that suits their needs (North Bank)
- Roll out the CP-IS monitoring for children and pregnant women who attend scheduled settings
- Development of a SOP for clinical staff and other AHP to create and 'flag' safeguarding on the Electronic Patient Record
- Review of a nominated lead for Modern Slavery across HHP

Challenges

- No midwifery safeguarding practitioners to support Named Midwife role North Bank impacting on development of strategic work.
- Evidence and the embedding of learning into practice.
- Attendance at regional SARC meetings (acuity in the service and staff pressure).
- Slight reduction in child protection medical appointments this year compared to 2023-24 (10 fewer cases); medical assessments undertaken in the Anlaby suite

Numbers of multi-agency reviews undertaken regarding children (including Child Safeguarding Practice Reviews, Line of Sight, or Local Learning Reviews).

	CSPR	LOS/SAG	LLR	PSII
Hull	**3**	**8**	**1**	**0**
East Riding	**1**	**2**	**2**	**0**
Nth East Lincs	**1**	**0**	**0**	**0**
Nth Lincs	**1**	**0**	**0**	**0**

South Bank

NEL – Safeguarding Children Review = 1. Learning- staff to consider neglect when children failed to be brought to outpatient appointment, family composition to be added to first outpatient appointment paperwork, and myth of invisible fathers to be added to all safeguarding level 3 training and supervision.

NL – Request for a Safeguarding children Review = 1. multiagency review arranged for senior leaders and involved practitioners.

North Bank

Child Safeguarding Practice Review's – HUTH have actively participated in 3 Child Safeguarding Practice Reviews - the learning has not yet been concluded

Hull Line of Sight reviews – there have been 8 learning reviews that have followed the 'Line of Sight ' process for HSCP

East Riding- 2 learning reviews that HUTH have referred to for learning for the ERSCP- Whilst there was no identified learning for HUTH, it was acknowledged with one case, the escalation process was followed by HUTH to East Riding CSC. In the second case, whilst there was no learning for HUTH, it was acknowledged that a Child Protection Medical was not considered for the child and this would have provided the child with opportunities to seek specialist support.

Local Learning Reviews - HUTH have participated in 3 Local Learning Reviews that have been directed by the Executive Board for the respective partnerships 1 for HSCP and 2 for ERSCP.

North Bank Learning Outcomes:

- Improve oversight of 16 and 17 yr olds attending the Emergency Department who are in the adult department.

  Actions - Live Business Intelligence Surveillance dashboard developed and reviewed by SG Practitioners including daily contacts/walk rounds. Immediate benefits recognised with subsequent high risk child exploitation incident resulted in prompt safeguarding oversight.

- Improve documentation within electronic records moving away from written notes within handheld and departmental records.

  Actions - SOP developed to improve documentation so accessible to all services. Approved and currently being embedded.

- Improve Professional Curiosity across children's services and escalation pathways.

  Action – Group wide refresh of Professional Curiosity with support from the communication team with intranet page available on Bridget.

Priorities 2025-26

Embedding the learning from CSPR's into practice is crucial to improve safeguarding outcomes and preventing future harm. A more clear and structured approach is required to ensure the learning is effectively translated into meaningful action and monitored via audit for frontline practice and outcomes for children. This approach will be addressed though the safeguarding operational group.

Section 11 Children Act Audit

HUTH

- Hull – no outstanding actions
- East Riding – no outstanding actions

NLAG

- East Riding- no outstanding actions
- North Lincolnshire- No outstanding actions
- North East Lincolnshire- actions regarding accessible information for children/adults and review of MCA training.

Contextual Safeguarding

South Bank continue to be an active multi agency partner at pre Multi-agency Child Exploitation (MACE) and MACE meetings. Professionals within the safeguarding team have taken a lead on attendance at these meetings and provide regular feedback to the wider team on children / young people who have been highlighted as at risk of Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE). A flagging system is also in place to alert staff to children who have been highlighted as at risk of CCE /CSE. The GRAFT team regularly attend training within paediatric and Emergency departments to raise awareness of CCE/CSE and how it can be identified. There are currently 31 active flags for children / young people at risk of CCE /CSE in NL and 42 active flags in NEL. The South bank has a policy for the adding and removal of flags on children records.

North Bank referred 12 incidences to children's social care from October 2024 to March 2025, following completion of the Risk Indicator Tool. This included 8 incidences for young people residing in the Hull area and 4 residing in the East Riding. Differential data between CCE and CSE was not captured until August 2025. Since 01/10/2025, the safeguarding children started collecting data in respect of referrals to Children's Social Care when either CSE or CCE was identified as a factor.

Owing to ongoing workforce pressures on the North Bank, HUTH has been unable to maintain consistent representation at Multi-agency Youth Violence and Exploitation (MAYVE) and MACE meetings. The Paediatric Emergency Department continues to employ the CCE/CSE assessment tool, and the Safeguarding Team systematically collates all positive indicators that lead to referrals to Children's Social Care (CSC).

Priorities 2025-26

- To robustly monitor the data across HHP in respect of the CSE / CCE referrals to ensure timely identification and response to vulnerable children at risk of exploitation.
- Explore alignment of identification of vulnerable children through flagging (HHP)
- Consider capacity to support the Multiagency Youth Violence and Exploitation panel (MAYVE) as part of our violence duty requirements
- HUTH will consider how the embedded ED Navigator roles may be utilised to support improved engagement in multi-agency meetings and to strengthen collaborative safeguarding practice.

6. Child Sexual Assault Assessment Service (CSAAS)

The Anlaby Suite (HUTH) are commissioned as part of the CSAAS to deliver a high quality, service for children and young people aged 0-15 years from across the Humberside Police force area. This incorporates Hull, East Riding, NL, and NEL local authorities. The service can also accommodate cases for young people aged 16-17 years (up to their 18th birthday) if they have additional needs and are deemed clinically appropriate. When assessments are required outside of the Anlaby Suite working hours (including weekends and bank holiday), alternative pathways exist.

Sexual Abuse Referral Centre (SARC) services are provided to deliver both recent (forensic) and non-recent (historic) assessments and can offer the opportunity to assist in a police investigation of the sexual allegation, including a forensic medical examination with consent.

The Anlaby Suite provided medical examinations for acute cases (up to 7 days of the alleged incident), recent cases (7-30 days since the alleged incident) and non-recent cases (after 30 days since the alleged incident. Referrals are received from either the Police or Children's Social Care, providing thresholds have been met for Section 47 (Children Act 1989).

Throughout 2024/25 staff participated in 216 Strategy Meetings. There was, however, a disparity in the conversion rates regarding the number of medical appointments offered at strategy meeting in comparison to the number of cases attending for medical appointments. The disparity was frequently discussed at commissioner meetings, shared with external partnership agencies and raised internally

Year: 2024-25	Q1	Q2	Q3	Q4	Total
OOA Acute Cases (Core)	5	1	2	3	11
OOA Acute Cases (Weekend/Bank Holiday)	2	0	2	1	7
Humberside SARC	2	2	4	9	17
Total Cases	7	1	4	4	51

(Appendix 3)

A total of 16 acute sexual abuse cases were recorded as attending either Sheffield Children's SARC or Mountain Healthcare/West Yorkshire SARC throughout 2024/25. A total of 11 acute cases attended other SARC's within core hours. In addition, a further 7 cases attended the other two SARC's over bank holidays or weekends.

Notably, only 17 acute cases attended the Anlaby Suite during core hours throughout 2024/25. However, an additional 11 core-hour acute cases were seen at other SARC's during the same period.

Challenges

The forensic SARC service is currently under review. All SARC's are required by 2nd October 2025 to have obtained accreditation of UKAS and meet Forensic Science regulator standards, and changes to the current service may lead to a shift in priorities and adjustments to the existing workloads.

Priorities 2025-26

- CSAAS lead; this is currently sat with the Named Nurse Safeguarding Children and will be reviewed as funding allocation is provided.
- Continue to meet and work with the ICB leaders, Safeguarding Children Partnership, OPCC and NHS England to develop future pathways and a model that meets the needs of local children. The voice of the child and professionals involved in the new Hub and Spoke model will be used alongside relevant data to ascertain efficacy of the new model. Consideration of returning acute forensic work to Hull remains a possibility.

Risk 2025-26

- De-skilling of highly trained specialist workforce

- Reduction in referrals across all four local authorities and attendance for child protection medicals (allegation of child sexual assault)
- Risk of children not having an assessment within required timescales to meet the forensic needs due to declining to travel outside of the Humberside area

7. Sudden Unexpected Death in Childhood (SUDIC) South Bank

Arrangements across North and North East Lincolnshire are the responsibility of Public Health and the Integrated Care Boards to ensure this statutory framework is implemented. Child Death Review (CDR) managers in the Local Authorities are responsible for the operational management of these arrangements. Not all babies, children and young people will have safeguarding concerns however where concerns do arise these are referred through the safeguarding children's procedures. All deaths of children and young people under the age of 18 years of age are reviewed under this process, regardless of the cause of death, including the death of any baby that shows signs of life at birth, regardless of their gestational age and viability.

Where a baby, child or young person has died we need to understand why and if there are any modifiable factors to prevent future deaths and identify any learning, any immediate safety concerns and any wider support needed for the community should a tragedy occur.

As a partner agency our Specialist SUDIC (Sudden Unexpected Death in Childhood) Nurse, ensures that the Trust fulfils its requirements to the Child Death Review process along with the Designated Doctor for Child Deaths, supported by the Chief Nurse for Neonates, Children and Young People and the Head of Safeguarding. As of the 1st April 2025, the Specialist SUDIC Nurse' role was moved from Safeguarding into the Family Services Directorate.

Although there is currently no identified key worker role for childhood deaths at HUTH, the Safeguarding Children Team actively participates in Joint Agency Review (JAR) meetings when safeguarding concerns have been identified. The team also provides guidance and support to other professionals involved in these meetings to ensure effective multi-agency collaboration and information sharing.

Achievements

- Undertook an audit into memory work undertaken by the trust and identified areas for improvement regarding consistency of memory work offered.
- Delivered training within the trust around the CDR process to Paediatric and ED colleagues
- Supported with staff debriefs
- Supported the keyworker role for bereaved families
- Worked with the CDR Team to develop a bereavement pack for families containing information around the CDR process and available bereavement support
- The trust were gifted 2 Cuddle Blankets, the one for SGH was donated by funds raised by a bereaved family and the one for DPoW was donated via 4Louis in memory of a baby who passed away, their parents chose DPoW to be the recipient in their baby's honour

- Involved in developing a bereavement booklet
- Received Cuddle Blankets though Charity 4 Louis

Priorities for 2025/2026

- Finalise the Snuza Hero SOP
- Develop a SOP for the use of the Cuddle Blankets
- Develop guidelines/a policy around Safer Sleep within the trust and alongside this do a survey into staff's understanding of safe sleep practices (ED, Paediatrics, Maternity)
- developing the CDR/SUDIC pages on Bridget
- Explore obtaining 2 trolleys for memory making/ bereavement (Healthtree Foundation)
- Review the memory work audit

8. Midwifery

Named Safeguarding Midwives for safeguarding children support our maternity services for safeguarding the unborn, children, vulnerable women and families for concerns arising in the ante and post-natal periods of pregnancy. Their role is to support midwifery services to carry out their safeguarding responsibilities, and the most complex cases for example cases relating to domestic abuse, substance misuse, neglect or poor mental health. Our teams offer safeguarding advice and access to safeguarding supervision for our staff across both North and South Banks. They are responsible for providing safeguarding leadership within maternity services to ensure high standards of safeguarding practice are maintained, including identifying opportunities for practice improvement and driving change where required. They support compliance with regulatory and commissioning standards including safeguarding children training and supervision within maternity services.

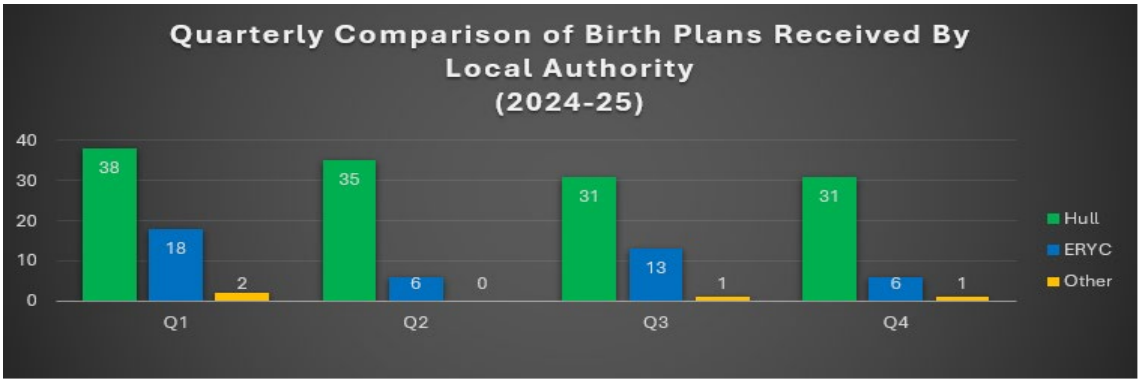
The Named Midwives have robust links with the maternity leadership team to ensure the delivery of safeguarding arrangements for maternity services as well as the wider Partnership.

Prebirth panel meeting

Named Midwives (North and South Banks) are actively involved in the pre-birth panel meetings where there are safeguarding concerns in pregnancy and have played an active role in the implementation of the unborn procedures guidance and pre-birth pathway which includes regular multi-agency panel meetings These forums have been designed to ensure there is consistent pre-birth assessment practice, which identifies potential vulnerability early in pregnancy. This supports appropriate information sharing and early identification or risk and review of thresholds in pregnancy. Multi-agency forums are effective in ensuring there is appropriate information sharing and has supported the early identification of risk and review of thresholds.

Multiagency pre-birth meetings in NL, NEL, Hull and East Riding are attended by the safeguarding midwives to ensure robust pre-birth planning and seamless communication with the partnerships.

Unborn subject to Child Protection plans (North Bank)



This data is available via BadgerNet and added to the maternity safeguarding dashboard held by the safeguarding children team.

On average HUTH maternity services have approximately 40-50 unborn babies subject to a Children Protection Plan at any one time. The data available for those on a Child in Need Plan is not as robust as these are managed by the community teams and Badgernet is not always updated in a timely manner.

This is something which will be fed into supervision and training so that we can have a clearer picture of safeguarding activity for 25/26.

Hope Box Project

The Hope Box project continues to be led by named Midwifes. The Giving HOPE Project is an initiative that aims to improve support and minimise the trauma for women who are separated from their babies during the early postnatal period following Court intervention or parent's voluntary agreement to separation (section 20). This project commenced July 2024 and is now well embedded within maternity on the North and South Bank. Continuous funding is provided through the LMNS. Local evidence and feedback collected from maternity demonstrates positive outcomes for the woman who receives a Hope box, minimising trauma through birth separation and providing kindness and empathy to families at a difficult time.

- 27 babies separated following birth due to care proceedings. 24 of these accepted a Hope Box (South Bank)
- 39 babies proposed to be separated as documented on birth plans. 22 of these offered and 21 accepted (one declined) a Hope Box (North Bank)

SIRS project

The Named Midwife continue to work with safeguarding partners and NHSE to review and develop processes to ensure implementation of Sharing Information Regarding Safeguarding (SIRS). It was anticipated that processes for sharing information relating to father of unborn baby would be utilised within the new maternity information system

(Badgernet). Unfortunately, the new system does not provide the functionality to enable these processes. This has been a feature nationally and has been escalated via the National Maternity Safeguarding Network (NMSN) / NHSE. The Named Midwife attends a task and finish group led by NMSN (North Bank)

Digital Systems

Badgernet Maternity (North Bank) was implemented in the organisation in February 2024, and October 2024 (South Bank). The South Bank use Badgernet to document all maternity safeguarding information. This ensures all safeguarding information is seamless from the ante -natal to the post-natal period. Other areas of the hospital on the South bank which include the emergency department neonatal units and paediatric areas have read only access to Badgernet for the sharing of safeguarding information. On the South bank flags are added to the Web V hospital digital system for unborn babies and children on child protection plans, multi-agency high risk (MARAC) cases and those children and young people who are children looked after.

During north bank implementation there were gaps in the integration of safeguarding and FGM reporting processes between digital systems. In addition, access Trust wide to Badgernet Maternity was raised as a concern as safeguarding information may not be available to all staff when required if this was limited to Badgernet. A task and finish group was established, and the Named Midwives have worked closely with the Head of Midwifery, Digital Midwife, Trust Information Team and change manager to establish any risks and work together to mitigate these and provide solutions where available. New risks on the maternity and digital risk register were submitted to flag the associated risk related to non-compliance with the notifications of completion of FGM and dual reporting of safeguarding information on both Lorenzo and Badgernet.

The North bank continues to utilise two clinical systems for recording safeguarding information. It has not been possible to provide full assurance that maternity Badgernet is easily accessible to key areas in the organisation which may require access. This includes the Emergency Department, Neonatal and Paediatric wards despite read only access being granted to staff in these areas.

In order be able to move safely to Badgernet as the main record for recording all safeguarding information a systems and processes review has taken place. This culminated in the development of a new Standard Operating Procedure for the reporting and recording of safeguarding in maternity services.

Additional on-going support from the Information team will be required in 25/26 to support the development of Business Intelligence reports which will provide clear and robust assurance that safeguarding information is available in the child's record when a mother has delivered.

The Child Protection Information System (CP-IS) has been audited for Hull and East Riding. This has proved to be an effective system for reporting on those unborn/children subject to a Child Protection Plan or Child Looked After for Hull Local Authority. Due to ongoing technical issues within the East Riding systems, manual flagging of child's

/pregnant woman's records continues by the Safeguarding Children Team. The team will continue to work in partnership with East Riding until resolved.

Key achievements North and South Bank

- Supported maternity with improvements post CQC Inspection 23-24 period (now complete) with assurance that arrangements meet the needs of the service (North Bank)
- Safeguarding Supervision audit has confirmed that good evidence of understanding and compliance is in place with reminders to ensure this is recorded by staff (North Bank).
- Developed a standard operating procedures for high-risk birth planning with clinical safeguarding midwives for high risk offenders accessing the Trust (North Bank).
- All Datix/ Ulysses have oversight of the Named Midwives.
- Learning from incidents are discussed with the Governance Midwife to share learning and practice (North Bank)
- Work in collaboration with the perinatal mental health midwife for those with diagnosed mental illness or severe depression (South Bank).
- Collaboration with the specialist learning disability nurses (North and South Bank) to ensure all appropriate services are included during pregnancy and post-natal planning (South Bank)
- Regular supervision for perinatal mental health midwives for high risk cases to ensure safe outcomes for mother and baby which aims to prevent a negative impact upon the attachment between mother, baby and family unit (South Bank).
- The Named Midwives are linked with local, regional and national maternity safeguarding forums
- North Bank- Safeguarding supervision is delivered to vulnerabilities midwives, clinical safeguarding midwives, maternity leadership team, LMNS, and Head of Midwifery.
- South bank midwifery training has been updated to reflect current themes of Domestic Abuse, FGM and its management in pregnancy and women with learning need and those in early help.
- Working with the vulnerabilities and adult safeguarding professionals to support the care of our most vulnerable pregnant women with additional learning needs, this includes both physical and cognitive disabilities.
- Collaborative working across HHP with Named Midwives meeting monthly and chaired by the Director of Midwifery.
- South Bank Safeguarding midwives have attended strategy meetings. Case conferences core groups and early help meetings are attended by community midwives; North bank clinical safeguarding midwives attend these.
- Delivered training to newly qualified midwives (South). All newly qualified midwives new in post have received face to face level 3 safeguarding children's training.
- Robust links with named midwives in other provider organisations.
- Completed a family file audit and presented to the operational meeting. The introduction of Badgernet has reduced repetitive information and duplication as there are safeguarding alerts throughout maternity documentation.
- Joint audit completed with the LMNS to look at babies that have been admitted to NICU as a place of safety. This to be presented to the Children's Multi Agency Resilience and Safeguarding Board (MARS) (South Bank).

- Named midwives presented at the Safeguarding conference for the Humber Health Partnership in July 25, regarding the Hope box project.
- Named midwives will flag all female infants born to women who have undergone FGM themselves. Referrals to children's social care will depend on the appropriate risk assessment (South Bank)
- Court statements continue to be requested by the local authority. Named midwives support staff with completing statements. In the last year South bank has completed 24 statements for maternity and 29 for North Bank and delivered within the timeframe
- Undertaken an audit evidencing that CP-IS processes in East riding are working effectively in the Trust (North Bank)
- Development of new pathway and associated SOP- High risk Birth planning for high-risk offenders accessing the Trust.
- The new Badgernet digital maternity record is now in operational; implemented 2024 on South Bank. The safeguarding platform of Badgernet is used and working well ensuring documentation is in the same place and visible throughout the full episode of maternity care.
- Named Midwives deliver a Safeguarding and Threshold session to all newly qualified midwives (North Bank).
- Worked collaboratively with the Named Nurses Safeguarding Children and Adults in the delivery of safeguarding practice for maternity and children / adult services.

Challenges

- There is an impact on Named Midwife capacity due to the frequency of Hull prebirth meetings. Additional team support has been facilitated (2025-2026).
- Increase year on year for court statements requests from the local authority. Safeguarding information may not be available to all staff at times when it is required. As mitigation, dual reporting remains in place on both Lorenzo and Badgernet.

Priorities 2025-2026

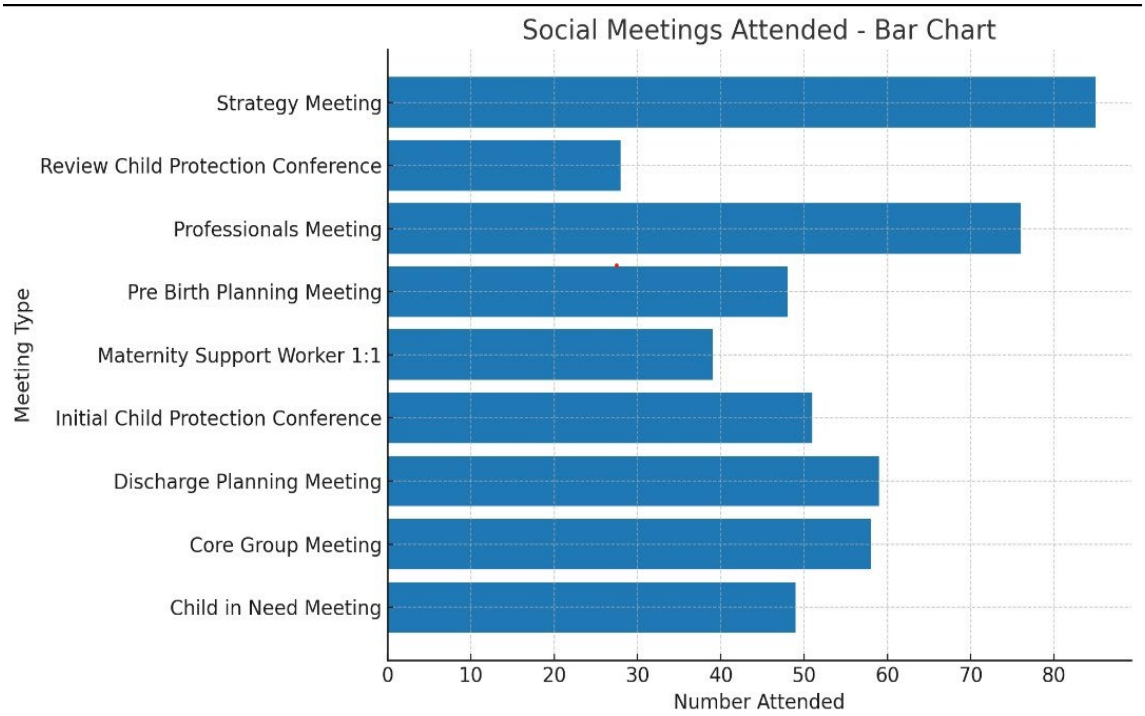
- Review of pre-birth arrangements and operational support from maternity services
- Creation of a safeguarding dashboard on Ulysses which provides details of the numbers submitted with safeguarding concerns by care group.
- Continue to work with the Head of Midwifery to review safeguarding support into the safeguarding team and develop a resilient workforce.
- Further develop the maternity safeguarding operational dashboard
- Continue to raise awareness of the Hope Box Project internally and across local partnerships secure recurrent funding
- Support the midwife who has been appointed as specialist safeguarding midwife to work within the safeguarding team and improve outcomes for women and babies (South Bank).
- To continue to deliver early help training by working with the local authority to provide training and support to midwives who offer targeted consent-based support to families, education midwives on the local early help offer.
- BadgerNet audit – to support the improvement of completion of maternity safeguarding information within the social tab within the post-natal period.

- South team to review adopting the North Bank Guideline that supports those parents who have a current or historical risk of offending behaviours. To ensure the safety of staff and individuals within the maternity unit. This includes safe planning of the birth of unborn baby in a multiagency arena. This could include children's social care, Management of Sexual Offenders and Violent Offenders (MOSOVO), police and probation
- Review Court statement request processes North bank for both medical and nursing statements.
- Creation of a maternity operational safeguarding dashboard (South Bank) to evidence key themes and trends.
- Work with National, regional and local Maternity safeguarding partners, including LMNS, NLAG, YSTH, NHSE and Safeguarding Children Partnerships to share information and learning, review practice and develop action plans to implement change.
- Develop a SOP and Business Intelligence report to aid a safe and smooth transition to Badgernet as main record for recording safeguarding information on the North Bank
- Continue work with the information team to move towards collecting FGM information for the dataset from Badgernet for national notification purposes. (North Bank).

Data

Chart (a) Social Care meetings attended (South Bank)

- Safeguarding midwives have attended strategy meetings. Case conferences core groups and EH meetings are attended by community midwives.



North Bank

Within the Corporate safeguarding team there is 1 WTE Named Midwife role, no deputy nor midwifery safeguarding practitioners. This therefore limits any ability to attend operational safeguarding meetings. These are attended either by the community midwifery teams or the

clinical safeguarding midwives. On average the clinical safeguarding midwives attend 70-80 safeguarding meetings each month. Last financial year was around 1000 meetings attended.

In this year on average 17% of meeting were not attended due to lack of capacity

The clinical safeguarding midwife role was created in response to very low attendance at safeguarding meetings. This has been effective in increasing attendance and improving information sharing.

Challenges

North bank Midwifery team have started to lose some of the skill set which is required when engaging with multi-agency forums and safeguarding meetings. Moving the demand back to the community midwifery team will be challenging in terms of training needs capacity due to high caseloads.

9. Female Genital Mutilation

Female Genital Mutilation (FGM) encompasses 'all procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs for non-therapeutic reasons. FGM can have far reaching consequences for the physical, psychological, and sexual health of the women and girls affected.

It is a violation of their human rights, a form of child abuse and is illegal in the UK. Midwives will offer sensitive support to survivors of FGM to ensure the safety of the new baby if a daughter is born and provide support and guidance to midwives providing care for these families. Where a pregnant woman has herself been a victim of FGM midwives will offer support to the woman emotionally and sensitively.

There are different reporting processes on the North and South banks. This is paper based on the South and digital on the North Bank.

Key achievements

- The Trusts have identified FGM Leads
- FGM-IS Standard Operating Procedures both sites
- All cases are reported to the Trust FGM leads – South Bank
- The Named Midwives receive a validation report month via the information team which provides details of all newly reported cases and those women who have delivered a baby (North Bank)
- Midwives complete FGM risk identification assessment tool in Badgernet (North)
- Mandatory quarterly reporting of FGM notifications to NHS Digital by the Named Midwife (South), and Information team/ Named Midwives (North Bank).
- Named midwives operate a manual failsafe process to ensure all female infants are reported and manually added to FGM-IS (South Bank)
- Badger net maternity digital system does now include a detailed risk assessment to support midwives to make a safeguarding assessment.

- Following an incident on the South bank in 2022-23 all midwives continue to receive mandatory FGM training by the named midwives to ensure the correct documentation and risk assessments have been completed.

Challenges North Bank

- Currently the FGM risk identification assessment tool is undertaken in Badgernet (maternity information/digital system) however the FGM enhanced dataset for national reporting form is completed in Lorenzo digital information system. The implementation of Badgernet in March 2024 has added an additional layer of complexity as midwives are unable to complete the FGM notification form directly in Badgernet. This has led to a fall in the number of notifications which have been completed / correctly completed. The number of FGM notification for Maternity services on the North Bank and increasing, therefore the need to be able to easily assess risk and complete the notification is essential. Delay in completion increases the risk of FGM-IS alerts (family history of FGM) not being added to a female baby born to mother identified as having FGM in a timely manner.
- Named Midwife is the sole lead for FGM on the North bank working collaboratively with the wider maternity MDT to improve safeguarding of mothers and female babies.

Priorities

Work will continue with the information team to move to developing a reporting tool via Badgernet which fulfils all the statutory requirements. This may include changes to present reporting which is twice during a pregnancy episode.

Risk

- FGM-IS (information sharing) delays in processes not being followed increases potential FGM safeguarding risks of female babies / girls under 18 years.

Plans

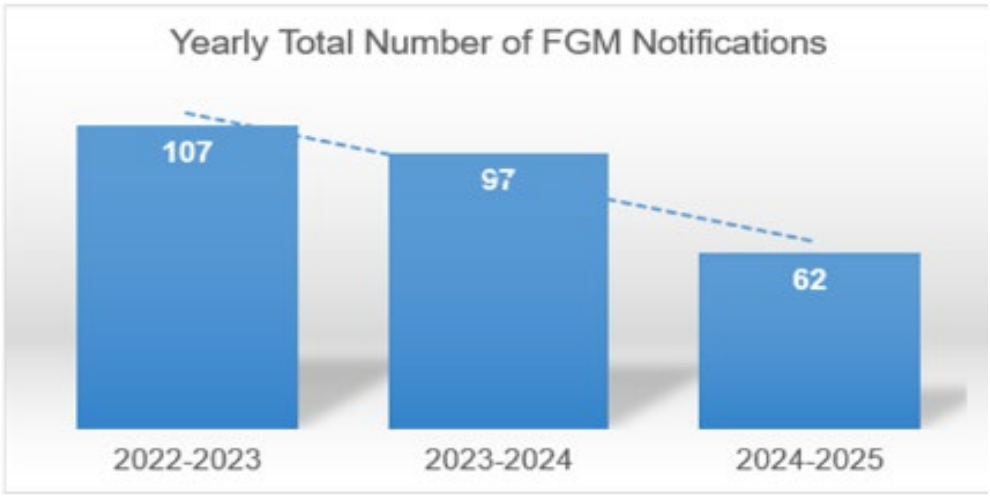
- Ongoing work continues with Director of Midwifery, Digital midwifery lead and Head of Information team to review the possibilities of all forms accessed via Badgernet and failsafe database
- Awareness of FGM reporting processes has been raised across midwifery leadership team and all maternity / obstetric staff by Named Midwife
- Included in mandatory midwifery yearly safeguarding training facilitated by Named Midwife
- Proposal to consider adding to FGM processes to family and women's risk health register

Priorities 2025-2026

- Work with the information team to develop a national reporting tool on Badgernet.
- Explore alignment of FGM reporting North and South Banks.
- Monitor the number of FGM notifications monthly.
- Work with Maternity Leadership to emphasize and embed the role of the midwife in ensuring the national notification is completed in Lorenzo (North Bank)
- Review and align FGM notification pathway including completion of an assurance audit to ensure no missed opportunities to flag safeguarding risks.

Data

North Bank



** The national notifications have reduced due to the midwife not completing the national notification within Lorenzo. Lorenzo is used as the digital platform to upload the national notifications on the North bank. This risk has been raised with the midwifery and the digital team with solutions to remove the dual reporting requirements under discussion.*

South Bank (2024-2025)

Number of FGM cases	DPOW	SGH
38	20	18

There were 38 cases reported on the South bank this year compared to 62 on the North Bank. However there are concerns North Bank regarding the number of notifications made. The new system for retrieving data which will be created by the information team will address these issues.

10. Training, Safeguarding Supervision and Development

a) Training

The provision and delivery of safeguarding training for both children and adults is mandatory for all staff and volunteers. This is in line with the Intercollegiate Documents for Safeguarding Children (2019) and Adults (2024). This ensures that all staff understand what a safeguarding concern is and what to do when concerns arise. This is a key line of enquiry in CQC Inspections.

Both organisations monitor the essential levels of Safeguarding training (Levels 1-5) of the Intercollegiate Documents. However, there are distinct differences in other training offered and being monitored over the North and South Banks. Work has begun this year to align

some of this, but differences will remain due to each organisation previously targeting their training to support the needs of the organisation.

a) Data for safeguarding training

North Bank Compliance

Training	%
Deprivation of Liberty Safeguards (DoLS)	87.6%
Mental Capacity Act	85%
Preventing Radicalisation: Basic Prevent Awareness	94%
Preventing Radicalisation: Prevent Awareness	91.5%
Safeguarding Adults Level 1	96.1%
Safeguarding Adults Level 2	90.8%
Safeguarding Adults Level 3	78.5%
Safeguarding Adults Level 4 / 5	100%
Safeguarding Children and Young People Level 1	95.5%
Safeguarding Children and Young People Level 2	91.5%
Safeguarding Children and Young People Level 3	86.8%
Safeguarding Children and Young People Level 4 / 5	75%

All levels of safeguarding training are in within target apart from adults' level 3; and Children level 4/5 (one person to complete this which has since been met).

South Bank Compliance

Training	%
Mental Capacity Act (inc. DoLS)	83%
Preventing Radicalisation: Basic Prevent Awareness	91%
Preventing Radicalisation: Prevent Awareness	87%
Safeguarding Adults Level 1	96%
Safeguarding Adults Level 2	92%
Safeguarding Adults Level 3	75%
Safeguarding Adults Level 4	75%
Safeguarding Children and Young People Level 1	96%
Safeguarding Children and Young People Level 2	93%
Safeguarding Children and Young People Level 3	75%
Safeguarding Children and Young People Level 4	75%
Safeguarding Children and Young People level 5	100%
FGM	87%

Training compliance has increased since March 2024 in basic prevent awareness, MCA, FGM adults level 3 and level 4,

Key Achievements

- Maintained compliance in levels 1 and 2 safeguarding children and adults training (delivered via eLearning)
- Delivered level 3 adult and children training face to face and eLearning (blended approach) South Bank

- Level 3 safeguarding children training for midwifery is consistently above 85%
- Oliver McGowan mandatory training has now fully commenced- now led by training and development.

Challenges

- Delivery of face-to-face safeguarding children training level 3 due to present staffing and maternity leave in the team (North Bank). Mandatory eLearning training is still accessed via HEY247

Priorities 2025-26

- Further roll out to all staff of basic prevent awareness training North Bank
- To review whether FGM should be mandatory on the North Bank
- To continue to monitor underperforming clinical groups through the Safeguarding Strategic Board.
- Increase compliance at level 3 and 4 training
- Improve safeguarding level 3 midwifery compliance South Bank

b) Safeguarding Children / Midwifery Supervision

There are two different models of supervision across North and South banks. South supervision is delivered by the safeguarding team and North Bank through a cascade model of supervision. Each model is delivering its statutory requirements in line with commissioning arrangements and the Intercollegiate document Safeguarding Children. The frequency of this differs depending upon those staff who case hold clients and their contact with children/ babies.

- Safeguarding Children Supervision North Bank has increased from 5.1% to 78.2% showing good compliance
- 59 midwives trained as safeguarding supervisors providing a cascade model of safeguarding supervision covering the service 24/7.
- All Midwives receive at least one mandatory safeguarding supervision session delivered as part of the Maternity and Obstetrics Symposium Training (MOST). North Bank
- Section 31 requirements related to safeguarding supervision in maternity have been complete with assurance that arrangements are now in place to meet the needs of the service.
- A Safeguarding Supervision Audit was completed Jan 2025 which showed 100% of midwives were aware of safeguarding supervision requirements and how to access it. (North bank)
- On the South bank named midwives and the safeguarding specialist midwife support all safeguarding supervision currently. Yearly supervision is currently 94% and delivered as part of the maternity mandatory training week of which the Named midwives complete both supervision and training in safeguarding.
- On the South bank named midwives support 3 monthly supervision with those midwives who are holding a caseload and those midwives managing complex cases.

Priorities 2025-2026

- The South bank maternity service is to commence a small cascade model of safeguarding supervisors to support those midwives in remote areas. This will begin as soon as training is completed and will improve compliance which is currently at 74%.

Data

Chart (a)



This data shows that safeguarding supervision figures are good which provides assurance that safeguarding supervision is embedded in maternity services.

11. Serious Violence Duty

The Duty is a key part of the Governments programme of work to collaborate and plan to prevent and reduce serious violence. Health and Care Partnerships are required by the Duty to work collaboratively with several specified authorities.

a) A&E Navigator Service

A pilot ED Navigator programme was commissioned by the Violence Prevention Partnership with the first victims of violence being supported in December 2024.

The Navigator programme places a case worker, called a 'Navigator', in Hull Royal Infirmary, the Diana Princess of Wales Hospital (Grimsby) and Scunthorpe General Hospital to support young people with a violence related injury. They aim to develop trusting relationships with the injured young people(aged 11-35 years) attending, provide informal mentoring and help them access services. The Navigator team also plan to implement a Trust-wide training programme to improve the delivery of trauma informed care and treatment. They will provide ongoing guidance and support for clinical and non-clinical professionals.

Goals

- Increase visibility of the Navigators programme so the target demographic is aware of the service if they should ever need it.
- Show that ED Navigators is a confidential service and young people can trust them not to judge their situation.

- Showcase the success of the service by sharing insights from collected data

Due to the successful implementation of Navigator service on the North and South Banks subsequent funding for 2025/26 was secured. Table below shows the number of victims presenting to the Emergency Department due to a violent assault.

	DEC	JAN	FEB	MARCH
HULL	**17**	**42**	**33**	**48**
SCUNTHORPE	**3**	**2**	**0**	**0**
GRIMSBY	**1**	**0**	**0**	**2**

**referrals received monthly*

	DEC	JAN	FEB	MARCH
HULL	17	42	33	48
SCUNTHORPE	3	4	2	0
GRIMSBY	1	0	0	2

**support provided monthly*

Priorities for 2025/25

The ED Navigator models differ between north and south of the Humber resulting in fewer number of children and young adults effected by serious violence to be offered support on the south bank due to issues with the referral mechanisms. A review will be undertaken to examine Police intelligence/heat mapping and the ISTV/ED intelligence. The aim will be to establish missed opportunities, share and build on best practice, ensuring the voice the victim and stakeholders involved in the pathway are heard.

North bank will continue to build on the success of the pilot and further collaborate with additional VCSE and youth programme pathways to support victims of violence choose alternative lifestyle choices.

b) Sexual Safety

In September 2023, NHS England published the ‘sexual safety in healthcare organisational charter’. NHS Humber Health Partnership (HHP) signed the charter and commenced improvement works across the ten key principles. Widespread support from stakeholders across the partnership has enabled excellent progress against these priorities.

Achievements

- A full review and alignment of all relevant policies and guidelines has been completed to ensure compatibility with the sexual safety priorities.
- Multiple disclosure pathways remain in place to ensure psychological safety for our staff and volunteers who want to report sexual misconduct. These pathways include Datix/Ulysses, HR, line manager, safeguarding and F2SU guardians.
- All disclosures, including anonymous reports, are discussed and actioned at a monthly zero tolerance ‘Sexual Misconduct Circle Group’.

- The Circle Group is the centralised platform for all disclosures of sexual misconduct to enable strategic oversight and data collection.
- Produced a launch video, promotional posters and mirror stickers. Embedded within the promotional material is the QR code that links directly to the sexual safety reporting tool. The posters and stickers are being shared by the safeguarding team to all services across the partnership for discreet advertising in non-patient facing areas (e.g. staff toilets and changing rooms).

Priorities

- continue to embed the actions to eradicate sexual misconduct in our workplace.
- align our priorities to the national Violence Against Women and Girls strategy (VAWG), Domestic Abuse strategy and the NHS Violence Prevention and Reduction (VPR) standard.
- improvement in training and preparedness to consistently deliver trauma-informed care
- appoint a dedicated domestic abuse and sexual violence lead

12. Domestic Abuse

Domestic abuse is any incident or pattern of incident of controlling behaviour, violence or abuse between those aged 16 or over who are family members or who are or have been intimidate partners.. This includes psychological, physical, sexual, financial and emotional abuse. It also includes ‘honour-based violence and forced marriage.

The Domestic Abuse Coordinator (DAC) started Feb 2024 (south bank site only), with the role funded for 12 months by Standing Together Against Domestic Abuse (DA charity with funding from the Home Office). Funding ended in February 2025. The DAC role is to coordinate a trust wide response to domestic abuse for patients and staff.

DAC Role Project (South Bank)

The Pathfinder project was a 3-year project led by STADA and other expert partners to address the links between health and domestic abuse and to increase capacity in responding to victims effectively within the health setting. This is where the recommendation of a domestic abuse coordinator came from. DAC role includes;

- Coordinate a trust wide response to domestic abuse, creating an environment where staff feel confident to identify, ask and respond to domestic abuse.
- Improve DA identification and responses by engaging health professionals developing an infrastructure of policies and procedures, and extra resources
- Supporting professionals offering advice support and guidance with DA enquiries.
- Build relationships with specialist DA services including co-located IDVA’s and embed their support within the Trust’s domestic abuse response.
- Monitor the progress of the Trust’s response and evidence the need for further actions and long-term investment.

Training

2024-2025	Total number of staff trained and level of training
Q1	HUTH 501 NLAG 160
Q2	HUTH 534 NLAG 287
Q3	HUTH 579 NLAG 256
Q4	HUTH 622 NLAG 271

Summary of key achievements in the role and evidence of success

The DAC was a speaker at the NL Safeguarding Adults Conference in February, Public Health Against Domestic Abuse (PHADA) and Crossing Pathways Webinars delivering a talk on DAC. Better connections between health and local DA services. Better communication between health and DA front line workers improving response to victims of DA. Improvement of quality and quantity of DA referrals. Introduction of new referral pathways. Creation and implementation of DA Champions North and South bank.

Kay Achievements

- DA Champions rolled out by DAC north and south bank. 125 domestic abuse champions with 93 of those based in HUTH, 32 in NLaG (2024-25)
- Updated the Domestic Abuse and safeguarding policy and guidance (North and South Banks).
- Routine enquiry (RE) is mandatory question on admission to HUTH; now implemented in the ED (May 2024) supported by a training package
- Regular DA Awareness training and DA Champion training for all staff north and south bank.
- DA training to FY1 (south bank only).
- DA training to ED nurses to support digitalisation of RE in ED (North Bank only)
- DAC supporting specialist children and safeguarding nurses with supervision (South Bank).
- DAC providing training and supervision on mandatory session with paeds, neonates and midwifery.
- DA & DAC discussed in induction for all staff. Medium risk referrals implemented for DA available on WebV for NLincs and NEL DA services.
- Routine enquiry embedded south bank for EPU TOPS and Gynae. DAC supporting line managers and HR in return to work.
- Worked with IDVA services and security to implement safety plans for staff and patients
- The DAC is working with the Police to facilitate Domestic violence Disclosure (Claires Law) to staff/ patients safely (South Bank)
- Continued to support staff who are victims of Domestic Abuse. North data not available as support provided by the IDVA.
- The North bank IDVA provides an invaluable service to support victims of DA and also the North Bank safeguarding adults team (data collected by Hull DAP, not known to HUTH).
- DAC has directly supported 19 staff cases who were experiencing DA with advice, information and safety planning.

Patient Story

Young female patient, known to MARAC, allocated IDVA support in place and now 12 weeks pregnant. IDVA allocated but struggled to engage with patient as she was still in the relationship. During 12-week scan appointment it was agreed by IDVA for DAC to attend to speak with patient. DAC communicated with Dr, midwives and security to create an opportunity to speak with the patient by herself. DAC had knowledge of DVDs and agreed for Humberside police to attend. DVDs and safety plan completed at 12 weeks scan away from partner and confirmed future IDVA support. Patient went on to report partner to the police. Partner was arrested, remanded and pled guilty. Relationship remains separated and improved engagement between patient and IDVA.

Assurance

- Routine enquiry around DA is a mandatory question on admission to HUTH; now implemented within the ED in 2024.
- Delivered monthly training by the SGA team at ED training days (North Bank).
- Secured further funding for the DAC role until December 2025 only
- Delivered as part of L3 adults training north and south banks
- Supporting domestic abuse partnership audits and self-assessments and delivery plans for the DA strategies for Hull and ER.
- The DAC has led this year on providing DA awareness training and DA champion training with 125 across the HHP group
- Attendance at external partnership meetings- Domestic Abuse Boards and Subgroups (Group Wide)
- IDVA is in place supporting patients and staff at HUTH/ CHH/ SGH.
- Established coordination of children safeguarding referrals related to DA and forwarded to the Adult safeguarding team for further enquiry and support/ signposting (North Bank).
- HUTH Trust IDVA has received two commendations within Humberside Police this year which recognises the exceptional work undertaken to support victims of domestic abuse.
- Victims who are heard at multi-agency risk Assessment Conferences (MARAC) are flagged – this creates an opportunity at hospital attendance to offer support if required and advocates professional curiosity.
- A North bank DA briefing paper developed is presented to the Bimonthly Safeguarding Operational Group by the Named Nurse providing all activity undertaken in relation to DA, including learning identified, training available, patient stories, DA Champions, newsletters and updates.
- Attendance at external operational groups with the local authorities
- Working with IDVA services to implement safety plans for staff and patients.
- Routine/Selective enquiry training is part of Domestic Abuse Level 3 training developed and implemented 2022/23, mandatory for identified cohort of staff as part of phase 2 safeguarding adult's level 3 training (North Bank)

Non-fatal Strangulation

A document has been developed to improve the treatment of patients who present with any form of non-fatal strangulation injury to any area of the trust by providing a standardized approach for healthcare professionals in identification and assessment. It therefore aims to reduce the risk of potential complications associated with non-fatal strangulation and further harm occurring. This is

being led by an ANP from ED at NLAG and has been presented at the Strategic safeguarding Board.

North Bank DARDRS/ requests for information

There were 9 cases considered for DARDR during 2024/25 in which the safeguarding adults team prepared chronology and reviews to support decision making for a DARDR. 4 cases have been confirmed as a DARDR and are all ongoing. The learning identified is in relation to improving professional curiosity and increase the awareness of RE within the ED, and parental alienation in families.

South Bank DARDRS/ requests for information

The south team have 12 active DARDR's , 9 are NL/NEL and 3 Lincolnshire. All have required chronologies to be completed and are at various stages of completion. Learning that has been identified is, the introduction of routine enquiry in ED and the application of the Homelessness Reduction Act.

Priorities 2025-2026

- Undertake a campaign to promote the awareness of parental alienation
- Promote awareness of professional curiosity among stall staff.
- Develop an audit tool and audit the completion of RE in ED.
- To pursue submission of a business case for a dedicated DAC for the North and South bank
- Routine Enquiry and training to continue across all relevant departments
- To undertake an audit following the implementation of RE as a digitalised mandatory part of nursing assessment
- To gain White Ribbon UK Accreditation to support ending men's violence against women (Group Wide).
- To continue to work in collaboration with the South Bank DAC to provide additional training offer to develop further DA champions across the Group
- DAC to continue DA champion network for support and supervision for DA Champions
- To support partnership audit and self-assessments for domestic abuse
- To aligning the flagging of high-risk domestic abuse victims North and South Banks
- DAC to work with partner agencies to develop a staff specific drop-in support service north and south bank
- DAC to work with Lincolnshire services for appropriate flagging of MARAC victims
- DAC to work with Lincolnshire services to create referral pathway into DA services.
- Audit routine enquiry in the ED (North Bank).

North Bank Data- Referrals received

There has been an increase of DA related concerns raised by HUTH staff year on year. These are triaged and referred to the most appropriate service to support. This has impacted on the Named Nurse/ Specialist Nurse for Adult safeguarding capacity.

Year	Numbers	% increase

2022/23	103	16%
2023/24	162	16%
2024/25	211	19%

South Bank DA Referral Data

Pre DAC role – MARAC referrals only

April 2023 – March 2024 Total DA referrals received 149

DAC role (started Feb 2024) – MARAC and medium risk referrals introduced

April 2024 – March 2025 Total DA referrals received 155

DAC role embedded MARAC and medium risk referrals

April 2025 – present day October 2025 Total DA referrals received 122.

Predicted increase of 22%. Predicted referrals by end of March 2026 189.

13. Allegations Against Members of Staff

The Trust is under a legal obligation, within the Children's Act, for managing cases where allegations are made about Trust staff that indicate that children, young people or adults at risk are believed to have suffered, or are likely to suffer, significant harm. Staff who fit the criteria are referred to the Local Allegations Designated Officer (LADO) in the Local Authority. The Trust also has a legal obligation for raising and managing concerns raised about Trust staff under the People in Positions of Trust (PiPoT) Process. The Care Act (2014) defines PiPoT as: "people who work in paid or unpaid capacity, including celebrities and people undertaking charitable duties with adults with care and support needs".

Both safeguarding teams on the North and South Banks act as points of contact and conduit for reporting Allegations Against staff in line with Multi-agency Policies and Procedures.

Assurance

Safeguarding teams offer advice and support to staff and Human Resources in relation to managing these processes

Challenges

- Insufficient numbers of the team to have the capacity to manage the process impacting on operational work. Plan to train additional members of the team to support the process.

Mitigation

Regular cleansing of data and updating of PIPOT/ LADO concerns undertaken

Priorities 2025-2026

- Develop a HHP Allegations Against Staff Policy

14. Transition Children into Adulthood (South Bank)

The transition from children to adult services can be a very stressful and difficult time for young people and their families. The successful seamless transition for young people with long term conditions and/or complex health needs into adult health services is essential to reduce health inequalities, ensure young people receive the right care at the right time and receive the support they require as a young adult.

Key Achievements

- HSJ awards 2025 finalist for patient safety this is due to our joint working with RDaSH involving the introduction of transition clinics in our special schools / colleges. (From this we have identified 80 young people who were not on Learning Disability register).
- First personalised complex transition patient pathway completed.
- Diabetes Transition clinics now to be held in the Adult Diabetes centres Trust wide – these areas have been decorated and made more younger person friendly.
- Our Transition Web V alerts work celebrated in the NCEPOD The Inbetweeners re-review report 2024.
- NLaG Diabetes teams from both DPOW/SGH (medical and nursing) completed a 6-month seamless diabetes programme funded by the Hull and North Yorkshire ICB.
- Lead Nurse Transition meeting with other Leads twice a year within the Yorkshire region to share good practice.
- Melatonin referral form on Web V for age 17 ½ years + referrals to RDaSH/sleep charity. As there had been some complaints surrounding this as there had been no official process and GPs are not licensed to prescribe it. So, it was causing worry to parents surrounding sleep.
- Lead Nurse Transition asked to present at national SBK Healthcare Transition conference regarding the work we have achieved at HHP.

Data

- Transition alerts 711 (identifying patients aged 14+ who will be moving into adult services)
- Transition database has 185 patients on it.
- Transition contacts at present are 1050 – this includes often complex MDT's that are held.

Plans for 2025-2026

- Youth Forum – on the south bank
- Work with Care plus group to commence Transition clinics across in NEL
- Continue to develop personalised pathways for our complex patients
- Continue to add to our Transition database
- Adding Transition to all Clinical Nurse Specialist job specifications within Paediatrics and Adults

- To ensure that Transition is added to the new group Job descriptions
- Band 6 Paediatric Transition Nurse funded by Paediatrics -to lead on transition in the community, hospital and schools.
- Submit a business case for Band 7 specialist nurse to support with complex Transition pathways (186) in total, and work BAME and Immigration population.
- Devise pathways within Gastroenterology and port-a- cath clinics. This type of work requires Leadership from a Band 7.
- Explore what End of life care looks like at the ages between 16-18 and the grey areas of this.

Risks

Currently only one Lead Nurse Transition employed. The success of this role is at risk of not progressing further due to capacity of one person, impacting on implementing a personalised pathway for each complex person who presents at our emergency department. Paediatrics have funded a Band 6 Paediatric Transition Nurse post who will start and lead on transition within the community, hospital and schools.

Currently, there is no identified Transition Nurse role within HUTH to support the coordination and continuity of care for young people transitioning from child to adult services.

15. Vulnerabilities

North and South teams have collaborated and led by the Lead Nurse Vulnerabilities this year. The team supports the Trust strategic objectives to 'reduce health inequalities,' by ensuring patients have the adjustments required to ensure equitable access, excellent experience and optimal outcomes. Our team undertake and complete Structured Judgement Reviews (SJR's) of patients with a Learning Disability and/or autism who pass away in the care of HHP, and a referral is made to the LeDeR programme. The team work across the partnership with colleagues to provide the right care are at the right time and work towards preventing hospital admission. The Vulnerabilities team is committed to ensuring that vulnerable patients in our hospitals receive excellent patient centred care and that they and their relatives/carers have a quality experience.

Learning Disabilities Mortality Review (LeDeR) Supported the LeDeR programme with completion of SJR's for all patients who pass away in hospital with a learning disability. We will continue to review, revise and enhance the processes and governance of the LeDeR programme with partner agencies and commissioners.

We have retrospectively reviewed patients over the last 3 years and found 5 patients who had not had SJR or LeDeR referral. These patients have all now had an SJR completed and are going through the LeDeR process. Within the ICB footprint there has been work done with the medical examiner teams to ensure patients with a learning disability are identified to enable SJR and referral to LeDeR.

Identified Good practice from SJRs and LeDeR reviews

- ReSPECT documents reviewed during hospital admission and updated accordingly

- Evidence of patient centred care planning with involvement of relevant MDT
- Good interaction and engagement with patient/families/carers
- Evidence of the patient being involved in decisions about his care whilst in hospital
- Excellent joint working between professionals both internally and externally

Identified learning from SJRs and LeDeR reviews

- Application of the Mental Capacity Act
- Awareness of these individuals and support through reasonable adjustments
- Personalised care and support
- End-of-life care
- Respiratory, cancer, and cardiovascular outcomes
- Recognition of deterioration
- Swallowing assessments

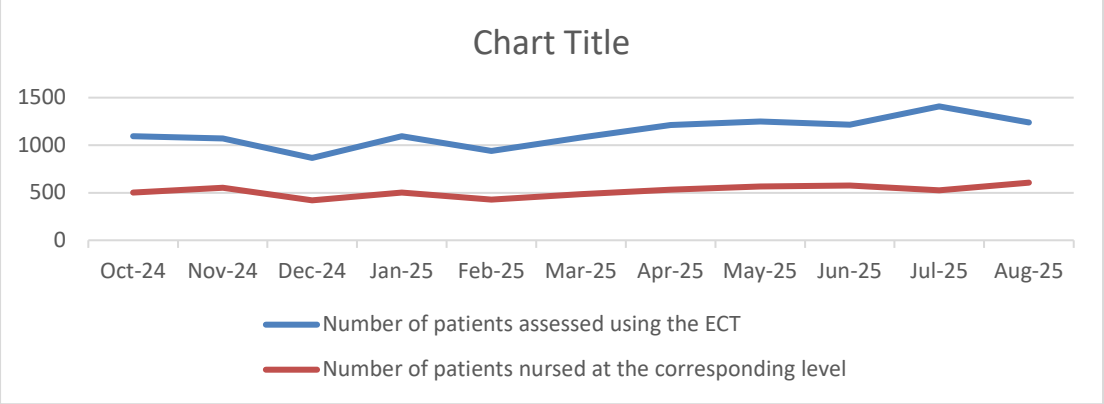
HHP Achievements

- The new Nerve centre tool (mandated for adult in patient in use since October 2024, monthly audit suggests that approximately 50% of patients are managed at the correct level of restraint and restriction. New pathways have recently been introduced to enable the care groups to ensure patients are receiving the correct level of restraint and restriction.
- Quarterly newsletters shared as part of the vulnerabilities operational group regarding lessons and learning from LeDeR reviews. Any learning from specific LeDeR reviews shared directly with care groups
- Working with the ICB regarding health inequalities and achieved access to reports of patients on waiting lists and outpatient appointments.
- National Audit for Dementia completed across the group
- Completed the action plan from the National Audit of Dementia 2022. Electronic delirium screen in place within symphony to enable patients to be assessed on admission to the emergency department. (South bank)
- Legacy money (South Bank)- 3 wards at Scunthorpe now refurbished with two bays and one side room, work continues other wards at a steadier pace. This has enhanced the environment for patients with Dementia in hospital
- Joint event and presentation at NL carers experts together pledge event
- Presentation in conjunction with partners at NEL Safeguarding Adults Conference
- Completed the Learning Disabilities Benchmarking audit for development of group wide priorities once report received
- Celebrated Dementia Action, Learning Disabilities, and carers awareness weeks
- Launched the Carers Strategy and carers lanyard during carers week (South bank)
- Developed a new vulnerabilities dashboard for oversight of activity and assurance
- Implemented the new vulnerabilities operational group that reports to the Strategic Safeguarding Board.
- Continued collaboration with the community LD teams to reduce admissions and re-admissions and improve patient/carer experience.
- Supported care groups at multiagency strategic meetings for complex needs patients.
- Updates and compliance with Policies and Procedures in line with review dates and changes required.

- Joint events with Community LD Team and Cloverleaf to celebrate LD awareness week
- Celebrated carers action week with comms around supporting carers with loved ones in hospital
- Celebrated delirium awareness day by going around the wards delivering information and ad hoc teaching
- Took part in drop sessions across the group for dementia action week

Enhanced Care North Bank

In October 2024, an electronic assessment tool was rolled out across HUTH, this assessment is mandated for all inpatients within 6 hours of admission with re-assessment after 72hrs or a change in the patient presentation. Assessment/observation levels are between 0-5 with patients assessed as level 4 or 5 having daily oversight from the band enhanced care team. Any patients on level 5 and requiring high observation from security are escalated at the 8.30 safety huddle and at the safe staffing meetings at 9.30 and 4pm, this enables the care groups to have oversight of their patients with enhanced needs and any additional staffing requirements that may be needed. The enhanced care team support the wards to ensure patients are assessed at the correct level and if required that patients have the correct legal frameworks place for restraint and restriction.



**On average the number remains static with an average of 1033 patients being assessed every month. In addition, an average of 50% of these patients are being nursed at the correct corresponding level and therefore have a proportionate level of restraint and restriction in place.*

Currently due to time constraints the enhanced care team are only able to review the level 4&5 patients daily, once they can monitor the level 3 patients this should make a difference to the number being managed at the correct assessment level.

On the South bank an exercise took place in 2019 to identify a suitable tool to provide a consistent assessment approach across the Trust. The Trust drafted an assessment scoring tool, the Avoiding Falls Level of Observation Assessment Tool (AFLOAT). The assessment has four levels, green-purple and is mandated for all inpatients, all patients are managed at ward level with assistance from security to de-escalate. Currently the electronic version of AFLOAT is in development in WebV and in addition an enhanced care tool will be replicated once the new EPR for the group has been procured.

Enhanced Therapeutic Observation and Care ETOC

On 18th October 2024, The Enhanced Therapeutic Observation and Care (ETOC) Collaborative was launched, this is currently working with fourteen trusts split across the seven regions to support the further development of existing ETOC interventions through peer-to-peer best practice knowledge sharing.

Structured around four primary areas of focus. The collaborative will support participating trusts to analyse their specific ETOC drivers through a series of diagnostic interventions and help identify their key areas of challenge and opportunity in:

- Clinical assessment/decisions making
- Deployment and redeployment models
- Temporary staffing escalation
- Insights and regular review

This will involve developing an improvement plan, evaluating the subsequent ETOC initiatives, and evolving their workforce models to improve patients' outcomes and experience.

In addition, in their ambition to improve the provision of ETOC NHS England has co-developed, as part of a national strategic group, an ETOC strategy which focusses on how organisations can be supported to deliver high quality, patient centred ETOC that supports, improves, and promotes good patient care. Through testing within the collaborative, they have identified four pillars as elements the system is looking for support with to achieve this:

- Effective leadership and oversight
- Effective, person-centred, and safe therapeutic care
- Effective education and training of staff
- Effective workforce planning and deployment

Each pillar is being supported by a co-design advisory group and subsequent task and finish groups that will develop several improvement resources. As part of the effective leadership and oversight pillar all Trusts have been asked to submit data in relation to the number of hours used for ETOC in Q3, this has been submitted for both NLaG and HUTH and we are awaiting the outcome from the national team.

Humber Health Partnership is represented at the strategic and advisory group by the Lead Nurse for Vulnerabilities and Enhanced Care as well as involvement the task and finish groups emerging from the strategy. From a HHP perspective ETOC will be developed using QI methodology to develop a plan for what ETOC will look like across the group.

Audits

National Audit of Dementia – The last round of the NAD took place in 2023 with the results received in 2024. Both HUTH and NLaG were notified of being outliers for delirium screening and HUTH also for pain assessments. Following additional submission of data, the outlier status for NLaG was removed but to mitigate any further risk the 4AT was embedded into symphony and made mandatory for any patients attending the emergency department over the age of 75. At HUTH the Abbey pain assessment is now available with this EPR for use with patients with

reduced cognition, there are plans that in the next 2 months the 4AT will also become mandatory for those over 75 being admitted to the ED in HUTH, this has been delayed due to IT issues.

In addition to the above, on the south bank, the dementia nurses are carrying out a monthly audit of patients assessed as having delirium to ascertain if, following the positive assessment, a delirium care pathway is initiated. Results are due to be reviewed in October 2025 with the development of an action plan dependent on the results.

The National Learning Disability (LD) Improvement standards audit (2023-2024) reports was received in August 2025 and is currently being evaluated with development of a group wide action plan. (North and South Banks).

Priorities 2025/26

- Explore workforce planning in Learning Disabilities across the Group
- Support the admin and digital teams to roll out the reasonable adjustments flag
- Embed the use of the patient passport
- In conjunction with the Acute and Emergency care group develop the RCEM toolkit into a format that is user friendly and able to be used effectively within the Emergency Department
- Collaborate with voluntary services to improve the voice of patients with a vulnerability to ensure their and their carers voice is heard
- Establish safe and responsive pathways for people with Learning Disabilities across key acute services
- Action outlier results of Round 6 of the National Audit of Dementia
- Review dementia flagging and the connecting schemes (Butterly scheme/This is me)
- Roll out the use of dementia volunteers on the South bank and re-energise the team on the North bank
- Propose and deliver a delirium quality improvement project
- Develop a Group wide Task and Finish Group to establish the needs of the group in relation to enhanced care
- Continue to improve the electronic tool within nerve centre of the North bank and replicate in WebV on the South bank
- Lead the roll out of the agreed ETOC plan

Patient Story

Patient admitted from a Residential Home to the Emergency Department with renal failure and urosepsis. Has high-functioning autism and insisted on routine in all aspects of his life as routine made him feel safe. During his inpatient journey, that lasted over four months, the patient had an unwitnessed fall, became bedbound, catheterised, sustained severe pressure damage Category 4) and experienced a failed discharge with him being readmitted on the same day.

The patient was discharged back to the Residential Home for palliative care. Due to the length of hospital stay and time lapse since the patient's admission, an MDT professionals meeting was called to discuss the following key lines of enquiry to learn from the multiple patient safety incidences. The MDT was a good opportunity for all members of the team involved in the patients care to work together to identify gaps in the care provided to prevent a similar situation in the future. The conclusion of the MDT review established that there were gaps in the patients care, as detailed below

Conclusions

- even though the residential home provided documentation with regards to the patients' needs this information wasn't used or understood by the clinical staff. Whilst it was clear the professionals thought they had the patient's best interest at the forefront of decision making, he experienced care and treatment done to – rather than done with him.
- that silo working, had a detrimental effect in the holistic assessment and planning of fundamental needs. Through discussing the timeline, the MDT review established that clinical practitioners often focused on their own role delivery, in isolation, with limited cross-conversations and/or safety huddles. This was compounded by the delay in seeking specialist support from the LD nurse who, once involved, quickly and successfully bought the MDT together.
- communication had not been as robust nor as timely as it should have been with the patient, his advocate and between the paid professionals. Once coordination between the MDT was in place and the patient was involved in day-to-day decision making, care and treatment provision quickly improved and continued to be delivered successfully until discharge. In addition to the above the MDT panel recognised there was a level of discrimination experienced by this patient was wholly inappropriate and distressing for him.

In relation to the outcomes of the MDT review there were two actions specifically for the Safeguarding and Vulnerabilities team. These are

- Improve the use of health and care passports to support the care and treatment of vulnerable individuals Using ACE audits, establish a baseline compliance rate of patients at HUTH who have a patient passport in place and set an improvement trajectory
- Clearly documented evidence by the registered MDT on capacity assessment and next steps taken when decision to refuse care and treatment by patient, this will utilise the already established quality improvement project for Mental capacity.

16. Children Looked After North and Northeast Lincolnshire

The Children Looked After (CLA/ Children in Care) Nursing team plays a vital role in safeguarding and promoting the health and well-being of the children and young people in care. These are children who are subject to care orders (Section 31 Children Act 1989), and those who are voluntarily in care (Section 20, Children Act 1989).

The team ensures that all statutory health requirements are met in accordance with the Promoting the Health and Wellbeing of Children Looked After statutory guidance (2015). Through partnership working with social care, education, foster carers, and health services, the team strives to reduce health inequalities and support positive outcomes for this vulnerable group.

North East Lincolnshire Council and North Lincolnshire Council Children Looked After teams work in partnership with North and North East Lincolnshire councils to ensure that the health needs of CLA and young people are met, reduce health inequalities, improve health and wellbeing outcomes for CLA , care leavers and those placed for adoption. The health team

provides advice and support to health and social care practitioners to improve health outcomes.

CLA nurses have responsibilities not only within the NHS but also externally. They are required to report and share information with key statutory partners to ensure that looked after children receive safe, effective, and coordinated care, reporting to Children's Social Care/ Corporate parenting board, the Independent Reviewing Officer (IRO), Children's Services Governances meeting, Safeguarding operational group forum, Safeguarding prevent assurance meeting, Care experienced Health Reference group (ICB) and completing the NHS England (DATA Collection Framework).

Children Looked After arrangements on the North Bank are within the Family Services Care Group and not reflected in this report.

Data

Numbers of children who are looked after.

NELC	2023	2024	2025
Number of Children becoming Looked after	575	469	438
Number of children seen within the LAC NELC team of children placed in this area, either own LA or other LA			639
NL			
Number of Children becoming Looked after	203	206	221
Number of children seen within the LAC NL team of children placed in this area, either own LA or other LA			359

There has been a yearly increase in the number of CLA in North Lincolnshire. This rise reflects both national trends, such as the increase in cases of abuse and neglect and local decision-making processes.

In contrast, North East Lincolnshire has seen a decrease in the number of CLA. This reduction is due to several factors, including children being placed out of area, young people reaching the age of 18 and ceasing to be looked after, and a review of care orders. A significant number of children previously placed under care orders while still residing with their parents have now had these orders discharged, with many moving to Special Guardianship Orders (SGOs).

Key Performance Indicators for completing health assessments

2024-25 NL	Q1	Q2	Q3	Q4
Initial Health Assessments	45.8%	0%	29.4%	36.6%
Review Health Assessments	96%	96.4%	92.9%	93.6%

2024-25 NEL	Q1	Q2	Q3	Q4
Initial Health Assessments	63.1%	68%	72%	36%
Review Health Assessments	92.9%	83.4%	93.3%	82.7%

The NL Initial Health Assessment (IHA) process was changed last year, and the NL CLA team now has full control over the process, from a child entering LA care arranging clinics, and right the way through to typing up and distributing the care plans.

This process had formally been a collaboration with paediatrics and the NL CLA team, it was following this process change and the establishment of that new process in the team, that had an impact on our poor IHA performance figures.

We acknowledge some of the challenges the new process brought and took action to look at these alongside our social care partners and this has seen our figures improve.

Challenges in meeting KPIs

- Clinic availability, no consent for Section 20 child, carer cancelling appointments, ceasing being CLA before being seen, failure to be brought, absconded
- Late notifications from Local Authortities out of area of children brought into NL and NEL.

Improvements made since Q4, which will be reflected in the forthcoming quarterly and annual reports for 2025–2026, include the introduction of a new system and approach for booking Initial Health Assessment (IHA) appointments. This revised process enables bookings to begin while consent is being obtained, helping to minimise delays.

To further strengthen this improvement, a dedicated member of the administration team has been appointed to lead on the management and oversight of bookings. These changes are designed to enhance efficiency, reduce waiting times, and ensure that children's health assessments are completed more promptly.

Key Achievements

- 93% Initial health assessments were completed time
- 98% Young people are up to date with immunisations and oral/teeth checked.
- 100% of young people had an annual health assessment.
- The looked after children's team staff members safeguarding supervision compliance is 100%
- All statutory completed assessments and reports are shared electronically with 0-19 children's health services, LAC designated doctor, GP, children's social care.
- CLA team continue to roll out of the dental form to support the trial pilot of the dental commissioning, for the outcome of this pilot is to be able to produce meaningful data to inform the commissioners and hold improved dental data.
- Data Management Improvements: Implementing aligned data recording and reporting procedures to ensure accuracy, enable better tracking of health outcomes, and support compliance with statutory requirements.
- Health passports issued to all children newly Looked After (health, medical information and emergency contacts)
- Worked collaboratively with Children's Social Care (CSC) to resolve challenges in the timeliness of health assessments with solution focused discussions
- Significant Work to Support Process Alignment for North and North East Lincolnshire CLA Teams (2024–2025) to foster improving service delivery.

- Process Harmonisation: Mapping, reviewing, and standardising clinical and administrative processes across both localities to ensure uniformity in service delivery, reduce duplication, and streamline workflows.
- Creation of 18 plus consent form for CLA. (Once a CLA turns 18 years of age, the CLA team will no longer directly be involved with the young person's health care unless the young person consents to this, this will be asked and consented too at the last health assessment.

Priorities 2025-2026

- Deliver joint training sessions for staff in the Trust/ individual teams regarding CLA team, consent and parental responsibility
- Recruit 2 new CLA specialist nurses
- Recruit one administrator
- Review and update the health histories and health care plans to create a more user-friendly toolkit for NEL/NL focusing on capturing the voice of the child
- Work towards IT and systems alignment using SystmOne template for specialist nurses supporting the integration of digital platforms
- Audit health assessments and review existing templates
- Review the adoption audit
- Update policies and procedures
- Voice of the child pilot project for 24 months regarding an additional contact with children from April 2026.
- Specialist Nurses to offer sexual health screening including pregnancy testing during health assessments, drop-in clinic and ADHOC if required.
- Specialist Nurses are flexible with conducting health assessments, these are undertaken within the family community hubs, home & residential settings, the Haven and a new clinic space is to be allocated within the Children's department of DPOW.
- Specialist Nurses have introduced a drop-in Health Promotion Clinic held on the first Tuesday of each month at The Haven, aimed at supporting children aged 13 years and above.
- Completion of a new Review Health Assessment template has been created and will be piloted 1st Jan.
- A review of the Children Looked After (CLA)template has been completed for the Independent Reviewing Officers (IROs) within the Children's Social Care team.
- NELC Specialist Nurses are raising their profile internally within DPOW by visiting the children's wards, children's outpatients, and A&E, offering additional support and guidance to professionals caring for Children Looked After (CLA) during hospital stays.
- The Children Looked After (CLA) mandatory training is due for review, with consideration being given to how it may be delivered, either through e-learning or face-to-face sessions.
- Consideration and planning are underway for 2025–2027 to host a (CLA) Conference.

17. Mental Health

Mental Health (MH) is important within acute Trusts and good mental health care is essential in striving for holistic care within our Care Group. We work with our mental health partners across the region for our local populations to deliver safe effective practice; RDaSH NHS Foundation Trust, Navigo and Humber NHS Foundation Trust. Our mental health partners provide liaison mental health services into our acute hospitals. Humber provide a mental health response service into Goole and District hospital.

Currently the responsibility is sat within the safeguarding team (North Bank), however this is currently under review.

Key Achievements

- The team have offered support and guidance to staff
- Humber, RDASH and NAVIGO approved Mental Health Professional (AMHP) / MHA office lead and psychiatrist have provided training and continue to provide for receipt and scrutiny and for the doctors within the Trust completing the MHA applications

Section 136 MHA

South Bank have now got a standard operating procedure (SOP) for persons in the Acute Trust (usually in the emergency department) for section 136 of the MHA for both DPOW and SGH, ensuring a more robust process is in place and aligned with Royal College of emergency medicine guidance. North Bank is currently working through implementing a SOP.

Priorities 2025-2026

- A new HHP Mental Health Strategy (current strategy is NLaG only).
- Establish clear governance arrangements for Mental Health aligning workforce, training and leadership across HHP
- Delivery of Mental Health training across the HHP Care Groups.
- Establish a mental health steering Group and its governance to enable delivery of the strategy and report on activity and compliance
- Develop a HHP self-harm policy
- Patient alert on WebV (South Bank for restriction of medication on discharge for patients who have been admitted with life threatening self-harm).
- Annual all age Mental Health report that incorporates MHA detentions, compliance with the MHA and mental health referral data within the Acute Trusts to enable overview of demand, themes, and trends.
- Develop a Mental Health act report that incorporates detentions and compliance with the MHA
- Activity and oversight of the Mental Health Act across the HHP will be reference in the Mental Health Annual Report. Governance processes for the operational and strategic management of MH going forward across the groups are being reviewed.

Governance processes for the operational and strategic management of MH going forward across the groups are being reviewed. Currently on the North Bank this sits within the responsibility of the Safeguarding Team, and with the consultant nurse in mental health for the South Bank.

18. Safeguarding Partnerships

The safeguarding partnership arrangements of Safeguarding Children and Safeguarding Adult Board arrangements in North and Northeast Lincolnshire, Hull and East Riding are on a statutory footing and ensure the arrangements for safeguarding children and adults are embedded into partner arrangements across the HHP footprint. By co- ordinating this work and promoting the welfare of children and adults at risk it ensures the effectiveness of the arrangements, monitoring and evaluating effectiveness and advising on ways to improve safeguarding performance. The safeguarding teams support both children partnership and adult safeguarding board arrangements by being an active member of safeguarding multiagency partnership groups. These include,

- NEL Safeguarding Children Partnership (SCP) Assurance Group
- NEL Safeguarding Children Partnership (SCP) Performance and Practice Assurance Group
- NEL Safeguarding Children Partnership (SCP) Practice Thematic Strategic Group
- NEL Safeguarding Children Partnership (SCP) Learning Audit Development Group
- NL Children Help and Protection Pathway Meeting (CHaPP)
- East Riding LSCP's.
- Hull SCP
- East Riding SCP
- HSCP Learning from Individual Cases group
- ERSCP Keeping Babies and Young Children Safe subgroup
- ERSCP Learning and Improvement subgroup
- ERSCP Risk Outside the Family Home subgroup
- HSCP Neglect subgroup
- HSCP Contextual Safeguarding subgroup
- HSCP Task and Finish groups (where required)
- HSCP Multi-agency Arrangements subgroup
- HSCP Learning and Improvement group
- ERSCP Safeguarding Assurance group

Key focus areas for Board and Partnerships are:

- HSCP – Neglect, Contextual Safeguarding, Multi-Agency Arrangements and Domestic abuse
- ERSCP – Neglect, Reducing Risk Outside the Family Home and Keeping Babies and Young Children Safe

Achievements

- Submitted quarterly assurance statements to the ICB for North and South Bank relating to our safeguarding arrangements and discharge statutory duties

- Responded to Section 11 requests from Safeguarding Boards/ Partnerships.

19. Conclusion

The Safeguarding and Vulnerabilities Annual report 2024-25 reflects that safeguarding continues to be a far reaching and an often-challenging area, but also demonstrates that safeguarding children, young people, families and adults at risk remains a key HHP priority, demonstrating meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework and from a national perspective.

Our safeguarding agendas continue to be a challenging area for all health agencies and multi-agency partners; however we continue to actively respond and contribute to regional and national developments.

We recognise that there is much more to achieve in the development and delivery of the future priorities in our response and will help ensure that the Trust is engaged in the effective prevention and response to safeguarding concerns. The Trust has responded to these challenges to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant achievements have been made in all the key safeguarding agendas detailed in this report, the team have prioritised and identified the key strategic developments required for 2025-26. We are ambitious in the delivery of these key priorities in the report whilst working in a challenging and ever-changing health service.

Our key underpinning message in this report is that Safeguarding is everybody’s responsibility regardless of their role within the Trust.

20. Priorities

Adult Safeguarding

- Share the results of the Making Safeguarding Personal: A Review of the Effectiveness of Safeguarding Referrals audit and address actions arising from this (South Bank)
- Progress and seek agreement from a HHP perspective regarding compliance with the Intercollegiate Document for SG Adults (2024) and delivery of Level 3 Adult training Aligned across North and South
- To explore aligning data collection across Safeguarding Adults teams
- Improve Level 3 Adult safeguarding training compliance.
- Review the pilot project (North Bank) of adults 'Not brought to appointments' in line with the Was not brought Policy- not completed (2024-25) due to team absence and acuity.
- promote closer working with the complaints team to ensure that any complaints making reference to abuse or neglect are reviewed by the safeguarding team.
- Develop a Was Not Brought Policy Group and audit the quality of the concerns raised (North Bank)
- Establish a consistent s42 process across the partnership by integrating the best aspects from each bank to create a stronger, unified process.

MCA DOLS

- Finalise missing and absconded patient policy
- Co-produce the joint MCA/ DOLS HHP policy
- Review the Quality Improvement work and development actions
- Bridging the gap between MCA knowledge and practice
- Digitisation of DOL application using Lorenzo platform launching Nov 25 North Bank.
- Improve reporting on mental capacity and best interest prevalence
- Targeted audits with specialist provision e.g. Dementia/ Fractured NOF surgical pathway
- Explore data capture of IMCA referrals South Bank.

Safeguarding Children

- South Bank – to analyse the number of referrals that led to safeguarding investigations as well as the quality of the information provided
- Embed CPIS Phase 2
- Align DPOW and SGH liaison data to ensure accurate data recording
- Review and align safeguarding children activity across HHP
- To review learning from audit and multiagency learning reviews, collaborating with the Care Groups and Governance to ensure learning is embedded into practice.
- Band 7 deputy for the North Bank Named Nurse to increase resilience, succession planning and support for safeguarding team. In addition this would mirror and align with the safeguarding children team at NLaG
- Band 7 deputy for the North Bank Named Midwife to increase resilience, succession planning and support within midwifery. In addition this would mirror and align with the safeguarding midwifery team at NLaG
- Develop the threshold of need presentation to enable staff to access via the Big Blue Button, at a time that suits their needs (North Bank)

- Roll out the CP-IS monitoring for children and pregnant women who attend scheduled settings
- Development of a SOP for clinical staff and other AHP to create and 'flag' safeguarding on the Electronic Patient Record
- Review of a nominated lead for modern slavery across HHP
- Embedding the learning from CSPR's into practice is crucial to improve safeguarding outcomes and preventing future harm. A more clear and structured approach is required to ensure the learning is effectively translated into meaningful action and monitored via audit for frontline practice and outcomes for children. This approach will be addressed though the safeguarding operational group.

Contextual Safeguarding

- To robustly monitor the data across HHP in respect of the CSE / CCE referrals to ensure timely identification and response to vulnerable children at risk of exploitation.
- Explore alignment of identification of vulnerable children through flagging (HHP)
- Consider capacity to support the Multiagency Youth Violence and Exploitation panel (MAYVE) as part of our violence duty requirements
- HUTH will consider how the embedded ED Navigator roles may be utilised to support improved engagement in multi-agency meetings and to strengthen collaborative safeguarding practice.

CSAAS

- CSAAS lead; this is currently sat with the Named Nurse Safeguarding Children and will be reviewed as funding allocation is provided.
- Continue to meet and work with the ICB leaders, Ssafeguarding Children Partnership, OPCC and NHS England to develop future pathways and a model that meets the needs of local children. The voice of the child and professionals involved in the new Hub and Spoke model will be used alongside relevant data to ascertain efficacy of the new model. Consideration of returning acute forensic work to Hull remains a possibility.

SUDIC actions – forwarded to Paediatrics for oversight and monitoring

Midwifery

- Review of pre-birth arrangements and operational support from maternity services
- Creation of a safeguarding dashboard on Ulysses which provides details of the numbers submitted with safeguarding concerns by care group.
- Continue to work with the Head of Midwifery to review safeguarding support into the safeguarding team and develop a resilient workforce.
- Further develop the maternity safeguarding operational dashboard
- Continue to raise awareness of the Hope Box Project internally and across local partnerships secure recurrent funding
- Support the midwife who has been appointed as specialist safeguarding midwife to work within the safeguarding team and improve outcomes for women and babies (South Bank).

- To continue to deliver early help training by working with the local authority to provide training and support to midwives who offer targeted consent-based support to families, education midwives on the local early help offer.
- BadgerNet audit – to support the improvement of completion of maternity safeguarding information within the social tab within the post-natal period.
- Review adopting the North Bank Guideline that supports those parents who have a current or historical risk of offending behaviours. To ensure the safety of staff and individuals within the maternity unit. This includes safe planning of the birth of unborn baby in a multiagency arena. This could include children's social care, MOSOVO, police and probation
- Review Court statement request processes North bank for both medical and nursing statements.
- Creation of a maternity operational safeguarding dashboard (South Bank) to evidence key themes and trends.
- Work with National, regional and local Maternity safeguarding partners, including LMNS, NLAG, YSTH, NHSE and Safeguarding Children Partnerships to share information and learning, review practice and develop action plans to implement change.
- Ensure Business Intelligence reports are created and utilised to aid a smooth transition to Badgernet as main record for recording safeguarding information on the North Bank
- Support the delivery of training to midwives to ensure
- Continue work with the information team to move towards collecting FGM information for the dataset from Badgernet for national notification purposes. (North Bank).

FGM

- Work with the information team to develop a national reporting tool on Badgernet.
- Explore alignment of FGM reporting North and South Banks.
- Monitor the number of FGM notifications on a monthly basis.
- Work with Maternity Leadership to emphasize and embedded the role of the midwife in ensuring the national notification is completed in Lorenzo (North Bank)
- Review and align FGM notification pathway including completion of an assurance audit to ensure no missed opportunities to flag safeguarding risks.

Training and Supervision

- Further roll out to all staff of basic prevent awareness training North Bank.
- To review whether FGM should be mandatory on the North Bank
- To continue to monitor underperforming clinical groups through the Safeguarding Strategic Board.
- Increase compliance at level 3 and 4 training
- Improve safeguarding level 3 midwifery compliance South Bank
- The South bank maternity service is to commence a small cascade model of safeguarding supervisors to support those midwives in remote areas. This will begin as soon as training is completed and will improve compliance which is currently at 74%.

Serious Violence Duty

- A review will be undertaken to examine Police intelligence/heat mapping and the ISTV/ED intelligence. The aim will be to establish missed opportunities, share and build on best practice, ensuring the voice the victim and stakeholders involved in the pathway are heard.
- North bank will continue to build on the success of the pilot and further collaborate with additional VCSE and youth programme pathways to support victims of violence choose alternative lifestyle choices.
- continue to embed the actions to eradicate sexual misconduct in our workplace.
- align our priorities to the national Violence Against Women and Girls strategy (VAWG), Domestic Abuse strategy and the NHS Violence Prevention and Reduction (VPR) standard.
- improvement in training and preparedness to consistently deliver trauma-informed care
- appoint a dedicated domestic abuse and sexual violence lead

Domestic Abuse

- Undertake a campaign to promote the awareness of parental alienation
- Promote awareness of professional curiosity among stall staff.
- Develop an audit tool and audit the completion of RE in ED.
- To pursue submission of a business case for a dedicated DAC for the North and South bank
- Routine Enquiry and training to continue across all relevant departments
- To undertake an audit following the implementation of RE as a digitalised mandatory part of nursing assessment
- To gain White Ribbon UK Accreditation to support ending men's violence against women (Group Wide).
- To continue to work in collaboration with the South Bank DAC to provide additional training offer to develop further DA champions across the Group
- DAC to continue DA champion network for support and supervision for DA Champions
- To support partnership audit and self-assessments for domestic abuse
- To aligning the flagging of high-risk domestic abuse victims North and South Banks
- DAC to work with partner agencies to develop a staff specific drop-in support service north and south bank
- DAC to work with Lincolnshire services for appropriate flagging of MARAC victims
- DAC to work with Lincolnshire services to create referral pathway into DA services.
- Audit routine enquiry in the ED (North Bank).

Allegations Against Staff

- Develop a HHP Allegations Against Staff Policy

Transition

- Youth Forum – on the south bank
- Work with Care plus group to commence Transition clinics across in NEL
- Continue to develop personalised pathways for our complex patients
- Continue to add to our Transition database
- Adding Transition to all Clinical Nurse Specialist job specifications within Paediatrics and Adults

- To ensure that Transition is added to the new group Job descriptions
- Band 6 Paediatric Transition Nurse funded by Paediatrics -to lead on transition in the community, hospital and schools.
- Submit a business case for Band 7 specialist nurse to support with complex Transition pathways (186) in total, and work BAME and Immigration population.
- Devise pathways within Gastroenterology and port-a- cath clinics. This type of work requires Leadership from a Band 7.
- Explore what End of life care looks like at the ages between 16-18 and the grey areas of this.

Vulnerabilities

- Explore workforce planning in Learning Disabilities across the Group
- Support the admin and digital teams to roll out the reasonable adjustments flag
- Embed the use of the patient passport
- In conjunction with the Acute and Emergency care group develop the RCEM toolkit into a format that is user friendly and able to be used effectively within the Emergency Department
- Collaborate with voluntary services to improve the voice of patients with a vulnerability to ensure their and their carers voice is heard
- Establish safe and responsive pathways for people with Learning Disabilities across key acute services
- Action outlier results of Round 6 of the National Audit of Dementia
- Review dementia flagging and the connecting schemes (Butterly scheme/This is me)
- Roll out the use of dementia volunteers on the South bank and re-energise the team on the North bank
- Propose and deliver a delirium quality improvement project
- Develop a Group wide Task and Finish Group to establish the needs of the group in relation to enhanced care
- Continue to improve the electronic tool within nerve centre of the North bank and replicate in WebV on the South bank
- Lead the roll out of the agreed ETOC plan

Children Looked After NL and NEL

- Deliver joint training sessions for staff in the Trust/ individual teams regarding CLA team, consent and parental responsibility
- Recruit 2 new CLA specialist nurses
- Recruit one administrator
- Review and update the health histories and health care plans to create a more user-friendly toolkit for NEL/NL focusing on capturing the voice of the child
- Work towards IT and systems alignment using SystmOne template for specialist nurses supporting the integration of digital platforms
- Audit health assessments and review existing templates
- Review the adoption audit
- Update policies and procedures
- Voice of the child pilot project for 24 months regarding an additional contact with children from April 2026.

- Specialist Nurses to offer sexual health screening including pregnancy testing during health assessments, drop-in clinic and ADHOC if required.
- Specialist Nurses are flexible with conducting health assessments, these are undertaken within the family community hubs, home & residential settings, the Haven and a new clinic space is to be allocated within the Children's department of DPOW.
- Specialist Nurses have introduced a drop-in Health Promotion Clinic held on the first Tuesday of each month at The Haven, aimed at supporting children aged 13 years and above.
- Completion of a new Review Health Assessment template has been created and will be piloted 1st Jan.
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- NELC Specialist Nurses are raising their profile internally within DPOW by visiting the children's wards, children's outpatients, and A&E, offering additional support and guidance to professionals caring for Looked After Children (LAC) during hospital stays.
- The Looked After Children (LAC) mandatory training is due for review, with consideration being given to how it may be delivered, either through e-learning or face-to-face sessions.
- Consideration and planning are underway for 2025–2027 to host a Looked After Children (LAC) Conference.

Mental Health

- A new HHP Mental Health Strategy (current strategy is NLaG only).
- Establish clear governance arrangements for Mental Health aligning workforce, training and leadership across HHP
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- Activity and oversight of the Mental Health Act across the HHP will be reference in the Mental Health Annual Report. Governance processes for the operational and strategic management of MH going forward across the groups are being reviewed.

Acknowledgements/ Contributions

Thank you to the Safeguarding and Vulnerabilities teams for their contributions and work. Particularly:

Karen Harrison Deputy Head of Safeguarding

Lynn Benefer Deputy Head of Safeguarding / Name Nurse Safeguarding Children

Jayne Wilson and Sharon Humberstone Named Nurses Safeguarding Adults

Joanne Marrow Named Nurse Safeguarding Children

Leonora Lockhart Domestic Abuse Coordinator

David Welburn and Rachel Hoggarth Mental Capacity and Deprivation of Liberty Leads

Named Safeguarding Midwives; Helen Ward, Paula Peacock, Louise Gilliat and Patricia Darley

Specialist SUDIC Nurse Stacy Pope

Named Nurses Children Looked After NL / NEL Samantha Reeve and Amanda Clark

Education Department – Ben Greenwood and Katherine Bosanquet

Mental Health Lead Kay Fillingham

Jackie Fenwick Lead Nurse Vulnerabilities

Holly O'Connor Lead Nurse Transition

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)237

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 December 2025
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer / Author	Tracy Campbell, Group Director of Patient Safety & Quality Governance Melanie Sharp, Group Deputy Chief Nurse Michela Littlewood, Associate Director of Quality Governance Simon Treacher, Lead Nurse Patient Experience
Title of Report	**Patient Experience Annual Report – April 2024 to March 2025**
Executive Summary	The 2024–2025 Annual Patient Experience Report reflects a year of progress and integration for the Humber Health Partnership, following Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole NHS (NLAG) Trusts forming a Group partnership. The introduction of a new Care Group model has strengthened leadership and accountability, with the Patient Experience Team playing a central role in listening to and acting on patient feedback. Key achievements were a reduction in complaints at HUTH, improved early resolution in PALS and interpretation services supporting over 28,000 calls. National surveys showed progress in Urgent & Emergency Care, particularly at NLAG and Inpatient feedback identified areas for improvement. Over 600 volunteers contributed 57,449 hours, enhancing patient care and engagement. Initiatives such as the Extended Visiting Framework, the rollout of the Patient Cash and Valuables Policy, and planned improvements to signage and wayfinding demonstrate a commitment to compassionate and patient centred care. The Group also strengthened learning dissemination through governance structures and patient stories and maintained high satisfaction in the Friends and Family Test, with over 91% positive feedback. Looking ahead, priorities include enhancing communication training, embedding learning from feedback, expanding volunteer involvement in feedback collection, and continuing to improve access, inclusion, and service quality across all sites.
Background Information and/or Supporting Document(s) (if applicable)	Annual Patient Experience Report 2024–2025, attached
Prior Approval Process	The report was taken to Quality & Safety CiC as per work plan on the 29 May 2025. This report then went retrospectively to the July Patient Experience Group which is held Bimonthly due to the meeting dates.
Financial Implication(s) (if applicable)	Financial Year: 2024/25- Patient Experience
Implications for equality, diversity and inclusion,	**None**

including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Assurance	ü Information ☐ Other – please detail below:

Annual Patient Experience Report

Humber Health Partnership

1 April 2024 to 31 March 2025



1. Table of Contents

1. Table of Contents……2
2. Introduction & Background……3
3. Strategic Objectives, Strategic Plan and Trust Priorities 4
4. Complaints……4-7
5. Patient Advice and Liaison Service (PALS) 7-10
6. Patient Experience Group..... 10-12
7. Interpretation Service 12-13
8. National and Local Patient Surveys 13-19
9. Voluntary Services……..19-20
10. Learning themes and Dissemination..... 20-21
11. Summary Conclusion 21
12. Key Actions for 2024/25 21-22
13. Appendix 1. 23-24

2. Introduction / Background

This report presents an overview of the key patient experience initiatives and activities undertaken during the 2024–2025 financial year. It aims to detail the progress made, challenges encountered, lessons learned, and the continuous efforts being made to ensure that all patients, carers, and families receive care that is consistently compassionate, timely, and safe.

As of this reporting period, Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust have formally come together under the Humber Health Partnership. This marks a significant landmark in our organisational development, enabling greater collaboration, shared learning, and alignment of services across the region. However, it is important to emphasise that this report is not a comparative analysis between the two Trusts. Due to differences in size, service complexity, and patient demographics, direct comparisons would not yield meaningful insights.

To support this new structure, the Group has transitioned to a Care Group model, comprising 16 Care Groups that are responsible for delivering specific areas of patient care and services. This model, implemented at the end of the 2023–2024 financial year, is designed to enhance clinical leadership, improve accountability and innovation in care delivery. These Care Groups are supported by a range of corporate and other services that work collaboratively to ensure high-quality, patient-centred care.

One of the key services is the Patient Experience service, which plays a vital role in ensuring that the voices of patients, carers, and families are heard and acted upon. This function is delivered through three core service areas:

Complaints – Provides a structured and supportive process for investigating formal complaints. The team works closely with complainants and clinical services to ensure concerns are addressed thoroughly and transparently.

PALS (Patient Advice and Liaison Service) – Acts as the first point of contact for patients, relatives, and the public seeking advice, raising concerns, or offering compliments. The team also facilitates access to services such as interpreters and signposting to other support.

Patient Experience – Leads on patient engagement, feedback collection, and experience-based service improvement. This includes surveys, focus groups, and co-production initiatives aimed at shaping services around what matters most to patients.

In cases where concerns cannot be resolved locally, the Parliamentary and Health Service Ombudsman (PHSO) provides an independent review process. The PHSO has the authority to determine whether an organisation has acted appropriately and, where necessary, can recommend actions such as explanations, formal apologies, and service improvements to ensure learning and accountability.

3. Strategic Objectives, Strategic Plan and Group Priorities

The Vision for 2024/25 is:

Our Patient Experience team (PET) will have the skills and competencies to support and offer our patients, visitors, staff and Care Groups the very best experience and service.

Using new technologies to improve the current working practices across HUTH & NLaG to create an effective and efficient Group team to ensure our Complaints, PALS and Patient Experience staff can provide a timely and responsive service.

Learning from patient feedback, concerns and complaints data to ensure we are listening, responding and improving in the care and services we provide to our patients.

Our Patient experience priorities for 2024/25

- Complaint responses addressing the concerns raised
- PALS Call answered with consistent processes
- Use of new Risk Management System
- Implementation joint telephony system
- Working with Group Education/ Development teams training package for current/ new staff members
- Care Group Governance meetings monthly feedback themes/ trends learning
- Care groups to identify a Patient Experience cascade learning lead
- Support & Challenge meetings to provide escalation routes

The Patient Experience team will work with the wider Qaulity Governance to support the patients voice across compliance, clinical effectiveness, patient safety, risk and Qaulity improvement

- Complaints responses – 85% within 40 Days
- PALS 5 Days responses KPI 60%
- Live PALS Call answer rate KPI 80%
- Reduction in complaints

4. Complaints

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

The Complaints team, based at Hull Royal Infirmary and Diana, Princess of Wales Hospital are a dedicated team of complaints facilitators and two complaints managers that support an individual to register their dissatisfaction and concern on a formal basis. This allow our Care

Group, led by a Lead Investigator to undertake a thorough and systematic review of the issues that are raised. The aim is to achieve an early resolution addressing the concerns that the complaint that has registered.

The Patient Experience Team are now working as a single team with collaborative working between the two offices at both Trusts. This work will progress further once a single risk management system is procured improving sharing of information between the team. The chart below shows comparative complaint data for the past displays five years complaint from April 2020 to March 2025. Complaint numbers have shown a significant decrease at HUTH for 2024-2025 from the previous year 2023-2024, whilst NLaG has shown a slight increase.

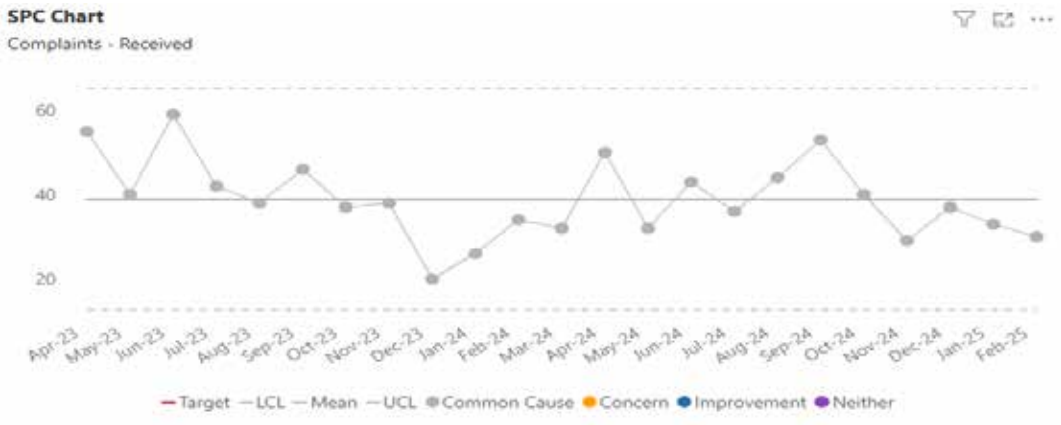
Complaints Received HUTH/NLAG from 2021 to 2025

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	HUTH	NLaG	Total
2020-21	17 10	29 23	24 24	25 18	42 27	29 31	44 33	39 40	27 19	38 27	46 25	50 30	**410**	**307**	**717**
2021-22	51 28	20 41	37 48	65 29	44 25	51 26	36 37	49 41	37 20	37 40	31 27	43 34	**501**	**396**	**897**
2022-23	35 34	47 34	27 41	35 26	46 26	38 27	41 20	22 29	41 21	55 29	50 29	67 24	**504**	**340**	**844**
2023-24	66 26	68 26	74 28	69 37	60 17	44 29	76 36	52 31	29 21	27 25	32 28	38 29	**635**	**333**	**967**
2024-2025	50 31	32 31	43 29	36 19	44 25	53 29	40 30	29 40	37 22	33 29	30 39	27 28	**454**	**352**	**806**

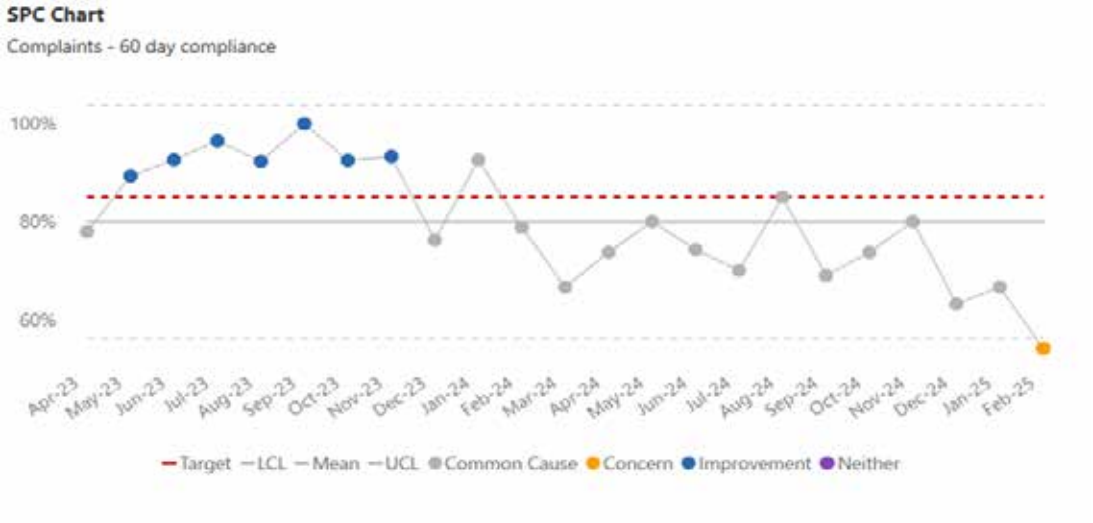
HUTHs decrease in complaints is due to several reasons. PALs concerns are sent to the front line operational service who contact the complainants resulting in issues being resolved before they become a formal complaint. Improved Quality checking, quicker implementation of actions has resulted in a reduction in second complaints. The joint HUTH / NLAG work of shared templates and best practice shared across the two organisations has also helped reduce the number of complaints.

NLAGs rise in complaints is partly due to complex health, social care packages as providers of community care. In addition, from December 2024 a small number of complaints from HUTH have been managed by NLAG.

HUTH Formal Complaints Received



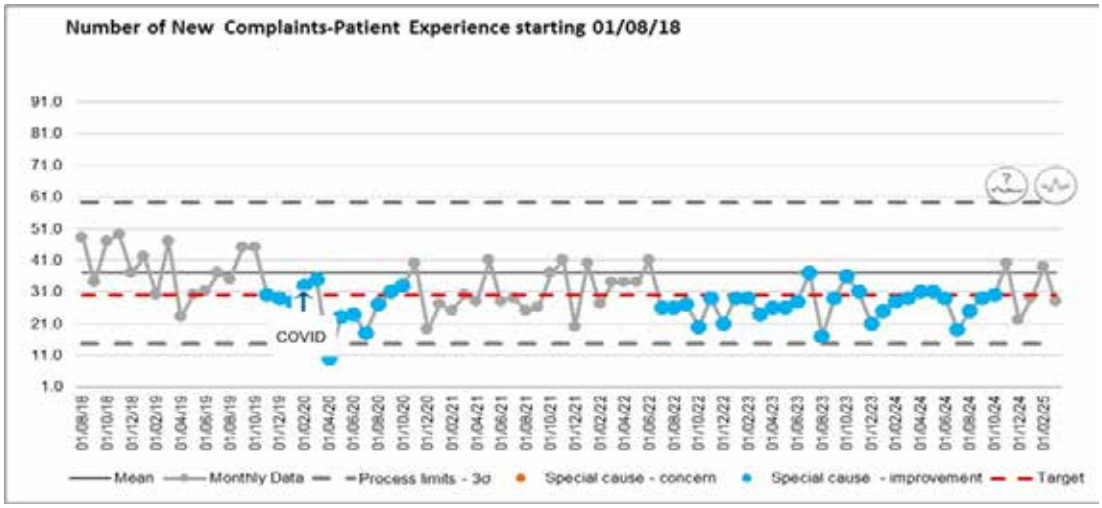
HUTH formal complaints received has started to show a downward trajectory towards the end and start of 2024/ 25, currently there is insufficient data to show if this will be maintained.



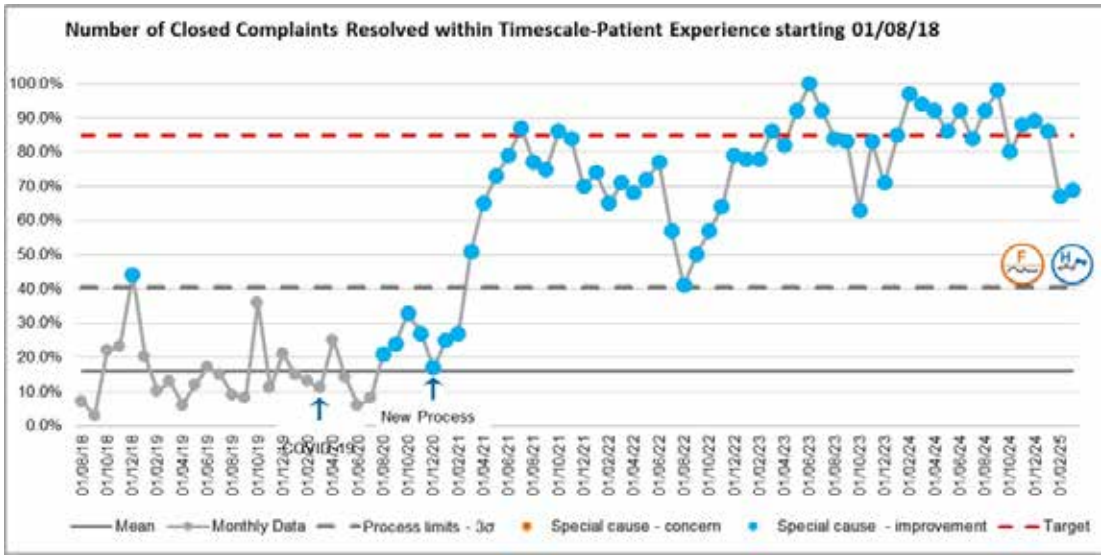
The national target is that 85% will be responded to within 60 days, or a mutually extension will be agreed. The 60-day compliance rate of replying to complaints for HUTH has negatively fallen from summer of 2024. This is due to a number of quality checking and Incident management reasons, which are being addressed by the Patient Experience team.

This is partly because of changes in the Quality checking processes and there are plans to change this. In addition, the HUTH incident/ complaint management system does not allow for a change in any mutually agreed extension timescale or when consent is being arranged.

NLAG Formal Complaints Closed



NLAGs complaint numbers have remained relatively consistent. With the table below showing the majority of complaints are closed within 60 days.



The top 5 Complaint themes for the Group 2024/2025 were:

Clinical Treatment
Clinical Care/Treatment & Nursing Care
Nursing Care
Attitudes & Behaviours
Communication

The HUTH office have, at the start of 2025, changed to a letter response format aligning with NLAG, previously an investigation report was sued. As this process becomes more familiar to staff there should be an expected improvement in the 60 days closure time. Both HUTH and NLAG have recently seen a downturn in closure time this is due to several factors which are being addressed. Care Groups are now receiving performance reviews, and the quality checking process is being reviewed in order to improve towards the closure time KPI of 85%.

5. Patient Advice and Liaison Service (PALS)

The PALS Team, led by the two Patient Experience Manager, have responded to

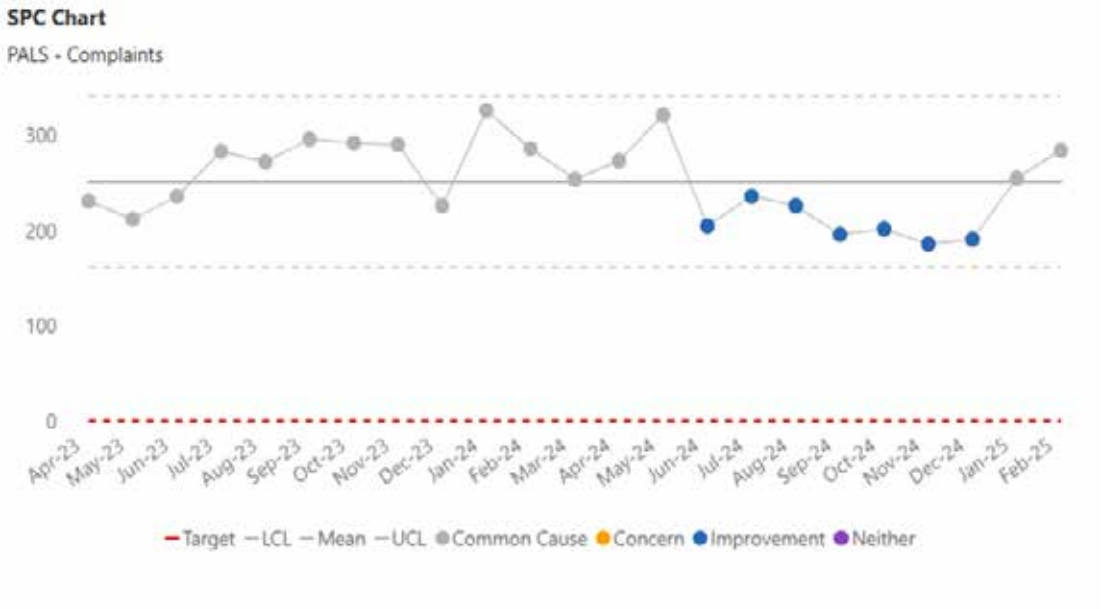
5607 of concerns, enquiries and compliments over the last financial year.
HUTH 2960 and NLAG 2647
53% have been within the 5-day period at HUTH and 59% at NLAG (measured against a KPI of 60%). Group performance 56%.

The team continue to achieve a high standard of closures to responses of concerns and enquiries raised, whilst performing slightly below the KPI as a Group.

The key themes are communication and increases to waiting times - it is expected that the waiting time concern would be a national trend given the current NHS position of over 7.46 million people currently waiting treatment until the end of February 2025 (NHS England).

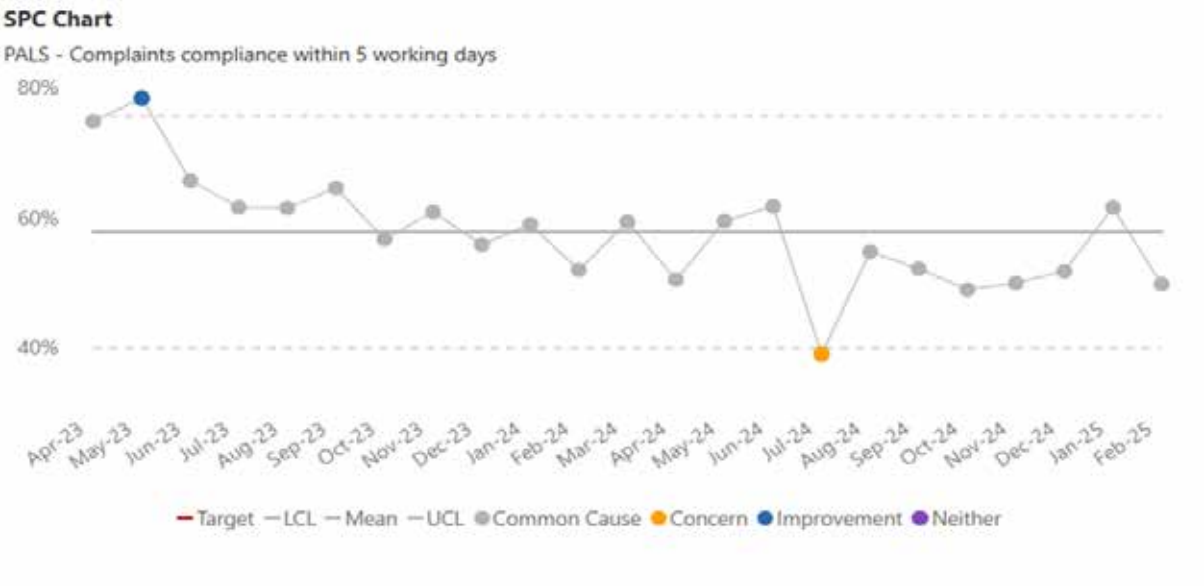
The Deputy Chief Nurse, Associate Director for Quality and Lead Nurse for Patient Experience are currently exploring options for Communication training with a focus on reducing the number of concerns regarding communication and values & behaviours of our staff.

HUTH PALS Received (concerns only)



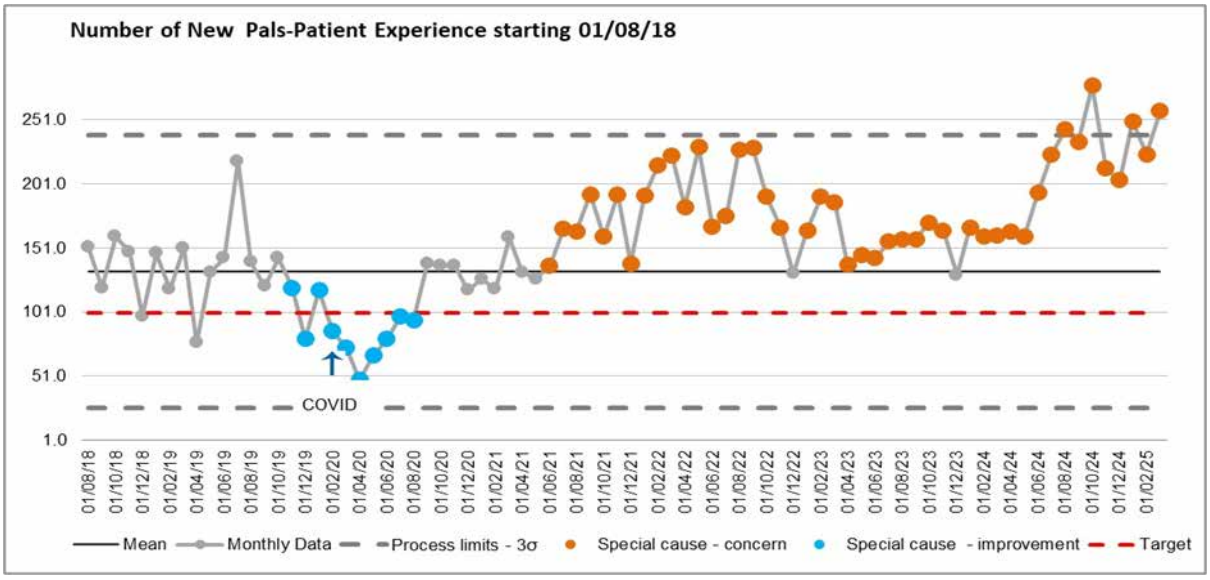
Following a consistent decrease in PALs calls there has been a recent increase in, predominantly due to increased waiting times for appoints, surgery. However, there is currently insufficient data to draw any conclusions.

HUTH PALS Closed (concerns only)



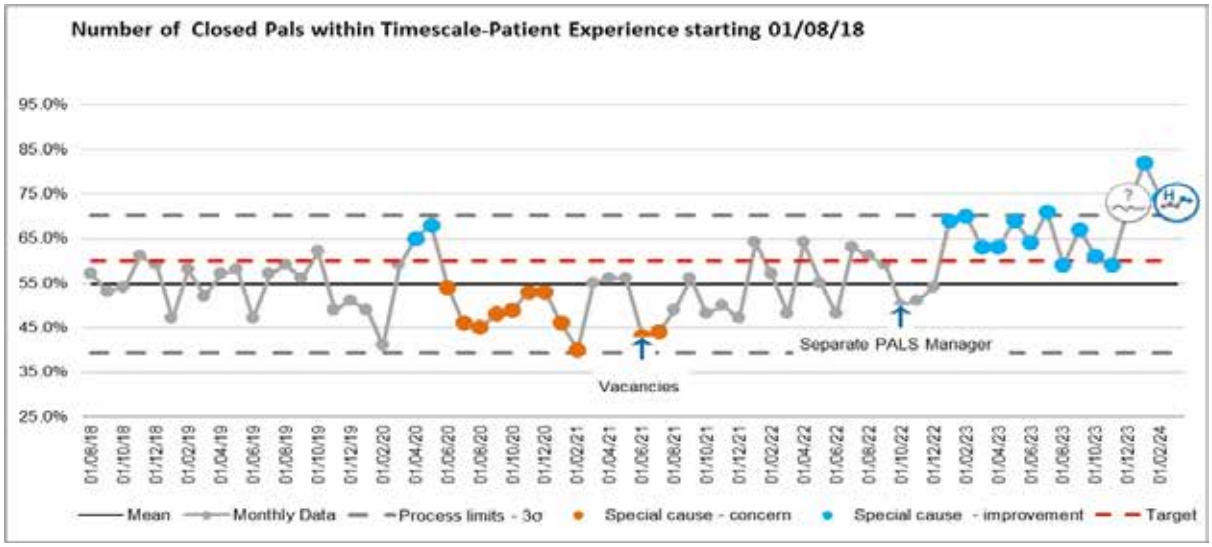
Due to the increase in PALs calls, maintaining consistent percentage of closures with timescale has been challenging.

NLAG PALS Received (concerns only)



There has been an increase in PALs calls, predominantly due to increased waiting times for appoints, surgery.

NLAG PALS Closed (concerns only)



Due to the increase in PALs calls, maintaining consistent percentage of closures with timescale has been challenging and consistently achieved. **The top 5 Pals themes for Group 2024/2025 were:**

Clinical treatment – delays and failure in treatment
Appointments – waiting times for new and follow up appointments.
Communication with patients/relatives
Values & behaviours – attitude of staff
Waiting times for procedures

Sharing Learning Themes/Trends

The following processes are used to share the learning from Complaints and PALs;

- Patient stories were taken to board and to other relevant groups for example directorates
- Patient Experience Group (PEG) meetings started with a monthly Patient story, as a powerful reminder of the purpose of the meeting
- Weekly Directorate Group meetings undertaken with Patient Experience Team to track progress, review actions
- Dissemination of information at Directorate Clinical Governance and sub-specialty meetings
- Quarterly reports to Quality Safety Committee
- Patient Experience Team reported quarterly to the Quality Governance Group meeting
- Updates to external ICB meetings as requested

6. Patient Experience Group

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

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

Extended Visiting Framework: Enhancing Patient-Centred Care

Following successful implementation and positive feedback, we are planning to progress alignment of visiting hours across the Group to a consistent 11am–8pm framework.

Developed through engagement with patients, carers, staff, and volunteers, the new approach has supported a more compassionate, accessible, and person-centred visiting experience.

Key benefits include:

- Improved patient wellbeing through flexible, individualised visiting arrangements.
- Enhanced support for vulnerable patients, including those with dementia, learning disabilities, or cognitive impairments.
- Greater consistency across all hospital sites, reducing confusion and ensuring equitable care.
- Stronger collaboration between staff, patients, and families, reinforcing trust and shared decision-making.

The framework also aligns with emerging national standards and upcoming regulatory reviews, positioning the Group as a leader in best practice. A phased rollout is planned, supported by staff training and regular reviews to ensure continued relevance and effectiveness.

This proposal is subject to Executive approval and a paper is due to be presented to them in in June 2025. An update and future plans will be included in next year's Annual Report.

Patient Cash and Valuables Policy, Safes and Brightboxes

In response to ongoing concerns about the safe handling of patient valuables following the closure of a central storage point, the Trust has successfully developed and begun rolling out a comprehensive new approach to safeguard personal belongings.

Key developments include:

- A newly approved Cash & Valuables (C&V) Policy to standardise procedures across all wards and departments.
- Installation of secure safes in clinical areas to provide local, accessible storage.
- Introduction of Patient Property Books to ensure accurate documentation and accountability.
- Use of Brightboxes for the secure storage of essential items belonging to vulnerable patients.

This initiative is now being implemented across wards and departments, providing reassurance that patient valuables are being managed with care and consistency.

To ensure the effectiveness of this rollout, Northern Lincolnshire and Goole will conduct an audit and gather feedback from staff and patients during summer 2025. Following this review, and any necessary refinements to embed best practice, consideration will be to extend the policy and associated tools across all hospital sites within the Group.

Signage & Wayfinding Improvement Project

As part of our commitment to improving patient and visitor experience, Northern Lincolnshire & Goole had previously undertaken a comprehensive review of signage across our hospital sites. Working in collaboration with a local design company, we developed a new signage concept featuring coloured zoned areas, clear icons, and simplified written information to support navigation for all individuals, regardless of ability.

This project has been shaped by valuable input from our Vulnerabilities Team, patient representatives, and volunteers, ensuring the design is inclusive and accessible.

While we received support from one of our Group's charities, throughout the development phase, we were unfortunately unsuccessful in securing long term funding.

The Trust remains committed to this important initiative and is actively exploring alternative financial options to progress the project and bring these improvements to fruition.

Once funding is identified the project would commence with Diana, Princess of Wales Hospital, as the pilot site. There would then be intention for all of the hospitals within Group to adopt appropriate signage to improve wayfinding around our sites, following a successful pilot.

External collaboration

Improving End-of-Life Care Through Tissue and Eye Donation Awareness

This year, our Group took significant steps to ensure tissue and eye donation is not overlooked in end-of-life care. While organ donation is limited to a small percentage of patients, many more are eligible to donate tissue and corneas—gifts that can restore sight and repair damage from trauma or illness.

Prompted by a missed opportunity to honour a patient's donation wishes due to staff unfamiliarity with the referral process, the Group responded swiftly. We embedded NHS Blood and Transplant's new e-learning module into our internal training platform, equipping staff with the knowledge to identify and refer potential donors confidently.

This initiative has already made a difference. Shortly after implementation, staff at Goole Hospital successfully supported a patient's wish to donate their corneas - an act that will help restore vision for others.

We remain committed to raising awareness, empowering staff, and ensuring every patient's final wishes are fulfilled with dignity and compassion.

7. Interpretation Service

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

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

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

Face-to-Face Interpretation

Between 1 April 2024 and 31 March 2025, HUTH staff made 4,055 face-to-face interpreter requests, including:

3,444 during office hours
611 out-of-hours

Top 5 Languages Requested: 1. Polish, 2. Romanian, 3. Arabic (Modern Standard), 4. British Sign Language (BSL), 5. Kurdish (Sorani)

Audio/Video Interpretation

A total of **21,269 interpretation calls** were made through LanguageLine, up from **17,211** the previous year:

17,614 audio calls

3,655 video calls (including 86 BSL sessions)

Top 5 Languages Requested: 1. Romanian, 2. Polish, 3. Sorani, 4. Arabic, 5. Spanish

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

Face-to-Face Interpretation

193 requests were made, up from 118 the previous year.
Managed by the PALS Team, ensuring smooth coordination, including short-notice and special requests.
Top 5 languages: Romanian (41), Polish (32), Lithuanian (19), Bengali (18), Russian (15).
34 British Sign Language (BSL) requests were fulfilled, including hand-on-hand interpretation, up from 30 last year.
Cancellations were efficiently managed to avoid unnecessary costs.

Audio/Video Interpretation (via LanguageLine)

7,691 calls made (up from 6,890), including:

7,132 audio calls

559 video calls (16 for BSL)

Accessed via phone, tablets (Insight App), or 42 Interpreter on Wheels (IOWs) across Grimsby, Scunthorpe, and community sites.
Top 5 languages: Romanian (2,498), Polish (836), Bengali (768), Soreni (485), Lithuanian (400).

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

8. National and Local Patient Surveys

Maternity 2024 National Survey

Hull University Teaching Hospitals (HUTH)

The Maternity 2024 National Survey has been conducted in 2024 and feedback was positive and that the experience of patients and their families was largely a good experience. Positive highlights are shown below alongside areas to consider for action planning. Twelve questions featured a score of 95% or greater, with a further sixteen questions 90% or higher.

Positive Highlights 95%>:

- ✓ 98% Had enough time to ask questions or discuss during antenatal check-ups
- ✓ 96% Felt midwives listened (antenatal)
- ✓ 97% Asked about mental health by midwives (antenatal)
- ✓ 98% Given the help needed by midwives (antenatal)
- ✓ 99% Spoken to in a way they could understand (antenatal)
- ✓ 95% Had confidence and trust in staff (antenatal)
- ✓ 98% Treated with respect and dignity (antenatal)
- ✓ 99% Found staff introduced themselves (during labour and birth)
- ✓ 96% Treated with respect and dignity (during labour and birth)
- ✓ 96% Treated with kindness and compassion during labour and birth
- ✓ 97% Found decisions as to how to feed their baby were respected by midwives
- ✓ 96% Felt midwives listened (postnatal)

+ a further 16 Questions 90% or higher

Consideration for Action Planning

Q	Question	HUTH 2024	HUTH 2023	All 2024
B3	Offered a choice of where to have baby	61%	56%	84%
B4	Given enough information about where to have baby	76%	72%	82%
B6	Felt midwives or doctor aware of medical history (antenatal)	79%	84%	87%
B17	Concern during your antenatal care taken seriously	80%	82%	88%
C4	Given information / advice on risks of induced labour	67%	67%	74%
C11	Not left alone when worried (during labour and birth)	72%	74%	75%
C19	Able to ask questions afterwards about labour and birth	72%	79%	75%
D2	Discharged without delay	64%	70%	58%
D6	Found partner was able to stay with them as long as they wanted (in hospital after birth)	43%	46%	67%
F4	Saw the midwife as much as they wanted (postnatal)	58%	56%	59%
F5	Felt midwives aware of medical history (postnatal)	79%	83%	75%

	Given information about changes to mental health after having baby	79%	85%	84%
F12	Told who to contact for advice about mental health after having baby	78%	80%	81%
F14	Received help and advice about feeding their baby (first four weeks after birth)	77%	N/A	82%
F15	If needed it, received support or advice about feeding their baby during evenings, nights or weekends	75%	73%	70%
F17	Felt GP talked enough about physical health during postnatal check-up**	68%	73%	68%
F18	Felt GP talked enough about mental health during postnatal check-up**	67%	75%	72%
F19	Considered making a complaint about the care received	58%	72%	63%

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

The Maternity Survey shows a consistent position for Northern Lincolnshire & Goole NHS Hospitals, in comparison to the 2023 survey, with largely maintained improvements against internal and external benchmarking scores.

Positive highlights are again shown below alongside areas to consider for action planning. Eighteen questions featured a score of 95% or greater, with a further fifteen questions 90% or higher.

Positive Highlights 96%>:

- ✓ 98% Had enough time to ask questions or discuss during antenatal check-ups
- ✓ 100% Felt midwives listened (antenatal)
- ✓ 99% Asked about mental health by midwives (antenatal)
- ✓ 97% Given the help needed by midwives (antenatal)
- ✓ 99% Spoken to in a way they could understand (antenatal)
- ✓ 99% Involved enough in decisions about their care (antenatal)
- ✓ 95% Provided with relevant information about feeding their baby
- ✓ 98% Had confidence and trust in staff (antenatal)
- ✓ 98% Treated with respect and dignity (antenatal)
- ✓ 96% Information given about any warning signs to look out for during pregnancy
- ✓ 98% Partner / companion involved (during labour and birth)
- ✓ 98% Found staff introduced themselves (during labour and birth)
- ✓ 99% Spoken to in a way they could understand (during labour and birth)
- ✓ 98% Involved enough in decisions about their care (during labour and birth)
- ✓ 98% Treated with respect and dignity (during labour and birth)
- ✓ 98% Treated with kindness and compassion during labour and birth
- ✓ 97% If contacted a midwife / midwifery team, given the needed help
- ✓ 97% Felt midwives listened (postnatal)

+ a further 15 Questions of 90% or higher

Consideration for Action Planning

Q	Question	NLaG 2024	NLaG 2023	All 2024
C11	Not left alone when worried (during labour and birth)	81%	78%	75%
C12	Felt concerns were taken seriously (during labour and birth)	78%	81%	81%
C19	Able to ask questions afterwards about labour and birth	80%	86%	75%
D2	Discharged without delay	54%	61%	58%
D6	Found partner was able to stay with them as long as they wanted (in hospital after birth)	83%	35%	67%
F4	Saw the midwife as much as they wanted (postnatal)	73%	72%	59%
F11	Given information about changes to mental health after having baby	82%	87%	84%
F12	Told who to contact for advice about mental health after having baby	82%	91%	81%
F13	Given enough information about their own physical recovery	79%	85%	85%
F15	If needed it, received support or advice about feeding their baby during evenings, nights or weekends	79%	85%	70%
F17	Felt GP talked enough about physical health during postnatal check-up	73%	58%	68%
F18	Felt GP talked enough about mental health during postnatal check-up	72%	60%	72%
F19	Considered making a complaint about the care received	68%	69%	63%

The above areas were identified for inclusion in an overarching action plan for the Family Service Care Group encompassing both Trusts. The Senior Nursing Maternity team will shape strategy and direction for improvements which will be reflected in the 2025 survey. Our Maternity services also continue to work very closely with Humber & North Yorkshire Maternity and Neonates Voices.

Other National Surveys conducted during **2024-2025**

Inpatient 2024 National Survey

Survey Period: January – April 2024

The 2023 Adult Inpatient Survey results show a maintained level of positive responses across both HUTH and NLAG, with participation and demographic representation improving year-on-year.

At HUTH, 48% of inpatients (565) responded, up 6% from 2022 and 5% above the national average. Of the sixty-three questions asked, forty-five scored positively, with thirty-nine comparable to previous years. Internally, one question improved while twenty-five declined. Compared to other trusts, HUTH matched in forty questions, scored worse in five, and better in none. The Trust's national ranking dropped to 39th (from 21st) for average positive scores and to 57th (from 18th) for historical improvement, indicating a decline in relative performance.

At NLAG, 44% of inpatients (505) responded, up 5% from 2022. Similarly, forty-five questions scored positively, with thirty-nine historically comparable. Internally, nineteen questions improved and seventeen declined. Compared to other trusts, NLAG matched in thirty-six questions, scored worse in eight, and better in one. The Trust's national ranking improved to 40th (from 48th) for average positive scores and to 39th (from 65th) for historical improvement, reflecting a positive shift in performance.

Both Trusts saw strong engagement from older age groups and a representative gender and ethnic mix. While NLAG showed encouraging progress, HUTH experienced a decline in comparative performance. These insights will inform targeted action planning for future patient experience improvements.

Urgent & Emergency Care 2024 National Survey

Survey Period: April - July 2024

The 2024 National UEC24 Survey highlights significant improvements in patient experience across both HUTH and NLAG compared to the 2022 results. Both Trusts demonstrated strong internal progress and improved external benchmarking, though some areas remain below average.

At HUTH, 31% of patients (363) responded, up 10% from 2022. The Trust showed internal improvement in fourteen questions, including overall A&E experience, with three areas declining. Compared to other trusts, HUTH improved in eight questions, declined in twenty-one, and matched in three. The Trust's national ranking rose to 36th (from 59th) and rose by a third for internal improvement (from 60th).

At NLAG, 30% of patients (357) responded, up 7% from 2022. The Trust improved internally in eighteen questions with no declines. Externally, NLAG improved in twenty-one questions, declined in five, and matched in six. Its national ranking rose to 16th (from 49th) and first for internal improvement (from 30th).

Both surveys reflected a more balanced demographic spread across age groups and ethnicities, enhancing the representativeness of the feedback. These results demonstrate a strong upward trajectory in urgent and emergency care experience across the Group.

Local Surveys

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

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

Friends and Family Test (FFT)

Hull University Teaching Hospitals (HUTH)

The Patient Experience Team at HUTH has actively promoted the use of QR codes and paper forms to gather patient feedback. A reduction in outpatient responses was observed following the transition from health groups to care groups, attributed to clinic coding changes that disrupted data extraction. Work is ongoing to resolve this issue.

Friends and Family Test (FFT) Highlights:

Total Responses: 91,766
Positive Feedback: 91.88%
Negative Feedback: 4.75%

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

During the 2024/2025 period, NLAG received 23,003 pieces of feedback—the highest volume since FFT data collection began. Monthly feedback consistently exceeded 1,500 responses, with over 2,000 per month during the second quarter. A decline in the third and fourth quarters is currently under review by the Patient Experience Team.

Friends and Family Test (FFT) Highlights:

Total Responses: 23,003
Positive Feedback Range: 91.03%
Negative Feedback: 5.53%

Further information:

These results reflect a strong overall satisfaction rate, with over 9 in 10 patients rating their experience positively. The Group and Care Groups remain committed to enhancing patient engagement and service quality across all departments.

Since September 2024, SMS feedback in Maternity has been paused due to the implementation of Badgernet. Integration with our FFT provider, Health Care Communications, is being explored to address data collection challenges. The Patient Experience Teams are working closely with Maternity and IT teams to implement a sustainable solution.

Feedback continues to be provided to Ward/Departmental Managers monthly, and efforts are ongoing to ensure it reaches Nurse Directors and Governance Groups. There has been a significant improvement in data collection from Community areas for NLaG, with staff in Community Dental, Short Term Care, Virtual Care, and Intermediate Care collaborating with the Patient Experience Team to implement new collection methods.

The Patient Experience Team continue to work with Care Groups to ensure FFT feedback is collected at every opportunity and used to drive service improvements.

Further project work is being discussed to include how our Volunteers may form part of our feedback gathering processes.

Examples of our FFT Posters:







9. Voluntary Services



Humber Health Partnership – Voluntary Services 2024-2025 Summary

The Humber Health Partnership proudly celebrates the vital contributions of over six hundred volunteers, who collectively donated 57,449 hours of service in 2025. Their efforts have significantly enhanced patient care, staff support, and community engagement across the Group.

Key Contributions

Patient Support: Companionship, wayfinding, nutrition, hydration, and mental health support.
Administrative Help: Easing workloads for staff.
Community Outreach: Health campaigns, fundraising, and peer support.
Special Projects: Including the *Bluebell Project* for end-of-life care and the *voluntary trolley service* at Castle Hill Hospital.



Impact Highlights

98% of patients reported positive experiences with volunteers.
Increased participation from youth and student volunteers.
Notable initiatives like *Get Up Get Dressed Get Moving* at Grimsby promote patient independence and well-being.

Inspiring Stories

Sam's Gardening Sessions: Boosted patient morale at Hull Royal Infirmary.
Ash's Emergency Department Volunteering: Reinforced her healthcare career aspirations.

Therapy Dogs: Visits from dogs like Molly, Jasper, and Archie brought comfort to patients and staff, supporting emotional well-being.



Future Plans



Training & Development: New modules and flexible learning options.
Volunteer-to-Career Pathways: Encouraging long-term engagement.
Partnership Expansion: Collaborations with schools and businesses.
Recognition & Retention: Enhanced rewards and appreciation events.
Programme Growth: Wider rollout of Humber Health Champions and PAT dog visits.

Volunteer Conclusion

The Humber Health Partnership extends heartfelt thanks to its volunteers for their compassion and dedication. Their service continues to enrich the lives of patients, staff, and the broader community. The Group remains committed to expanding and evolving its volunteer network to meet future healthcare needs.

10. Additional Learning, Themes and Trends

Ongoing work is required to ensure learning from Complaints and PALs is moved into effective actions, table below shows what has been undertaken in 2024/25.

Top 5 themes from Complaints / PALs Feedback

Complaints	PALs
Clinical Treatment	Clinical Treatment
Delays	Communication
Communication	Values & Behaviour
Discharge	Delays
Nursing Care	Nurse Care

Commitment to Support Concerns

We are exploring communication training options
We will identify learning actions from complaints
Share learning with all Care Groups
Take Learning actions to all relevant forums, meetings and handovers
Promote Staff training and reflections from concerns

The following processes are used to share the learning from Complaints and PALs;

Patient stories were taken to board and to other relevant groups for example directorates
Patient Experience Group (PEG) meetings started with a monthly Patient story, as a powerful reminder of the purpose of the meeting
Weekly Directorate Group meetings undertaken with Patient Experience Team to track progress, review actions
Dissemination of information at Directorate Clinical Governance and sub-specialty meetings
Quarterly reports to Quality Safety Committee
Patient Experience Team reported quarterly to the Quality Governance Group meeting
Updates to external ICB meetings as requested

11. Summary Conclusion

The 2024–2025 reporting year has marked a period of significant progress and collaboration for the Humber Health Partnership. The formal alignment of Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust under a unified Group structure has enabled more responsive and consistent approaches to patient experience, learning, and service improvement.

Throughout the year, the Patient Experience Team has worked diligently to ensure that patient voices are heard and acted upon. From managing complaints and PALS concerns to leading engagement initiatives and national survey participation, the team has demonstrated a strong commitment to compassionate, responsive, and inclusive care. Notable achievements include improvements in urgent and emergency care survey results, expanded interpretation services, enhanced volunteer contributions, and the rollout of key initiatives such as the Extended Visiting Framework and the Patient Cash and Valuables Policy.

While areas of challenge remain, particularly in inpatient survey performance and communication-related concerns, the Group has shown a clear willingness to learn, adapt, and improve. The insights gained from patient feedback have informed targeted action planning and will continue to shape the strategic direction for the year ahead.

As we move forward, the Humber Health Partnership remains committed to embedding a culture of continuous improvement, shared learning, and patient-centred care across all services and sites.

12. Key Actions for 2024/25

1. **Complaints & Learning**
   - Develop an action plan for sharing learning from complaints and PALS across all services
   - Continue our work to bring PALS and Complaints together within our Group model.
   - Increase collaboration with external partners (ICBs, ambulance services, mental health services)
2. **Policy & Process Development**
   - Complete work on a Group Complaint, PALS and Compliment Policy
   - Develop joint working processes across HUTH and NLAG
   - Coordinate themes and trends with the Care Groups, Deputy Chief Nurse and Governance leads
3. **Service Improvement**
   - Ensure PALS concerns are resolved directly by Care Groups where possible
   - QI team to support role out of patient experience specific initiatives with care groups during 2025/26
   - Continue to work with the QI team to support patient experience information for the wider trusts five quality priorities
   - Review the rollout of the Patient Cash and Valuables Policy, including safes and Brightboxes
   - Adopt the Patient Cash and Valuable Policy for HUTH following review, if appropriate
4. **Communication & Training**
   - Review customer care training packages for suitability to address patient experience concerns
   - Explore additional communication training to address concerns about staff values and behaviours
5. **Access & Inclusion**
   - Continued involvement in a new interpretation contract
   - Continue work on aligning visiting hours across the Group
6. **Environment & Navigation**
   - Progress signage improvement work with Finance and pilot at Diana, Princess of Wales Hospital
7. **Feedback & Engagement**
   - Enhance FFT feedback processes, collection and utilisation across all departments
   - Explore volunteer involvement in feedback gathering processes

Appendix 1

1. Key Actions for 2023/24 NLAG / HUTH Progress update

List of Joint Key Actions from 2023 Annual report	NLAG	HUTH	Update
1. In partnership develop an action plan and strategy for the best approach in sharing learning to all areas that receive complaints about their service.			Written into Joint Policy for Patient Experience.
2. As part of organisational change bring PALS/ Complaints together as a Group Model	✓	✓	Templates, processes aligned.
3. Develop joint working processes across HUTH/ NLAG			Templates, processes aligned. Telephony/ IT equipment required to complete.
4. Complete draft version of the newly created Joint Policy for Patient Experience			Review by Patient Experience & Learning Group – July 2025.
5. Ensure ongoing Coordination of Themes, Trends working with the Chief Nursing Team and Operational leads to improve patient care	✓	✓	Process changed
6. PALs concerns to be resolved directly by Care Groups where possible.	✓	✓	Process changed
7. To continue to work with the Five quality priorities for 24/25 by addressing the feedback provided from Complaints and PALs. (Sepsis, Deteriorating Patients, End of Life Care, Mental Capacity, Medication Safety)	✓	✓	Quality Governance team have representation at all 5 Quality priority workstreams. Patients experience information, learning is shared.
8. Work to develop new interpretation contract ensuring Quality measures are included			Contract work being led by NHS England date to award contract 11/2025.
9. Sharing and reviewing alignment of visiting with HUTH	✓	✓	For implementation date after Board review – June 2025.

10. To continue roll out Patient Cash and Valuables Policy, Safes and Brightboxes			Review and feedback for NLaG - June 2025. Patient Experience & Learning Group - July 2025. Planning implementation for HUTH August 2025.
11. Signage work to continue with Health Tree committee, to assist HUTH with roll out			Funding required and being sought.
12. To review the HUTH customer care training package with the learning and development team and roll out into NLAG.			Current training materials being reviewed ongoing
13. To increase collaborative working on complaints with partner organisations specifically the integrated care boards (ICB), Care Plus Group (North East Lincolnshire), ambulance services and mental health services .			Progress made working across the system with ICB

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)238

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 11 December 2025
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance Donna Pickering, Head of Patient Safety (HUTH) Kelly Burcham, Head of Patient Safety and Risk (NLAG)
Title of the Report	**PSIRF Annual report**
Executive Summary	The purpose of the report is to illustrate the management of Patient Safety Incidents Response Framework (PSIRF). The key aims of PSIRF are set out in the paper and an overview of the achievements and challenges is provided. Patient Safety is paramount in providing good care to our patients, and seeking to learn and improve through the range of systems-based investigation activities, is intended to result in the required change Details of learning identified over the year is provided in the tables for each trust found in the appendix to this report.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	Quality and Safety Committees-in-Common (June 2025)
Financial implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None specifically
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ü Assurance ☐ Other – please detail below:

PSIRF Annual Report 2024/25

Introduction

The National Patient Safety Incident Response Framework (PSIRF) sets out the approach to achieving effective learning and improvement following patient safety incidents.

The four key aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening how we learn and apply improvements

This report provides the following elements:

- The number of learning responses declared in 2024/25
- The number of learning responses closed in 2024/25 including those declared in the previous year.
- Summary of successes and challenges in relation to achieving the PSIRF aims
- Examples of areas for improvement/safety actions from investigations/reviews (Appendix 1)
- Key priorities for 2025/26

Number of Learning Responses declared and closed in 2024/25

NLaG Learning Responses Figures:

NLaG Learning Responses declared in 2024/25 by Care Group

Care Group	PSII*	AAR	MDT	Total
Acute & Emergency Medicine	1	9	4	**14**
Cardiovascular	1	1	0	**2**
Community, Frailty and Therapy	0	5	0	**5**
Digestive Diseases	1	1	1	**3**
Family Services	3	6	0	**9**
Head and Neck	0	1	1	**2**
Neuroscience	0	1	1	**2**
Patient Admin	0	0	1	**1**
Specialist Cancer & Support Services	0	1	2	**3**
Specialist Medicine	1	1	0	**2**
Specialist Surgery	0	2	4	**6**
Theatres, Anaesthetics and Critical Care	2	3	1	**6**
Total	**9**	**31**	**15**	**55**

Open NLaG Learning Responses declared in 2023/24 by Care Group (carried forward)

Care Group	PSII	AAR	MDT	Total
Acute & Emergency Medicine	2	-	-	**2**
Specialist Medicine	-	1	-	**1**
Total	**2**	**1**	**0**	**3**

NLaG Thematic Reviews declared in 2024/25

Declared	Care Group	Title	Stage
July 2024	Trust-wide	Thematic investigation of medication allergies	Investigation

Overview of Patient Safety Incident Investigations (PSIIs) under the PSIRF

The table below represents a summary of the 9 PSII* cases declared in 2024/25.

One PSII met the Never Event criteria

Two PSIIs were referred to Maternity and Newborn Safety Investigations (MNSI) for investigation

Acute and Emergence Medicine (1)

Speciality (No. PSIIs)	PSII Type
Emergency Care (1)	2024 8197: Deterioration of patient transferred to CHH

Cardiovascular (1)

Speciality (No. PSIIs)	PSII Type
Cardiology (1)	2024 7422: Inappropriate discharge prior to angiogram

Digestive Diseases (1)

Speciality (No. PSIIs)	PSII Type
Endoscopy (1)	2025 1430: Delay in identification and treatment of sepsis

Family Services (3)

Speciality (No. PSIIs)	PSII Type
Obstetrics/Maternity (2)	2024 8183: IUD 2025 1060: Intrapartum Stillbirth meeting MNSI criteria
Maternity (1)	2024 10043: Intrapartum Stillbirth meeting MNSI criteria

Specialist Medicine (1)

Speciality (No. SIs)	PSII Type
Endocrinology (1)	2024 9501: Delay in diagnosis (LD patient)

Theatres, Anaesthetics and Critical Care (2)

Speciality (No. PSIIs)	PSII Type
ITU (2)	2024 8585: Never Event – Retained Guidewire 2025 518: Tracheostomy complications

All investigations declared and remaining under SIF are now complete with 2 action plans still open. 12 SI investigations were completed during 2024/25. The Integrated Care Board have a sign off process for SI investigations using an assurance rating and as part of ongoing monitoring, there has been a 91% rate of approval on first review.

The following SIs were moved to PSI Investigations under PSIRF as agreed by the ICB. One is on hold due to police primacy. The other is a complex case which required clinical support for the Learning Response Lead and there have been significant delays and difficulties in obtaining that support. This investigation is now at report writing stage.

Acute and Emergence Medicine (2)

Speciality (No. PSIIs)	PSII Type
Emergency Care (2)	Death following anaphylaxis (police primacy) Child Death – Progressive deterioration.

All carried forward NLaG PSIIs and those declared in 2024/25 remain open investigations.

NLaG Learning Responses closed in 2024/25

Care Group	PSII	AAR	MDT	Total
Acute & Emergency Medicine	-	6	2	**8**
Cardiovascular	-	1	-	**1**
Community, Frailty and Therapy	-	11	1	**12**
Digestive Diseases	-	1	2	**3**
Family Services	-	4	1	**5**
Head and Neck	-	1	3	**4**
Neuroscience	-	1	1	**2**
Patient Admin	-	-	-	**-**
Specialist Cancer & Support Services	-	-	-	**-**
Specialist Medicine	-	-	1	**1**
Specialist Surgery	-	2	2	**4**
Theatres, Anaesthetics and Critical Care	-	3	1	**4**
Total	**0**	**30**	**14**	**44**

Safety actions and improvement in relation to the closed learning responses are outlined in Appendix 1

HUTH Learning Responses Figures:

HUTH Learning Responses declared in 2024/25 by Care Group

Care Group	PSII	AAR	MDT	Total
Acute & Emergency Medicine	7	2	4	**13**
Cardiovascular	5	5	2	**12**
Community, Frailty and Therapy	1	1	4	**6**
Digestive Diseases	2	1	2	**5**
Family Services	8	10	4	**22**
Head and Neck	0	2	1	**3**
Neuroscience	3	2	1	**6**
Patient Admin	0	0	0	**0**
Specialist Cancer & Support Services	1	4	0	**5**
Specialist Medicine	0	3	0	**3**
Specialist Surgery	2	6	1	**9**
Theatres, Anaesthetics and Critical Care	2	4	0	**7**
Total	**31**	**40**	**19**	**90**

Open HUTH Learning Responses declared in 2023/24 by Care Group (carried forward)

Care Group	PSII	AAR	MDT	Total
Major Trauma	1	-	-	**1**
Specialist Medicine	1	-	-	**1**
Total	**2**	**0**	**0**	**2**

Major Trauma – PSII was paused due to policy primacy; HUTH informed in April 2025 that the police investigation had been reviewed by the Crown Prosecution Service and did not meet the evidential threshold for criminal prosecution. The PSII has been restarted, and the report is at report writing stage.

Specialist Medicine – this is a complex multi-agency investigation also subject to a Coronial Inquest into the death of a patient with learning disabilities; the report is undergoing sign off by the Care Group prior to presentation at the PSIRF Oversight Group meeting.

Overview of Patient Safety Incident Investigations (PSIIs) under the PSIRF

The table below represents a summary of the 31 PSII cases declared in 2024/25.

Four PSIIs met the Never Event criteria

Four PSII were referred to Maternity and Newborn Safety Investigations (MNSI) for investigation

Acute and Emergence Medicine (7)

Specialty (No. PSIIs) / PSII Type

Emergency Department (7)

2024 4358 – Patient death – delayed diagnosis of myocardial infarction (MI).
2024 5004 – Death of patient following cardiac arrest; hyperkalaemia not recognised/treated
2024 7249 – Patient death; lack of escalation for senior review
2024 9465 – Patient death; delayed recognition, escalation and treatment for sepsis
2024 9467 – Treatment delay; delay in transfer from ECA to cardiology resulting in cardiac arrest in ED
2024 9897 – Patient death; delayed recognition, escalation and treatment for sepsis
2025 540 – Patient death; delayed recognition, escalation and treatment for sepsis

Cardiovascular (5)

Specialty (No. PSIIs) / PSII Type

Cardiology (4)

2024 7401 – Patient death; cardiac MRI showing abnormality not acted upon
2024 10090 – Death of patient awaiting TAVI
2025 1452 – Death of patient in cath lab following delay in receiving angiogram
2025 1275 – Patient death; telemetry not connect and no recording prior to death

Vascular Surgery (1)

Specialty (No. PSIIs) / PSII Type

2024 8941 – Patient death; Incorrect discharge of patient with presumed heart failure and poor renal function - missed sepsis

Community, Frailty and Therapy (1)

Frailty (1)

Specialty (No. PSIIs) / PSII Type

2025 1878 – Patient death; no antigoagulation administered

Digestive Diseases (2)

Specialty (No. PSIIs) / PSII Type

Gastroenterology (1)

2025 1450 – Patient death; abnormal lesion not followed up leading to presentation with extensive metastases 3 years later

Upper GI Surgery (1)

Specialty (No. PSIIs) / PSII Type

2025 1451 – Death of patient following cholecystostomy

Family Services (8)

Specialty (No. PSIIs) / PSII Type

Obstetrics/Maternity (6)

2024 4529 – Early neonatal death meeting MNSI criteria
2024 7530 – Intrauterine death meeting MNSI criteria
2024 5907 – unexpected admission of term baby to NICU
2024 7525 – Intrauterine death meeting MNSI criteria
2024 8086 – Never Event; Retained surgical swab following caesarean section
2024 8693 – Intrauterine death meeting MNSI criteria

Paediatric Surgery (1)

Specialty (No. PSIIs) / PSII Type

2024 4820 – Patient death; missed sepsis	

Neonatal Services (1)

Specialty (No. PSIIs) / PSII Type

2024 9129 – Neonatal death; slipped ETT tube

Neuroscience (3)

Stroke (3)

Specialty (No. PSIIs) / PSII Type

2204 4072 – Patient death; no follow up of abnormal results
2024 5314 – Never Event; misplaced NG tube
2024 8498 – Patient death; patient fed with incorrect feeding device

Specialist Cancer and Support Services (1)

Radiology (1)

Specialty (No. PSIIs) / PSII Type

2024 6706 – Never Event: Wrong site injected during root nerve block procedure

Specialist Surgery (2)

Specialty (No. PSIIs) / PSII Type

Orthopaedics (Elective)

2024 4609 – Patient death; delay in transfer to cardiology following MI

Urology

Specialty (No. PSIIs) / PSII Type

2025 374 – Death of patient following testicular surgery

Theatres, Anaesthetics and Critical Care (2)

Theatres (1)

Specialty (No. PSIIs) / PSII Type

2024 7521 – Never Event: Wrong sided implant inserted during knee surgery

Anaesthetics (1)

Specialty (No. PSIIs) / PSII Type

2025 725 – Death of patient undergoing ERCP as a day patient

HUTH Learning Responses closed in 2024/25

Care Group	PSII	AAR	MDT	Total
Acute & Emergency Medicine	9	2	2	**13**
Cardiovascular	1	1	0	**2**
Community, Frailty and Therapy	2	2	3	**7**
Digestive Diseases	0	1	1	**2**
Family Services	4	9	2	**15**
Head and Neck	0	1	1	**2**
Neuroscience	3	2	1	**6**
Patient Admin	0	0	0	**0**
Specialist Cancer & Support Services	1	6	0	**7**
Specialist Medicine	1	3	0	**4**
Specialist Surgery	1	3	1	**5**
Theatres, Anaesthetics and Critical Care	3	4	1	**8**
Total	**25**	**32**	**12**	**71**

Safety actions and improvement in relation to the closed Patient Safety Incident Investigations are outlined in Appendix 1.

Never Event update (June 2025):

There is a workstream that is currently reviewing the Never Events across the Group and a paper was presented to the Patient Safety and Learning Group in June 2025 outlining the action being taken to reduce the risk of further Never Events.

Summary of the successes and challenges in relation to achieving the four aims of PSIRF in 2024/25

Compassionate engagement and involvement of those affected by patient safety incidents

NLaG had Family Liaison Officer roles in place under the previous Serious Incident Framework and this model was retained when the Trust transitioned to PSIRF. For all learning responses a designated Family Liaison Officer is assigned to support patients and families through the investigation/review process and ensure that the voice of the patient is central throughout. Support from the central patient safety team is provided to ensure engagement and duty of candour requirements are met when a learning response is declared.

HUTH do not have dedicated Family Liaison Officers (or Engagement Leads), the Patient Safety Leads based in the central Patient Safety Team undertake this role as investigation lead for PSIIs.

The Patient Safety Leads have supported the patients and families through the investigation/review process for all PSIIs declared in 2024/25. They have contacted the patients and families at the beginning of the investigation process to explain PSIRF principles and have maintained regular contact throughout, often meeting with the families on completion of investigations to explain the report findings.

However, this will change through 2025/26 to adopt the same model as NLaG with dedicated Family Liaison Officers allocated within the Specialty/Care Groups where the incident occurred (preferably someone known to the patient or their family), taking the responsibility away from the Investigation Leads allowing them to focus on staff engagement.

Challenges in meeting this aim is that PSIRF specifies that Engagement Leads should be adequately trained meeting the minimum PSIRF requirements. Whilst there is a cohort of HUTH staff that have undertaken the required training, further investment in training is required if HSSIB no longer offer this training for free to NHS Organisations. None of the Family Liaison Officers that are allocated in NLaG have been trained in line with PSIRF. They are being guided by the central team in the interim. The difficulty is that the Family Liaison Officer can be allocated from a large pool of staff which changes overtime. Therefore, maintaining a cohort of trained individuals comes with its own challenges.

For PSIIs, patients and families are provided with a leaflet which outlines what to expect during an investigation, how they can be involved and what support they will receive. As part of the review of processes, the NLaG and HUTH leaflets will be aligned and put into a Group template when one becomes available.

The existing NLaG AAR staff leaflet has been reviewed and updated to be a Group wide leaflet and now forms part of the updated AAR toolkit for group wide use. The leaflet also contains information on what support is available and signposts staff to the health and wellbeing page on Bridget.

All other information, that is provided to patients, families and staff that exist in both organisations will be aligned as part of the review work in 2025/26 to ensure consistency.

In NLaG a simple feedback tool for staff attending AAR and MDT Reviews was used during 2024/25. Overall, the outcome of this anonymous feedback was positive and support the PSIRF principles:

Feedback from attendance at AAR or MDT

- A safe space for sharing information and discussions.
- Meetings are open and systematic.
- Attendees felt that they could ask for any support if needed.
- Received information about the process and meeting prior to attending, which felt helpful including how to access supervision.
- Felt able to contribute to the meetings and felt able to clarify details in their involvement in the incident.
- Everybody involved had an opportunity to speak and was given the time to. There was no blame, only learning.
- Keen to find solutions and work together to improve.
- Learning from the outcome seemed to be identified quicker than previous investigations.
- The meetings were looking at how systems can improve patient care.

Improvements from feedback

- If staff involved in patient care are on annual leave, then to postpone the meeting until the staff involved are able to have the option to attend so that learning can be identified, and further information can be provided.

This tool is being rolled out group wide in 2025/26 and will be used to inform improvement work.

For completed PSIIs at HUTH, three face to face feedback meeting with families were held on completion of the investigation. These meetings were well received with no negativity feedback from the families; they were assured that the investigation had been thorough, and their questions were answered.

There have been no formal complaints or PALS enquiries received post investigation/ review for HUTH or NLaG.

Further work and improvements in relation to capturing feedback from staff, patients and families involved in learning responses will be a priority in 2025/26.

Application of a range of system-based approaches to learning from patient safety incidents

A system-based approach recognises that patient safety is an emergent property of the healthcare system, that is, safety arises from interactions and not from a single component, such as the actions of people. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.

A system-based approach will identify where changes need to be made and then monitored within the system to improve patient safety.

Both organisations have adopted the Systems Engineering Initiative for Patient Safety (SEIPS) model for its investigations/responses to patient safety incidents. SEIPS is the systems-based framework endorsed by PSIRF and all national PSIRF tools are based on SEIPS.

SEIPS describes how a **work system** can influence **processes** (work as done), which in turn shapes outcomes. A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s).

Learning response toolkits developed locally are all based on SEIPS and system-based methods such as interviews, observation, cognitive walk-throughs are used for information gathering to understand the work as done.

The following describes the range of systems-based learning response methods used by both HUTH and NLaG:

After Action Review	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT.
MDT Review	Used to review an incident or multiple incidents where recollections are more difficult to obtain due to passage of time; or to review a safety theme. Involves key stakeholders/subject experts.
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. Nationally mandated PSIIs include e.g. Never Events, and deaths thought more likely than not due to problems in care (i.e. incidents meeting the LfD criteria).
Thematic Review	Thematic Reviews aggregates (or combines) learning from individual incidents (meeting the scope of the theme) to identify broader more system-focused learning and areas for improvement.
MNSI	Maternity and neonatal incidents meeting MNSI criteria require a referral to MNSI for independent PSII. If not accepted by MNSI, LRP to decide level of investigation.

In NLaG, learning responses including PSIIs are led by senior individuals from within the Care Groups supported by the central patient safety team. In HUTH a central investigation team was created as part of the preparation to transition to PSIRF to undertake all learning response types.
PSIRF standards clearly outline the training and competencies required to lead learning responses and that training must be provided by accredited providers. Learning Response Lead training has been delivered locally by approved course providers MedLed at HUTH and via the online HSSIB training courses for both NLaG and HUTH.

Successes and Challenges

All central patient safety teams are fully trained under PSIRF and whilst there is a cohort of trained learning response leads within the Care Groups, numbers for some remain low or are non-existent.

For NLaG this has resulted in some learning responses being led by non-trained leads although supported by the central team who are trained. It is evident that knowledge of SEIPS is lacking and can impact on the quality of learning responses and the ability to identify the right areas for improvement. Toolkits to support learning response leads have been developed and the central team will be developing training packages to support staff who are leading the responses or engaging with staff and families. This has been delayed whilst moving to a Group structure and supporting a number of significant changes and reporting requirements over the last 12 months.

The training provided by HSSIB is free and virtual which whilst it brings flexibility it is time consuming (20-30hrs approx.). Time also has to be allocated to reading the learning materials and actively engage in the training and support sessions provided by HSSIB. Learners can complete the training over 6 months, but the commitment required to complete is significant.

Dedicated time to undertake the Patient Safety Incident Investigations (PSII) remains a challenge for both NLaG and HUTH. For NLaG, staff are required to lead these in-depth reviews of a patient safety incident whilst also meeting their operational commitments. The PSIRF standards require leads to have dedicated paid time to conduct learning responses and if necessary, their normal roles are backfilled. This is difficult for Care Groups to always prioritise when there are operational and financial pressures.

Whilst moving to a Group model last April, there are currently two separate PSIRF policies, PSIRPs, processes and supporting documentation/templates which has been challenging for the Care Groups and Oversight leads/groups to navigate. Work is ongoing to unify the processes, documentation, polices and to have a joint PSIRP.

Considered and proportionate responses to patient safety incidents

PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Apart from the nationally mandated responses to certain categories of events

such as incidents meeting the learning from deaths criteria and Never Events, organisations are able to balance effort between learning through responding to incidents or exploring issues and improvement work.

Both Trusts have a patient safety incident response plan (PSIRP) which outline how certain incidents will be responded to including those that meet the national thresholds. The plans also identify the existing improvement workstreams to consider when responding proportionately to patient safety incidents. There has been a tendency, particularly in the early phase of transitioning to PSIRF, to apply the SIF approach to decision making, and on occasion, to repeat a learning response for same type incidents where improvements plans are already in place. PSIRF standards requires learning and improvement work to be adequately balanced. Organisations should not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

The two panels that already existed in each organisation were joined in December 2024 and renamed the Weekly Learning Response Panel. Patient safety events are presented for decisions on whether a learning response is required and if yes, what is the most appropriate or required method. Decisions on whether a learning response is required will include consideration as to whether the learning has already been identified or whether there is an existing improvement plan that negates the need for an additional review.

The Pressure Ulcer process of rapid review only requires a learning response where the issues identified are not already in the Pressure Ulcer Improvement Plan. Consequently, there has been a marked reduction in investigations undertaken over the last few years which enables an increased focus on improvement work. A similar process exists in Falls and again the number of investigations/learning responses are low allowing a focus on improvement.

Patient safety learning responses are required to start as soon as possible after the incident is identified and, although dependent on complexity, they should ideally be completed within one to three months and/or no longer than six months.

In NLaG there has been a notable reduction in the time it has taken to complete a proportionate learning response in 2024/25 when compared to 2023/24. This is largely attributed to embedding of the new approach, refining of processes overtime, and improved engagement with Care Groups.

For PSIIs, delays in identifying Learning Response Leads that are independent from the area under review has meant that some have not been completed within a 6-month timeframe. Others have taken longer due to the complexities of the case.

In HUTH, the Patient Safety Learning Response Leads have been dependent on the Care Groups in organising the learning responses to ensure the appropriate staff are in attendance. As there is a different model to NLaG there is limited coordinator/facilitator support to arrange the learning responses and therefore there are a number of outstanding learning responses where there has been no engagement from the Care Groups.

HUTH PSIIs have also seen some investigations take more than the 6-month timeframe, this is also due to complexity of the cases and, due to the large number of cases the central Patient Safety Teams carry.

Supportive oversight focused on strengthening how we learn and apply improvements

PSIRF is supported by strong leadership commitment which is evident in the oversight structures within the Group. There are joint daily incident navigation meetings with Care Group representation reviewing patient safety incidents and escalating any of concern. The weekly learning response panel commissions PSIIs as well as other proportional learning responses and is chaired by the Site Medical Directors.

The PSIRF Oversight Group meets bi-weekly and is chaired by the Site Directors. This group has oversight of all PSIIs reports ensuring they are conducted in line with PSIRF requirements, and its members review all PSII draft reports prior to being shared with patients/families. The outcomes/reports from all proportionate learning responses are also received for review and to ensure the scope of the safety actions are appropriate.

Traditionally (under the Serious Incident Framework) oversight included commissioners and ICBs holding NHS Providers to account for the quality of patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

ICBs are expected to consider the strength and effectiveness of NHS providers' incident response process and support the continuous development of an effective incident response system. There is ICB representation on both the Weekly Learning Response Panel and the PSIRF Oversight Group to provide that oversight and support.

At the Weekly Learning Response Panel, the ICB representative engages and contributes to our learning response decisions and also highlights from their perspective themes that are arising amongst our incidents. They also provide support from a system-wide perspective of how learning can be shared and how improvements can be made.

The Patient Safety Teams work in partnership with other areas across the group including but not limited to, the Care Groups and the Quality Governance Teams who support them, Quality Assurance, Patient Experience, Safeguarding, and other specialised services / subject experts. There has been a lack of alignment between patient safety and quality improvement from a PSIRF perspective. This is in part due to the quality improvement team being moved under transformation when the Group model was established, and although part of QI team resource has since moved under Quality Governance, they have a defined remit to deliver on the quality priorities, learning from complaints and to deliver QI training.

Challenges

PSIRF oversight focusses on enabling and monitoring improvement in the safety of care, not simply scrutinising investigation quality.

Safety action development and monitoring improvement are key steps in the approach to continuous quality improvement of care and safety for patients. Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Learning response methods enable collection of information to acquire knowledge. It is imperative that there is a continued focus on moving from identifying the learning to implementation of the lessons. Working collaboratively with the Care Groups and Quality Governance Teams, the delivery of the safety actions is monitored centrally by the patient safety teams and any overdue actions are reported to the PSIRF Oversight Group.

There are processes in place to ensure that relevant learning is integrated into wider improvement work across the organisation as outlined in the current PSIRPs. However, the monitoring of continuous quality improvement remains a challenge particularly where integration and collaboration between patient safety and the quality improvement team is less embedded, and also where data capture has not been developed to demonstrate improvements over time.

Insights from investigations and learning activity are used to inform the quality priorities which are supported by the Quality Improvement Team, although these have remained the same priorities over the past two years.

Following learning from investigations and reviews a group wide audit relating to acknowledging and acting on test/scan results has been added to the Group priority audit programme. Other audits used to test embedding of change tend to be more locally led. They are often spot checks over a short time and not a real measure of the effectiveness of change. They are also not evident in all improvement plans. Links to the audit programme of work in relation to existing projects and consideration of new priority projects informed by the outcomes of learning responses needs further development. The existing approaches to oversight will need to be reviewed to ensure that completed investigations and learning responses can demonstrate that the proposed changes are effective and sustainable. This might indicate the need for a wider improvement plan not already identified within the existing PSIRPs.

Key priorities for 2025/26

- Alignment of PSIRF policies and develop a Group PSIRP.
- Family Liaison model adopted group wide.
- Increase the number of trained leads in line with PSIRF requirements.
- Continue to align processes and procedures including templates and toolkits for learning responses across the group.
- Develop and align existing patient and staff information leaflets.
- Develop guides for learning response leads and engagement leads (Family Liaison Officers / Staff Liaison roles).
- Further develop the process to proactively capture the feedback of ‘people affected’ of their experience of the learning response.
- Commence an evaluation of the extent to which the PSIR standards are being met and develop a plan for improvement.

It is recognised that the above will be a key focus of the central patient safety teams however the ability to achieve these objectives is dependent on resource/capacity particularly in light of any unplanned priorities placed on the team in year and the restrictions placed on recruitment in 2025/26. Some objectives are also dependent on the support and commitment of others outside their sphere of control.

Appendix 1

NLAG

Ulysses ref	Areas for improvement/safety actions
MDT 309110	• To amend the letters from colposcopy MDT to the patient to include the histology results. • To review the administration support to the colposcopy service during periods of absence within the administration team. • To review there is adequate administration support to the colposcopy service. • Discuss and share the incident and the Cervical Screening Management Meeting and the Colposcopy Management meeting. • Review current administration processes to streamline and achieve letters and follow on actions completed within 3 weeks of dictation. • To discuss at the Colposcopy Management meeting to ensure the biopsies are reviewed and approved in the absence of the Consultant. • Ensure the whole team know to follow the pathway for referral to theatres if required.
MDT 303673	• Implementation of the auto e-approve functionality within Dictate IT after 7 days. • A robust induction and training package for new starters in ENT to ensure urgent letters are distributed dictated not signed if Clinician is on annual leave for new starters. • Ensure ENT clinicians are aware of the SOP for Dictate IT and aware of the required timescales for completing e-approve within Dictate IT. • Regular performance monitoring of outstanding IT Dictation data and discuss regularly in SAT team meetings any areas of concern.
MDT 310196	• Adding prompts to follow up template in SystmOne to support assessment process with particular reference to ‘red flags’. • Add a poster on display in clinical areas to prompt clinical staff on ‘red flag’ symptoms. • Card to be given to appropriate patients with potential for developing ‘red flag’ symptoms so they can safety net effectively.
AAR 311067	• Create a care plan or communication sheet to use in patient’s homes to enable communication of patient care. • Include information of hand contractures in tissue viability education and training. • Update SOP for Referrals to Community TVN. • Implement planned and unplanned Community Nursing model.
AAR 313145	• Staff to be trained around off pathway guidance and the need to transfer out as soon as possible. • Coordinators to ensure supernumerary coordinators are supervised when undertaking complex cases. • All guidelines that include CTG monitoring are being updated to reflect national current guidance which is for electronic fetal monitoring to be performed from 26 weeks without a discussion with a senior obstetrician.

Ulysses ref	Areas for improvement/safety actions
	• BSOTS paperwork WQN 1741 to be updated for all yellow patients to be reviewed by a Registrar.
AAR 313977	• Reiterate the GPICS requirements to ITU staff. • Inform staff not to switch off Oxygen saturation alarms even if they are beeping. • discuss with staff the importance of asking a colleague for support. If additional member of staff available ask them to seek the equipment. If staff are busy do not leave the patient alone without requesting a colleague to have oversight of the patient. • Highlight the importance of following guidelines and requesting assistance.
AAR 315239	• Raise overall awareness on the incident for learning, to be shared and cascaded widely. • Huddles to be explored for relevant areas to share the skill sets with the Anesthetic Team, for night shifts only. • Director of Allied Health Professional to look at the possibility of expanding the night shift team in the CT Department. To always ensure cover and create a more effective service during the night shifts. • Ward Manager to share the bleep policy and the options of escalation if bleeps are not responded to/Anesthetist is busy elsewhere.
AAR 315039	• Audit to be completed as per deteriorating patient audit to ensure that holistic assessments are always undertaken by Nursing staff on initial/review assessment or if patient deteriorates. • Equipment requests to be added to care plans/therapy plans within SystmOne with equipment Asset Number. This is to ensure that Community & Therapy staff can check the equipment ordered is being used by the correct patient as far as is reasonably practicable. • Discuss / request that care homes pass the 'CES handover sheet' to DNs for appropriate Asset Number which can then be added to the care plan/therapy plan. • Request care homes keep an inventory of all equipment delivered and which patient was assessed as requiring the equipment and to regularly check they are using the equipment. • React to Red team to also review equipment in care home and source initial equipment delivered – once found update CES. • Community Nursing to consider trialling a care home link person. • All equipment should be returned to CES for decontamination once patient no longer requires – equipment should NOT be used for another patient. Patients re-using equipment may be at risk of Infection • Request to care homes to return all equipment for cleaning after use by the specific patient and not to be used for any other patients • React to Red team to also review equipment in care home and source initial equipment delivered – once found update CES. • CES business continuity plan for reduced admin staffing capacity to include a process for prioritising the processing of both urgent and routine equipment orders and collections within a reasonable time frame.

Ulysses ref	Areas for improvement/safety actions
	• CES to check correct job designations assigned on BEST to requesting staff to avoid confusion. • Learning to be shared division and Trust wide to specifically include Community Nursing, Community Therapies and React to Red
AAR 315259	• Training to be provided tot the Emergency Department Clinical Educators in relation to pain assessments that are being undertaken on patients who have a diagnosis of dementia. • Embed practice within the Emergency Department, with all Junior and Middle Grade Doctors, if a patient has a fall within the department, then this needs to be escalated to the Emergency Physician in Charge by the Doctor who undertakes the initial assessment, this escalation needs to be documented within the records. • To implement within the Symphony System, if a patient falls whilst in the Emergency Department then a post falls care plan should be completed and recorded within the Symphony System.
AAR 316209	• Check with the equipment stores manager if they received the equipment request on 25 January 2024 about repose wedge. • Review the possibility of automatically sending equipment form via SystmOne instead of having to add this to a separate email and risk this not being sent due to IT issues etc. • Reminder to staff about the importance of using templates to provide prompts and to take photos at every visit where consent is given. • Discussion to be had with staff about details to be included in triage – guide to be created.
AAR 317481	• A poster to highlight to the whole Emergency Department that any fluids/medications that are not part of the routine stock should be sent back to Pharmacy and not put into the drug cupboards. • A safety alert/poster to be displayed within the department and on the drug cupboard, including the second check aspects. • Nominate an individual to review the main utility areas for general tidiness, storage, clutter and general checks on the drug cupboards to ensure everything is stored as it should be as per the Medicine Management. • For all ED Nursing Staff to read the Medicine Management Code (DCP 040 Part 6: Injectable Medication) second checks should be completed at the bedside this policy and sign once reviewed.
AAR 319321	• Leaflets to be produced by the Repose company and provided to staff for giving to patients as written advice, alongside verbal advice. • Explore the possibility of Equipment Store emails being returned to a central generic email account. • Remind staff about the importance of the daily huddle to discuss patients. • Promote the use of the care plan for equipment order reminders to whole team.
AAR 321330	• A Streaming Nurse to be assigned to the reception area of the Emergency Department 24/7. • A poster is to be drafted and displayed outside the baby feeding room clearly stating, ‘this room is not to be used for patients waiting to be seen’. To also be shared with the Security Team.

Ulysses ref	Areas for improvement/safety actions
	• If the Triage Nurse is not triaging a patient, then they are to be based at the reception desk capturing what patients are coming through the door, rather than being sat in the triage room.
MDT 308835 /309753	• Barrett's SOP to be completed and shared with gastroenterology, Endoscopy and surgical teams. • Explore a process where all patients that flag from path links with a diagnosis of dysplasia to be escalated to requesting clinician for MDT. • To explore with the ICB the possibility of wider education around Barrett's to the public. • A policy to be created for patient engagement and optimising communications with patients on surveillance and follow up pathways for Barrett's. • To explore streamlining digestive disease services for the care of Barrett's patients across sites by establishing a Barrett's registry for the region.
315558	• Radiology to reinforce the need for red/yellow flag despite any pathway involvement. • Review recommendations on alerts and notification of imaging reports from RCR Guidance and implement as far as achievable within the available resources. • For patients who are awaiting investigations to be added onto a Tracking Access Plan within Lorenzo. • Deployment of a Results Management Dashboard in PowerBI to support Governance Teams and business support in managing outstanding results that remain unacknowledged. • Deployment of the Results Management Module in WebV Version 3 for all patient encounters at NLAG. • Deployment of an agreed escalation plan for all unacknowledged results that will result in a senior clinical review.
319524	• Communicate out to staff again about the expectation to do a care plan and wound assessment and document what has been done. Also, the use of care plans as a prompt to check a task. Review the task allocation timings.
322608	• Red flag be added to the Emergency Departments electronic system 'Symphony' highlighting the need for a full capacity assessment be completed on admission.

Ulysses ref	Areas for improvement/safety actions
288727	• Include INR Management within the FLOW project. • Remind staff via the Bridget announcement. • Review access to Yorkshire Humber Care Record. • Share report with the Site Management Care Group to ensure awareness of risks around the skill mix and experience of staff that are familiar with the environment. • E-mail to PGME regarding awareness over the festive period to ensure additional safety nets are in place for patient safety. • E-mail to PGME regarding sending to all staff regarding the risk of the increased risk of VTE when a patient has a pelvic fracture.
313209	• Discussion at the Acute Medicine Governance Meeting to understand decision making. • Discussion with the Pathology Laboratory manager in relation to critical results telephone extension numbers and a more robust process of being alerted of critical results. • WebV to provide training to Acute Medicine staff on the use of the Handover Module. • For the IAAU Standard Operating Procedure (DCR 183) to be updated and strengthened in relation to the handover process within Acute Medicine. • Teaching session to be held for Junior Doctors in relation to the IAAU Standard Operating Procedure (DCR 183).
314085	• All Registered Nurses on Ward 27 to complete the diabetes care training on clinical skills.net. • All registered staff out of preceptorship period to complete practice supervisor module either online or in workbook • Education with Diabetes Specialist Nurse on 12th and 19th September in relation to managing diabetes, DKA for all Registered Nurses and TNA's.
322453	• Update Policy DCG133 to include alternative types of insulin and recommendation of escalation to pharmacy. • Email Policy DCG133 to Consultants highlighting section around admittance to HDU of DKA patients. • Audit of SNCT by Ward Manager. • Sharing of the learning from this incident at the Vulnerabilities Operational Group. • Sharing of the learning from this incident at the Community, Frailty and Therapies Governance meeting and the Frailty Governance meeting. • Provide a flyer or training update to staff on ED at DPoW and Ward C6. • Report to be shared with Site Team at DPoW for cascade to all teams.
325360	• For a Task & Finish Group to be implemented driving forward electronic prescribing within the Emergency Departments. • To review the paper prescription chart within the Emergency Department documentation, for the dose box to be split. • To increase the number of cascade trainers within the Emergency Department and an induction process is undertaken to ensure all agency staff have a barcode and have completed the online training.

Ulysses ref	Areas for improvement/safety actions
AAR 313407	• Review process for scan results to enable effective change to practice – e.g. admin staff will now email the Registrar with all scan results and copy in the Consultant. If this is not acted upon it is escalated to the Consultant.
AAR 319893	• Ensure YAS and EMAS are following the same process for referrals. • Ensure there is a clear plan to identify the routes of escalation when there is a lack of certainty around ECGs. • If a patient is deteriorating, and needs intubation but is considered unsafe for transfer, ensure there is a discussion between the ICU Consultant at SGH and the ICU Consultant at CHH and consideration of thrombolysis. • Ensure the ED Team are aware that sending an ECG to CHH is not a compulsory step of referral if there is evidence of a STEMI on an ECG, they should just refer and transfer rather than provide evidence of the ECG. • Review and agree the preferred method of communication between ED and CHH. • Ensure all CHH staff handling PPCI referrals cease requesting a copy of the ECG before accepting the patient. • The Cardiology Registrar involved in this case should undertake reflective practice and discuss with their supervisors how they can enhance their proficiency to prevent similar incidents in the future.
MDT 322225	• Review process for scan results to enable effective change to practice – e.g. admin staff will now email the Registrar with all scan results and copy in the Consultant. If this is not acted upon it is escalated to the Consultant.
MDT 323212	1. Support and education should be provided to IEN to improve their skills and confidence in questioning clinical decisions. • To explore the possibility of developing and delivering an assertiveness course to IEN which will develop skills and confidence to advocate for patients with clinical colleagues. 2. Referrals from ED to specialties should be made, accepted, and managed using WebV. • Consideration should be given to the process for managing referrals used by Acute Medicine being adopted by all clinical specialties who accept in-patient referrals from ED, if this is not adopted, there should be the expectation that referrals are reviewed prior to clerking and prescribing medications. 3. The referral template in Symphony should be reviewed to allow the ED team to select that the patient requires follow up by ED. • The template is updated to allow the option for shared care to be selected. 4. Specialties should implement the Consultant team worklist in WebV utilising the “Internal Consultation” WebV process. • There is the ability for Consultant Teams to generate a list of patients who require their specialist input but when they are not the admitting Consultant using the WebV System. This is to be explored within Trauma & Orthopaedics. 5. The WebV clinical handover should be used by Orthopaedics. • Consideration should be given for using the electronic handover template on WebV is used consistently by the Orthopaedic team to provide handover information.

Ulysses ref	Areas for improvement/safety actions
	6. The possibility of updates from Refer a Patient being added to the WebV timeline as they are received should be explored. • To present the request for consideration to the Trust's EPR Operational Group Meeting for discussion. 7. The Trust should adopt a consistent approach to the management of patients with a head injury who require local admission for observation. • There is a consistent pathway used at Scunthorpe General Hospital and the Diana, Princess of Wales Hospital. 8. The Trust should develop guidance to support decision-making for VTE prophylaxis for patients who have traumatic head injuries. • Guidance will be developed and available, or HUTH guidance will be adopted by NLaG.
AAR 324496	1. Capacity of acute dietetic service and management of demands. • Review of criteria and referral form used to aid in ensuring correct patients referred and accepted onto the dietetic caseloads. • Review of system One waiting lists, refining, and applying consistent approach across sites. • Review and agreement of cross-site cover arrangements with clarity of priorities inclusive of plans across bank holidays. • CPD work/event with team around malnutrition and pressure damage and alternative methods. 2. Capacity of nursing teams, skill mix and alignment dependent on patient acuity. • Nurse staffing review for stroke services. • Review and audit of appropriate use of escalation beds on ward 22. • Education to the stroke ward staff around when a referral can be made to the dieticians. 3. Suitability and application of tools of identification and monitoring of malnutrition. • AMAT audit to be undertaken on MUST outlining further suggestions for implementations. • All staffs on stroke ward to be reminded of previous weight loss to be factored into routine MUST scores.
MDT 325901	1. A Trust Wide reliable process for PSA outpatient follow up appointments to be arranged/booked • Create a process for follow up appointment for PSA outpatients. • Deployment of an agreed escalation plan for all unacknowledged results that will result in a senior clinical review. • Explore the adoption of a Trust Wide Results Acknowledgement of Standard Operating Procedure for all clinical services. • To explore if Pathology Lab can contact department if the detail on the request is ineligible. • Reiterate the importance of including specialty when completing pathology request form. • Urology department to discuss at next business meeting with regards to unacknowledged results. • Concerns around the reporting of PSA to be added onto the Care Group Risk Register. • Flagged abnormal result to be emailed to Urology Department.
AAR 325432	• Compliance in Advanced Life Support and Surviving Sepsis Training within the Emergency Department for the Doctor involved in this particular incident.

Ulysses ref	Areas for improvement/safety actions
	• To improve the overall compliance in relation to EoL within the Emergency Department.
AAR 326809	• Ensure staff know the importance of patient identity checks both verbal and written prior to commencement of a procedure. • Reiterate the importance of cross referencing with the patient notes, theatre list and consent form, the procedure and site of surgery. • Encourage and support staffs to speak up to ensure the process is followed. • To ensure all staff state, 'out loud' the eye that is being treated following the patient checks i.e. "Left eye injection, left eye marked up" and check that the eye marked up matches with the patient notes, theatre list and consent form. (Stop the line policy).
AAR 328373	• Ensuring wristbands are being used for each item that is being inserted except for catheters and cut the wristbands at the time of removal of these items. • To implement a tick box to show that the Bakri balloon and vaginal pack has been put in and another tick box to say it has been taken out. • To explore the removal of Bakri balloons and whose responsibility it is to do these.
MDT 328986	1. Training for the ED Team on miscarriage and the disposal of sensitive products. • Add information to the ED induction booklet for new starters about the correct process for disposing of sensitive products. • Link in with the ED Team to provide training on miscarriage and the disposal of sensitive products. • Link in with the ED Team about attending the Pregnancy Loss Study Day (1/2 day session run 4 times a year). 2. Standard Operating Procedure to be produced in relation to spontaneous miscarriage under 16 weeks gestation. • Develop an SOP for the escalation of clinical concerns for patients experiencing spontaneous miscarriage under 16 weeks gestation.
MDT 311824	1. A Glaucoma pathway is required this which will assist clinicians in referrals and prioritisation. • Discuss the case with clinicians to highlight the importance of ensuring selection of the urgent option on Dictate IT to enable the SAT Team to prioritise the appointment. • A glaucoma pathway to be developed to assist clinicians in referrals and prioritisation. • Raise clinical awareness of NICE Guidelines with Ophthalmology Clinicians.
AAR 314618	• Community Nursing Caseload Management Toolkit to be updated to reflect process for escalation of complex cases and shared with staff so they have clearer guidance on when to escalate complex patients.
AAR 313488	• The Community Tissue Viability Standard Operating Procedure (SOP) is to be updated and disseminated so staff are aware of the referral criteria. • The Community Nursing Caseload Management Toolkit needs to be updated to reflect the process for escalation of complex cases.

Ulysses ref	Areas for improvement/safety actions
AAR 317483	• EMAS pathway to be reviewed regarding patients presenting with a GCS of 7/15. • ED Teams to be aware of the referral process to Neurosurgery. • ED Teams to be aware of the North Yorkshire and Humberside Major Trauma Network guidelines for the Management of Severe Traumatic Brain Injury. • The Neurosurgery referral criteria and the thresholds for acceptance to be reviewed out of hours. Share the learning from the report at the Morbidity & Mortality meetings for Neurosurgery, ED, ITU and the Trust-wide Incident Review Group meeting for EMAS. • Promote a good incident reporting culture, to ensure facts not opinions are captured in the incident forms via the share the learning document that is being produced.
AAR 324878	• A review of the ERCP MDT processes. • A review of the requirement of a Chair/MDT Co-Ordinator for the ERCP MDT meetings. • Monitoring of the ERCP MDT meetings actions and outcomes. • Following the MDT meeting, patient pathways are to be clearly documented as to what is required next.
AAR 322322	• All Ward 27 staff members to undertake brace training. • Capacity and best interest bitesize sessions for Ward 27 staff members and bank/agency staff. • Ensuring staff are aware of what is being handed over to them and taking on board what is required for their patients in that bay. • The incident to be discussed at the Specialist Surgery Care Group Governance meeting to share learning and awareness on documentation.
AAR 323958	• Are ‘Stop and Check’ huddles happening daily. Nursing Teams did escalate to other members of the Team including the Matrons. Are staffs empowered to escalate earlier if the plan is not working; clear escalation processes should be in place. • Earlier intervention of a Best Interest Meeting for complex patients facilitated by liaison with the Mental Health Teams, family (where appropriate) Nutritional Teams and Ward Clinical Teams. • Education for ward staff so they feel supported in decisions around capacity assessments and empowered to know who to contact if delays in nutrition happen.
AAR 325979	• Ensure following every operative delivery the body map for the baby and the forceps marks are drawn on the diagram documented on BadgerNet. • To document the position of the baby at delivery to confirm the initial examination. • Ensure operators verbalise and the number of pulls to enable the scribe to accurately document at time of procedure. • If forceps blade does not lock review position of the head and consider moving to theatres and Consultant-on-call should be asked to attend.

Ulysses ref	Areas for improvement/safety actions
	• To ensure delivery phones are installed in each labour room. • To reiterate incident forms must be completed by all health professionals who are involved in the care of the patient.
AAR 325952	• Highlight to the Doctors and Midwifery staff that a temperature less than 36.5C requires escalation to the Paediatric Team. If the temperature is below 36.0C the Paediatric Team must see the baby urgently. • Thermoregulation Flowchart Control for Newborn Infants on Maternity Wards to be shared with all staff within Maternity and Neonates to ensure this is being followed and for a copy to be available in every labour room. • Ensure all Midwives are making sure room temperatures are being documented and any room temperature that is below 25.0C needs an incident form completing and escalating to Estates and Facilities. • Explore the possibility of purchasing the same thermometers as used on NICU.
MDT 326935	1. To flag up lack of capacity to book appointments to Service Manager • A reliable escalation process for outpatient follow up appointments. 2. To ensure all Ophthalmology clinical staff 'grade and record' patient's visual acuity during their appointment. • Ophthalmology clinical staff 'grade and record' patient's visual acuity during their appointment.
MDT 329100	1. Check to make sure that the admission paperwork is reviewed by all involved. • Highlight with ED / HDU clinicians the importance of reviewing all clinical documentation, investigations, and imaging by all involved in the treatment and ongoing care of the patient. 2. Explore changes to documenting consultant ward rounds for verification of senior staff involvement. • HDU to ensure all consultant reviews are documented within the patient's clinical records to ensure patient safety and continuity of care. 3. Allocate Consultant in Resus to be the second checker. • Junior medical staff / ACPs to ensure that the Senior Doctor in Resus is consulted as a second checker of unreported plain film X-ray's. 4. The importance of thorough examination and documentation to prevent future errors. • Explore the current handover process between Emergency Department and Critical Care to ensure plans of care are appropriately communicated and all outstanding tasks are highlighted to the receiving team. 5. Enhanced documentation and review processes recommended to ensure accurate patient care and minimise errors. • Reiterate the significance of all senior staff involvement in patient's treatment to be documented.
AAR 329446	• Team Lead acting as FLO to have a follow up conversation with patient's son regarding why equipment and support were declined on multiple occasions and if they were aware of the possible risk/impact. • The triage template and WebV referral through the hub to be reviewed. • Roll out of Purpose T across the organisation (a new pressure ulcer coding mechanism).

Ulysses ref	Areas for improvement/safety actions
	• Information about Occupational Therapy and Crisis Team shared with staff and discussed at induction with new starters. • Assignments on Malinko (scheduling system). Timings to be reviewed to allow time to check System One. • Create a proforma for daily huddles. • Referral to Tissue Viability Nurses to be completed. • Equipment training for relevant staff to improve knowledge and understanding of what equipment is available and when it is appropriate to use it. • Mental Capacity Training – specific to community and how we document conversations to evidence patients understanding when they have capacity.

HUTH

STEIS Ref	Areas for improvement/safety actions
2023 17895	• There were no specific safety actions required to prevent this incident from occurring in the future; however, poor documentation and lack of documentation are recurring themes in patient safety investigations and would benefit from a Trust wide quality improvement project at an appropriate time.
2023 19579	• Where patients are identified as self-handover whilst at initial assessment with a crew (majors side of ED) the hospital will release the crew and transfer the patient to self-handover instead of crews waiting with the patient and booking them in. • Patients are often taken to hospital wards from ED via a hospital trolley. There is one lift for this that needs to be available for patients and relatives across 13 floors. A few patients could be identified to be transferred in a wheelchair meaning that it speeds up the process. This means more portering and clinical staff are available as well as trolleys for patients to use. • The hospital status and escalation plans revised which enables early escalation to create more flow within the ED. For example, rather than escalating when 24 out of 24 beds are full in majors it will now be enacted at 20 beds out of 24 bed full. This should speed up processes and try to promote de-escalation within the hospital. This additionally allows us to pre-empt cohorting to avoid delays with this and improve patient safety. • The hospital nerve centre records patient's observations and gives visibility to ED of their most unwell patients. This will be introduced for the patients waiting in the ambulances, so hospital staff have full visibility of patients. HRI will have someone to input the data. This should encourage ambulance staff to do patient observations every 15 minutes and therefore improve patient safety. • Joint Handover Process Standards have been created. This includes a clear set of action cards that will be followed during handover and capacity escalation periods. It is agreed that one cubicle in Initial Assessment at HRI will always be available to enable initial triage by HRI staff. All patients will be brought inside the ED and will not queue on the back of an ambulance. This will allow visibility of patients by the hospital staff and YAS HALO.

STEIS Ref	Areas for improvement/safety actions
2023 20597	• To improve the quality of care for patients 75+ and older in ED in line with the Royal College of Emergency Medicine (RCEM) relating to delirium, screening for frailty and falls risk assessments. o Improve completion of observations at initial assessment, o Improving screening for delirium, screening for frailty, and falls risk assessments. • Review Nerve Centre assessment algorithms to understand what risks are highlighted when completion has taken place. • Ensure communication is clear throughout the patient's journey. Ensure both the patient and family understand what is happening, this should include treatment, location, transfers etc. • Improve patients that are clinically stable to transfer from ED and have been confirmed by the receiving ward/service are allocated to a bed within 1 hour from decision to admit. • Clinical rationale needs to be clearly documented as to why something is not required, omitted or a decision was made to show that the pathway has been followed and/or an informed decision was made. • Critical medication review to be undertaken to clearly assess benefits versus risk when patients presenting have also occurred a recent medication change. • The importance of warfarin reversal to be highlighted in all current associated policies/guidance to ensure emergency reversal is in line with national guidance.
2023 21334	• Management of the 13th floor wards has been transferred to the Discharge Liaison and Management Team. A Discharge to Assess model has been implemented incorporating system partners, and the wider multi-disciplinary team (MDT) facilitating all discharge assessments and planning. • Since the incident occurred, the wards are now fully established with their own permanent nursing team and a full medical team. This includes a Consultant and a full time Registrar. Morning Consultant ward rounds occur Monday to Friday, and the Resident Medical Officer (RMO) covers at the weekend. • Safety briefs and daily ward rounds have been introduced. The nursing team/Junior Doctor escalate any deteriorating patient to the Senior Doctor/Parent Consultant, following the Trusts Discharge and going home policy, CG023.

STEIS Ref	Areas for improvement/safety actions
	• Ward 130 now has reliable internet, consistent Patient Discharge Assistant support with the electronic information being completed at the appropriate time. • Improvements have been made to the completion of the IDL when completed by the ward, the Medics GMC/name must be recorded on the IDL whenever it is amended. • Since the incident occurred the ward now has an integrated discharge team who work seven days per week. The role of the team is to ensure that the patients are assessed for the most appropriate beds in community.
2023 16082	• A Standard Operating Procedure has been developed for patients requiring cardiovascular services with distinct criteria for where patients should be treated – under this SOP this patient would have not been admitted to Scunthorpe and would have been taken straight to Castle Hill Hospital. • The Care Group are developing an SOP for transfer of patients from cardiology to cardiac surgery as part of the patient's management plan. • New care pathways have been written for patients with aortic stenosis; there is work ongoing to develop the joint single point of access pathway for aortic stenosis. • There is a daily huddle which is chaired by the cath lab coordinator to monitor, discuss and allocate dates for patients waiting for transfer between sites. There is also a huddle between the cath lab coordinator and the bleep 918 senior nurse coordinator to discuss transfers. • The patient administration systems (Lorenzo) have been merged and the same patient information is available at both Trusts. • A system has been put in place with the administrative staff that requires escalation to the patient's consultant if a patient or relative calls with concern about a deterioration in the patient's condition.
2024 3018	• Reinforcement of the full capacity protocol when selecting patients to be boarded when the protocol is in force. • Compliance with frequency and type of physiological monitoring as per the Deteriorating Patient Guidelines. • To improve ReSPECT discussions, decision, communication and review in line with both the Trust and national guidance.

STEIS Ref	Areas for improvement/safety actions
2024 5314	• Harmonisation and clarity of NG tube policy and associated documentation across Humber Health Partnership • Consistency in use of checking devices for NG tube placement • Quality of insertion, care, management and documentation of NG tubes on ward 110 • Communication of escalation plans at shift handover / use of ReSPECT forms
2023 18780	• To ensure the pathway for commencement of NIV in the ED is recorded and documented. • To review the referral mechanism for medical and critical care reviews for patients in the ED. • To ensure all nursing staff are aware of how to escalate staffing concerns appropriately and the recording of safety assessed and actions taken. • To improve the timeliness of medical reviews and referrals to the critical care team for patients in the ED. • To ensure that pathways in place for seriously ill patients are followed with timely and appropriate referral to the critical care team. • To review the protocol for commencement of NIV in ED and ensure it is followed. • To review the mechanism of escalating concerns regarding staffing levels for ED. • Emergency department crowding is already on the Trust corporate risk register (ID 3439).
2023 18431	• Changes have been made to NerveCentre to allow a Lying and Standing blood pressure assessment to be not recorded. • To review pathways to eliminate unnecessary transfers for the frail elderly patient group; to avoid wherever possible moves at 02:00hrs. • Patient Falls Prevention and Management Policy to be reviewed to ensure the guidance on when to complete the Multi Factorial Assessment Tool (MFAT) is clear and is undertaken for the benefit of patient safety. • For the 4AT /Dementia and or Delirium assessment to be added to the electronic patient records to improve documentation (QIP currently underway). • To improve communication with families in regards to a change in a patient's condition/history, bed moves, following a fall etc to improve the experience of patients and their families following an episode of care regardless of the outcome.

STEIS Ref	Areas for improvement/safety actions
	• For all communication with family members to be clearly documented within the patient's electronic record; for a "preferred method of contact" to be documented. • For the implementation of the Avoiding Falls Level of Observation Assessment Tool (AFLOAT for all Elderly care wards led by falls improvement work QIP.
2023 20598	• To improve the administration of intravenous fluids to ensure that the regimes are monitored to time. • To review practice of monitoring/repeat ECG in Initial Assessment; to review the criteria for initiating primary and serial ECGs for unwell elderly patients. • Sepsis Guidance – Ensure all clinical teams are sighted on sepsis team advice when sepsis markers are present, so that trust agreed guideline is adhered to. • To review impact on individual patients of ED crowding and the ability of the wider organisation to support and escalate to relieve pressure
2023 21333	• Continue improvement work within the Trust alongside system partners to improve the flow of patients through ED whilst managing demand and capacity within ED. • Review mechanisms for contemporaneous documentation within ED to support accurate recording of NEWS score on arrival to ED, thus supporting staff with prioritisation of patients presenting with a high NEWS score.
2024 452	For improved compliance with National and hospital Trust policies on antimicrobial prescribing/stewardship to ensure safe prescribing, administering, supply and monitoring of antimicrobial prescriptions to prevent suboptimal prescribing and to improve patient safety. • The Bronchiectasis Team to develop a procedure for prescribing drugs following MDT instead of sending advice over email. • For Tobramycin to only be prescribed when there is a clear rationale and benefit over gentamicin. • All Trust guidance that refers to tobramycin to be reviewed by the Advisory Committee on Antimicrobial Therapy (ACAT)

STEIS Ref	Areas for improvement/safety actions
	• The restricted status of tobramycin to be reviewed at the Advisory Committee on Antimicrobial Therapy (ACAT) and with the relevant clinical areas. • Aminoglycoside use in bronchiectasis to be discussed with the bronchiectasis team, and the Advisory Committee on Antimicrobial Therapy (ACAT) to agree a protocol for its use. • The Trust Tobramycin Antibiotic guidance (MicroGuide) to provide guidance on dosing for non-cystic fibrosis patients, highlighting the importance of appropriate dose selection, administration intervals and monitoring requirements. • For ePMA to be configured so that tobramycin has to be prescribed every 24/48 hours which will prompt for tobramycin serum concentration levels to be checked prior to prescribing and to advise a maximum dose is given, as per the gentamicin configuration to improve the safety, accuracy and clarity of tobramycin prescriptions. • To review tobramycin level requesting requirements on Lorenzo and to explore, whether a flag for abnormal results could be added to the system to prompt review. • For NICE Guideline NG177 to be revisited for baseline compliance review/audit to ensure NICE recommendations are taken into account when deciding what treatments are offered to patients ensuring that the care provided is based on best evidence available. For all patients to receive harm free care and to be informed on the side effects of medications and any risks of ototoxicity and nephrotoxicity • For a Patient information leaflet to be developed to give to patients who may receive prolonged courses (i.e. >5days) or repeated courses of aminoglycoside therapy on the side effects of aminoglycosides and to raise awareness of what patient's should look out for. • For baseline audiometry to be undertaken prior to prescribing/administering aminoglycosides to patients who are planned to have a prolonged course (>5days) (such as Cystic Fibrosis & bronchiectasis patients, tuberculosis (TB) treatment and endocarditis (this is already undertaken for other patient groups when the drug cisplatin is administered).

STEIS Ref	Areas for improvement/safety actions
2024 4072	• Develop and publish on Bridget (the Trust intranet where clinical guidelines are held) a Humber Health Partnership Iron Deficiency Anaemia pathway • Radiology team will discuss in Radiology Event And Learning Meeting (REALM) and disseminate learning points • Explore use of an electronic system to enable teams to monitor and chase outpatient requests
2024 4358	• Increase awareness of the HOBs SOP as the standard operating policy was not followed. • Ensure clear communication between specialities. • Increase the walk around of Consultants/Registrars in the Resus area. • To ensure blood results are reviewed on Lorenzo by a Medic without relying on a system prompt; as a part of the clinical handover.
2024 4609	• To develop robust pathways for escalation of care or alteration of parent specialties if face to face ward reviews are not possible • To update VTE policy to include treatment options for the management of submassive pulmonary embolism, including most appropriate ward / specialty where the patient would receive optimal treatment e.g. respiratory medicine. • For an improvement in accuracy / responsiveness of fluid balance recording; to consider removing four hourly fluid balance chart option from Nerve Centre • For an article to be published in the Patient Safety Bulletin to highlight the importance of accurate fluid balance recording and the reset issue
2024 5004	• To ensure the original ReSPECT document when completed is given to patients; and a copy is scanned onto Lorenzo. This it to ensure that the patient's wishes are followed when the need arises/they are at end-of-life care to ensure they have the experience that they requested. • To ensure blood tests are interpreted correctly to ensure clinical decision making; the procurement of a new lab IT system will help achieve this. • For all blood gas results to be available on the electronic system to inform decision making and safe patient care.

STEIS Ref	Areas for improvement/safety actions
2024 7521	• Raised awareness of increased risk in procedures with increased complexity by sharing learning in patient safety bulletin • For Scan4Safety to be used across all Humber Health Partnership Sites to mitigate the risk of incorrect implants/equipment being used • To mitigate the risk of mis-selection of implants until Scan4Safety go live o Procedure and implant to be written on the scrub board and checked with the operating list and patient consent form. o To have the correct sided implants in a variety of sizes on a trolley in the operating theatre prior to the start of the procedure so they can be checked with the surgeons prior to the procedure commencing • For details of implant – side, size, width – to be read out loudly when being checked so that all in the room can hear and laterality checked against the consent form and operating list.
2024 1643	• To prevent the risk to patient safety there is a requirement for a standard consistent approach to the perioperative management of patients with diabetes. To ensure that no insulin-treated patient leaves theatre without glucose potassium insulin (GKI) or glucose insulin (GI) being administered; all patients must continue to remain connected to the glucose potassium insulin (GKI) or glucose insulin (GI) infusion as they leave theatre. If the Anaesthetist deems for safety reasons that the GKI or GI needs to be discontinued in theatre, the Anaesthetist will need to create an alternative plan for the operative phase after which the GKI or GI must be resumed prior to sending the patient to PACU. • For a perioperative booklet for staff for the management of insulin infusions to be introduced to ensure standardisation of care in theatres. • Anaesthetic department and diabetes department develop an audit to ensure compliance with the guidelines for diabetes management. • Education and process of handover in PACU to be improved; retention of the anaesthetic chart and care plans • To improve the identification and management of non-improvement in a deteriorating patient. • To improve insulin safety within the Trust and to reduce the number of patients coming to harm as a result of poor or mismanagement of diabetes by ensuring correct practices and guidelines are in place.

STEIS Ref	Areas for improvement/safety actions
	• The development of a Diabetes Technology policy for inpatients using insulin pumps and sensors to help guide staff caring for patients using such devices. • The development of a perioperative diabetes pathway to standardise care regarding intravenous insulin infusions in the perioperative period.
2024 2054	• Safe prescribing of anticoagulants in patients with CKD to be undertaken alongside individual needs and collaboration amongst MDT specialists, • Focused delivery of education to be completed with medical staff including rotational resident doctors relating to anticoagulation, regularity of coagulation blood tests and the importance of documentation to outlining the balance of risk to patients when the decision is made to administer medication or not • Improve Trust compliance against VTE risk assessments to reduce the risk of adverse events • Adherence to policy on testing of coagulation related blood tests in the presence of CKD and infection • Article to be produced for Trust wide Patient Safety Bulletin to clearly highlight the risk of bleeding in patients with CKD and the importance of assessment and reassessment. The article needs to include the importance of anticoagulant selection and correcting clotting abnormalities

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)239

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11th December 2025
Director Lead	Helen Wright / Gill Ponder, Non-Executive Directors / Chairs of Performance, Education and Finance Committees-In-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Tuesday 30th September and Tuesday 04th November 2025.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Performance, Estates and Finance Committees-in-Common on 04th November and 02nd December 2025.
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 30th September 2025 at 09:00 to 12:30 hours in The Boardroom, Castle Hill Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director (HUTH) – Chair
Gill Ponder	Non-Executive Director (NLaG)
Peter Sedman	Group Deputy Chief Medical Officer
Simon Parkes	Non-Executive Director (NLaG)
Sarah Tedford	Interim Group Chief Delivery Officer
Jane Hawkard	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Financial Officer

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance - (Virtual)
Ivan McConnell	Group Director of Transformation
Philippa Russell	Deputy Director of Finance
Tom Myers	Group Director of Estates
Chris Fry	Associate Director of Performance (attending for Adam Creeggan, item 4.3) – (Virtual)
Jeevan Gill	Director of Operational Transformation (item 4.4) – (Virtual)
Bill Parkinson	Associate Director of Safety & Statutory Compliance (item 4.5.1) – (Virtual)

Observers

Ian Reekie	Lead Public Governor (NLaG)
Katie Shepherd	Head of Quality Compliance and Risk (NLaG) – (Virtual)

KEY

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Helen Wright, welcomed those present to the meeting. Apologies for absence were noted for Dr Kate Wood, Group Chief Medical Officer, and Adam Creeggan, Group Director of Performance.

1.2 Staff Charter and Values

Helen Wright noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 02 September 2025 and Private Minutes from 02 September 2025

The minutes of the meeting held on 02 September 2025 and private minutes from 02 September 2025 were accepted as a true and accurate record.

1.5 Matters Arising

No items were raised.

1.6 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
4.5.2	Contract Approval: Smile Contract to run Health Tree Foundation (HTF)	Emma Sayner to provide a verbal update on progress of Charitable Funds and the Smile Contract.	**The Smile Contract was extended to June 2026 and a procurement exercise was underway. Action closed.**
3.1	CQC Actions Report – Group	Leah Coneyworth to pick up the Estates issues with Tom Myers outside of this meeting.	**An ED walkaround took place. A flooring infection control risk was outstanding and the Group were reviewing mitigations for Summer 2026. Action closed.**
3.1	Board Assurance Framework to include Risk Register Report	David Sharif to review and update the timing and sequence of Board Assurance Framework to align with CiC and	**An analysis was conducted and there were no immediate concerns identified. The BAF Framework timing**

		Board-in-Common meetings.	**and sequence would remain the same. Action closed.**
3.1	Board Assurance Framework to include Risk Register Report	David Sharif to ensure responsible action owners are providing updates on the BAF actions.	**It was determined through Executive Director meetings that BAF action owners were aware of the elements they held ownership of. Action closed.**
3.1	Board Assurance Framework to include Risk Register Report	Philippa Russell to discuss the tolerable risk score on page 6 with Emma Sayner and determine whether the score needs adjusting.	**Confirmed with Emma Sayner that the tolerable risk score should be amended to 12 (L3 x C4). Action closed.**
4.1	Winter Plan 2025/26	Helen Wright to refer to WEC CiC around how much effort should go into pushing vaccination in order to reduce staff absence.	**Helen Wright referred to WEC CiC. Action closed.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.2 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Annual Business Plan – Timetable Approval (Operational & Financial) including CIP

Emma Sayner apologised for a typing error on the first page of the report and clarified that the date was August 2025. The Group were working with NHSE colleagues from a multidisciplinary perspective on the requirements for complying

with operational planning requirements before Christmas 2025. She shared that from an immediate response perspective, the Group were in a positive position by having a programme that would see them into the medium term. Sarah Tedford mentioned that the Group met with Operations Directors last week to devise a template which was agreed with all specialties across the Group. There was a comprehensive approach to ensure the Group understood what was required to be delivered and that adequate support was in place. The ongoing work around trajectories would be crucial to support this.

Gill Ponder noted a statement on page 6 which alluded to 'working with NHSE to assess the impact of rebasing fixed payments', and she queried whether it posed a significant risk to the Group. Emma Sayner shared that significant work was in place to review activity being delivered for the level of income received across the Group. Challenges around coding, the approach to costing and service line reporting were noted as they were not delivering the levels of activity in proportion to the level of income. NHSE were mindful of inconsistencies with how Organisations across the country undertake this work, however they would not use this information to de-stabilise Organisations. The tertiary nature of HUTH presented a challenge as income levels for tertiary services appeared unusual in comparison to activity and delivery.

Gill Ponder shared surprise that the planning process did not mention that the workforce plan would be presented to the Workforce, Education and Culture CiC for scrutiny. Chris Fry shared that it was assumed that the workforce plan would be presented to WEC CiC for scrutiny as the workforce team were heavily involved in the planning process.

Simon Parkes recognised that the Group had plans in place that were expected to be delivered and wondered why they were involved in a process which may result in replicating work that was already being undertaken. Ivan McConnell shared that several corporate templates required completion, and this could only be done by fully integrating the strategic workforce plans. Chris Fry shared that delivering a planning cycle three months earlier than usual and forecasting that over a five-year period provided an additional challenge, however it also provided an opportunity to re-engage with the data and think about how it relates to the strategic plans within the Group.

Sarah Tedford noted that the Group did not understand their services well enough and it was crucial to tackle known challenges and develop clear plans for the Group to build on over the next five years.

4.2 Group Finance Report: Month 5

Emma Sayner updated that there was a significant focus seen internally from a finance point of view and greater focused attention from the Care Groups which was seen in the improved numbers in month 5. The deterioration in expenditure and run rate numbers had reduced in comparison to month 4. Variance to plan had stabilised and the Group delivered £14 million deficit against a plan of £11 million deficit. Run rate numbers forecast had reduced significantly from £40 million to £32 million and the adjusted run rate had reduced marginally. She

recognised that although improvement was seen, the Group had a long way to go and had recognised all the non-recurrent technical flexibility in the YTD position which makes delivery in the second half of the year even more challenging.

A new process was implemented around how the Group sign-off variable pay, including double pay initiatives, WLIs (Waiting List Initiatives), and use of long-term Agency. The Executive team meet weekly to review the granular level of the proposals put forward.

An NHSE-led mid-year review was due to take place, with a date yet to be confirmed. The Group expected that Sir Jim Mackey may hold the mid-year review due to the level of scrutiny the Group were currently under. Positive feedback was received across Humber and North Yorkshire regarding the RONDA rating, the overall assessment was devised by a number of metrics around risk, pay levels and grip and control mechanisms. The regional team recommended that the system receive deficit support funding during Q3 which would represent receipt of c£6 million and was significant from a revenue and cash point of view.

It was raised that the ongoing organisational changes at senior leadership level within the Group presented a potential significant challenge in delivering the financial plan due to the changing approaches on how the Group undertake business/decisions. This was being raised and taken forward with and by Lyn Simpson.

Simon Parkes raised concerns that the Group were at risk of putting the rights of individuals above the impact of a significant number of patients.

Action: The CiC agreed to escalate the need for prompt decision making to the Boards-in-Common as a private matter.

Philippa Russell shared concerns that delays in decision making would impact financial opportunities. The CIP (Cost Improvement Plan) had significantly improved by £10 million in comparison to month 4. Schemes that were not delivered in 2025 would be required to be delivered in 2026.

Simon Parkes recognised an improvement in the balance between recurrent and non-recurrent savings initiatives. He noted that risks were still present and the Group needed to understand which decisions were not being taken.

Emma Sayner updated that the most significant challenges on the difficult decisions list were linked to Workforce, and five business cases would be presented to Boards-in-Common in October 2025.

Helen Wright asked for an update regarding Capital expenditure. Tom Myers shared that the Group had seen a significant increase in the activity of orders however there was outstanding 2024/25 work required to be delivered and paid for in 2025/26. Discussions were taking place to support pushing through constitutional standards funding.

Emma Sayner noted that a significant Capital challenge was in relation to the EPR (Electronic Patient Record), and Andy Haywood was leading conversations with NHSE England to address this. The Group were looking to broker circa £16 million between 2025/26 and 2026/27. NHSE confirmed there would be no facility to broker that money, however they were providing support with speeding up the sign-off of the business case to enable the Group to make cash payments appropriately in 2025/26 to help mitigate that.

Helen Wright queried whether there was anything that could be done regarding increasing creditors given the impact of this reduction on the cash position. Philippa Russell shared that various protocols were in place which could be utilised to manage cash and explained that the Group had not changed their approach to cash; this was simply a phasing issue.
Emma Sayner shared that significant work was underway to standardise across the Group and tidy up the balance sheet at HUTH. The Group expected to see the working Capital implications of that work in due course.

4.2.1 Update on Transformation Programme

Ivan McConnell highlighted that the risk adjusted forecast was currently £105 million with an unidentified gap of £15 million. A collective discussion was required to aid in making decisions that would help bridge the gap. Intensive support was put in place for the red RAG-rated Care Groups and recovery plans were provided, with one recovery plan still outstanding however that was due this week. WLI data would be analysed by the top 20 Consultants. He emphasised that it was instrumental to carry this work out sensitively. Between months 1 to 5, HUTH spent £5.5 million on WLIs and NLaG spent £2.1 million. The Group expected a year-end of £18.5 million, assuming a straight run rate. Acute and Emergency Medicine spent £1.1 million on WLIs and £2.2 million on Agency. Family Services spent £1 million on WLIs and £895k on Agency, however a significant proportion of that was bad cost, and flipping the bad cost to good cost would have a significant impact. Agency spend across the Care Groups was £5.4 million at HUTH and £2.6 million at NLaG. Efforts were underway across the Group to improve stock control however NLaG did not have a materials management process in place therefore this was being reviewed via a manual process. Challenges with materials would be addressed through this work. Work was ongoing with a pharmacy technician to improve the control and management of medicines. There was a focus on improving recurrent savings and reducing non-recurrent savings. Ivan McConnell highlighted that the risk profile and position was changing.

Gill Ponder mentioned the extra support that was provided for Care Groups and wondered whether there was evidence that the support in place was yielding positive results. Ivan McConnell shared that a review was undertaken in Q1 to RAG-rate all the Care Groups and the presentation showed the Month 4 and Month 5 positions. The Group would re-run this process in October 2025 and all Care Groups would be required to answer a specific set of questions regarding their performance.

Gill Ponder highlighted the £47 million risk within the actions required to achieve a planned break-even position, noting that they were significant requirements. Ivan McConnell explained that although plans in total were not present, actions were in place. Emma Sayner mentioned that putting actions in place to deliver £105 million was the right approach.

Action: Ivan McConnell and Emma Sayner to present a full recovery plan outlining the offsets to achieve the committed full year position in the next report.

Gill Ponder mentioned that Pathology Service performance was a contributory factor to not meeting cancer targets and she hoped that performance was included in the discussions that were taking place. Sarah Tedford explained that performance was discussed within the contracting meetings.

4.2.2 Costing & Benchmarking

Emma Sayner took the paper as read and explained that the submission was made in July 2025 and was determined to be an acceptable submission for both Organisations. The Group were aware of areas of development that were required to be undertaken. The 2023/24 National Cost Collection data submission showed an improved index of 86 against a target of 100 at HUTH, and an index of 103 at NLaG which was an improvement since the previous years' index of 106. The Group were awaiting the formal 2024/25 report from NHSE and it would be shared with the CiC once available. The first part of benchmarking work was undertaken alongside Logex (the Group's Costing System Provider). Further benchmarking work was undertaken to compare performance against other Logex providers. A granular level of variation was seen which would be reviewed further and was expected to support sustainable opportunities for the Group. Work would take place to review utilisation of e-roster, job planning and scan for safety systems within Theatres. Work was required to be carried out around the available data being used in Critical Care to make the submission. There was a significant challenge nationally regarding comprehension of the data around community, mental health and primary care led services. There was a challenge structurally around the contrast in the quantity and costs of ED departments across the Group, as some Trusts only had one ED, whereas others had more which increased costs.

Gill Ponder queried when the CiC would expect to see the output and actions that were taken as a result. Emma Sayner explained that the first draft of the benchmarking information for both Organisations was obtained from Logex comparators and provided in the report, however the formal submission report from NHSE was awaited which would provide further detail of the benchmarking.

The Committees-in-Common agreed limited assurance, however for the first time they were seeing signs that the grip and control put in place by the Executive Team was starting to deliver results. Improvements were seen in the run rate, Care Group performance and visibility. Grip and control in many areas had improved however concerns were raised that the Group were delaying difficult decisions due to ongoing changes in the senior leadership team.

4.3 **Group Performance Report**

Chris Fry took the report as read and provided an update.

RTT

There was significant deterioration seen in the 52-week compliance for August 2025, particularly in HUTH. As per the national oversight framework, the performance percentage for the Group was around 3.6% against a target of 1% by the end of 2025/26. The percentage at HUTH was 4% and NLaG was 2.6%. A reduction was seen in RTT compliance for patients under 18-weeks. A key driver was the ongoing validation sprint work which saw a significant number of patients removed from the 0-18 week waiting list. A reduction in the waiting list and referrals had been seen at NLaG. Paediatrics and ADHD services were significantly challenged areas due to access to outpatient service. There was a significant volume of breaches seen in ENT and Dermatology at HUTH due to outpatient capacity. A deterioration was seen in ENT 18-week performance at NLaG.

Chris Fry mentioned that Luna Rova uses AI (Artificial Intelligence) to review the detail of letters and how they associate to patients on RTT pathways. It was expected that the impact of that would free up the validation resource and the Group expected to see a clearer PTL (Patient Tracking List).

Sarah Tedford shared that the Group were working towards achieving 0 patients over 65-weeks by the end of December 2025 and a clear plan was in place. A business case would be presented to Group Executive requesting external support for ADHD services. She highlighted that financial support was considered and the ADHD service would return to the care of the ICB in March 2026 due to the Group not having the resource to provide that service.

Gill Ponder noted the Group continued to offer unreasonable dates to patients which were declined and recorded as a patient choice breach. She asked when the Group would offer appointments that were in line with the Group access policy. Sarah Tedford shared that work was ongoing around outpatients, and in the meantime the intensive support team were due to join the Group on 08 and 09 October 2025 to review the Group systems and processes in place.

Gill Ponder mentioned extra patients that were added to lists at NLaG below 85% capped utilisation and wondered whether an analysis was undertaken to determine whether there was correlation between the addition of extra patients and cancellations on the day. Sarah Tedford explained that there was a range of reasons why patients were being cancelled however it was not due to running out of time and clarified that data revealed that lists were finishing early and work was ongoing to ensure lists were utilised adequately.

Jane Hawkard queried the reason for the delay on Luna Rova. Chris Fry explained that the reason for the delay was due to MBI Health's inability to access patient letter data which was significant to the tool. The Digital team were working to mitigate the delivery of letter meta data to MBI Health by the end of

March 2026. The CiC highlighted that they were previously told a deadline of December 2025 for implementation of Luna Rova.

Action: Further work to take place with the Performance team and MBI Health around commencing Luna Rova for a deadline date of December 2025.

Diagnostics

A worsening position was seen for 6-week waits. HUTH performance was 32.4% which had deteriorated by 6.2% and NLaG performance was 38.7% which had deteriorated by 3.6%. Areas impacted were endoscopies, radiology imaging and echocardiography, however plans were in place for echo and recovery was expected. A constriction of elective activity was a key driver to lower activity seen in August 2025. Non-elective imaging and scoping was prioritised due to high demand. Work was underway regarding utilisation of the waiting list and booking profiles to bring elective patients forward, particularly those on Cancer pathways.

Gill Ponder noted the concerning deterioration in diagnostic performance that was taking place monthly. Implementation of CDCs was supposed to increase capacity and reduce waiting times however she struggled to see how the Group would achieve improvement and delivery of a better service to patients. Sarah Tedford shared that CDCs were nowhere near full-capacity and a senior manager was identified to oversee and optimise the capacity, working alongside GPs to ensure improved activity. Improvement was expected to be seen over the next few months.

Helen Wright queried whether the challenge around annual leave that was prevalent in previous Summers was resolved. Sarah Tedford confirmed that the challenge around annual leave was still present and further work was required to address this. This issue is being handled by the WEC CIC.

Cancer

Improvement was seen in the 62-day performance in July 2025, particularly at HUTH by 7.2%, NLaG saw an improvement of 1%. The 28-day FDS (faster diagnosis standard) was a significant challenge and a deterioration was seen at HUTH. The unvalidated position for August 2025 at NLaG was significantly high. Breast was a key area of concern for HUTH, and endoscopy and imaging contributed to delays across the Group. Sarah Tedford shared that a deterioration in the 28-day FDS position was expected, and work was underway to clear the backlog of patients.

Bill Parkinson joined the meeting at 11:32 hours.

Jane Hawkard queried the reason for the 7.2% improvement in the 62-day performance. Sarah Tedford mentioned that an increase in patients being treated and a now resolved challenge around the calculation of consultant pay rates contributed to the improvement.

ED

An improvement was seen in the 4-hour standard performance, particularly at HUTH which was 61.9%. The percentage of patients waiting 12-hours in ED had improved. Ambulance handover times had improved across the Group, HUTH saw an average handover time of 21 minutes and an average handover time of 31 minutes was seen at NLaG.

Gill Ponder mentioned that it was hard to determine why the Group were not improving performance quicker, considering that attendances were below plan for type-1 and type-3 across the Group. Chris Fry shared that the predominant area that contributed to performance challenges was non-admitted breaches. Challenges were ongoing with UTC availability particularly overnight and further discussions were required to address this.

Jeevan Gill joined the meeting at 11:42 hours.

Sarah Tedford shared that positive feedback was provided following the recent CQC visit. They felt that ED had made improvements and praised the ability to identify deteriorating patients and the greater grip and control. The Group were working with CHCP (City Health Care Partnership) to see if they could increase the opening times for UTC which would be a significant benefit going forward. ENT was under significant pressure from an RTT and cancer perspective. Work had commenced to review outpatient activity which identified that a magnitude of ENT patients required both an Audiology and ENT appointment. An initiative was commenced from June 2025 to separate ENT and Audiology patients and through this work the Group reduced the waiting time to 30-weeks and reduced the waiting list down from 1300 to 749 patients. Work was underway with Matt Rutter at NHSE to reduce the volume of endoscopies and scopes significantly. This work was expected to take a few months.

David Sharif left the meeting at 11:45 hours.

Gill Ponder mentioned that she was concerned that the CiC do not review performance through the lens of health inequalities and that it was not on the workplan.

This would be considered for the 2026 workplan.

The Committees-In-Common agreed limited assurance, noting the RTT waiting list had reduced however the Group were not addressing in chronological order which resulted in breaches and deterioration on 52-week waits. Diagnostics deterioration was seen. Cancer improvement on 62-day performance and expecting deterioration on 28 days due to not optimising backlogs. Urgent care had seen improvement in 4-hour performance. Concerns remained on non-admitted breaches and HUTH ED. Improvements were seen through the CQC visit.

4.4 Urgent Emergency Care Improvement Length of Stay and Bed Modelling Deep Dive

Sarah Tedford updated that the ability to provide meaningful data around beds and bed management was hindered due to manual work and teletracking would provide significant support to ensure efficiencies around bed management.

Jeevan Gill shared that bed modelling work was ongoing with a focus on whether Care Groups had enough inpatient facilities and capacity that was required from a planned and unplanned perspective, ensuring involvement of individual Care Groups so they understood the demand. The model currently focused on the North Bank, and work on the South Bank would be undertaken in due course. A comprehensive UEC programme plan was devised, and the Group reported to NHSE on a fortnightly basis. The plan focused on improving flow, working closely with ECIST to review ward and board rounds. A short stay ward was opened at HRI in June 2025 which had resulted in a reduction in length of stay from 7 days to 4 days. In August 2025, 22 beds for NCTR (No Criteria To Reside) patients were closed on the 13th Floor. Work was ongoing with CHCP on a daily basis to further reduce the number of NCTR patients.

Gill Ponder questioned whether there was anything that the CiC could do to speed up the bed roll-out to other wards and sites. Sarah Tedford explained that clinical engagement was a challenge and the Group would require greater planning around patient management. Work was ongoing to move patients from ED to specialty wards. The biggest challenge was around the medical patients and patients delayed coming out of ED. Efforts were underway to encourage specialists to participate in a General Medical rota. The Group were currently out to consultation and Nick Cross, Anwer Qureshi and Ben Davidson were leading on that work.

Jane Hawkard queried the rationale behind a short stay ward. Sarah Tedford clarified the rationale behind a short stay ward was to have clear pathways and quick turnarounds for treating and discharging patients. Peter Sedman noted that there was not enough Consultant support at the weekends. Simon Parkes raised concerns that it was not acceptable for the Group to stop functions working out of hours. Sarah Tedford noted that running a 5-day service gave rise to significant pressure on the weekend. It was determined that this was a national challenge and Organisations could not operate without senior people during the weekends.

Jeevan Gill left the meeting at 12:02 hours.

The Committees-In-Common agreed limited assurance, noting improved performance however there were too many patients in beds and insufficient tracking around bed management.

4.5 Directorate of Estates, Facilities and Development Update (including HRI Tower Block Update)

Tom Myers updated that there were four high risks on the risk register for HUTH, three were carried across, and one additional risk was in relation to the Tower Block. There had been a steady period of time with all lifts operating in the Tower Block. Funding was in place to invest in two service lifts and this was currently out to tender. Upgrades to theatres were ongoing which would support the critical

ventilation systems. Decant challenges continued although progress was seen at HRI due to the closure of the 13th floor. There were six high risks currently at NLaG, no new risks were added and one risk was closed around the Ageing-Diesel Powered Generator as it was replaced. Regular upgrades were undertaken for electrical works and Estates Safety Funding would support additional electrical work that was required. A significant volume of the electrical works would be undertaken at SGH (Scunthorpe General Hospital) through the PSDS works. The primary heat source risk would be closed following the conclusion of PSDS works. Flat roof works were underway, six areas would be replaced and the risk would be assessed following that work. Critical heating, ventilation and air conditioning was an ongoing risk, areas were replaced around SGH and DPoW (Diana, Princess of Wales Hospital), the impact on Goole theatres would be reviewed. A decant facility was implemented due to the CPE situation. Retail Catering was out to expressions of interest on the North Bank, discussions had taken place with suppliers and the Group continued to advocate for inhouse services. There were concerns around the length of time in terms of procurement for cleaning. Work was ongoing to pull together options and further information would be presented in October. Car parking continued to be a challenge, patient and visitor parking charges were uplifted to align with the South Bank. Staff parking charges were currently held and would be reviewed in early 2026. The risk around accommodation of property was ongoing and an update would be provided in December 2025. A decision was required to be made by the end of 2025 around whether to extend the Decontamination Contract.

The Committees-In-Common agreed significant assurance, noting schemes being worked up and ongoing progress, decant opportunities for HRI as a result of 13th floor closure. The Tower Block risk, ensuring that risks were fully documented and liaison with Humber Fire and Rescue Service. The need to balance fire risk with patient safety risk which may require CEO influence.

4.5.1 Security / LSMS Annual Report & Work Plan

Bill Parkinson took the report as read and shared that there were differences in the structure of security management across the Group. A recruitment process was ongoing and the Group were out to recruitment to secure a local security management specialist with the aim of replicating the process that takes place on the South Bank across to the North Bank. A number of patient watches were identified and inconsistencies were seen as it seemed prevalent on the North Bank rather than the South Bank. Work was ongoing to address this. Crime statistics were equal across the Group. Lone working devices were being reviewed and work was underway to identify device usage and recall devices that were not being utilised. The Group were still awaiting detailed guidance on the enactment of Martyn's Law (Counter-Terrorism), they expected to enter the enhanced Tier-4 which would require a designated senior individual and involve legal responsibilities and criminal sanctions. The training requirements was currently the biggest unknown factor as every person across the Group would require training, the Group were awaiting guidance which would provide a sense of direction. The workplan had undergone its quarterly review and was updated. Any updates on the workplan were reported to the Safe Security Committees.

Bill Parkinson left the meeting at 12:24 hours.

The Committees-in-Common endorsed the report for Boards-in-Common approval. Noting additional work that was required in relation to Martyn's Law, ensuring a SRO (Senior Responsible Owner) and adequate training in place.

4.6 Contract Approvals

None to note.

4.7 NHSE Self-Assessment on Provider Capability

The CiC would be updated outside of this meeting.

4.8 Emerging Issues

Nothing to raise.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Planned Care Board Meeting Minutes

This was shared for information.

5.3 Unplanned Care Board Draft Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Emma Sayner noted that a discussion had taken place with Lyn Simpson regarding the ongoing status of the financial strategy and Lyn Simpson had provided further direction on how to approach the financial strategy. Emma Sayner would bring this to the next meeting in November 2025.

The CiC thanked Sarah Tedford for the positive influence and impact she had on the Organisation and wished her the best for the future.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

Action: Helen Wright to refer to Workforce, Education and Culture CiC, to review whether operational demands can be met by current workforce arrangements that are currently five days.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

The next meeting will take place on Tuesday 04th November in the Boardroom, Diana, Princess of Wales Hospital, Grimsby.

The meeting closed at 12:30 hours.

Cumulative Record of Attendance at PEF CiC 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug 05/08 07/08	Sep 02/09	Oct 30/09	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	D 02/09	Y 30/09		
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08 N 07/08	N 02/09	Y 30/09		
Clive Walsh	Interim Site Chief Executive North		D	Y	Y	D	D						

Sarah Tedford	Interim Group Chief Delivery Officer		Y	D	D	Y	Y	Y	Y 05/08 D 07/08	Y 02/09	Y 30/09		
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	D 30/09		
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Andy Haywood	Group Digital Information Officer		N	N	N	N	N	N	N 05/08 N 07/08	N 02/09	N 30/09		
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09		
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09		

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 4th November 2025 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) – Chair
Helen Wright	Non-Executive Director (HUTH)
Matt Powls	Interim Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Dr Kate Wood	Group Chief Medical Officer
Julie Beilby	Non-Executive Director (NLaG) (attending for Jane Hawkard and Simon Parkes)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Director of Transformation
Philippa Russell	Deputy Group Chief Finance Officer
Adam Creeggan	Group Director of Performance
Tom Myers	Group Director of Estates
Leah Coneyworth	Head of Quality Compliance and Risk (HUTH)
Scott Fitzgerald-Becker	Director of Operational Transformational (North)

Observers

Ian Reekie	Lead Public Governor (NLaG)
Katie Shepherd	Head of Quality Compliance and Risk (NLaG)
Jenny Sharp	Deputy Director of Operational Finance (NHSE)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. Apologies for absence were noted for Jane Hawkard, Non-Executive Director (HUTH), and Simon Parkes, Non-Executive Director (NLaG).

1.2 Staff Charter and Values

Gill Ponder noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 30 September 2025 and Private Minutes from 30 September 2025

The minutes of the meeting held on 30 September 2025 and private minutes from 30 September 2025 were accepted as a true and accurate record.

1.5 Matters Arising

No items were raised.

1.6 Review of Effectiveness

David Sharif mentioned that the Group conduct an annual Effectiveness review across the Committees-in-Common, drawing the survey from the NHS audit handbook. A link to the survey would be circulated to the CiC members outside of this meeting and the results of the Effectiveness review would be presented at the next meeting.

1.7 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
5.1	Work Plan for PEF CiC	Helen Wright and Gill Ponder to review Deep Dives on the Workplan in relation to diagnostics and trajectories.	**Detailed trajectory numbers would be presented to future meetings, including remedial action plans, steps to take and timelines to recover off-track performance. Action closed.**

7.1	Matters to be Referred to other Board Committees	The limited assurance on CIP to be considered and reviewed by Boards-in-Common.	**This was discussed at the Private Boards-in-Common on 09 October 2025. Action closed.**
4.2.1	Update on Transformation Programme	Ivan McConnell and Emma Sayner to present a full recovery plan outlining the offsets to achieve the committed full year position in the next report.	**Update provided within Transformation Programme report. Action closed.**
4.3	Group Performance Report	Further work to take place with the Performance team and MBI Health around commencing Luna Rova for a deadline date of December 2025.	**An in-house solution was currently being tested to import letters from Lorenzo into the MBI product. A further meeting would take place and providing that the outcome was positive, the Group would expect to be on track to commence in December 2025. Action closed.**
7.1	Matters to be Referred to other Board Committees	Helen Wright to refer to Workforce, Education and Culture CiC, to review whether operational demands can be met by current workforce arrangements that are currently five days.	**Helen Wright referred for discussion at WEC CiC. Action closed.**
4.2	Group Finance Report: Month 5	The CiC agreed to escalate the need for prompt decision making to the Boards-in-Common as a private matter.	**Escalated within the Highlight report to the Boards-in-Common in October 2025. Action closed.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

The Agenda was taken out of order at this point.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Unplanned Care Board Draft Meeting Minutes

This was shared for information.

Dr Kate Wood shared that she was now the Chair of the Unplanned Care Board meeting and work was underway to refresh the alignment of the meeting.

3. RISK & ASSURANCE

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.1 CQC Actions Report

The Agenda returned to the correct order.

Leah Coneyworth updated that the 2 HUTH actions that were open in the previous update were now closed. Two green-rated actions remained open at NLaG. One of those actions related to the End of Life (EOL) dashboard which was quality-tested and the Group expected that action to progress for closure in November 2025. The second action related to the clinical and financial strategies. The clinical strategy was approved in September 2025 and the Care Group delivery plans were on track to be delivered by March 2026.

Emma Sayner mentioned that a draft version of the financial strategy was shared alongside the finance report for today's meeting. Discussions would take place with Lyn Simpson to organise a workshop-style event in 2025 with the aim of progressing the financial strategy.

The Committees-in-Common were satisfied with the significant progress that was made since the previous report.

Tom Myers joined the meeting at 09:10 hours.
Leah Coneyworth and Katie Shepherd left the meeting at 09:12 hours.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Finance Report: Month 6 (including Finance Strategy)

Emma Sayner updated that significant work was underway. The Group received mainly positive feedback from the mid-year review however, significant concern remained regarding the ability to deliver and the level of risk across the Group from both a financial and constitutional standards perspective. Concerns were raised regarding patient safety and quality challenges that the Group currently faced. The finance team produced a best-case, worst-case, and likely-case forecast and the Group were still forecasting to deliver the financial plan. The best-case scenario for the Group was delivering the breakeven position, a likely-case scenario would indicate a deficit position of £35 million, if the run rate continued to worsen, and the worst-case scenario for the Group would be an adjusted £50 million. A deterioration of £300k was seen in month 6. No additional financial support would be available to the Group to deliver the constitutional standards performance, and it was crucial for the Group to make savings in other areas. Intense recovery meetings had taken place with the Care Groups and while some Care Groups were confident in their approach, others required further intensive support. A fully dedicated Finance Planning Improvement Board meeting took place on 27 October 2025 to review current positions with the Care Groups, which identified some services that would require further and firmer action to achieve delivery of the recovery position.

Pay Spend continued to be a significant concern as growth was seen in substantive cost, Bank, Agency and WLIs (Waiting List Initiatives). Emma Sayner explained that as one area of spend increases, the Group would expect to see another area compensate however, this was not the case and further work would take place to determine the key drivers for this. Data Quality concerns were raised regarding how the Group were tracking Agency Spend following a change in supplier and work was ongoing to determine whether there was a potential contributing factor to the declining position. A newly established Senior Leadership Team (SLT) meeting was taking place fortnightly which was attended by Chiefs of Service (CoS) and Group Executives, to review clinical engagement and challenges the Group faced. Ivan McConnell would present a paper regarding extra-contractual payments to the SLT meeting which was due to be held on 04 November 2025.

Philippa Russell updated that the Group reported an in-month deficit of £1.9 million, with a £0.3 million adverse variance to plan. The year-to-date deficit was £16 million, with a £3.3 million adverse variance to plan and included £11 million of non-recurrent support. The challenge for Q3 and Q4 had further increased due to slower than expected performance in progressing the Cost Improvement Plan (CIP) target. The year-to-date CIP delivery of £7.8 million was behind target. There was an increase in the profiling of CIP as the Group approached Q3 and Q4 and the Group would also be expected to recover the overspend year-to-date. There was a risk of £4.5 million of additional spend to enable the Group to deliver the constitutional standards. Significant work was underway to determine those plans however, it was likely to include Independent Sector spend that was not

factored into the forecast. She acknowledged that the Group would scrutinise on every element prior to authorising to ensure value for money and justified expenditure.

The income that the Group received from the Integrated Care System (ICS) to support IPT referrals was likely to be claimed back due to referrals that the Group made in 2024 and 2023, which provided a significant £2 million risk and discussions would take place with ICS colleagues regarding liability for these costs. Positive progress was made regarding the 72% delivery of CIP plans however, there was £15.5 million of unidentified CIP which was the greatest challenge for Q3 and Q4. An increase was seen in the amount spent on high-cost drugs and devices within the Group's block contract with the ICS. The adjusted forecast for the Group was £48 million which was an increase of £8 million in comparison to the previous month. The Group were likely to require cash support in Q4 unless they could significantly improve the position.

Gill Ponder queried whether the grip and control measures put into place with the Care Groups were working and whether they were stringent enough to bring the Agency Spend position back under control.
Emma Sayner explained that measures put into place with the Care Groups were not translating to the level that was required, and further work would take place to enhance restrictions on spending capability.

Helen Wright queried whether people were aware internally of the deficit and adverse positions, and whether communications were being shared in a robust way across the Group. Emma Sayner clarified that communications were being shared through every opportunity. She noted the cultural reliance that the Group had on money. Interventions would be put into place to remove all ability and authority to spend money at as low a level as possible.

Helen Wright wondered how to rebalance the risks and wished to see a set of numbers outlining the risks, the available opportunities, and the confidence in delivering the financial plan.

Helen Wright raised concerns regarding the significant reduction seen on the cash graph for 2025/26, and shared that it would be helpful to see a forecast into the future of when the Group may run into problems with cash.
Philippa Russell shared that the Group expected a cash challenge in Q4 which would depend on the timing of Capital.

Gill Ponder wondered whether there were any interventions that could be put into place to get debtors to pay sooner and help alleviate the Groups cash position.
Philippa Russell explained that significant work was undertaken over the last 4-5 weeks to review any accrued income and every Care Group head of finance was being challenged regarding accrued income to ensure prompt raising of invoices. She was confident that this work would resolve most of those challenges.

Philippa Russell shared that there were outstanding income requirements from the ICS and the Group were told that they would receive income but were yet to receive it. Work was underway with system colleagues to ensure they release it.

Gill Ponder asked a question on behalf of Jane Hawkard who was not present at the meeting.

Gill Ponder queried why the Group showed a deficit position against the Elective Recovery Fund (ERF) as the Group were on a block arrangement and wondered whether there was anything further that could be done to increase income for ERF. Philippa Russell clarified that the ERF was neither a source of concern or benefit as it was for monitoring purposes only and not linked to the amount of income the Group received. She mentioned that the Group identified a Data Quality challenge regarding figures that were not aligned to the central figures used to calculate the ERF and it was assumed that £300k per month was absent from the HUTH position. Emma Sayner highlighted that there was national focus on levels of ERF activity that were being delivered. She emphasised the importance of ensuring that productivity and levels of ambition in relation to the elective activity was a key focus.

Julie Beilby raised that it was crucial to instil a different reality into the Care Groups to emphasise the importance of recurrent savings.

Gill Ponder asked a question on behalf of Jane Hawkard who was not present at the meeting.
Gill Ponder wondered whether there was a recovery plan for Capital spend and whether it could be shared with the Committees. Emma Sayner mentioned that significant work was undertaken regarding the plan for 2025/26 across the system and was happy to share that plan with the CiC at a future meeting.

4.1.1 Update on Transformation Programme

Ivan McConnell took the paper as read and provided an update. The Group were currently forecasting £114.5 million with a risk adjusted £110 million, against a £130 million target. Further significant controls would be implemented as the control environment within the Care Groups was not adequate, although some Care Groups were better than others. He recognised that behavioural and cultural challenges were ongoing, which would be monitored. North East Yorkshire (NEY) previously undertook improvement work on the South Bank in 2018/19, which had identified a £18 million structural deficit, however, the Group predicted that deficit had currently increased to £28 million, and it was expected to take time to enable the Group to undertake the substantive service changes that were required. The Group was £10.1 million below plan on CIP year-to-date delivery. Workforce spend was below plan due to extra contractual payments and Care Group CIP delivery was £4.8 million below plan. Corporate Services was £50k below plan however, forecasted surplus full-year effect which would result in a run rate deficit. Despite efforts to progress forward, 100 projects within the gateway process were behind their milestone plans which saw a £5 million risk adjusted impact, and finance colleagues were working closely with Care Groups to close the gap. Intensive support for the Care Groups would increase to twice-weekly, with a focus on CIP delivery and trajectories, extra contractual pay, agency spend and overtime spend. A review of extra contractual pay was undertaken. Data by every doctor, site, specialty, Care Group, payment and cost

would be analysed to establish where that spend was being incurred, how that spend was authorised and stringent measures would be implemented. The metrics that sit below that data will be reviewed to determine whether the Group were paying unnecessary extra contractual payments. New criteria would be implemented for authorisation of additional contractual payments and the Group would review how to utilise that and the approval processes bi-weekly.

A number of decisions were taken to improve cost management for Q3 and Q4 regarding areas of closure and reduction in Independent Sector spend. Actions were in place to improve cost management. There was a potential £8 million saving per year should the Group integrate Scarborough, Hull and York Pathology Service (SHYPS) into Path Links. Work was underway to review clinical wholly owned subsidiaries. An expansion of Goole Hospital was under consideration. A Boards-in-Common discussion was required to determine what the Group needed to stop doing.

Emma Sayner explained that flipping bad cost to good cost meant that premium spend was removed and replaced with a lower cost.

Helen Wright noted the top 15 outliers on WLI and queried what agreements were determined. Ivan McConnell explained following a review of the processes it was revealed that the processes were variable across the Group. Amendments were suggested and a discussion was due to take place to determine how to tighten that process and which metrics to use.

Helen Wright wondered whether there were any further escalations to pick up regarding changes in leadership roles and the impact that had on decision making. Emma Sayner shared that significant improvements were seen and she would undertake a further review of historical decisions taken where the expenditure had not happened yet. Work was underway to collect cases that had not yet started which would be presented to the Senior Leadership Team to determine whether they were still the right things to progress and the financial implications.

Gill Ponder wondered whether impact was seen towards the cultural challenge and the Care Groups understanding the requirement to restrain their own spending. Emma Sayner shared that there was a mixed response received from the Care Groups. Raising accountability, visibility and including Clinical Leaders in decision-making would significantly support that.

Dr Kate Wood highlighted that it was crucial to establish a robust Equality Impact Assessment (EQIA) process behind taking financial decisions and ensuring that unintended consequences to other areas were considered when reducing spending.

Emma Sayner shared that Regional and National colleagues were looking at the system as a whole regarding eligibility and the likelihood of the Group receiving Q3 deficit support funding.

The Committees-in-Common agreed limited assurance, noting the unidentified CIP gap, the forecast including significant risk and that the Group were not yet seeing the work undertaken in the Transformation Programme to improve

confidence in achieving the financial plan translate into improvements in run rates. The month 6 position had worsened in comparison to month 5 but confidence in the CIP delivery had improved. The PMO and the transformation team appeared to be doing all they could. The culture and consequence for Care Groups overspending remained a concern and there was a risk to deficit revenue and cash support funding for Q3 and Q4.

4.2 Group Performance Report

Adam Creeggan took the report as read and highlighted that the performance position was largely unchanged from the previous report, with a few areas of improvement. 2 week wait performance at NLaG and Faster Diagnosis Standard (FDS) performance had improved. Improvements were seen in diagnostic waiting times and activity (DM01) across the Group however, the Group had a long way to go in achieving the target.

The Group were currently navigating through a challenging 2026/27 planning process without the support of technical guidance, functional and non-functional templates, and clarity on the metrics around improvement. Crucial performance targets in place were achieving 78% UEC delivery, elimination of 65-week waits by Christmas 2025, moving towards 1% of patients at 52-weeks on the Patient Tracking List (PTL), and delivery of the RTT percentage compliance. Shortfall in delivery of the 78% UEC target would present a challenge moving into 2026/27. The actions in place had been effective in mitigating quality and safety concerns around UEC and predominantly focused on inpatient flow, however, were not generating the percentage change in UEC compliance that was required to deliver by year-end. A meeting would take place today with Senior Clinicians to determine the radical actions required to be taken between now and year-end to achieve delivery. Efforts were underway to determine how to rapidly assess and discharge non-admitted patients to improve compliance.

Scott Fitzgerald-Becker joined the meeting at 10:43 hours.

Helen Wright wondered how the Group were able to measure the effectiveness of different initiatives. Adam Creeggan explained that each action had an incremental and cumulative benefit. It was a challenge to differentiate what was effective and the focus should be on how the Group would decompress departments through radically changing the way of assessment and discharge of non-admitted patients.

Matt Powls shared that it was crucial to ensure which streams of work would have the greatest impacts. The Group were looking to implement a CDU over the Winter period at HUTH and discussions were taking place regarding implementing a 24/7 UTC and ICB colleagues were taking an options appraisal to their management team on 12 November 2025.

Dr Kate Wood mentioned that ECIST had moved into the GIRFT umbrella and were now known as GIRFT UEC. It was expected that this would be beneficial to the Group and the approach moving forward.

Julie Beilby acknowledged that the establishment of the Strategic Partnerships Committees-in-Common would aid discussions around place and integration with Partners.

The Committees-In-Common agreed limited assurance.

4.3 Deep Dive: Elective Care

Scott Fitzgerald-Becker took the report as read. Data over the last few months revealed that new outpatient appointments that did not require a procedure had reduced by 14k and follow-up outpatient appointments that did not require a procedure had reduced by 54k. Outpatient appointments had declined by 10% across the Group, which was an indication that positive progress was made, and patients were being treated at their appointments. Non-elective admissions had exceeded plan by 3,406 admissions and a decrease in elective admissions was seen due to a significant amount of non-elective cases occupying the elective bed base. Work was ongoing to look at bed modelling with an aim of securing further beds and historical ward utilisation was being reviewed to determine whether specific wards could be utilised in a more effective way. An increase was seen in ITU over the last month which had impacted admissions for high-risk patients and efforts were underway daily to resolve this. He shared that the Group needed to think about utilisation of job planning and how to use the Day Surgery Unit (DSU) more effectively for day cases due to the amount of opportunity within DSU. The Group were reviewing outsourcing stages and increasing the number of slots on lists to ensure there was a greater chance of moving patients forward that were unsuitable for outsourcing. Work was underway to put interventions in place as the Group anticipated a delay in patients being seen and treated in November and December 2025 due to the possibility of patients declining elective procedures in the weeks approaching the holiday period. NHSE challenged the Groups aspirations to deliver trajectories however, they acknowledged that improvements were made. Unvalidated data revealed a downward trend in the volume of patients on the waiting list. Scott Fitzgerald-Becker mentioned that the Group faced a risk regarding the amount of pressure that Care Groups would face due to the expected amount of additional Locums, resourcing, and work ongoing with external people.

Adam Creeggan shared that 2k patients would breach 65 weeks by the end of November 2025, and 907 of those patients would require dating. Capacities were available to the Group that were currently absorbed by patients who were not deemed ‘high risk’. There was significant opportunity for the Group to deliver this target that was not reliant on further investment and capacity.

Dr Kate Wood shared that the Group should be using GIRFT clinic templates to measure themselves against national practice, which was not evident in the paper.

Gill Ponder noted that slight improvements were seen in Diagnostics and asked for assurance that the Group were maximising utilisation of the CDC diagnostic capacity. Ivan McConnell explained that the trajectories and referral patterns had

increased however, the anticipated number of referrals into primary care were lower than expected, and significant work had taken place with ICB colleagues to promote CDC referral within primary care. There continued to be challenges in some areas regarding staffing, particularly in obstetric ultrasound however, the imaging team were looking at re-phasing some of that activity. The CDCs made a marginal surplus when first opening however, the Secretary of State since reduced the tariff payment and the Group now make a significant loss, and work would take place to review whether the Group should continue the services with CDCs or look into alternative supply.

Julie Beilby noted that an ongoing area of concern was cancelled operations. Scott Fitzgerald-Becker recognised that a strategic approach was required to drive productivity in utilisation of theatres.

Action: Matt Powls to present a paper at a future meeting regarding the loss of capacity within Theatres.

Helen Wright acknowledged the deterioration in performance despite the Group being in Tier One for cancer and receiving additional support, and queried what conversations were taking place to address this. Matt Powls explained that the Group were seeing a reduction in backlog as planned, performance improvement would follow this, and NHSE were aware. A cancer performance tier one meeting took place yesterday which was constructive and the ICB and NHSE were made aware that the Group expected to see increased performance in December 2025 and January 2026.

Gill Ponder asked for clarity regarding the decline in 2ww performance at HUTH. Adam Creeggan clarified that significant improvement was seen in 2ww performance and work was underway to support challenges the Breast pathway was experiencing. An additional consultant would be appointed for front-of-house which would improve the FDS position. There was a high level of urgent suspected cancer patients and work was taking place with the referrers.

Action: Matt Powls and Scott Fitzgerald-Becker to pull together a one-page briefing around Breast, and circulate to the PEF CiC outside of this meeting.

The Committees-In-Common agreed limited assurance and noted that although improvements were seen and detailed action plans were in place, they wanted to see if there was a more radical approach to determine if there was something more that could be done to make a difference more promptly.

Scott Fitzgerald-Becker left the meeting at 11:25 hours.

4.4 Directorate of Estates, Facilities and Development Update (including HRI Tower Block Update)

Tom Myers updated that the Estates Returns Information Collection (ERIC) data was published on 17 October 2025 and was currently being reviewed to understand the position in comparison to other organisations, a further update

would be shared at the next meeting. The increase in Estate over last few years was significant, hence the need for rationalisation of that estate as productivity had not increased as expected. Further work would take place to understand that in further detail and determine cost and whole time equivalent (WTE). Spend on Capital remained below plan however, a significant increase in the amount of committed cost was seen over the last month. An increased volume in orders was seen and a significant amount of funding was currently under assessment to get those schemes underway. Schemes were progressing well, particularly at Scunthorpe General Hospital (SGH). A HV switchover was planned for 22 November 2025, which would require the SGH site to be taken off-grid. Scenario testing had taken place over the last few weeks which highlighted challenges and disruptions towards the diagnostic site. Work continued to try and resolve this prior to 22 November 2025.

Discussions were taking place with external partners regarding moving forward to a tender process for retail catering, and work was underway with internal teams to try and improve the situation. Costa at Diana, Princess of Wales Hospital (DPoW) was generating significant income. Performance was being monitored for the Starbucks coffee shop in the Family Services block at DPoW, which was yet to achieve a substantial profit. Work continued with Mark Watson, an external consultant, who was providing an insight into accommodation across the Care Groups at HUTH. There were challenges with obtaining information from the Care Groups, however the Group would continue to pursue this with the aim of understanding the position from a contractual basis and hopefully finding potential efficiencies. Concerns were raised regarding health and safety risks which were being addressed throughout the process.

The Committees-In-Common agreed significant assurance, noting measures in place around the Tower Block, the increased activity with the action plan, and the ongoing work with Humberside Fire and Rescue Service (HFRS).

4.4.1 Sterilisation Services (Decontamination)

Tom Myers took the report as read and explained that the purpose of the paper was to request the Committees-in-Common to approve the direction of travel to not extend the current service contract on the South Bank and explore an in-house model (option 5 within the paper). He explained that the biggest challenge within sterilisation was regarding concerns from NHSE around the resilience of the market. There were concerns around not gaining the commercial advantage from the private sector due to the number of suppliers in the market and significant delays experienced by other organisations in gaining approval through Cabinet Office regarding going out to tender for sterilisation. The STERIS contract on the South Bank was performing well, which was a joint contract with United Lincolnshire Teaching Hospitals (ULTH) however, early indications following discussions with ULTH was that they were considering an in-house model rather than extending the contract. Equipment would require replacement which would see costs increase between 7 and 14%. An in-house model was currently in place on the North Bank which would require Capital investment, and the Group would need to understand the scale of that.

Julie Beilby wondered what would happen if the Group were to discover that in-house options were more expensive after notice was given to the provider. Tom Myers shared that the Group would go out to the market in that scenario. He explained that the contract was due to expire in January 2028 which provided the Group with the timescale to explore the market, however the deadline to extend the contract was the end of 2025.

Helen Wright shared that it would be helpful to understand the market versus in-house as it was difficult to understand the financial implications of exploring in-house without seeing a comparison.

Gill Ponder raised a concern regarding the high volume of critical work needed to maintain the current facilities highlighted in the report and wondered how the repairs to the equipment would be funded if the Group were to not extend the contract.
Tom Myers clarified that STERIS would re-direct any issues with equipment to their centre at Lincoln. Currently, the Group rarely experienced issues with the equipment and continued to monitor all equipment until the end of its lifespan.

The Committees-in-Common approved the recommended direction of travel on the basis that the Group would not extend the current contract and would explore option 5 further before making further recommendations on the best way forward.

4.5 Procurement Improvement Plan and Expired Contracts

Edd James explained that several changes had taken place following submission of the report. The plan was presented to Finance Planning and Improvement Board last week which received endorsement that the Group were on target to deliver for 2025/26 and more than likely to exceed that target. 208 expired contracts that were presented in October 2024 had been addressed and cleared. There were currently 88 outstanding contracts with a combined value of £16 million that had expired since October 2024. Contracts expired each month, with a particular spike in expiring contracts expected in April 2026. Work would take place to determine how to spread that workload out throughout the year.

Helen Wright queried whether there was anything the Group should be looking at that they were not. Edd James explained that the projects that do not go ahead were highlighted and challenged through Procurement Board and Finance Improvement Board. He noted that resource and vacancies was a challenge and there were outstanding vacancies being worked through with finance colleagues.

Dr Kate Wood queried whether there were any unintended consequences of the teams harmonising and whether the Procurement team tracked against a KPI to progress procurement contracts in specific areas. Edd James explained that the Procurement team did not currently have a KPI to deliver and report on. The team would need to determine which element they were reporting on and which element they were trying to improve and understand.

The Committees-In-Common agreed significant assurance.

4.6 Contract Approvals

4.6.1 Contract Approval: Cleaning Harmonisation - (HUTH)

Tom Myers shared that the report outlined a series of different options that were considered with the recommendation of extending the current OCS contract by an additional year. The contract was previously extended for a year with the expectation that the Group would carry out a procurement exercise in the meantime. Due to several reasons, the Group were unable to fulfil that and would miss the date in terms of getting the procurement completed by the contract expiry date. He requested that the Group go out to market in November 2025 and return with a subsequent paper in December 2025 to extend by a further 12 months once discussions were finalised with OCS, to enable a robust testing of the market, supplier innovations and all procurement stages to be completed.

Action: Tom Myers to bring a subsequent Cleaning Harmonisation contract paper back to the next meeting.

The Committees-in-Common approved the proposal to go out to market for the tender process and a subsequent contract paper would be presented at the next meeting.

4.7 Emerging Issues

Nothing to raise.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Nothing to raise.

Performance, Estates and Finance Committees-in-Common Terms of Reference - HUTH and NLaG

David Sharif took the report as read. He noted that the Terms of Reference made more explicit reference to the strategic objectives now in place across the Group and the assurance responsibility that this Committees-in-Common has around patient access and the public purse element. A standard five-working day turn-around time was given for completion of the draft minutes and escalation highlight report, acknowledging that a quicker turnaround time was required in the event of a Boards-in-Common meeting.

Gill Ponder mentioned that ‘health and safety’ was listed as within scope of this Committee and proposed being more specific regarding the definition of ‘health and safety’.

Helen Wright suggested reflecting that Sean Lyons had left the Group on the cover page.

The Committees-in-Common approved the Terms of Reference to go to Boards-in-Common, subject to the proposed changes.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None raised.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

The next meeting will take place on Tuesday 02nd December 2025 via Microsoft Teams.

The meeting closed at 12:12 hours.

Cumulative Record of Attendance at PEF CiC 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug 05/08 07/08	Sep 02/09	Oct 30/09	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	D 02/09	Y 30/09	Y	
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	D	
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08	N 02/09	Y 30/09	D	

									N 07/08				
Clive Walsh	Interim Site Chief Executive North		D	Y	Y	D	D						
Sarah Tedford	Interim Group Chief Delivery Officer		Y	D	D	Y	Y	Y	Y 05/08 D 07/08	Y 02/09	Y 30/09		
Matt Powls	Interim Group Chief Delivery Officer											Y	
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	D 30/09	Y	
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	
Andy Haywood	Group Digital Information Officer		N	N	N	N	N	N	N 05/08 N 07/08	N 02/09	N 30/09	N	
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)240

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Philippa Russell, Deputy Director of Finance
Title of Report	**Finance Report – Month 7**
Executive Summary	This report highlights the reported financial position of Month 7 of the 2025/26 reporting period.
Background Information and/or Supporting Document(s) (if applicable)	-
Prior Approval Process	-
Financial Implication(s) (if applicable)	Contained within the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:



NHS
Humber Health
Partnership

Finance Report Month 7
October – 2025/26

Finance Overview

In-month I&E Performance – page 3

(£0.6m) The Group reported an in-month deficit for month 7 of (£0.6m), (£1.5m) adverse to plan. This includes £4.7m of non-recurrent balance sheet support in month.

Year to Date I&E Performance – page 3

(£4.8m) The Group reported a (£16.6m) year to date deficit for month 7, (£4.8m) adverse to plan. This also includes £15.7m of non-recurrent balance sheet support.

I&E Forecast Outturn – page 4

(£18.2m) The Group is forecasting a deficit of (£53.2m) based on an adjusted straight-line projection. Mitigating actions are forecast to reduce the deficit leaving an unidentified gap of (£18.2m), but many of these mitigations are high risk.

YTD Cost Improvement Plan – page 5 to 6

(£12.1m) The Group has delivered £53.5m in CIP against a YTD target of £65.6m, (£12.1m) behind target. The Group are forecasting CIP delivery of £108.7m, (£21.3m) adverse to plan.

Underlying I&E – page 7

(£86.6m) The Group's underlying position is estimated at a deficit of circa (£86.6m). Recurrent CIP and FYE of in year schemes will be the key variable to the Group's underlying position.

System Performance – page 8

(£12.0m) The ICS reported a YTD deficit of (£29.9m), (£12.0m) adverse to plan at month 7. The ICS is forecasting a break-even position as planned.

Capital Expenditure – page 9

(£18.7m) The Group has spent £25.9m on capital expenditure against a plan of £44.7m, (£18.7m) behind plan.

Balance Sheet & Cash – pages 10 to 11

£45.0m The Group's cash balance at the end of month 7 was £45.0m. CIP delivery and financial recovery will be the key variables in determining if external cash support will be required in year. This will be monitored closely.

Elective Recovery Performance – page 12

(£2.7m) The Group is currently under-performing against ERF baselines by (£2.7m). Due to the block income arrangements no additional income or penalties have been assumed year-to-date.

Temporary Staffing – pages 13 to 16

(£0.8m) The Group has spent £39.9m on agency and bank pay YTD. This is (£0.8m) more than the same period in 2024/25.

Key Risks

- ❑ Continued high value of unidentified CIP and high-risk CIP opportunities.
- ❑ ICS Risk share arrangement for CDC and HCDs growth.
- ❑ Unfunded costs associated with delivery of Constitutional Standards improvement plan.
- ❑ Unidentified stretch income target
- ❑ Capital Expenditure profile
- ❑ Requirement for Revenue Cash Support if CIP not fully identified

Key Actions

- ❑ Reducing cost pressures: reliance on premium bank and agency; minimising escalation beds; and greater control of non-pay expenditure.
- ❑ Maximising planned care activity within core capacity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- ❑ Delivering a challenging CIP programme – conversion of non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target.
- ❑ Delivery of Care Group Recovery Action Plans.

Financial Performance Summary

The Group ended October with a year-to-date (YTD) deficit at month 7 of (£16.6m), (£4.8m) adverse to plan.

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.5	75.9	0.4	527.8	530.5	2.7	46.7	47.1	0.4	326.5	326.3	(0.2)	122.2	122.9	0.7	854.3	856.8	2.5
Other Income	5.9	7.0	1.0	57.7	58.8	1.2	6.3	5.0	(1.3)	43.9	38.0	(5.9)	12.3	12.0	(0.3)	101.5	96.8	(4.7)
Total Operating Income	**81.4**	**82.8**	**1.4**	**585.4**	**589.3**	**3.9**	**53.0**	**52.1**	**(0.9)**	**370.4**	**364.3**	**(6.1)**	**134.5**	**134.9**	**0.4**	**955.8**	**953.6**	**(2.2)**
Pay Costs																		
Clinical Pay	(39.2)	(40.7)	(1.5)	(274.8)	(283.7)	(9.0)	(27.5)	(28.6)	(1.1)	(196.1)	(199.0)	(2.9)	(66.7)	(69.3)	(2.6)	(470.9)	(482.8)	(11.9)
Other Pay	(8.4)	(8.2)	0.2	(58.6)	(58.6)	(0.0)	(7.4)	(7.3)	0.1	(51.2)	(50.3)	0.9	(15.8)	(15.5)	0.3	(109.8)	(109.0)	0.8
Total Pay Costs	**(47.6)**	**(48.9)**	**(1.3)**	**(333.4)**	**(342.4)**	**(9.0)**	**(34.9)**	**(35.9)**	**(1.0)**	**(247.3)**	**(249.3)**	**(2.0)**	**(82.5)**	**(84.8)**	**(2.2)**	**(580.7)**	**(591.7)**	**(11.0)**
Clinical Non Pay	(18.2)	(17.9)	0.3	(128.0)	(133.5)	(5.5)	(6.6)	(8.5)	(1.9)	(51.5)	(54.4)	(2.9)	(24.8)	(26.4)	(1.6)	(179.5)	(187.8)	(8.4)
Other Non Pay	(11.2)	(11.9)	(0.6)	(86.9)	(81.6)	5.3	(6.9)	(5.6)	1.3	(48.5)	(46.3)	2.2	(18.1)	(17.4)	0.7	(135.4)	(127.9)	7.5
Total Non Pay Costs	**(29.4)**	**(29.7)**	**(0.3)**	**(214.9)**	**(215.1)**	**(0.2)**	**(13.5)**	**(14.1)**	**(0.6)**	**(100.0)**	**(100.7)**	**(0.7)**	**(42.9)**	**(43.8)**	**(0.9)**	**(314.8)**	**(315.7)**	**(0.9)**
Total Operating Expenditure	**(77.0)**	**(78.6)**	**(1.6)**	**(548.2)**	**(557.4)**	**(9.2)**	**(48.4)**	**(49.9)**	**(1.5)**	**(347.3)**	**(350.0)**	**(2.7)**	**(125.4)**	**(128.6)**	**(3.2)**	**(895.5)**	**(907.4)**	**(11.9)**
EBITDA	**4.4**	**4.2**	**(0.2)**	**37.2**	**31.9**	**(5.4)**	**4.6**	**2.1**	**(2.5)**	**23.1**	**14.3**	**(8.8)**	**9.0**	**6.3**	**(2.7)**	**60.3**	**46.2**	**(14.1)**
Depreciation	(2.5)	(2.5)	0.0	(17.3)	(17.1)	0.2	(2.2)	(1.9)	0.3	(14.6)	(13.3)	1.4	(4.6)	(4.3)	0.3	(32.0)	(30.4)	1.6
Non Operating Items	(1.4)	(1.2)	0.2	(9.8)	(9.4)	0.4	(0.7)	(0.7)	0.0	(4.7)	(4.2)	0.5	(2.1)	(1.9)	0.2	(14.5)	(13.6)	0.9
Surplus/(Deficit)	**0.5**	**0.5**	**(0.0)**	**10.1**	**5.3**	**(4.8)**	**1.8**	**(0.4)**	**(2.2)**	**3.7**	**(3.1)**	**(6.9)**	**2.3**	**0.1**	**(2.2)**	**13.9**	**2.2**	**(11.7)**
NHSE Allowable Adjustments	0.0	(0.3)	(0.3)	(15.2)	(13.8)	1.4	(1.5)	(0.4)	1.0	(10.5)	(5.0)	5.5	(1.4)	(0.7)	0.7	(25.7)	(18.8)	6.9
Adjusted Surplus / (Deficit)	**0.6**	**0.2**	**(0.4)**	**(5.0)**	**(8.4)**	**(3.4)**	**0.3**	**(0.8)**	**(1.2)**	**(6.8)**	**(8.1)**	**(1.4)**	**0.9**	**(0.6)**	**(1.5)**	**(11.8)**	**(16.6)**	**(4.8)**

- **The Group reported a (£0.6m) deficit for October, (£1.5m) adverse to plan. However, an extra £4.7m of non-recurrent technical balance sheet was released in month to support the financial position. £15.7m of balance sheet has now been released year-to-date to support the Groups financial position.**
- The Group is behind on its CIP programme by (£12.1m). The programme has £40.9m of schemes rated as high risk with £35.5m rated as an opportunity or unidentified.
- The Group cash balance increased by £9.9m in month to £45.0m (£20.5m HUTH / £24.5m NLAG). CIP delivery and Care Group overspends will be the key risks to cash flow for the remainder of the year and continue to be monitored closely. The Group is behind plan year to date and currently forecasts an unmitigated gap of £18.2m which potentially adds a further risk from failing to secure the Quarter 4 Deficit Support funding (£7.0m across the Group).

See Appendix A on Page 19 to 20 for Detailed I&E Position

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£53.2m) based on an adjusted straight-line projection. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£18.2m) across the Group.

A straight-line forecast based on the M1-7 deficit position would leave the group with a £28.4m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent benefits in the year-to-date position, this deficit increases to £53.2m.

To achieve the planned break-even position, the group will need to:

- Significantly improve efficiency delivery including delivery of £14.2m of 'opportunity' that is yet to be fully identified.
- Identify a further £18.2m of efficiency that is currently unidentified and unmitigated.
- Develop recovery plans of at least £5.5m to offset the additional pressure in the run-rate due to Care Group overspends.
- Secure £6.8m of unidentified income.

Failure to deliver the required recovery and close the gap will also result in the withdrawal of the Q4 Deficit Support Funding (£7m for the Group).

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m
YTD deficit (M6)	(8.4)	(8.1)	(16.6)
Straight line forecast	**(14.5)**	**(14.0)**	**(28.4)**
Seasonality	(4.4)	(1.3)	(5.6)
Industrial Action	0.5	0.1	0.6
CDC	(2.5)	-	(2.5)
Daycase Unit	(0.6)	-	(0.6)
CPE & Opthalmology (Ironstone/Freshney)	-	(0.6)	(0.6)
Expected changes to run-rate	(6.9)	0.1	(6.7)
Non Recurrent Flexibility in YTD position	(5.8)	(2.7)	(8.4)
Depreciation, Interest Received & PDC	-	(1.0)	(1.0)
Adjusted Run Rate	**(34.0)**	**(19.2)**	**(53.2)**
Forecast CIP delivery (improvement in run-rate)	12.4	5.1	17.5
Non recurrent mitigation	3.2	2.0	5.2
Care Group Recovery Plans	5.5	-	5.5
Income target	3.4	3.4	6.8
Unidentified Gap	9.5	8.7	18.2
Reported Forecast deficit	**-**	**-**	**-**
Plan	**-**	**-**	**-**
Variance	**-**	**-**	**-**

Financial Performance – Forecast Outturn (FOT) - RISKS

At Month 7 the Group reported a net risk to delivery of the forecast break-even position of £47.5m.

Updated Risk Position	Plan 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Comments	Current risk status	Risk adjusted £'000
Risks and mitigations	Group	HUTH	NLAG	Group		RAG	Group
(Risks)/(Offsets to benefits):							
Additional cost risk - HCD growth (ICS block funded)	(5,000)	(4,000)	(1,000)	(5,000)	ICS Risk Share: Growth		(4,300)
Additional cost risk - CDC 15% cost reduction	(3,000)	(1,840)	0	(1,840)	ICS Risk Share: CDC		0
Additional Cost risk - emerging			(1,500)	(1,500)	CPE outbreak, Esclation beds, RTT and Cancer recovery		(750)
Additional Cost risk - Industrial Action		(500)	0	(500)	Assumes no further risks		(500)
Additional cost risk (NP inflation)	(3,500)	(1,000)	0	(1,000)	Inflationary pressures above CUF		(150)
Efficiency risk	(47,072)	(10,860)	(10,428)	(21,288)	Unidentified CIP		(21,288)
Efficiency risk		(11,619)	(2,542)	(14,161)	Opportunity / Plans in Progress		(9,431)
Further recovery actions to be identified		(6,400)		(6,400)	Additional gap to recover due to: YTD cost pressures, Pay Award funding gap and Industrial action		(3,200)
Income risk	(13,950)	(3,400)	(3,400)	(6,800)	Income target - not yet indentified		(5,100)
Deficit Support Funding							
Income risk - IPT claw-back		(2,000)	(750)	(2,750)	IS spend with ICS relating to 24/25 IPT referrals		(2,750)
Mitigations/benefits:							
Additional cost control or income	7,050	0	0	0	Opportunity to review costs not yet fully implemented / income generation (Growth)		0
Non-recurrent mitigation	10,400	0	0	0	Non Recurrent flexibility / non -recurrent income		0
Total Provider Net Risk	**(47,072)**	**(41,619)**	**(19,620)**	**(61,239)**			**(47,469)**

Financial Performance – CIP Delivery

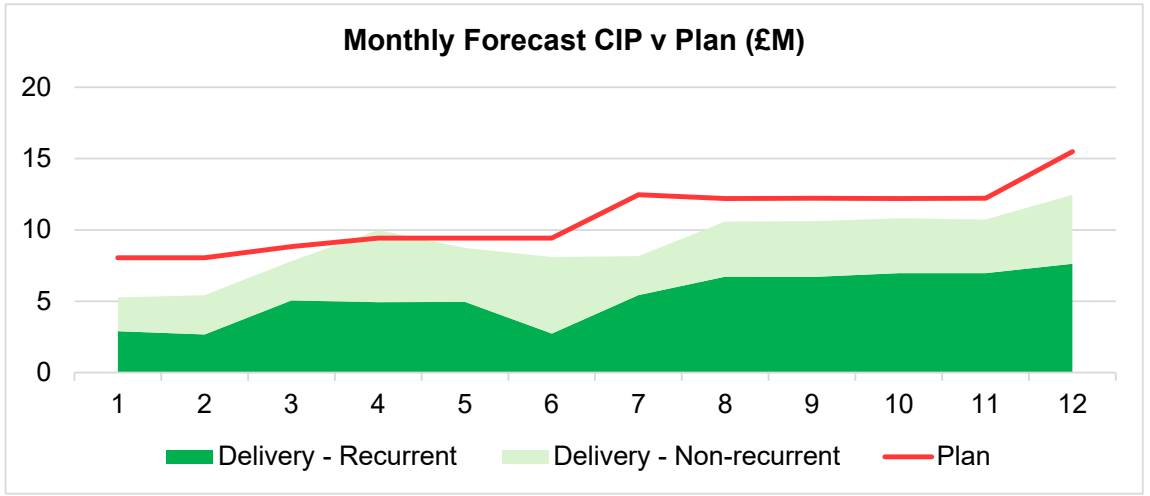
The Group has delivered £53.5m CIP year-to-date against a target of £65.6m, (£12.1m) adverse. The Group is forecasting CIP delivery of £108.7m, (£21.3m) adverse to plan. However, the forecast is inherently high risk and heavily reliant on NR schemes.

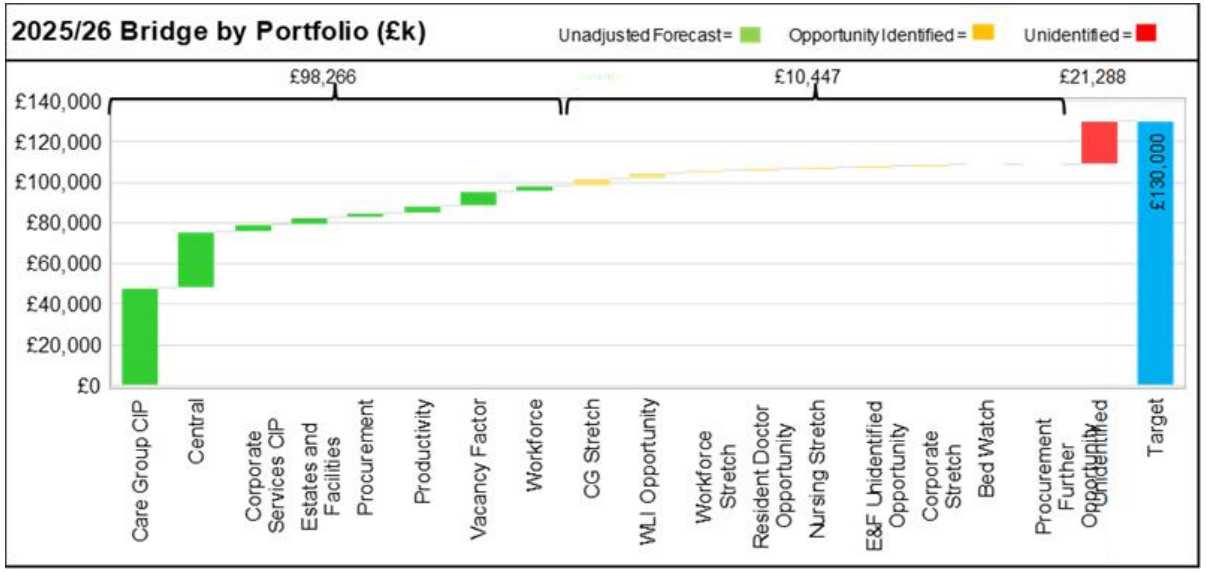
	HUTH						NLAG						Humber Health Partnership					
	Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Acute And Emergency Medicine	990	551	(438)	1,800	1,131	(668)	2,977	2,650	(327)	5,086	4,451	(635)	3,967	3,201	(765)	6,886	5,583	(1,303)
Cancer Network	112	55	(56)	196	99	(97)	118	71	(47)	202	122	(80)	230	127	(103)	398	221	(177)
Cardiovascular	873	1,626	753	1,491	2,517	1,027	363	452	89	490	581	91	1,236	2,077	841	1,981	3,098	1,118
Chief Delivery Officer	22	26	4	38	34	(4)	21	136	115	37	159	123	44	162	119	75	193	119
Community, Frailty & Therapy	781	417	(364)	1,324	1,013	(311)	1,641	1,460	(180)	2,620	2,279	(340)	2,422	1,877	(545)	3,944	3,292	(652)
Digestive Diseases	488	87	(402)	848	374	(474)	1,895	1,599	(296)	3,018	2,382	(636)	2,384	1,685	(698)	3,866	2,756	(1,110)
Family Services	2,053	1,456	(597)	3,066	2,552	(513)	2,034	1,736	(298)	3,132	3,133	1	4,088	3,192	(896)	6,197	5,685	(512)
Head & Neck	1,082	1,178	96	1,765	1,886	121	715	619	(96)	1,098	978	(120)	1,797	1,797	0	2,863	2,864	2
Major Trauma Network	199	54	(144)	249	67	(183)	41	34	(6)	73	59	(14)	239	88	(151)	322	125	(196)
Neuroscience	1,023	662	(361)	1,560	1,180	(380)	236	190	(46)	393	309	(84)	1,259	852	(407)	1,953	1,488	(464)
Pathology Network Group	393	412	18	608	671	63	1,462	1,127	(336)	2,347	1,883	(464)	1,856	1,539	(317)	2,956	2,555	(401)
Patient Services	557	286	(271)	955	592	(363)	484	454	(30)	830	885	55	1,041	740	(301)	1,785	1,476	(308)
Site Management & Discharge Teams	61	22	(39)	104	46	(58)	171	132	(39)	257	179	(78)	232	154	(78)	361	225	(136)
Specialist Cancer And Support Services	4,379	4,096	(283)	7,626	6,876	(749)	1,385	1,527	142	2,481	2,774	293	5,765	5,623	(141)	10,107	9,650	(457)
Specialist Medicine	1,227	855	(372)	1,985	1,288	(698)	666	616	(49)	1,041	914	(127)	1,893	1,471	(422)	3,026	2,201	(824)
Specialist Surgery	1,061	786	(275)	1,694	1,259	(435)	786	639	(147)	1,140	1,237	97	1,848	1,425	(422)	2,834	2,496	(337)
Theatres, Anaesthetics And Critical Care	1,872	1,891	19	3,071	3,566	496	971	749	(221)	1,845	1,531	(314)	2,842	2,640	(202)	4,915	5,097	182
ions	**17,175**	**14,461**	**(2,715)**	**28,378**	**25,152**	**(3,226)**	**15,966**	**14,192**	**(1,773)**	**26,088**	**23,857**	**(2,231)**	**33,141**	**28,653**	**(4,488)**	**54,466**	**49,008**	**(5,458)**
Chief Executive	31	26	(4)	52	40	(12)	27	22	(5)	46	44	(2)	57	48	(9)	98	85	(14)
Chief Medical Officer	549	370	(179)	957	635	(321)	456	675	219	781	1,077	297	1,005	1,045	40	1,738	1,713	(25)
Chief Nurse	258	305	47	442	495	53	226	407	181	388	626	238	484	712	228	829	1,121	291
Director Of Assurance	6	7	0	11	7	(5)	27	6	(21)	46	14	(31)	33	12	(21)	57	21	(36)
Director Of People	386	441	55	662	725	63	360	574	214	618	964	346	746	1,015	269	1,280	1,689	409
Finance - E&F	2,064	1,422	(642)	3,555	2,952	(603)	1,413	919	(494)	2,428	1,840	(588)	3,477	2,341	(1,136)	5,983	4,792	(1,191)
Finance - Finance	234	327	93	401	485	84	164	197	34	280	274	(6)	397	524	127	681	759	78
Strategy And Partnerships	217	312	95	371	497	125	138	355	217	237	572	335	355	667	312	609	1,069	460
rate	**3,745**	**3,209**	**(535)**	**6,451**	**5,836**	**(615)**	**2,810**	**3,155**	**345**	**4,823**	**5,411**	**588**	**6,554**	**6,364**	**(190)**	**11,274**	**11,247**	**(27)**
ted CIPCore Programme	**20,920**	**17,670**	**(3,250)**	**34,829**	**30,988**	**(3,842)**	**18,775**	**17,347**	**(1,428)**	**30,911**	**29,268**	**(1,643)**	**39,695**	**35,017**	**(4,678)**	**65,740**	**60,255**	**(5,485)**
Reserves	6,184	7,410	1,226	12,053	11,269	(784)	9,128	9,603	475	15,647	15,273	(374)	15,312	17,013	1,701	27,700	26,542	(1,158)
Technical	368	409	41	630	671	41	272	272	0	466	466	0	639	680	41	1,096	1,137	41
Unallocated	7,444	774	(6,671)	20,808	14,533	(6,275)	2,556	33	(2,524)	14,656	6,245	(8,411)	10,001	806	(9,194)	35,464	20,778	(14,686)
ical & Unallocated	**13,996**	**8,592**	**(5,404)**	**33,491**	**26,473**	**(7,018)**	**11,956**	**9,907**	**(2,048)**	**30,769**	**21,984**	**(8,785)**	**25,952**	**18,499**	**(7,452)**	**64,260**	**48,457**	**(15,803)**
	34,916	**26,262**	**(8,654)**	**68,320**	**57,460**	**(10,860)**	**30,731**	**27,254**	**(3,477)**	**61,680**	**51,252**	**(10,428)**	**65,647**	**53,516**	**(12,131)**	**130,000**	**108,712**	**(21,288)**

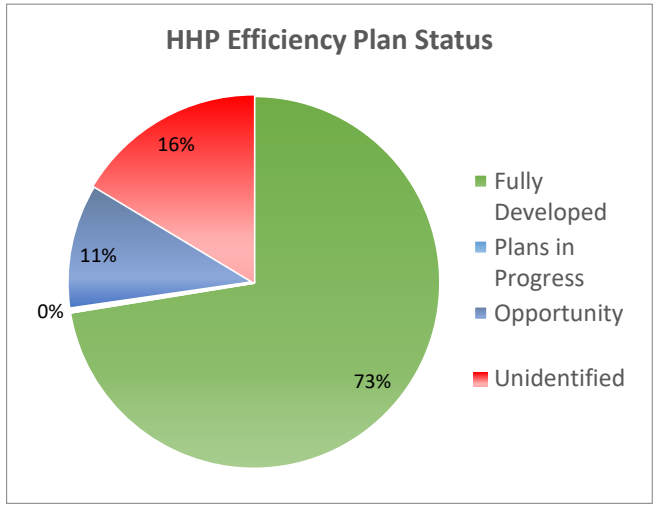
Financial Performance – CIP Planning Progress

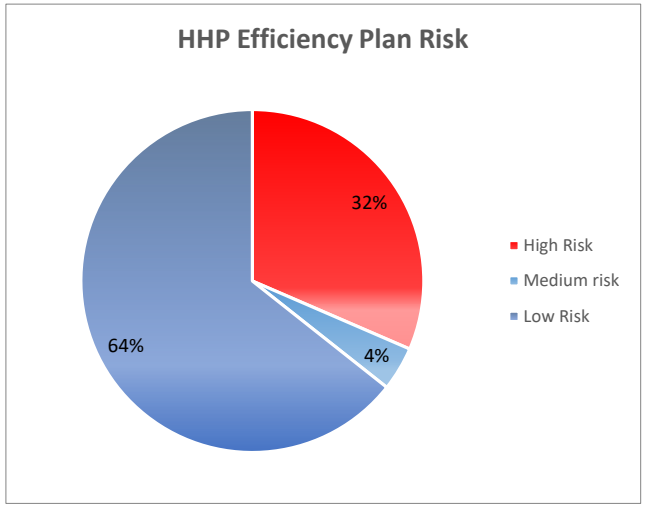
Efficiency Plan Status	HUTH	NLAG	HHP
Fully Developed	46,362	47,805	94,167
Plans in Progress	197	173	370
Opportunity	10,902	3,274	14,175
Unidentified	10,860	10,428	21,288
TOTAL	**68,320**	**61,680**	**130,000**

Efficiency Plan Risk	HUTH	NLAG	HHP
High Risk	26,656	14,283	40,939
Medium risk	4,384	1,025	5,409
Low Risk	37,281	46,372	83,653
TOTAL	**68,320**	**61,680**	**130,000**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£86.6m)

Bridging from the balanced planned for 2025-26 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income support totalling (£26.9m).
2. Non-Recurrent Deficit funding received in 2025/26 of (£29.1m).
3. The Group has historically relied on Non-Recurrent savings delivery to achieve its financial targets. This is forecast to be (£26.6m) within the current year's savings plan. The Group must look to convert non-recurrent savings schemes into recurrent schemes where possible.
4. In addition, the Group currently has unidentified CIP of (£21.3m).
5. The in year CIP schemes have a potential FYE of £31.1m if delivered in full in year.
6. The Groups has been heavily reliant on Non-recurrent technical support in year of (£13.8m)

CIP delivery will be the key driver for the Trust's underlying financial position both in year and the potential full year effects of in year schemes.

£million	NLAG	HUTH	HHP
2025/26 - Surplus/(Deficit) Plan	**0.0**	**0.0**	**0.0**
Non-recurrent Adjustments			
NR Additional Stretch Income Support	(1.4)	(25.6)	(26.9)
NR 25/26 Deficit Funding	(14.9)	(14.2)	(29.1)
NR CIP (Forecast)	(11.9)	(14.7)	(26.6)
Undidentified CIP (Forecast)	(10.4)	(10.9)	(21.3)
FYE 25/26 CIP	7.8	23.3	31.1
NR Flexibility	(5.7)	(8.1)	(13.8)
Underlying Deficit	**(36.4)**	**(50.1)**	**(86.6)**

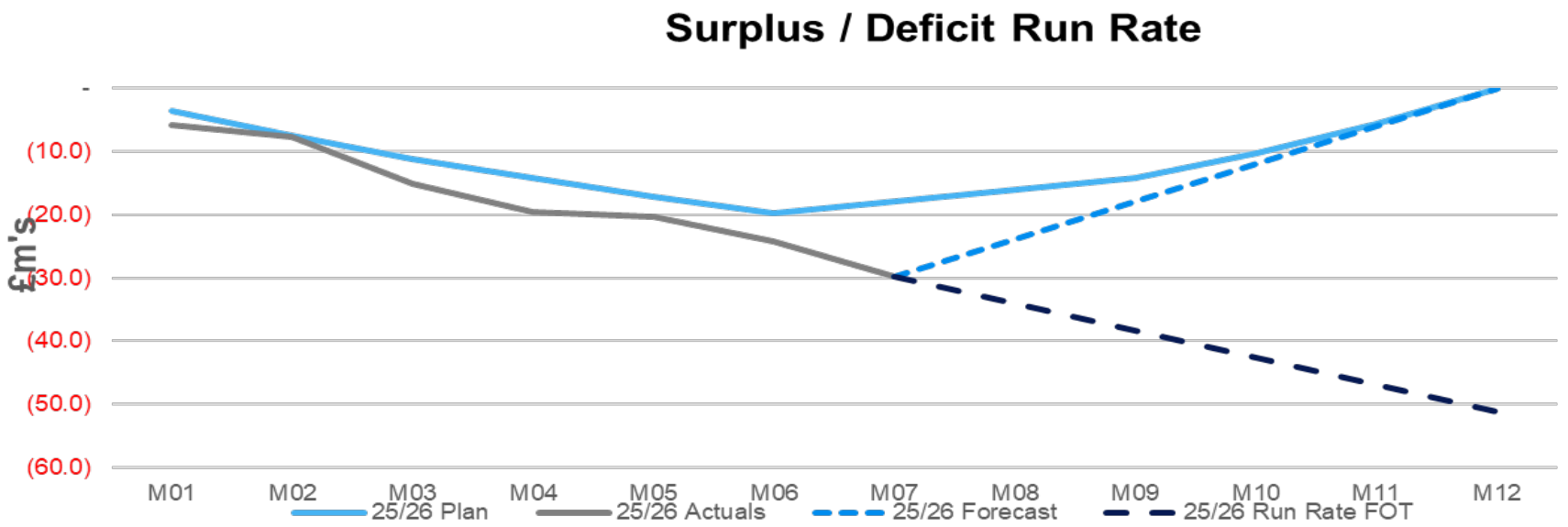
System Financial Performance – October 2025

The ICS reported a YTD deficit of (£29.9m), (£12.0m) adverse to plan. The ICS is forecasting a break-even position as planned.

M7 Position

- ICB £5k underspend YTD, FOT breakeven.
- Providers £12m overspend YTD, FOT breakeven.
- Straight line extrapolation of run rate is circa £51m deficit.
- YTD variance has deteriorated in providers by circa £7m mainly due to further slippage against efficiency schemes. Medical staffing and drugs and devices cost pressures continue.

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	5	5	0.0%	-	-	-	0.0%
Harrogate And District NHS Foundation Trust	(4,649)	(11,623)	(6,974)	(3.1%)	-	-	-	0.0%
Hull University Teaching Hospitals NHS Trust	(5,052)	(8,438)	(3,386)	(0.6%)	-	-	-	0.0%
Humber Teaching NHS Foundation Trust	(613)	2,392	3,005	1.9%	-	-	-	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(6,754)	(8,147)	(1,393)	(0.4%)	-	-	-	0.0%
York And Scarborough Teaching Hospitals NHS Foundation Trust	(812)	(4,046)	(3,234)	(0.6%)	-	-	-	0.0%
ICS Total	(17,880)	(29,857)	(11,977)	(0.4%)	-	-	-	0.0%



Capital Expenditure

The Group has spent £25.9m year to date on capital expenditure against a plan of £44.7m plan, (£18.7m) behind plan.

£million	NLAG Year to Date			HUTH Year to Date			HHP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	0.3	0.2	(0.0)	2.4	1.6	(0.8)	2.7	1.8	(0.8)
Day Surgery CHH	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Theatres & IRT	0.0	0.0	0.0	2.2	0.5	(1.7)	2.2	0.5	(1.7)
Community Diagnostic Centres	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NEEF 4	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Total Estates Major Schemes	**0.3**	**0.3**	**0.0**	**4.6**	**2.3**	**(2.3)**	**4.9**	**2.5**	**(2.3)**
Other Estates Schemes	0.1	0.0	(0.0)			0.0	0.1	0.0	(0.0)
IM&T Programme	1.0	0.3	(0.6)	0.7	0.6	(0.1)	1.7	0.9	(0.7)
EPR	2.3	0.2	(2.0)	0.0	0.2	0.2	2.3	0.4	(1.8)
Equipment Renewal	1.3	0.4	(0.9)	0.9	1.1	0.2	2.2	1.5	(0.7)
Facilities Maintenance	2.2	0.5	(1.7)	0.9	0.9	0.0	3.1	1.4	(1.7)
Other Capital Expenditure	12.2	5.6	(6.6)	18.3	13.6	(4.7)	30.5	19.2	(11.3)
Total Capital Programme	**19.2**	**7.2**	**(12.0)**	**25.4**	**18.7**	**(6.7)**	**44.6**	**25.9**	**(18.7)**
Funded By:									
Internally Generated	5.3	1.6	(3.8)	10.7	3.8	(6.9)	16.0	5.4	(10.7)
PDC Funded	1.7	0.1	(1.6)	0.2	0.0	(0.2)	1.9	0.1	(1.8)
Donated	11.2	5.5	(5.7)	0.9	1.9	1.0	12.1	7.4	(4.7)
IFRS16	1.0	0.1	(1.0)	13.6	13.0	(0.6)	14.6	13.1	(1.6)
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**19.2**	**7.2**	**(12.0)**	**25.4**	**18.7**	**(6.7)**	**44.7**	**25.9**	**(18.7)**

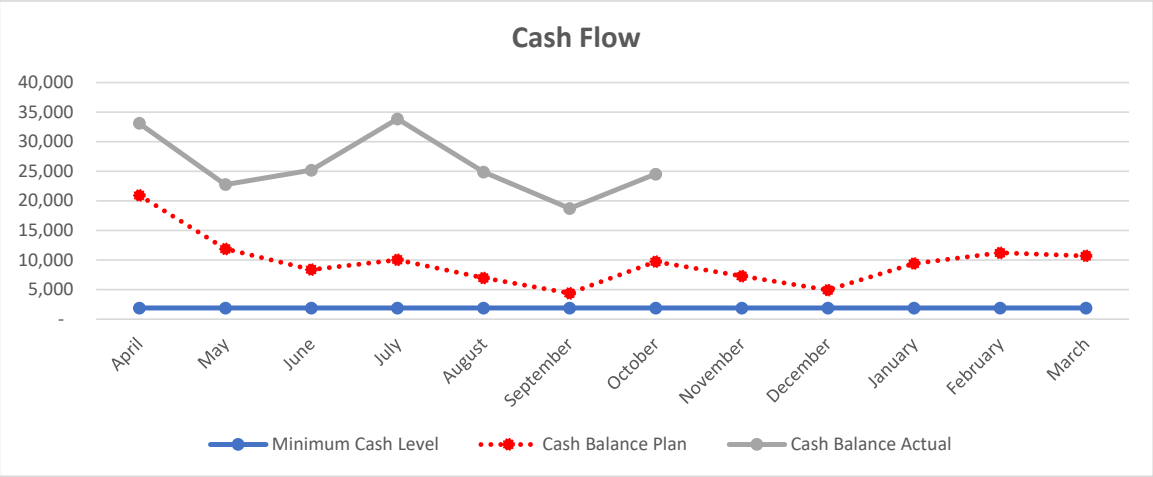
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 30-Sep-25	Actual 31-Oct-25	In month movement	Actual 30-Sep-25	Actual 31-Oct-25	In month movement	Actual 30-Sep-25	Actual 31-Oct-25	In month movement
Fixed Assets	295.5	294.6	(0.8)	487.3	486.5	(0.8)	782.8	781.1	(1.6)
Other Investments	0.0	0.0	0.0	0.6	0.6	0.0	0.6	0.6	0.0
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Inventories	4.4	4.7	0.3	19.4	19.1	(0.2)	23.8	23.8	0.0
Trade and Other Debtors	24.2	21.9	(2.2)	34.8	37.9	3.2	58.9	59.9	0.9
Cash	18.7	24.5	5.8	16.4	20.5	4.1	35.1	45.0	9.9
Total Current Assets	**47.3**	**51.1**	**3.8**	**70.5**	**77.5**	**7.0**	**117.8**	**128.7**	**10.9**
Current Liabilities									
Trade and Other Creditors	(44.2)	(42.8)	1.4	(49.6)	(52.9)	(3.2)	(93.8)	(95.6)	(1.8)
Accruals	(18.7)	(17.7)	1.0	(48.1)	(38.6)	9.4	(66.8)	(56.3)	10.4
Other Current Liabilities	(8.3)	(14.5)	(6.2)	(19.3)	(31.6)	(12.3)	(27.6)	(46.1)	(18.5)
Total Current Liabilities	**(71.2)**	**(74.9)**	**(3.8)**	**(117.0)**	**(123.1)**	**(6.1)**	**(188.2)**	**(198.0)**	**(9.9)**
Net Current Liabilities	**(23.9)**	**(23.8)**	**0.1**	**(46.5)**	**(45.6)**	**0.9**	**(70.4)**	**(69.4)**	**1.0**
Debtors Due > 1 Year	0.8	0.8	0.0	2.3	2.3	0.0	3.0	3.0	0.0
Creditors Due > 1 Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans > 1 Year	(4.2)	(4.2)	0.0	(3.8)	(3.8)	0.0	(8.0)	(8.0)	0.0
Finance Lease Obligations > 1 Year	(7.7)	(7.4)	0.4	(72.7)	(72.3)	0.4	(80.4)	(79.7)	0.7
Provisions - Non Current	(3.6)	(3.6)	(0.0)	(2.3)	(2.3)	0.0	(5.9)	(5.9)	(0.0)
Total Assets/(Liabilities)	**256.8**	**256.4**	**(0.4)**	**364.9**	**365.3**	**0.5**	**621.7**	**621.7**	**0.1**
TOTAL CAPITAL & RESERVES	**256.8**	**256.4**	**(0.4)**	**364.9**	**365.3**	**0.5**	**621.7**	**621.7**	**0.1**

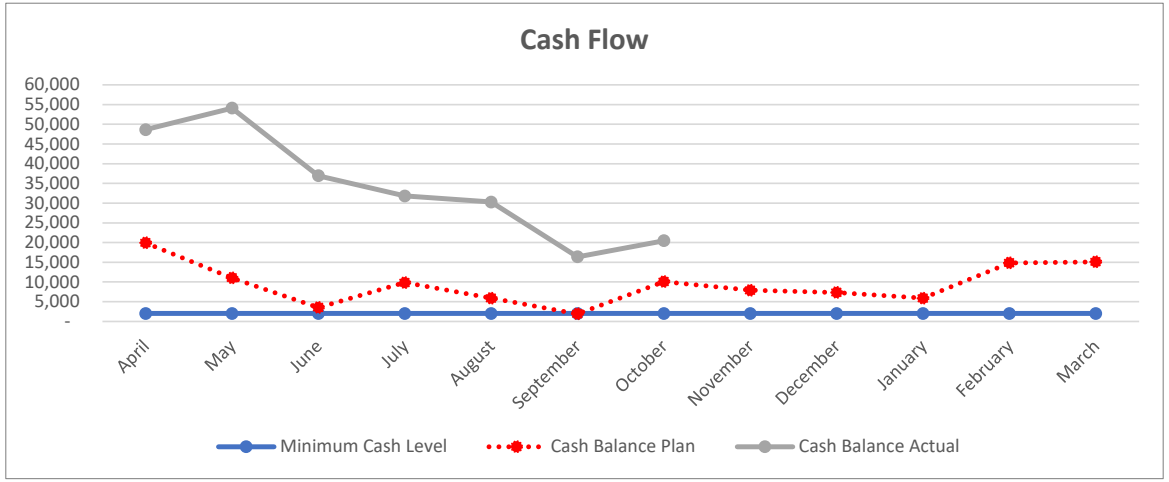
Cash Flow

The Group's cash balance at month 7 was £45.0m. CIP delivery will be the key variable in minimising any cash support requirements in year. The Group's cash position will be monitored closely each month.

NLAG



HUTH



Elective Recovery

The Group is currently under-performing against ERF baselines by £2.7m. Due to the block income arrangements no additional income or penalties have been assumed year-to-date.

	YTD											
£000's	NLAG				HUTH				HHP Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	42,877	44,297	768	103%	93,249	89,194	(4,054)	96%	136,125	133,492	(2,634)	98%
External Contracts	5,768	6,450	682	112%	1,652	1,489	(163)	90%	7,420	7,938	518	107%
Specialist	1,044	1,502	458	144%	26,333	25,334	(998)	96%	27,377	26,836	(541)	98%
Sub Total ERF	**49,689**	**52,249**	**1,907**	**105.2%**	**121,233**	**116,017**	**(5,216)**	**95.7%**	**170,922**	**168,266**	**(2,656)**	**98.4%**
A&G	541	540	(1)	N/A	2,236	2,236	0	N/A	2,776	2,775	(1)	N/A
Total	**50,229**	**52,789**	**1,906**	**105.2%**	**123,469**	**118,253**	**(5,216)**	**95.7%**	**173,699**	**171,042**	**(2,657)**	**98.4%**

	Forecast											
£000's	NLAG				HUTH				HHP Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	72,803	75,411	2,607	104%	158,334	153,398	(4,936)	97%	231,137	228,809	(2,329)	99%
External Contracts	9,888	10,907	1,019	110%	2,832	2,549	(283)	90%	12,720	13,457	737	106%
Specialist	1,790	2,502	712	140%	45,142	43,222	(1,920)	96%	46,932	45,724	(1,208)	97%
Sub Total ERF	**84,481**	**88,820**	**4,338**	**105.1%**	**206,308**	**199,170**	**(7,138)**	**96.5%**	**290,789**	**287,990**	**(2,800)**	**99.0%**
A&G	918	917	(1)	N/A	3,796	3,796	0	N/A	4,714	4,713	(1)	N/A
Total	**85,400**	**89,737**	**4,337**	**105.1%**	**210,104**	**202,966**	**(7,138)**	**96.5%**	**295,504**	**292,703**	**(2,801)**	**99.0%**

Temporary Staffing Summary

The Group has spent £39.9m on agency and bank YTD. This is (£0.8m) more than the same period in 2024/25 and remains below the NHSE Target of 3.2% of total pay expenditure at 2.8%.

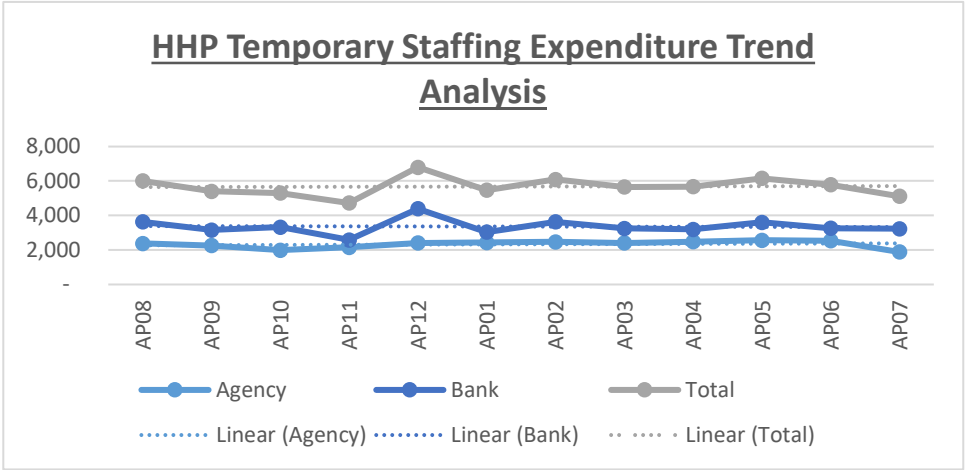
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Agency	Medical Staff	5,668	5,150	518	6,549	7,696	(1,147)	12,218	12,847	(629)
	Nursing Staff	112	887	(775)	1,879	1,900	(21)	1,990	2,787	(796)
	Scientific, Therapeutic & Technical Staff	404	126	278	937	922	15	1,341	1,047	294
	Admin & Clerical Staff	297	29	268	213	16	197	511	45	466
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	0	22	(22)	2	2	0	2	24	(22)
Agency Total		**6,481**	**6,213**	**268**	**9,581**	**10,536**	**(955)**	**16,062**	**16,749**	**(688)**
Bank	Medical Staff	2,295	2,571	(276)	6,626	5,704	922	8,921	8,275	646
	Nursing Staff	3,228	2,607	622	7,195	7,508	(314)	10,423	10,115	308
	Scientific, Therapeutic & Technical Staff	301	426	(125)	720	880	(160)	1,021	1,306	(285)
	Admin & Clerical Staff	29	492	(463)	1,265	1,153	112	1,293	1,645	(351)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	34	91	(57)	1,359	1,764	(404)	1,393	1,855	(461)
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**5,886**	**6,186**	**(300)**	**17,165**	**17,008**	**156**	**23,051**	**23,195**	**(144)**
Grand Total		**12,367**	**12,400**	**(32)**	**26,746**	**27,545**	**(799)**	**39,113**	**39,944**	**(831)**

Agency Spend as % Total Pay (3.2% is the NHSE Target)	1.8%	4.2%	2.8%

Temporary Staffing Summary – Directorate / Care Group

The Group has spent £34.8m on all agency and bank pay YTD. This is (£1.5m) more than the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	**Care Group**	**2024/25**	**2025/26**	**Variance**	**2024/25**	**2025/26**	**Variance**	**2024/25**	**2025/26**	**Variance**
Operations	Acute and Emergency Medicine	2,660	2,534	127	7,534	8,516	(982)	10,195	11,049	(855)
	Cancer Network	0	22	(22)	27	48	(21)	27	70	(43)
	Cardiovascular	318	408	(90)	294	277	16	611	685	(74)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	1,174	1,693	(519)	2,197	2,035	161	3,371	3,728	(358)
	Digestive Diseases	608	429	180	1,284	1,592	(308)	1,892	2,020	(128)
	Family Services	1,215	846	369	3,073	2,962	111	4,288	3,808	481
	Head & Neck	728	832	(104)	1,372	1,218	155	2,100	2,049	51
	Major Trauma Network	35	106	(71)	130	128	2	164	234	(70)
	Neuroscience	718	338	379	687	741	(53)	1,405	1,079	326
	Pathology Network Group	13	5	8	609	617	(8)	622	622	0
	Patient Services	36	381	(346)	769	618	152	805	999	(194)
	Site Management & Discharge teams	39	285	(247)	190	168	22	228	453	(225)
	Specialist Cancer and Support Services	1,756	1,591	165	1,458	1,750	(292)	3,215	3,342	(127)
	Specialist Medicine	642	398	243	1,625	2,012	(387)	2,267	2,411	(144)
	Specialist Surgery	651	667	(16)	1,597	1,245	352	2,248	1,912	336
	Theatres, Anaesthetics and Critical Care	1,620	1,530	91	2,066	1,914	152	3,686	3,444	242
Total Operations		**12,212**	**12,065**	**147**	**24,914**	**25,841**	**(928)**	**37,126**	**37,907**	**(781)**
Corporate	Chief Executive	9	0	9	7	0	7	16	0	16
	Chief Medical Officer	5	0	5	152	21	131	156	21	136
	Chief Nurse Office	1	45	(44)	88	99	(11)	89	144	(55)
	Director of Assurance	0	0	0	0	0	0	0	0	0
	Director of People	11	78	(67)	50	46	4	62	124	(63)
	Director of Finance, Estates & Facilities	285	140	145	1,418	1,761	(343)	1,703	1,901	(198)
	Strategy and Partnerships	0	3	(3)	50	62	(12)	50	65	(15)
Total Corporate		**312**	**266**	**46**	**1,764**	**1,989**	**(225)**	**2,076**	**2,255**	**(179)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(125)	68	(193)	67	(323)	390	(57)	(255)	198
	Reserves	(32)	(0)	(32)	0	37	(37)	(32)	37	(69)
Total Central Income, Reserves & Technical		**(156)**	**68**	**(224)**	**67**	**(286)**	**353**	**(89)**	**(218)**	**129**
Surplus / (Deficit)		**12,367**	**12,400**	**(32)**	**26,746**	**27,545**	**(799)**	**39,113**	**39,944**	**(831)**

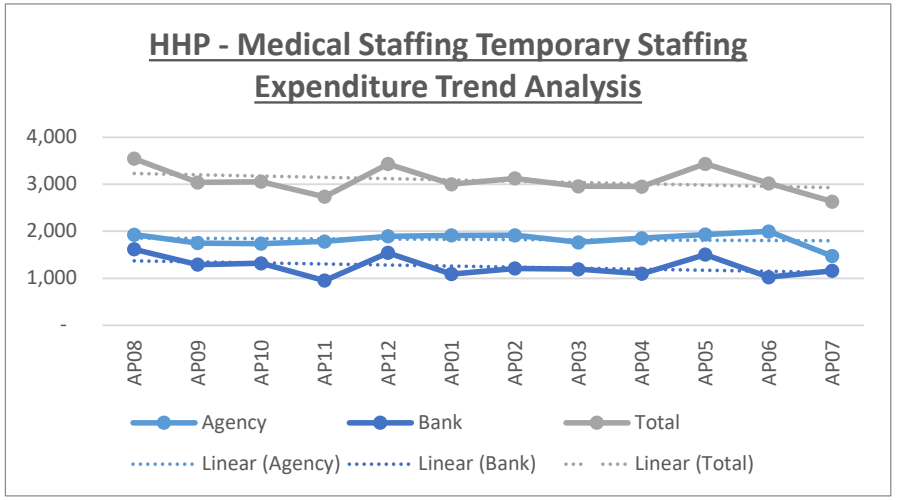


Type	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07
Agency	2,378	2,255	1,980	2,147	2,403	2,433	2,465	2,405	2,478	2,558	2,527	1,884
Bank	3,628	3,150	3,322	2,579	4,391	3,035	3,627	3,249	3,195	3,598	3,259	3,232
Total	**6,006**	**5,405**	**5,302**	**4,726**	**6,794**	**5,468**	**6,092**	**5,654**	**5,673**	**6,156**	**5,786**	**5,116**

Temporary Staffing Summary – Medical Staffing

The Group has spent £21.1m on Medical Staffing agency and bank pay YTD. This is £0.0m marginally in line with the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	2,094	1,776	317	4,705	5,358	(653)	6,798	7,134	(336)
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	98	256	(158)	29	31	(2)	127	287	(160)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	521	797	(276)	814	838	(24)	1,335	1,635	(300)
	Digestive Diseases	228	127	101	550	822	(272)	779	949	(170)
	Family Services	905	557	348	1,216	1,024	192	2,121	1,582	539
	Head & Neck	681	774	(93)	1,178	937	241	1,859	1,711	148
	Major Trauma Network	3	21	(19)	0	0	0	3	21	(19)
	Neuroscience	505	236	269	355	391	(36)	860	627	233
	Pathology Network Group	0	0	0	298	275	23	298	275	23
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	801	924	(123)	510	558	(48)	1,311	1,483	(172)
	Specialist Medicine	276	181	95	879	1,192	(314)	1,155	1,374	(219)
	Specialist Surgery	338	509	(171)	1,300	941	359	1,638	1,450	187
	Theatres, Anaesthetics and Critical Care	1,542	1,486	55	1,356	1,469	(114)	2,897	2,956	(58)
Total Operations		**7,990**	**7,647**	**344**	**13,191**	**13,837**	**(646)**	**21,181**	**21,484**	**(303)**
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	4	0	4	0	0	0	4	0	4
	Chief Nurse Office	0	12	(12)	0	0	0	0	12	(12)
	Director of Assurance	0	(0)	0	0	0	0	0	(0)	0
	Director of People		(0)	0	0	0	0	0	(0)	0
	Director of Finance, Estates & Facilities	0	0	0	0	0	0	0	0	0
	Strategy and Partnerships	0	0	0	0	0	0	0	0	0
Total Corporate		**4**	**12**	**(8)**	**0**	**0**	**0**	**4**	**12**	**(8)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	0	62	(62)	(15)	(437)	422	(15)	(375)	359
	Reserves	(32)	0	(32)	0	0	0	(32)	0	(32)
Total Central Income, Reserves & Technical		**(32)**	**62**	**(94)**	**(15)**	**(437)**	**422**	**(47)**	**(375)**	**328**
Surplus / (Deficit)		**7,963**	**7,721**	**242**	**13,176**	**13,400**	**(225)**	**21,138**	**21,121**	**17**

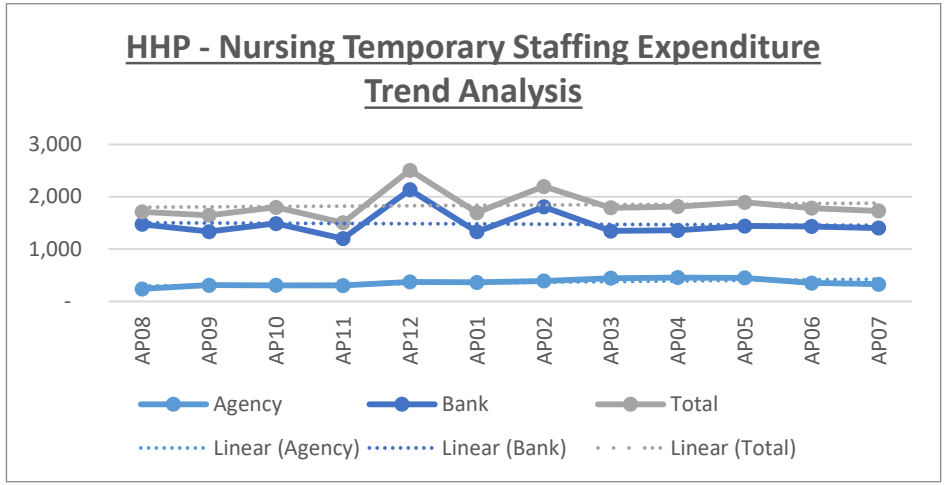


Type	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07
Agency	1,927	1,750	1,737	1,783	1,892	1,911	1,917	1,763	1,854	1,930	1,998	1,472
Bank	1,618	1,289	1,319	952	1,540	1,089	1,208	1,194	1,097	1,505	1,024	1,158
Total	**3,545**	**3,040**	**3,056**	**2,735**	**3,432**	**3,000**	**3,125**	**2,957**	**2,951**	**3,435**	**3,022**	**2,631**

Temporary Staffing Summary - Nursing

The Group has spent £12.9m on Nursing agency and bank pay YTD. This is (£0.5m) more than the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	566	757	(191)	2,730	3,047	(317)	3,296	3,804	(508)
	Cancer Network	0	0	0	8	0	8	8	0	8
	Cardiovascular	131	136	(5)	172	211	(39)	303	347	(44)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	501	760	(259)	1,038	939	99	1,539	1,698	(160)
	Digestive Diseases	380	301	79	730	769	(39)	1,110	1,071	40
	Family Services	310	286	24	1,809	1,884	(76)	2,119	2,171	(52)
	Head & Neck	47	27	20	42	21	21	89	48	41
	Major Trauma Network	32	85	(53)	123	128	(5)	155	213	(57)
	Neuroscience	213	101	112	314	305	9	527	406	120
	Pathology Network Group	1	0	1	0	0	0	1	0	1
	Patient Services	7	5	2	135	60	75	142	65	77
	Site Management & Discharge teams	39	280	(241)	185	163	23	224	442	(218)
	Specialist Cancer and Support Services	505	314	191	121	127	(6)	626	441	185
	Specialist Medicine	365	216	149	715	803	(88)	1,081	1,020	61
	Specialist Surgery	313	155	158	283	304	(21)	596	459	137
	Theatres, Anaesthetics and Critical Care	52	43	8	621	405	215	672	449	224
Total Operations		**3,461**	**3,468**	**(6)**	**9,027**	**9,165**	**(139)**	**12,488**	**12,633**	**(145)**
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	0	0	0	0	0	0	0	0	0
	Chief Nurse Office	0	2	(2)	22	28	(6)	23	30	(8)
	Director of Assurance	0	0	0	0	0	0	0	0	0
	Director of People	3	17	(14)	17	30	(13)	20	48	(27)
	Director of Finance, Estates & Facilities	0	0	0	0	1	(0)	0	1	(0)
	Strategy and Partnerships	0	0	0	0	0	0	0	0	0
Total Corporate		**4**	**20**	**(16)**	**40**	**59**	**(19)**	**43**	**79**	**(35)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(125)	6	(131)	7	147	(140)	(118)	153	(271)
	Reserves	0	0	0	0	37	(37)	0	37	(37)
Total Central Income, Reserves & Technical		**(125)**	**6**	**(131)**	**7**	**184**	**(177)**	**(118)**	**190**	**(308)**
Surplus / (Deficit)		**3,340**	**3,493**	**(153)**	**9,073**	**9,408**	**(335)**	**12,413**	**12,902**	**(489)**



Type	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07
Agency	239	310	309	304	372	366	391	444	456	450	352	328
Bank	1,473	1,335	1,489	1,201	2,134	1,330	1,806	1,345	1,358	1,442	1,433	1,402
Total	**1,712**	**1,645**	**1,797**	**1,505**	**2,505**	**1,696**	**2,196**	**1,789**	**1,814**	**1,892**	**1,785**	**1,730**

Appendices



Appendix A – Trust I&E & Divisional Budgetary Performance

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.5	75.9	0.4	527.8	530.5	2.7	46.7	47.1	0.4	326.5	326.3	(0.2)	122.2	122.9	0.7	854.3	856.8	2.5
Other Income	5.9	7.0	1.0	57.7	58.8	1.2	6.3	5.0	(1.3)	43.9	38.0	(5.9)	12.3	12.0	(0.3)	101.5	96.8	(4.7)
Total Operating Income	**81.4**	**82.8**	**1.4**	**585.4**	**589.3**	**3.9**	**53.0**	**52.1**	**(0.9)**	**370.4**	**364.3**	**(6.1)**	**134.5**	**134.9**	**0.4**	**955.8**	**953.6**	**(2.2)**
Pay Costs																		
Medical Staff	(17.3)	(17.9)	(0.6)	(122.0)	(126.0)	(4.0)	(9.6)	(10.5)	(0.8)	(70.8)	(72.5)	(1.7)	(26.9)	(28.4)	(1.4)	(192.7)	(198.4)	(5.7)
Nursing Staff	(14.9)	(15.8)	(0.9)	(104.1)	(108.2)	(4.1)	(12.9)	(12.9)	(0.0)	(90.1)	(90.0)	0.0	(27.8)	(28.7)	(0.9)	(194.2)	(198.3)	(4.0)
Scientific Therapeutic & Technical Staff	(7.0)	(7.0)	0.1	(48.7)	(49.6)	(0.9)	(5.0)	(5.2)	(0.2)	(35.2)	(36.5)	(1.3)	(12.0)	(12.2)	(0.2)	(83.9)	(86.0)	(2.1)
Total Clincial Pay	**(39.2)**	**(40.7)**	**(1.5)**	**(274.8)**	**(283.7)**	**(9.0)**	**(27.5)**	**(28.6)**	**(1.1)**	**(196.1)**	**(199.0)**	**(2.9)**	**(66.7)**	**(69.3)**	**(2.6)**	**(470.9)**	**(482.8)**	**(11.9)**
Admin & Clerical Staff	(6.2)	(6.2)	0.1	(43.4)	(43.8)	(0.3)	(5.4)	(5.3)	0.1	(37.4)	(36.6)	0.8	(11.6)	(11.4)	0.2	(80.8)	(80.4)	0.4
Maintenance Staff	(0.3)	(0.3)	0.0	(2.3)	(2.1)	0.2	(0.2)	(0.2)	0.0	(1.3)	(1.2)	0.1	(0.5)	(0.5)	0.0	(3.6)	(3.3)	0.2
Support Staff	(1.7)	(1.6)	0.1	(11.6)	(11.3)	0.3	(1.7)	(1.7)	(0.0)	(11.5)	(11.5)	0.0	(3.4)	(3.3)	0.1	(23.1)	(22.8)	0.3
Other Staff	(0.0)	0.0	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	(0.0)
Apprentice Levy	(0.2)	(0.2)	0.0	(1.2)	(1.3)	(0.1)	(0.1)	(0.2)	(0.0)	(1.0)	(1.0)	0.0	(0.3)	(0.3)	(0.0)	(2.2)	(2.3)	(0.1)
Total Other Pay	**(8.4)**	**(8.2)**	**0.2**	**(58.6)**	**(58.6)**	**(0.0)**	**(7.4)**	**(7.3)**	**0.1**	**(51.2)**	**(50.3)**	**0.9**	**(15.8)**	**(15.5)**	**0.3**	**(109.8)**	**(109.0)**	**0.8**
Total Pay Costs	**(47.6)**	**(48.9)**	**(1.3)**	**(333.4)**	**(342.4)**	**(9.0)**	**(34.9)**	**(35.9)**	**(1.0)**	**(247.3)**	**(249.3)**	**(2.0)**	**(82.5)**	**(84.8)**	**(2.2)**	**(580.7)**	**(591.7)**	**(11.0)**
Drugs	(10.8)	(9.4)	1.4	(76.3)	(78.1)	(1.8)	(2.6)	(3.6)	(1.0)	(23.5)	(23.8)	(0.3)	(13.4)	(13.0)	0.3	(99.8)	(101.9)	(2.1)
Clinical Supplies & Services	(7.4)	(8.5)	(1.1)	(51.6)	(55.4)	(3.7)	(4.0)	(4.8)	(0.8)	(28.0)	(30.5)	(2.5)	(11.4)	(13.3)	(1.9)	(79.6)	(85.9)	(6.3)
Total Clinical Non Pay	**(18.2)**	**(17.9)**	**0.3**	**(128.0)**	**(133.5)**	**(5.5)**	**(6.6)**	**(8.5)**	**(1.9)**	**(51.5)**	**(54.4)**	**(2.9)**	**(24.8)**	**(26.4)**	**(1.6)**	**(179.5)**	**(187.8)**	**(8.4)**
General Supplies & Services	(1.8)	(1.4)	0.4	(13.3)	(13.1)	0.1	(0.6)	(0.7)	(0.1)	(3.6)	(5.0)	(1.4)	(2.4)	(2.1)	0.3	(16.9)	(18.1)	(1.2)
Establishment Expenses	(0.5)	(0.5)	(0.0)	(3.7)	(3.7)	(0.1)	(0.7)	(0.4)	0.3	(4.8)	(4.2)	0.6	(1.2)	(1.0)	0.2	(8.4)	(7.9)	0.5
Other Establishment Costs	(2.4)	(2.4)	0.0	(16.9)	(16.8)	0.1	(1.5)	(1.4)	0.1	(10.4)	(10.3)	0.1	(3.9)	(3.8)	0.1	(27.4)	(27.2)	0.2
Premises and Fixed Plant	(2.4)	(3.3)	(1.0)	(22.0)	(19.3)	2.7	(2.1)	(2.0)	0.2	(15.0)	(14.2)	0.8	(4.5)	(5.3)	(0.8)	(36.9)	(33.5)	3.4
Purchase of Healthcare Services	(3.5)	(3.6)	(0.1)	(26.5)	(24.2)	2.3	(1.6)	(0.9)	0.7	(11.9)	(9.9)	2.0	(5.1)	(4.5)	0.7	(38.4)	(34.1)	4.3
Miscellaneous Expenditure	(0.0)	(0.1)	(0.1)	(0.1)	(0.4)	(0.3)	(0.1)	(0.1)	0.0	(0.7)	(0.8)	(0.1)	(0.1)	(0.2)	(0.1)	(0.8)	(1.2)	(0.4)
Education Expenditure	(0.6)	(0.5)	0.1	(4.5)	(3.9)	0.6	(0.2)	(0.2)	0.0	(1.9)	(1.6)	0.3	(0.8)	(0.6)	0.2	(6.3)	(5.5)	0.9
Consultancy Expenditure	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	0.1	0.1	(0.2)	(0.3)	(0.1)	(0.0)	(0.0)	0.0	(0.3)	(0.4)	(0.2)
Total Other Non Pay	**(11.2)**	**(11.9)**	**(0.6)**	**(86.9)**	**(81.6)**	**5.3**	**(6.9)**	**(5.6)**	**1.3**	**(48.5)**	**(46.3)**	**2.2**	**(18.1)**	**(17.4)**	**0.7**	**(135.4)**	**(127.9)**	**7.5**
Total Non Pay Costs	**(29.4)**	**(29.7)**	**(0.3)**	**(214.9)**	**(215.1)**	**(0.2)**	**(13.5)**	**(14.1)**	**(0.6)**	**(100.0)**	**(100.7)**	**(0.7)**	**(42.9)**	**(43.8)**	**(0.9)**	**(314.8)**	**(315.7)**	**(0.9)**
Total Operating Expenditure	**(77.0)**	**(78.6)**	**(1.6)**	**(548.2)**	**(557.4)**	**(9.2)**	**(48.4)**	**(49.9)**	**(1.5)**	**(347.3)**	**(350.0)**	**(2.7)**	**(125.4)**	**(128.6)**	**(3.2)**	**(895.5)**	**(907.4)**	**(11.9)**
EBITDA	**4.4**	**4.2**	**(0.2)**	**37.2**	**31.9**	**(5.4)**	**4.6**	**2.1**	**(2.5)**	**23.1**	**14.3**	**(8.8)**	**9.0**	**6.3**	**(2.7)**	**60.3**	**46.2**	**(14.1)**
Depreciation	(2.5)	(2.5)	0.0	(17.3)	(17.1)	0.2	(2.2)	(1.9)	0.3	(14.6)	(13.3)	1.4	(4.6)	(4.3)	0.3	(32.0)	(30.4)	1.6
Non Operating Items	(1.4)	(1.2)	0.2	(9.8)	(9.4)	0.4	(0.7)	(0.7)	0.0	(4.7)	(4.2)	0.5	(2.1)	(1.9)	0.2	(14.5)	(13.6)	0.9
Surplus/(Deficit)	**0.5**	**0.5**	**(0.0)**	**10.1**	**5.3**	**(4.8)**	**1.8**	**(0.4)**	**(2.2)**	**3.7**	**(3.1)**	**(6.9)**	**2.3**	**0.1**	**(2.2)**	**13.9**	**2.2**	**(11.7)**
NHSE Allowable Adjustments	0.0	(0.3)	(0.3)	(15.2)	(13.8)	1.4	(1.5)	(0.4)	1.0	(10.5)	(5.0)	5.5	(1.4)	(0.7)	0.7	(25.7)	(18.8)	6.9
Adjusted Surplus / (Deficit)	**0.6**	**0.2**	**(0.4)**	**(5.0)**	**(8.4)**	**(3.4)**	**0.3**	**(0.8)**	**(1.2)**	**(6.8)**	**(8.1)**	**(1.4)**	**0.9**	**(0.6)**	**(1.5)**	**(11.8)**	**(16.6)**	**(4.8)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine	(3.3)	(3.5)	(0.2)	(23.4)	(25.2)	(1.8)	(5.7)	(5.8)	(0.1)	(39.9)	(40.6)	(0.7)	(9.0)	(9.4)	(0.3)	(63.3)	(65.8)	(2.5)
	Cancer Network	(0.5)	(0.4)	0.1	(3.0)	(3.0)	(0.0)	(0.2)	(0.3)	(0.1)	(1.8)	(1.8)	0.0	(0.7)	(0.7)	0.0	(4.8)	(4.8)	(0.0)
	Cardiovascular	(3.4)	(3.9)	(0.5)	(24.2)	(25.3)	(1.1)	(0.9)	(0.8)	0.1	(6.4)	(6.4)	0.0	(4.3)	(4.7)	(0.4)	(30.6)	(31.7)	(1.1)
	Chief Delivery Officer	(0.1)	(0.1)	(0.1)	(0.5)	(0.5)	(0.0)	(0.1)	(0.1)	0.0	(0.5)	(0.4)	0.1	(0.2)	(0.2)	(0.0)	(1.1)	(0.9)	0.1
	Community, Frailty & Therapy	(3.5)	(3.6)	(0.1)	(24.8)	(26.0)	(1.2)	(4.1)	(4.1)	0.0	(27.9)	(28.3)	(0.4)	(7.6)	(7.7)	(0.0)	(52.7)	(54.3)	(1.5)
	Digestive Diseases	(2.9)	(3.3)	(0.5)	(20.4)	(22.5)	(2.1)	(2.6)	(2.6)	(0.0)	(17.6)	(17.6)	(0.1)	(5.5)	(5.9)	(0.5)	(37.9)	(40.1)	(2.2)
	Family Services	(4.8)	(5.1)	(0.4)	(32.8)	(35.2)	(2.4)	(4.4)	(5.0)	(0.6)	(30.6)	(32.1)	(1.5)	(9.2)	(10.1)	(1.0)	(63.4)	(67.2)	(3.9)
	Head & Neck	(3.5)	(3.7)	(0.2)	(24.5)	(25.0)	(0.5)	(1.3)	(1.4)	(0.1)	(9.3)	(9.7)	(0.3)	(4.9)	(5.1)	(0.3)	(33.9)	(34.6)	(0.8)
	Major Trauma Network	(0.5)	(0.5)	0.0	(3.2)	(3.3)	(0.1)	(0.2)	(0.2)	(0.0)	(1.4)	(1.4)	0.0	(0.7)	(0.7)	(0.0)	(4.6)	(4.8)	(0.1)
	Neuroscience	(2.1)	(2.3)	(0.2)	(14.9)	(15.8)	(0.9)	(0.6)	(0.7)	(0.1)	(4.5)	(4.8)	(0.3)	(2.8)	(3.1)	(0.3)	(19.4)	(20.6)	(1.2)
	Pathology Network Group	(1.9)	(1.7)	0.2	(13.5)	(13.6)	(0.1)	(2.2)	(2.2)	(0.0)	(14.7)	(14.9)	(0.2)	(4.1)	(3.9)	0.2	(28.3)	(28.5)	(0.3)
	Patient Services	(2.2)	(2.1)	0.1	(15.4)	(15.6)	(0.2)	(1.7)	(1.6)	0.1	(11.8)	(11.6)	0.2	(3.9)	(3.7)	0.2	(27.1)	(27.1)	0.0
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(1.9)	(2.2)	(0.3)	(0.4)	(0.4)	(0.0)	(2.4)	(2.5)	(0.1)	(0.6)	(0.7)	(0.0)	(4.3)	(4.7)	(0.4)
	Specialist Cancer and Support Services	(18.0)	(17.7)	0.3	(126.1)	(126.2)	(0.1)	(6.1)	(6.3)	(0.2)	(42.7)	(42.5)	0.1	(24.1)	(24.0)	0.1	(168.7)	(168.7)	0.1
	Specialist Medicine	(3.9)	(3.8)	0.0	(26.8)	(27.4)	(0.6)	(2.0)	(1.9)	0.1	(13.6)	(14.0)	(0.4)	(5.9)	(5.7)	0.1	(40.4)	(41.4)	(1.0)
	Specialist Surgery	(3.8)	(4.0)	(0.2)	(24.7)	(25.9)	(1.2)	(1.8)	(1.9)	(0.1)	(12.3)	(12.8)	(0.4)	(5.6)	(5.9)	(0.3)	(37.0)	(38.7)	(1.7)
	Theatres, Anaesthetics and Critical Care	(7.4)	(7.7)	(0.3)	(51.5)	(52.8)	(1.3)	(4.3)	(4.7)	(0.3)	(29.6)	(29.9)	(0.3)	(11.8)	(12.4)	(0.6)	(81.1)	(82.7)	(1.7)
Total Operations		**(62.1)**	**(64.0)**	**(1.9)**	**(431.4)**	**(445.4)**	**(14.0)**	**(38.7)**	**(39.9)**	**(1.3)**	**(267.1)**	**(271.3)**	**(4.1)**	**(100.8)**	**(103.9)**	**(3.2)**	**(698.5)**	**(716.6)**	**(18.1)**
Corporate	Chief Executive	(0.1)	(0.2)	(0.1)	(0.8)	(1.0)	(0.2)	(0.1)	(0.1)	(0.0)	(0.7)	(0.9)	(0.2)	(0.2)	(0.3)	(0.1)	(1.6)	(2.0)	(0.4)
	Chief Medical Officer	(0.5)	(0.3)	0.2	(8.3)	(8.4)	(0.1)	(0.7)	(0.8)	(0.0)	(8.9)	(8.5)	0.4	(1.2)	(1.0)	0.1	(17.2)	(17.0)	0.2
	Chief Nurse Office	(3.0)	(3.0)	(0.1)	(20.9)	(21.4)	(0.5)	(2.2)	(2.2)	0.0	(15.6)	(15.4)	0.2	(5.2)	(5.2)	(0.0)	(36.5)	(36.8)	(0.2)
	Director of Assurance	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.5)	(0.5)	(0.0)	(0.1)	(0.1)	(0.0)	(0.6)	(0.6)	(0.0)
	Director of People	(0.9)	(0.9)	0.0	(6.2)	(5.9)	0.4	(0.8)	(0.8)	(0.0)	(5.7)	(5.6)	0.2	(1.7)	(1.7)	0.0	(12.0)	(11.4)	0.5
	Director of Finance, Estates & Facilities	(6.4)	(6.0)	0.4	(41.1)	(39.4)	1.8	(4.3)	(4.4)	(0.1)	(27.5)	(28.4)	(0.9)	(10.7)	(10.4)	0.2	(68.7)	(67.8)	0.9
	Strategy and Partnerships	(0.9)	(0.8)	0.1	(3.9)	(3.7)	0.2	(0.6)	(0.6)	(0.0)	(2.7)	(2.5)	0.2	(1.5)	(1.4)	0.1	(6.7)	(6.3)	0.4
Total Corporate		**(11.8)**	**(11.2)**	**0.6**	**(81.5)**	**(79.9)**	**1.5**	**(8.8)**	**(9.0)**	**(0.2)**	**(61.7)**	**(61.8)**	**(0.1)**	**(20.6)**	**(20.2)**	**0.4**	**(143.2)**	**(141.8)**	**1.4**
Central Income, Reserves & Technical	Central Income	76.3	76.2	(0.0)	550.7	548.0	(2.6)	48.5	48.6	0.1	338.4	337.3	(1.1)	124.7	124.8	0.1	889.1	885.3	(3.8)
	Central Technical	(3.5)	(0.8)	2.8	(27.2)	(17.2)	10.0	(1.1)	(0.1)	1.1	(7.6)	(6.8)	0.7	(4.6)	(0.8)	3.8	(34.7)	(24.0)	10.7
	Reserves	1.6	0.2	(1.4)	(0.5)	(0.2)	0.3	2.0	0.1	(1.9)	1.7	(0.5)	(2.2)	3.6	0.2	(3.3)	1.2	(0.7)	(1.9)
Total Central Income, Reserves & Technical		**74.4**	**75.7**	**1.3**	**523.0**	**530.6**	**7.6**	**49.3**	**48.6**	**(0.7)**	**332.6**	**330.0**	**(2.6)**	**123.7**	**124.2**	**0.6**	**855.6**	**860.6**	**5.0**
Surplus / (Deficit)		**0.5**	**0.5**	**(0.0)**	**10.1**	**5.3**	**(4.8)**	**1.8**	**(0.4)**	**(2.2)**	**3.7**	**(3.1)**	**(6.9)**	**2.3**	**0.1**	**(2.2)**	**13.9**	**2.2**	**(11.7)**
Adjustments to adjusted financial performance		0.0	(0.3)	(0.3)	(15.2)	(13.8)	1.4	(1.5)	(0.4)	1.0	(10.5)	(5.0)	5.5	(1.4)	(0.7)	0.7	(25.7)	(18.8)	6.9
Adjusted financial performance Surplus / (Deficit)		**0.6**	**0.2**	**(0.4)**	**(5.0)**	**(8.4)**	**(3.4)**	**0.3**	**(0.8)**	**(1.2)**	**(6.8)**	**(8.1)**	**(1.4)**	**0.9**	**(0.6)**	**(1.5)**	**(11.8)**	**(16.6)**	**(4.8)**

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)241

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11th December 2025
Director Lead	Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common Julie Beilby Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on Wednesday 24th September and Wednesday 29th October 2025.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Workforce, Education and Culture Committees-In-Common held on Wednesday 29th October and Wednesday 26th November 2025.
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 24th September 2025 at 09:00 to 12:30 in The Boardroom, Diana, Princess of Wales Hospital, Grimsby

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) – Chair
Julie Beilby	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH) – (Virtual)
Peter Sedman	Deputy Group Chief Medical Officer (attending for Group Chief Medical Officer)
Simon Nearney	Group Chief People Officer
Amanda Stanford	Group Chief Nurse

In Attendance:

Rebecca Crashley	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Helen Knowles	Director of People Services
Lucy Vere	Group Director of Learning and Organisational Development
Wajiha Arshad	Guardian of Safe Working Hours (HUTH) (item 4.7.1) – (Virtual)
Dr Elizabeth Evans	Guardian of Safe Working Hours (NLaG) (item 4.7.2)

Observers:

Robert Pickersgill	Governor Observer – (Virtual)
Helen Marks	Group Improvement Director
Hilda Gwilliams	Interim Senior Site Delivery Director

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. Apologies were noted for Dr Kate Wood, Group Chief Medical Officer, Sue Liburd, Non-Executive Director (NLaG), Laura Treadgold, Non-Executive Director (HUTH), and Myles Howell, Group Director of Communications and Engagement.

Sean Lyons expressed his heartfelt gratitude to the Committees-in-Common for their continued hard work. The CiC thanked Sean for his support over the years and wished him every success in the future.

1.2 **Staff Charter and Values**

Tony Curry noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meeting held on 27th August 2025**

The minutes of the meeting held on 27th August 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to note.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

1.7 **Urgent and Emerging Issues**

Simon Nearney provided an update on the Band 2/3 Health Care Support Workers (HCSW). The remaining Unions had agreed the offer through the JNCC process and an MOU (Memorandum of Understanding) was being developed. Communications would be published shortly and payments were expected to commence at the end of October 2025. The backdated process would then begin which was expected to take 12-15 months.

Lyn Simpson, Interim Chief Executive had appointed an Improvement team. A meeting took place yesterday with Executives, Improvement team and Care Group management teams regarding a new way of working to improve clinical engagement. The new approach was well received by Chiefs of Service.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

None to note.

3. RISK & ASSURANCE

3.1 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate**

None to note.

3.2 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Workforce Integrated Performance Report**

Paul Bunyan explained that the report showed an artificial decline in Agency percentage usage due to data challenges from the transfer to our new provider, Retinue. This affected non-nursing staff, however nursing agency data remained accurate. The Group were currently £4.3 million behind plan against the 30% Agency reduction target. Meetings were ongoing with all Care Groups and there was a great focus on reviewing current agency and locums and looking at different ways to progress to meet the Agency reduction target of 30%. The Group acknowledged that ongoing plans for the remainder of 2025/26 would provide a significant impact on the financial programme for 2026/27. A reduction in core compliance and an increase in role-specific training was seen at HUTH. An increase in core compliance and role-specific training was seen at NLaG. Job planning sign-off compliance had improved by 12% in the last month and was contributed by the work that Dr Kate Wood and Peter Sedman were undertaking with the Care Groups.

Peter Sedman shared that significant efforts were underway to achieve the target of improving job planning compliance by mid-October 2025. Three Care Groups were over 80% and six Care Groups were below 80% for job planning compliance. The implementation of the two systems across the Group had contributed to greater challenges than initially anticipated, particularly sign-off challenges and system glitches.

Paul Bunyan updated that the Time to Hire position remained high against the doctor rotations, however the Group expected a higher Time to Hire position between June and September. Rotation was expected to return to a more positive position by November 2025.

Julie Beilby expressed dissatisfaction in the vacancy and recruitment activity. She emphasised the importance of not losing sight of metrics that would impact broadly on the Group and suggested that the Group should focus attention on how to work differently to drive improvement. Paul Bunyan shared that significant opportunities were present around digital innovation. He highlighted that it was currently an atypical time for the Group due to the sheer amount of recruitment which impacted the KPI position and was not unusual for the time of year, however, efforts were underway to find a solution. Simon Nearney shared that work was ongoing to reduce the vacancy position, but it was extremely challenging.

Tony Curry stated that the Group were not hitting statistics for mandatory training

where it counts, and key areas were not where they needed to be. Simon Nearney stated that overall core mandatory training was green at 88.8%.

The Committees-in-Common agreed that assurance was not required for this item.

4.2 **Registered Nursing and Midwifery Staffing – HUTH & NLaG**

Amanda Stanford took the report as read and provided an update. She acknowledged that SNCT (Safer Nursing Care Tool) methodology was previously not implemented at HUTH but this had been rolled out since Amanda had commenced in post. The fourth data collection was now nearing completion with the aim of the Safer Staffing Paper due in November 2025 and then to be presented at Trust Boards-in-Common in December 2025. The risks remained the same. HUTH continued to be in the lower quartile when benchmarked with other acute providers for CHPPD (Care Hours Per Patient Day) and NLaG remained in the mid to upper quartile for CHPPD. There was a risk predominantly focused on non-registered workforce and the number of vacancies, however work was ongoing with the Workforce Team and efforts were underway with a focus on how to bridge that gap.

There was a risk at HUTH around registered and non-registered nursing. There were 21 areas at HUTH that achieved just below 6 hours for CHPPD. The birth rate plus tool for midwifery identified a gap of 10.5 WTE (Whole Time Equivalents) at NLaG and 15 WTE at HUTH which included specialist midwives, however if broken down to clinical midwives it was 10 WTE. Work was ongoing around neonatal staffing. Data collections for Paediatric and Adult services were expected to end on 30 September 2025. Data collections for ED would end on 13 September and the risks were on the risk register. Fill-rates continued to vary significantly.

Tony Curry queried the scale of cost within the Nursing business cases. Amanda Stanford explained there was a phased approach. The total gap was circa £9 million for general nursing. A midwifery business case was in place for £2.5 million, a neonatal business case was in place for £2.5 million, however this excluded the consultant workforce. The business cases for General Nursing, Neonatal Nursing, Consultant Workforce, Midwifery, and Obstetrics totalled circa £21 million annually. She shared that it was agreed with Lyn Simpson to present all 5 business cases. A cover paper would be developed with Emma Sayner which would cover the 5 workforce areas and would identify the risks, approach and prioritisation.

Julie Beilby noted historical financial planning within the NHS. She understood the phased approach and noted that the sooner the Group were on board with multi-year financial planning, the easier it would be for the NHS to get a real grip on those things. She queried whether developing quality metrics across the Group was currently essential as the Group were being judged on metrics as individual sovereign organisations. She recognised the importance of not losing sight on the individual organisations and metrics, but also the harmonisation of Group metrics.

Tony Curry asked for clarification around the reason for the phased approach within the business cases. He wondered whether the Group were constraining themselves on financial affordability. Amanda Stanford confirmed that this was due to present challenges around recruitment and demographics of the workforce. She explained that a significant number of Consultants were near retirement which would be factored into the workforce profile. Tony Curry suggested highlighting the

potential turnover challenge within the report and clarity around affordability. Amanda clarified that the purpose of the report was to identify the gap and what was required. Further discussions at Boards-in-Common would identify how to do that.

The Committees-in-Common agreed limited assurance.

4.2.1 **Nursing, Therapies and Midwifery Education Progress Report**

Amanda Stanford updated that the purpose of the report was to outline the work undertaken around educational progress which was a priority to ensure students have a good experience and want to continue working within the Group. An NHSE Senior Leadership Engagement visit took place at NLaG on 30 July 2025 and positive feedback was provided. There were no concerns raised from a Nursing and Midwifery perspective. The safe learning environmental charter was praised and NHSE felt that the work that had taken place had a positive impact on students. The Group received positive feedback rates from a Nursing perspective which were consistently above 85%. The Group were working with the University to improve Midwifery feedback which was anticipated to be a data collection issue. Nursing and Midwifery were receiving positive feedback and success stories were shared.

Tony Curry noted the downward trend in Nursing University places and wondered how it was factored into future planning for the Group. Amanda Stanford clarified that it was taking place nationally and was not unique to the Group. The Group maintained strong working relationships with the University. Further work would be undertaken to look at how the Group could provide positive work experiences with the aim of attracting young people across communities, as well as allied health professionals across midwifery to offer them a career within the NHS.

Simon Nearney mentioned that historically, the Group had great apprenticeship programmes in place for HCSW's, nurse associates and nurse apprenticeships where people could join our group at 16 years old and become a registered nurse. Local people, local education and local jobs and careers. These programmes would be continuing.

Amanda Stanford shared that the apprenticeship programme was well-embedded at HUTH however not as well-embedded at NLaG and efforts were underway to ensure equity across both Organisations with a great focus on developing apprenticeship roles on the South Bank.

Amanda Stanford mentioned the NLaG Practice Development Team won an HSJ award in the category of Staff Health and Wellbeing for their work supporting the pastoral welfare of internationally educated nurses. The CiC Chairs were in favour of this story being presented to Boards-in-Common.

Lucy Vere shared that the North Bank had changed the apprenticeship process to a more widening participating approach and over 300 people attended the Learning and Innovation Centre, with only 60 places available. The Group were working collaboratively with the University to pass names on.

4.3 **Workforce Race Equality Standards (WRES) - HUTH & NLaG**

Lucy Vere thanked Paul Bunyan's team for their support with the report and acknowledged that reporting to harmonise across the Group was challenging. She took the report as read and updated that success stories had highlighted the ability for BAME (Black, Asian and Minority Ethnic) staff to access non-mandatory training and CPD (Continuing Professional Development). She highlighted that increased discrimination was seen, and although she was unaware whether it was specific to the Group, she recognised the challenges within our society which was currently being felt across the country.

HUTH

The current BAME workforce at HUTH was 21% and the composition of Medical and Dental staff was 53%. Recruitment was an ongoing challenge across the Group with a lower amount of BAME staff being recruited. A full inclusive recruitment project was in place and the Group would undertake a deep dive to understand the reasons for recruitment shortfalls. The formal disciplinary process was positive at HUTH and required further work at NLaG. The Group had seen an increase in bullying and harassment, primarily from patient relatives and the public. Staff were reporting this through the zero-tolerance tool and further work was required to support staff to tackle those challenges. An increase in bullying and harassment was seen from staff, however there was an assumption from Network colleagues that the current challenges in society had emboldened staff. Further work would take place to address this. Lucy Vere highlighted that HUTH did not have BAME representation from a voting Board members perspective. There was BAME representation from a wider Boards-in-Common perspective, however not for HUTH. Support was in place for internationally educated staff through the zero-tolerance framework. The Group required improvements to take effect within Governance to enable effectiveness through the EDI Steering Group. EDI training was now embedded in the first induction to allow people to explore all areas of discrimination.

NLaG

The overall BAME workforce at NLaG was 18.4%, which was lower than at HUTH, and the composition of Medical and Dental staff was 74.2% which was significantly higher than HUTH. There was strong engagement from a medical point of view. Recruitment challenges were ongoing and would be addressed through the inclusive recruitment project. It was determined that staff at NLaG were more likely to enter a disciplinary procedure and a deep dive would be explored to address this. Staff had equal opportunities to access non-mandatory CPD training. Harassment had increased, however a decline was seen in abuse from staff. Progress was made through the focus on cultural competency and further work was required to improve career progression. Discrimination from staff remained unchanged. The BAME representation from a voting Board member perspective was 16.7%. The zero-tolerance approach that was implemented at NLaG had a positive impact and people were reporting issues. Positive engagement events were ongoing. The Networks at NLaG were less established than those at HUTH and a structured recruitment process had taken place to address this.

Simon Nearney mentioned that the cultural challenges taking place across the country had a profound impact on staff. He continued that the Group had done some good work on communicating with staff when demonstrations were happening and the support available to staff. Managers also received a separate briefing to ensure they were ready to lead and support staff with practical ways to

help. He proposed presenting statistics from the zero-tolerance work to the CiC every six months.

David Sulch shared concerns that that the percentage of staff bullied by colleagues mirrored the percentage of staff bullied by the public.

Julie Beilby urged the CiC to reaffirm the zero-tolerance approach as it was unacceptable for staff to act in ways that could be seen as bullying and harassment. She recognised the leadership role the CiC played in escalating this and proposed escalating this matter to the Boards-in-Common.

Tony Curry noted that the report did not provide a sense of the actions that were in place and the reasons for challenges in appointing BAME staff. He noted that the WRES and WDES reports were presented to the CiC annually however they did not appear to show any improvement. Simon Nearney acknowledged that it would take time to see real progress, however improvements had been made. The Group were aware of the challenges within recruitment. Development programmes were ongoing and the Group were utilising available resources.
Lucy Vere recognised that there was only so much that the Group could co-ordinate and suggested that the Organisational Development team could attend the WEC CiC to present future reports and provide the required assurance.

Amanda Stanford wondered how the CiC could improve their engagement to understand the lived experience of the report, noting that there was no representation of the WRES and WDES voice present at the CiC. She emphasised the importance of engagement with those teams to understand their barriers in acquiring the level of assurance that the CiC required.

Julie Beilby stated that the Group did not take the opportunity to enable other staff to provide valuable support at Boards-in-Common from different levels in the Group. She reflected that looking at the national context may indicate greater progress and proposed escalating the composition of the Board to the Boards-in-Common.

Julie Beilby wondered how to structure a more inclusive package for recruiting into NED roles. David Sharif shared that the Group made attempts through various networks to access individuals with backgrounds and interests of that environment. He assured the CiC that efforts would continue. Julie Beilby proposed looking at whether there were other Boards-in-Common across the region that had successes with that.

Helen Knowles noted that 20% of staff were BAME and wondered whether there was anything the Group could do to encourage BAME staff to attend NED development programmes.

The Committees-in-Common endorsed the paper for approval at Boards-in-Common.

4.4 **Workforce Disability Equality Standards (WDES) - HUTH & NLaG**

Lucy Vere updated that the Group were likely to enter a formal capability process due to sickness absence. An inclusive recruitment process was being considered to support challenges within recruitment of BAME and non-disabled staff. An

increase in reporting was seen which was positive as historically staff were not comfortable to report. HUTH recently launched the REACH service, which was positive from a reasonable adjustment point of view. The Group co-produced a positive action leadership programme with the Network which was out for recruitment and a positive impact was expected. Sickness absence management and HR policies required further review. Recruitment would be reviewed to support special educational needs and neurodiversity.

Julie Beilby wondered whether the Group were taking a positive stance around working from home and whether it was playing a part in accommodation and transformation adjustments. Simon Nearney shared that a new flexible working Group policy was being produced and was expected to be published on 01 November 2025. Efforts were underway to convert back-office capacity into rest spaces which would support staff welfare.

The Committees-in-Common endorsed the paper for approval at Boards-in-Common.

Dr Wajiha Arshad joined the meeting at 10:50 hours.

4.5 **Staff Lottery Committee – Annual Report 2024-25**

Simon Nearney took the report as read and updated that £103k was raised in subscriptions for NLaG. £52k was allocated to prizes and £25k was allocated to staff-development activity. He explained that the Lottery Committee was previously suspended for six months because the Group were unable to take deductions from staff salaries due to the national minimum wage increase on 01 April 2025 and not receiving the NHS Pay Award until later in the year. Plans were in place to move to a Group-wide Lottery Committee, which was expected to be communicated in January 2026 and commence in March 2026.

Julie Beilby mentioned that moving to a partnership Trust and using the Gambling Commission rules and regulations rather than local authority rules and regulations was significantly time-consuming and complex. She wondered whether it was an efficient priority and cost-effective approach.

Action: Simon Nearney to pick this up with the team and update the CiC outside of the meeting.

David Sharif queried whether the Group were satisfied that the financial expertise and knowledge from the Staff Lottery Committee provided adequate support. Simon Nearney confirmed that the Group were happy with the level of financial knowledge they received however conversations had taken place regarding reduction of administration costs to put more money into staff engagement activities.

The Committees-in-Common took the paper for information.

4.6 **Medical Education Annual Report – HUTH & NLaG**

4.6.1 **Medical Education Annual Report - HUTH**

Peter Sedman took the report as read and updated that the resident doctors

satisfaction GMC survey at HUTH was generally successful however there were challenges with Oncology due to gaps within the rota. This was actively being addressed and a new rota was now in place. Educational supervisor compliance was 80% which was a positive picture. Educational appraiser compliance required improvement due to a lack of appraisers for doctors and a business case was in place to address this.

The recruitment of the Associate Medical Education Fellows and Assistant Psychologist Associate had revealed a positive uptake. The Medical Education team at HUTH were shortlisted for The Medical Educator Award 2025. Challenges were anticipated with an increased volume of doctors that were due to complete their training from medical school and enter into resident doctor posts. This would require significant education and supervision from the Group and work was ongoing to address this.

Tony Curry queried the allocation of PAs to supervisors. Peter Sedman confirmed that the more trainee doctors the Group had the more PAs would need allocating to cover that activity. Work was ongoing to ensure PAs were fully allocated for job training. He shared that there were policy differences between standard PAs across the Group.

David Sharif queried the risk within Educational Supervisor compliance. It was revealed that a proportion of trainers were not up to date in their certification to be supervisors.

Tony Curry noted the risk of financial restraints within the medical education budget.

Simon Nearney confirmed that certain elements of the medical education budget was funded by the Group and other elements were funded by the deanery.

Dr Elizabeth Evans joined the meeting at 11:10 hours.

The Committees-in-Common agreed reasonable assurance.

4.6.2 **Medical Education Annual Report - NLaG**

Peter Sedman raised concerns that the Medical Education team at NLaG were at risk of losing resident doctors if performance did not improve through the GMC survey results, which would have a catastrophic effect on the workforce. Significant work was ongoing with support from the PGME (Post Graduate Medical Education) Office at NLaG and actions were in place to encourage improvement prior to the next survey. Resident doctors were reallocated to other hospitals and available education supervisor space was relocated into the deanery for resident doctors. Work was ongoing to support rotas. The Group expected to receive the results of the next GMC survey by December 2025.

David Sulch wondered whether the departments had an understanding of the true challenges taking place and understood the implications.

Simon Nearney queried whether frequent updates were provided from the Medical Education team to senior leaders to provide assurance that improvements would be made. Peter Sedman confirmed that regular updates were provided and efforts

were underway to drive improvement.

David Sulch noted that it felt the Group were required to do something radical to support resident doctors and proposed escalating this matter to the Boards-in-Common.

Julie Beilby recognised that the Group needed to get basics and fundamentals right. Peter Sedman agreed that fundamental challenges needed to be worked through. He highlighted challenges on the South Bank regarding the allocation of resident doctors within the new national systems.

Helen Marks and Hilda Gwilliams left the meeting at 11:26 hours.

The Committees-in-Common agreed minimal assurance.

4.7 **Guardian of Safe Working Hours Annual Report – HUTH & NLaG**

4.7.1 **Guardian of Safe Working Hours Annual Report – HUTH**

Dr Wajiha Arshad provided an update. HUTH received 592 exception reports due to excess hours worked. 43 fines were accrued totalling £55k, the majority of which was due to the Paediatric Surgery Middle Grade non-resident on call rota. She shared that upon reviewing the rota data from the last 18 months, it was revealed that fines accrued a total of £70k. Work was ongoing to resolve the rota challenges and a business case was in place for a resident doctor to support the rota. This was expected to reduce the volume of fines and exception reports, however it would not be able to alleviate all the rota challenges. Efforts were underway to reinvest in training education for the resident doctors.

The Committees-in-Common agreed reasonable assurance.

4.7.2 **Guardian of Safe Working Hours Annual Report – NLaG**

Dr Elizabeth Evans provided an update for NLaG. She shared that a pattern was seen in exception reporting which was assumed to be due to people being unhappy. The volume of reports with immediate safety concerns remained low and minimal fines were accrued. Interventions were implemented in Trauma and Orthopaedics, and Medicine due to systemic cultural challenges, however the challenges had re-occurred. The volume of reports had steadily increased which was assumed to be contributed to high work pressures.

The Committees-in-Common agreed reasonable assurance.

Dr Elizabeth Evans and Dr Wajiha Arshad left the meeting at 11:35 hours.

4.8 **Health and Well-Being Progress Report Q2**

Paul Bunyan updated that Q1 focused on the establishment of a health and well-being provision to bring together all health and well-being practitioners which was now operational and benefits were seen.
The primary focus of Q2 was predominantly focused on Aid Quarter in line with the CARE programme (Communication and Engagement) which provided a positive scale of provision to peak interest.

Q3 would focus on embedding project delivery with a ground-up approach by triangulating were survey scores were of concern.

Julie Beilby praised the report and suggested that talking about funding available to new posts would be helpful.

The Committees-in-Common agreed significant assurance.

4.9 **Temporary Staffing - Agency Usage**

Helen Knowles updated that in 2024/25 the Group achieved a reduction of £11.5 million Agency Spend. NHSE provided the Group a target to achieve a further 30% reduction of Agency Spend. To achieve the 30% reduction target, the full year effect was £8.1 million, and the Group were £4 million off target. The Nursing and Midwifery 30% reduction totalled a £1.1 million reduction, and the Group were off-target at month 5. The authorisation process was strengthened and no new Agency workers over one week or any contract extensions could be put in place unless approved by Group Executive. As a focus on patient safety was required, exemptions would be requested and considered on a weekly basis. Work was ongoing to review standard placement bookings, consideration would be made to either end standard placement bookings or convert them to direct engagement saving c20% on each role. The number of standard placement bookings from the beginning of September 2025 had reduced from 24 to 21 with further work on-going. Three of those bookings in Anaesthetics were expected to convert to direct engagement by the end of October 2025. Significant work was ongoing regarding AHPs (Allied Health Professionals), particularly Sonographers and Audiologists across NLaG. Focused work was taking place work with Agencies, services and Retinue. There was expectation that newly qualified Nurses would support with achieving the £1.1 million reduction in Agency Spend target.

Paul Bunyan shared that an ‘on the ground’ team were working to support Care Groups by looking at what their perspective targets were from a cost point of view and WTE point of view to understand what the Group could do differently and put those actions into place.

Simon Nearney stated that the historic position of standard placement bookings had reduced significantly as they converted to direct engagement.

David Sulch wondered whether the Group did not expect to achieve the 30% Agency Spend target and that they should tell NHSE this. Simon Nearney recognised that it was challenging to meet the 30% target. Julie Beilby favoured driving forward to meet the target and then risk assessing that ability through the CIP (Cost Improvement Plan) and budget setting cycle.

Amanda Stanford left the meeting at 11:57 hours.

The Committees-in-Common agreed limited assurance, noting an understanding of challenges and an increased grip of control.

4.10 **Job Planning Monthly Update**

Peter Sedman shared that the Group were making progress however 35% of medical staff were registered on the system as ‘never having had a job plan’ which

was not an accurate picture, however this was due to being registered on the pre-existing system. Improvements were seen in trajectories however job planning was not where it needed to be to meet the 90% target by the end of October 2025.

Julie Beilby shared dissatisfaction that it was previously reported that a significant increase was expected in job planning progress however the Group were nowhere near meeting target. Peter Sedman confirmed that job plans were migrated however sign-off with the clinical leads was not happening, he explained that sign-off required 15 minutes per job plan and noted that previous system glitches were resolved two weeks' ago.

Tony Curry queried how many job plans currently required sign-off. Peter Sedman confirmed that 300 job plans were awaiting sign-off.

The Committees-in-Common agreed limited assurance.

4.11 **Mandatory Learning**

Lucy Vere shared that national guidance was provided around locally-mandated and role-specific training. Locally mandated training was required to report compliance and role specific training was not a requirement however was essential to job roles. Data revealed that HUTH had less locally mandated training topics than NLaG, and Nurses had the most additional locally mandated learning. New Governance would be implemented through a Mandatory Learning Oversight Group, with support from Nursing and Medical staff. Significant work was ongoing around staff engagement and attendance. A clear annual mandatory learning plan would be developed by April 2026 that would be fully harmonised mandatory learning across the Group. This would be presented to a future WEC CiC.

Julie Beilby noted the absence of patient safety within the report. Lucy Vere confirmed that this would be included in the report.

4.12 **NLaG Resident Doctors GMC National Training Survey Results and Progress Update**

This was covered within the Medical Education report and discussed as part of the agenda.

The Committees-in-Common agreed limited assurance.

4.13 **NHSE Capability Assessment - Quality of Care Domain**

David Sharif shared that as part of the NHS Oversight Framework, NHSE issued guidance and direction to Boards to assess their Organisations' capability against a range of expectations derived from the insightful provider board. David Sharif and Simon Nearney had reviewed questions posed and given an initial RAG status choosing one of the three options available to the Group. There was only one partially confirmed position regarding whether the Group regularly reviewed skills across the Organisation. In completing this fully, the Group would benefit to gain assurance that there was evidence to support the assessment being made. There would be a supporting narrative in the final submission to where those responses were not confirmed. He shared that it was a work in progress and there was an opportunity for the CiC to contribute and share immediate concerns.

5. ITEMS FOR INFORMATION

5.1 Workplan

This was shared for information.

5.2 Workforce Transformation Group Minutes

This was shared for information.

5.3 Trade Union Facility Time Publication Requirements

This was shared for information.

5.4 Specialist Cancer and Support Services risk briefing

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note.

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Band 2/3 Health Care Workers update
- Improvement team and new ways of working to improve clinical engagement
- Nursing Feedback positive feedback from NHSE
- HSJ Award for Best Health and Well-being initiative 2025
- Medical Education HUTH team nominated for a Medical Educator Award
- Agency Spend was limited assurance
- Job planning was limited assurance
- WRES and WDES endorsed for Boards-in-Common approval
- Escalation of the composition of the Board
- Nursing Safe Staffing Paper was limited assurance and investment required
- NLaG Medical Education supervision
- GMC survey required improvement

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 29th October 2025 at 9am till 12:30pm, in The Boardroom, Alderson House, Hull Royal Infirmary

The Committee Chair closed the meeting at 12:26 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y			
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y	Y	Y			
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y			
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D				D	Y			
Heather McNair	Interim Group Chief Nurse					Y	D	Y					
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y	Y	D			
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y	Y	Y			
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y	Y	N			
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y	N	N			
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y	Y	Y	Y	Y			

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 28th October 2025 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Julie Beilby	Non-Executive Director (NLaG) – Chair
Tony Curry	Non-Executive Director (HUTH)
David Sulch	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Dr Kate Wood	Group Chief Medical Officer
Simon Nearney	Group Chief People Officer
Jo Ledger	Deputy Group Chief Nurse (Attending for Group Chief Nurse)
Laura Treadgold	Non-Executive Director (HUTH)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Lucy Vere	Group Director of Learning and Organisational Development
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement
Leah Coneyworth	Head of Quality Compliance and Risk (HUTH) (item 3.1)
Fran Moverley	Freedom to Speak Up Guardian (HUTH) (item 4.3.1)
Elizabeth Houchin	Freedom to Speak Up Guardian (NLaG) (item 4.3.2)
Lindsey Harding	Group Director of Workforce (item 4.5)
Helen Knowles	Director of People Services (item 4.6)

Observers:

Robert Pickersgill	Governor Observer

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. Apologies were noted for Amanda Stanford, Group Chief Nurse, Katie Shepherd, Head of Quality Compliance and Risk (NLaG).

Dr Kate Wood shared that she would need to leave the meeting temporarily between 10:00-11:00 hours to attend another meeting.

1.2 **Staff Charter and Values**

Julie Beilby noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

Julie Beilby and Dr Kate Wood declared an interest regarding an Employee Relations case.

1.4 **To approve the minutes of the meeting held on 24th September 2025**

The minutes of the meeting held on 24th September 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to note.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

1.7 **Urgent and Emerging Issues**

Simon Nearney updated that the Group were still awaiting a response from the NLaG LNC regarding the offer that was proposed for the additional on-call rate. Additional efforts were being made by the Group Chief Medical Officer to obtain a response. Once a response was received, the Group would cross-reference to HUTH rates to harmonise.

NHSE had written to the Group regarding a 10-point plan with the aim of providing a better environment for resident doctors and work was ongoing to achieve this. The plan detailed wellbeing support, exception reporting, schedules, rotas, pay and study leave. The resident doctor industrial strike action would have a significant impact on staff, particularly the Consultants, as the Group would be required to move them from their usual activity to support urgent and emergency care and ward rounds that resident doctors usually cover. The Group are trying to protect elective activity particularly cancer and long wait patients, but the Group would know more in a couple of weeks.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Julie Beilby noted that a referral was received from the Performance, Estates and Finance Committees-in-Common regarding adequate care coverage at all times, especially across evenings and weekends. It did not feel that the Group was appropriately set up to currently achieve this.

The CiC concluded that this was an operational delivery and quality issue, rather than a workforce-related issue. They determined that the workforce plan was designed to support the current needs and services of the Group, and if that model required amendments, then it was to be managed appropriately through PEF CiC.

Action: Julie Beilby to re-refer this matter back to PEF CiC and highlight to the Boards-in-Common.

The Agenda was taken out of order at this point.

4.4 **NHSE Annual Self-Assessment Return for HUTH and NLaG**

Lucy Vere took the paper as read. She explained that the Annual Self-Assessment Return was a mandatory requirement from NHSE. She mentioned that undertaking the self-assessment had been a challenge due to the formation of the Group. The aim of the paper was to ensure that the Group provide the adequate levels and standards of care that were required for students and post-graduate trainees and that a good learning environment was provided. Lucy Vere explained that the deadline for the submission was due by 31st October 2025 and feedback was welcomed. There was positive partnership working taking place between Nursing and Midwifery, and the University. Positive progress was made in the responsiveness to students. The Learning Innovation Centre had a positive impact in ensuring that newly qualified nurses had an immersive experience. A positive impact was seen across the Group following the introduction of the Group-wide resident doctor induction and work was ongoing to strengthen the process. Self-Development Time was a challenge on the South Bank and challenges regarding the student placement within Nursing and Midwifery were being addressed. Recruitment challenges were ongoing for nurse apprenticeships at HUTH and efforts were underway to review how to introduce traineeships for Level-3 nursing assistant apprenticeships which would support the pathway. There were also challenges regarding availability of the funding. There was a focus on improving the resident doctors' experience at NLaG. Educational supervision challenges were ongoing.

Jo Ledger mentioned that during a JNCC meeting, an RCN representative raised concerns that were received from students regarding being moved within the Group. Forums had now been established for students to raise issues and they were being encouraged to raise any issues through those forums. Work was ongoing to monitor whether students were being utilised in a different capacity and a regular review would be presented to JNCC and shared through WEC CiC.

Laura Treadgold queried what actions were being taken regarding the concerns around the placement tariff. She asked if there was anything that the university could do to support the Group around facilitating the discussion around this. Lucy Vere recognised that there were smaller levels of placements and tariffs may not be adequate to cover support for those placements. She advised that transparency regarding money would support with allowing the Group to make decisions and re-allocating resources.

Paul Bunyan joined the meeting at 09:26 hours.
Leah Coneyworth joined the meeting at 09:28 hours.

David Sharif raised that there was a potential risk in not receiving the placement tariff, should it be determined that educational money was not being spent on education. He advised being careful around the tariffs and obtaining a proper audit trail to review distribution of the educational money.

Julie Beilby mentioned that the Group explicitly stated in the submission form that the funding provided by the NHS Education Funding agreement, support and deliver education training was not used explicitly for that purpose. She challenged whether it was correct to state this. Lucy Vere noted that budgets were set differently from a medical point of view and a discussion with the finance team would be required to ensure consistency. Julie Beilby emphasised that stating 'no' in the submission form may provide a risk.
David Sulch queried whether the Group were confident from a strategic level that all the educational money was being spent on education.

Jo Ledger mentioned that work was being undertaken to review the Nursing and Midwifery tariff. Clinical educators were utilised to provide support to the students, and there was a historical agreement at HUTH that surplus money above baseline could be reinvested.

Action: Jo Ledger to bring a report to a future WEC CiC detailing the allocation and expenditure of placement tariff funding, including nurse educator costs.

Dr Kate Wood shared that the Group did not have thread-to-needle on their educational income for medical students, particularly that they were fully sighted of the income into the organisation and how it was utilised. The Group required a financial ledger to show thread-to-needle the amount of educational money received and spent. She emphasised that it was important to know whether the Group should be reinvesting in education to improve the education of all staff.

Lucy Vere would have conversations with the Directors of Medical Education, Dr Kate Wood and Jo Ledger, to determine a decision regarding an appropriate answer to the NHS Education Funding statement by 31 October 2025.

Action: Lucy Vere invite an appropriate finance representative to a future WEC CiC to present a short paper that provides a high level of understanding on the structure of educational funding.

Sue Liburd noted section 6 of the report that stated 'The learning environment is one in which education and training was valued and championed'. She mentioned that the response was marked as an exception in relation to tariff tracking which did not correlate to what was being asked.

Julie Beilby queried the reason why the Group answered 'no' to the following statement on the submission form: 'The organisational culture is one in which all staff, including learners, are treated fairly with equity, consistency, dignity and respect'. She queried the reason why the Group answered 'no' on the submission form. Lucy Vere explained that NHSE were focusing on transparency and honesty and given the recent feedback provided in the GMC surveys, it felt transparent to report those exceptions. Dr Kate Wood highlighted that the Group were at the bottom line in the GMC national training survey at NLaG due to challenges faced. Efforts were underway to address those challenges.

The Committees-in-Common approved the paper.

The Agenda returned to the correct order.

3. RISK & ASSURANCE

3.1 CQC Actions Group Report

Leah Coneyworth took the report as read and provided an update from an NLaG perspective. 14 actions remained open, 5 of which were red-rated, which all linked to medical staff compliance with mandatory training across Children and Young People, End of Life, Surgery, and Medical Care. There was a reduction of 2 red-rated actions in comparison to the previous update. 4 of the green-rated actions were in the process of being closed. Improvements were seen across most areas in September 2025, however a decline was seen in every Care Group in October 2025. Work that had taken place with the Care Groups revealed that rotation of staff had caused the decline. Upon further investigation into 2024/25 data, a decline was also seen in October 2024 following staff rotation.

Dr Kate Wood shared that there was a Memorandum of Understanding (MOU) across the country to passport mandatory training across Trusts.
Lucy Vere clarified that staff would not be compliant if they had not completed their training prior to rotation. She explained that training would be transferred over if it was available and work was ongoing to support with training compliance.

Action: Leah Coneyworth to reword the paper to clarify that the decline in data was due to resident doctors rotating in from other organisations without up-to-date mandatory training.

Dr Kate Wood left the meeting at 09:57 hours.

Tony Curry wondered when the long-standing actions would be closed and whether the bar was too high, given the operational challenges the Group were currently experiencing. Simon Nearney shared that significant changes were taking place nationally. He noted that there did not appear to be a consequence for people not completing their mandatory training and that it would be useful to have an insight into the conversations that were taking place with respective medical managers and leaders regarding mandatory training. Simon proposed that Lucy Vere be involved with the next report to ensure accuracy of data provided by the Care Groups.

Leah Coneyworth shared that improvements were made in some areas. ED compliance had increased to 76% for medical staff capacity, whilst a slight decline was seen in the data for October 2025, the Group would continue to monitor this. Improvements were made within Children and Young People. Regular discussions were taking place with Amanda Stanford and the Care Groups regarding how to progress the actions. The Group were returning to business-as-usual approach once satisfied that progress was made and sustained for 2-3 months. Letters were sent from Chiefs of Service in Surgery and Medicine to individual medical staff asking them to complete their training by a particular date, and failure to complete this would be escalated to a zero-tolerance approach with HR.

There were several actions where the CQC had specified core and role specific training. It was recognised that the Group remained non-complaint in several areas

due to the volume of training required. Lucy Vere shared that the Group were looking to move from a compliance to competency assessment, which was expected to take time to work through and there would be a focus on medics to begin with. A Terms of Reference was being pulled together, and regular updates would be presented through this report to WEC CiC in due course.

Julie Beilby shared surprise that revised dates were not provided for the actions. Leah shared that Amanda Stanford was clear about not setting revised dates as it was crucial for the Care Groups to agree trajectories for delivery on those actions. She mentioned that all actions were led by the Triumvirates of the Care Groups.

Action: Leah Coneyworth to include the trajectories set by Care Groups on the CQC actions, and the completion dates in the next report.

Simon Nearney advised escalating to the Care Group Chiefs of Service, Medical Directors and Site Management team that if actions were not completed they would be called to attend WEC CiC and be held accountable.

From a HUTH perspective, 8 actions remained open. 2 of those actions were green-rated and in the process of being closed. 2 actions were red-rated which related to restraint training and resuscitation training, and work was ongoing to support the Care Groups with improving the compliance.

David Sulch noted that restraint was part of the potential response to someone in a mental health crisis attempting to abscond from the Organisation. He wondered whether the Group were confident in their approach and the policies currently in place to ensure that similar incidents would not happen within the Organisation.
Jo Ledger explained that complete assurance could not be determined currently, however robust mental health assessments were undertaken in ED at triage to identify any patient at high risk and appropriate interventions were put into place.

Action: Jo Ledger to speak with the ED Nurse Director to ensure that the Group were auditing their assessment process, following this she will provide an update from a safeguarding point of view at the next meeting.

Leah Coneyworth mentioned that the CQC draft report suggested complimentary feedback of EDs approach to mental health and how assessment of the patients had improved since the 2022 inspection.

The Committees-in-Common agreed limited assurance.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate**

None to note.

3.3 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 People Strategy Progress Report – Q2

Paul Bunyan explained that the overall People Strategy was currently at 55% delivery against the milestones spread out across the four quarters. 94% of all milestones were in progress and the delivery timescales for some of those milestones were weighted towards Q3 and Q4 for final completion in terms of delivery, particularly for learning leadership and talent development until the Group see the overall completion of those milestones. He highlighted that despite the project being on-track to achieve delivery in terms of the agreed actions identified within the projects, the outcomes were not on track, specifically in relation to reduction in Agency Spend. Month 6 saw a £5.1 million overspend against a target of 30% reduction which provided a challenge for delivery in the following six months of year 1. Agency Spend within nursing had reduced across the Group and the delivery for Nursing Agency was below the 3% model hospital benchmark which continued to see reduction. The Group expected to see reduction continue over the next months following the introduction of the newly qualified nurses, which would have a further impact on variable pay. ED at Diana, Princess of Wales Hospital (DPoW) had achieved below 30% Agency spend in October 2025.

An interventional response had been established for 5 Care Groups that were responsible for 80% of the challenge in Agency spend: ED, Family Services, Community and Therapies, Specialist Surgery, and TAC.
The interventional approach would see a multidisciplinary team (MDT) made up of finance improvement teams, workforce teams, and site medical specialty teams. Key drivers of Agency Spend would be reviewed, with a particular focus on tighter grip and control at a Care Group level, rostering efficiency and re-design, alternative solutions, ending long-term bookings and reducing rates. Work would take place with new Agency providers to drive down individual rates of booking of Agency doctors. The overall approach seeks to aid recovery within month 6.

From a health and wellbeing point of view, a new flexible working approach was expected to go live on 17 November 2025, which focused on how to approach flexible working for medical and clinical workforces, and the corporate workforce. The Group received £320k funding from NHS Charities Together for HUTH which would support refurbishment of staff rooms across HUTH in partnership with WISHH charities. This was in-line with the health and wellbeing project and would provide revitalisation to staff health and wellbeing areas.

A further period of industrial action was due to commence from 14 to 19 November 2025 with resident doctors. This was expected to have a significant impact on flow and recovery and would likely result in increased Agency Spend. As the Group moved into Winter, they anticipated a higher level of activity and sickness.

Tony Curry mentioned that the activity was unclear against the long-term outcome. Paul Bunyan explained that year 1 of the strategy was designed to determine what the Group did not do well but should be doing well. He recognised that greater basic recovery was seen rather than transformational activity.

Julie Beilby noted that the Group were staffing above plan and asked for clarification on this. Simon Nearney clarified that the Group were currently 107 over-plan including temporary staffing and work would take place with Care

Groups and Corporate Services to improve this position. He continued that if Care Groups were able to deliver their cost improvement plans than NHSE would not be overly worried about staff in post. Meeting our financial target was key.

Simon Nearney recognised that the Group were in a transitional period and noted that Lyn Simpson was clear that constitutional standards and money were a priority. He assured the CiC that this work contributed to achieving the outcome for the people strategy and that additional work was underway to support achieving the outcome of the people strategy.

Jo Ledger mentioned the resolution of the Band 2 and 3 profiles and that work had commenced on the other profiles. She asked if the other Nursing and Midwifery profiles could be included within the Q3 and Q4 deliveries section of the report. She mentioned Agency reduction and shared that staff would be re-allocated when over-established from a Nursing and Midwifery perspective. Jo highlighted that there were patients in ED that required additional staff support, and this provided a risk from a financial perspective, particularly as the Group entered the Winter period.

Simon Nearney asked the CiC to consider that the Group were in a challenged space and reminded them to be careful regarding how Agency Spend was managed.

The Committees-in-Common agreed reasonable assurance.

4.2 **Operational Workforce Planning Summary**

Paul Bunyan shared that informal guidance from NHSE showed that the Group would be expected to produce a 5-year workforce plan, consisting of a technical plan for 2026/27, and years 2-5 would be more strategic assumptions regarding what would happen regarding the 3 key themes in the 10-year plan. The Group would be required to reduce Agency Spend to zero by 2029/30, and were currently in a position where plans must respond to the 3 key themes: analogue for digital, hospital to community, and sickness to prevention. He acknowledged that there was no current national guidance available in terms of what those priorities would look like and how that would happen logistically working across the wider system.

The Group had engaged with all the Care Groups regarding whether there were any impactful schemes that may change the Whole Time Equivalent (WTE) approach and it was determined that there was nothing impactful in year-one that would result in WTE change. Efforts were underway to develop a CIP plan that would be built financially into the workforce plan. Work was ongoing to build a technical workforce plan which would support the trajectory of minimal Agency usage by 2029/30. This would be presented to WEC CiC for information in November prior to being presented to Boards-in-Common for sign-off in December 2025.

Julie Beilby noted the 2025/26 operational workforce recovery plan and queried who were the responsible owners of the recovery actions and who determines those recovery actions. Paul Bunyan explained that the Executive team had oversight and the MDT team would take on a level of accountability to ensure those actions were followed through at Care Group level.

Julie Beilby mentioned that assumptions that the Group would make regarding invest to save and patient safety was absent from the 2026/27 operational workplan. Paul Bunyan shared that discussions would take place next week to discuss the business case process, ultimately with a focus around how to keep patients safe and following this, those assumptions would be implemented into the planning process.

Julie Beilby queried whether the Group expected the recovery actions to achieve the recovery that was required to be made in 2025/26. Simon Nearney explained that although he could not provide assurance that the Group would deliver this, the actions were in place and the MDT team would meet with Care Groups every fortnight. The Group expected challenging conversations to take place and it was crucial to tread carefully regarding patient safety, staff experience and expenditure.

Dr Kate Wood joined the meeting at 11:05 hours.

The Committees-in-Common agreed reasonable assurance.

4.3. **Freedom to Speak Up Quarterly Report – HUTH & NLaG**

4.3.1 **Freedom to Speak Up Q2 Report 2025/26 – HUTH**

Fran Moverley and Elizabeth Houchin joined the meeting at 11:20 hours.

Fran Moverley shared that there were 82 cases reported in Quarter 2, which was a 21% increase in comparison to Q1. No anonymous cases were reported. The national annual results from the previous reporting year showed that 11% of cases were anonymous. The main concern for reporting was due to inappropriate behaviours, and a couple of themes relating to this included poor behaviours reported from peers, colleagues and people that were more senior than the individual, being inappropriately challenged, singled out, shouting and nasty behaviour. This was closely followed by worker safety, with a mix of physical safety and elements of psychological safety, burnout, high acuity on the ward, and being asked to work in an unfamiliar environment with changes. She highlighted that the national report from the previous year mentioned a significant increase in worker safety concerns nationally, however there was an assumption that this was potentially incorrect data. Fran Moverley explained that she had written to the National Guardian Office to request clarification around that data.

The third top reason for reporting was due to concerns with roles, particularly occupational health recommendations that were not accepted, changes to shifts and working practices with no consultation, lack of appraisals and development areas and reasonable adjustments. General concerns were regarding information governance. A small number of potential fraud concerns were raised and work was underway with the fraud team to review those. The REACH programme was now in place which would support significantly with reasonable adjustments. Admin and Clerical were the top reporter during Q2, followed by AHPs, and medical and dental staff.

Dr Kate Wood left the meeting at 11:24 hours.

Julie Beilby raised concerns regarding the reporting of inappropriate behaviours, she noted that the highest volume was from admin and clerical staff and wondered whether there was a link to the areas undergoing restructure and savings. Fran

Moverley shared that Patient Services was the highest reporter as a Care Group in Q2 and the annual report revealed that the most common reason for reporting nationally was due to inappropriate behaviours.

David Sharif wondered whether there was a Gender or BAME aspect to concerns raised. Fran Moverely shared that previously there were a small number of cases reported due to this, however this was not a current theme.

The Committees-in-Common agreed significant assurance.

4.3.2 **Freedom to Speak Up Q2 Report 2025/26 – NLaG**

Dr Kate Wood joined the meeting at 11:27 hours.

Elizabeth Houchin provided an update. 94 cases were raised in Q2 which was an increase of 2 in comparison to Q1. 2 cases were raised anonymously, which was below the national average. 9% of cases were closed on the same day after giving advice. Main themes were around worker safety, HR processes and inappropriate behaviours. Reasons for worker safety concerns were due to staffing levels, colleagues not feeling psychologically safe to speak up, impact on wellbeing and working conditions. The concerns raised regarding HR processes were due to interpretation of policies and being unsure regarding what was happening during a process. Most inappropriate behaviour concerns were colleague on colleague. The top 3 professions were Nursing and Midwifery, additional clinical services, and admin and clerical. A few cases were regarding racism and gender discrimination, and work was ongoing to review this. Elizabeth Houchin mentioned that inappropriate behaviours covered a wide range of issues.

Sue Liburd congratulated the FTSUGs on their Golden Stars Award.

Sue Liburd queried whether there were any concerns regarding the National Guardians Office transition. The FTSUGs shared that there was no further information at this time.

Julie Beilby queried whether the drop-in sessions were well attended. Elizabeth Houchin shared that she undertook regular walk arounds which received a good response. Fran Moverley shared that she received a mixed response to the sessions.

The Committees-in-Common agreed significant assurance.

Fran Moverley and Elizabeth Houchin left the meeting at 11:33 hours.

Helen Knowles joined the meeting at 11:33 hours.
Lindsey Harding joined the meeting at 11:43 hours.

4.5 **Employee Relations Case Analysis – Focus on Timescales**

Lindsey Harding took the paper as read and updated that there were 120 cases in the last 12 months which were over 100-days. Data revealed that 42% of delayed cases were due to health reasons, and 35% of case delays were due to scheduling conflicts for staff involved in the cases. Reasons for investigation delays were due to extended Terms of Reference and a change in personnel involved in the process. Recommended actions to improve delayed cases included utilising retired

people who still wanted involvement within the Group, requesting ringfence time, and for the HR team to closely monitor cases through the annual review process.

Julie Beilby noted that it was crucial to not only consider the health and wellbeing of the subject of disciplinary, but it was also important to consider the wellbeing of their colleagues.

Tony Curry queried why Family Services were an outlier in the high number of cases raised. Lindsey Harding shared that Family Services were responsible for 20% of employee relations cases. Work was ongoing to address this, and a new process was being trialed with the team to triage cases before being submitted as a formal employer relations case.

Laura Treadgold recommended avoiding the use of external investigators to support with employee relations cases, as they did not have the level of information and understanding that was required within the Group.

The Committees-in-Common noted that it was premature to provide assurance at this stage and agreed to take the report for information. An assurance review would be considered and the recommended actions that were taken would be confirmed in 12 months' time.

Lindsey Harding left the meeting at 12:01 hours.

4.6 **Job Planning Monthly Update**

Helen Knowles updated that job planning compliance was 64% as of 17th October 2025, which was an increase of 19% in comparison to the previous month. Job planning compliance had further improved to 68% as of 28th October 2025. Further improvement was anticipated as Care Groups shared that numerous job plans were agreed and were awaiting system sign-off.

Dr Kate Wood acknowledged that the current 68% compliance was a significant improvement in comparison to the previous position a few months' ago. The Group were optimistic in achieving the target, however they did not expect to meet their internal target of 90% by the end of October 2025. She explained that the national target was to achieve 95% of job plans signed off by March 2026. Hotspot areas were Family Services, Specialist Surgery, Specialist Medicine and Neuroscience, and work was ongoing to address this. The National team were pleased at the progress that the Group had made, considering the challenges experienced whilst forming a Group. Dr Kate Wood mentioned that productivity would need to be a focus for 2026/27.

Dr Kate Wood explained that the mandatory and statutory training element within the job planning policy was yet to be agreed. Challenges were ongoing due to receiving verbal feedback rather than written feedback from HUTH and NLaG LNC Consultants. Julie Beilby advised to continue with the individual job planning policies if resolution was not made by March 2026. She recognised that the ambition to move to a Group job planning policy possibly held the Group back in terms of focusing on job planning.

The Committees-in-Common agreed reasonable assurance, advising that they expected progress to continue at pace and monthly reports would continue for

monitoring purposes.

Helen Knowles left the meeting at 12:15 hours.

4.7 **EDI Steering Group Re-design**

Lucy Vere shared that a timeout session took place in September 2025. The Terms of Reference was adjusted to reflect the feedback received from members of the EDI Steering Group. Feedback received showed that members advocated for inclusive culture and the desire to normalise inclusive language, an environment where people felt safe to ask questions and express concerns, and further focus around psychological safety and support for those facing discrimination. They desired clearer leadership accountability, influencing governance structures and how they reflected EDI priorities. Lucy Vere shared that whilst equality impact assessments were taking place, they were not thorough, and members felt that diversity was excluded. They requested to still have conversations around health inequalities within the Steering Group, however the question remained around where to take those conversations and the actions coming out of them. Understanding and addressing the root cause of discrimination was a challenge, given the current cultural challenges taking place. Members requested greater structure around how staff network plans were aligned and signed off. Lucy Vere mentioned that the structure of the EDI Steering Group was more mature than how it was addressed from a patient experience and quality and safety perspective, and 2 working groups would be formed to enact plans that were specific to patients and staff.

Dr Kate Wood raised concerns regarding a proposal that health inequalities was part of the EDI Steering Group and reiterated that health inequalities were regarding the population health that we manage; in relation to smoking, alcohol, deprivation and social circumstances, waiting lists and management of learning disabilities. Lucy Vere agreed about being clear on where the accountability was for health inequalities.

David Sharif advised Lucy Vere to remove ‘Terms of Reference’ from the adjusted version of the EDI Steering Group Terms of Reference.

David Sharif suggested streamlining how the reporting of the EDI Steering Group would work in practice. Lucy Vere mentioned that input was required from a governance and patient experience point of view and further discussions would take place to finalise this.

The CiC proposed that the EDI Steering Group meet on a quarterly basis.

The EDI Steering Group would reconvene on 06 November 2025 and a follow up meeting would take place to explore the Terms of Reference and build the governance structures.

The Committees-in-Common approved the paper.

4.8 **Workforce Education and Culture Committees-in-Common Terms of Reference – HUTH and NLaG**

David Sharif updated that the Workforce Education and Culture Committees-in-

Common Terms of Reference was shared with the CiC for annual review prior to Boards-in-Common approval.

Julie Beilby proposed updating the minute taking process to state that there was a new process regarding Executives reviewing the CiC minutes prior to the Chairs having oversight. She shared frustrations regarding the time taken to receive oversight of the minutes following Executive review.

A discussion took place regarding the dates on the cover sheet of the Terms of Reference. It was determined that the Terms of Reference were up to date, however the dates on the cover sheet reflected the previous years' and would be updated to reflect that of 2025.

Dr Kate Wood proposed an amendment of using the term 'their' when referencing the Chief Executive in section 5.3.9.

Action: David Sharif to amend the WEC CiC Terms of Reference.

The Committees-in-Common approved the Terms of Reference for Boards-in-Common approval, subject to the proposed amendments being made.

5. ITEMS FOR INFORMATION

5.1 Workplan

This was shared for information.

Action: Karena Groom to update the workplan to include a 12-month review of the Employee Relations Case Analysis.

5.2 Workforce Transformation Group Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note.

7.1 Matters to be Referred to other Board Committees

- Julie Beilby to re-refer adequate care coverage back to PEF CiC and highlight to the Boards-in-Common.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- There was a challenging discussion and debate around the Operational Workforce Planning Summary and the Group did not underestimate the challenge of the actions that were agreed to recover the Group position.
- Limited assurance was agreed on the CQC Actions Group report due to the Group not meeting performance on the CQC must do actions.
- Assured that the Group were following processes and targets set out in the people strategy.
- £320k funding received from NHS Charities Together would be utilised to support refurbishment of staff rooms across HUTH in partnership with WISHH charities. This was in-line with the health and wellbeing project and would provide revitalisation to staff health and wellbeing areas and rest spaces.
- The CiC expected job planning progress to continue at pace and expected to see monthly reports continuing.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 26th November 2025 at 9am till 12:30pm, via Microsoft Teams

The Committee Chair closed the meeting at 12:39 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y	Y	Y	Y		
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D				D	Y	D		
Heather McNair	Interim Group Chief Nurse					Y	D	Y					
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y	Y	D	Y		
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y		
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y	Y	N	Y		
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y	N	N	Y		
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y	Y	Y	Y	Y	Y		

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)242

Name of the Meeting	**Trust Boards-in-Common (Public)**
Date of the Meeting	11 December 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Wajiha Arshad, Guardian of Safe Working Hours Joey Robson, Group Medical Staffing Manager Rose Bundy, Guardian of Safe Working Hours Analyst
Title of the Report	**Guardian of Safe Working Hours Quarter 2 Report (Doctors and Dentists in Training) Hull University Teaching Hospitals NHS Trust (HUTH) - 1st July 2025 to 30th September 2025**
Executive Summary	Exception reports: 170 exception reports submitted over the quarter, with the highest number (109) submitted by foundation year 1 doctors. Exception reports were submitted for a variety of reasons with the main reason being excess hours worked. Of the 170 exception reports, 130 were submitted due to excess hours worked, 17 due to rota working pattern, 11 due to missed educational opportunities, and 7 due to support received by the service. Fines: 16 fines were issued over the quarter, totaling £14,974.36. Of the 16 fines issued, 9 were issued to the Paediatric Surgery department totaling £11,786.77. The other 7 fines were issued to a range of other departments, summarised within this report. The fines issued to Paediatric Surgery were in relation to non-resident on call shifts where doctors have not received adequate rest and have breached 13-hour maximum shift length. Paediatric Surgery have a business case pending for an additional doctor to support the roster; in the interim higher cost locum cover is being booked to support the roster and associated compliance. Since August 2022, the Paediatric Surgery department has incurred £117,875.83 in fines relating to safe working breaches. Trainee Doctor Fill Rate: Over the quarter, 93.3% of NHSE appointed doctor in training posts were filled, a slight decrease on 94% last quarter. Chemical Pathology has a fill rate of 0% due to their establishment consisting of 1 doctor which NHSE were unable to recruit to. Emergency Medicine is the department with the highest bank and agency usage over the quarter. Emergency Medicine has a fill rate of 92% which has increased slightly since the previous quarter (88.8%). Emergency Medicine has several NHSE

	vacancies and a number of LTFT trainees who are ST4 and above.
Background Information and/or Supporting Document(s) (if applicable)	Doctors and Dentists in Training Terms and Conditions (England) 2016 – Available on NHS Employers website: https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf
Prior Approval Process	Workforce, Education and Culture Committees-in-Common meeting held on Wednesday, 26 November 2025
Financial implication(s) (if applicable)	The Guardian of Safe Working Hours Funds stands at £66,047.38 at the time of the report being written and plans to utilise these funds are detailed in this report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The ability to exception report is not constrained by any issue related to Equality, Diversity and Inclusion.
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st July 2025 - 30th September 2025

1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from 1st July 2025 - 30th September 2025:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	714.8
(establishment)	766
Amount of time available in job plan for guardian to do the role:	1 PA (4 hours per week)
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the doctors and dentists contract (pages 39-45)

3. Immediate Safety Concerns

Resident doctors can escalate exception reports and categorise them as an immediate safety concern where they feel appropriate. Any exception reports flagged as an immediate safety concern are investigated by the Guardian of Safe Working team and escalated where necessary.

Nine exception reports were flagged as immediate safety concerns by resident doctors over the quarter: all escalated due to a lack of support mainly resulting from short staffing.

Following the exception reporting reforms which will be fully implemented from February 2026 there will no longer be an option to highlight immediate safety concerns. This is because it was felt that there is a risk nationally that safety issues are not being reported and investigated correctly. The resident doctors will instead be asked to use the local incident reporting system (Ulysses) to highlight issues that are concerning for the safety of staff or patients.

4. Exception Reports

There was a total of 170 exception reports (170 episodes) reported by doctors in training and locally employed doctors for this quarter. An increase of 125 reports since the preceding quarter. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

Oncology (F1 rota) received the most exception reports (26) over the quarter, with most reports relating to overtime (18).
Concerns relating to staffing levels and support have been raised with the Guardian of Safe Working, and at the Resident Doctors Forum.
The North Bank Site Medical Director, Guardian of Safe Working, Group Medical Staffing Manager, and Resident Doctor Lead are due to meet to discuss how the Oncology and Haematology rotas can be improved for resident doctors. There are significant staffing issues within the department and high levels of sickness

absence, which puts further pressure on the already stretched rota. The Resident Doctor Lead within the department advises that additional doctors are needed to support the rota when considering annual leave, mandatory training and SDT. The number of additional doctors required needs to be identified and supported by submission of a business case.

Figure 1: Exception reports (episodes) by department

Exception reports (episodes) by department 1st July 2025 - 30th September 2025

Department (Where exception occurred)	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
General medicine	87	68	19
Vascular Surgery	16	14	2
Paediatric surgery	14	14	0
Medical oncology	9	7	2
Accident and emergency	7	7	0
Acute Medicine	6	4	2
Anaesthetics	5	4	1
Cardiology	4	4	0
General surgery	4	2	2
Plastic surgery	4	2	2
Haematology	3	3	0
Surgical specialties	3	0	3
Geriatric medicine	2	2	0
Otolaryngology (ENT)	2	2	0
Psychiatry	2	1	1
Obstetrics and gynaecology	1	1	0
Paediatric medicine	1	1	0
Total	**170**	**136**	**34**

Figure 2: Exception reports (episodes) by grade

Exception reports (episodes) by grade 1st July 2025 - 30th September 2025

Grade	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
FY1	109	92	17
FY2	27	20	7
CT/ST1&2	24	16	8
ST3+	10	8	2
Total	**170**	**136**	**34**

Figure 3: Exception reports (episodes) by rota

Exception reports (episodes) by rota 1st July 2025 - 30th September 2025

Rota	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
Rota 18 - Medicine F1 - Oncology	26	20	6
Rota 18B - Medicine F1 - Endo	20	18	2
Rota 4 - Medicine F1- Acute/Rheuma/DME/Stroke	16	15	1
Rota 23 - Surgery F1	16	13	3
Rota 66 - Paediatric Surgery	13	13	0
Rota 8 - Oncology and Haematology	9	7	2
Rota 1 - A&E F2	6	6	0
Rota 14 - DME (Blp 431)	6	5	1
Rota 18 - Medicine F1 - Renal	6	5	1
Rota 19 - AAU SHO	5	3	2
Rota 18 - Medicine F1 - Cardio	5	4	1
Rota 18B - Medicine F1 - Psychiatry	5	5	0
Rota 76 - Major Trauma F2/Clinical Fellows	5	4	1
Rota 9 - Bleep 575	5	0	5
Rota 40 - Plastic Surgery SpR	4	2	2
Rota 25 - Acute/Elective F1	4	2	2
Rota 29 - Vascular Surgery	3	3	0
Rota 18 - Medicine F1	3	3	0
Rota 4 - Medicine F1 Acute Medicine	3	3	0
Rota 51 - O&G ST1-2	1	1	0
Rota 124b GS - ENT	1	0	1
Rota 6 - RMO 1, 3, 4	1	1	0
Rota 123 - ENT/Plastics	1	0	1
Paediatrics - Rota 59	1	1	0
Rota 15 - Bleep 450	1	0	1
Rota 130 - NCTR / Gen Medicine	1	0	1
Rota 2C - A&E SHO	1	1	0
Rota 60 Paediatric F1 and F2	1	1	0
Rota 137 - Psychiatry SHO	1	0	1
Total	**170**	**136**	**34**

Figure 4: Exception reports (episodes) - response time

Exception reports (episodes) - response time 1st July 2025 - 30th September 2025

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	No. outstanding
FY1	15	21	56	17
FY2	1	9	10	7
CT/ST1&2	7	3	6	8
ST3+	1	2	5	2
Total	**24**	**35**	**77**	**34**

The 2016 T&Cs require that the trainer meets with the resident doctor to discuss an exception report within seven days. It has continually been identified that meeting within this time frame is difficult. The Guardian of Safe Working continues to educate both resident doctors and supervisors on the importance of exception reporting and meeting in a timely manner. The exception report reform being implemented by NHS Employers will remove the requirement for the educational supervisor to review the reports which will simplify the exception reporting process.

Both the Oncology and Cardiology departments continue to be areas of concern, with resident doctors raising concerns over short staffing and lack of senior support at the RDF and with the Guardian of Safe Working directly.

5. Work Schedule Reviews

Throughout the period 1st July 2025 - 30th September 2025, the following rotas were under review, and the outcome of the organisational change process is listed below.

The Tower Block rotas went live part way through the quarter, in August, consisting of 5 rotas (5, 9,13, 14, and 15) covering the medical specialties in the Tower Block at Hull Royal Infirmary.
The rotas have been standardised with identical working hours and consist of several consecutive weeks of day shifts to enable annual leave to be taken more easily and allow consistent attendance at handover.

Care Group	Rota number	Stage of Consultation
S- Specialist Medicine	9, 15	Implemented August 2025 - Consultation complete.
S- Community, Frailty and Therapy	14	Implemented August 2025 - Consultation complete.
S- Neuroscience Specialist Care	5	Implemented August 2025 - Consultation complete.
N- Digestive Diseases	15	Implemented August 2025 - Consultation complete.
S- Specialist Surgery	15	Implemented August 2025 - Consultation complete.
S- Specialist Surgery	134, 135, 124b, 124a	Implemented August 2025 - Consultation complete.
N- Digestive Diseases	124a	Implemented August 2025 - Consultation complete.
N- Cardiovascular	124a	Implemented August 2025 - Consultation complete.
S- Neuroscience Specialist Care	133	Implemented August 2025 - Consultation complete.
N- Head and Neck	124b	Implemented August 2025 - Consultation complete.
S- Family Services	124a	Implemented August 2025 - Consultation complete.

6. Fines

The 2016 Medical and Dental contract states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule).
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts).
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved.
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine.

Standard rates are outlined in the Terms and Conditions.

Summary of fines issued 1st July 2025 - 30th September 2025

16 fines were issued over the quarter, totaling £14,974.36.
Of the 16 fines issued, 9 were issued to the Paediatric Surgery department costing the department £11,786.77.

The fines issued to Paediatric Surgery were in relation to non-resident on call shifts where doctors did not receive adequate rest and breached 13-hour maximum shift length.
Paediatric Surgery have a business case pending for an additional doctor to support the roster; in the interim higher cost locum cover is being booked to support the roster and associated compliance.
Since August 2022, the Paediatric Surgery department has incurred £117,875.83 in fines relating to safe working breaches.

The other 7 fines were issued to a range of other departments, summarised below:

Figure 5: Fines issued to other departments

Department:	Reason for fine:	Total fine issued to department:
Vascular Surgery	13 hour breach	£43.54
Plastic Surgery	8 hours rest breach 5 hours rest breach	£882.56
Plastic Surgery	8 hours rest breach	£1638.26
Plastic Surgery	13 hour breach	£151.14
Paediatric Medicine	13 hour breach	£148.04
Acute Assessment Unit	13 hour breach	£302.28
Surgery	13 hour breach	£21.77

Steps taken to resolve issues:

Paediatric Surgery is still awaiting financial approval on their pending business case to combat rota issues resulting in frequent breaches. The department have now sought Care Group approval to seek internal locums for overnight cover on Fridays as there is no on call cover built into the rota.

The Guardian of Safe Working, Group Medical Staffing Manager and Resident Doctor Lead are continuing to meet and discuss how Oncology and Haematology can be improved for resident doctors. There are significant staffing issues within the department and high levels of sickness absence, which puts further pressure on the already stretched rota. The rota is currently staffed by 18 doctors, but the Resident Doctor Lead within the department advises that additional doctors are needed to support the rota when considering annual leave, mandatory training and SDT. The number of additional doctors required needs to be identified and supported by submission of a business case.

Concerns around out of hours staffing within Cardiology were raised at the RDF in relation to out of hours staffing. The Guardian of Safe Working has met with the department and rotas are under review, pending further feedback.

7. Guardian of Safe Working Funds Expenditure

Over the quarter, the GoSW funds have been used to make a range of purchases to benefit resident doctors. The GoSW funds continues to support the purchase of refreshments for resident doctors attending teachings within Medical Education, totalling £6,730 over the quarter.
The GoSW funds has also supported the purchase of new furniture for the neonatal staff room and registrars' room at Hull Royal Infirmary (£2944.97); funded 30 places for resident doctors to attend a British Society of Emergency Radiology conference (£7500) being held in Hull this November and supported an F1 doctor attending a conference to present a poster (£179.13).
The GoSW funds are also funding 30 resident doctors to attend an RCGP conference which is estimated to cost approximately £10,000.

All expenditure from the GoSW Funds is agreed at the Resident Doctors' Forum.

8. Resident Doctors Forum

The Guardian of Safe Working runs a monthly Resident Doctors Forum in line with the T&Cs. This is attended by resident doctors, representatives from Medical Education, Medical Staffing, and higher management. This allows issues raised to be effectively handled and provides resident doctors with a supportive environment to discuss any concerns.

Officer to Contact
Dr Wajiha Arshad, Guardian of Safe Working
Rose Bundy, Admin for Guardian of Safe Working

Appendices

Locum bookings 1st July 2025 - 30th September 2025

This section details the use of Bank and Agency doctors to backfill vacant shifts. This is broken down into bank (not including additional hours) and agency bookings. This is presented by department, grade and reason for booking.

Appendix 1: Locum bookings (bank) by grade
1st July 2025 - 30th September 2025

The Trust has a number of avenues to fill rota gaps with gaps filled by doctors working within the Trust initially either as additional hours/overtime or via our Medical Bank. The bank data details bookings made with doctors working through the Trust's Medical Bank and does not include data on any rotational doctors working additional hours/overtime above their base working hours. From 4th August 2025, the Trust went live with the Locums Nest App to support easier booking of bank shifts, electronic timesheets and payment tracking.

The information covers shifts that have been booked by the Medical Staffing Team, Emergency Department and Anesthetics. There are several departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Grade	Total number of shifts requested	Number of bank shifts worked	Total number of hours requested	Number of bank hours worked
F1	116	44	849	402.25
F2	949	166	8383	1620.49
CT/GPSTR/ST1-2	2832	755	24538.77	7364.67
ST3+	2082	351	16676.56	3545.75
Total	**5979**	**1316**	**50447.33**	**12933.16**

Appendix 2: Locum bookings (bank) by specialty
1st July 2025 - 30th September 2025

Specialty	Total number of shifts requested	Number of bank shifts worked	Total number of hours requested	Number of bank hours worked
Acute Medicine	162	21	1269	232.25
Anaesthetics	44	0	294.75	0
Breast Surgery	129	4	1004.5	31.5
Cardiology	147	89	1195.75	810.25
Cardiothoracic Surgery	15	0	137.5	0
Chest Medicine	39		319.75	
Clinical Oncology	20		187.25	
Colorectal Surgery	45	10	272.5	59.5
Dermatology	1	1	12.25	12.25
Elderly Medicine	494	133	4557.42	1280.17
Emergency Department	2933	341	23419.56	3039.5
Endocrinology and Diabetes	18	5	178	42.5
ENT	119	71	1401	896.66
Gastroenterology	83	10	789.5	85
General Medicine	145	127	1384.5	1214.75
General Surgery	106	41	1005.67	361.67
Haematology	33	0	268	0
Infectious Diseases	88	27	699.5	255.5
Intensive Therapy Unit (ITU)	4	4	31.5	31.5
Maxillo-facial Surgery	6	5	61	46
Medical Oncology	19	0	162.75	0
Neonatology	14	6	139.15	78
Neurology	90	37	774.25	356
Neurosurgery	67	18	589	196
Obstetrics & Gynaecology	99	29	866.75	338.75
Oncology	95	61	954.5	606.25
Ophthalmology	24	0	189.5	0
Oral and Maxillofacial Surgery	130	55	1228.5	710.5
Orthopaedic Surgery	26	26	284.5	284.5
Paediatric Surgery	55	13	384	92
Paediatrics	79	36	647.5	365
Plastic Surgery	40	16	447.5	176.5
Radiology	19	0	164.25	0
Renal	59	0	528.75	0
Respiratory Medicine	13	10	131.25	100
Rheumatology	64	20	539.95	179.5
Stroke Medicine	26	6	237.5	61.5
Trauma & Orthopaedics	196	22	1560	235.83
Upper GI	22	6	171	75.5
Urology	173	52	1627.33	531.33
Vascular Surgery	38	14	330.5	147
Total	**5979**	**1316**	**50447.33**	**12933.16**

Appendix 3: Locum bookings (bank) by reason
1st July 2025 - 30th September 2025

Reason	Total number of shifts requested	Number of bank shifts worked	Total number of hours requested	Number of bank hours worked
Additional Resource	1287	315	9797.69	3096.67
Annual Leave	398	6	3284.5	45
LTFT	152	11	1380	129.75
Maternity/Paternity Leave	5	2	53.5	14
Occupational Health	15	2	187	24.5
Sickness	507	143	4525.39	1329.5
Strike cover	38	10	393.75	132.83
Study Leave	61	17	412.77	143.25
Vacancy	3516	810	30412.73	8017.66
Total	**5979**	**1316**	**50447.33**	**12933.16**

Appendix 4: Locum bookings (agency) by grade
1st July 2025 - 30th September 2025

All agency bookings are managed by the Medical Staffing team but are only used when internal and bank routes are exhausted. The Medical Staffing team work within a clearly defined authorisation process which requires the request for agency to be approved by the Care Group Triumvirate and Site Medical Director for bookings of less than a week and Group Executive Team for any bookings of greater than one week.

Grade	Total number of shifts requested	Number of agency shifts worked	Total number of hours requested	Number of agency hours worked
F1	116	0	849	0
F2	949	250	8383	2229.49
CT/GPSTR/ST1-2	2832	280	24538.76667	2553.33
ST3+	2082	206	16676.56	1874
Total	**5979**	**736**	**50447.32667**	**6656.82**

Appendix 5: Locum bookings (agency) by specialty
1st July 2025 - 30th September 2025

Specialty	Total number of shifts requested	Number of agency shifts worked	Total number of hours requested	Number of agency hours worked
Acute Medicine	162	11	1269	117
Anaesthetics	44	0	294.75	0
Breast Surgery	129	116	1004.5	928
Cardiology	144	0	1158.25	0
Cardiology	3	0	37.5	0
Cardiothoracic Surgery	15	0	137.5	0
Chest Medicine	39	0	319.75	0
Clinical Oncology	20	0	187.25	0
Colorectal Surgery	45	0	272.5	0
Dermatology	1	0	12.25	0
Elderly Medicine	494	194	4557.42	1750.58
Emergency Department	2933	324	23419.55667	2828.49
Endocrinology and Diabetes	18	0	178	0
ENT	119	0	1401	0
Gastroenterology	83	32	789.5	315.5
General Medicine	145	0	1384.5	0
General Surgery	106	3	1005.67	23.5
Haematology	33	0	268	0
Infectious Diseases	88	0	699.5	0
Intensive Therapy Unit (ITU)	4	0	31.5	0
Maxillo-facial Surgery	6	0	61	0
Medical Oncology	19	0	162.75	0
Neonatology	14	0	139.15	0
Neurology	90	2	774.25	18
Neurosurgery	67	0	589	0
Obstetrics & Gynaecology	99	0	866.75	0
Oncology	95	6	954.5	74
Ophthalmology	24	2	189.5	48
Oral and Maxillofacial Surgery	130	0	1228.5	0
Orthopaedic Surgery	26	0	284.5	0
Paediatric Surgery	55	0	384	0
Paediatrics	79	0	647.5	0
Plastic Surgery	40	0	447.5	0
Radiology	19	0	164.25	0
Renal	59	7	528.75	87.5
Respiratory Medicine	13	0	131.25	0
Rheumatology	64	2	539.95	22.75
Stroke Medicine	26	1	237.5	12
Trauma & Orthopaedics	196	0	1560	0
Upper GI	22	0	171	0
Urology	173	34	1627.33	411.5
Vascular Surgery	38	2	330.5	20
Total	**5979**	**736**	**50447.32667**	**6656.82**

Appendix 6: Locum bookings (agency) by reason
1st July 2025 - 30th September 2025

Reason	Total number of shifts requested	Number of agency shifts worked	Total number of hours requested	Number of agency hours worked
Additional Resource	1287	80	9797.69	733
Annual Leave	398	9	3284.5	71
LTFT	152	2	1380	16
Maternity/Paternity Leave	5	0	53.5	0
Occupational Health	15	0	187	0
Sickness	507	45	4525.39	546.25
Strike cover	38	0	393.75	0
Study Leave	61	3	412.77	31.5
Vacancy	3516	597	30412.72667	5259.07
Total	**5979**	**736**	**50447.32667**	**6656.82**

Appendix 7: Vacancies

The below table details the Doctors and Dentists in training establishment and current doctors in training in post as appointed by NHS England (formerly Health Education England

	Trainee Establishment						Trainee In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Fill Rate September 2025**	% Fill Rate June 2025
Academic, GP, Psych & Community	9	34	5	144	7	199	8.5	31	2.6	124.9	7	174	**87.4%**	93.2%
Acute Medicine	6	8	9	0	7	30	6	7	9	0	4.6	26.6	**88.7%**	99.2%
Anaesthetics	5	4	14	0	40	63	6	4	10.3	0	40.1	60.4	**95.9%**	96.6%
Breast Surgery	4	0	1	0	2	7	4	0	1	0	2	7	**100.0%**	100.0%
Cardiology	3	2	1	1	7	14	3	2	1	1	6.6	13.6	**97.1%**	126.7%
Cardiothroacic Surgery	0	3	0	0	5	8	0	2	0	0	6	8	**100.0%**	83.3%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	0	0	**0.0%**	100.0%
Colorectal Surgery	10	0	1	0	0	11	10	0	1	0	0	11	**100.0%**	96.9%
Dermatology	1	0	1	0	3	5	1	0	0	0	3	4	**80.0%**	90.0%
Elderly Medicine	7	4	5	7	6	29	7	3.8	4	5.2	8	28	**96.6%**	96.6%
Emergency Medicine	0	14	5	6	45	70	0	13.6	6	4.8	40	64.4	**92.0%**	88.8%
Endocrinology	3	0	1	0	5	9	3	0	1	0	4.8	8.8	**97.8%**	88.9%
ENT	0	2	2	3	5	12	0	2	1.8	3	5	11.8	**98.3%**	94.3%
Gastroenterology	3	1	2	0	6	12	3	1	1.8	0	7.8	13.6	**113.3%**	98.0%
General Surgery	0	1	1	0	1	3	0	0	1	0	1	2	**66.7%**	66.7%
Haematology	0	2	1	0	5	8	0	1.8	1	0	5	7.8	**97.5%**	80.0%
Histopathology	0	0	4	0	3	7	0	0	3.8	0	2	5.8	**82.9%**	65.7%
Immunology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**	0.0%
Infectious Diseases	2	1	1	2	6	12	1.8	1	1	1.8	6.1	11.7	**97.5%**	94.6%
Neuro-Rehab	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**	100.0%
Neurology	3	2	1	0	6	12	3	2	1	0	5	11	**91.7%**	98.3%
Neurosurgery	2	2	2	0	4	10	2	0.5	1.8	0	4	8.3	**83.0%**	95.0%
Obstetrics & Gynaecology	0	4	7	4	13	28	0	4	5.7	4	13.4	27.1	**96.8%**	100.0%
Oncology	4	3	1	4	3	15	4	2	1	3	2.6	12.6	**84.0%**	90.0%
Ophthalmology	1	1	3	0	3	8	1	1	2.6	0	3	7.6	**95.0%**	100.0%
Oral & Maxillofacial Surgery	0	0	0	0	2	2	0	0	0	0	1.8	1.8	**90.0%**	23.1%
Paediatric Neonatal Medicine	0	0	4	0	3	7	0	0	3	0	2.8	5.8	**82.9%**	98.8%
Paediatric Surgery	5	1	2	0	0	8	4.4	1	2	0	0	7.4	**92.5%**	96.7%
Palliative Care	0	0	0	3	0	3	0	0	0	3	0	3	**100.0%**	100.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	7	10	**111.1%**	100.0%
Paediatrics	0	5	5	2	12	24	0	4.8	4.4	1.8	12.1	23.1	**96.3%**	89.0%
Radiology	0	1	17	0	15	33	0	1	16.8	0	14.4	32.2	**97.6%**	117.6%
Renal Medicine	2	1	1	0	6	10	2	1	1	0	6.4	10.4	**104.0%**	107.5%
Respiratory Medicine	6	2	3	2	8	21	6	2	3.6	2	8.6	22.2	**105.7%**	102.2%
Rheumatology	3	1	2	2	2	10	3	1	1.6	2	2	9.6	**96.0%**	92.5%
Stroke Medicine	2	3	1	0	1	7	2	3	1	0	1	7	**100.0%**	87.5%
Trauma & Orthopaedics	0	5	5	1	9	20	0	5	4	1	9	19	**95.0%**	94.4%
Upper GI	9	0	2	0	4	15	9	0	2	0	3.6	14.6	**97.3%**	90.7%
Urology	1	3	2	0	3	9	1	3	1.6	0	3	8.6	**95.6%**	93.0%
Vascular Surgery	5	0	1	0	6	12	5	0	1	0	6	12	**100.0%**	98.2%
TOTAL	96	110	116	183	261	766	95.7	100.5	103.4	159.5	255.7	714.8	**93.3%**	94.0%

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)242

Name of the Meeting	**Trust Boards-in-Common (Public)**
Date of the Meeting	11 December 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Liz Evans, Guardian of Safe Working Hours Joey Robson, Group Medical Staffing Manager Helen Fitzpatrick, Admin for Guardian of Safe Working Hours
Title of the Report	**Guardian of Safe Working Hours Quarter 2 Report (Doctors and Dentists in Training) Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) – 1st July 2025 to 30th September 2025**
Executive Summary	Exception reports: 212 received this quarter- an increase of 81 since last quarter. The reasons for this are unclear, and may reflect difficulties in the working environments, coupled with an improved culture of exception reporting. The department with the highest rate of reporting is general surgery, which is frequently due to theatre overruns. Fines: No fines were issued over the quarter, there remain funds which have not been spent due to access difficulties. This has now been resolved. Trainee Doctor Fill Rate: Over the quarter, 93% of NHSE appointed doctor in training posts were filled, a slight increase from 82.5%in the last quarter. There is information contained concerning locum spends and fill rates per department. The number of reports in this quarter is not directly linked to this locum data. The Highest Locum spend is in Emergency Medicine, however, department with the highest submission of reports is General Surgery.
Background Information and/or Supporting Document(s) (if applicable)	Doctors and Dentists in Training Terms and Conditions (England) 2016 – Available on NHS Employers website: https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf
Prior Approval Process	Workforce, Education and Culture Committees-in-Common meeting held on Wednesday, 26 November 2025
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The ability to exception report is not constrained by any issue related to Equality, Diversity and Inclusion.

Recommended action(s) required	☐ Approval ☐ Assurance	✓ Information ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st July 2025 - 30th September 2025

1. Purpose of this Report

Under the terms of the Doctors and Dentists in Residence Terms and Conditions (England) 2016, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from 1 July 2025 to 30 September 2025. This will include:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst doctors in training
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in resident (total):	297
(establishment)	320
Amount of time available in job plan for guardian to do the role:	2 PA (8 hours per week)
Admin support provided to the guardian (if any):	37.5 hours per week
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between health groups)

Information on exception reporting is detailed within the resident doctor's contract.

3. Immediate Safety Concerns

There have been 5 reports this quarter with an immediate safety concern highlighted. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.
Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and escalated appropriately.

This quarter the immediate safety concerns are mostly within Acute Medicine in both DPOW and SGH, with concerns relating to lack of supervision on the wards and insufficient rota cover for resident doctors impacting safe service delivery of care.
In addition to acute medicine, safety concerns have been raised within Diabetes in DPOW, these concerns relate to F1 doctors being left on the wards with no consultant or registrar presence due to both being in clinics at the same time. A steering group has been set up in conjunction with the site medical director to address the underlying cause of these reports. This work is ongoing.

Following the exception reporting reforms which will be fully implemented from February 2026 there will no longer be an option to highlight immediate safety concerns. This is because it was felt that there is a risk nationally that safety issues are not being reported and investigated correctly. The resident doctors will instead be asked to use the local incident reporting system (Ulysses) to highlight issues that are concerning for the safety of staff or patients.

4. Exception Reports

There have been a total of 212 exception reports received in this quarter. This represents an increase of 82 reports from the preceding quarter. This is a higher number of reports than would usually be received. The reasons for this are multifactorial. There have been concerns raised about the working environment across the medical departments in both hospitals, and this is reflected by a high rate of reporting in these areas. By far the most common reason for reporting is excess hours worked and missed breaks; this is usually the case as these seem to be the most common type of incident which is easily quantifiable and thus easy to report.

The highest rate of reporting was in General Surgery in this quarter, with a total of 53 reports submitted. 41 of these reports were for overtime worked within this area, 12 reports were relating to missed breaks. Although this area has a high submission rate for exception report, no concerns have been raised within this area relating to rotas or lack of service support, and the reports have mostly been for very small amounts of time. A frequent cause of this overtime requirement is theatre overruns.

We have now fully implemented, to the extent we are able, the changes to the Terms and Conditions of service which fairly radically changes the exception reporting process. We were the first trust in the country to do this, which is a significant achievement. The new system allows doctors to report without the fear of repercussions from senior clinicians, and the confidentiality of reports is guaranteed. In light of this moving forward the information concerning reports received by department will be provided at care group level only, to protect the confidentiality of doctors working in smaller departments.

Figure 1: Exception reports (episodes) by department

Exception reports (episodes) by department 1st July 2025 - 30th September 2025

Department (Where exception occurred)	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
General surgery	53	48	5
General medicine	36	40	1
Gastroenterology	26	26	0
Accident and emergency	25	27	1
Respiratory Medicine	21	17	5
Acute Medicine	12	11	2
Geriatric medicine	10	8	3
Diabetes & endocrinology	9	7	2
Obstetrics and gynaecology	6	6	0
Trauma & Orthopaedic Surgery	5	5	0
Rheumatology	4	0	4
Paediatrics	2	8	0
Anaesthetics	2	2	0
Cardiology	1	1	0
TOTAL	**212**	**206**	**23**

Figure 2: Exception reports (episodes) by grade

Exception reports (episodes) by grade 1st July 2025 - 30th September 2025

Grade	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
F1	161	154	14
F2	10	12	1
CT/ST1&2	38	34	8
ST3 +	3	10	0
TOTAL	**212**	**206**	**23**

Figure 3: Exception reports (episodes) by rota

Exception reports (episodes) by rota 1st July 2025 - 30th September 2025

Rota	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
DPOW Medicine FY1 FY2 August 25	67	54	11
DPOW Gen Surg Junior August 25	55	50	5
SGH Gen Med FY1 F2 August 25	14	12	2
DPoW A&E FY1 Aug 25	12	12	0
Acute SpD Rota DPoW	12	10	3
DPOW Medicine FY1 FY2 April 25	9	9	0
DPOW Medicine IMT in 14 Aug 25	7	7	0
SGH A&E FY2 ST1/2 1 in 14 SGH 25	7	7	0
DPoW A&E FY2 ST1/2 1 in Feb 25	6	6	0
DPOW T&O FY1 Aug 25	5	5	0
SGH Med Rota IMT April 25	5	3	2
DPOW Medicine IMT in 14 Aug 25 FT	4	4	0
SGH Gen Surg FY1 Aug 25	4	4	0
SGH A&E FY1 April 25	3	3	0
SGH O&G Junior April 25	3	3	0
DPOW O&G FY1 Aug 25	3	3	0
DPOW Gen Surg Junior April 25	2	2	0
DPOW T&O ENT Resident Aug 25	2	2	0
SGH Gen Surg FY1 April 25	2	2	0
Acute SpD Rota SGH Jan 24	1	1	0
DPoW A&E FY1 Dec 24	1	1	0
DPOW Anaesthetics CT/ST August 25	1	1	0
DPOW Anesthetics St3+ SAS	1	1	0
SGH Gen Med FY1 F2 April 25	1	1	0
SGH Gen Med FY1 F2 Dec 24	1	1	0
SGH Paediatrics Junior March 25	1	1	0
SGH Paediatrics St4+ SAS Dr Loo LTFT 80%	1	1	0
TOTAL	**230**	**206**	**23**

Figure 4: Exception reports (episodes) - response time

Exception reports (episodes) - response time 1st July 2025 - 30th September 2025

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	Outstanding
F1	101	170	18	0
F2	1	7	5	0
CT/ST1&2	12	16	12	0
ST3+	3	0	0	0
Total	**117**	**193**	**35**	**0**

The 2016 T&Cs require that the trainer meets with the resident doctor to discuss an exception report within seven days. It has continually been identified that meeting within this time frame if at all is unlikely to happen. The Guardian of Safe Working continues to educate both resident doctors and supervisors on the importance of exception reporting and meeting in a timely manner, however all of the reports received in this quarter were closed by the Guardian of Safe Working. The exception report reform will remove the requirement for the educational supervisor to review the reports which will simplify the exception reporting process, and these reports will be closed in future by the Guardian of Safe Working Team.

A particular area of concern are the Departments of Medicine in both Scunthorpe and Grimsby. Concerns in these area have been raised previously at the Resident Doctors Forum (RDF) and have been escalated to the site medical director for intervention and resolution. Meetings have previously been held between PGME, Medical staffing, the GoSW team and site directors. A medicine steering group has now commenced on a weekly basis. The meetings have been planned to run on a rolling three week cycle: 1st week dedicated to Resident doctors, 2nd weekly meeting with Chiefs of Service or a nominated clinician and the 3rd weekly meeting with the core team to ensure actions for improvement are being implemented.

Key areas of concerns raised by Residents addressed in the medicine steering group include;

- Consultants not attending handover
- Ownership of the GIM rota
- Residents working without senior supervision (especially FY1 Level Doctors)
- On call cover (1 Dr to 8 wards)
- Regular missed breaks
- Staffing issues and ward cover (frailty and Acute medicine)
- Crash bleep cover
- Missed teaching sessions.
- Departments discouraging exception reporting

In addition to the steering group, as part of the response to these concerns and concerns raised within the GMC Survey, a full rota review across the group has commenced with the aim to address staffing issues highlighted by residents and workload pressures. This is being undertaken by the Medical Directors.

5. Work Schedule Reviews

No work schedule reviews have been requested or carried out during this quarter.

6. Fines

The 2016 Medical and Dental TCS states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule)
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.

- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts)
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine.

Standard rates are outlined in the Terms and Conditions. No fines have been issued this quarter.

7. GOSW Funds Expenditure

No fines have been issued in this quarter, however, there remains a fund of money which was accrued during the preceding quarter. There have been some issues with accessing this fund, however this issue has now been resolved so these funds can now be spent following discussion with the resident doctors' forum.

8. Resident Doctors Forum

The Guardian of Safe Working runs a monthly Resident Doctors Forum in line with the Terms and Conditions of service. This is attended by the resident doctors and representatives from PGME, Medical Staffing, and higher management. This allows issues raised to be effectively handled and provides the resident doctors a supportive environment in which to air their concerns.

Some issues which have been raised continually during both this quarter and last concerning the working environment in general medicine have been escalated to the site Medical Director for further action, issues are beginning to be resolved, however, further work is required to ensure resolution.

Officer to Contact
Dr Liz Evans, Guardian of Safe Working Hours NLaG
Joey Robson, Group Medical Staffing Manager
Helen Fitzpatrick, Admin for Guardian of Safe Working

Appendices

Locum bookings 1st July 2025 - 30th September 2025

This section details the use of bank and agency doctors to backfill vacant shifts. This is broken down into Bank (not including additional hours) and Agency bookings. This is presented by department, grade and reason for booking.

Appendix 1: Locum bookings (bank) by grade
1st July 2025 - 30th September 2025

The Trust has several avenues to fill rota gaps with post gaps filled by doctors working within the Trust initially either as overtime or via our Medical Bank. The bank data details bookings made with doctors working through the Trust's 'Care 1 bank and agile bank' and does not include data on any rotational doctors working additional hours/overtime above their base working hours.

The information covers shifts that have been booked by the Rota coordinators for all care groups.

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	28	22	178.2	178.2
F2	691	22	252.5	252.5
CT1	480	166	1360	1360
ST3+	933	465	3649	3649
Total	**2131**	**675**	**5439.7**	**5439.7**

Appendix 2: Locum bookings (bank) by specialty
1st July 2025 - 30th September 2025

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	224	33	297.2	297.2
Anaesthetics	5	0	0	0
Cardiology	9	0	0	0
Diabetes	106	0	0	0
Care of the Elderly	14	4	31.1	31.1
Emergency Medicine	445	253	2112	2112
ENT	93	3	35.49	35.49
Gastro	167	99	792.2	792.2
General Medicine	196	196	1453.01	1453.01
General Surgery	147	28	310.1	310.1
Obs and Gynae	150	22	144	144
Orthopaedic and Trauma	98	2	23.4	23.4
Paediatrics and Neonates	20	10	60	60
Respiratory	150	0	0	0
Rheumatology	2	0	0	0
Stroke Medicine	236	25	181.2	181.2
Urology	68	0	0	0
Rehab	3	0	0	0
Total	2131	675	5439.7	5439.7

Appendix 3: Locum bookings (bank) by reason
1st July 2025 - 30th September 2025

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Additional Activity	4	1	7.5	7.5
Compassionate Leave	1	0	0	0
Annual leave	6	6	46.78	46.78
Deanery gap - Vacancy	47	47	359.4	359.4
Establishment Vacancy	443	14	112.5	112.5
Exempt from on calls for health reasons	24	14	159.7	159.7
Induction/Rotation	20	10	91.74	91.74
Incumbent Worker	922	0	0	0
LTFT gap	23	0	0	0
Medics Strike Cover	5	5	57.88	57.88
Major Incident	5	0	0	0
Sick	58	11	115.7	115.7
Other approved Leave	8	2	12	12
Vacancy	565	565	4476.5	4476.5
Total	**2131**	**675**	**5439.7**	**5439.7**

Appendix 4: Locum Bookings (agency) by grade
1st July 2025 - 30th September 2025

All agency bookings are managed by the Rota Co-Ordinator team but are only used when internal and bank routes are exhausted. The Rota Co-Ordinator team work within a clearly defined authorisation process which requires the request for agency to be approved by the Care Group Triumvirate and Site Medical Director for bookings off less than a week and Group Executive Team for any bookings of greater than one week.

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	28	5	40	40
F2	691	559	5352	4472
CT/GPSTR/ST1-2	480	240	2512	1920
ST3+	933	428	3744	3424
Total	**2131**	**1232**	**11648**	**9856**

Appendix 5 Locum Bookings (agency) by specialty
1st July 2025 - 30th September 2025

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute medicine	224	160	1520	1280
General Medicine	196	196	1453.01	1453.01
Anaesthetics	5	5	40	40
Cardiology	9	9	72	72
Diabetes	106	96	848	768
Emergency medicine	445	146	1544	1168
Gastro	167	68	544	544
General Surgery	147	113	952	904
Obs and Gynae	150	76	1024	608
Orthopaedics	98	89	752	712
ENT	93	80	720	640
Peadiatrics	20	4	80	32
Respiratory	150	133	1200	1064
Rheumatology	2	2	16	16
Stroke Medicine	236	175	1688	1400
Urology	68	68	544	544
Rehab	3	2	24	16
Elderly Medicine	14	6	80	48
Total	**2131**	**1232**	**11648**	**9856**

Appendix 6: Locum Bookings (agency) by reason
1st July 2025 - 30th September 2025

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Additional Activity	4	3	24	24
Compassionate Leave	1	1	8	8
Annual leave	6	0	0	0
Deanery gap - Vacancy	47	0	0	0
Establishment Vacancies	443	305	3432	2440
Exemption from oncall	24	10	80	80
Incumbent Worker	922	861	7376	6888
Induction / Rotation	20	0	80	0
LTFT gap	23	15	184	120
Medic strike cover	5	0	0	0
Major Incident	5	2	40	16
Other approved Leave	8	5	48	40
Sickness	58	30	376	240
Vacancy	565	0	0	0
Total	**2131**	**1232**	**11648**	**9856**

Appendix 7: Vacancies

The below table details the Doctors and Dentists in resident establishment and current doctors in resident in post as appointed by NHS England (formerly Health Education England).

		Trainee Establishment						Trainee In Post						
Care Group	Department	F1	F2	CT/ST1	GPSTR	ST	**Total**	F1	F2	CT/ST1	GPSTR	ST	**Total**	**% Fill Rate Feb 2025**
Patient Admin & Corporate	Academic, GP, Psych & Community	0	17	0	86	0	103	0	16	0	84.5	0	100.5	**97.6%**
Acute & Emergency Medicine	Acute Medicine	3	0	7	1	4	15	3	0	8	0	1	12	**80.0%**
Theatres, Anaesthetics & Critical Care	Anaesthetics	1	6	9	0	6	22	0	4	8.7	0	5.6	18.3	**83.2%**
Specialist Surgery	Breast Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Cardiovascular Care Group	Cardiology	1	0	3	0	4	8	1	0	3	0	2	6	**75.0%**
Cardiovascular Care Group	Cardiothroacic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Pathology Network Group	Chemical Pathology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Digestive Diseases	Colorectal Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Surgery	Dermatology	0	0	0	1	0	1	0	0	0	1	0	1	**100.0%**
Community, Frailty and Therapy	Elderly Medicine	6	1	8	6	1	22	6	1	8	5	2	22	**100.0%**
Acute & Emergency Medicine	Emergency Medicine	7	5	2	2	3	19	5	6	3	2	5	21	**110.5%**
Specialist Medicine	Endocrinology	3	2	4	0	2	11	4	2	3	0	2	11	**100.0%**
Head and Neck	ENT	0	3	0	1	0	4	0	3	0	1	0	4	**100.0%**
Digestive Diseases	Gastroenterology	2	1	2	0	2	7	1	0	2	0	2	5	**71.4%**
Digestive Diseases	General Surgery	12	6	1	0	6	25	11	6	1	0	3	21	**84.0%**
Specialist Cancer and Support Services	Haematology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Pathology Network Group	Histopathology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Cancer and Support Services	Immunology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Cancer and Support Services	Infectious Diseases	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Neuroscience Specialist Care Group	Neuro-Rehab	0	1	0	0	0	1	0	1	0	0	0	1	**100.0%**
Neuroscience Specialist Care Group	Neurology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Neuroscience Specialist Care Group	Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Family Services	Obstetrics & Gynaecology	4	3	0	3	4	14	4	3	2	2	2.6	13.6	**97.1%**
Specialist Cancer and Support Services	Oncology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Head and Neck	Ophthalmology	1	1	0	0	2	4	1	1		0	1	3	**75.0%**
Head and Neck	Oral & Maxillofacial Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Family Services	Paediatric Neonatal Medicine	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Family Services	Paediatric Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Community, Frailty and Therapy	Palliative Care	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Surgery	Plastic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Family Services	Paediatrics	3	11	0	0	12	26	3	9	0	0	10.8	22.8	**87.7%**
Specialist Cancer and Support Services	Radiology	0	0	4	0	2	6	0	0	3.8	0	2	5.8	**96.7%**
Specialist Medicine	Renal Medicine	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Medicine	Respiratory Medicine	8	3	4	0	0	15	7	3	4	0	0	14	**93.3%**
Specialist Medicine	Rheumatology	1	0	2	2	0	5	1	0	2	1	0	4	**80.0%**
Neuroscience Specialist Care Group	Stroke Medicine	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Surgery	Trauma & Orthopaedics	2	2	1	0	3	8	2	1	1	0	3	7	**87.5%**
Digestive Diseases	Upper GI	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Specialist Surgery	Urology	3	1	0	0	0	4	3	1	0	0	0	4	**100.0%**
Cardiovascular Care Group	Vascular Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
	TOTAL	**57**	**63**	**47**	**102**	**51**	**320**	**52**	**57**	**49.5**	**96.5**	**42**	**297**	**92.8%**

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)243

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	11 December 2025
Director Lead	Simon Parkes, Non-Executive Director / NLaG Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Simon Parkes
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – July 2025 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 31 July 2025, approved at the ARG CiC meeting on 12 November 2025.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 31 July 2025
Prior Approval Process	ARG CiC meeting – 12 November 2025
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 31 July 2025 at 9.00am to 12.30pm in the Boardroom, DPoWH and via MS Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Jane Hawkard	Chair of ARG CiC (HUTH) - Non-Executive Director
Simon Parkes	Chair of ARG CiC (NLaG) - Non-Executive Director
Tony Curry	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)
Gill Ponder	Non-Executive Director (NLaG)
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Emma Sayner	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Sally Stevenson	Assistant Director of Finance – Compliance and Counter Fraud
Jason McCallion	Sumer NI – External Audit NLaG
Louise Stables	Forvis Mazars – External Audit HUTH
Neil Thomas	Partner, KPMG – Group Internal Audit (to item 13.2)
Harriet Fisher	Senior Manager, KPMG – Group Internal Audit
Matt Overton	Group Operations Director (item 9.1)
Richard Dickinson	Associate Director of Quality Governance (NLaG) (item 9.8)
Gerard Curran	Head of Legal (item 9.8)
Tony Deal	Group Chief Technology Officer (section 13)
Manoj Konanki	Group IT Security Manager (section 13)
Sue Meakin	Group Data Protection Officer and IG Lead (section 13)
Mike Bateson	NLaG Governor Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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

The meeting was recorded, and the recording will be deleted once the draft minutes are approved as correct.

1. Welcome and Apologies for Absence

Jane Hawkard, HUTH ARG CiC Chair welcomed those present to the meeting. Apologies for absence were received from Brian Clerkin, Managing Director (Sumer NI) – External Audit NLaG and James Collins, Director (Forvis Mazars) External Audit HUTH.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interests and none were made.

3. To approve the minutes of the meetings held on 24 April 2025 and 20 June 2025

3.1 Public Minutes – 24 April 2025

The public minutes were approved as a true and accurate record of the meeting.

3.2 Private Minutes – 24 April 2025

The private minutes were approved as a true and accurate record of the meeting.

3.3 Public Minutes – 20 June 2025

The public minutes were approved as a true and accurate record of the meeting.

4. Matters Arising and Review of ARG CiC Action Tracker

The ARG CiC Chair invited members to raise any matters requiring discussion not captured on the agenda. The following items were discussed from the action tracker:

- July 2024 item 17.3 – To leave open. Risk Management Strategy at November 2025 meeting.
- July 2024 Item 17.5 – action closed
- October 2024 Item 14.5 – David Sharif to bring a paper to the next meeting detailing the process and the position on this and action to be taken, as it was clear that declarations were not being received. Jane Hawkard stated that at the next meeting it should be a dramatically different position. Helen Wright questioned whether there were any consequences in place for non-submission. David Sharif responded that this was a requirement of the terms & conditions of employment and other than reputational consequences for the organisation, there was nothing more. Jane Hawkard asked what the process was for requesting the declarations. David Sharif confirmed that an action being taken forward was embedding the process into the job planning and appraisal process for the medical workforce. David Sharif stated that he was the lead Executive for declarations of interest but was dependent upon colleagues responding. Julie Beilby was concerned to hear that this was to be incorporated into job planning and appraisal work on the basis that these were seemingly inadequate and behind schedule across the Group, as had been reported at the Workforce, Education & Culture Committee (WECC), and therefore did not feel confident that work was being done to increase the uptake in declarations. Julie Beilby emphasised that again, these were basic asks of the staff which needed to be complied with and asked whether under the Declarations of Interest Policy, a nil return was required. David Sharif confirmed that it was, but advised there was some lack of uniformity in gathering responses as there were currently still two different systems in operation across the Group, with plans to change this, but added that fundamentally this was about people recognising the need to comply to protect themselves and the organisation. Simon Parkes suggested that if efforts were made to change the culture behind this and include it as part of mandatory expectations and link it to pay rises, the position would improve very quickly, and the Group should consider this. Julie Beilby agreed and reiterated that although two systems in use was not ideal, every member of staff was covered by one of the

systems therefore there was no excuse for not responding. A change in cultural conversations was clearly needed in that the Group communicates to staff what it is committed to do to support them, but likewise staff should agree to commit to assist the organisation to do basic things required of them to perform effectively. David Sharif agreed to relook at the process and essentially pass basic expectations through to Care Groups for them to be able to manage effectively. Tony Curry was of the view that this amounted to a lack of personal responsibility which needed good management oversight. Simon Parkes concluded that considering the pressure the Trusts were currently under, he was concerned that if basics such as this were not done, then there would be little confidence that the Group could do complicated things like looking after patients, and the Group needed to get the basics right and pay greater attention to doing them. Helen Wright added that she was uncomfortable with the fact that the Non-Executive Directors (NEDs) were having a conversation around such basic things, stating they should be under the influence and control of the Executives and NEDs should not be having to step in and make suggestions. Helen Wright looked for reassurance that these basics were happening.

ACTION: David Sharif

- October 2024 Item 18.1 – overtaken by changes to IG training in the new Cyber Assessment Framework (CAF) - action closed.
- January 2025 Item 7.3 – sufficient assurance via other forums - action closed.
- January 2025 Item 13.3 – to be covered later in the agenda – action closed.
- April 2025 Item 5.3 – action closed.
- April 2025 Item 7.1b – on the agenda - action closed.
- April 2025 Item 7.2 – action closed.
- April 2025 Item 10.2 – Julie Bielby confirmed position monitored by WECC through the receipt of monthly reports and robust discussion - action closed.
- April 2025 Item 11.3 – Sally Stevenson to follow up on using the Bad Apple system at HUTH.
- April 2025 Item 12.6a – Links to earlier discussion on declarations of interest - action closed.
- April 2025 Item 13.1 - response awaited.
- June 2025 Item 4 – to check date of external penetration test then action to be closed.
- June 2025 Item 5.2a – keep on tracker until policy is approved.

All other actions were either confirmed as on the agenda, closed or due at a later ARG CiC meeting.

5. NLaG External Audit (Sumer NI)

5.1 Verbal Update

Jason McCallion advised that planning for the 2025/26 audit would commence in October 2025.

5.2 NLaG Auditors Annual Report 2024/25 – Final

Jason McCallion advised that the draft had been presented at the June 2025 meeting and the only change to note was that an unqualified audit opinion had now been issued and the audit was now complete with the exception of the outstanding audit certificate which would be issued when the National Audit Office (NAO) completes the group audit.

5.3 NLaG EA Recommendations – Status Update

There were no comments or questions.

6. HUTH External Audit (Forvis Mazars)

6.1 Verbal Update

No update.

6.2 HUTH Auditors Annual Report 2024/25 – Final

Louise Stables advised that the draft report had been presented at the June 2025 meeting, and the final version had been updated to reflect that an unqualified opinion on the financial statements had been issued on 26 June 2025 and, as with item 5.2, the audit certificate was outstanding at this stage.

6.3 HUTH EA Recommendations – Status Update

Emma Sayner referred to the action plan and asked for any questions. Jane Hawkard referred to some seemingly outstanding actions within Appendix A of item 6.2 but Sally Stevenson clarified the detail, and this query was resolved. There were no further comments or questions.

6.4 HUTH Additional Audit Fees 2024/25

Gill Ponder questioned why the Transcatheter Aortic Valve Implantation (TAVI) issue was part of the end of year audit and Jane Hawkard responded that at the June 2025 meeting, which Gill Ponder was not present for, there had been a discussion around this. Louise Stables explained that this had been covered as part of the Value for Money arrangements work, particularly around economy, efficiency and effectiveness, and following recent media coverage of the police investigation and it entering the public domain they had a duty to check whether it presented a risk of significant weakness within the Trusts arrangements and as a result had to undertake more work in this area. Jane Hawkard commented that it was disappointing to have more costs incurred. Emma Sayner advised that herself and Sally Stevenson had had held robust discussions with James Collins around the additional fees.

Jane Hawkard referred to the ARG CiC Board Highlight Report and the need to refer to the value for money issue being seen as a weakness in CIPs, along with the Care Quality Commission (CQC) inadequate rating.

7. Group Internal Audit - KPMG

7.1 Group Internal Audit Progress Report 2025/26 inc. Status of Management Actions

Harriet Fisher advised that the paper was positive with regards to the position against the plan, with lots of work ongoing; the AI benchmarking fieldwork was complete and going through their national internal calibration process; fieldwork was underway with the CQC follow-up and the Theatre Utilisation audits; and the Data Quality audit was scheduled to commence the following week.

Harriet Fisher also confirmed that KPMG had now received a handover of open legacy actions made by the previous Auditors, and these had been loaded onto their follow-up system (JIRA) and training would commence for action holders in August 2025. Harriet Fisher also explained that the follow-up process would be slightly different in that an action would not be confirmed as implemented unless evidence had been seen by KPMG at the time an action was submitted for closure, and all overdue actions would now have a revised implementation date, but still with visibility of previous dates. Jane Hawkard referred to the recent Data Security and Protection Toolkit (DSPT) audit reports and there being a significant number of actions and Harriet Fisher confirmed that these would be put straight onto JIRA for following up.

Helen Wright reflected on the Trust's current position and was conscious that management time needed to be prioritised and asked whether some of the low impact actions should be closed at this point. Harriet Fisher responded that she believed some of this work had already happened. Emma Sayner agreed and confirmed that some of this cleansing work had been done in the run up to the transfer point. Helen Wright questioned whether that work had gone far enough and Emma Sayner stated that it was helpful to have this view from the ARG CiC and they would continue to consider this for remaining actions. Helen Wright stressed it was very important in the current climate to revisit actions and ensure that air time was not given to the wrong things.

David Sharif agreed with Helen Wright and shared that there were currently sixty action plans arising from External Visits across the Group and that this generated a large amount of work and strain on resources and time. David Sharif asked if the ARG CiC would endorse the same message that they had just given with Internal Audit actions, to External Visit actions. Jane Hawkard asked for clarification on what was meant by External Visits and David Sharif explained this was regulatory bodies, networks, etc. adding that they were all very legitimate and necessary. Helen Wright commented that they may be legitimate if the Group was in a stable state and suggested that the actions could be 'parked' until things were stabilised and priorities sorted, and then the actions could be revisited.

Simon Parkes considered there needed to be consolidation of actions across all sources and for them to be refocussed by the Executives and Transformation Director and presented as a prioritised plan for the ARG CiC. It would then be for the ARG CiC to determine whether they are assured that there is the right balance and focus to have the maximum impact and report back to the Boards-in-Common.

Action: David Sharif

Gill Ponder commented that it was a vicious circle and that Simon Parkes suggestion of consolidation was well made and was of the view that taking each action and considering whether completion would help achieve the Group's

strategic priorities was the way to resolve this. There could then be a new plan which extracts just the priority actions and the remainder are 'parked'. Jane Hawkard clarified that 'parking' actions didn't mean they were not important, just not right now.

Jane Hawkard asked that this be included in the Highlight Report to Boards-in-Common.

7.2 HUTH Inventory Management IA Report – Recommendations Status Update

Emma Sayner advised that the discussion around cleansing actions was timely for this report, adding that she had taken a robust but pragmatic approach to the actions contained in the report and would fully expect that KPMG would test the ones considered closed. Emma Sayner stated that more fundamentally she was working with Andy Haywood in conjunction with Edd James, Rachael Ellis and Nicola Parker, to develop a stock management policy and strategy which states what the Group will use for the different elements of procurement, inventory management and Scan for Safety. Emma Sayner considered this was the main focus needed rather than some of the reports actions.

Jane Hawkard noted that the priority of this work on stock management seemed to have increased from a previous discussion at the Performance, Estates & Finance (PEF) CiC. Emma Sayner acknowledged that from her statement made two PEF CiC meetings earlier, there was now the need to prioritise the work due to the decentralisation of the way stock levels were handled and it would indeed take time, but it needed to commence. Emma Sayner suggested this audit report be closed but the two remaining amber actions be integrated into the bigger piece of work. Jane Hawkard considered that the first action on the report should be closed off anyway in her view, and that action number four was part of the bigger issue.

Jane Hawkard asked that the piece of work to improve stock management and expenditure management is included in the Boards Highlight Report. Also to be added to the ARC CiC action tracker for a further update from Emma Sayner at the January 2026 ARG CiC meeting.

Action: Emma Sayner

7.3 Group Care Group Governance IA Report – Recommendations Status Update

David Sharif updated that the Group Executives had approved the new governance framework, which was now subject to document control aspects and would then be communicated to ensure full adoption of the policy across the Group.

Jane Hawkard questioned whether this had been presented to the Boards-in-Common, as she had not been at the last meeting, and David Sharif advised that it had not, but had been through the Group Executives who approved the framework. Jane Hawkard questioned if the framework was based on the Accountability Framework and David Sharif clarified that it had been based on the sub-committee level across the Group and had produced a governance framework that was very specifically targeted at how their arrangements ought to work in practice and the nuts and bolts of everyday business. David Sharif confirmed that it had been

developed with the Care Groups and clarified that it would help confirm how the Care Groups should be working on a consistent basis. Jane Hawkard asked how this was being communicated and David Sharif replied that this would be the next step in the process after document control processes had been completed, and would be working with the Communications team to do this.

Helen Wright stated that it was important to ensure that Care Group governance was correct but queried whether putting the governance framework in place would allow them to measure the effectiveness of the Care Groups. David Sharif stated that he believed it would help.

Jane Hawkard asked if there was a forum where Executives meet with Care Group leads and David Sharif confirmed that this was at the Performance & Accountability meetings, and additionally, corporate directorate meetings in a similar vein were due to commence shortly.

Julie Beilby commented that again, it was important to get the basics right and doing so consistently to achieve the level of improvement required and queried whether the Care Groups would comply. David Sharif was confident that this new governance framework would simplify and clarify some of the basic arrangements how the Care Groups need to comply and ultimately allow them to see how they could improve. Julie Beilby responded that there were many areas where staff needed to comply on various things such as job planning and appraisals, mandatory training, etc., and queried if the messaging was not right or whether simply more time was needed to see improvements. David Sharif advised that with the arrival of the new Interim Group Chief Executive and her early communication to staff on performance and getting the basics right, that this would initiate a change in response.

Tony Curry noted that there was a level of personal responsibility, but it also needed management to actively chase their staff to ensure compliance with the basics and queried where this was in the organisation, adding that there did not seem to a consequence of not complying. The ARG CiC discussed that it might be as simple as staff not really understanding what was meant by ‘basics’ and agreed that there needed to be clarity on what the ‘basics’ were, what the Group’s top priorities were, etc. It was also discussed that there was a need for a culture shift in terms of agreeing actions in Internal Audit reports for example, and saying ‘if we are doing this action then we can’t do this other one’ rather than just keep adding to workloads and overloading staff / teams.

Julie Beilby recalled a discussion at the recent WEC CiC meeting where a member of staff had been asked to do an additional piece of work and responded, quite rightly, that they did not have the capacity to do it as their team had been downsized and asked was it a priority and if so what should their team not do. Julie Beilby considered that this was exactly the robust challenge needed from management when being asked to do additional work . In this instance the WEC CiC considered the additional work was a nice to have item, not a priority.

7.4 NLaG and HUTH Risk Management/BAF IA Reports – Recommendations Status Update

Gill Ponder referred to the risks on the Board Assurance Framework (BAF) and the deep dives the Auditors were recommending and how it seemed like they were

going round in circles because the PEF CiC used to undertake a deep dive on strategic risks at each meeting and it did not really work. As the former Auditors were recommending the deep dives again, Gill Ponder considered there was a need to be clear on what a deep dive meant on a strategic risks and also whether it should be performed at Board level with one strategic risk per meeting. David Sharif responded that the Board agenda had been adjusted to include the new six strategic priorities and considered parking the deep dives until a few Board meetings had taken place whilst the priorities were being looked at.

In response to a question from Jane Hawkard, David Sharif confirmed there was a process in place for risk but it needed to get to a better place through the planned training. Jane Hawkard stated she felt assured on this report.

Gill Ponder asked whether the Group was on target to achieve the shortfalls in the BAF and Risk Register by the end of September 2025, as the Risk Register had already been deferred a couple of times due to amalgamation into a single system and for visibility on the mitigations of risks. Jane Hawkard queried if there was a new single system and David Sharif confirmed there was, and that it was one of the existing systems (Ulysses) and there was a lot of work to go into it coupled with training of the Risk Champions, etc. and that data migration was already underway. David Sharif was confident in achieving the timescale, but added there was always more to be done but was of the view that things were in a good position.

Matt Overton joined the meeting.

8. Counter Fraud – Group

8.1 Group LCFS Progress Report

Sally Stevenson was pleased to advise that the new Local Counter Fraud Specialist (LCFS) had now commenced in post. Daryl Cheetham was not at the meeting however due to undertaking a day of mandatory training. Julie Beilby was pleased to hear that the mandatory training for the new employee was taking priority over attendance at the meeting.

Sally Stevenson also updated that in relation to the new offence of Failure to Prevent Fraud, which is specifically around fraud committed by an organisation through its employees, not against it, she had discussed with Emma Sayner possible scenarios of this new offence in the Group and cited a couple of examples of where this could be applicable. The ARG CiC considered the issue of reputational risk associated with this.

The report was accepted.

8.2 Group Annual LCFS Report 2024/25 – *to be circulated by September 2025*

9. Management Reports for Assurance

9.1 Group EPRR Highlight Report

Matt Overton confirmed that the percentage of Business Continuity Plans (BCPs) was gradually increasing and now at 72%. Instances of non-compliance were

being followed up with the relevant Directors who had plans in place to ensure actioned by 31 August 2025 to increase compliance to over 90%. New and emerging risks included the current doctors industrial action and there would be a debrief meeting on the impact and feedback findings shortly with a view to learning lessons for any future industrial action.

Juie Beilby commented that she liked the format of the report and looked forward to hearing further detail on the feedback received on the doctors strike.

Jane Hawkard referred to the tower block issue not in the report relating to the emerging issue of a fire risk. Matt Overton replied that there was work ongoing to review the north bank full and partial site evacuation plan and was working closely with fire and safety colleagues to review all those processes. There was a meeting scheduled with some of the Executives to formulate a communications strategy.

Jane Hawkard asked on the timescale for the evacuation plan review, and Matt Overton advised that there was a current and in date full and partial evacuation plan in place which had been tested and validated. Matt Overton explained that now being tested was the horizontal and vertical evacuation and this was planned for August 2025, so it was expected there would be a revised plan in September 2025 which would be put through a table top exercise to validate it.

Julie Beilby had assumed that the tower block had not been included in the report because it needed to link in with the communications strategy which needed to be timely, and reinforced the fundamental importance of ensuring that everything was documented in detail . David Sharif added that the PEF CiC and Board were a very important step in the process of dealing with this risk and a governance structure was being set up with Executive oversight to deal with this.

Helen Wright agreed the report was of a good format and asked whether in the event of a cyber-attack, whether there was sufficient access to the BCPs if locked out of Trust systems. Matt Overton replied that table top exercises had been done and the IT recovery plans had been tested and updated, with the support of the ICB and NHSE, and confirmed that printed versions of BCPs were held in the incident coordination centres and also operation / control rooms. Helen Wright advised this was very reassuring.

Jane Hawkard thanked Matt Overton for his report and he left the meeting.

9.2 Group Board Assurance Framework

David Sharif shared a presentation on screen of the BAF and focussed on the next steps on page 29. Group Executives had approved the updates through the single Risk Register and David Sharif commented that he was due to meet with Dr Kate Wood to discuss actions around Martha’s Rule. The control ratings had also been updated.
Gill Ponder asked why the patient risk had not been reviewed since 1 May 2025, considering the large gap between the appetite (9), the actual score (20) and the optimal score (4) and this should be one that is focussed on much more given its patient status. David Sharif replied that this would be reviewed in his meeting with Dr Kate Wood in a weeks time.

Gill Ponder also referred to the list of risks aligned with CiCs on page 31 and referred to Risk 12 which seemed to be more a capital risk and therefore would be more appropriately aligned to the Strategic Programmes and Partnerships CiC, should the Board approve the re-naming of the CiC at the August 2025 meeting. David Sharif confirmed he was content to make that change.

Helen Wright thanked David Sharif and his team for including a rating around assurance controls following her previous concern, but asked for clarity on the 'level of assurance' statement and David Sharif confirmed that it referred to the level of assurance that the control was working effectively.

9.3 Group Risk Register

Gill Ponder asked why there were overdue high risks for review and what was being done about it. David Sharif accepted this and advised there had been a reduction in the number of non-compliant risk reviews in the last month, it was disappointing as the Care Groups know they have to review the risks and there is the need for some further alignment in some of the associated governance aspects. David Sharif stated that the numbers were more manageable compared to where they were a few months ago.

Jane Hawkard commented that they were seeing more grip on this. David Sharif added that the DPoWH Emergency Department (ED) risk of 25 had received a lot of discussion with Group Executives and he hoped that the work undertaken by the ED would move the risk back into alignment.

9.4 Annual Review of Adequacy & Effectiveness of System for Devising and Monitoring the Board Assurance Framework (BAF) – Group

David Sharif highlighted the alignment table on page 5 which showed the alignment of each of the new strategic objectives to the previous risks. There were no questions or comments.

9.5 Annual Review of Adequacy & Effectiveness of System for Management and Monitoring of Risk (inc, ICS Risks) – Group – *Deferred to November 2025 meeting*

9.6 Annual Review of Risk Management Strategy

Jane Hawkard asked whether it was possible for the ARG CiC to see a copy of the draft strategy and, following discussion, David Sharif replied that he would be prepared to circulate a final draft copy via email due to the long wait until the November 2025 meeting.

ACTION: David Sharif

There was a ten minute break at this point.

9.7 Daisy Appeal Governance Arrangements

Jane Hawkard advised that she had requested this paper to aid her understanding of the arrangements around this. Emma Sayner introduced the map and matrix on the interdependencies and governance arrangements of the different buildings and proposed it needed to be logged and visible so that staff were aware.

Gerard Curran joined the meeting.

Julie Beilby noted an inconsistency in the purpose of the paper, in that it was noted on the agenda for assurance but on the front sheet, it was indicated for review and assurance. Julie Beilby noted it was just one example of this nature in the meeting papers and was of the view that it was important to be clear and consistent on the purpose of the papers at the CiC meetings. Emma Sayner replied that as Jane Hawkard had requested the paper, it would be for review and assurance and Jane Hawkard agreed. Sally Stevenson added that there was possibly some general confusion from those submitting papers around which boxes to tick and would discuss further with David Sharif outside of the meeting around simplifying the terminology in the interests of clarity.

ACTION: Sally Stevenson / David Sharif

Jane Hawkard asked whether the contract ended in 2033 at the end of the 40-year lease and was unsure whether the building belonged to the Trust. Emma Sayner clarified that although the land belonged to the Trust, only the Radiopharmacy part of the building belonged to the Trust not the Cyclotron part of the building and on expiry of the contract in 2033, there would be further contract negotiations entered into.

Jane Hawkard asked for this item to be included in the Board Highlight Report.

9.8 Review of Legal Fees and External Consultancy Fees – Group

Jane Hawkard highlighted this was an annual paper but that the external consultancy fee detail was not included in the report, and it was agreed that this be circulated.

Action: Emma Sayner

Richard Dickinson joined the meeting.

David Sharif suggested splitting the paper in future, so that there were separate reports on Legal fees and another on External Consultancy fees as the consultancy fees sat better with Emma Sayner's remit. Emma Sayner agreed with this suggestion but was also happy to work together on it. Sally Stevenson to reflect this change on ARG CiC workplan.

Action: Sally Stevenson

Emma Sayner referred to Jane Hawkard's request for the detailed breakdown of the £2.9m, of which the two big items were spend on PA Consulting and Officio (a procurement partner), and also assurance over the NHSE business case approval. Emma Sayner clarified that any spend over £50k needed NHSE approval and assured the ARG CiC that the PA Consulting spend had gone through the NHSE approval process as it was one of the first things she did when she arrived into post in December 2024. Emma Sayner also advised she had been assured that Officio had also gone through the correct governance process when the procurement collaborative was established but had not seen documentary evidence of this.

Emma Sayner referred to Jane Hawkard's question on how assurance was routinely and systematically gained that NHSE approval had been given, and recommended that this could be covered on the business case review group

template to ask the question as to whether there was a requirement to seek NHSE approval . Also, David Sharif had suggested this be captured on the scheme of delegation. Helen Wright commented that in a period of financial challenge it is often the case that an organisation would block spending on consultancy services, and so having the controls in place would allow the Group to do that if that was the approach it wanted to take.

Helen Wright commented that given the significant workforce she assumed the Group could tackle most things in-house, and asked if there was merit in bringing the legal service in-house to help reduce expenditure on outsourcing employment legal advice. Emma Sayner responded that she knew other NHS organisations employed solicitors directly. Gerrard Curran advised that a big piece of work was ongoing to look at reducing the spend on healthcare advisory side of legal services by employing specialists within the team that are being trained up to deal with Court of Protection work. This is a 5-year plan, which is currently only in year 2 of training up specialists but there was already a noticeable reduction in the need to use the external resources (Capsticks Solicitors) and gave an example of this and the size of possible reductions in spend.

Helen Wright questioned whether there were any plans to reduce spend on employment legal advice and Gerard responded that there was the potential to review what was currently being outsourced and what could be done in-house and then build it up including employing lower bands to do some of the administration work. Helen Wright also proposed the team consider the use of a fractional model where a legal professional would maybe spend a day a month in-house on a consultancy basis, alleviating costs to the Group.

Jane Hawkard thanked Gerard Curran for his input on this item and noted a significant reduction in the spend already but with an opportunity to reduce further.

9.9 Annual Claims Report 2024/25 – Group

Gerard Curran clarified that the report did not include Court of Protection work and it was something they did need to look at. The report included civil litigation matters (clinical negligence claims and EL / PL claims) and inquest work.

Julie Beilby referred to a discussion on this paper at the Quality & Safety (Q&S) CiC where it was agreed that the issue of learning and recommendations would be raised at the ARG CiC meeting, in terms of the level of assurance around learning and recommendations. The Q&S CiC had discussed whether there was an opportunity / need for Internal Audit to do a sample review of recommendations and whether they had translated into actions and become embedded in the organisations. Richard Dickinson added that the question came about as a result of asking how the Group knows something has happened as a direct consequence of the recommendations made, and whilst there may be evidence in a lot of areas, it was also important to oversee how the actions from themes were picked up by the Care Groups and implemented in the most effective way. It was therefore raised as a way of putting it on the radar for Internal Audit at some point as to whether this could be explored. Richard Dickinson also advised that as part of the Get It Right First Time (GIRFT) work, the Care Groups with a quartile 4 performance were expected to feed back about the actions being taken to improve clinical claims. Jane Hawkard stated that it could be added to the long list of possible future audit areas.

Helen Wright asked that in terms of the causes of the types of claims where the organisation was looking at health and safety issues e.g. slips and trips, and seeing very evident themes and trends, who oversees the work on health and safety incidents and associated initiatives to prevent slips and trips, etc. Richard Dickinson replied that going forward, there was a plan to provide more information to the health and safety forums on a quarterly basis by the Legal team who were working on the cases and had first-hand knowledge, and allowing those forums the opportunity to learn from them.

Gerard Curran added that from a learning perspective, one of the difficulties with claims work was having to factor in a significant time delay between incident occurrence date and claim settlement, which is 4.9 years on average. As a result, they see very historical claims, unlike incidents or claims which are seen in more real time. Gerard Curran explained that they look at what is done through incidents and complaints and whether it is taking effect or whether still being seen in the claims reports, adding that it was important to note that any learning introduced today would not be seen for, potentially, a seven year time lag.

Simon Parkes did not consider it appropriate to ask Internal Audit to do additional tasks such as this, although acknowledged that it would be good to know that the recommendations were being implemented, however he thought it should be more of an Executive function to manage this, especially at such a critical time. Simon Parkes added that there were lots of risks that the Group needed Internal Audit to focus on and he could not think of which audit area would be removed from the plan to look at this one, adding however that if there was a broader issue about how health and safety was managed then that would be something to consider.

Jane Hawkard stated it would not be looked at this year, but possibly considered for the three year plan long list. Harriet Fisher suggested that it could possibly be included in an existing audit e.g. Estates rather than a stand-alone piece of audit work, and confirmed she had captured it for their tracker.

Jane Hawkard noted that benchmarking data had been included in the report as the ARG CiC had requested, but was unclear what some elements represented and asked, for future reference, if a narrative could be included in what it related to to assist understanding of whether the Group was good, bad or indifferent. In addition, in relation to the Trust specialities on pages 23 and 24, HUTH showed poor performance but there were no actions recommended to improve this. Richard Dickinson explained they had limited visibility of other Trust's claims, so used NHS Resolutions publications (2023/24 data) and explained the ranking method used, etc. Richard Dickinson added that Gerard Curran and his team had provided quite a lot of information for learning for the specialties involved in areas of high claims areas, which had been well received.

In response to a question from Jane Hawkard around triangulation, Gerard Curran explained that with the GIRFT report there is a process of validation completed first to correct any possible errors, followed by a review of the trends, etc. The data is quite high level, but it is then provided to the services / specialties in the form of a pack to look at in a more detailed way. Jane Hawkard considered whether in terms of triangulation, this should be considered at the Quality & Safety CiC, in terms of identifying problem areas and the potential for a deep dive. Jane Hawkard agreed to discuss with the Q&S CiC's Chair.

ACTION: Jane Hawkard

Jane Hawkard thanked both Richard Dickinson and Gerard Curran for their participation in the meeting and for the evidence of their proactiveness, which gave a high level of assurance to the ARG CiC.

Richard Dickinson and Gerard Curran left the meeting

9.10 Well Led Assessment Plan

David Sharif explained the trigger for this was that the well led assessments for both organisations are due, which is an external requirement. The review for HUTH was due in 2022 and NLaG in 2019. Discussions had taken place with the Acting CEO's and the Interim Chief Nurse, although a formal steering group had not yet been convened. David Sharif stated that there were both pro's and con's to undertaking the review at this particular time, including the implications of being in segment four / five and the associated interventions, and the current Acting CEO was going to pick it up with Regional colleagues. David Sharif highlighted that the plan was shown as starting in July 2025 but the planning element has only been done so far, whilst the Acting CEO has conversations with the Region.

Helen Wright commented this was a sensible approach and also noted that it was only three years since HUTH had a review, and asked whether there was a need for another one yet and whether anything had been learnt from the last one. David Sharif replied it was before his time at the Group, but added that every three to five years was the standard timescale, and the formation of the Group may well have superseded some of the work that had been identified previously. Helen Wright considered whether it would be worth looking at the findings from the last review and sense checking it under a light touch approach rather than revisiting it in a detailed way.

Julie Beilby questioned whether this was a priority for the Group at this point given the state of flux in management arrangements and the Group's performance, but welcomed the regional discussions and looked forward to the outcome.

Gill Ponder also questioned this review as, from her experience, they were extremely resource-intensive and may detract from the focus on tackling the current major issues that the Group is measured on. Gill Ponder was of the view that concentrating fully on the five or six issues which demonstrated a successful organisation was paramount and this review, albeit beneficial, could follow at a later point.
Jane Hawkard agreed with these reservations, as it was another diverting administration task taking the Group away from its real operational focus. The ARG CiC also discussed the financial costs – both external and internal – that would be incurred with such an exercise when finances were so tight. The ARG CiC asked that David Sharif feed these comments back accordingly.

Action: David Sharif

9.11 Group Governance Update inc. Committee Structure – *to be covered in item 9.4*

9.12 Triangulation of Information between Committees and the Boards

David Sharif hoped that the paper evidenced what was needed for good triangulation and what the challenges were to this, as there was no single easy answer around it. Jane Hawkard agreed and stated that when Board members raised issues around triangulation in future they should be challenged as to what exactly the issue is and what they would want.

Jane Hawkard noted there was a good mix of representation amongst the different CiCs therefore plenty of opportunities to ask the right questions and get the right information. Jane Hawkard considered that this paper went a long way to setting it out, and the organisation should be able to triangulate but was still not getting to where it needed to get to.

Helen Wright agreed with this point and shared that she had noted more referrals being made now across the CiCs which was positive, but she did consider the CiCs needed to be better at working out what really matters in terms of escalations to the Boards. Helen Wright acknowledged the revised Highlight Report format which was concise and brief, whereas previous ones were a mini set of minutes and was just being escalated for information, when it should only be something that the Board needs to get involved in and for anything else the Boards can check the CiCs minutes. David Sharif expected that the new Highlight Report would go through various iterations and also anticipated that this report would reassure those colleagues questioning the triangulation process.

Simon Parkes reminded colleagues that the length of the Highlight Reports previously was deliberate as the Board had been asked to spend more time at its meetings discussing the work of the committees, having previously been quite short Highlight Reports before that. However Simon Parkes agreed with the change to a more focussed approach and only highlighting those things that the Boards really need to understand.

Julie Beilby agreed on the change in focus but also considered, for balance, that the escalation report should act as a signpost for the reader to check the minutes if a topic is one they are concerned about. Helen Wright held a different view. David Sharif added that the aim was to quickly see what the CiCs had completed, as opposed to spending time reading through minutes.

Gill Ponder referred to the example of a triangulation process and questioned when the Integrated Performance Report (IPR) would hold real-time data. David Sharif responded that Adam Creeggan, Group Director of Performance, and his team were currently working on it but would speak with him for an update on timescale.

ACTION: David Sharif

9.13 Group EPR Asset Accounting

Emma Sayner spoke briefly to the paper and referred to the request for the External Auditors approach on the asset valuation approach and also a recommendation for approval on how cost is apportioned between the two Trusts.

It was acknowledged there needed to be a way of splitting it within the Group and Helen Wright offered an alternative method using average patient numbers although commented that may be too difficult. Emma Sayner agreed to take the alternative suggestion back and discuss further with colleagues. Helen Wright

stated that she was happy to support the recommendation in the paper if that was what was decided.

ACTION: Emma Sayner

The ARG CiC agreed that the recommended approach was sensible and supported the two recommendations.

10. Policies for Review/Approval

10.1 Group Document Control Policy

Jane Hawkard advised that it had been queried why this policy was at the ARG CiC. David Sharif advised that the policy had been approved by the Executives, and he was just following historical precedent bringing it to the ARG CiC. Gill Ponder was of the view that the ARG CiC may be more assured in just having a list of policies with a date of when they were due to be reviewed and when they were reviewed, rather than seeing the actual policy. David Sharif stated that the ARG CiC did receive such a report periodically. Gill Ponder stated that the policy did not need to come to the ARG CiC unless they are risk based policies.

There were no questions or comments on the policy itself. The ARG CiC noted that Executives had approved the policy.

Tony Deal, Sue Meakin and Manoj Konanki joined the meeting.

10.2 NLaG Salary Overpayment Policy

Sally Stevenson advised that review of these policies (10.2 and 10.3) was on the ARG CiC workplan, adding that they were scheduled for their annual review and that the plan was to produce a single Group policy in due course. Sally Stevenson stated that the changes were all tracked within the document and minor in nature.

Jane Hawkard referred to Section 4.1 of the policy regarding producing an overpayment letter for the employee within ten working days. Jane Hawkard asked why it was ten days and if this was missed, whether it made a difference to asking for the overpayment to be returned. Sally Stevenson responded that the ten days was an internal timescale and to her knowledge, there had never been an issue, but she would add in the word ‘normally’.

Action: Sally Stevenson

Following discussion around the policy being on the ARG CiC workplan, the ARG CiC approved the policy.

10.3 NLaG Salary Underpayment Policy

The ARG CiC approved the policy.

11. ARG CiC Governance Items

11.1 Schedule of ARG CiC Meetings 2026

This was noted.

12. Highlight Reports and Action Logs from Board Sub-Committees-in-Common

12.1 Performance, Estates & Finance CiC
12.2 Capital & Major Projects CiC
12.3 Quality & Safety CiC
12.4 Workforce, Education & Culture CiC
12.5 Health Tree Foundation Committee - NLaG

The above highlight reports and action logs were received for information. There were no issues raised.

13. Private Agenda Items

Items 13.1 to 13.4 were minuted as private agenda items.

Following a discussion around actions arising from private agenda items, the ARG CiC agreed to have a private action log going forward.

Action: Sally Stevenson

14. Any Other Urgent Business

There was no urgent business to discuss.

15. Matters for Escalation to the Trust Boards-in-Common (Public/Private)

The following items of business were agreed to be highlighted to the public Trust Boards-in-Common:

- Two significant weaknesses raised in the HUTH External Auditors Annual Report (historical CQC Report and financial sustainability).
- Cleansing of legacy Internal Audit actions, and in a similar vein focussing on external body actions that will assist the Group in achieving its priority strategic objectives.
- Piece of work underway on stock management and scan4safety systems.
- Group Executive have signed off a set of clear governance processes for Care Groups to follow to ensure consistency of approach.
- Constant theme of 'getting the basics right'; Executive communications across the Group that are clear about what the 'basics' are would be welcomed.
- High level risks not always reviewed within agreed timescales. Work is ongoing to resolve these issues.
- The current capacity within the Group to undertake a Well Led Assessment.

16. Matters to Highlight to other Trust Board CiCs

There were no matters to highlight.

17. ARG CiC Workplan – for information only

18. Review of the Meeting

No comments received.

19. DATE AND TIME OF THE NEXT MEETING

The next meeting of the Audit, Risk and Governance Committees-in-Common will be held on Wednesday 12 November 2025 at 9am to 12.30pm in the Boardroom at DPoWH and via MS Teams.

The ARG CiC Chair closed the meeting at 12.32pm.

Schedule of Attendance at ARG CiC Meetings 2025/26

Member / Attendee	Apr-25	Jun25 Audited Accounts	Jul-25	Nov25	Jan-26	Total
Members - NLAG:						
Simon Parkes – NED / ARG CiC Chair	Y	Y	Y			3/3
Gill Ponder – NED	Y	N	Y			2/3
Julie Beilby – NED (from Jan 25)	Y	Y	Y			3/3
Members - HUTH:						
Jane Hawkard – NED / ARG CiC Chair	Y	Y	Y			3/3
Tony Curry – NED	Y	N	Y			2/3
Helen Wright – NED (from Jun 24)	Y	Y	Y			3/3
Regular Attendees:						
Emma Sayner – Group CFO (from Jan 25)	Y	Y	Y			3/3
David Sharif – Group Director of Assurance	Y	Y	Y			3/3
Rebecca Thompson – Deputy Director of Assurance - HUTH	Y	N	N			1/3
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y			3/3
External Audit - NLAG (Sumer NI)	Y	Y	Y			3/3
External Audit – HUTH (Forvis Mazars)	Y	Y	Y			3/3
Internal Audit - NLAG (Audit Yorkshire)	Y	Y				2/2
Internal Audit – HUTH – (RSM)	Y	Y				2/2
Internal Audit – Group (KPMG)	Y	Y	Y			3/3
Sue Meakin - Group DPO / IG Lead	Y	N[1]	Y			2/2
Mike Bateson - NLAG Governor Observer	Y	Y	Y			3/3
Ad-hoc Attendees:						
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y	N			2
HUTH Vice Chair (Murray MacDonald)	Y	-	N			1
Acting Group Chief Executive (Amanda Stanford)	Y	Y	N			2
Group Chief Strategy & Partnerships Officer (Ivan McConnell)	Y	-	N			1
Group Chair (Sean Lyons)	-	Y[2]	N			1
Group Deputy Director of Communications (Adrian Beddow)	-	Y	N			1
Ad-hoc Attendees continued….						

DRAFT

Associate Director of Quality Governance (Richard Dickinson)	-	-	Y[2]			1
Operations Director – Group Emergency Planning (Matt Overton)	-	-	Y[2]			1
Group Head of Legal (Gerard Curran)	-	-	Y[2]			1
Group Chief Technology Officer (Tony Deal)	-	-	Y[2]			1
Group IT Security Manager (Manoj Konanki)	-	-	Y[2]			1

Notes:
[1]Not required to attend, audited accounts meeting only
[2]Part meeting

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)244

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11 December 2025
Director Lead	Gill Ponder, Committee Chair, Capital & Major Projects Committees-in-Common Helen Wright, Committee Chair, Capital & Major Projects Committees-in-Common
Contact Officer / Author	Gill Ponder, Committee Chair, Capital & Major Projects Committees-in-Common Helen Wright, Committee Chair, Capital & Major Projects Committees-in-Common
Title of Report	Capital & Major Projects Committees-in-Common Minutes – June 2025
Executive Summary	The Capital & Major Projects Committees-in-Common minutes from the meeting held on 18/6/25
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Capital & Major Projects Committees-in-Common Minutes held on 22/10/25
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday 18 June 2025 at 9.00am to 12.00pm in the Boardroom, DPoW

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) - Chair
Helen Wright	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Financial Officer
Sarah Tedford	Interim Chief Delivery Officer
Simon Parkes	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Andy Haywood	Group Chief Digital Officer
David Sharif	Group Director of Assurance
Ivan McConnell	Group Director of Transformation
Rebecca Thompson	Group Deputy Director of Assurance
Alex Best	Deputy Director – Major Developments
Ian Reekie	Governor Observer
Jo Palmer (Minutes)	PA to Trust Board Committees

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair welcomed those present to the meeting. The following apologies for absence were noted: Clive Walsh, Interim Chief Executive (North), Tony Curry, Non-Executive Director (HUTH) and Tom Myers, Group Director of Estates & Facilities.

1.2 Staff Charter and Values

The committee Chair reminded attendees to be mindful of these throughout the course of the meeting.

1.3 Declarations of Interest

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

1.4 **To approve the minutes of the meetings held on 30 January 2025 & 22 April 2025**

The minutes of the meetings held on 30 January 2025 & 22 April 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda. There were no items raised.

1.6 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

Item 6.1 June 2024 – Item to be closed. Update to be provided at the Board Development Day after the September 2025 meeting. Jane Hawkard suggested that this topic was added to the workplan, and it was agreed that progress updates would be provided to the Committee at each meeting.

Item 3.1 October 2024 – David Sharif advised that following discussion at the Audit, Risk & Governance Committee (ARG), the Quality & Safety Committee (QSC) would oversee the Risk Register until a new system was in place. Action closed.

Item 1.8 November 2024 – item to be closed.

Item 3.1.1 November 2024 – item to be closed.

Item 3.1.2 November 2024 – item to be closed (ref Item 3.1 October 2024).

Item 3.1.3 November 2024 – item to be closed.

Item 3.1.4 November 2024 – Gill Ponder questioned whether the Committee was confident that the medical and digital capital elements were now included in the BAF and Risk Register reports and it was confirmed that the Capital risk management process has been updated. Item to be closed.

Item 4.4 November 2024 - to consider whether there is a need to inform NHSE that IAAUs were indeed delayed and over budget. To be carried forward to the August meeting as a Lessons Learned piece.

Item 4.1 January 2025 – this related to the underspend in 2025/26 and Emma Sayner confirmed that Cabinet had approved the reallocation of circa £4m funding. Item to be closed.

Item 4.5 January 2025 – Emma Sayner had requested that this was now a standing agenda item going forward and to be included on the workplan. Helen Wright suggested a rolling timetable to discuss project evaluation progress updates.

Item 1.3.1 April 2025 – item to be carried forward to August for an update following the meeting of 30/6/25 between David Sharif and Andy Haywood.

Item 1.3.2 – item to be closed as would now be reviewed at PEF.

Item 1.4.1 – Completed, so action to be closed.

Item 1.4.2 – Completed, so action to be closed.

Item 1.4.3 – Completed, so action to be closed.

Item 1.5 – Completed and now business as usual. Closed.

Item 1.6.1 – Completed, so action to be closed.

Item 1.6.2 – Completed, so action to be closed.

Item 1.6.3 April 2025 – a proposal to change the name of the Committee had not been approved due to insufficient time for discussion, although the request had been included in the Highlight report. Jane Hawkard asked that the matter be added to the NED meeting agenda.

Item 1.9 – Completed, so action to be closed.

Item 2.1.1 – Completed, so action to be closed.

Item 2.1.2 – It had been clarified that the Core Committee Members for HUTH were Helen Wright and Jane Hawkard. Closed.

1.7

Final Review of Terms of Reference & Workplan

Sarah Tedford pointed out that her role of Group Chief Delivery Officer needed to be included and David Sharif confirmed that all new role titles would be included in time for submission to Board.

Gill Ponder referred to the section on the Highlight report and asked that more detail was added, including discussions at Committee, the level of assurance gained and where notable achievements were made, along with identified risks and the mitigations against these risks.

She also highlighted other areas requiring amendment, notably the proposed inclusion of the Director of Transformation.

Jane Hawkard considered that there needed to be more detail on the reference to partnerships and for this to be included in the workplan, and for the reference to capital planning to include transformation.

There was discussion around the frequency of the meetings changing from bi-monthly to quarterly and it was agreed to include an escalation for when an extra-ordinary meeting was needed. Helen Wright also suggested that a discussion could be held at the monthly Performance, Estates & Finance CiC (PEF) if required.

ACTION: David Sharif to circulate a further draft prior to submission to Board, without tracked changes

ACTION: David Sharif to liaise with Ivan McConnell to discuss planned transformation pieces that may need escalation discussion

There was discussion around the workplan, which would now need to incorporate the changes to the ToRs.

Jane Hawkard and Helen Wright suggested there be a section on partnerships and strategic capital programme development plans.

It was pointed out that the Digital Strategy would be updated in a year's time but going forward, would be reviewed every three years.

Gill Ponder considered that either a brand new workplan to show the work of the committee going forward was drafted or the current version needed to show what work had been undertaken so far, as well as what was planned. Ivan McConnell suggested that it was redrafted as it did not currently reflect the work going forward.

Gill Ponder expressed her preference for a totally new workplan showing the planned work going forward, with the old version showing what work had been undertaken. Helen Wright considered this would be helpful for the Non-Executive Directors to be able to see how the line of work was changing.

Ivan McConnell suggested that an evaluation also be included which would assist in the event of a Well Led assessment.

ACTION: Ivan McConnell to check whether an evaluation template was available for moving from one workplan to a new one

ACTION: David Sharif to table the new draft ToRs and workplan at the next NED meeting and Board Development Session

Simon Parkes joined the meeting at 9.45am

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

There were no matters referred by the Trust Board or Committees.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif reported that there were no changes to the BAF score or risk appetite and advised that there were several capital and equipment risks.

Jane Hawkard referred to the digital assurance gap and the statement of a lack of technical expertise for the Board. She asked for clarification as there was clearly expertise within the Committee.

ACTION: David Sharif to amend wording on risk from lack of technical expertise of the Board.

Helen Wright asked for confirmation that the score on partnerships was indeed accurate at only 12 and questioned how influential the Group was with its partners and whether it had appropriate partnerships within the private sector. Ivan McConnell responded that the focus to date had been with business partners and building confidence with regional as well as local partners, the ICB and local authorities. He recognised that there was more work to do with academic partners, which were largely local and any issues they may experience would have an impact on the Group. He advised that the University of Lincoln was the only World Health Organisation-funded rural and coastal health faculty in Europe, but it was proving difficult to initiate introductions. Simon Parkes offered to assist with this. Andy Haywood was in dialogue with Microsoft, also giving more scope for building better relationships.

Sarah Tedford considered that the relationship with NHSE was quite good but there was a need for clarity on what the organisation was looking for.

Gill Ponder suggested that in line with the Government focus on the health of the population, this matter needed the attention of Board and suggested that it was added to the Highlight report.

David Sharif recognised the work of Linsay Cunningham in building up a better understanding of the BAF between stakeholders and departments.

3.2 **Risk Register Report Q4**

David Sharif noted that there was a great deal more information on work undertaken and control measures in place than what was displayed within the report.

Helen Wright asked if the governance team were able to add a summary against each risk for the CiC to gain some assurance and David Sharif advised that at the ARG CiC, it had been agreed that the Quality & Safety CiC (QSC) would be used on a trial basis to monitor the risks.

Helen Wright reflected that currently, the report did not clearly state the areas of concern for both Executives and Non-Executives.

Jane Hawkard agreed and asked for an idea of when the CiC could be confident that the Group was in control of the position and the necessary actions.

Gill Ponder also agreed and commented that there was a lack of ownership around the risks and subsequently a lack of mitigation against them. David Sharif estimated it would take around three months to create a new register which would provide the level of information the non-executives were looking for, but Helen Wright asked if in the meantime, an overview could be provided on how assurance is gained in managing risks. David Sharif shared that changes were being made through Risk & Compliance so non-executives could gain some assurance from that.

Sarah Tedford agreed with the need for a summary and considered it merely needed to be a column at the end of the table which detailed the mitigations and could be completed by the risk owners.

It was agreed that a summary of mitigations would be provided on risks with a score of 15+ to assist the CiC in gaining some level of assurance. Ivan McConnell emphasised the need to be able to evidence what had been reviewed in the event of a Well Led assessment.

ACTION: David Sharif agreed to take risk document back to Executives and re-draft to include summary of mitigations

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

None to discuss.

3.4 **Review of Relevant External Reports, Recommendations & Assurances**

None to discuss.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Strategic Programme Planning & Delivery</u>

4.1 **Delivery & Expenditure Against Capital Plan for Major Projects**

a) HASR – changes since the last meeting

Sarah Tedford gave a verbal update in that the team were currently refocussing and pulling all information together to produce a clear plan on the way forward. She thanked Ivan McConnell and Linsay Cunningham for the work they had undertaken prior to this. Alex Best gave an update on the estates pieces of work involved.

b) CDC – changes since the last meeting

Ivan McConnell advised that the Scunthorpe site was now open, with Grimsby open for diagnostics and ophthalmology moving in from July and Hull hopefully open in July. He reported a 15% reduction in budget since the original business cases. Activity was below forecasted level, due to lack of equipment, issues with staff needing training on life support causing delays in scanning and referral patterns changing. For Grimsby, private sector referrals had increased, for which the ICB would be undertaking an

audit. It had been noted that urgent referrals had decreased, and routine had increased.

At DPoW there had been two episodes of flooding which had delayed progress and work was underway with Freshney Place to recover potential damages.

A decision had been made to relocate the second MRI scanner from Scunthorpe to Grimsby due to changes in the demand profile.

Helen Wright questioned when the Post Project Evaluation on CDC would be brought to the CiC and Ivan McConnell considered this would be around October.

ACTION: Post Project Evaluation of the CDCs to be added to the agenda for October by Jo Palmer.

Jane Hawkard referred to the statement around IT being problematic at Grimsby and Scunthorpe and how this could be resolved.

ACTION: Andy Haywood to review this before the next meeting

Emma Sayner advised there is a financial risk in relation to the overall CDC programme and the team are monitoring the impact this year. Since the business case had been submitted and approved, the national policy around CDCs had notably changed, including the availability of the funding.

Gill Ponder was surprised that there were still issues with recruitment and training despite the CDCs having opened later than planned. Ivan McConnell responded that there were national issues affecting radiology and non-obstetric ultrasound.

c) PMO Update

Ivan McConnell advised that the governance structure had changed, along with the reporting format. The Care Groups were being encouraged to formulate trajectories, thanking Sarah Tedford for her support with engaging Ops Directors in this.

An NHSE review with ICB colleagues had been undertaken and NHSE had issued a revised assurance framework, recognising the challenge the Group faced. They recognised the openness and transparency of the Group and several areas of good work but noted issues around the pace of delivery, some unidentified cost improvement schemes and some high-risk ones, recognising that some schemes linked to others. There was a clear need to look at bigger areas of transformation and reconfigure the team to be more aligned.

Helen Wright remarked on the close links with the PEF CiC and hoped to see updates featured there once the workplan had been reconfigured.

Ivan McConnell highlighted that it was National Healthcare Estates & Facilities Day and Gill Ponder asked Alex Best to pass on the CiC's thanks for all their hard work.

Assurance was determined as reasonable.

The meeting took a break at 10.49am.

4.2 **Review & Evaluation of Business Cases**

There were none to discuss.

4.3 **Approval of Investment & Disinvestment Decisions & Business Cases within Delegated Limits and/or Endorsement for Trust Board Approval**

There were none to discuss.

4.4 **Post Capital Project Evaluation NHSE Process**

Emma Sayner updated the CiC that there were no projects currently for evaluation but the Castle Hill Hospital (CHH) Day Surgery unit would be due in November 2025

Jane Hawkard asked when the Allam Building at CHH would be evaluated and Alex Best responded to estimate June 2026.

ACTION: Jo Palmer to add CHH Day Surgery unit to the workplan and agenda for evaluation in November 2025 and Allam Building CHH for June 2026

ACTION: Emma Sayner, Ivan McConnell and Andy Haywood to liaise and ensure future reviews are integrated into the workplan appropriately

Emma Sayner also referred to DrDoctor, the new patient-led booking system, that needed scheduling into the workplan. Andy Haywood gave a verbal update on this, advising that there was a four-month slip at HUTH on the Go Live date. This was NHSE related, along with supplier issues, but lessons were being learned for NLaG. He suggested, with the support of Sarah Tedford, working with Ops Directors to gain an overview on the operational assumptions that went into benefits from their business cases to review whether they were realistic.

4.5 **Post Strategic Programme Completion Benefit Realisation Review**

This was discussed along with Item 4.4.

There was a short discussion around facing transformation and how it was perceived. It was considered important to try new ways of working, monitoring closely and trying something else if it does not work.

Digital

4.6 **Digital Strategy**

Andy Haywood advised the meeting that he had noted the comments from the April timeout session and the new draft would be presented to Board in July 2025, as there had been insufficient time at the June meeting, along with the fact that the strategic framework had only been approved at the June meeting and he could link this now with the Strategy.

4.7 **Digital Plan Delivery Updates**

Andy Haywood gave updates as follows:

- EPR – outline business case approval with minimal conditions had now been received from NHSE for the programme and the Group had gone out to tender. Funding was due to be spent in 2025/26, so work was underway to review the possibility of deferring some of the funding into the following year as it was doubtful if the project could be completed by then.

  He expressed thanks to Alison Dury, Deputy Director (Finance) and Neil Proudlove, Deputy Chief Information Officer, for their excellent work in enabling the smoothest transition that NHSE had seen.

The team were working with KPMG looking at project management specifically on EPR, with Air Logic to look at the infrastructure, Wi-Fi and so on to assess whether it is compatible with the EPR. Restart would look at data migration and UpHere would look at the operational and clinical readiness for the new system. Early meetings had been held with leaders to look at the areas of risks. An assurance mechanism would be required on delivery of the significant cash releasing benefits of introducing an EPR.

- DrDoctor – at HUTH patients will receive their digital letters in June 2025, with the ability to manage appointments on the system from August-September 2025.

- Electronic document management system (EDMS) - clinical teams were being approached to move records initially, moving onto corporate.

Andy Haywood gave a brief explanation on the different functions; EDMS for the scanning of current paperwork, archiving for the scanning of old legacy paperwork and the new EPR which does not generate paperwork at all. Discussions were due to be held on deciding the priority of the new EDMS.

Gill Ponder thanked him for this and suggested that these terms be explained to the Board.

- Bed management – presented to Board

- Co-Pilot – this is the AI assistant within Microsoft. There were plans for Microsoft to sit in on Multi-Disciplinary Team meetings to assess whether it would be suitable to enable the meetings to be more efficient in saving clinical and administrative time

Gill Ponder remarked that it would be beneficial to have Co-Pilot Champions within the Care Groups and asked whether there had been some good expressions of interest from the clinical staff. Andy Haywood replied that there indeed had been a lot of interest, which was positive at this early stage. To promote the involvement, Andy Haywood considered it would be advantageous to include the highlight report and the papers from the EPR Programme Board for the period between the C&MP meetings as a form of governance.

Helen Wright thanked Andy Haywood for his clear update and noted the high level of engagement with EPR.

Gill Ponder thanked him and his team and concluded there was clearly a lot of work ongoing within the Digital remit and it was all positive evidence of transformation for the Group.

Jane Hawkard noted that the cash releasing benefits were potentially significant, and Andy Haywood confirmed it was on the risk register with noted mitigations should the benefits not be achieved.

Gill Ponder suggested that an NLaG non-executive director attend the EPR benefit review meeting in September and then the outcome presented at a Board Development meeting.

David Sharif also noted a good update and asked whether the team were yet able to provide a view of the challenges ahead. Andy Haywood replied that they needed to establish whether it was to be a phased implementation or not first.

David Sharif also asked whether the Chair might consider writing to Alison Drury and Neil Proudlove to thank them for their work on behalf of the CiC, which Gill Ponder agreed to do.

ACTION: Gill Ponder to write to Alison Drury and Neil Proudlove on behalf of the Committees to thank them for their hard work on EPR

Assurance was determined as significant.

5. HIGHLIGHT REPORTS FROM SUB-GROUPS

5.1 Group Capital Committee – Summary of Minutes & Escalations from 19 February, 19 March & 19 May 2025

Papers were taken as read and there were no comments.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (including actions agreed that positively influence culture)

The following items were raised:

Bed management – Helen Wright advised that this had been discussed at Board and referred back to PEF. She asked David Sharif when the best time would be to see Murray MacDonald's requests relating to the revenue and commercial

elements of the business case and requested him to ensure that PEF received the relevant information.

Action: David Sharif to ensure that PEF receives the information required to enable the CiC to review the items raised during the Board discussion on the Bed Management business case.

Emma Sayner suggested that some training on procurement be included in the Board Development programme and Helen Wright agreed it should be discussed at the PEF CiC initially.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

The following item was to be referred:

- Training on procurement to be discussed at PEF CiC and subsequently at Board Development

7.2 Matters for Escalation to the Trust Boards As we discuss this in each section of the agenda, please can we minute it accordingly, rather than at the end from the next meeting.

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- The CiC proposes to change the focus of the Committee to cover strategic partnerships and programmes, as the partnership risk was not currently reviewed by any of the assurance committees, which would result in a proposed name change to Strategic Partnerships and Programmes Committees
- ToRs and workplan to be amended and presented at the next NED meeting and subsequent Board Development meeting
- The CiC recognised the focus needed on building partnerships with local and regional businesses
- The CiC has a continued concern that it is unable to provide a level of assurance due to a lack of clear mitigations against risks
- Executives to provide a summary of mitigating actions against risks with a score of 15+
- HASR is still awaiting the Secretary of State's response on whether the project would be called in
- The CiC recognised the change of use at the CDCs to maximise capacity and income, currently below expected range due to reduction in referrals, workforce issues including staff training and equipment issues.
  More Board agenda time going forward was required for PMO due to the need for a Board review of transformation programmes and discussions and to ensure Board is sighted on what is on and off target
- Four-month slip on DrDoctor patient-led booking system Go Live at HUTH, but slippage may be reduced at NLaG due to lessons learned. Benefits review in hand
- EPR tender review deadline of 17/7/25

- Glossary of Digital schemes – EDMS to digitise current paper documents, archiving to digitise legacy documents, and the new EPR does not generate paperwork
- Paper records at DPoW can be moved to enable pending HASR work on ITU (January at the earliest)
- Co-Pilot potentially beneficial to MDT function. KPMG is undertaking an audit on AI governance to highlight area of focus

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Capital & Major Projects CiC meeting:**

Wednesday 20 August 2025 at 9.00am to 12.00pm in the Nightingale Room, Education Centre, SGH

The committee Chair closed the meeting at 11.44am.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2025/2026

Name	Title	2025 / 2026											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Helen Wright	Non-Executive Director (HUTH)	Y		Y									
Gill Ponder	Non-Executive Director (NLaG)	Y		Y									
Emma Sayner	Group Chief Financial Officer	Y		Y									
Clive Walsh	Interim Chief Executive (North)	N		N									
Sarah Tedford	Interim Group Chief Delivery Officer	Y		Y									
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y		Y									
Andy Haywood	Group Chief Digital Officer	Y		Y									
Ivan McConnell	Group Chief Strategy & Partnerships Officer	Y		Y									
Rebecca Thompson	Group Deputy Director of Assurance	Y		Y									
Tony Curry	Non-Executive Director (HUTH)	Y		N									
Julie Beilby	Non-Executive Director (NLaG)	N		N									
Simon Parkes	Non-Executive Director (NLaG)	Y		Y									
Jane Hawkard	Non-Executive Director (HUTH)	Y		Y									
Alex Best	Deputy Director – Major Developments	Y		Y									
Ian Reekie	Governor Observer	Y		Y									

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)245

<table>
<tr><td>Name of Meeting</td><td>Trust Boards-in-Common</td></tr>
<tr><td>Date of the Meeting</td><td>11 December 2025</td></tr>
<tr><td>Director Lead</td><td>Matt Powls, Group Chief Delivery Officer
Emma Sayner, Group Chief Financial Officer</td></tr>
<tr><td>Contact Officer / Author</td><td>Adam Creeggan, Group Director of Performance
Jackie Railton, Deputy Director, Planning and Performance</td></tr>
<tr><td>Title of Report</td><td>Group Performance Report – NLaG and HUTH</td></tr>
<tr><td>Executive Summary</td><td>Key messages:

Significant challenges relating to patient access
Group Trusts are in national Tier 1 oversight for UEC, Cancer, Diagnostics and RTT (NLAG only)
An Operational Improvement Plan and associated in year recovery trajectories has been developed by the outgoing Interim Chief Delivery Officer, Sarah Tedford.
Delivery against both original 25/26 Operating Plan and in-year recover trajectories for UEC and RTT are detailed in the paper.

Summary Compliance:
<table>
<tr><th>DOMAIN</th><th>GROUP</th><th>HUTH Performance</th><th>NLAG Performance</th></tr>
<tr><td>RTT Long Waits</td><td>Oct-25</td><td>Oct-25</td><td>Oct-25</td></tr>
<tr><td>104 Weeks</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>78 Weeks</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>65 Weeks</td><td>123</td><td>96</td><td>27</td></tr>
<tr><td>52 Weeks</td><td>4165</td><td>3221</td><td>944</td></tr>
<tr><td>% 52 Weeks
(target =<1.3% March '26)</td><td>3.5%</td><td>4.0%</td><td>2.50%</td></tr>
<tr><td>Diagnostics (DM01)</td><td>Oct-25</td><td>Oct-25</td><td>Oct-25</td></tr>
<tr><td>% greater than 6 weeks</td><td>35.30%</td><td>31.3%</td><td>38.4%</td></tr>
<tr><td>Cancer</td><td>Oct-25</td><td>Oct-25</td><td>Oct-25</td></tr>
<tr><td>% FDS with 28 days</td><td>62.20%</td><td>59.8%</td><td>66.7%</td></tr>
<tr><td>% Treated within 62 days</td><td>52.90%</td><td>50.1%</td><td>59.1%</td></tr>
<tr><td>UEC</td><td>Oct-25</td><td>Oct-25</td><td>Oct-25</td></tr>
<tr><td>ED 4 hour standard
(target 78% March '26)</td><td>63.2%</td><td>55.8%</td><td>69.5%</td></tr>
<tr><td>ED 12 hour standard</td><td>17.1%</td><td>17.4%</td><td>16.8%</td></tr>
</table></td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td></td></tr>
<tr><td>Prior Approval Process</td><td></td></tr>
<tr><td>Financial Implication(s) (if applicable)</td><td>Report references delivery of activity versus plan with inherent links to income generation via block contract.</td></tr>
</table>

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Report references delivery of access targets, with inherent links to equity of access across the Group
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Integrated Performance Report

MONTH 7: October 2025 Performance

September 2025 for Cancer data
Produced November 2025

Table of Contents

1. Executive Summary 5

2. Pathway Summary – Benchmark Report – Elective Care 6

2. Pathway Benchmarking & Trend – Elective Care 7

3. Referral to Treatment - HUTH 8

4. Referral to Treatment - NLAG 9

5. Referral to Treatment – 65w Waits - HUTH 10

6. Referral to Treatment – 65w Waits - NLAG 11

7. Referral to Treatment – Data Quality - HUTH 12

8. Referral to Treatment – Data Quality - NLAG 13

9. Cancelled Operations - HUTH 14

10. Cancelled Operations - NLAG 15

11. Capped Theatre Utilisation - HUTH 16

12. Capped Theatre Utilisation - NLAG 17

13. Pathway Summary – Benchmark Report – Diagnostics 18

14. Pathway Benchmarking & Trend – Diagnostics 19

15. Diagnostic 6 Week Standard - HUTH 20

16. Diagnostic 6 Week Standard - NLAG 21

17. Pathway Summary – Benchmark Report – Cancer Waiting Times 22

18. Pathway Benchmarking & Trending – Cancer Waiting Times 23

19. 62 Day Cancer Performance - HUTH 24
20. 62 Day Cancer Performance - NLAG 25
21. 28 Day Faster Diagnosis Standard - HUTH 26
22. 28 Day Faster Diagnosis Standard - NLAG 27
23. Pathway Summary – Benchmark Report – Unscheduled Care 28
24. Pathway Benchmarking & Trending – Unscheduled Care 29
25. Emergency Care Standards – 4 hour Performance - HUTH 30
26. Emergency Care Standards – 4 hour Performance - NLAG 31
27. Core Objective 1 – Mean Time to Treatment 32
28. Core Objective 2 – Non-Admitted Total Time in Department 33
29. Core Objective 3 – Total Time in Department (Patients >= 65 years) 34
30. A&E Attendances – All Types 35
31. A&E Attendances – Type 1 Attendances 36
32. A&E Attendances – Type 3 Attendances 37
33. Ambulance Handovers >60 minutes - HUTH 38
34. Ambulance Handovers >60 minutes - NLAG 39
35. Activity 40
36. Financial Activity Summary - HUTH 44
37. Financial Activity Summary - NLAG 44

1. Executive Summary

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

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**October 2025** **0** **0** **96** **3,221**	**October 2025** **0** **1** **27** **944**	• Decrease in 65w breaches for NLAG (-37) and increase at HUTH (+11) on previous month • Decrease in 52w breaches for NLAG (-101) and increase at HUTH (+5) on previous month • Increases in total waiting list size at both HUTH and NLAG
Diagnostic 6w Performance	**October 2025** **31.3%**	**October 2025** **38.4%**	• Deterioration in performance for both HUTH and NLAG compared to previous month
Cancer 62-day Performance (all sources)	**September 2025** **50.1%**	**September 2025** **59.1%**	• Both Trusts are in Tier 1 for Cancer delivery, working with NE&Y Regional Office on recovery assurance • 62-day performance at HUTH improved from 48.8% in August to 50.1% in September. • 62-day performance at NLaG deteriorated from 71.1% in August to 59.1% in September. • Delays in the front of pathway (outpatient and diagnostics) driving increases in the total volume of patients waiting for Cancer assessment or treatment. The >104-day backlog remains a challenge at 42 in NLAG and 298 in HUTH.
ED: 4-hour standard (Type 1 & 3)	**October 2025** **55.8%** **Trust compliance inclusive of on-campus UTCs**	**October 2025** **69.5%** **Trust compliance inclusive of on-campus UTCs**	• HUTH A&E 4 Hour standard (all types) was 55.8% in October 2025 (plan 72.9%). Type 1 performance of 40.9% was below the 25/26 operating plan target of 62.3%. Type 3 performance (HRI UTC) was 90.0% against the 95% target. Type 1 attendance volumes were above plan whilst Type 3 attendances were below planned levels. • NLaG combined type 1 and 3 performance was 69.5% against a target of 76.2%. Type 1 performance = 47.5% (Target 60.9%) and Type 3 performance = 99.2% (Target 99%). Type 1 attendances were lower than planned levels and Type 3 attendances were above planned levels for October 2025.

2. Pathway Summary – Benchmark Report – Elective Care

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

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 25	0	3,216			5
RTT 65 Week Breach	Sep 25	-	85			26
RTT 78 Week Breach	Sep 25	0	2			38
RTT 95th Percentile Admitted Waiting Time	Sep 25	18.0	63.0			32
RTT 95th Percentile Non-Admitted Waiting Time	Sep 25	18.0	56.8			24
RTT Admitted Treatment Within 18 Weeks	Sep 25	90.0%	57.3%			56
RTT Average (Median) Admitted Waiting Time	Sep 25	9.0	13.7			57
RTT Average (Median) Non-Admitted Waiting Time	Sep 25	5.0	8.0			70
RTT Average Wait for Incomplete	Sep 25	7.00	15.12			19
RTT Incomplete 18 Week Standard	Sep 25	-	56.70%			18
RTT Incomplete 92nd Percentile	Sep 25	-	46.0			10
RTT Incomplete Pathways With a DTA	Sep 25	25.0%	18.1%			30
RTT Non-Admitted Treatment Within 18 Weeks	Sep 25	95.0%	68.2%			58
RTT Total Clock Starts	Sep 25	-	19,464			87
RTT Total Clock Stops	Sep 25	-	20,041			92
RTT Total Incompletes	Sep 25	-	80,583			13

NLAG

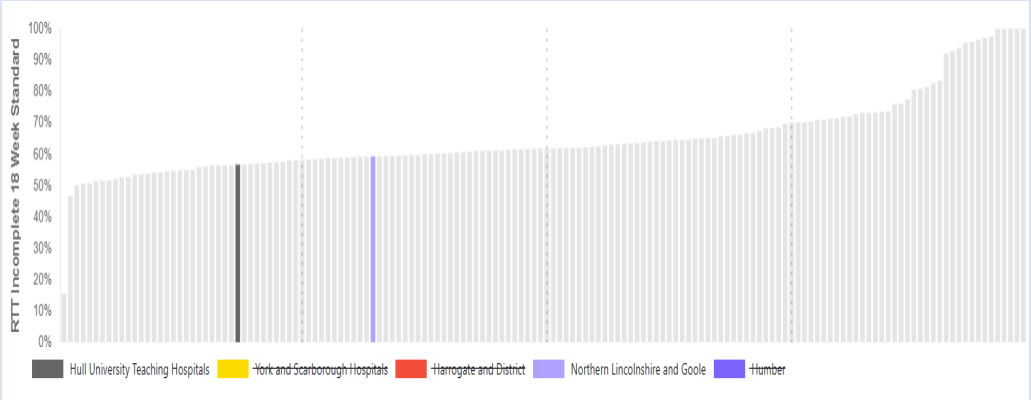
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 25	0	1,045			44
RTT 65 Week Breach	Sep 25	-	64			29
RTT 78 Week Breach	Sep 25	0	3			31
RTT 95th Percentile Admitted Waiting Time	Sep 25	18.0	60.0			52
RTT 95th Percentile Non-Admitted Waiting Time	Sep 25	18.0	52.7			41
RTT Admitted Treatment Within 18 Weeks	Sep 25	90.0%	53.4%			37
RTT Average (Median) Admitted Waiting Time	Sep 25	9.0	15.6			38
RTT Average (Median) Non-Admitted Waiting Time	Sep 25	5.0	9.4			54
RTT Average Wait for Incomplete	Sep 25	7.00	13.83			40
RTT Incomplete 18 Week Standard	Sep 25	-	59.33%			32
RTT Incomplete 92nd Percentile	Sep 25	-	42.9			30
RTT Incomplete Pathways With a DTA	Sep 25	25.0%	16.3%			41
RTT Non-Admitted Treatment Within 18 Weeks	Sep 25	95.0%	67.8%			56
RTT Total Clock Starts	Sep 25	-	10,206			52
RTT Total Clock Stops	Sep 25	-	8,990			53
RTT Total Incompletes	Sep 25	-	40,146			49

2. Pathway Benchmarking & Trend – Elective Care

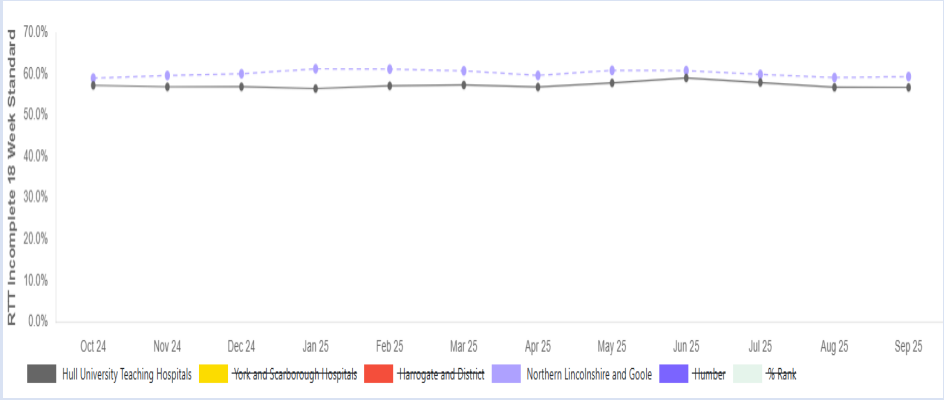
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

RTT – Incomplete Standard

Ranking Chart

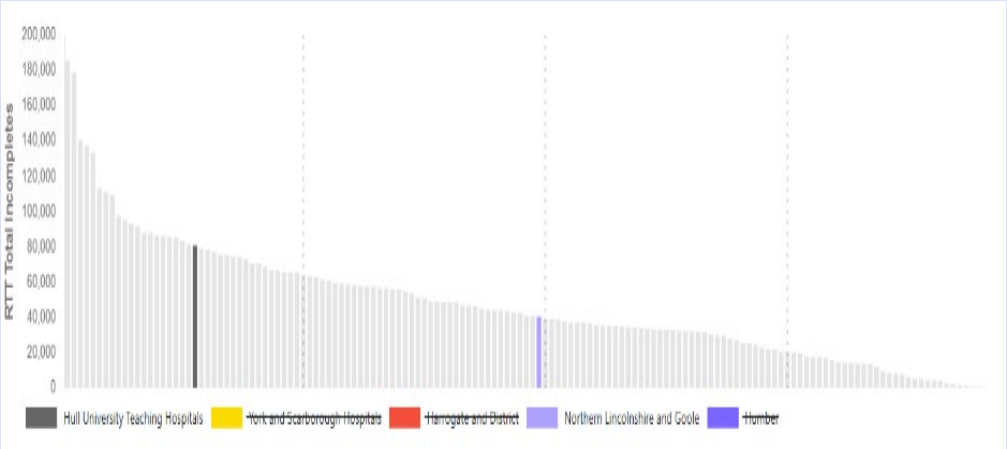


Trend Chart

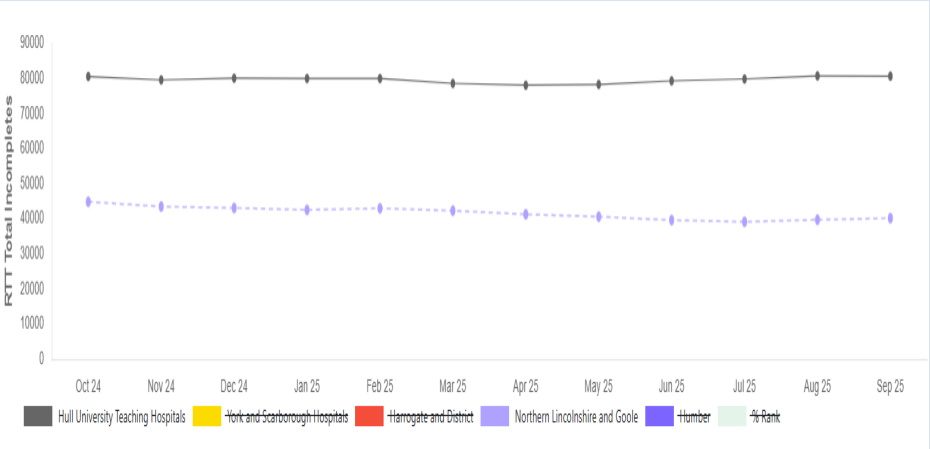


RTT – Total Waiting List Volume

Ranking Chart

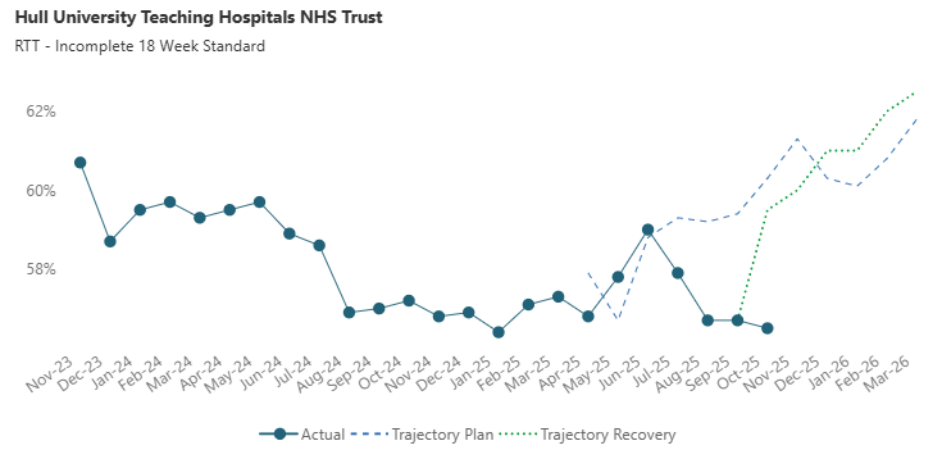


Trend Chart



3. Referral to Treatment - HUTH

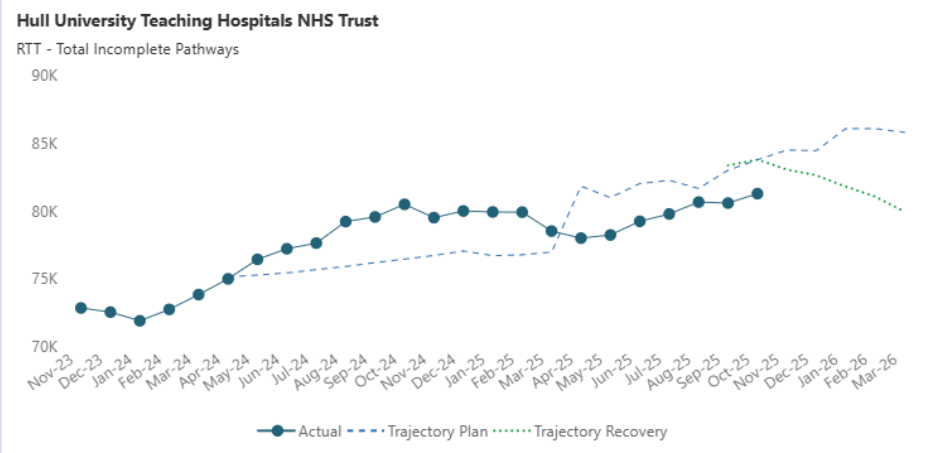
Compliance



Key Themes

- The total waiting list volume increased slightly to 81,279 but is below the trajectory due to enhanced in year validation volumes.
- October RTT performance of 56.5% which is broadly unchanged on the previous month and 3.8% below the 25/26 trajectory.
- Referrals are 0.3% up on last year, but below the 3% planning assumption.
- 58% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Dermatology, Ophthalmology, Neurology, Oral Surgery and Gastroenterology
- Average wait for incomplete pathway is 15 weeks but remains broadly stable.

Critical Enabler



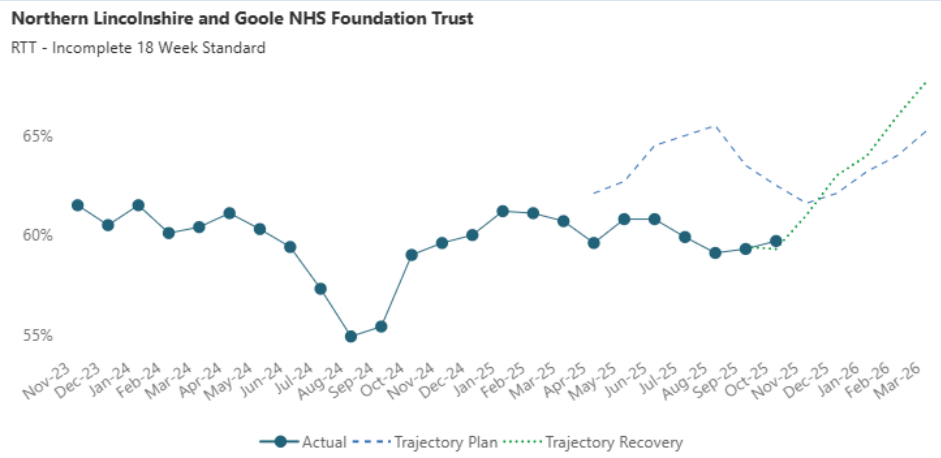
Actions

Critical actions being progressed through RTT Delivery Group:

- LUNA ROVA (automated validation) Deployment project enacted at both HUTH and NLAG, with the supplier indicating an early Q4 go-live.
- Ongoing planning process to develop additional outpatient & day case/inpatient capacity in response to sustained demand increases.
- Commencement of the Q3 validation Sprint from 3.11.25 with incentive payment of £33 per clock stop above baseline.
- Operational Improvement Plan developed to create enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

4. Referral to Treatment - NLAG

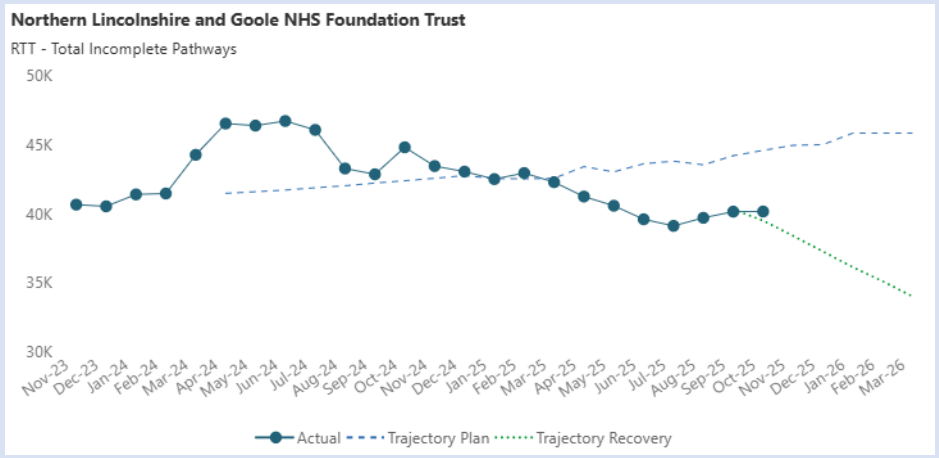
Compliance



Key Themes

- October performance of 59.7% is 2.8 % below the 25/26 Operating Plan planned but consistent with in year improvement plan.
- Since the correction of ASI reporting in April 2024 the RTT waiting list volume has subsequently been reduced to 40,158 and is significantly below the planned trajectory.

Critical Enabler



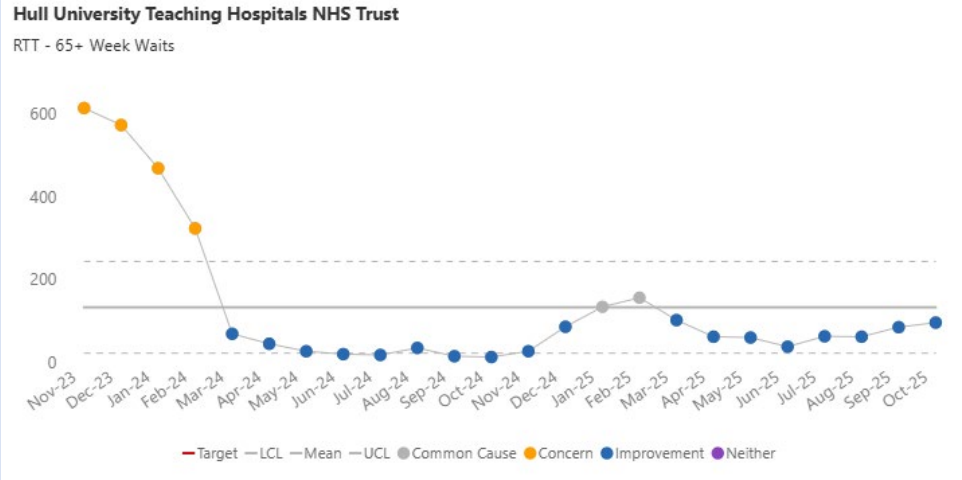
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Focused use of PIFU to increased outpatient discharge rates
- Continuation of the validation Sprint with incentive payment of £33 per clock stop above baseline.
- NLAG placed in Tier 1 for Elective Care in August 2025.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

5. Referral to Treatment – 65w Waits - HUTH

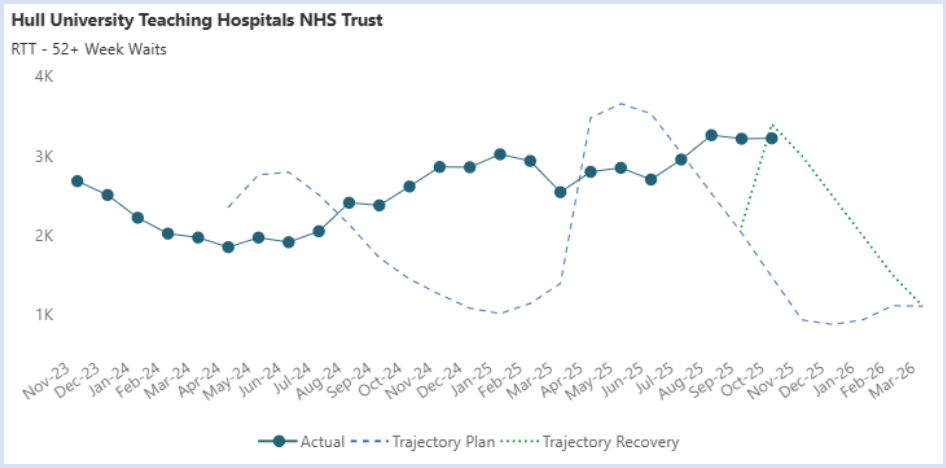
Compliance



Key Themes

- 0 patients exceeded 78 weeks at the end of October.
- 96 patients exceeded 65 weeks at the end of October which is an increase of 11 on the previous month
- Risks relating to delivery: -
  - ENT – additional weekend audiology and outpatient capacity is being delivered through DMC. Paediatric inpatient and thyroid inpatient capacity is limited.
  - Plastic Surgery – additional sessional requirement to support delayed DIEPs
  - Breast Surgery – gender surgery – acknowledgement from NHSE and Spec Comm that due to increased referral demand no performance sanctions on long wait breaches
  - Neurology – a plan is in place to deliver limited diagnostic EMG capacity
  - Delays in offering admission dates leading to unreasonable offers and patient choice breaches.
- 4% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year 2024. The 25/26 planning requirement is to achieve no more than 1% waiting over 52 weeks by March 26.

Critical Enabler



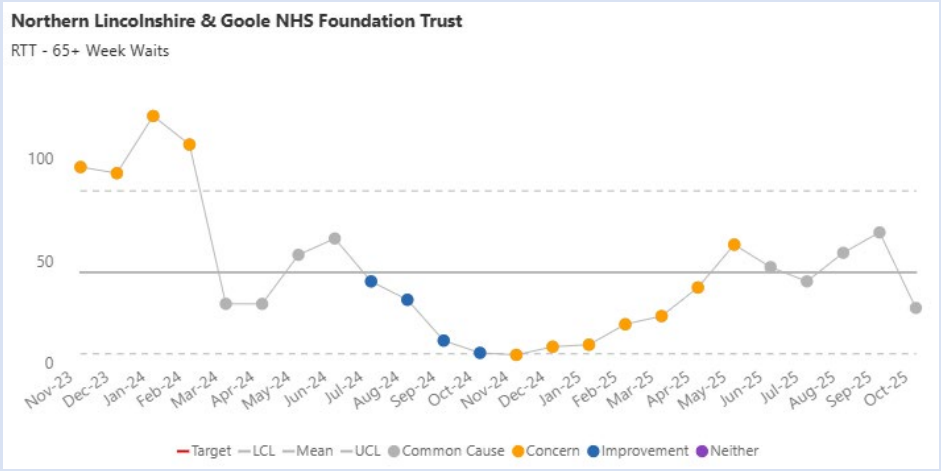
Actions

Critical actions being delivered through the RTT Delivery Group

- Additional insourced activity in place and ongoing engagement with system partners on mutual aid support
- Insourced capacity from Pioneer to deliver Dermatology first outpatient capacity to commenced September 2025.
- Executive oversight and scrutiny of patients dated and/or risks to eliminate the number of >65-week waits
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

6. Referral to Treatment – 65w Waits - NLAG

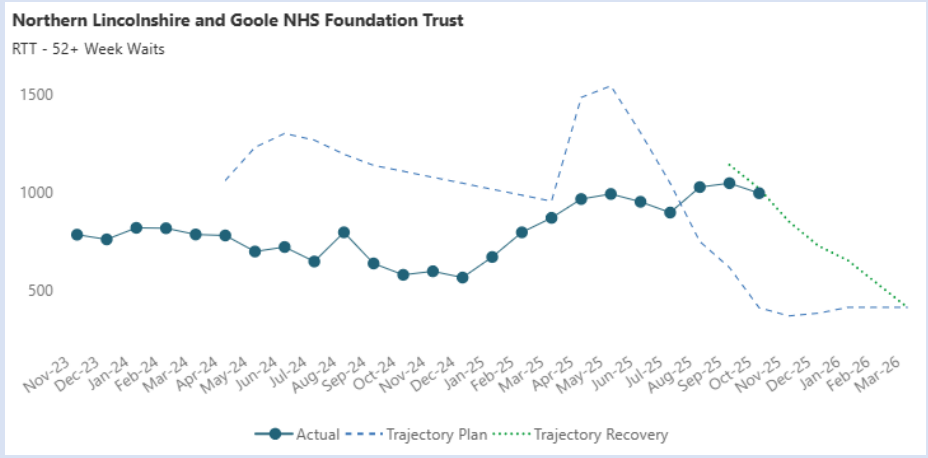
Compliance



Key Themes

- 1 x 78 week breach reported at the end of October
- 27 breaches >65 weeks at the end of October which was a reduction of 37 on the previous month. The remaining volume are predominately due to capacity constraints in Paediatric ADHD
- 2.5% of the PTL is over 52 weeks, down 0.1% on the previous month.

Critical Enabler



Actions

Critical actions being delivered through the RTT Delivery Group

- An insourcing contract for Paediatrics (ADHD commenced in October 2025 to clear the 65-week cohort. In tandem NHSE have issued new guidance which removes ADHD from RTT Acute Provider reporting an transfers to Community reporting.
- Focus on booking practice via earlier planning of admission dates to reduce unreasonable offers and subsequent patient choice breaches, as per the revised Group Access Policy.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

7. Referral to Treatment – Data Quality - HUTH

Compliance

83,916	4,459	4,556	99.39%	5.31%
Pathways on RTT PTL	Pathways with Metrics	DQ Metrics on RTT PTL	RTT PTL Confidence Level	% Pathways with Metrics on RTT PTL

Key Themes

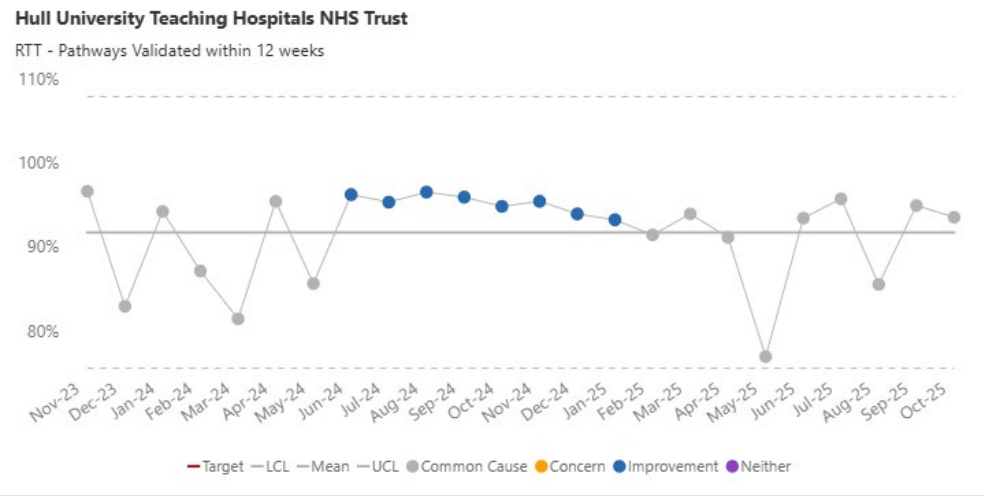
It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.39% confidence level for RTT PTL data quality.

93.5% pathways have been validated every 12 weeks.

The Q3 validation sprint commenced on 3rd November and is supported by ongoing over-time to existing staff.

Critical Enabler



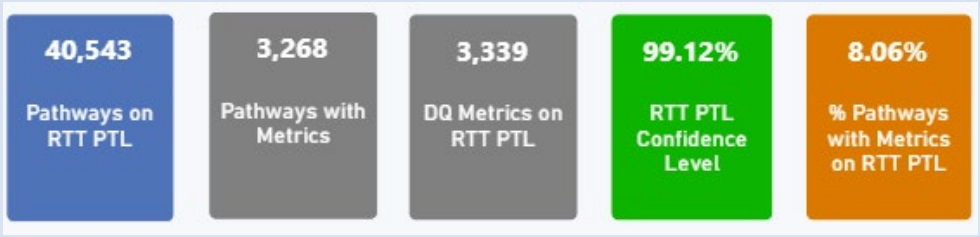
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment
- Deployment of LUNA ROVA proof of concept trial to support the national drive to deliver a minimum 65% incomplete standard by March 2026.

8. Referral to Treatment – Data Quality - NLAG

Compliance



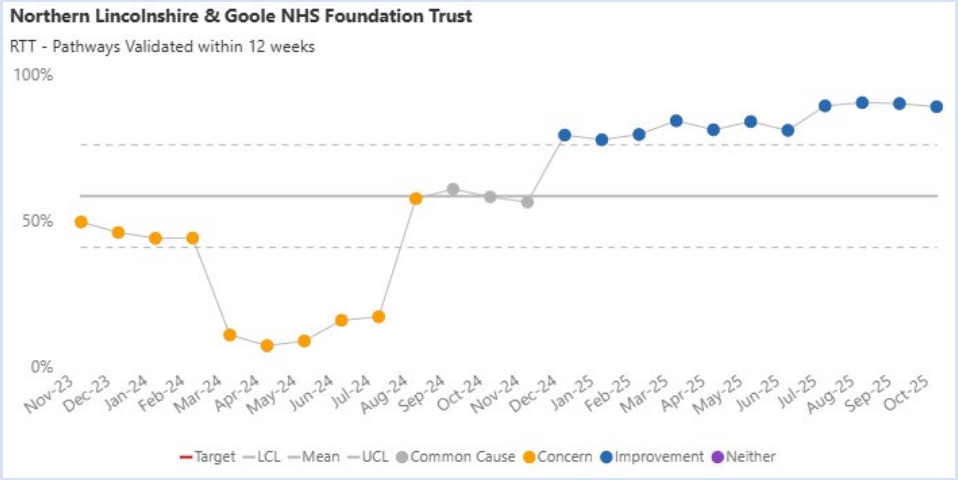
Key Themes

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

- LUNA data quality is showing a confidence rate to 99.12%.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks. Current performance is at 89.1%

The Q3 validation sprint is due to commence on 3rd November and is supported by ongoing over-time to existing staff from HUTH.

Critical Enabler

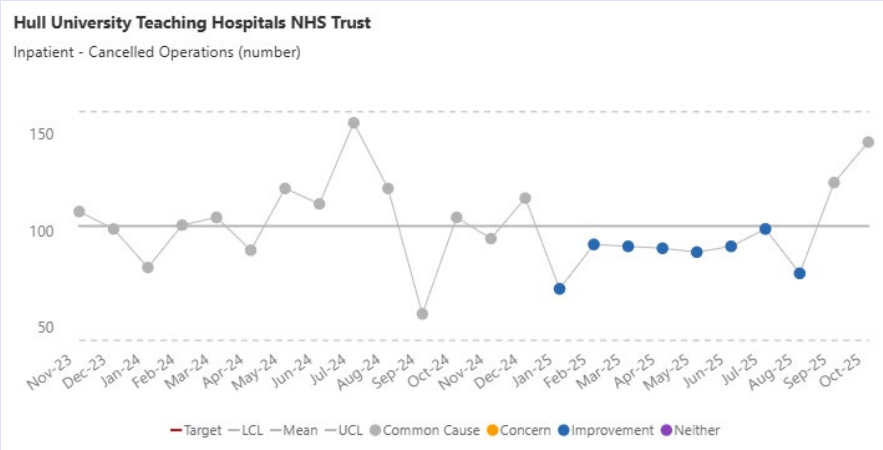


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments.
- Deployment of LUNA ROVA proof of concept trial to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- The Q3 Validation Sprint commenced on 3rd November. Additional national income at £33 per clock of the baseline waiting list.

9. Cancelled Operations - HUTH

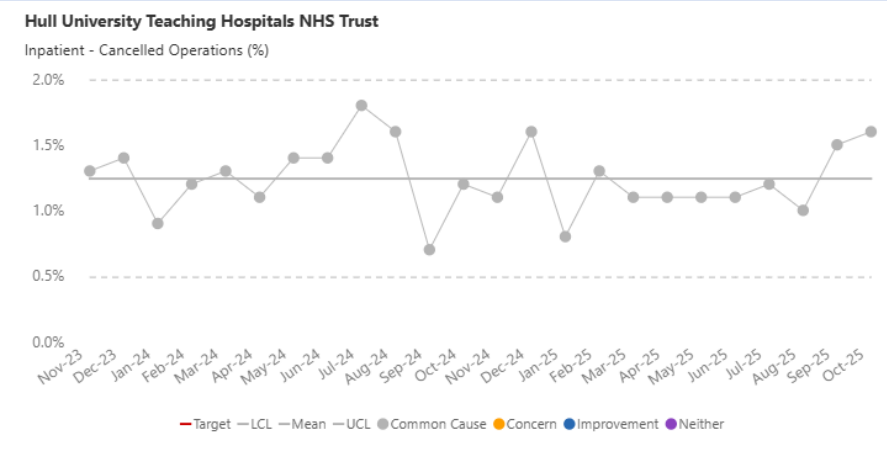
Compliance



Key Themes

- In October there were 146 cancelled operations on the day for non-clinical reasons.
- The largest reasons were –
  - No Theatre Time
  - Bed unavailable (including critical care)
  - Emergency case
- The main specialties incurring cancellations on the day were –
  - Vascular Surgery
  - Upper GI Surgery
  - Interventional Radiology
  - Urology

Critical Enabler

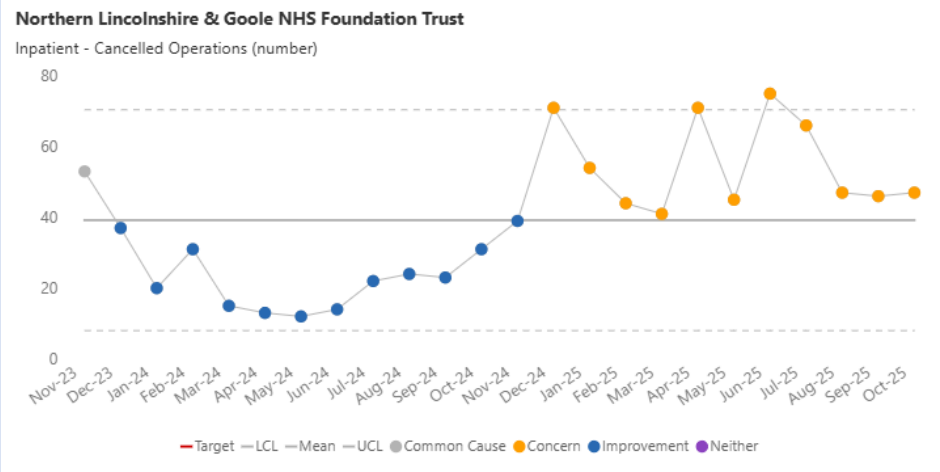


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28-day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focused operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 pre-op.

10. Cancelled Operations - NLAG

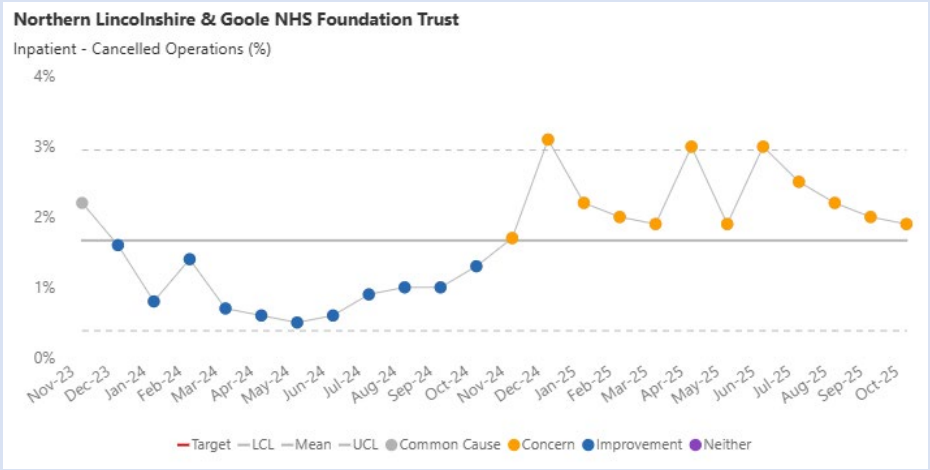
Compliance



Key Themes

- October cancellation volumes totalled 47
- The largest reasons were –
  - List overrun
  - Surgery deferred
  - Clinical staff unavailable
  - Other cancellation
- The main specialties incurring cancellations on the day were –
  - Gynaecology
  - Ophthalmology
  - General Surgery

Critical Enabler

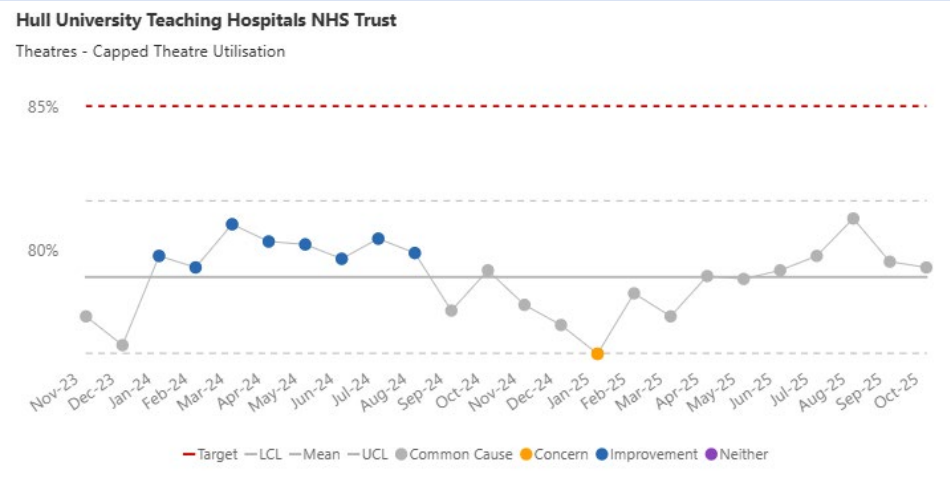


Actions

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

11. Capped Theatre Utilisation - HUTH

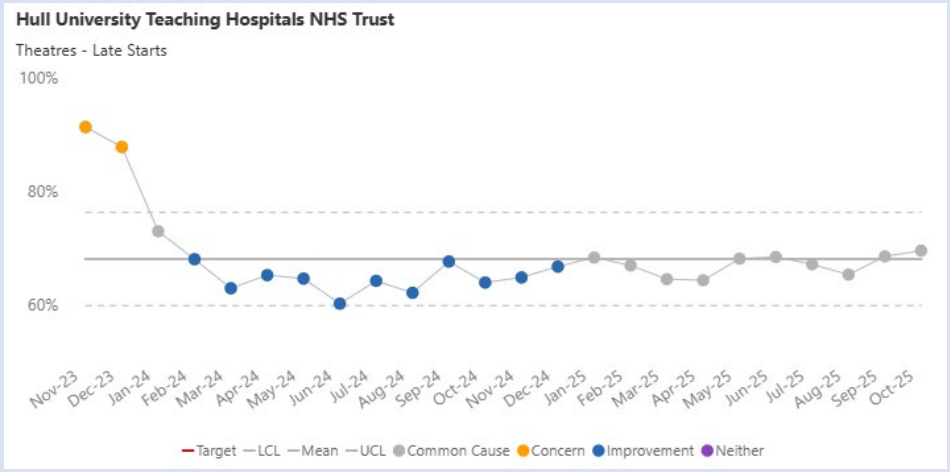
Compliance



Key Themes

- Internal reporting at 79.4% for capped theatre utilisation for October.
- Day Case capped theatre utilisation is at 74.8% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- Utilisation deterioration linked to increase in late starts to 69.6% (methodology 0 minutes = late start)

Critical Enabler

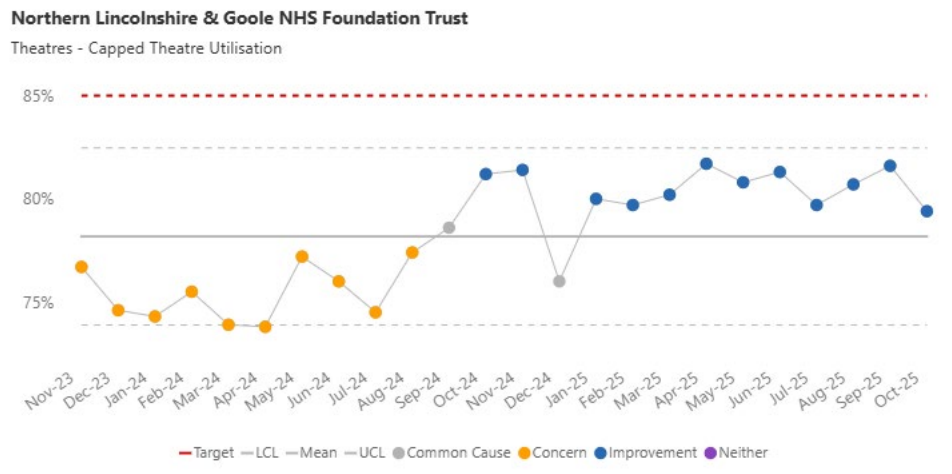


Actions

- Improve recording of day case touch points in ORMIS
- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

12. Capped Theatre Utilisation - NLAG

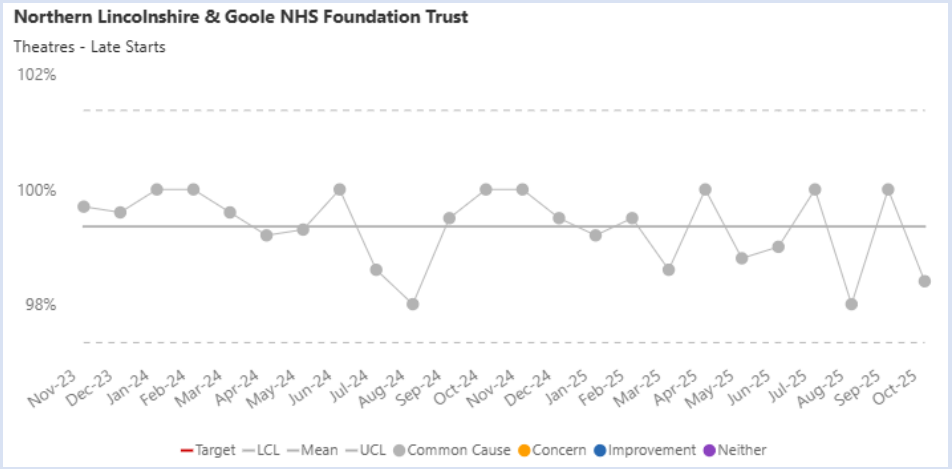
Compliance



Key Themes

- Internal reporting shows performance at 79.4%.
- Theatre late starts issue at NLAG with 98.4% of sessions starting late in October on the zero-minute measure.

Critical Enabler



Actions

- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments. Detail of this plan relayed to Committee in Common in the 'Elective Deep Dive' paper.

13. Pathway Summary – Benchmark Report – Diagnostics

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

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Sep 25	5.00%	37.65%			41
Barium Enema	Sep 25	5.00%	0.00%			100
Colonoscopy	Sep 25	5.00%	40.57%			19
Computed Tomography	Sep 25	5.00%	24.27%			8
Cystoscopy	Sep 25	5.00%	21.95%			42
DEXA Scan	Sep 25	5.00%	38.75%			8
Diagnostic activity levels - Audiology Assessments	Sep 25	-	1,072			84
Diagnostic activity levels - Barium Enema	Sep 25	-	61			85
Diagnostic activity levels - Colonoscopy	Sep 25	-	326			51
Diagnostic activity levels - CT	Sep 25	-	6,762			72
Diagnostic activity levels - Cystoscopy	Sep 25	-	401			85
Diagnostic activity levels - Dexa Scan	Sep 25	-	430			74
Diagnostic activity levels - Echocardiography	Sep 25	-	518			29
Diagnostic activity levels - Endoscopy	Sep 25	-	1,473			74
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 25	-	172			86
Diagnostic activity levels - Gastroscopy	Sep 25	-	574			76
Diagnostic activity levels - Imaging	Sep 25	-	15,271			69
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 25	-	4,837			57
Diagnostic activity levels - Total	Sep 25	-	18,912			66
Diagnostic activity levels - Urodynamics	Sep 25	-	50			74
Diagnostics - 6 Week Standard	Sep 25	5.00%	29.99%			28
Diagnostics - 6 Week Standard Reversed	Sep 25	95.00%	70.01%			28
DM01 Waiting <13 Weeks	Sep 25	100.00%	87.21%			19
Echocardiography	Sep 25	5.00%	64.78%			6
Gastroscopy	Sep 25	5.00%	23.37%			33
Magnetic Resonance Imaging	Sep 25	5.00%	7.47%			46
Neurophysiology	Sep 25	5.00%	53.94%			18
Non-obstetric Ultrasound	Sep 25	5.00%	10.90%			49
Urodynamics	Sep 25	5.00%	45.86%			35

NLAG

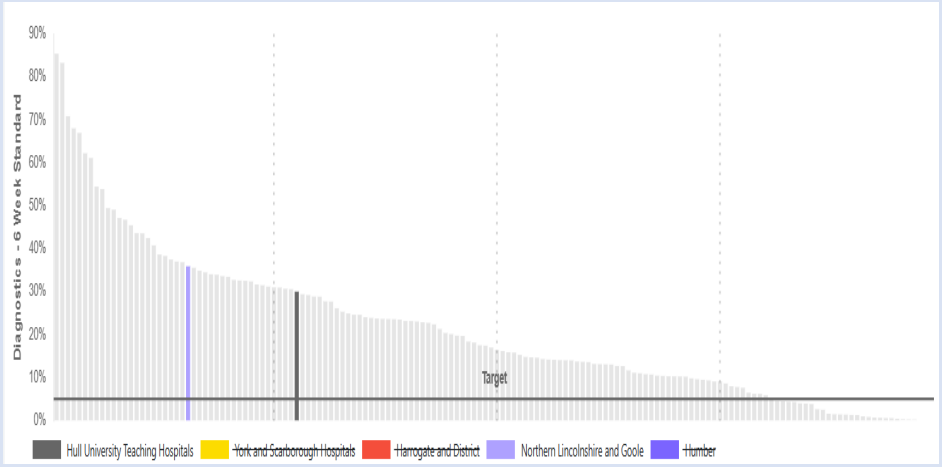
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Sep 25	5.00%	56.28%			25
Barium Enema	Sep 25	5.00%	1.49%			46
Colonoscopy	Sep 25	5.00%	47.10%			15
Computed Tomography	Sep 25	5.00%	1.24%			61
Cystoscopy	Sep 25	5.00%	5.70%			78
DEXA Scan	Sep 25	5.00%	32.57%			9
Diagnostic activity levels - Audiology Assessments	Sep 25	-	724			62
Diagnostic activity levels - Barium Enema	Sep 25	-	122			96
Diagnostic activity levels - Colonoscopy	Sep 25	-	281			47
Diagnostic activity levels - CT	Sep 25	-	10,993			94
Diagnostic activity levels - Cystoscopy	Sep 25	-	313			76
Diagnostic activity levels - Dexa Scan	Sep 25	-	325			55
Diagnostic activity levels - Echocardiography	Sep 25	-	1,207			64
Diagnostic activity levels - Endoscopy	Sep 25	-	1,008			53
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 25	-	94			54
Diagnostic activity levels - Gastroscopy	Sep 25	-	320			46
Diagnostic activity levels - Imaging	Sep 25	-	21,719			88
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 25	-	5,323			64
Diagnostic activity levels - Total	Sep 25	-	25,208			87
Diagnostic activity levels - Urodynamics	Sep 25	-	155			93
Diagnostics - 6 Week Standard	Sep 25	5.00%	35.88%			15
Diagnostics - 6 Week Standard Reversed	Sep 25	95.00%	64.12%			15
DM01 Waiting <13 Weeks	Sep 25	100.00%	91.91%			32
Echocardiography	Sep 25	5.00%	14.17%			48
Gastroscopy	Sep 25	5.00%	41.92%			16
Magnetic Resonance Imaging	Sep 25	5.00%	39.21%			7
Neurophysiology	Sep 25	5.00%	60.94%			11
Non-obstetric Ultrasound	Sep 25	5.00%	33.38%			14
Urodynamics	Sep 25	5.00%	2.50%			82

14. Pathway Benchmarking & Trend – Diagnostics

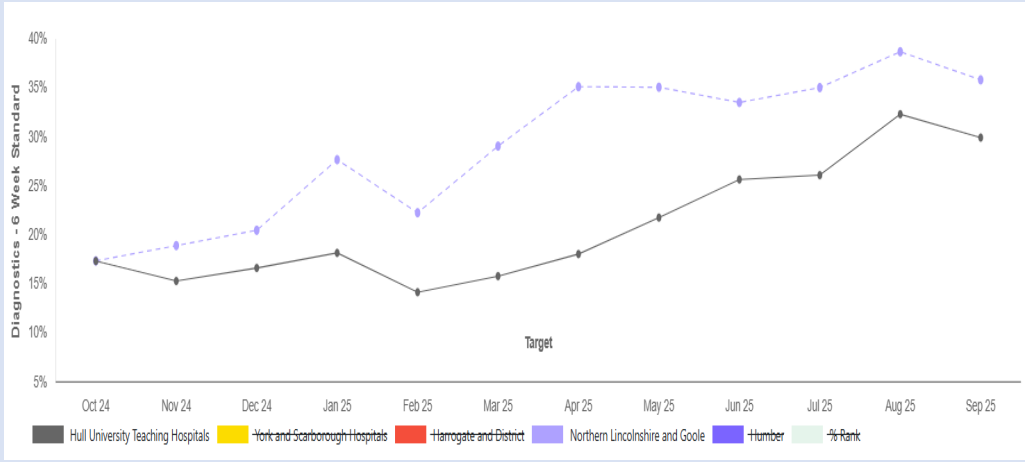
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

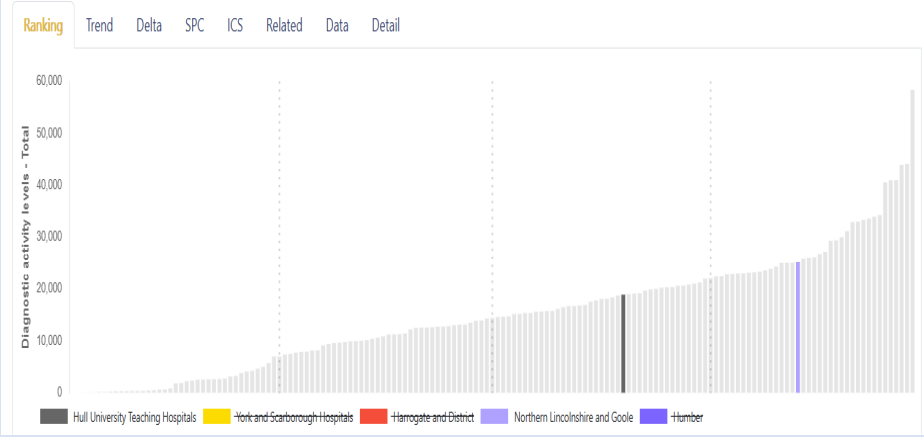


Trend Chart

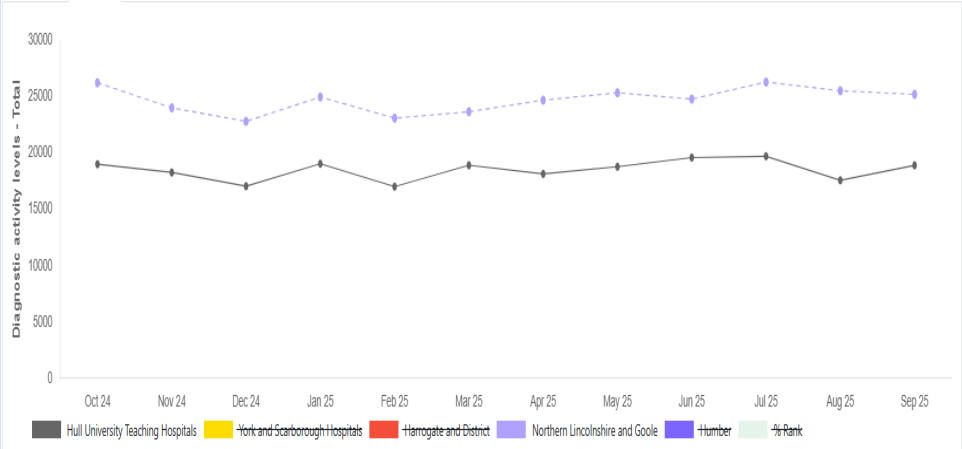


Diagnostics – Activity

Ranking Chart

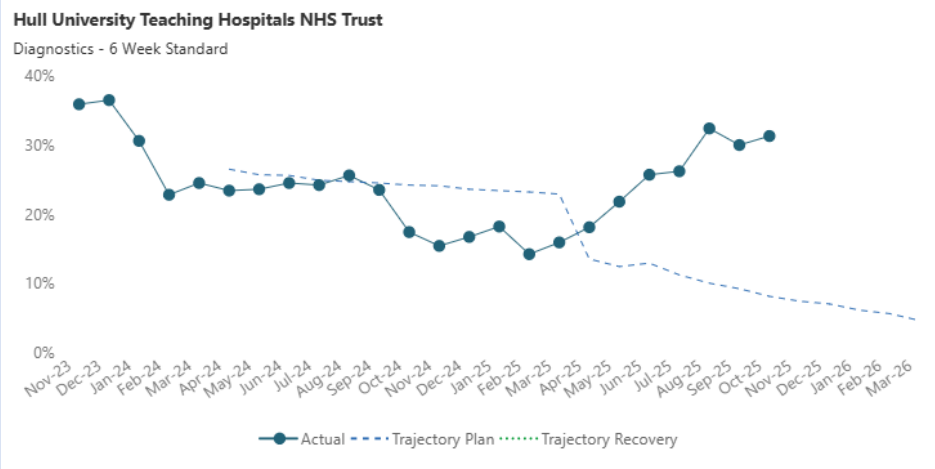


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

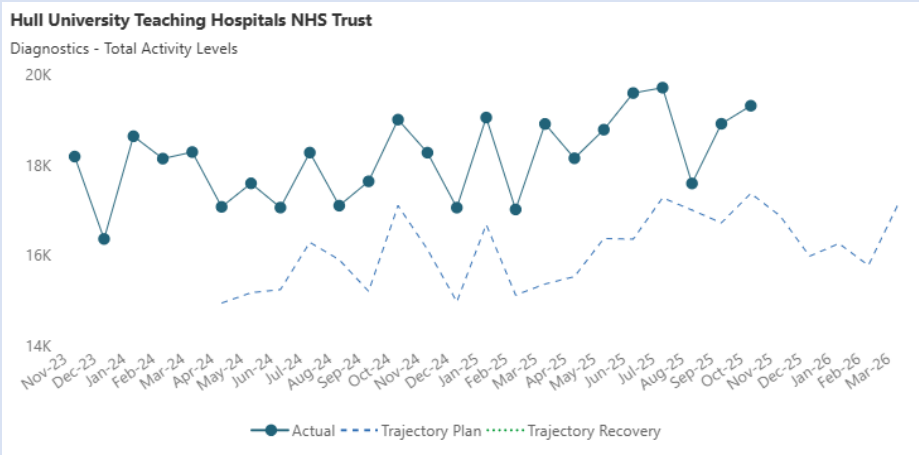
Compliance



Key Themes

- Activity levels have increased and remain above trajectory. Increased levels of emergency demand displacing elective.
- October saw a deterioration in performance to 31.3%.
- Deteriorating performance compared to previous month in CT, non-obstetric ultrasound, DEXA, Flexi Sigmoidoscopy and Sleep studies.
- Continuing demand pressures in Echo, Colonoscopy and Audiology although all saw improvements in October.

Critical Enabler



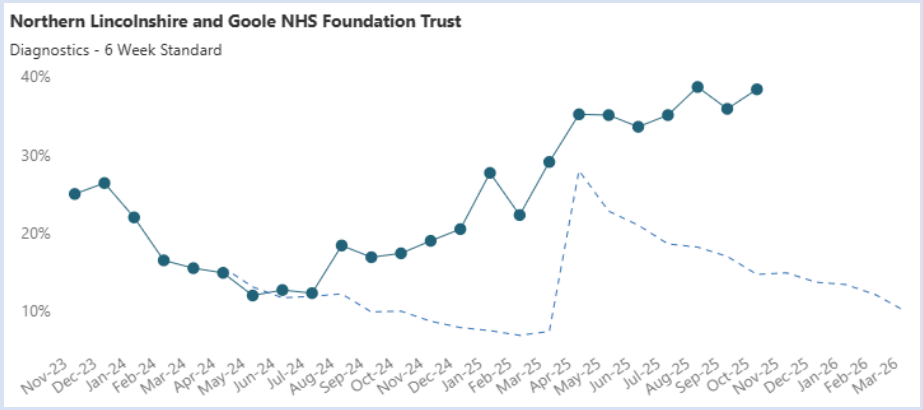
Actions

Critical actions being progressed through Diagnostic Delivery Group:

- Neurophysiology contract awarded with mobilisation from October.
- Echo capacity has started to be utilised at NLAG CDC following discontinuation of IS capacity and develop sonographer-led Stress Echo service.
- Colonoscopy business case being worked up.
- Additional accommodation secured to support Sleep Study capacity
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

16. Diagnostic 6 Week Standard - NLAG

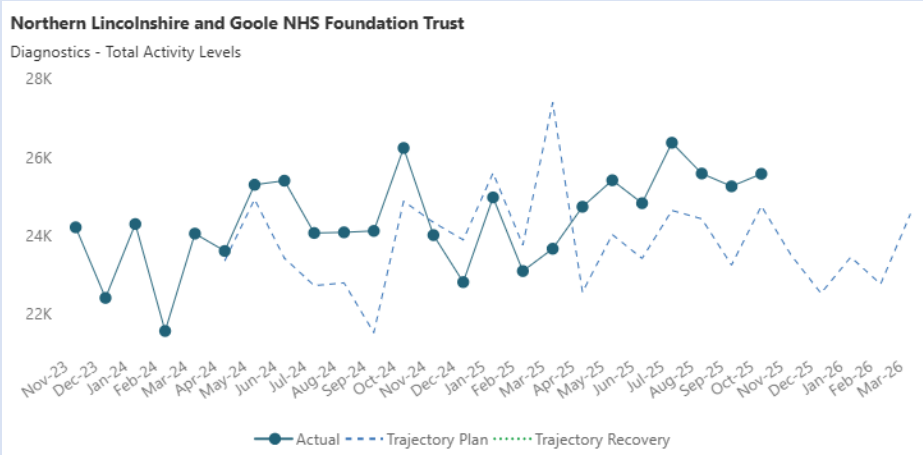
Compliance



Key Themes

- Activity levels remain above trajectory. Increased levels of emergency demand displacing elective.
- October performance at 35.4%.
- Deteriorations in performance in Audiology (61.3%), Colonoscopy 944.4%), MRI (43.4%) and Non Obstetric Ultrasound (38.3%)
- Improved performance in Neurophysiology, Echo, CT, DEXA and Flexi Sigmoidoscopy

Critical Enabler



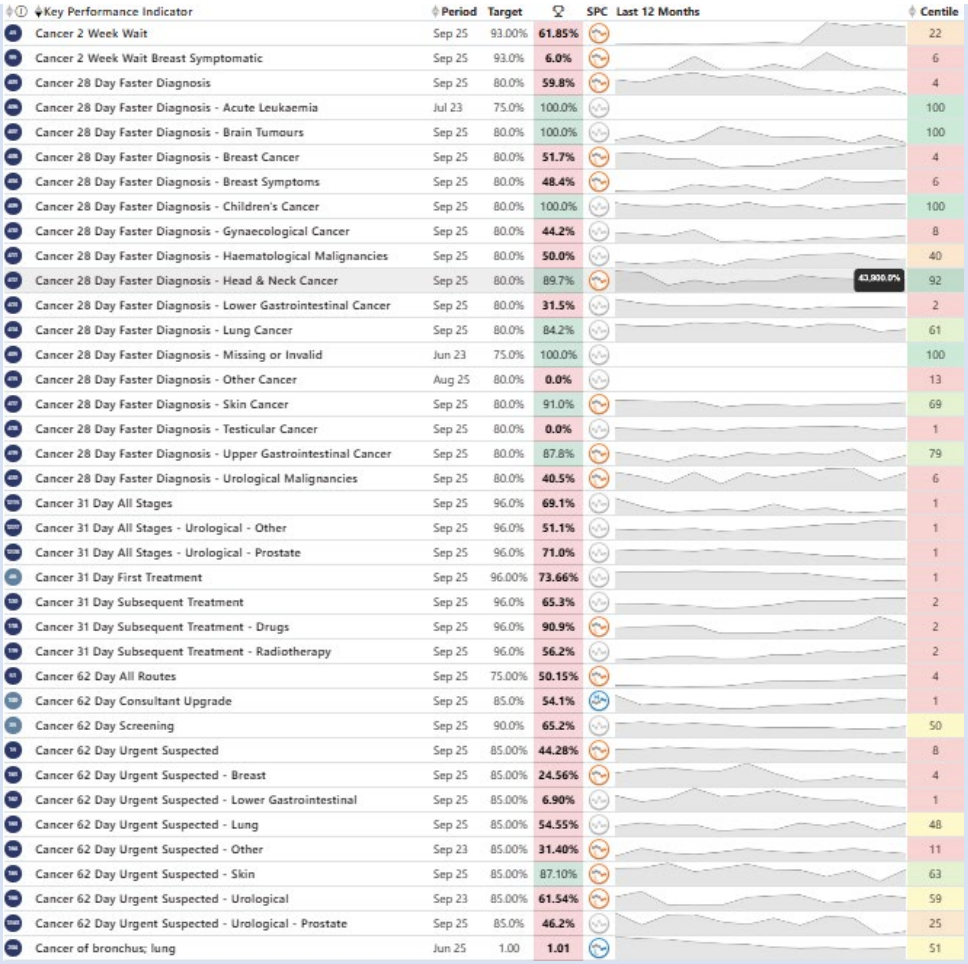
Actions

Critical actions being progressed through Diagnostic Delivery Group:

- Neurophysiology contract mobilisation commenced in October.
- Plans to progress weekend waiting list initiatives for Stress Echo and develop sonographer-led service.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

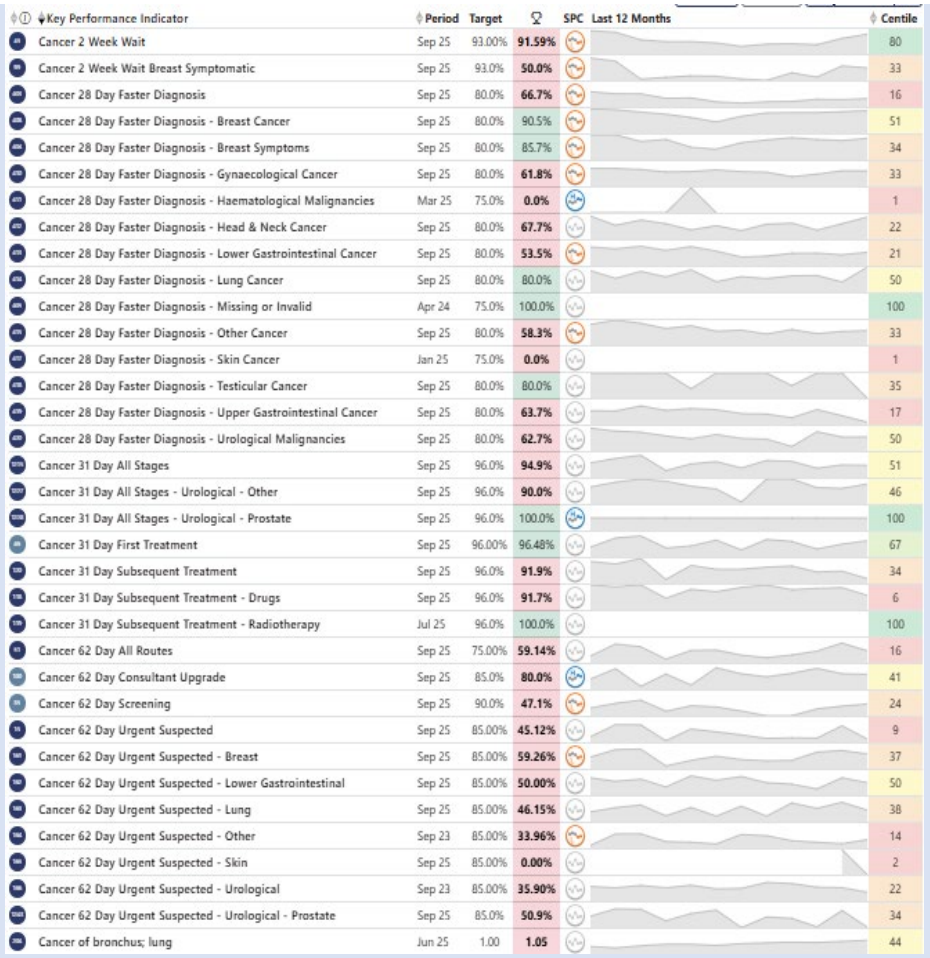
17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH



Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 25	93.00%	61.85%			22
Cancer 2 Week Wait Breast Symptomatic	Sep 25	93.0%	6.0%			6
Cancer 28 Day Faster Diagnosis	Sep 25	80.0%	59.8%			4
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Jul 23	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Brain Tumours	Sep 25	80.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 25	80.0%	51.7%			4
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 25	80.0%	48.4%			6
Cancer 28 Day Faster Diagnosis - Children's Cancer	Sep 25	80.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 25	80.0%	44.2%			8
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Sep 25	80.0%	50.0%			40
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 25	80.0%	89.7%			92
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 25	80.0%	31.5%			2
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 25	80.0%	84.2%			61
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Jun 23	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Other Cancer	Aug 25	80.0%	0.0%			13
Cancer 28 Day Faster Diagnosis - Skin Cancer	Sep 25	80.0%	91.0%			69
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 25	80.0%	0.0%			1
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 25	80.0%	87.8%			79
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 25	80.0%	40.5%			6
Cancer 31 Day All Stages	Sep 25	96.0%	69.1%			1
Cancer 31 Day All Stages - Urological - Other	Sep 25	96.0%	51.1%			1
Cancer 31 Day All Stages - Urological - Prostate	Sep 25	96.0%	71.0%			1
Cancer 31 Day First Treatment	Sep 25	96.00%	73.66%			1
Cancer 31 Day Subsequent Treatment	Sep 25	96.0%	65.3%			2
Cancer 31 Day Subsequent Treatment - Drugs	Sep 25	96.0%	90.9%			2
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 25	96.0%	56.2%			2
Cancer 62 Day All Routes	Sep 25	75.00%	50.15%			4
Cancer 62 Day Consultant Upgrade	Sep 25	85.0%	54.1%			1
Cancer 62 Day Screening	Sep 25	90.0%	65.2%			50
Cancer 62 Day Urgent Suspected	Sep 25	85.00%	44.28%			8
Cancer 62 Day Urgent Suspected - Breast	Sep 25	85.00%	24.56%			4
Cancer 62 Day Urgent Suspected - Lower Gastrointestinal	Sep 25	85.00%	6.90%			1
Cancer 62 Day Urgent Suspected - Lung	Sep 25	85.00%	54.55%			48
Cancer 62 Day Urgent Suspected - Other	Sep 23	85.00%	31.40%			11
Cancer 62 Day Urgent Suspected - Skin	Sep 25	85.00%	87.10%			63
Cancer 62 Day Urgent Suspected - Urological	Sep 23	85.00%	61.54%			59
Cancer 62 Day Urgent Suspected - Urological - Prostate	Sep 25	85.0%	46.2%			25
Cancer of bronchus; lung	Jun 25	1.00	1.01			51

NLAG



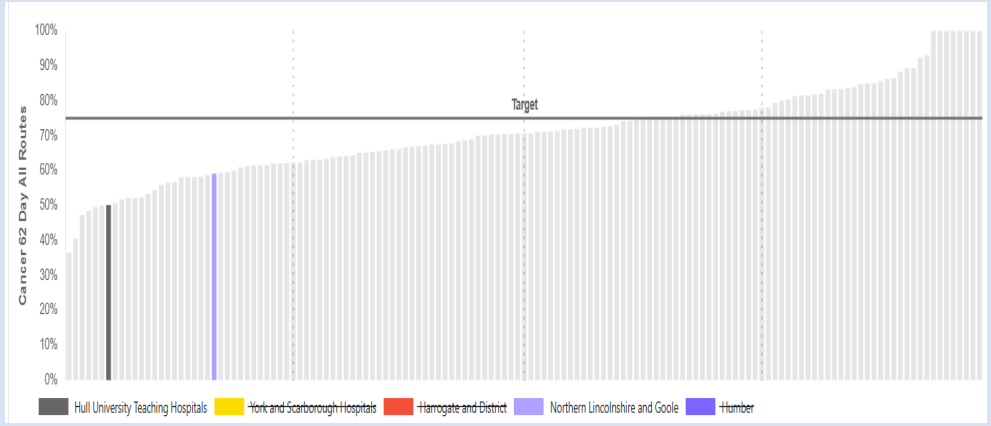
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 25	93.00%	91.59%			80
Cancer 2 Week Wait Breast Symptomatic	Sep 25	93.0%	50.0%			33
Cancer 28 Day Faster Diagnosis	Sep 25	80.0%	66.7%			16
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 25	80.0%	90.5%			51
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 25	80.0%	85.7%			34
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 25	80.0%	61.8%			33
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Mar 25	75.0%	0.0%			1
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 25	80.0%	67.7%			22
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 25	80.0%	53.5%			21
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 25	80.0%	80.0%			50
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Apr 24	75.0%	100.0%			100
Cancer 28 Day Faster Diagnosis - Other Cancer	Sep 25	80.0%	58.3%			33
Cancer 28 Day Faster Diagnosis - Skin Cancer	Jan 25	75.0%	0.0%			1
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 25	80.0%	80.0%			35
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 25	80.0%	63.7%			17
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 25	80.0%	62.7%			50
Cancer 31 Day All Stages	Sep 25	96.0%	94.9%			51
Cancer 31 Day All Stages - Urological - Other	Sep 25	96.0%	90.0%			46
Cancer 31 Day All Stages - Urological - Prostate	Sep 25	96.0%	100.0%			100
Cancer 31 Day First Treatment	Sep 25	96.00%	96.48%			67
Cancer 31 Day Subsequent Treatment	Sep 25	96.0%	91.9%			34
Cancer 31 Day Subsequent Treatment - Drugs	Sep 25	96.0%	91.7%			6
Cancer 31 Day Subsequent Treatment - Radiotherapy	Jul 25	96.0%	100.0%			100
Cancer 62 Day All Routes	Sep 25	75.00%	59.14%			16
Cancer 62 Day Consultant Upgrade	Sep 25	85.0%	80.0%			41
Cancer 62 Day Screening	Sep 25	90.0%	47.1%			24
Cancer 62 Day Urgent Suspected	Sep 25	85.00%	45.12%			9
Cancer 62 Day Urgent Suspected - Breast	Sep 25	85.00%	59.26%			37
Cancer 62 Day Urgent Suspected - Lower Gastrointestinal	Sep 25	85.00%	50.00%			50
Cancer 62 Day Urgent Suspected - Lung	Sep 25	85.00%	46.15%			38
Cancer 62 Day Urgent Suspected - Other	Sep 23	85.00%	33.96%			14
Cancer 62 Day Urgent Suspected - Skin	Sep 25	85.00%	0.00%			2
Cancer 62 Day Urgent Suspected - Urological	Sep 23	85.00%	35.90%			22
Cancer 62 Day Urgent Suspected - Urological - Prostate	Sep 25	85.0%	50.9%			34
Cancer of bronchus; lung	Jun 25	1.00	1.05			44

18. Pathway Benchmarking & Trending – Cancer Waiting Times

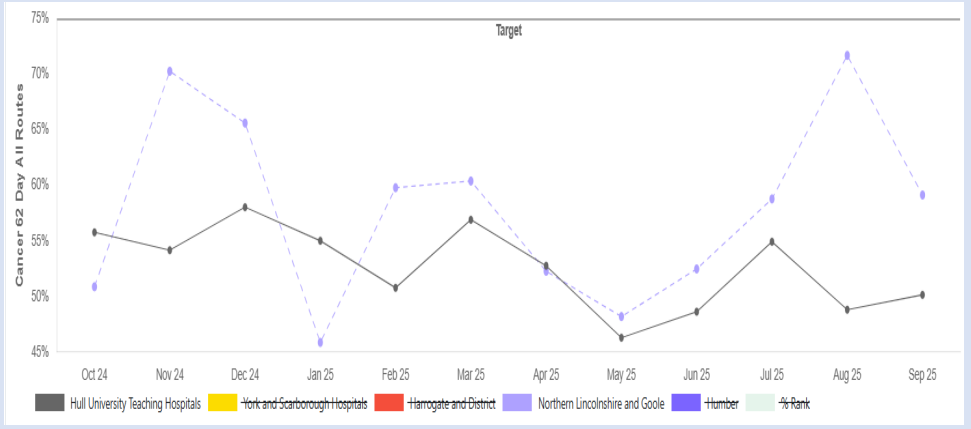
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

62 Day Performance

Ranking Chart

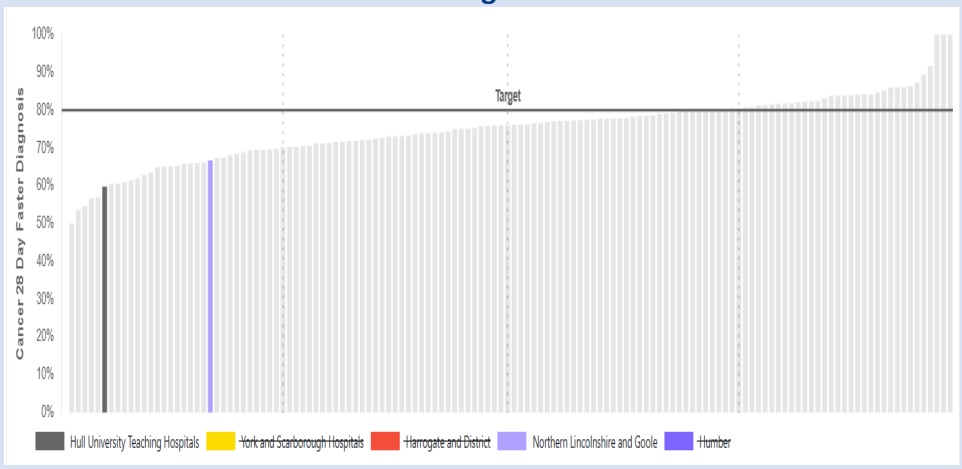


Trending Chart

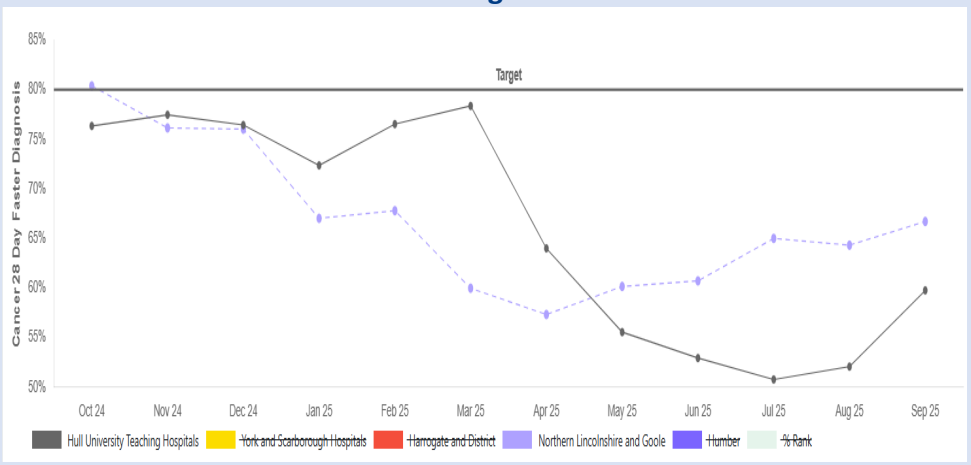


Faster Diagnosis Performance

Ranking Chart

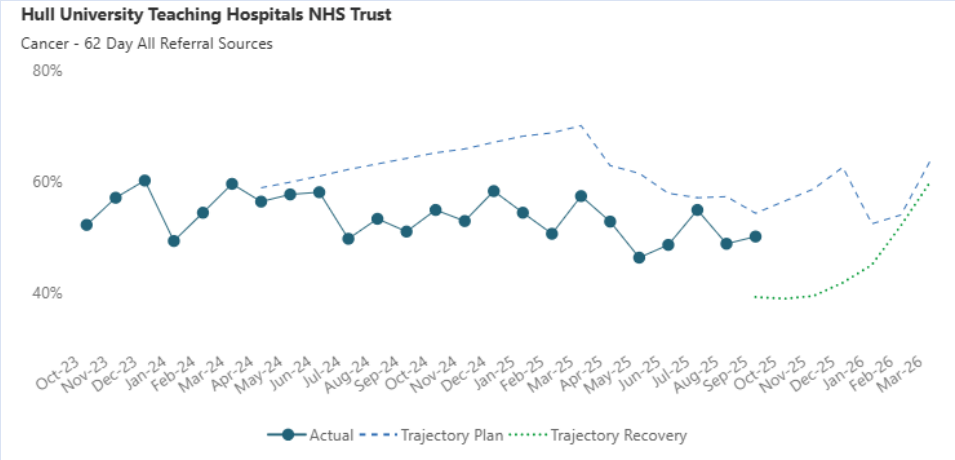


Trending Chart



19. 62 Day Cancer Performance - HUTH

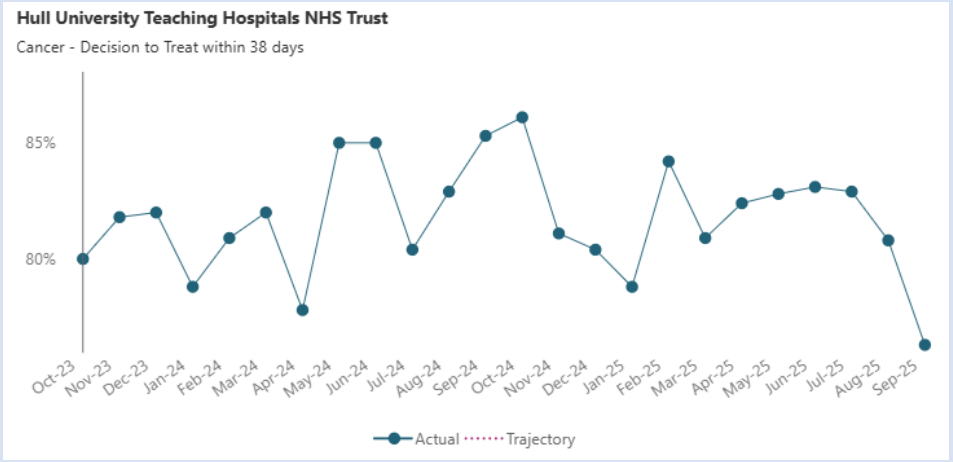
Compliance



Key Themes

- September performance of 51.4% shows an improvement on the previous month but remains within normal variation.
- Breast – 1st outpatient radiology capacity
- Colorectal- Significant endoscopy capacity constraints, high Histopathology turnaround times(TAT), endoscopy equipment
- Gynaecology- Long Histopathology TAT , late IPTs and theatre capacity constraints
- Head and Neck- Capacity and demand review being undertaken for Thyroid capacity
- Lung- Capacity in Radiotherapy and late IPTs
- Urology – Robotic surgery capacity constraints, loss of IS capacity
- Significant deterioration of first appointment within 2 weeks is impacting on 62 day and 28-day FDS delivery.
- 31-day DTT to treatment standard at 69.1% .

Critical Enabler

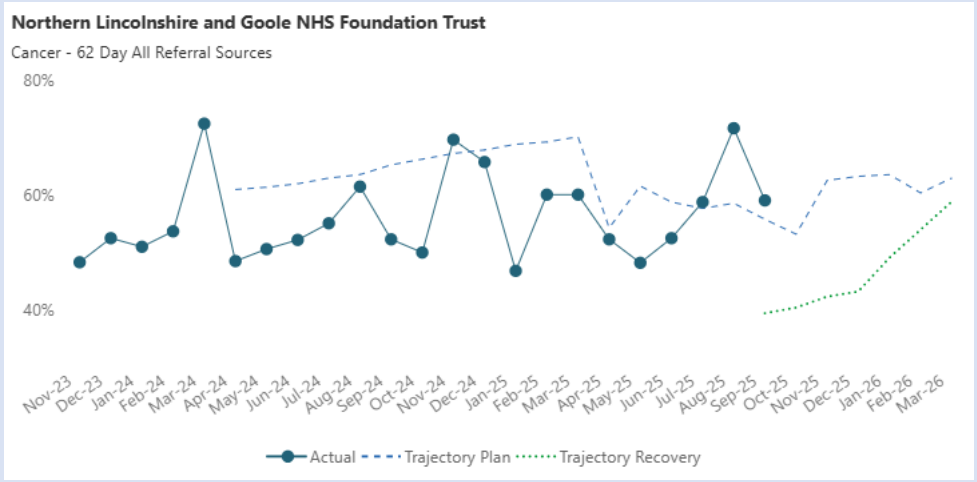


Actions

- Breast – Radiotherapy recovery in place. Additional weekend clinics agreed, but not enough to meet trajectories.
- Gynaecology –Demand and capacity paper submitted. Clinical lead to review MDT inefficiencies and late IPTs to develop improvement plan. Funding secured to hold 1 x extra list per month for remainder of financial year (approx. 12 additional sessions).
- Lung –Business Case for additional Thoracic Surgeon declined by executive team , productivity challenged.
- Urology – Cancer Alliance funding secured for additional weekend theatre lists, not a sustainable solution. Robotic theatre capacity remains a bottleneck as well.
- New fortnightly Service improvement and performance monitoring meetings in place
- Improvement trajectories in place for all tumour sites

20. 62 Day Cancer Performance - NLAG

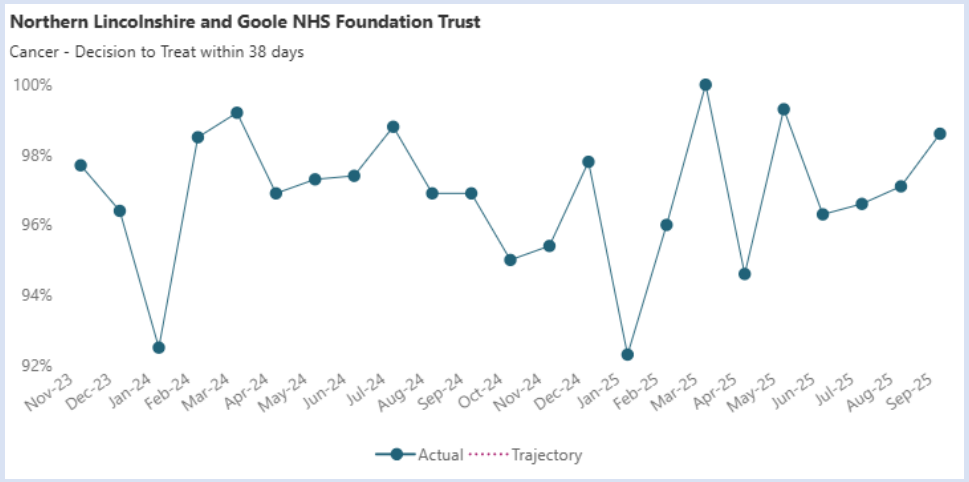
Compliance



Key Themes

- September performance of 57.1% shows a significant deterioration compared to August performance
- Breast- Consultant vacancies, radiotherapy capacity constraints, sickness and leave resulting in pathway delays
- Colorectal- Endoscopy capacity constraints
- Gynaecology- Capacity and Demand undertaken. This will confirm gynae oncology theatre requirements at NLAG. C&D work also to review hysteroscopy and USC capacity for 1st OPA
- Head & Neck- Thyroid and Max Fax capacity constraints
- Lung- clinical vacancies, Oncology capacity
- Urology- Haematuria pathway being worked up with CDC. Will enable CT to be undertaken prior to cystoscopy, within the CDC. This will enable diagnosis to be given to patient at the time of the cystoscopy.

Critical Enabler

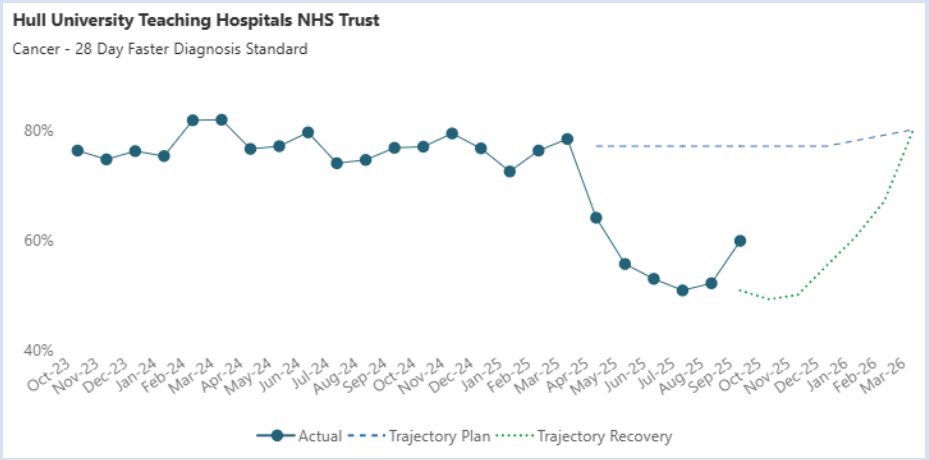


Actions

- Breast – Consultant recruitment underway. Radiotherapy recovery in place. Additional weekend clinics agreed
- Colorectal – Cancer Alliance funded WLIs in place. Weekly monitoring of the PTL with navigators and trackers to ensure delays are mitigated.
- Gynaecology – Capacity and demand work undertaken. Cancer Alliance funded WLIs in place to mitigate.
- Lung – Continuous advertisement for recruitment to 5 x WTE posts. Rightsizing paper being developed
- Urology – Weekend theatres and in week additional theatre sessions inhibited by pay dispute
- Improvement trajectories in place for all tumour sites.

21. 28 Day Faster Diagnosis Standard - HUTH

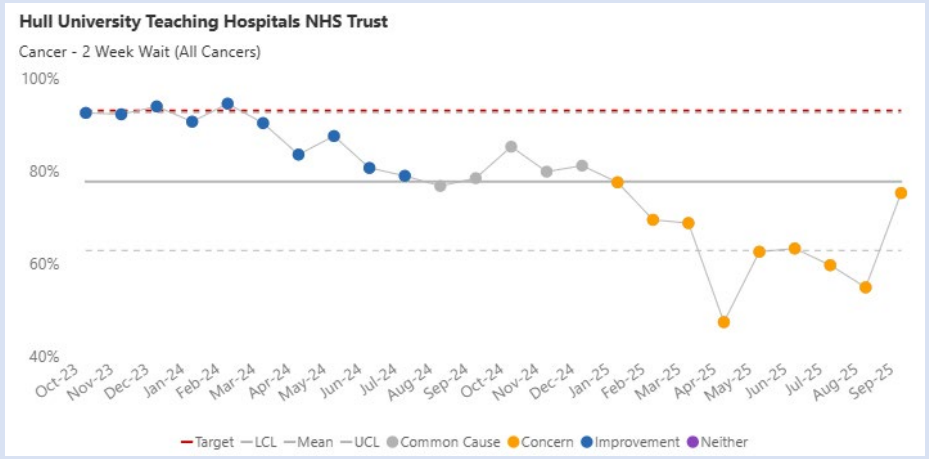
Compliance



Key Themes

- September performance 60.0%, which is an improvement on the previous month (52.1%).
- Breast; significant delays due to radiologist capacity constraints
- Colorectal; loss of CNS through Alliance funding has reduced capacity for triage, bowel screening Endoscopy capacity shortfall for accredited endoscopists, CT Colon radiologist capacity with current waits up to 4 weeks
- Gynaecology; outpatient capacity and US capacity, diagnostic histology turnaround times up to 3 weeks
- Head & Neck; significant delays with first outpatient consultant capacity
- Skin; significant delays with first outpatient consultant capacity
- Urology: Development of One Stop Prostate Pathway.

Critical Enabler

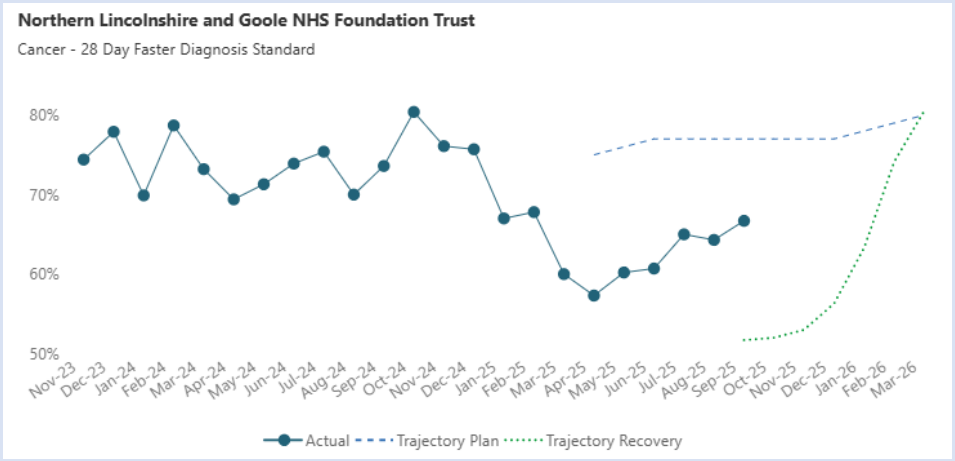


Actions

- Breast – Radiotherapy recovery in place. Additional weekend clinics agreed
- Lower GI – restructured endoscopic allocation to support focussed capacity for USC patients
- Gynaecology – Sub Spec Gynae Oncology Consultant Business cases developed alongside wider Workforce Expansion Paper (unit leads and nursing)
- Head & Neck – Additional outpatient capacity to be done via WLIs and service working on plans to clear backlog
- Urology – piloting AI MRI prostate pathway to deliver one-stop MRI biopsy
- Improvement trajectories in place for all tumour sites – Elective Deep Dive paper

22. 28 Day Faster Diagnosis Standard - NLAG

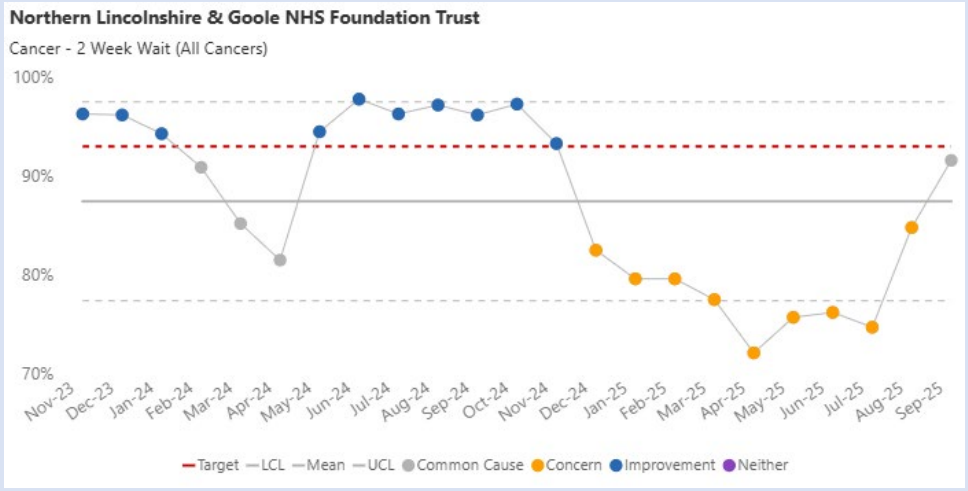
Compliance



Key Themes

- September performance 66.1%, which is an improvement on the previous month.
- Breast- first outpatient capacity constraints
- Colorectal- endoscopy capacity constraints, screening continued delays due to patient choice
- Lung- Due to vacancies we have booked locums to cover inpatient to allow the substantive consultants to focus on outpatient activity.
- Urology- increase in referrals and demand for prostate biopsies

Critical Enabler



Actions

- Breast- recruitment to consultant vacancies, additional capacity for biopsies
- Colorectal- Additional sessions for weekend theatres and STT capacity in place
- Gynaecology- Business case progressing to meet workforce constraints
- Head & Neck- Time out session with clinicians and managers arranged to streamline pathways
- Upper GI- extra contractual sessions not operating due to pay dispute
- Lung- Direct to CT for suspected CXR, introduction of Cancer Physician of the week, introduction of OPD triage by CNS
- Urology- Utilising additional capacity with registrars where possible.
- Improvement trajectories in place for all tumour sites

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 12 Hour Standard	Oct 25	-	16.5%			15
A&E - 4 Hour Standard	Oct 25	78.00%	55.84%			8
A&E - 4 Hour Standard (Type 1)	Oct 25	78.0%	40.9%			20
A&E - 4 Hour Standard (Type 2 or 3)	Oct 25	95.0%	90.0%			17
A&E - Conversion Rate	Oct 25	25.0%	27.3%			9
A&E - DTA to Admission >12 Hours	Oct 25	0.0%	17.2%			28
A&E - DTA to Admission >12 Hours#	Oct 25	0.0	670.0			19
A&E - DTA to Admission >4 Hours	Oct 25	10.00%	42.57%			28
A&E - Left Without Being Seen	Sep 25	5.00%	8.35%			9
A&E - Reattendance Rate	Sep 25	5.0%	9.5%			39
A&E - Time to Initial Assessment	Sep 25	15.0	18.0			9
A&E - Time to Treatment	Sep 25	60.0	89.0			24
A&E - Total Time in A&E	Sep 25	160.0	277.0			1
A&E - Total Time in A&E (Admitted)	Sep 25	180.0	369.0			29
A&E - Total Time in A&E (Non-Admitted)	Sep 25	140.0	257.0			2
A&E Attendances All	Oct 25	-	14,317			50
A&E Attendances Type 1	Oct 25	-	9,956			46
A&E Attendances Type 2	Oct 25	-	0			100
A&E Attendances Type 3	Oct 25	-	4,361			45
Emergency Admissions Type 1	Oct 25	-	3,902			21
Emergency Admissions Type 2	Oct 25	-	0			100
Emergency Admissions Type 3	Oct 25	-	0			100
Emergency Admissions via A&E	Oct 25	-	3,902			24
Friends & Family A&E Score	Jul 25	85%	0%			1
Other Emergency Admissions	Oct 25	-	2,281			11
Total Emergency Admissions	Oct 25	-	6,183			17

das

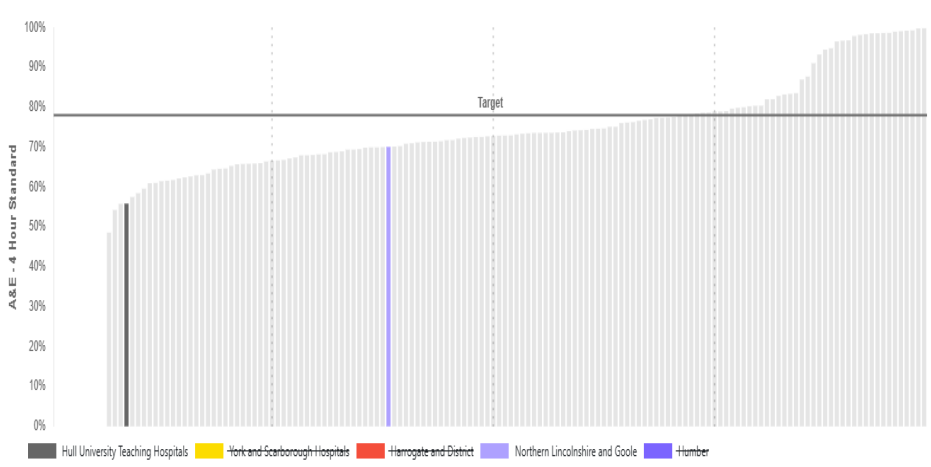
NLAG

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 12 Hour Standard	Oct 25	-	16.7%			13
A&E - 4 Hour Standard	Oct 25	78.00%	70.06%			38
A&E - 4 Hour Standard (Type 1)	Oct 25	78.0%	47.3%			28
A&E - 4 Hour Standard (Type 2 or 3)	Oct 25	95.0%	99.1%			72
A&E - Conversion Rate	Oct 25	25.0%	32.7%			1
A&E - DTA to Admission >12 Hours	Oct 25	0.0%	13.0%			36
A&E - DTA to Admission >12 Hours#	Oct 25	0.0	738.0			16
A&E - DTA to Admission >4 Hours	Oct 25	10.00%	26.74%			57
A&E - Left Without Being Seen	Sep 25	5.00%	2.76%			82
A&E - Reattendance Rate	Sep 25	5.0%	10.2%			22
A&E - Time to Initial Assessment	Sep 25	15.0	21.0			5
A&E - Time to Treatment	Sep 25	60.0	59.0			62
A&E - Total Time in A&E	Sep 25	160.0	157.0			67
A&E - Total Time in A&E (Admitted)	Sep 25	180.0	369.0			29
A&E - Total Time in A&E (Non-Admitted)	Sep 25	140.0	120.0			79
A&E Attendances All	Oct 25	-	17,432			38
A&E Attendances Type 1	Oct 25	-	9,779			48
A&E Attendances Type 2	Oct 25	-	0			100
A&E Attendances Type 3	Oct 25	-	7,653			28
Emergency Admissions Type 1	Oct 25	-	5,696			8
Emergency Admissions Type 2	Oct 25	-	0			100
Emergency Admissions Type 3	Oct 25	-	0			100
Emergency Admissions via A&E	Oct 25	-	5,696			8
Friends & Family A&E Score	Aug 25	85%	82%			53
Other Emergency Admissions	Oct 25	-	534			53
Total Emergency Admissions	Oct 25	-	6,230			15

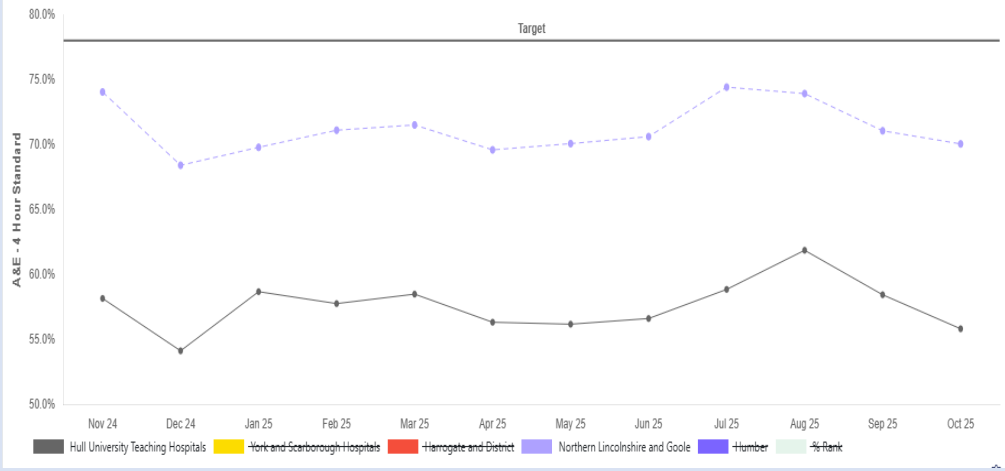
24.Pathway Benchmarking & Trending – Unscheduled Care

A&E - 4 Hour Performance

Ranking Chart

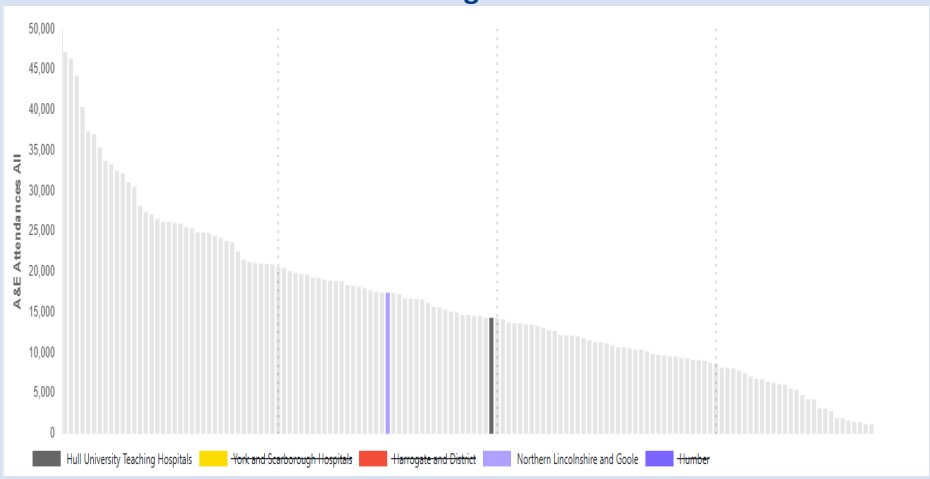


Trending Chart

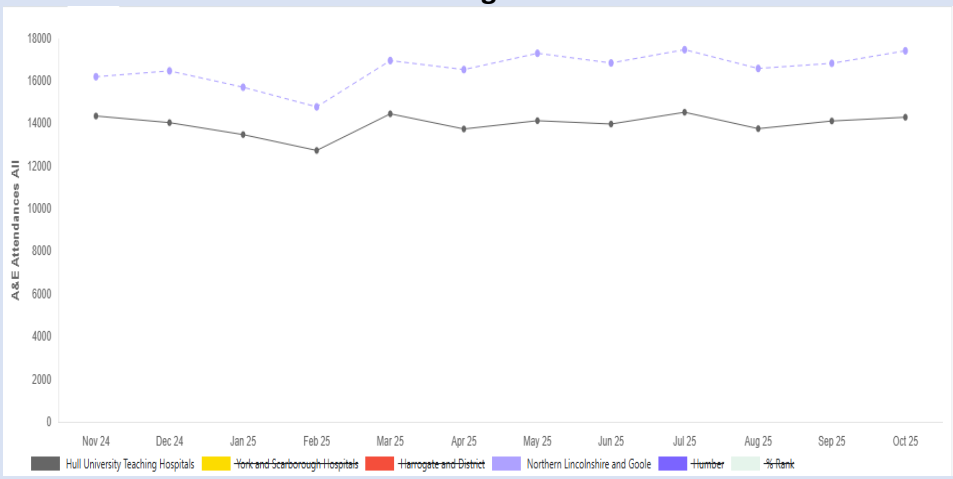


A&E – Attendances

Ranking Chart

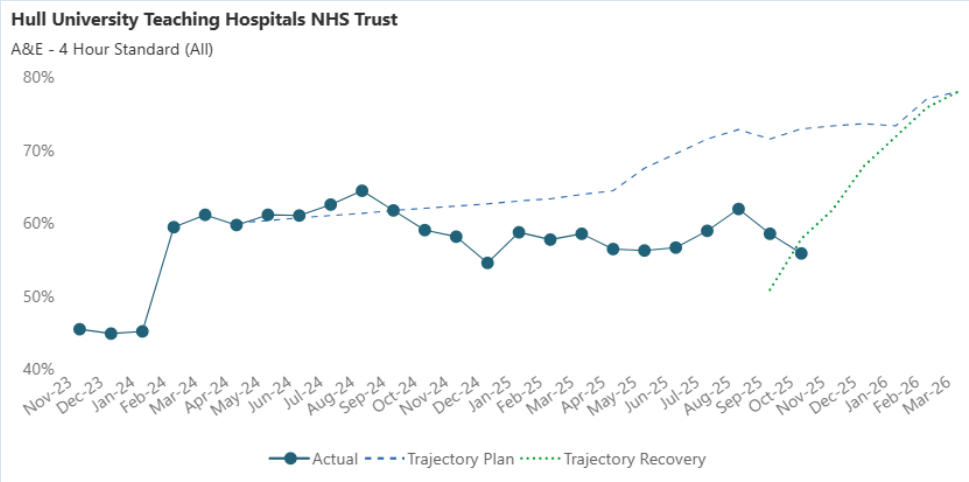


Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

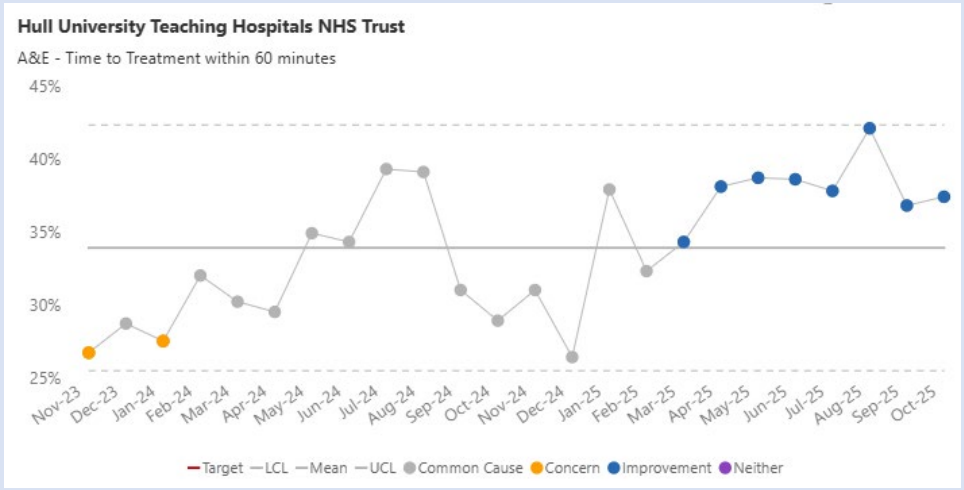
Compliance



Key Themes

- A&E 4 Hour standard (all types) remains challenged with performance of 55.5% in October 2025 behind the 25/26 Operating Plan (72.9%) and the in-year recovery plan of 58.0%.
- Type 1 performance of 40.9% was below the 25/26 operating plan target of 62.3% Attendances were above plan.
- Type 3 performance (HRI UTC) was 90.0% against the 95% target. Attendances at the UTC were below planned levels in October
- The percentage of patients seen by a clinician within 60 minutes of arrival totalled 37.4%, an improvement on the previous month's position

Critical Enabler

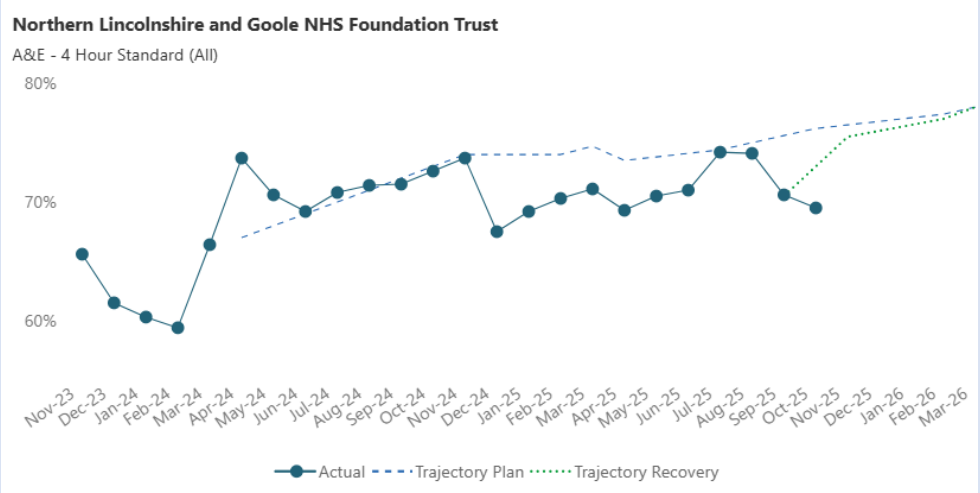


Actions

- Flow out of the department is a challenge, particularly if patients required side rooms. Close monitoring of 12 hours is being presented to Senior Leaders to increase awareness and ownership by Clinical Care Groups
- Working closely with Place partners aiming to increase UTC operating hours until 2am during winter to increase capacity
- Work ongoing with Yorkshire Ambulance Service to develop a falls care home pathway to avoid ED attendance where appropriate
- Plan to utilise H1 during winter pressures to reduce non admitted breaches, the unit will not be available until end of November / beginning of December
- The Group has reiterated its commitment to 78% delivery by March 2025 for both sites via the action programme agreed via national Tiering.

26. Emergency Care Standards – 4 hour Performance - NLAG

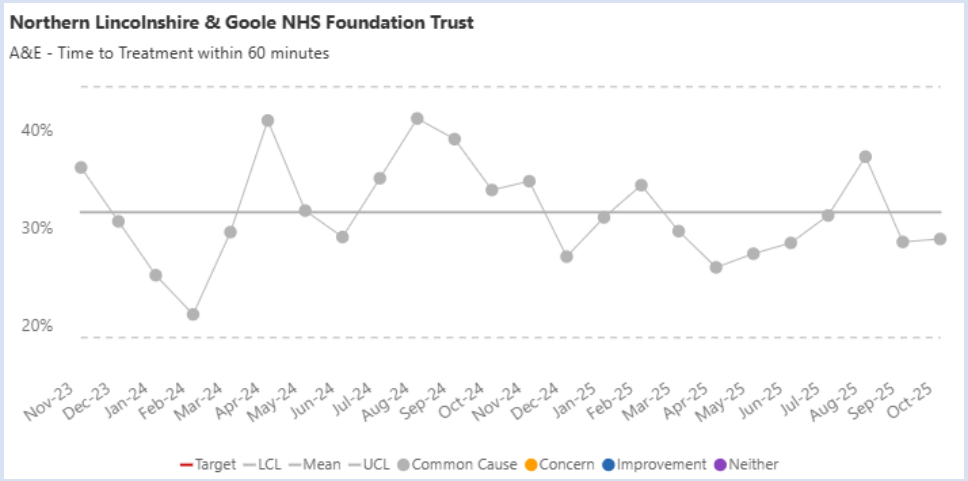
Compliance



Key Themes

- A&E 4 Hour standard (all types) performance was 69.5% in October 2025, which was behind the 25/26 Operating Plan (72.2%) and the in-year recovery plan of 73.0%.
- Type 1 performance of 47.5% was below plan at 60.9%. Attendances were below plan
- Type 3 performance of 99.2% which was above plan of 99%. Attendances were above plan
- Time to treatment within 60 minutes was 28.5% in September a deterioration on the previous month

Critical Enabler



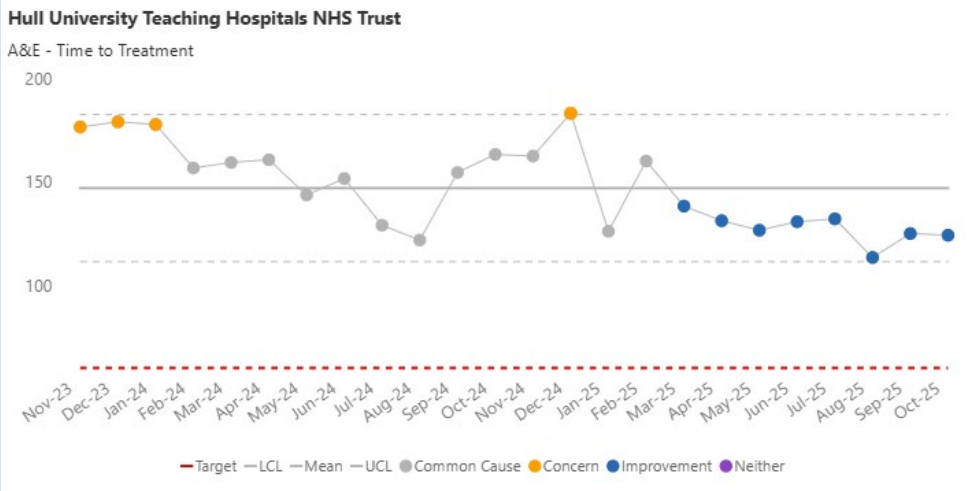
Actions

DPOW & SGH

- The Continuous Flow model was introduced in September in line with the new GIM model
- Expanding CDU pathways to increase utilisation of area
- Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC
- The Group has reiterated its commitment to 78% delivery by March 2025 for both sites via the action programme agreed via national Tiering

27. Core Objective 1 – Mean Time to Treatment

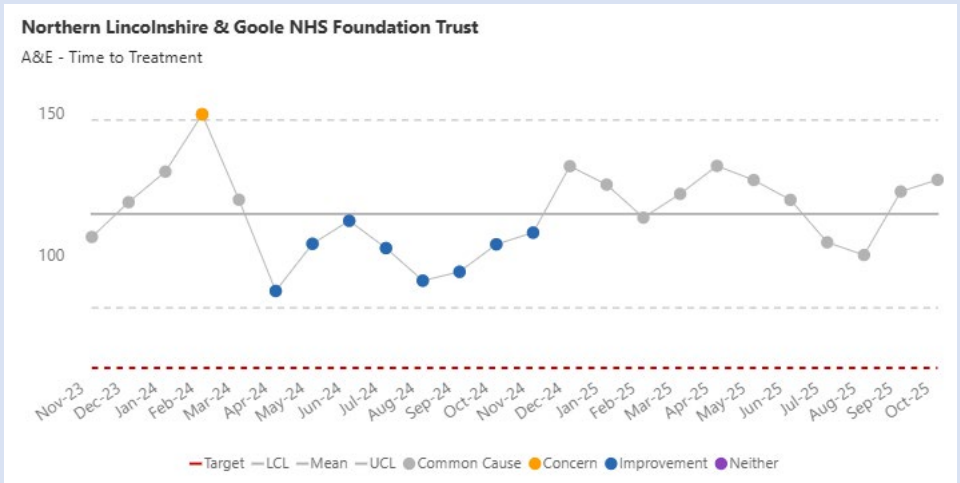
Compliance



Key Themes

- The Group established an operating target of 60 minutes for time to first clinician (time to treatment)
- HUTH performance in October was 124 minutes.
- NLaG performance was 126 minutes

Compliance

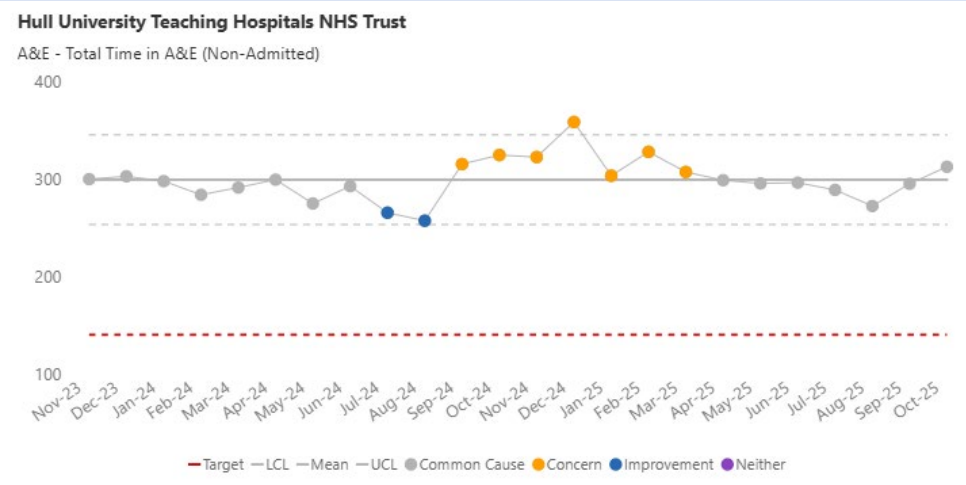


Actions

- Ongoing monitoring and focus on time first seen by doctor in department
- HUTH – Rapid Assessment now taking place in ECA & Majors.
- HUTH – consultant cover 24 hours Mon – Thurs. When team is fully established this will cover the 7 days.
- NLAG GIM ward and medical staff proposal agreed, launched in September.
- HUTH GIM consultation now complete, awaiting outcome

28. Core Objective 2 – Non-Admitted Total Time in Department

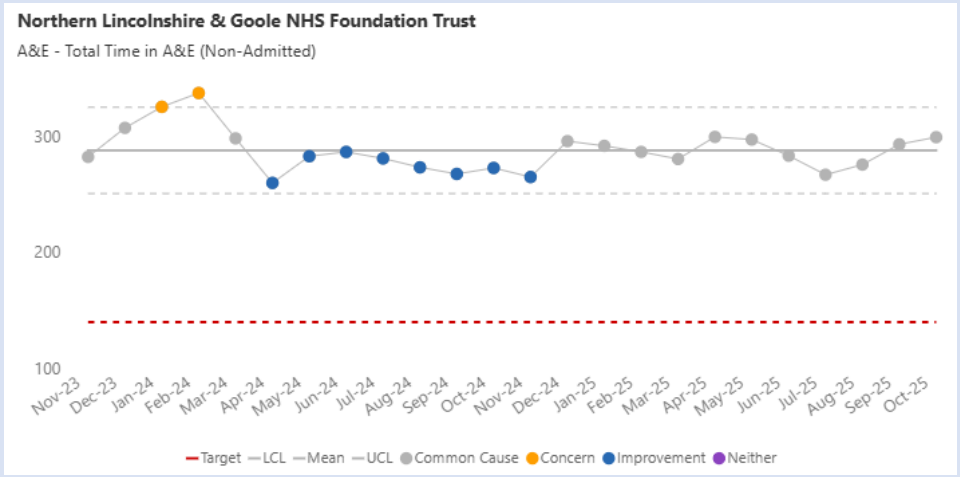
Compliance



Key Themes

- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED
- HUTH's performance decreased in October 2025 at 313 minutes average
- NLaG has performed consistently in 265-300 mins range since late Spring 2024. October 2025 performance saw a further deterioration at 299 mins

Compliance

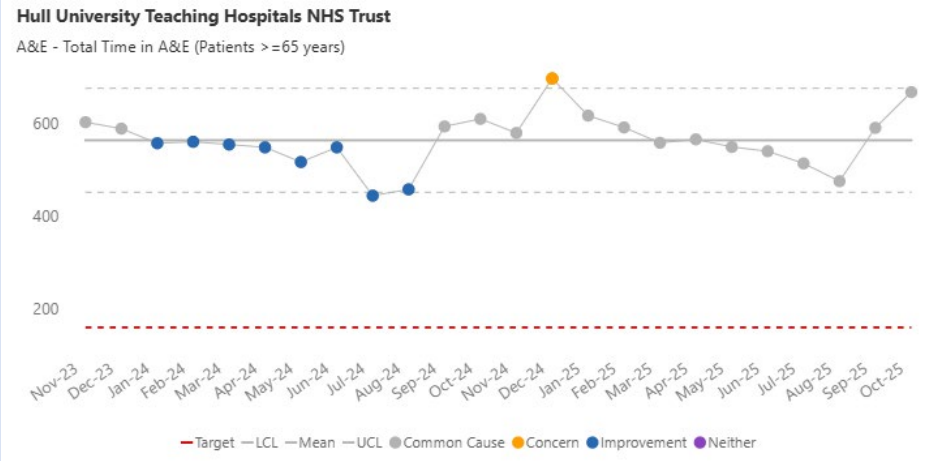


Actions

- Plan being worked up for H1 to support non admitted breaches for winter
- Challenge remains with limited flow, and discharges compound this issue. Raised with clinical colleagues at SLT to agree way forward and ownership

29. Core Objective 3 – Total Time in Department (Patients >= 65 years)

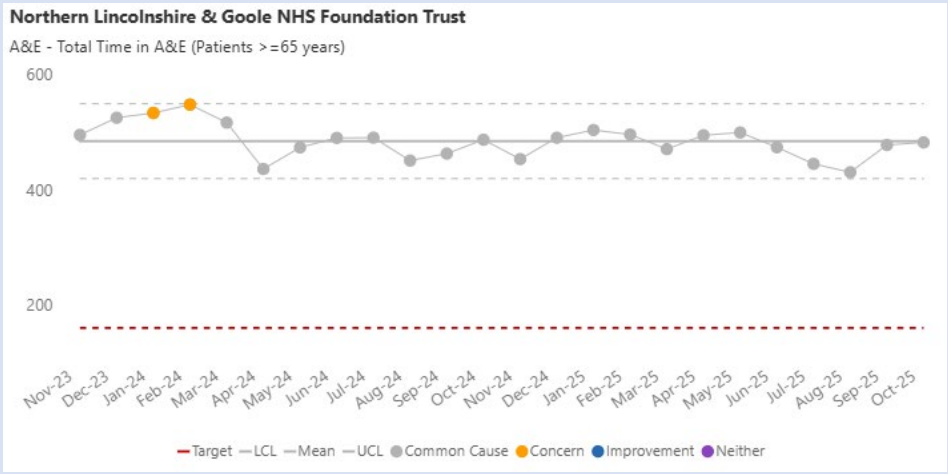
Compliance



Key Themes

- The Group established a target of 160 minutes for total time in the ED for patients aged 65 years and over
- The mean for HUTH was 667 minutes in October, a further deterioration on the August position
- NLaG saw a deterioration in waiting times in October at 483 minutes

Compliance

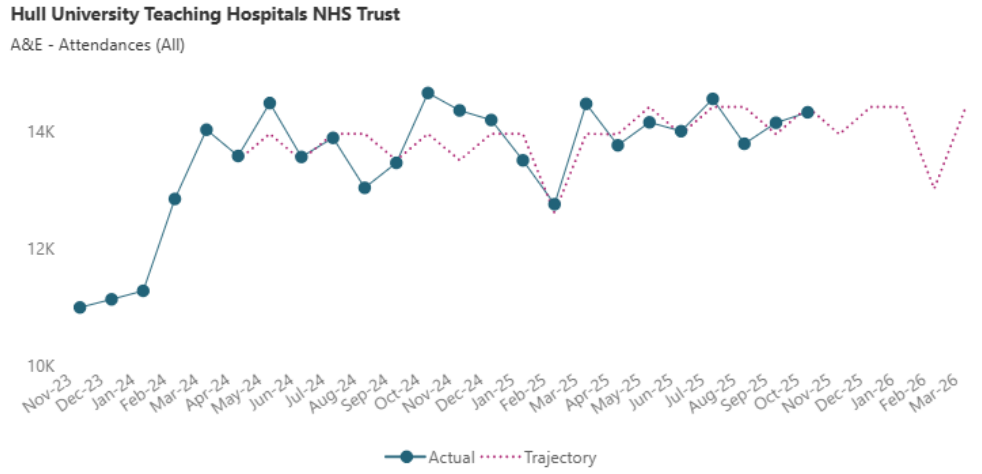


Action

- More movement out of ED in the morning due to continuous flow programme at HUTH
- Hourly monitoring of 12-hour position and reported to Director of the Day and visibility at Site Meetings for action
- Aim to move patients out of ED within 30minutes as per Continuous Flow model utilising TES/escalation spaces
- Optimise SDEC and UTC – ensure effective streaming

30. A&E Attendances – All Types

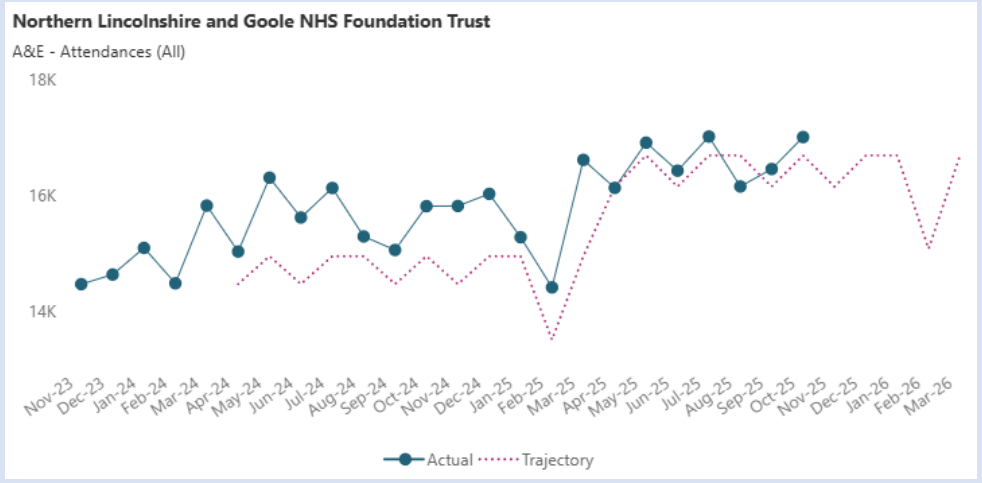
Compliance



Key Themes

- HUTH October 2025 – 14,317 total attendances comprising 9,956 Type 1 (above plan) and 4,361 Type 3 (below plan)
- NLaG October 2025 – 17,014 total attendances comprising 9,779 Type 1 (below plan) and 7,235 Type 3 (above plan)

Compliance

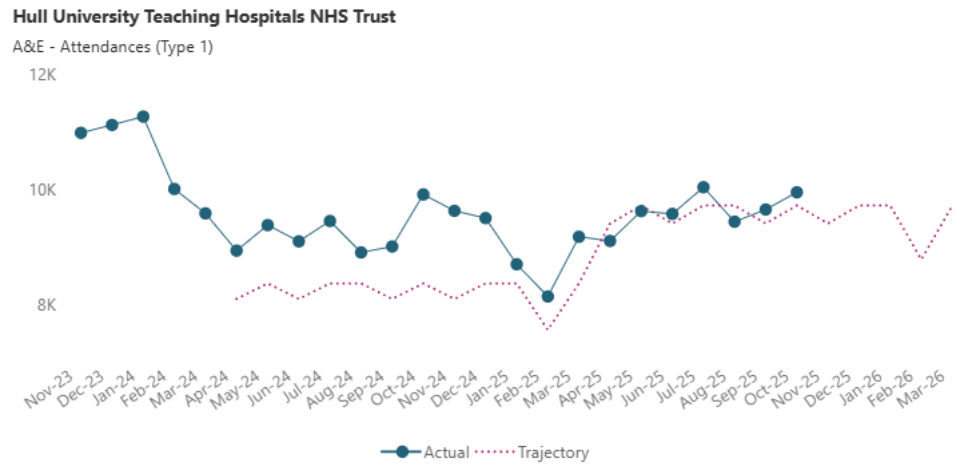


Actions

- Work taking place with system partners and Place to ensure pathways in place for community providers.
- Working with Yorkshire Ambulance Service on a Head Injury Pathway for Care Home patients.

31. A&E Attendances – Type 1 Attendances

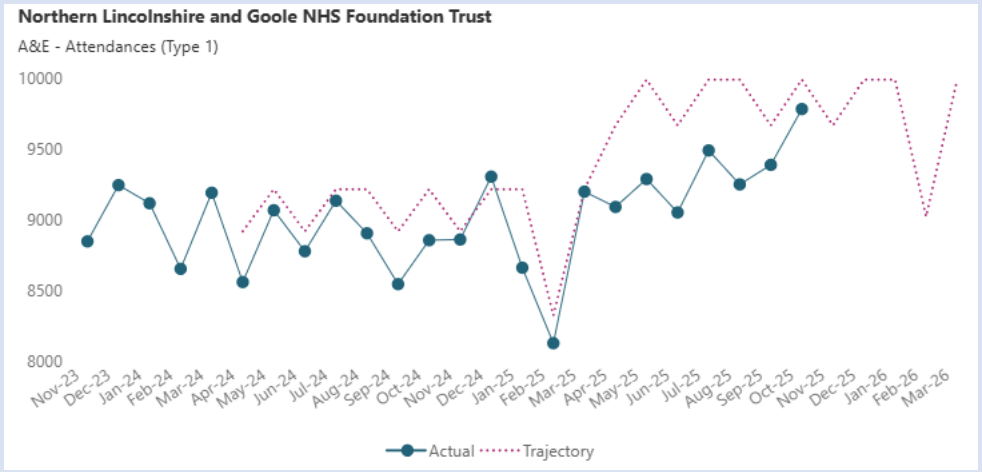
Compliance



Key Themes

- HUTH Type 1 attendances - October actuals were 9,956, above plan by 229.

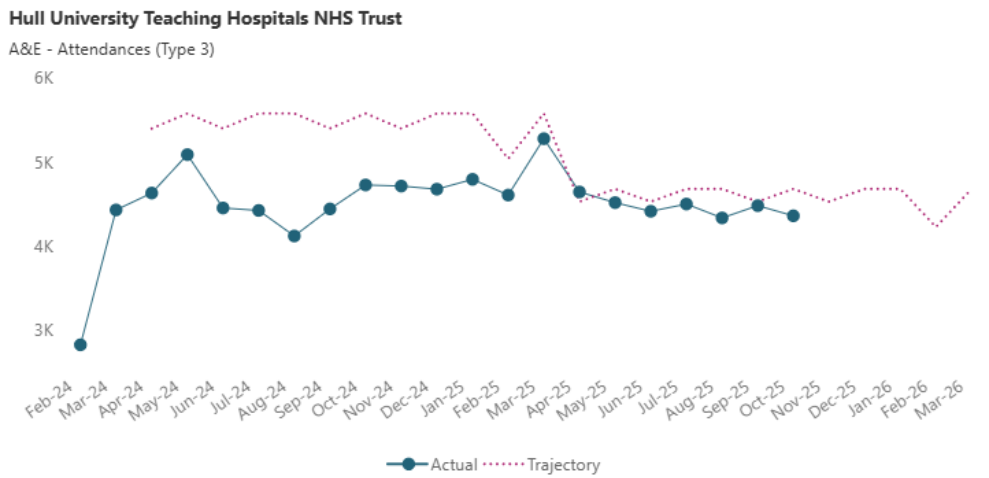
Compliance



- NLaG Type 1 attendances in October were 9,779 vs plan of 9,987 (208 below plan)

32. A&E Attendances – Type 3 Attendances

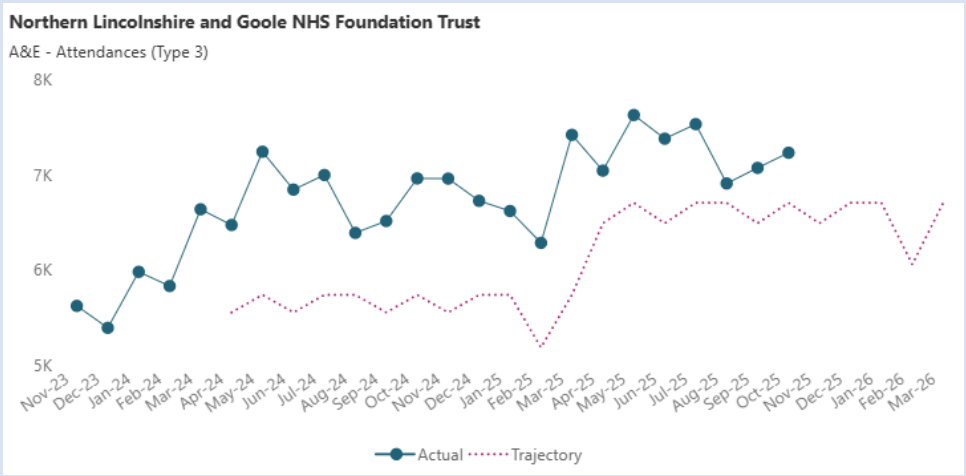
Compliance



Key Themes

- HUTH Type 3 attendances at HRI – 4,361 seen in October vs plan of 4,681 (320 below plan)

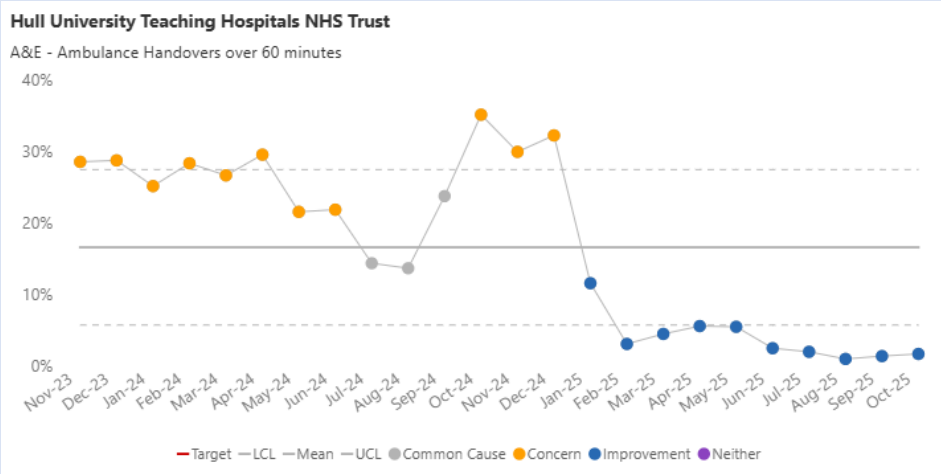
Compliance



- NLaG Type 3 attendances were 7,235 vs plan of 6,709 (526 above plan).

33. Ambulance Handovers >60 minutes - HUTH

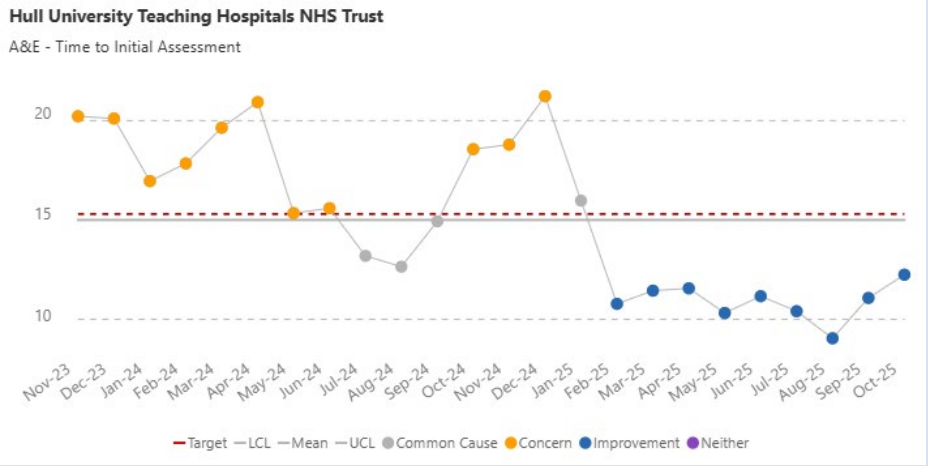
Compliance



Key Themes

- Significant sustained improvement on ambulance handover since the joint work with YAS in December 2024
- Average ambulance handover time in October was 24 minutes
- Total ambulance conveyances in October were 4,085
- Time to initial assessment 12 minutes

Critical Enabler

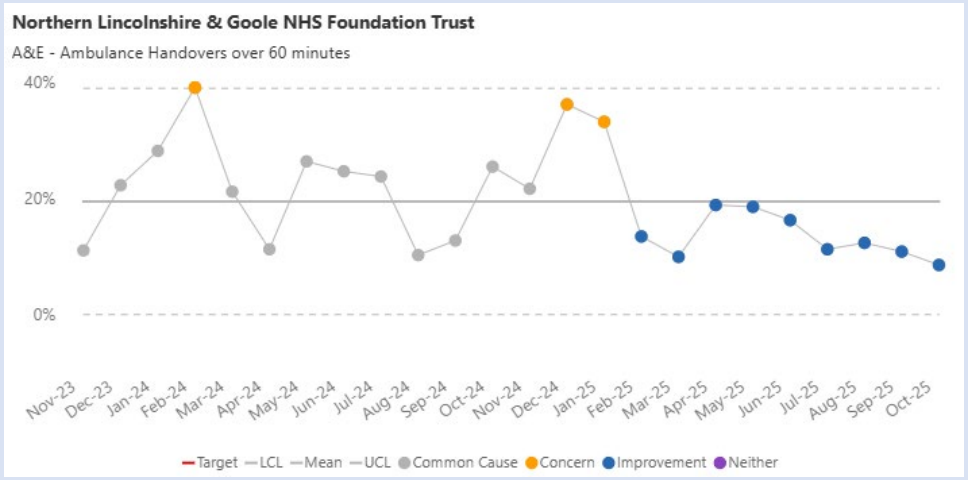


Actions

- Continue to review and monitor metrics to ensure improvement is sustained.
- Daily 2 hourly board round in ED to ensure all patients have a plan.
- Agree new pathways with YAS and EMAS for alternatives to ED. These pathways will be strengthened at HUTH when frailty and capacity is increased.
- Continued audit of category 4 conveyances and alternate pathways, working with Place partners.

34. Ambulance Handovers >60 minutes - NLAG

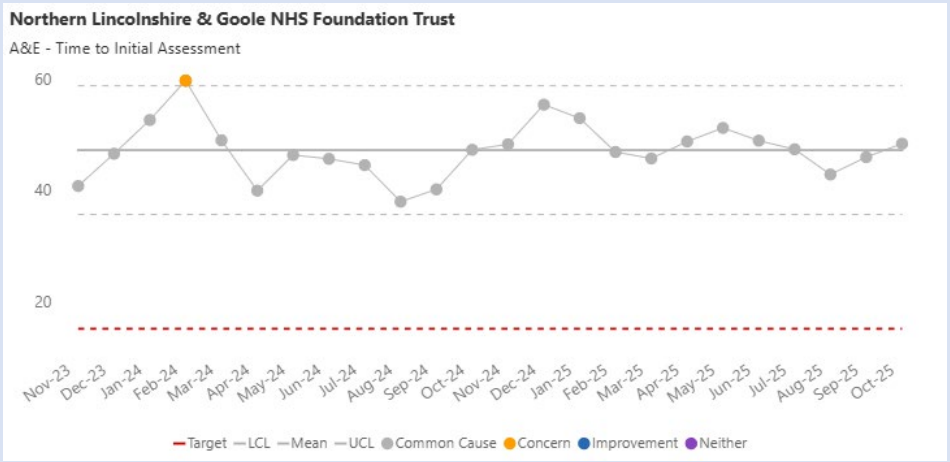
Compliance



Key Themes

- Performance in percentage of ambulance handovers >60 minutes has continued to improve. October 2025 = 8.5%
- Time to initial assessment was 48 minutes against target of 15 minutes
- Average ambulance handover time in October was 26 minutes
- Total ambulance conveyances were 3,640.

Critical Enabler



Actions

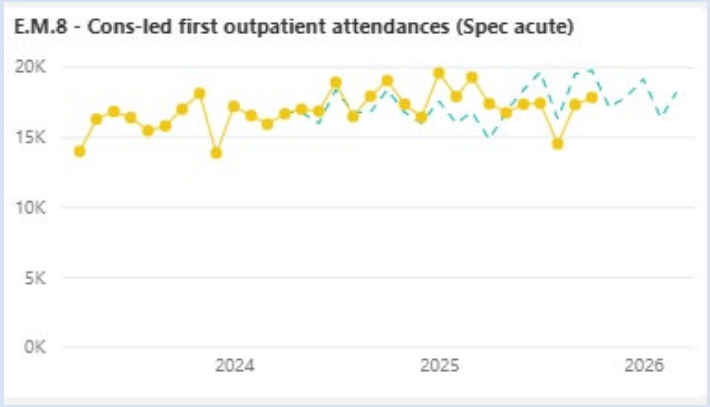
- Relaunched handover processes with ED and EMAS team which is working well.
- Daily 2 hourly monitoring and escalation are in place to maintain ambulance performance.
- Discuss and agree new pathways with EMAS sharing lessons learnt from work undertaken with YAS.

35. Activity

HUTH (Month 7)

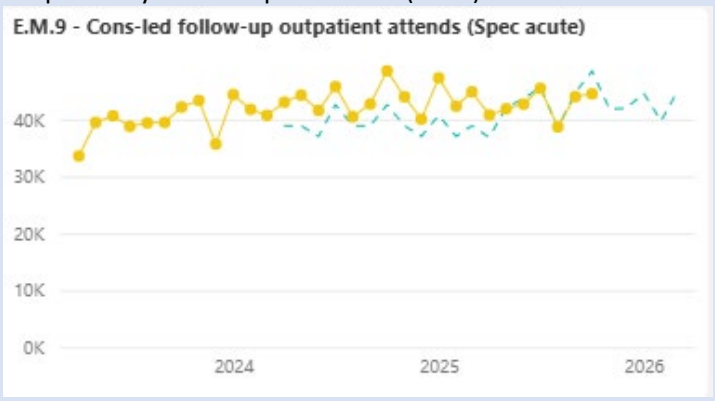
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -6,717 (-5.4%).



Follow up Outpatient Attendances vs Plan

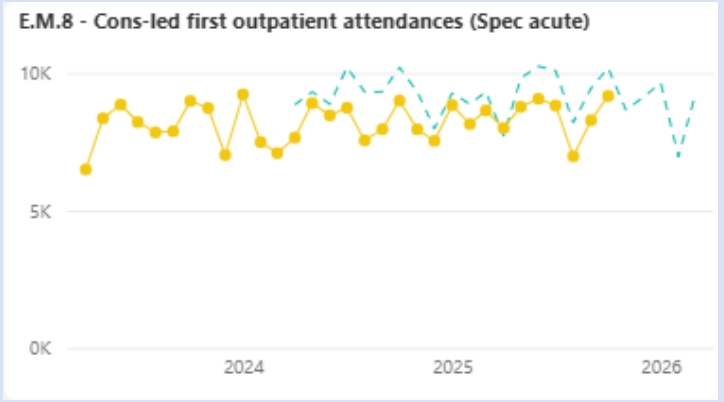
YTD Follow up activity is below plan -1.931 (0.6%).



NLAG (Month 7)

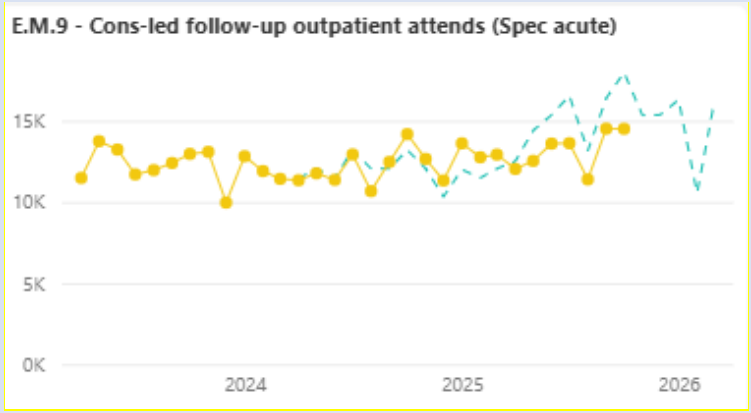
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -6,621 (-10.1%).



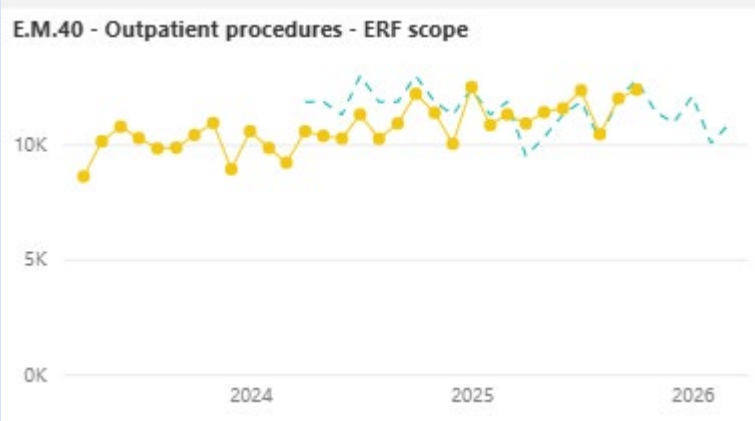
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is below plan -14,144 (-13.3%).



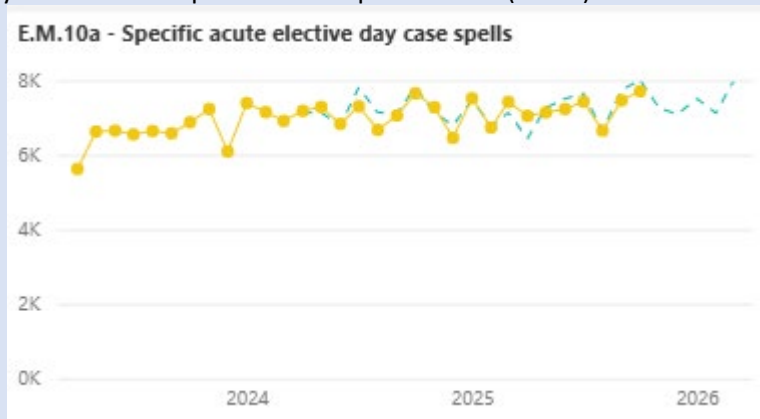
Outpatient Procedures vs Plan

YTD Outpatient procedure is above plan by 3,067 (3.9%).



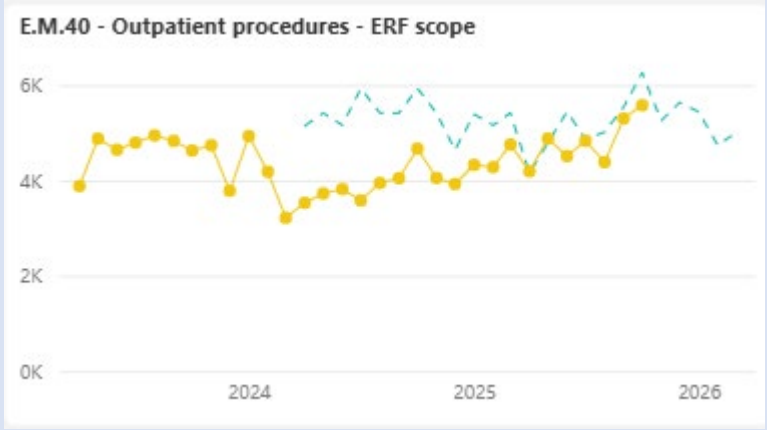
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -589 (-1.1%).



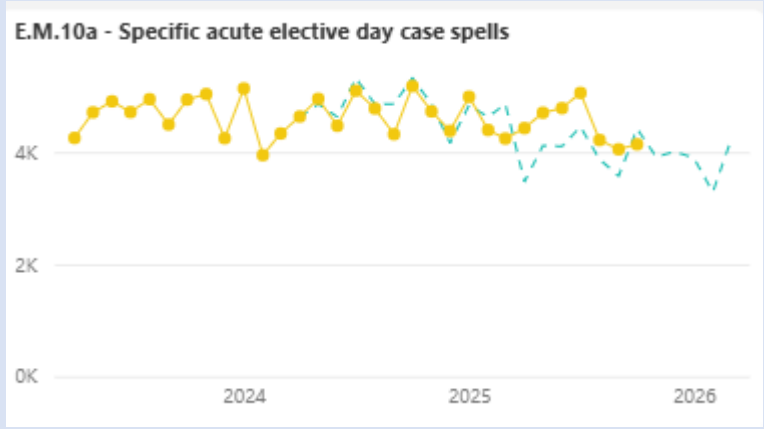
Outpatient Procedures vs Plan

YTD Outpatient procedure is below plan by 2,386 (-6.6%).



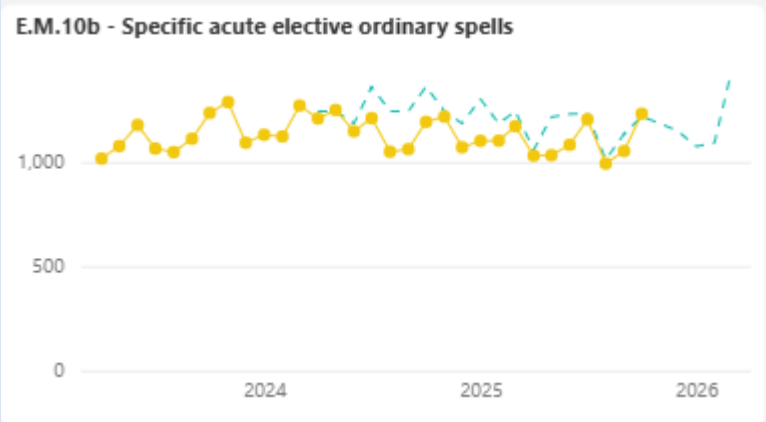
Day Case Admissions vs Plan

YTD Day case elective spells is above plan 3,375 (12.1%).



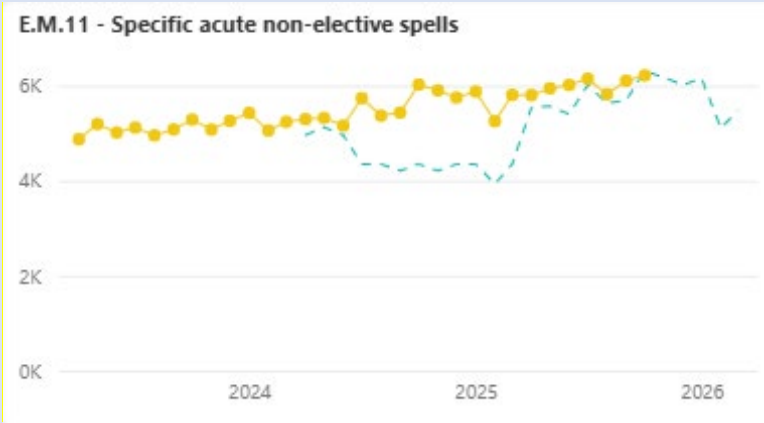
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -474 (-5.9%).



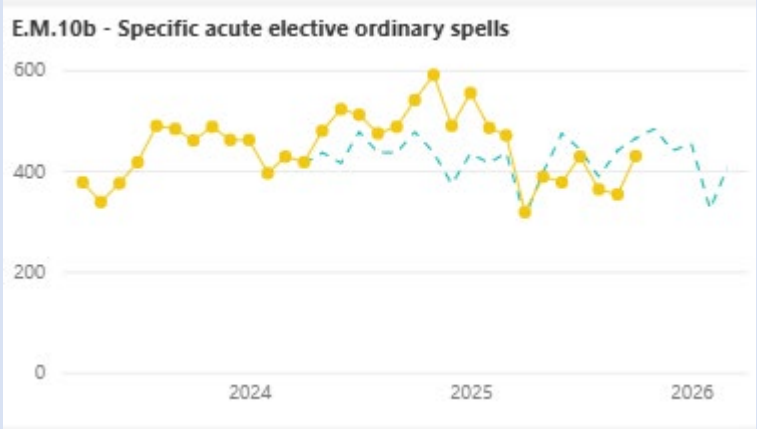
Non-Elective Admissions vs Plan

YTD non-elective spells +1,903 (4.7%) over plan.



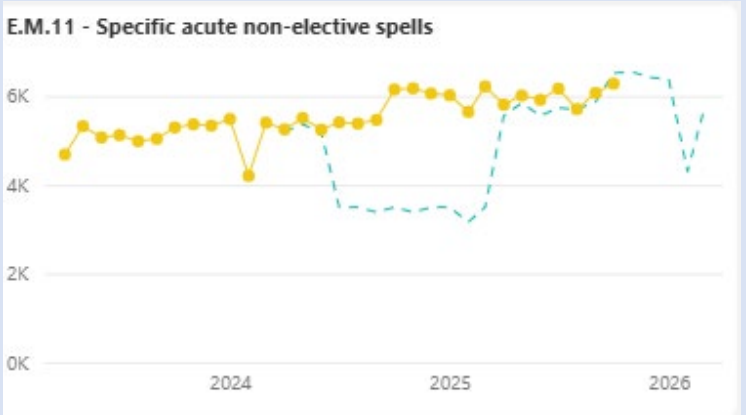
Elective Admissions vs Plan

YTD Inpatient spells is below plan -257 (-8.8%), however data is subject to further evaluation of correct operational recording of intended management (Daycase versus zero LOS inpatient). A recent audit has evidenced this to be a recording issue.



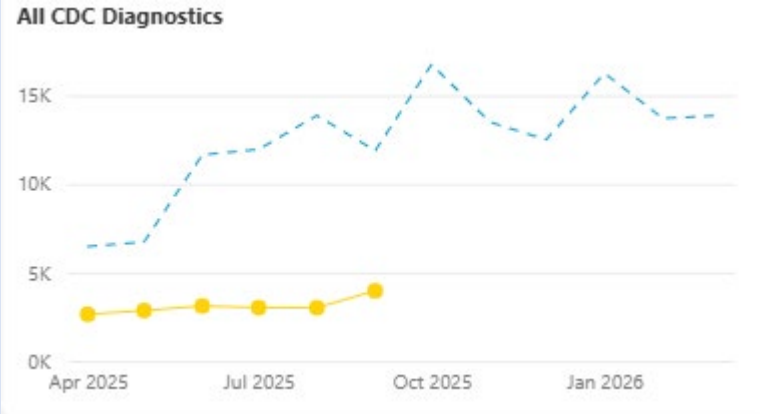
Non-Elective Admissions vs Plan

Non-elective spells above plan YTD +1,175 (2.9%).



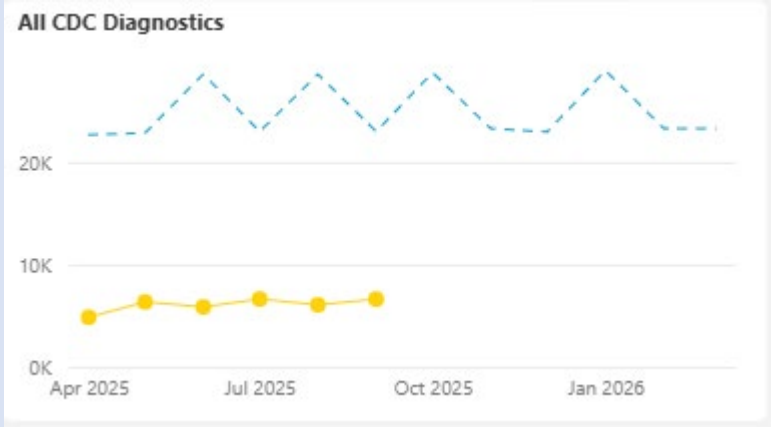
All CDC Diagnostics

YTD (September 2025) -54,422 against plan



All CDC Diagnostics

YTD (September 2025) -80,996 against plan



36. Financial Activity Summary - HUTH

HUTH 2025/26 Elective Recovery Activity M7

	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
Daycase	52,070	50,029	-2,041	£40,096,563	£37,636,143	-£2,460,420
Elective	11,257	10,458	-799	£44,771,644	£40,107,575	-£4,664,069
Outpatient New Attendance	118,194	114,706	-3,488	£23,858,773	£22,887,881	-£970,892
Outpatient New Procedure	21,691	23,136	1,445	£4,079,801	£4,368,726	£288,925
Outpatient Follow Up Procedure	67,889	70,229	2,340	£7,407,054	£7,396,526	-£10,528
	271,100	268,558	-2,542	£120,213,835	£112,396,851	-£7,816,984

Data includes 962 uncoded October spells priced at Average Tariff by Specialty

37. Financial Activity Summary - NLAG

NLAG 2025/26 Elective Recovery Activity M7

	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
Daycase	27,868	31,444	3,576	£ 19,510,018	£ 21,426,462	£ 1,916,444
Elective	3,508	3,058	-450	£ 13,637,712	£ 12,398,314	-£ 1,239,397
Outpatient New Attendance	45,696	44,725	-971	£ 9,516,588	£ 9,242,371	-£ 274,217
Outpatient New Procedure	14,851	12,824	-2,027	£ 3,038,858	£ 2,508,267	-£ 530,591
Outpatient Follow Up Procedure	24,069	26,544	2,475	£ 3,209,622	£ 4,847,561	£ 1,637,939
	115,992	118,595	2,603	48,912,798	50,422,975	1,510,177

Data includes 2958 uncoded October spells priced at Average Tariff by Specialty

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)246

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 December 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2026 and December 2026.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2026 - V15

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

	Quarter 4 (25/26)			Quarter 1 (26/27)			Quarter 2 (26/27)			Quarter 3 (26/27)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		12.02.26 **Boardroom, DPOW**		09.04.26 **Boardroom, DPOW**		11.06.26 **Boardroom, HRI**		13.08.26 **Boardroom, DPOW**		08.10.26 **Boardroom, HRI**		10.12.26 **Boardroom, DPOW**
Board Development (Thursdays - 9.00 am - 5.00 pm)			12.03.26 **Boardroom, DPOW**		14.05.26 **Boardroom, HRI**		09.07.26 **Boardroom, DPOW**		10.09.26 **Boardroom, HRI**		12.11.26 **Boardroom, DPOW**	
HUTH Annual General Meeting & NLaG Council Of Governors Annual Members Meeting (Virtual Meeting)										14.10.26 (2.30 pm - 5.00 pm)		
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	06.01.26 **Virtual Meeting**	03.02.26 **Boardroom, DPOW**	03.03.26 **Boardroom, HRI**		05.05.26 **Boardroom, CHH**	02.06.26 **Boardroom, DPOW**	07.07.26 **Boardroom, HRI**	04.08.26 **Nightingale, SGH**	01.09.26 **Boardroom, CHH**	29.09.26 **(please note falls in September)** **Boardroom, DPOW**	03.11.26 **Nightingale, SGH**	01.12.26 **Boardroom, HRI**
Strategic Programmes & Partnerships (Thursdays - 9.00 am - 12.00 pm with exceptions as stated)			19.03.26 **Boardroom, CHH**			30.06.26 **(virtual meeting)**			17.09.26 **Boardroom, DPOW**			15.12.26 (Tuesday - 1.30 pm - 4.30 pm) **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		26.02.26 **Boardroom, HRI**	26.03.26 **Nightingale, SGH**	30.04.26 **Boardroom, HRI**	28.05.26 **Boardroom, DPOW**	25.06.26 **Boardroom, HRI**	23.07.26 **Nightingale, SGH**		24.09.26 **Boardroom, HRI**	29.10.26 **Boardroom, DPOW**	26.11.26 **Nightingale, SGH**	17.12.26 **TBC, Goole**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		04.02.26			26.05.26			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26 **Virtual Meeting**	25.02.26 **Boardroom, DPOW**	25.03.26 **Boardroom, HRI**	29.04.26 **Boardroom, CHH**	27.05.26 **Nightingale, SGH**	24.06.26 **Boardroom, DPOW**	22.07.26 **Boardroom, CHH**	26.08.26 **Boardroom, HRI**	23.09.26 **Nightingale, SGH**	28.10.26 **Boardroom, CHH**	25.11.26 **Boardroom, HRI**	16.12.26 **Boardroom, DPOW**
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26 **Virtual Meeting**			23.04.26 (subject to NHSE Submission Deadline) **Boardroom, DPOW**		18.06.26 HUTH & NLaG **Annual Accounts** 1.30 pm - 4.30 pm **Nightingale, SGH**	30.07.26 **Boardroom, DPOW**				11.11.26 (Wednesday) **Boardroom, HRI**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26 **Boardroom, DPOW**			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			20.11.26	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays - 2.00 pm - 5.00 pm)	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	05.05.26 12.05.26 19.05.26 26.05.26	02.06.26 09.06.26 16.06.26 23.06.26 30.06.26	07.07.26 14.07.26 21.07.26 28.07.26	04.08.26 11.08.26 18.08.26 25.08.26	01.09.26 08.09.26 15.09.26 22.09.26 29.09.26	06.10.26 13.10.26 20.10.26 27.10.26	03.11.26 10.11.26 17.11.26 24.11.26	01.12.26 08.12.26 15.12.26 22.12.26
Financial Planning & Improvement Board (Mondays - 2.00 pm - 4.00 pm)	12.01.26 26.01.26	09.02.26 23.02.26	09.03.26 23.03.26	13.04.26 27.04.26	11.05.26	08.06.26 22.06.26	13.07.26 27.07.26	10.08.26 24.08.26	14.09.26 28.09.26	12.10.26 26.10.26	09.11.26 23.11.26	14.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	25.02.26 (2.30 pm - 5.00 pm) **(ARM - NED & Governor only Meeting)**		15.04.26			16.07.26	20.08.26 **(NED only Meeting - 4.00 pm - 5.30 pm)**			04.11.26	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			03.03.26			02.06.26			22.09.26		24.11.26	
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		19.02.26			28.05.26				24.09.26			
NED & CEO Meetings												
NED & CEO Meetings (Wednesdays - 10.30 am - 12.30 pm - exceptions ast stated)	14.01.26 (2.00 pm - 4.00 pm)	18.02.26	18.03.26	22.04.26 (10.00 am - 12.00 pm)	20.05.26	17.06.26	15.07.26	19.08.26	16.09.26	14.10.26 (10.00 am - 12.00 pm)	18.11.26	08.12.26 (2.00 pm - 4.00 pm)
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	19.01.26	16.02.26	16.03.26	20.04.26	18.05.26	15.06.26	20.07.26	17.08.26	14.09.26	19.10.26	16.11.26	14.12.26
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	08.01.26		05.03.26		07.05.26		02.07.26		03.09.26		05.11.26	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	20.01.26	17.02.26	17.03.26	21.04.26	19.05.26	16.06.26	21.07.26	18.08.26	15.09.26	20.10.26	17.11.26	15.12.26
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	14.01.26		18.03.26		20.05.26		15.07.26		16.09.26		18.11.26	

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Trust Boards-in-Common Front Sheet
Board Assurance Framework

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

BIC(25)247

Meeting name	Boards-in-Common
Meeting date	11 December 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q3 current risks and scores: 1. People – 20 (8 points from its tolerable score) 2. Performance, Patients and Access – 20 (4 Points from the tolerable score, see Appendix 1 for a review of tolerable score) 3. Patients, Safety – 20 (11 points from the tolerable score) 4. Pioneer – 12 (matching tolerable score) 5. Partnerships – 12 (matching tolerable score) 6. Public Purse – 16 (4 points from the tolerable score) 7. Population – TBC On 3 November 2025, the Group Executive Risk and Assurance Committee discussed the Patient Access risk and specifically the risk appetite giving rise to the small distance between the current score and maximum tolerable score (being 4 points). This was further discussed at PEF CiC on 2 December 2025.

The risk appetite assigned to this area is 'Open' in nature meaning acceptance of a high degree of risk with regard to meeting this objective. Colleagues agreed that not meeting Patient Access had a detrimental safety risk for patients and therefore the application of the 'Clinical Quality and Safety' risk appetite was more applicable, whilst accepting that the actions required were (partially) Transformational in nature. Appendix 1 provides a further explanation of the change. Appendix 2 details all risk appetite statements previously agreed by the Boards.

A narrative for the Population risk has been developed and its controls, assurances and actions will be developed through the same process:

We aim to help those with the greatest needs and help everyone to live well. However, if we fail to work with partners to tackle inequity in care delivery, listen to the patient's voice and choice, and embed new models of care, we will not address growing demand and improve the life chances of those living in the most deprived communities.

The Boards are invited to consider the risk score factors.

Executive Summary continued	For all Group risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders. Each CiC receives a quarterly update on the BAF for review and approval, this round will inform the October CiCs and bring all reviews up to date. The number of controls and assurances without an indication of their strength continues to reduce with each review. There are actions underway addressing all the listed BAF risks. The Boards are invited to consider the risk score factors. **Recommendations:** The Boards-in-Common are asked to: • Note and review the BAF risks in light of the findings of the valuecircle work, and that the next round of executive discussions will reflect on these in detail • Receive and approve the change to the risk appetite from Open to Cautious for Patients - Access • Note that the risks have been aligned to the Strategic Objectives (6 Ps)	**Background information and/or Supporting Document(s) (if applicable)**	All BAF risks are updated following discussion between the Executive Team and the Group Director of Assurance.
		Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.
		Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns
		Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group
		Recommended action(s) required	☑ Approval ☑ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other

Board Assurance Framework

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Purpose of the report

The purpose of the report is to update the Committee regarding the Group's strategic culture and leadership risk. The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

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

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

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

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information) with a circle indicated for each of the risk scores; current, tolerable and target.

#2

- The controls and assurances and their respective gaps

#3

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

Summary

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The following table summarises the 6 strategic risks facing the Group and the key aspects including their current score with current mitigations towards the target score. There are 4 risks scoring 15 or over. The risks coloured red indicate those risks scoring above the maximum score set by the appetite score.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk	Last reviewed
1	People	WEC	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.	Simon Nearney, Group Chief People Officer	20		23/09/2025	Balanced	12	8	23/09/2025
2	Patients - Access	PEF	We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.	Matt Powls, Interim Group Chief Delivery Officer	20	0	24/01/2025	Open	16	4	02/12/2025
3	Patients - Safety	QS	We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.	Kate Wood, Group Chief Medical Officer, Matt Powls, Interim Group Chief Delivery Officer	20		12/09/2025	Cautious	9	4	02/12/2025
4	Pioneers	QS	We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Kate Wood, Group Chief Medical Officer	12		05/09/2025	Open	12	4	02/12/2025
5	Partnerships	SPP	We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.	Lyn Simpson, Interim Group Chief Executive Officer, Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	12		28/04/2025	Balanced	12	4	09/10/2025
8	Public Purse	PEF	We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.	Emma Sayner, Group Chief Financial Officer	16	-4	04/02/2025	Open	12	9	02/12/2025

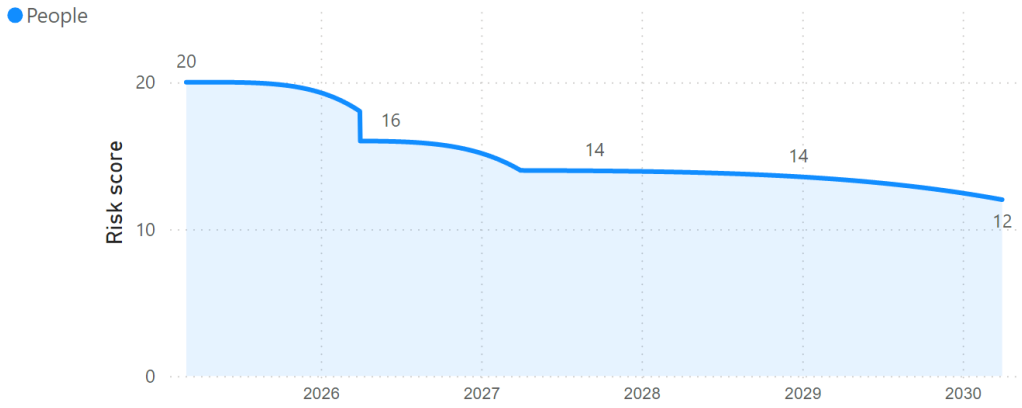
1. People

The strategic risk affecting our objective, 'People' is led by Simon Nearney, Group Chief People Officer and reported to the Workforce, Education and Culture Committees-in-Common. Under the risk category of People, the risk's current score is 20 and its score last changed on 23/09/2025. The actions were last reviewed on 23 September 2025. In full, the risk is:

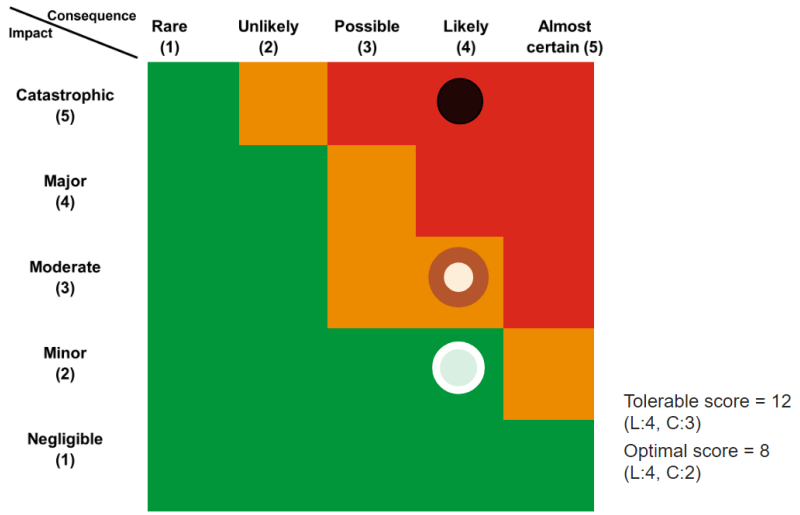
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Balanced)

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

1. People

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Annual Care Group Workforce plans	Limited
Care Group Performance and Accountability	Limited
CESR Programme	Significant
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Group Leadership Strategy (in development)	Limited
Group People Strategy 2025-28	Reasonable
Group Senior Management Team (was EMC)	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Limited
Talent management team for international recruitment	Limited
Workforce Transformation Committee	Reasonable
XXX - Resident Doctor 10 Point Plan Oversight Delivery Group	
XXX - Stability of Senior Leadership Team	Limited
XXX - Vacancy Control Panel	Reasonable

Gaps in control (and Action ID)	6	7	8	38	Total
Hard to recruit roles in medical specialities	1	1			2
Management and Leadership consistency in delivering the People Promise to staff			1	1	2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1		3
Total	**2**	**2**	**2**	**1**	**7**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable
External	XXX - External Safer Staffing report on application of model	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequent culture and staff experience measures	1	1
Lack of assurance re short term additional hours / overtime from Care Groups	1	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	1	1
Plans to address ageing workforce profile	1	1
Poor levels of mandatory training compliance	1	1
Total	**4**	**5**

1. People

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The table below details the 4 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
6	Recruitment drives using the Group values to attract high calibre candidates - focussed on medical staff and other key areas	31/03/26	01/04/26	Focus currently on medical staff.	23/09/25	Simon Nearney, Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	Care Groups / Corporates implementing actions plans. Some Corporate decisions are likely to have a detrimental impact on future engagement scores (e.g. car parking space / charges, food availability and prices)	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable
8	Group Leadership network and training programme - November 2024	30/12/25	01/04/27	New leadership programme for the Group launched (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable
38	Group Well-being platform live and being maintained	28/02/25	01/04/26	Went live with platform - now responding to requests from staff accessing the offer	23/09/25	Simon Nearney, Group Chief People Officer	Significant

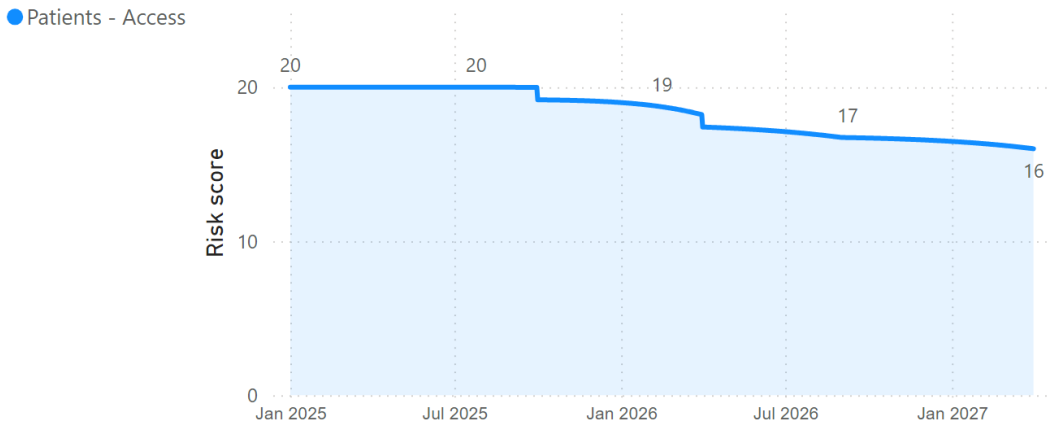
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Matt Powls, Interim Group Chief Delivery Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Patients - Access, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

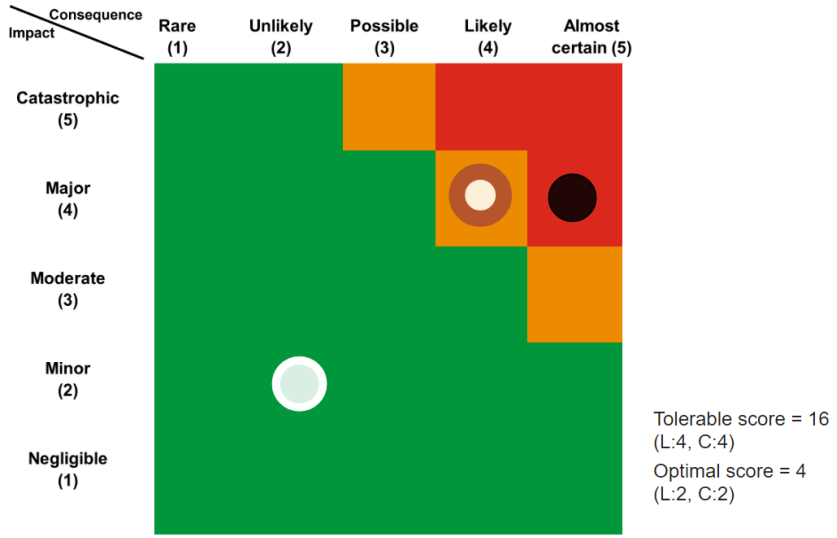
We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

2. Patients - Access

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Care Group Performance and Accountability	Limited
Financial Planning Improvement Board	Limited
Flow programme	Limited
National performance framework for support and scrutiny	Limited
Operating plan 2025-26	Limited
Planned Care Board	Reasonable
Tier 1 review processes - UEC and Cancer	Significant
Unplanned Care Board	Limited

Gaps in control (and Action ID)	21	31	37	41	53	Total
Challenge in resolving numerous national expectations / targets with available finance, degrading or overriding control			1			1
Data quality issues in supporting metrics		1				1
Lack of positive medical engagment in delivery	1					1
Lack of strong capabilities to identify and implement service improvement gains from exemplar sites or best practice	1					1
Lack of timely / realtime performance reporting (eg weekly dashboard)				1		1
Lack of trajectory setting to support robust performance management					1	1
Uncertainty over ICB role and function	1					1
Weak culture of improvement/change management and siloed working		1	1			2
Total	**3**	**1**	**1**	**2**	**1**	**1**	**9**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	
External	Acute Provider collaboration reports	
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Limited
External	ICU Network review	
Internal	Integrated Performance Report	Reasonable
External	NHS tiering arrangements and support or freedoms	
Internal	Planned Care Board reporting to Performance, Estates & Finance CiC	
Internal	Unplanned Care Board reporting to Performance, Estates & Finance CiC	

Assurance gaps (and Action ID)	20	31	42	53	Total
Absence of a comprehensive demand and capacity (bed) model that supports scenario analysis and planning	1			1	2
Absence of routine data quality monitoring and patient record validation		1	1		2
Inadequate coverage of performance metrics	1				1
Total	**1**	**1**	**1**	**1**	**1**	**5**

2. Patients - Access

NHS Humber Health Partnership

The table below details the 7 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
20	Strategic Bed Review (based on optimum LoS)	31/12/24	01/09/26	PA Consulting undertook a bed utilisation review (ahead of developing in-house modelling capacity). Work to be recalibrated in light of Improvement Plan Stabilise phase, demand and capacity at specialty level and Teletracking system implementation.	02/12/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Adam Creeggan, Group Director of Performance, Matt Powls, Interim Group Chief Delivery Officer	Limited
21	Embed QI Methodology	30/09/25	01/04/27			Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Heather McNair, Group Chief Nursing Officer	
31	Standing up revised organisational data quality governance		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
37	Developing skills and capability of Care Group leadership to tackle day-to-day challenges and lead on effective transformation programmes, intra-Care Group and cross-sites	31/03/26	01/04/26	Appointed Site Director of Operations and Transformation - due to start July-25	17/06/25	Simon Nearney, Group Chief People Officer, Matt Powls, Interim Group Chief Delivery Officer	Limited
41	Delivery of BI investment		01/04/26		18/02/25	Adam Creeggan, Group Director of Performance	
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised	30/09/25	01/10/25	Internal exercise underway at present with plan to engage AI later	01/05/25	Adam Creeggan, Group Director of Performance	
53	Develop and embed Care Group integrated plans aligning expendture, activity and workforce	31/05/25	31/03/26	Set clear and individual objectives across four domains of finance, activity and workforce	01/05/25	Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	Significant

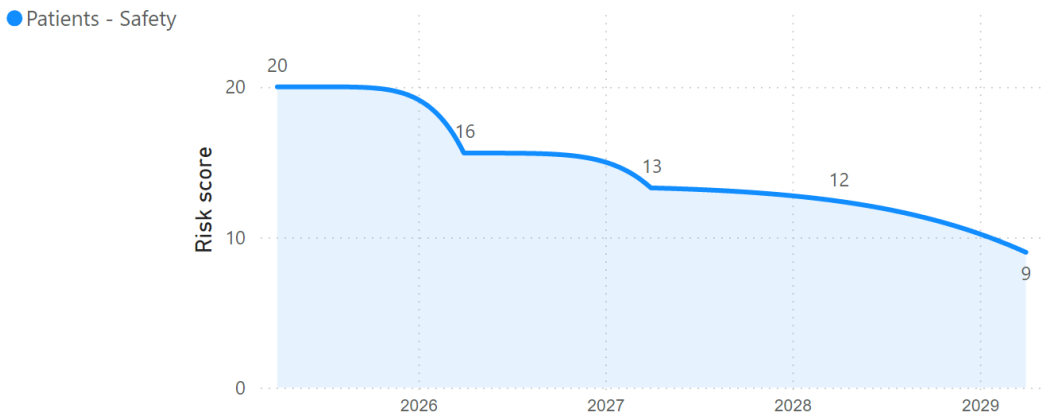
3. Patients - Safety

The strategic risk affecting our objective, 'Patients - Safety' is led by Kate Wood, Group Chief Medical Officer; Matt Powls, Interim Group Chief Delivery Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Patients - Safety, the risk's current score is 20 and its score last changed on 12/09/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

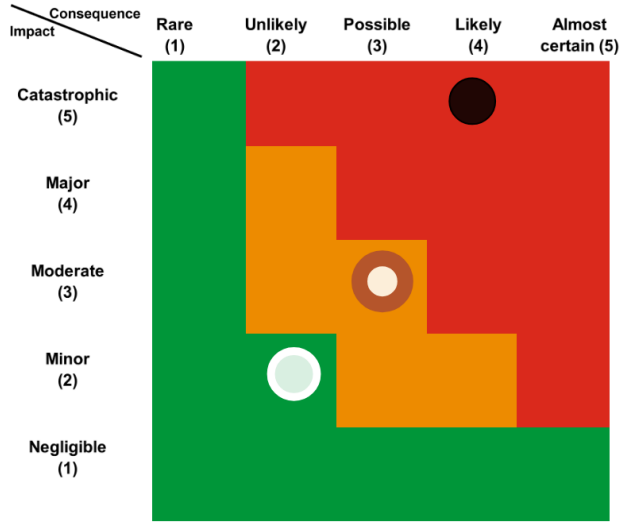
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Cautious). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Accreditation Frameworks	Limited
Care Group Performance and Accountability	Limited
Continuous Professional Development for all health professionals and mapped to Quality Priorities	
Freedom to Speak Up Guardian	Reasonable
Incident Reporting culture	Limited
Infection Control Committee	
Martha's Rule Compliance	Limited
Maternity and Neonatal Assurance Group	Reasonable
Mortality Improvement Group	Reasonable
National Best Practice for Audits	Reasonable
National NICE Guidance	Reasonable
Patient Experience and Learning	
Patient Safety and Learning Group	
Patient Safety Partners involvement	
Peer Review Process	
Quality and Safety Strategy	
Risk and Compliance Group	Limited
Safe Staffing Models	Reasonable
Statutory and Mandatory Training	Limited
Strategic Safeguarding Board	

Gaps in control (and Action ID)	12	13	14	15	52	54	Total
Comprehensive safety culture	1	1		1		1	**4**
Data quality issues in supporting metrics	1						**1**
Embedded awareness of requirement to fulfill EQIA process			1				**1**
Fully safe staffing levels (North)		1					**1**
Inconsistent evidence of embedded improved processes	1						**1**
Lack of consistent basic hygiene compliance				1			**1**
Lack of involvement in national quality audits					1		**1**
Lack of positive medical engagment in delivery						1	**1**
Martha's Rule compliance						1	**1**
Strong speak up and reporting culture				1			**1**
Total	**1**	**2**	**2**	**1**	**3**	**1**	**3**	**13**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Clinical audit outcomes	Reasonable
Internal	Complaint levels	Limited
Internal	CQC Action Plan	
External	External agency visit and inspection reports	Limited
Internal	Friends and Family Test reporting	Reasonable
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Limited
Internal	Incident reporting	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Maternity Neonatal Dashboard	
External	National Patient Survey	
Internal	Ouputs from QI Programme	Limited
Internal	Risk Management metrics	
Internal	Statutory and mandatory compliance levels	Limited
Internal	Ward accreditation metrics	

Assurance gaps (and Action ID)	12	13	15	Total
Absence of routine data quality monitoring and patient record validation	1			**1**
Manual triangulation of KPIs across Care Groups, Corporate and locations	1			**1**
Poor regulatory status		1	1	**2**
PSIRF Processes not fully embedded		1	1	**2**
Total	**2**	**2**	**1**	**1**	**6**

3. Patients - Safety

NHS Humber Health Partnership

The table below details the 8 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
12	Develop and publish Quality and Safety Strategy	01/06/25	31/03/26	Draft presented to 29 May Q&S with further draft planned for Sep copy following comments from CiC members	12/09/25	Heather McNair, Group Chief Nursing Officer	Reasonable
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25	31/03/29	1st Draft to NMB end of Jan	04/02/25	Heather McNair, Group Chief Nursing Officer	
14	Embed EQIA process (outlined in six-month finance report for 2024-25)	01/05/25	31/03/26	EQIA team well established within PMO. Completed full EQIA process as part of Winter Plan submission. Need to continually raise awareness among staff more broadly through FPIB.	12/09/25	Kate Wood, Group Chief Medical Officer, Heather McNair, Group Chief Nursing Officer	Limited
15	Develop and embed the Ward Accreditation programme	31/03/25	01/04/29	Action complete. 250 people to trained to date. SOPs agreed. Peer reviews set for next six months. Next iteration of reporting based on new programme.	04/02/25	Heather McNair, Group Chief Nursing Officer	Significant
52	Developing and implementing a robust clinical audit programme	31/03/26	31/03/27	Programme developed, now in process of implementation	12/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
54	Implementing programme of Martha's Rule actions (for pilot phase)	31/03/26	01/04/27	Piloting six wards, using feedback to inform rollout for organisation. Phase 2 in operation (to Mar 26). Patient Well Being questionnaire already implemented across the group - reporting to Q&S - except for staff gaps to enable paediatric second opinion	12/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
55	***** QS ***** Patient decision-making						
67	Implementation of Staffing business cases for maternity services	31/12/27	31/12/27		02/12/25	Heather McNair, Group Chief Nursing Officer	Reasonable

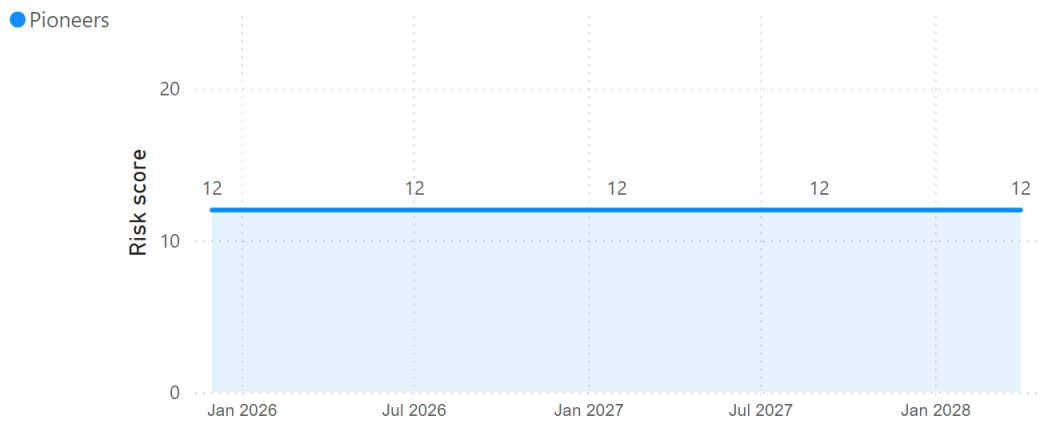
4. Pioneers

The strategic risk affecting our objective, 'Pioneers' is led by Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer; Kate Wood, Group Chief Medical Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Pioneers, the risk's current score is 12 and its score last changed on 05/09/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

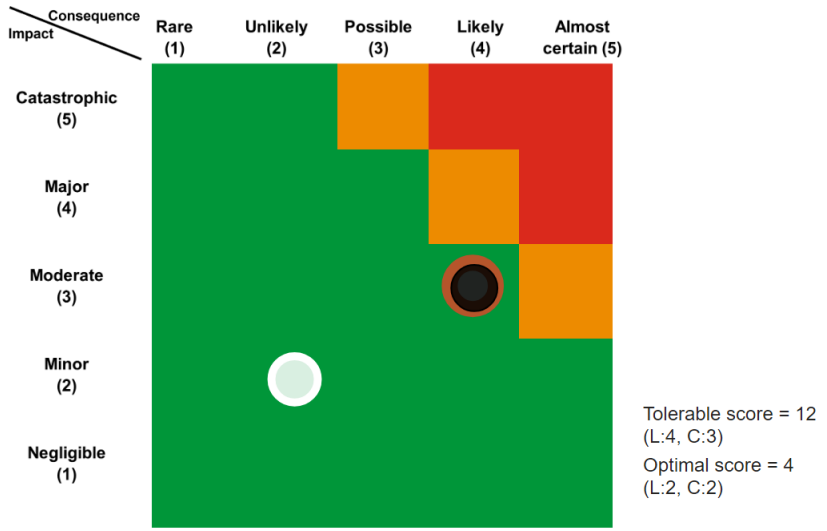
We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

4. Pioneers

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Available research service capacity eg labs	Limited
Business cases for investment / disinvestment decisions	Limited
Digital governance group	Reasonable
Digital Strategy	Significant
EPR Programme Board	Reasonable
Financial clarity over existing research resources	Reasonable
Financial management education for directors and budget holders	Reasonable
Financial Strategy	Limited
Full EPR Business Case	Limited
ICB / CAP Digital Governance	Limited
Innovation infrastructure	Limited
Long term Financial Model	Limited
Outline EPR Business case	Significant
Protected time	Limited
Research and innovation strategy	Significant
Research Committee	Reasonable
Senior digital leadership team	Reasonable
Senior research team	Reasonable

Gaps in control (and Action ID)	56	57	64	65	66	Total
Insufficient capacity within research team for expansion	1					1
Lack of comprehensive digital asset register				1		1
Lack of comprehensive oversight of all digital investment and management			1	1		2
Lack of innovation infrastructure		1				1
Out of date Long Term Financial Model inc investments					1	1
Research resources being part of CIP	1					1
Weak commercial and contractual grip and control	1					1
Weak culture of improvement/change management and siloed working		1	1	1	1	4
Total	**2**	**2**	**2**	**2**	**2**	**12**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
External	DSPT IA led	Limited
External	External agency visit and inspection reports	Limited
External	External support to the EPR programme	Reasonable
External	North Yorkshire and Humber Research Delivery Network reports	Reasonable
External	Numerous research publications	Reasonable
Internal	Self-assessment of CAF	Reasonable

Assurance gaps (and Action ID)	56	57	Total
Gaps in financial tracking and funding	1		1
Lack of available protected time for research		1	1
Lack of skilled resources to develop innovation		1	1	2
Poor framework to assess digital procurement performance and security	1		1
Weak understanding and resources from ICB and broader external relationships	1		1
Total	**3**	**2**	**1**	**6**

4. Pioneers

NHS Humber Health Partnership

The table below details the 5 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
56	Launch and continuous support via Comms to Partnership over R&I strategy	31/03/26	31/03/28	Post Board approval, discussing with Comms launch support	05/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
57	Pilot Innovation Hub (12 month period)	31/05/26	31/05/26	Project manager appointed (and a lead professor), started Nov 2025	02/12/25	Kate Wood, Group Chief Medical Officer	Reasonable
64	Digital Foundations Business case	30/11/25	30/09/26	financial profile piece - no template readily available for 5 year investment	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Limited
65	Centralisation of digital resource, governance and oversight, including a single group-wide asset register	31/03/26	31/03/27	Paper to Execs (Sep)	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Limited
66	EPR Full Business case production	28/02/26	31/03/28	Progressing well	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Reasonable

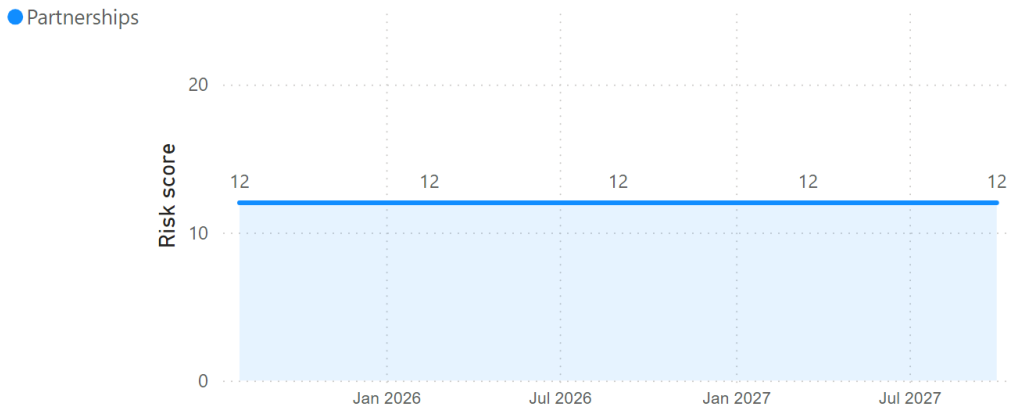
5. Partnerships

The strategic risk affecting our objective, 'Partners' is led by Lyn Simpson, Interim Group Chief Executive Officer; Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer and reported to the Strategic Programmes and Partnerships Committees-in-Common. Under the risk category of Partnerships, the risk's current score is 12 and its score last changed on 28/04/2025. The actions were last reviewed on 09 October 2025. In full, the risk is:

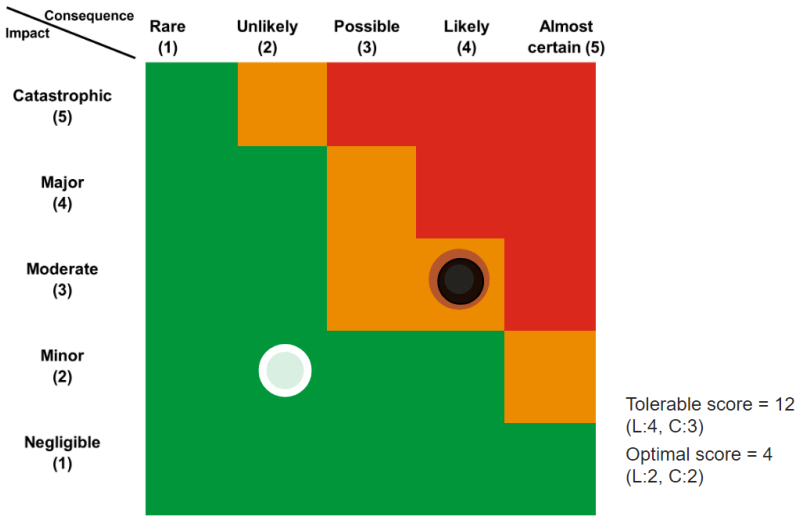
We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Balanced). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



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

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

Risk appetite statement (Balanced)

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

5. Partnerships

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Goole service review	Reasonable
Health and Overview Scrutiny Committees	Reasonable
Humber and North Yorkshire Collaboration of Acute Providers	Limited
Integrated Care Board	Limited
Place Boards	Limited

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	1	1
Lack of continuous leadership plus inconsistent engagement across region	1	1
Lack of ICB partnership strategy and identification of common opportunities and priorities	1	1
Lack of integrated CAP strategy despite workplan (limited progress)	1	1
Low system wide infrastructure to implement Goole plan	1	1
Variable quality of engagement with Place Boards	1	1
Total	**4**	**2**	**6**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
External	Establishment of operational CDC (vs strategic build) and financial delivery through PFIB	Reasonable
External	Positive Task and finish participation from Place Boards	Reasonable

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	1	1
Weak partnership approach embedded in Group strategies	1	1
Total	**2**	**2**

5. Partnerships

NHS Humber Health Partnership

The table below details the 2 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
32	Develop and publish partnership strategy	31/07/25	30/09/27	On course for completion, undergoing futher review to ensure alignment with the Ten Year Plan	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Significant
59	Align partership reporting to governance arrangements internally	30/09/25	31/03/26	Changes to Committees in Common, Capital and Major Projects to become Strategic Partnerships and Programmes - will ensure greater visibility of partnerships working going forward	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, David Sharif, Group Director of Assurance	Reasonable

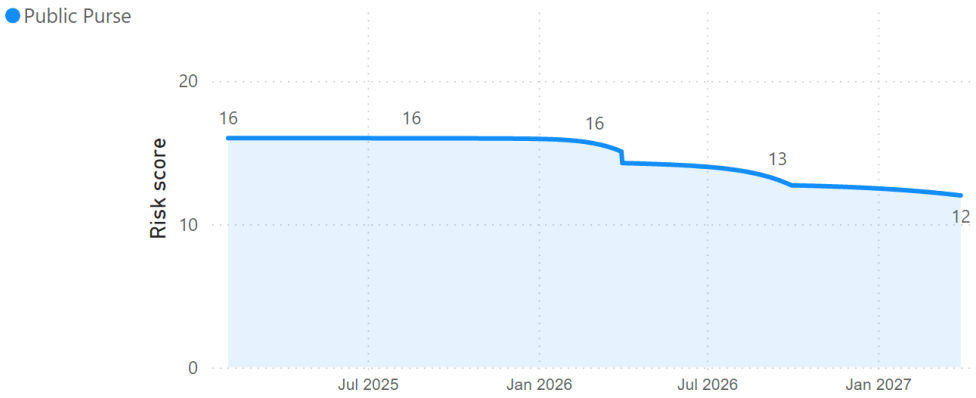
6. Public Purse

The strategic risk affecting our objective, 'Public purse' is led by Emma Sayner, Group Chief Financial Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Public Purse, the risk's current score is 16 and its score last changed on 04/02/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

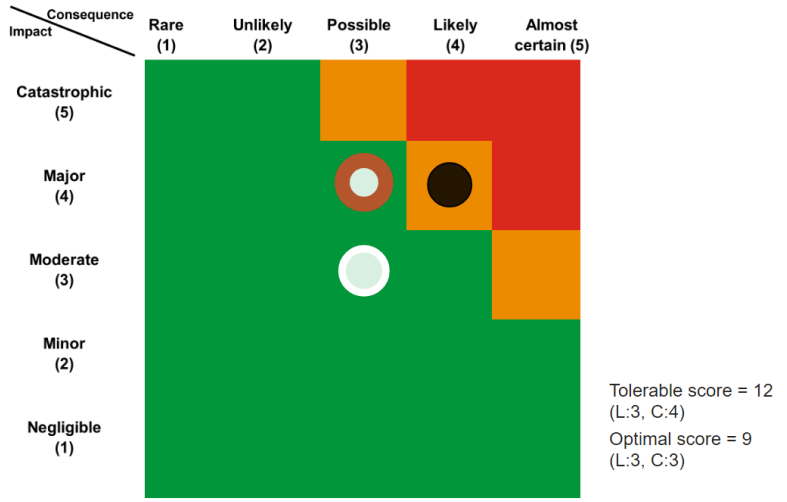
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

The graphic opposite shows the current risk score (the filled black marker), the tolerable score (dark amber circle) and the optimal risk score (the hollow white marker) against the matrix relevant to the risk's appetite (Open). The risk appetite statement is shown below the graphic.

The chart below shows the expected risk score trajectory towards the tolerable score given the actions being taken and detailed later in this report.



Current score and risk appetite



Risk appetite statement (Open)

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

6. Public Purse

The tables opposite detail the high-level Controls in operation (left) and the gaps in control that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Control	Rating
Board capability and education	Reasonable
Budgetary control system	Reasonable
Business cases for investment / disinvestment decisions	Limited
Care Group Performance and Accountability	Limited
Cash management controls	Significant
Cost Improvement Programme	Reasonable
Financial management education for directors and budget holders	Reasonable
Financial Planning Improvement Board	Limited
Financial Strategy	Limited
High functioning Finance department advice and guidance	Reasonable
ICS finance model	Reasonable
Long term Financial Model	Limited

Gaps in control (and Action ID)	22	23	33	35	36	46	49	Total
Absence of comprehensive Estates Strategy / 10-year plan	1							1
Absence of Group Clinical Strategy	1							1
Absence of Group Finance Strategy founded on clinical and estates strategies		1	1					2
Interim officers in place	1							1
Lack of understanding of current financial pressure and need to live within means				1	1			2
Out of date Long Term Financial Model inc investments	1							1
Sustainable PMO / CIP Engine room capability to deliver transformation and financial savings	1							1
Weak culture of improvement/change management and siloed working				1	1	1	1	4
Total	**4**	**1**	**1**	**1**	**2**	**2**	**1**	**1**	**13**

The tables opposite detail the high-level Assurances (left) and the assurance gaps that currently exist (right) together with references to the actions being taken to address those gaps (see over for action details).
The figures in the total column indicate the number of actions addressing that gap. The figures in the total row indicate the number of gaps being addressed by that action.

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	
Internal	Budget control reports	
Internal	Exception reporting on Standing Financial Instructions and Standing Orders compliance	
Internal	FPIB and PMO reporting on transformation and run-rate	
External	Internal audit review of key financial systems	
Internal	In-year operational plan progress	
External	NHSE external assurance reviews	
Internal	Service Line Reporting	
Internal	Vacancy control and Discretionary Spend Panel	
Internal	Workforce planning updates	

Assurance gaps (and Action ID)		Total
SLR not fully developed and embedded	1	1
Total	**1**	**1**

6. Public Purse

NHS Humber Health Partnership

The table below details the 9 actions underway to reduce the current risk score of 16. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
22	Develop a five-year long term financial model	31/10/25	31/03/27	Linked to Finance strategy development. Progress with meeting national model by Sep-25	06/08/25	Emma Sayner, Group Chief Financial Officer	Limited
23	Develop a comprehensive finance strategy	31/10/25	31/03/26	Draft financial strategy to PEF in Jul-25 and final planned for Sep-25	06/08/25	Emma Sayner, Group Chief Financial Officer	Reasonable
33	Business Case Review Group	31/01/25	30/09/26	Started w/c 20/1/25, now fully operational	23/06/25	Emma Sayner, Group Chief Financial Officer	Significant
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation	31/03/26	31/03/26		23/06/25	Matt Powls, Interim Group Chief Delivery Officer	Limited
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need value	31/03/26	30/09/26		23/06/25	Emma Sayner, Group Chief Financial Officer	Reasonable
46	Embedding a transformation plan / product with an external learning focus	31/03/26	01/04/26	to refresh each year	23/04/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	
49	Establish Group PMO approach with specialised transformation programme and resources	30/06/25	31/03/26		22/04/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	
62	Workforce pay and agency control programme	31/03/26	31/03/26	Lack of transformation impact on staffing and difficulties in medical recruitment, in certain specialties, and safer staffing requirements preventing further efficiencies.	23/09/25	Simon Nearney, Group Chief People Officer	Limited
63	Corporate services efficiency programme	31/03/26	31/03/26	Progress becoming more complex and lengthy. People Services reducing to staff (thereby giving leaders less capacity to transform)	23/09/25	Simon Nearney, Group Chief People Officer	Reasonable

Board Assurance Framework
Next steps and recommendations

Next steps

Audit, Risk and Governance Committees-in-Common received a detailed presentation on 24 April 2025 on the status and actions being taken to strengthen the Group's risk management system. This included a proposed format for future risk reporting to the Board (in support of the BAF) and to CiCs. This will include the development of a commentary on the high-scoring Group-wide risks. The advent of the single group-wide risk register will support this development in future reporting.

The management of the high-level risks will continue to be assessed through the Care Groups, corporate Directorates and the Risk and Compliance Group and the escalation processes in place. The Risk and Compliance Group will inform group-wide risks to the Group Risk and Assurance Committee before their adoption by corporate leads.

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

Recommendations

The Committees-in-Common are asked to:

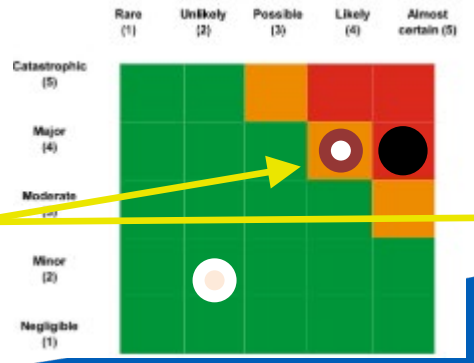
- Note and review the BAF risks
- Note that the risks have been reviewed by the Executive Team
- Approve the change to the risk appetite from Open to Cautious for Access

Appendix 1: Patient – Access

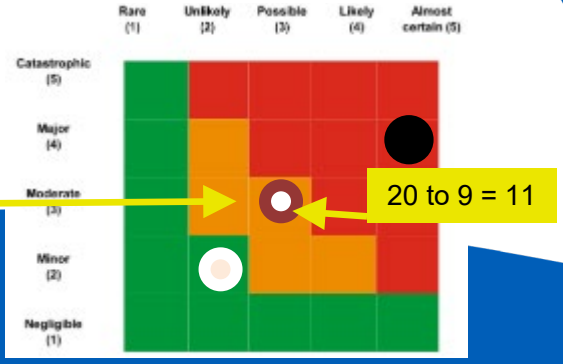
On 3 November 2025, the Group Executive Risk and Assurance Committee discussed the Patient Access risk and specifically the risk appetite giving rise to the small distance between the current score and maximum tolerable score (being 4 points). This one-page sets out the current risk, its appetite and proposed change. This was further discussed at PEF CiC on 2 December 2025.
Patients – Access risk: We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

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

This change results in a greater distance from the current score to the tolerable score and therefore greater expectation on the actions to achieve this goal. The distance to tolerable changes from 4 to 11.



- **Proposed risk category - Clinical Quality and Safety**
- Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
- = CAUTIOUS risk appetite



Appendix 2: Risk Appetite Statements

Risk category	Current risk appetite level	Risk appetite statement
Clinical Quality and Safety	Cautious	Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
Financial / Value for Money	Open	Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.
Partnership	Balanced	Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.
Transformation delivery	Open	Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.
Workforce	Balanced	Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity,