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, 9 October 2025 at 9.00 am to 12:30 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** Sean Lyons, Group Chair	Verbal	Information	**09:00**
1.2	**Staff Charter and Values** Sean Lyons, Group Chair	Attached	Information	
1.3	**Patient Story** Amanda Stanford, Group Chief Nurse	Verbal	Discussion / Assurance	**09:05**
1.4	**Declarations of Interest** Sean Lyons, Group Chair	Attached	Assurance	**09:25**
1.5	**Minutes of the Meeting held on Thursday, 14 August 2025** Sean Lyons, Group Chair	BIC(25)171 Attached	Approval	
1.6	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.7	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(25)172 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Group Chair's Report** Sean Lyons, Group Chair	BIC(25)173 Attached	Assurance	**09:35**
2.2	**Interim Group Chief Executive's Briefing, including** • **National Operating Framework** • **Improvement Plan** Lyn Simpson, Interim Group Chief Executive	BIC(25)174 Attached	Assurance	**09:45**
3.	**STRATEGIC PROGRESS**			
3.1	**Patients – Safety (including Assurance Committee update)** Dr Kate Wood, Group Chief Medical Officer & Amanda Stanford, Group Chief Nurse	BIC(25)175 Attached	Assurance	**10:00**
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)176 Attached	Assurance	
3.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(25)177 Attached	Assurance	
BREAK – 10:30 – 10:45				

3.2	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Sarah Tedford, Interim Group Chief Delivery Officer	BIC(25)178 Attached	Assurance	**10:45**
3.3	**People (including Assurance Committee update)** Simon Nearney, Group Chief Delivery Officer	BIC(25)179 Attached	Assurance	**11:00**
3.4	**Population** Amanda Stanford, Group Chief Nurse	BIC(25)180 Attached	Assurance	**11:10**
3.5	**Public Purse (including Assurance Committee update)** Emma Sayner, Group Chief Financial Officer	BIC(25)181 Attached	Assurance	**11:15**
3.6	**Partnerships** Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	BIC(25)182 Attached	Assurance	**11:25**
3.7	**Pioneering (including update on Electronic Patient Record (EPR))** Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	BIC(25)183 Attached	Assurance	**11:35**
4.	**OTHER ITEMS FOR ASSURANCE**			
4.1	None			
5.	**OTHER ITEMS FOR APPROVAL**			
5.1	**Workforce Disability Equality Standard (WDES)** Simon Nearney, Group Chief People Officer	BIC(25)185 Attached	Approval	**11:45**
5.2	**Workforce Race Equality Standard (WRES)** Simon Nearney, Group Chief People Officer	BIC(25)186 Attached	Approval	**11:50**
5.3	**Winter Plan** Sarah Tedford, Group Chief Delivery Officer	BIC(25)187 Attached	Approval	**11:55**
5.4	**Clinical Strategy** Dr Kate Wood, Group Chief Medical Officer	BIC(25)208 Attached	Approval	**12:05**
6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information / Assurance	
7.	**ANY OTHER URGENT BUSINESS**			
7.1	**Any Other Urgent Business** Sean Lyons, Group Chair / All	Verbal		**12:15**
8.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**12:25**
9.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Sean Lyons, Group Chair / All	Verbal	Discussion	

10. DATE OF THE NEXT MEETING	
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 11 December 2025 at 9.00 am**

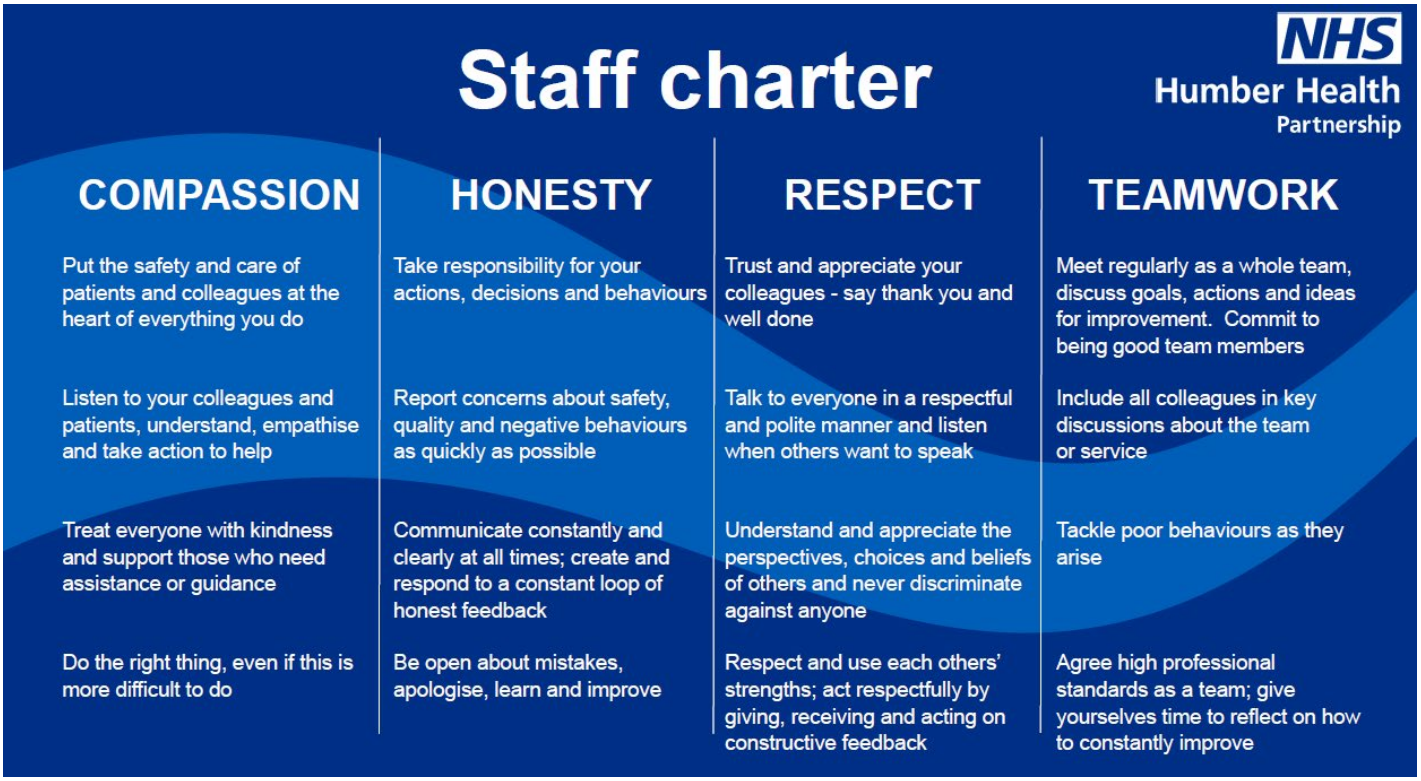
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – July 2025** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(25)188 Attached
6.1.2	**Infection Control Annual Report** Amanda Stanford, Group Chief Nurse	BIC(25)189 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Finance, Estates & Performance Committees-in-Common Minutes – August & September 2025** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)190 Attached
6.2.2	**Finance Report – Month 5** Emma Sayner, Group Chief Financial Officer	BIC(25)191 Attached
6.2.3	**Fire Annual Report & Work Plan** Tom Myers, Group Director of Estates & Facilities	BIC(25)192 Attached
6.2.4	**Group Annual Security Report** Tom Myers, Group Director of Estates & Facilities	BIC(25)193 Attached
6.3	**Workforce, Education & Culture Committees-in-Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – July & August 2025** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)194 Attached
6.3.2	**Guardian of Safe Working Hours – Quarter One Report** Dr Kate Wood, Group Chief Medical Officer	BIC(25)195 Attached
6.3.3	**Guardian of Safe Working Hours Annual Report** Dr Kate Wood, Group Chief Medical Officer	BIC(25)196 Attached
6.4	**Audit, Risk & Governance Committees-in-Common**	
6.4.1	None	
6.5	**Capital & Major Projects Committees-in-Common**	
6.5.1	None	
6.6	**Other**	
6.6.1	**Group Performance Report – NLaG and HUTH** Adam Creeggan, Group Director of Performance	BIC(25)197 Attached
6.6.2	**Trust Boards & Committees Meeting Cycle – 2025 & 2026** David Sharif, Group Director of Assurance	BIC(25)198 Attached
6.6.3	**Board Assurance Framework (BAF)** David Sharif, Group Director of Assurance	BIC(25)199 Attached
6.6.4	**Documents Signed Under Seal** David Sharif, Group Director of Assurance	BIC(25)200 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, 14 August 2025 at 9.00 am
in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Jennifer Clarke	Member of the Public
Andy Haywood	Group Chief Strategy, Partnership & Digital Officer
Liz Houchin	Freedom to Speak Up Guardian (NLaG) (For item 4.1)
Myles Howell	Group Director of Communications
Simon Nearney	Group Chief People Officer
Yvonne McGrath	Midwifery Director (For item 3.1.2)
Fran Moverley	Freedom to Speak Up Guardian (HUTH) (For item 4.1)
John Palmer	Trust Member
Dr Kiran Patel	Business Development Manager, Hexarad
Raj Purewal	C2 Ai.Com (attended virtually)
Ian Reekie	Lead Governor
David Sharif	Group Director of Assurance
Simon Tighe	Deputy Director of Estates & Facilities (For item 5.1)
Simon Treacher	Lead Nurse Patient Experience (HUTH & NLaG) (For item 1.3)
Jackie Weavill	Governance Lead (Staff Governor)
Cllr Kevin Woolas	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 9.00 am. He added that the format of the meeting agenda had changed, giving more structure around the organisation strategic objectives and priorities.

The following apologies for absence were noted:

Tony Curry	Non-Executive Director (HUTH)
Lyn Simpson	Interim Group Chief Executive
Prof Laura Treadgold	Non-Executive Director (HUTH)

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 Simon Treacher to Board members.

Simon Treacher shared the patient story on tissue and cornea donation. The story had started due to a complaint received to the Trust from a family whose father, Gordon, had sadly passed away. Unfortunately, due to a lack of understanding in respect of the process of donation his wishes had not been fulfilled. The staff had been keen to learn lessons from the family and wanted to address issues that had been raised. Following this experience, advice had been sought from the organisation's Lead Nurse for Organ Donation who had directed the staff to the Regional Lead & Specialist Nurse for the NHS Blood and Transplant team.

In conjunction with the organisation Training & Development Team a new e-learning module was produced as part of the End-of-Life Care for All Programme. Further to this, the module created by the team was being used nationally. The family had been thanked for having the courage to share their story. The story had been shared with the Patient & Experience Learning Group amongst other teams. Just weeks after the e-learning package had been introduced, staff at one of our hospitals supported a patient's wish to explore cornea donation, and the patient was able to donate both eyes helping restore vision for two others.

Sean Lyons was pleased that the organisation had learned from this, and that the e-learning module had been introduced nationally for staff. Dr Kate Wood explained she was Interim Chair of the Organisation Donation Committee and part of the work for the Committee was to try and promote awareness of organ and tissue donation. It was noted there had now been more donations due to this story being highlighted. Dr Kate Wood wanted to encourage everyone to sign up to the organ donation, she added that the Committee would also be writing to Lyn Simpson as Interim Group Chief Executive to make a request for the Trusts

to be organ donation hospitals in the hope this would encourage staff to sign up. Sean Lyons referred to the point made and agreed that although this was a personal choice everyone should consider this.

Dr Kate Wood noted thanks to the family for sharing their story.

Julie Beilby felt this had been a powerful story and recognised there was a need to share this message with staff, it was positive to see the e-learning module had been introduced. She was also pleased to see there had been focus on the complaints process with this story as it was important to embrace learning from complaints to minimise the risks in future care. Sean Lyons asked that everyone did consider this when families were spoken to ensure awareness was raised.

Sean Lyons thanked Simon Treacher for sharing the story.

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, 12 June 2025 – BIC(25)125**

The minutes of the meetings held on the 12 June 2025 were accepted as a true and accurate record and would be duly signed by the Chair following the amendments listed below.

- Jane Hawkard referred to page seven, third paragraph. It referred to the number of patients being seen overnight in the Emergency Department (ED), however, it should state that it had reduced the number of patients being lodged overnight.

1.6 **Matters Arising**

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

Jane Hawkard referred to a previous item in respect of the appointment of the Director of Quality Governance and queried if an appointment had been made. Amanda Stanford advised this had now been appointed to, back fill arrangements were being worked through for the person to commence in post.

1.7 **Action Tracker – Public – BIC(25)126**

The following updates to the Action Tracker were noted:

- Item 3.1.2, 12 June 2025 – Maternity & Neonatal Safety Assurance Reports - Low fill rate for unregistered neonatal staff at HUTH.
  Post Meeting Note : Yvonne McGrath advised that the service was now fully recruited to in respect of unregistered staff, the band four role should also sit on the unregistered line, however, they currently sat on the band five line, which finance were reviewing. The British Association of Perinatal Medicine

(BAPM) did not recognise the band three role in neonates; therefore, any vacancies would not be replaced, this would be converted to Band five money.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 Group Chair's Report – BIC(25)127

Sean Lyons explained the Trust Boards-in-Common agenda format had now changed to allow more focus on the strategic direction of the organisation. This would follow the six priorities that the organisation had to ensure appropriate time was spent on the correct issues. Sean Lyons wanted to thank everyone for framing the new agenda format. It was advised that the Committees-in-Common would also be held in the same format going forward.

Dr Kate Wood wanted to highlight that whilst the regulatory focus was on performance and finance it was important that the quality of care remained appropriate and that it needed to be discussed around the Board table. Sean Lyons agreed with the point made and wanted to commend Dr Kate Wood's recent paper shared in the British Medical Journal (BMJ) Leader publication that highlighted this.

Sean Lyons referred to his paper shared and highlighted key points. He welcomed Lyn Simpson as Interim Group Chief Executive who had joined the organisation from North Cumbria Integrated Care NHS Foundation Trust. It was noted that Lyn Simpson already had annual leave commitments this week and had sent apologies to this meeting, Amanda Stanford would be representing her at the meeting. Sean Lyons went on to thank Amanda Stanford on behalf of the Boards for acting up as Group Chief Executive. During her time in the role, she had made great progress which had also supported the new format of the Boards' agenda.

Thanks, were also noted to Heather McNair who had now left the Acting Group Chief Nurse role. It was reported that Andy Haywood had taken on an additional role which included Strategy & Partnerships. Sean Lyons paid tribute to Ivan McConnell who had now stepped down from his Strategy & Partnerships role, he would now be undertaking a role in transformation.

Sean Lyons reported that it was Linda Jackson's last public Trust Boards-in-Common meeting as her term of office was due to end in September 2025. He wanted to pay tribute to her for the 11 years at the organisation as a Non-Executive Director (NED). During this time, she had also undertaken the Acting Chair role at NLaG. Sean Lyons highlighted the key issues that Linda Jackson had supported during her time at the organisation including personal support to himself in his own role during this time. Linda Jackson thanked Sean Lyons for his kind words and commented that it had been an experience where she had met some amazing people wanting to do the best for the organisation. She wanted to wish Board members good luck to what would be a challenging time ahead.

Sean Lyons referred to his report and briefed the Trust Boards-in-Common on the current scrutiny in respect of regulatory requirements that had been put in place. He added that national weekly league tables for performance were an initiative being received for both Trusts. It was noted that for most of these the organisations were unfortunately in the lower part of the table.

Sean Lyons reported that Philip Dymoke DL had been appointed as Patron for the Health Tree Foundation at NLaG. He added that he was grateful to him for agreeing to undertake this role.

Sean Lyons advised he was now part of the Scunthorpe Neighbourhood Board.

It was noted that the Annual Members Meeting (AMM) for NLaG and the Annual General Meeting (AGM) for HUTH would be held together for the first time this year as a town hall live event in October 2025.

Board members were reminded that the Golden Stars Award evening was due to be held on the evening of the 10 October 2025 in Scunthorpe.

2.2 **Group Chief Executive's Briefing – BIC(25)128**

Amanda Stanford shared the report on behalf of Lyn Simpson, Interim Group Chief Executive. It was noted that Lyn Simpson had thanked Amanda Stanford for her time in the Acting Group Chief Executive role.

Amanda Stanford referred to the paper and highlighted key points. She wanted to note that there was concentration on highlighting communications through the organisations and that Lyn Simpson was committed to improving this. Care Groups were now meeting on a weekly basis to ensure key messages were shared, it was reported this had been well attended by those staff. This also gave staff the opportunity to raise issues, any key messages were then disseminated to relevant staff.

Amanda Stanford reported that Lyn Simpson had identified key priorities in terms of Constitutional Standards particularly around elective recovery and performance and that this would be focussed on. There would also be focus on the financial plan and the cost improvement programme (CIP). Amanda Stanford advised there would be focus on bank and agency spend and that steps had already commenced in terms of this. Lyn Simpson had also identified that there needed to be focus on the staff survey as staff welfare was crucial in ensuring improvements. Lyn Simpson had also attended meetings with the system Chief Executives since starting in the role.

Amanda Stanford thanked Linsay Cunningham for producing the Stakeholder mapping this showed the need to link across the system. It was reported that there had been several external visits across the organisations as detailed within the report. A critical care network peer review would be undertaken at the organisation which would highlight areas that needed to be addressed including workforce issues. Updates on this would be shared at the Quality & Safety Committees-in-Common.

Amanda Stanford wanted to draw the Boards attention to the Fuller Enquiry Report as detailed in the report, scrutiny would continue in respect of this. It was reported that the Financial Improvement Board would provide greater scrutiny with the care groups to ensure financial improvements were made. The Care Groups had attended a recent meeting and had provided their delivery plans. The Care Groups would be RAG-rated to show where improvements should be made in the future. Those Care Groups that had been rated red would have escalated support through Ivan McConnell and Sarah Tedford and would be provided with detail on what the ratings would mean.

Amanda Stanford wanted to draw the Boards attention to the good news stories included within the report at point eight.

Dr David Sulch referred to item seven in respect of the acronym detailed, he did not want this to be confused as ADEM did not always refer to that specifically. Amanda Stanford noted the point made.

Jane Hawkard referred to the Winter Plan at point 5.3 as it stated the process was ongoing, she queried when the Boards would have sight of this. Amanda Stanford explained this would form part of the Board Development session in September 2025 for discussion. It would also be discussed at the Executive team meeting prior to this. Amanda Stanford explained that Adam Creeggan had attended a meeting where it had been highlighted that planning for this year would not follow the usual timescales, it was noted this would be brought forward quite significantly. A dedicated session with the Executives would take place the following week to discuss this. Sarah Tedford felt it was more helpful to commence this earlier due to pressures over that period. Sean Lyons advised the Boards would approve the plan at the November 2025 meeting. David Sharif noted that there would be a higher expectation on Boards to have oversight of this including in-depth sessions for them.

Emma Sayner provided assurance that the work being undertaken around transformation and CIP was multi-year in ambition so there was a need to focus and what had already been identified. Sean Lyons agreed that it was positive that the organisation had commenced longer term planning of up to five years in some areas. Linda Jackson queried how many Care Groups had been rated as red. Amanda Stanford confirmed there had been six care groups with this rating. Sarah Tedford explained the red rating had been for different reasons. Amanda Stanford explained this had been a positive exercise that would be repeated again.

Amanda Stanford advised that a diagnostic piece of work in respect of the tower block at Hull Royal Infirmary (HRI) had commenced that week and would be led by Tom Myers, Group Director of Estates & Facilities.

Sue Liburd referred to point 4.2, Fuller Inquiry, within the report and confirmed this would be an item that would be reported regularly to the Boards through the Quality & Safety Committees-in-Common.

Sean Lyons referred to the tiering process and queried whether this would be undertaken separately due to there being two organisations. Sarah Tedford explained that Urgent Emergency Care (UEC) would be covered together, cancer and diagnostics would be covered in one meeting. In respect of Referral to Treatment (RTT) it had been separated for the two Trusts. It was requested at the last meeting that any requests or queries should be raised directly through Sarah Tedford to ensure there was an appropriate response and that everything was monitored in the correct way rather than through the care groups.

3. STRATEGIC PROGRESS

3.1 Patients – Safety – BIC(25)129

Amanda Stanford referred to the report and explained that this linked to the Group Performance Report (GPR) and the suite of metrics within that. Amanda Stanford referred to infection prevention and control (IPC) and explained the issues around this continued. There had been an invited external visit at Diana, Princess of Wales Hospital (DPoWH) the previous week due to the issues with the Carbapenemase Producing Enterobacterales (CPE) outbreak. The team had visited several areas and had identified compliance with good hygiene which had been positive. It was reported that the number of positive cases had started to reduce. Discussions would commence in respect of exiting from screening for CPE. The oversight would continue through the Quality & Safety Committees-in-Common and that a work programme for IPC would be introduced.

Amanda Stanford reported that there were high level risks in respect of ED that had been on the risk register, one at a score of 25. There had been ongoing discussions around this in respect of whether it should be a score of 25 due to the significant work that had been undertaken. It had been felt that the risk in respect of patient experience was correct. The other referred to overcrowding and the safety risk for this within the department. A proposal would be worked through which would include a review of those risks.

Amanda Stanford advised the team had undertaken a deep dive into the red Care Quality Commission (CQC) actions and it had been felt they did not reflect their current status. The oversight for them would continue through the Quality & Safety Committees-in-Common. Additional work would be undertaken to progress those actions included splitting the must-dos. It was reported there had been considerable work in respect of statutory and mandatory training and the Trusts were now in an improved position. The Care Groups had been meeting their core statutory and mandatory training, however, in some care groups the role specific training continued to remain under 85%. She wanted to provide the Boards with assurance that this position was improving.

Amanda Stanford explained that consent had remained an item of concern, and that a deep dive had been undertaken the previous week which identified that there was a policy in place and that audits were undertaken on a regular basis. Performance against those audits was around 83%. The team were waiting for 12 months of audit data before they changed from the red rating. It was expected this would now move to a blue rating and progress would continue. It was reported that the NLaG must-dos for Children & Young People had also progressed and would move to a green rating.

Amanda Stanford explained several issues had been identified around the quality of responses to complainants following a review of 250 complaints. It showed that some Care Groups had resolution meetings with families in place which was the preferred option. A piece of work on timeliness and how to learn from those meetings would be undertaken. It had highlighted that the overriding theme had been issues with communication, work would be undertaken with Care Groups to improve this over the next 12 months. A quality improvement programme had already commenced to support this. The team had also contacted someone at North Cumbria who had undertaken a piece of work around patient experience, and

they were keen to work with the organisation to support a programme on patient experience. It was felt this would also help with improvements in staff morale.

Gill Ponder referred to the point made around issues with communication and queried whether customer care training had been considered to support this. Amanda Stanford felt this would be an option to ensure there were improvements, issues had been discussed with staff, and it was felt there should be a back to basics. Part of this would include simple changes such as staff introducing themselves to patients as this was not always in place. She added that this would be focussed on until it was carried out correctly as it did support improvements with other issues that had been raised previously.

Gill Ponder referred to the Maternity Safety Champions report as it mentioned that security had been called due to some incidents; she queried whether staff could be trained in how to deal with such incidents instead of security being called in all circumstances. Amanda Stanford agreed that part of the issues were that staff did not know how to de-escalate situations. Emma Sayner felt the customer support training could be beneficial across all staff functions.

Dr Kate Wood referred to the mortality figures and confirmed that the NLaG Summary Hospital-level Mortality Indicator (SHMI) had been maintained. She added that HUTH also remained within range for the fifth month, this was testament to the hard work being undertaken by the teams to achieve this. She added that within that area quality improvement needed to be addressed in respect of sepsis management and deteriorating patients' management, this was being led as a multi-disciplinary approach across the Group.

Dr Kate Wood advised that the consultant dispute at NLaG had been discussed at the committees and specifically the impact this had had on waiting lists and initiatives. It was advised that in terms of harm to patients nothing had been identified due to the delays. Dr Kate Wood referred to the lack of data in respect of Patient Reported Outcome Measures (PROMs) for HUTH, this had been raised as it was felt this data was key in understanding how patients were feeling about procedures and whether this had gone well and been beneficial. This was now being worked through to be resolved as it was important the organisation had good patient outcomes.

Murray Macdonald sought further detail in respect of 'Never Events' at the organisations as referred to in the report. Dr Kate Wood advised there had been several events across the organisations, nine had been at HUTH and two at NLaG over the last year. There had been no common themes, and they had been across different specialties. There were processes at NLaG that had worked well which would now be implemented across the Group. This would also ensure that the team were supported including an awareness of the seriousness of what had happened.

Julie Beilby referred to the investment papers as detailed in the report, she highlighted that those papers had been received at the Committees and at the Workforce, Education & Culture Committees-in-Common. She noted that the detail provided had not shown where the source of funding would be from, and this had delayed the papers being endorsed. Considering this, she felt that the processes needed to be reviewed when investment was sought in the future. Amanda Stanford advised that in future the safer staffing papers would be shared with the Boards twice a year in June and December to provide assurance. The paper

shared in December would identify any gaps in terms of funding to allow this to be included in the financial planning. This would be shared at the relevant Committees-in-Common and then with the Boards to ensure it was sighted on risks, this would then allow the Boards to approve any investment required. A further paper on midwifery staffing would then be shared twice a year at the required Committees and the Boards. It was recognised there had been a delay in papers being shared with the Boards, however, a decision was made to delay this as it had not felt appropriate to progress anything until Lyn Simpson was in the Interim role. This would now be worked through with Lyn Simpson now that she had commenced in the role. Emma Sayner explained several discussions had taken place in respect of this and the recommendations were that this needed to be articulated further to enhance the requirements. It had been identified that it was not straight forward as from a financial perspective on reviewing the establishment there were several safer staffing costs included within the run rate due to agency and bank staff. David Sharif advised the aim was to move towards a detailed and robust process to ensure it was agreed as part of the overall planning

Dr David Sulch referred to the delay in staffing considerations being approved by the Boards, he appreciated the processes needed to be correct but was concerned that delays may mean that some quality concerns were not being addressed. Amanda Stanford appreciated the point made but had felt it was important for Lyn Simpson to be included in discussions. Dr David Sulch was concerned that process and protocols may be getting in the way of decision making. Sean Lyons queried whether there were risks due to the delay, Dr David Sulch was concerned there would be. Amanda Stanford explained that the splitting of rotas would mean considerable work due to what was required, therefore if approval had been received now, this would have meant it would not have been in place immediately. Amanda Stanford explained that herself, Emma Sayner and Lyn Simpson would work through all four business cases to ensure the detail was correct for Boards approval to ensure there were no more delays. Emma Sayner highlighted that safer staffing also linked with other issues being discussed in terms of the bed management systems as this did of course impact the time care staff spend on trying to address those issues. Sean Lyons highlighted that following discussions, the business cases would be shared with the Boards in October 2025.

Gill Ponder requested that when business cases were shared at Committees-in-Common that they included a standard section as to where funding would be provided from, this would then make it easier for the Committees to make a decision on approval. Sue Liburd referred to the points raised previously in respect of the maternity mitigations and explained that these were in place, however, a decision being made soon was important.

Simon Parkes highlighted that decision making was still slower than it should be, and this was needed more swiftly to support performance improvements. Sarah Tedford recognised that the process had been slow, however, it was important that decisions made were appropriate in terms of care. Simon Nearney felt that the senior level instability over the last six months had also contributed to some delays in decision-making.

3.1.1 **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(25)130**

Dr David Sulch referred to the report and highlighted key points. Visits to the maternity areas had been undertaken on all sites where services were in place, these had been undertaken following the Quality & Safety Committees-in-Common meetings. It was noted that on occasions patients and families had not behaved in an appropriate way within that service and that the support to staff when this occurred was important. It was reported that there had been some other risks highlighted as detailed within the assurance report. The visits had shown that staff had been very engaged and positive about their own work, the visits had also been extremely useful in that staff had highlighted what processes were not working. It had also provided staff with the opportunity to highlight any areas of concern.

3.1.2 **Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH – BIC(25)131**

Yvonne McGrath referred to the report in terms of the Clinical Negligence Scheme for Trusts (CNST). She explained that in respect of safety action one the report provided detail for quarter one in respect of the Perinatal Mortality Review Tool (PMRT) this included reviews and action plans. She highlighted some of the issues that had been identified as detailed within the report. HUTH were about to complete the Aspirin Quality Improvement Project which had been highlighted from PMRT, this would have positive financial implications as it would reduce by 70% once it was in place.

In respect of the bi-annual staffing report, the usual time for reporting was June and December in respect of safety action five, however, the birth rate plus was not received in time for June which had meant a delay. It was noted this had been included within the report for this month. Yvonne McGrath drew the Boards attention to the monitoring of red flags; an action plan would be shared in October 2025 to show how compliance would be achieved. She added that the gap was approximately 30 across the group split between clinical leadership and managerial roles.

In respect of safety action six she reported that the trajectories were set at 100% for March which did mean a challenge around pre-term birth due to small numbers on the NLaG site. The risks were being worked through at the moment to address any issues to progress compliance, HUTH were currently 81% with NLaG at 80%. In respect of safety action seven, there had been more expectation this year in respect of quoracy at meetings, the organisation had been advised it would be able to declare compliance once any non-attendance had been escalated appropriately.

Yvonne McGrath referred to the claim score cards for both Trusts and provided an update on the detail within the report to Board members. This also detailed the claims that were closed. She added that a deep dive in the induction of labour was also due to be completed, risks were being mitigated well in terms of moving patients and there had not been any incidents in respect of this.

It was highlighted that learning and themes were also detailed within the report. It was reported that Badgernet standardisation had improved, and that Venous Thromboembolism (VTE) risk assessment non-compliance was also an issue that was being addressed which had been fed back to staff. In respect of claims there were currently 25 that were open as highlighted within the report. A deep dive into

induction of labour at Scunthorpe General Hospital (SGH) was being undertaken to identify the impact of moving patients from Hull Royal Infirmary (HRI) to SGH to identify any issues.

Yvonne McGrath reported that meetings had been well attended and that the team were working through the culture plan. Issues had been identified in respect of student midwives and these would be reviewed. In respect of safety action ten incidents had all been referred to Maternity & Newborn Safety Investigations (MNSI) and families had received the required information. It was noted that the duty of candour for this had been in place.

Helen Wright referred to the delayed business cases and queried whether there was any subset of investment, or priority, that could be moved for this to be progressed. Yvonne McGrath explained that this was all phased within the report. She added that there had been over recruitment of students and this was being reviewed. Amanda Stanford added that nationally there were more newly qualified midwives than there were places, there had been some additional funding that would be used to address maternity leave within that area. There was also a need to review sickness over the weekend period.

Simon Parkes highlighted that the progress made was positive and so queried whether this item required as much discussion going forward as there were other issues that required more focus by the Boards. Amanda Stanford noted the point made, however, advised that this was a requirement to achieve the year seven CNST Standard. It was important to note that there were improvements that had been made to date, particularly over the last year. She added that the CQC were also encouraging HUTH to submit a request to remove the section 31 due to the improvements made, she added that this would be requested.

Jane Hawkard explained that during a recent visit to maternity the issue of triage overnight had been raised as it was difficult for staff that had to provide this as they may be required to provide other care at that time. Amanda Stanford advised that from the end of September 2025 this would be open from midnight and that from the end of January 2026 this would be extended. The delay had been to allow the newly trained band six midwives to have the required skills mix. It was felt this should be communicated to staff to ensure they were aware.

3.2 **Patients – Performance – BIC(25)132**
Cancer / Urgent & Emergency Care / Referral to Treatment / Diagnostics

Sarah Tedford referred to the paper and highlighted key points. She referred to UEC in respect of the summary detail, it showed that the four-hour standard in June 2025 had improved. The 12-hour standard had unfortunately slightly deteriorated. She added that the data shared was for June 2025 and that there had been some improvements since then. She further added that in respect of the tiering meetings they would continue to be held as one meeting for the moment and not split into separate meetings for each Trust. These were scheduled on a fortnightly basis and would have a clear plan of actions and trajectories.

Sarah Tedford explained that there had been some changes in respect of the Care Groups. In respect of acute medicine and the UEC, this had now been split into two sites. The HUTH element had been combined with the Major Trauma Care Group. The change had only just been implemented; however, it was felt that some

progress was already being seen. There had also been considerable change in respect of flow through the hospitals, the most area for concern was performance in ED. There was a team in place to support improvements within this area. There had been some improved performance at HUTH due to a short stay area being introduced for particular patients. Further improvements had been that patients were spending two hours less in the ED at HUTH and that 18 patients in one day had been seen by a consultant within one hour of their arrival. There had also been 10 less 12-hour breaches within a day. There would be further external support in the UECs, for example from the emergency care intensive support team who had been working with wards. There had been a request for them to focus on respiratory and other specific wards and there had been an increase in morning discharges from 5% to 30% which would continue. She added that the patient's length of stay on Ward 10 had significantly reduced. Some of the improvements had been made by reviewing patients that were due to be discharged ensuring everything was in place for this to be timelier. Other areas being reviewed were the internal medical rotas, to support out of hours. A piece of work in respect of this would include a consultation that would be undertaken through September 2025 which would hopefully mean the rota being in place for October 2025 to support the winter period.

Sarah Tedford advised there had been an additional consultant in place in the Urgent Emergency Centre (UEC) at Hull Royal Infirmary (HRI) this had supported patients being seen overnight and had meant reduced numbers within UEC the following morning. A daily meeting was being held at 5.00 pm to highlight issues that could be resolved more quickly, and this had worked well in supporting flow. Linda Jackson queried whether the general medicine rota improvements would be across both organisations. Sarah Tedford explained that this would be for both, this was currently being reviewed at NLaG by the team. Although NLaG was in a better position, there was still support required there. Linda Jackson referred to the acute medicine being split across the two Trusts and queried what support would be put in place for the teams to move this forward. Sarah Tedford explained that Jeevan Gill had been appointed and had been supporting ED at HRI. She added that the Major Trauma Care Group would provide support to acute medicine, they currently provided support to rehabilitation. However, discussions had taken place, and the Neuroscience Care Group would now support rehabilitation. Sarah Tedford added that the teams were being supported by weekly meetings to ensure any issues were highlighted. Dr Kate Wood advised that Dr Andy Simpson from NHS England was also supporting the team in that area, and he had already spent the day with them and further arrangements would be put in place shortly. Similar support would also be in place at the NLaG sites, however, there were more challenges at HRI that needed to be addressed.

Sean Lyons questioned what would support improvements in the four-hour wait time. Sarah Tedford explained that seeing patients in a timelier way would help, plus review of systems and processes that were in place to address issues. Sean Lyons was pleased to see the flow programme was having a positive impact. Sarah Tedford agreed there had been improvements made, and the teams had been able to identify patients on clear pathways to ensure they were cared for timelier. She added that there was definitely an improved response to flow through the organisation, patients that had not been moved appropriately within 30 minutes where being reviewed and ways of supporting this was in place.

Sarah Tedford referred to the report provided and advised that the data shared was for May 2025. In respect of the 28-day faster diagnosis standard the organisation had been at 57.40%, the target for this was 80%. In respect of the 62-day standard the organisation had been at 46.2%, the target was 63%. It was clear that the issues causing this were at the front of the pathway in respect of patients being seen within the first 28 days. The issues had been due to the number of patients requiring appointments and the capacity to treat them. There had been external support at the organisation to support achieving this. The cancer trajectories had now been completed and were being worked through with the teams to achieve the 80%. Sarah Tedford explained that part of this work was in respect of breast care as there had been some issues due to the non-availability of clinical staff. A plan had, therefore, been put in place to have additional sessions over the next few months. Going forward there would be a requirement to run a further four sessions a month to meet the demand, in addition to the planned appointments. She explained that it would be for all tumour sites to ensure that by the end of March 2026 the majority would be on track. Work in respect of this would continue to be reviewed. This information had also been shared at the Tier One meeting.

Sarah Tedford referred to the report in terms of diagnostics and confirmed the data. She explained that currently there was insufficient capacity to meet requirements. She added that in respect of imaging there were clear plans to ensure the organisations were on track. There were concerns in respect of the scope of work as the patients were on different pathways. It was noted that whilst cancer patients would always take priority, some patients' cancers were identified on other pathways.

Linda Jackson referred to the Community Diagnostic Centre (CDC) utilisation and queried whether this was in line with the plan. Sarah Tedford explained there had been issues that had arisen at HUTH, however, this had now been resolved with additional management being put in place. There had also been minor issues at the Grimsby CDC which had now been resolved.

Sean Lyons queried if delays would be included in the recovery projection and Sarah Tedford advised it would be included.

Dr David Sulch queried whether there had been any delays in the reporting of diagnostic tests and Sarah Tedford advised there had not been any delays due to this.

Sarah Tedford referred to the RTT detail within the report and explained that one of the current issues was that the information that was submitted in respect of the plan showed that the waiting lists would be larger at the end of the year than it had been at the beginning, whilst this had been accepted at the time a request had been made to share more detail. Discussions had taken place in respect of electronic validation and although the programme had been for this to commence by December 2025 it was hoped this would be earlier.

Sean Lyons referred to the validation at the two Trusts, as this had previously been undertaken differently, he queried how this would progress going forward. Sarah Tedford explained that it was hoped letters would be sent to patients on the waiting lists to identify whether they still required care. A more detailed process would also identify whether the detail of patients on the waiting lists was correct. Sarah Tedford explained that some patients that had not been on the waiting long were being seen

first due to urgent care being required. However, it was recognised that long waiters also needed to be addressed.

Murray Macdonald referred to the report as it highlighted that Radiology Reporting would be shared with the Trust Boards-in-Common for approval. He queried whether that should have been shared at the meeting that day. Emma Sayner advised that it had been identified to be under the limit for the Boards approval. Murray Macdonald felt the report had provided a thorough summary in terms of performance and thanked Sarah Tedford and the team for providing this.

Gill Ponder felt the report had been helpful and that providing it to the Performance, Estates & Finance Committees-in-Common in this way would be more beneficial. She added that the Committees had felt there was limited assurance, however. The improvements in ambulance handover times had been noted and were being sustained with the same process now being implemented on the South Bank. She added that the Committees had felt that it was important that the trajectory improvements provide assurance. Sean Lyons thanked Sarah Tedford for the summary shared and added that it was positive to see that there had been improvements.

Sarah Tedford reported that the industrial action had impacted the care of 20 cancer patients. However, those patients had had appointments rearranged. Sarah Tedford advised the organisation were working closely with system partners and that they were keen to reduce the number of no criteria to reside (NCTR) patients. They had been supportive in ensuring people were in the appropriate care setting following discharge. Part of this work was to ensure the capacity in the system was in place to support the winter period.

Jane Hawkard noted that she had spoken to colleagues working in the system and that they had been grateful for being included in the planning work. Sarah Tedford explained that part of the reconfiguration work included moving services around in the tower at HRI. Sean Lyons questioned if there was anything Board members could assist with in terms of changes being made to support improvements. Sarah Tedford explained that some staff were finding it difficult at times and that they required additional support to drive them through the changes needed. It was appreciated some changes would also affect patients.

3.3 **People – BIC(25)133**

Simon Nearney explained that the report shared was comprehensive and would be further defined going forward. The report included the key statistical information. He added that the People Strategy had been launched and that the work programmes were now working well, however, it was appreciated there would be further work to put in place. One of the main focuses for the team was the cultural transformation work which would be updated through the Workforce, Education & Culture Committees-in-Common. The first staff survey report in respect of the pulse survey would also be shared at the Committees that month. It was noted that the national response rates for the pulse survey had been lower.

Simon Nearney explained that the agency spend was £3.3 million off plan and this needed to be reduced by 30% this year. Work would be undertaken with the Care Groups to achieve the savings, and discussion would take place with the executives on how additional spend would be authorised and whether this would be

more centralised. There were also further discussions taking place in respect of job planning, following commitment to achieve 98% compliance by the end of October 2025. Dr Kate Wood was due to meet with each Care Group Chief of Service in respect of this issue.

Simon Nearney referred to the previous issues raised regarding the national education training survey for resident doctors as the results had been very poor. He explained that an improvement programme was now in place and would be led by Dr Silas Gimba who would meet with the Care Group Chiefs of Service to share information on what had been reported.

Simon Nearney advised that in respect of the Health Care Support Workers (HCSWs) a proposal had been shared with the trade unions for those staff transferring from a band two to three role. A response from them was hoped by the end of August 2025. The new roles would then be implemented from the 1 October 2025, with back pay to those staff being paid over the next 12 to 15 months.

Simon Nearney advised that the issues with the NLaG consultants was still ongoing, however, it was hoped this would be concluded by the end of September 2025. In respect of the resident doctors' industrial action, it was expected there would be further action taken as there was still no conclusion in respect of pay increases.

Simon Nearney reported that there had been positive challenge at the Workforce, Education & Cultures Committees-in-Common in respect of the CQC actions in respect of what was expected.

Simon Parkes felt the Boards needed to focus on culture to ensure it was more productive as an organisation. This included whether the organisations had the correct number of staff to make a difference. He requested that the report included what the Boards needed to be focussed on to progress in the future.

Jane Hawkard referred to the June 2025 Trust Boards-in-Common meeting where some members of staff had raised issues in respect of the band two and three job role changes and when those issues would be resolved. She queried whether those staff had now been advised of when back pay would be received. Simon Nearney advised that all staff within those roles had received letters in respect of the move from a band two to three. It was noted that not all staff had wanted to move to a band three role due to the additional responsibilities. He added that there had been some delays as the trade unions wished to discuss the proposals with staff, once this had been undertaken and feedback was received this would be implemented for staff. Julie Beilby advised that following the Boards meeting in June 2025 discussion had taken place at the Workforce, Education & Cultures Committees-in-Common and assurance had been received regarding the issue around pay to those band two roles. She added that the committees had been assured that progress was being made in areas around improving staff culture and progress had also been made in respect of job planning.

Dr Kate Wood provided assurance that discussions were taking place with relevant staff in respect job planning. She added that the process had been challenging going into a Group. However, reporting was now in place and reports were received on a fortnightly basis. It was noted that the Workforce, Education & Cultures Committees-in-Common did have oversight for progress with job planning. Simon

Nearney explained that there was a report for information that had been shared at the Committees for Medical Revalidation that required the Chair to approve. After discussion, it was agreed Sean Lyons would sign the report.

Julie Beilby noted the approval; however, she explained that there had been a challenging discussion in respect of the medical revalidation report as to how assured the Committees should be at signing this given the responsible officer had not been able to provide assurance that the organisations were compliant. She went on to report that Dr Kate Wood had provided assurance at the meeting that there was an understanding and that oversight of the medical staff was in place to ensure this was met. It was reported that HUTH had been non-compliant for several years and that an action plan was in place to ensure progress was made. This meant that HUTH was not compliant with statutory obligations and the Committees had been uncomfortable at approving the report for sign off. Dr Kate Wood assured the Committees that there was now sufficient funding in place following the approval of business cases which would ensure the compliance was achieved going forward. It was further noted that NHS England were sighted on the challenges and that there was a solution in place to resolve issues. She commended that the report was approved by the Chair.

Sue Liburd referred to the report in respect of the statement regarding risk-based assessment on organisational change and queried whether the risk was prioritising ‘burning platform issues’ versus long term cultural change. Simon Nearney explained it would impact on the cultural transformation work as it was in respect of reducing posts within the people directorate which would be managed. He added that staff were feeling the pressure and that the staff in the people directorate were supporting those staff. Gill Ponder felt that cultural change programmes made a difference when managers were the ones providing the information, she felt this should be considered moving forward.

3.4 **Population**

Sean Lyons advised there was no paper to share in respect of population at the meeting. However, Amanda Stanford wanted to note that the population item would include looking at the equity agenda and the role the organisation had in the move towards the 10-year plan. There was a need to be an active partner within the local population.

3.5 **Public Purse – BIC(25)134**

Emma Sayner referred to the report and highlighted key points. She added that a more detailed month three report was provided as an item for information. The teams were currently focussing on working with the care groups to support improvements. In terms of the commitment from the organisation to achieve a CIP of £130 million, it was reported that this was just under £10 million in respect of unidentified CIP. She added that in respect of cash it was still green as presented within the report and that if this continued it would provide further positive assurance.

There was a further piece of work in respect of capital, although, it appeared to be behind work being undertaken to ensure this was met. She added that some of this contributed to the delays with the HUTH CDC which had now been resolved.

Emma Sayner reported that the full executive team owned actions being taken. Discussions were being undertaken in respect of finance delegations for budget holders, in particular the use of bank and agency spend. Emma Sayner advised that vacant roles that had not been appointed to for some time, would become recurrent savings. She added that there was an improved financial control at NLaG with more centralised processes, this would now be deployed at HUTH with immediate effect. Emma Sayner explained that within the past three weeks there had been a request from NHS England to submit bids for available funding in respect of performance support. She added that the executive team would co-ordinate those bids centrally.

Sean Lyons was pleased there were further grip and control measures in place. Helen Wright appreciated that there needed to be more money in certain areas for investment, however she felt there was a need to discuss further what areas would be deprioritised. She added that it would also be useful to receive at the Performance, Estates & Finance Committees-in-Common the forecasting for under performance and the plans in place for this. Emma Sayner explained that in terms of de-prioritisation, the expenditure controls would mean the organisation reaching that point. She recognised that there was a culture of overspending which needed to change. Helen Wright felt there was a need to demonstrate at Board level that ways of working would need to be done differently.

Gill Ponder highlighted that the Committees had had limited assurance for the run rate and the deficit position. She noted that the actions that Emma Sayner and the team were taking were reassuring.

Simon Parkes felt the Boards needed to be willing to accept that there were risks to achieve improvements elsewhere in the organisation. However, he did not feel that this had been highlighted as an issue.

Dr David Sulch felt that half of the CIP programme was high risk and queried whether the organisation was an outlier in respect of this. Emma Sayner did not believe the organisation was an outlier.

Murray Macdonald felt the report highlighted what the important issues were for the organisation, however, it could not be ignored that there was no assurance in respect of the CIP programme. He noted that the Boards also did not receive a report on CIP routinely for oversight. He also commended that the committees had only raised (rightly) one issue for the Boards to be sighted on, and they would continue to exercise oversight over all the other issues.

3.6 **Partnerships – BIC(25)135**

Andy Haywood referred to the report and noted key points. He added that to deliver the 10-year plan there would be a need for strong partnerships. One risk with this was that some services may be directed elsewhere. One area focussing on this was the National Neighbourhood Health Implementation Programme (NNHIP) as detailed within the report, this would focus on moving from hospital to community-based care, likely to impact the organisation due to funding.

Andy Haywood reported that there were some risks around working in partnerships and those would be mitigated against and reported in the Board Assurance

Framework (BAF). Andy Haywood wanted to thank Linsay Cunningham for the piece of work she had undertaken in respect of this linking together.

Helen Wright advised she had discussed with Ivan McConnell the need to strengthen partnership working in the Humber region with the private sector. She felt this was currently a weakness that could be improved as they may like the opportunity to work with the organisation. She also felt there was a need to consider what the aim was when meeting with partners and MPs as to how they could best support the organisation.

Gill Ponder reported that the Capital & Major Projects Committees-in-Common had been conscious for the need to focus on transformation and partnership working within the system, this had been the reason for the proposal to change its scope and purpose to Strategic Programme & Partnerships. Julie Beilby queried where discussions on partnerships would be fed into the Boards as she was not assured in respect of the NLaG footprint in terms of East and West Lindsey and that this was under reported. She wondered whether this should be included within the new Terms of Reference for that Committee to highlight where the oversight was for system partnership and place. Amanda Stanford felt it was in the early stages in terms of the stakeholder mapping; however, she recognised that this should be considered in the future. Andy Haywood felt the Terms of Reference could be reviewed in three months' time to include further scope. Sean Lyons referred to the routine MP meetings and advised they had been scheduled in order to update MPs which add value to relationships with them.

3.7 **Pioneering – BIC(25)136**

Andy Haywood referred to the report and noted key points. Dr Kate Wood referred to the report and advised that the Research Innovation Strategy was due to be approved at the meeting that day. She added that the Quality & Safety Committees-in-Common had endorsed this for approval at the Boards as referred to in the report. She added that it had been extensively consulted on through the organisation over a period of months. She further added that herself and the research team welcomed the new Strategic Programme & Partnerships Committees-in-Common as it underlined that research and engagement with partners was important to the Boards.

Dr Kate Wood sought approval of the Research Innovation Strategy as it was referred to in this report.

The Trust Boards-in-Common approved the Research Innovation Strategy.

4. OTHER ITEMS FOR ASSURANCE

4.1 **Freedom to Speak Up Guardian Report – Quarter One – NLaG & HUTH – BIC(25)137**

Liz Houchin referred to reports and noted key points. She noted the number of concerns raised in respect of worker safety; it was reported that the national figures also showed an increase. Liz Houchin wanted to draw the Boards' attention to appendix one which summarised the Boards high-level development actions that required approval.

Fran Moverley referred to report and noted key points. She noted that there had been less anonymous concerns reported. She highlighted that behavioural concerns continued to be prominent in terms of those raised. Fran Moverley asked Board members how regularly they would like to receive the action plan.

Sean Lyons sought approval of the plan from Board members and queried how often they felt this should be received by the Trust Boards-in-Common.

Julie Beilby confirmed that there had been substantial discussion at the Workforce, Education & Culture Committees-in-Common with assurance being received on the action plan.

After discussion it was agreed the Boards would receive the action plan on an annual basis with routine oversight through the Workforce, Education & Culture Committees-in-Common.

Linda Jackson referred to the point in respect of worker safety as this had been high for this quarter, she queried what type of concerns this referred to. Liz Houchin explained this was a combination of psychological safety concerns that related to staff being stressed and burnt out. She also referenced the physical environment they worked in being too hot, thus affecting staff wellbeing. Furthermore, an element of psychological safety related to staff not feeling confident in speaking up to their own line managers. A request was made for this to be more detailed within the report going forward to show this against the specific concerns. Sean Lyons queried whether there had been an increase in line managers asking staff to refer themselves to the FTSUGs instead of solving issues themselves. Liz Houchin and Fran Moverley agreed this was the case. Sean Lyons felt it was disappointing that line managers were not dealing with issues within the workplace.

4.2 **Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(25)138**

Jane Hawkard referred to the report and noted key points. She explained that the committees had looked at the cleansing of the internal audit recommendations that were low priority. The committees had felt that they should all be reviewed with a decision being made. Sean Lyons queried whether this was something that should be put in place, Jane Hawkard felt it was as there were many action plans that had low priority actions. It was agreed David Sharif would action this.

Action: David Sharif to progress the cleansing of internal audit recommendations that were low priority

Jane Hawkard advised of a further issue raised around the recommendations on the basics not being completed. She referenced a further request that communications were improved. The Well Led assessment process was also discussed and the capacity to undertake them. The committees felt that there was not sufficient capacity at the moment to run an assessment. Amanda Stanford advised that a Well Led review was expected in quarter four. Sean Lyons felt this was something that would require Lyn Simpson's involvement and consideration. It was noted that the previous reviews were undertaken in 2022 and that the requirement was that this was undertaken every three years.

5. OTHER ITEMS FOR APPROVAL

5.1 Premises Assurance Model (PAM) – BIC(25)139

Simon Tighe referred to the report and noted key points. It was confirmed this had also been discussed at the Performance, Estates & Finance Committees-in-Common.

The Trust Boards-in-Common approved the Premises Assurance Model.

5.2 Modern Slavery Statements – NLaG & HUTH – BIC(25)140

Simon Nearney referred to the report and noted key points. It was confirmed this had also been discussed at the Workforce, Education & Culture Committees-in-Common.

The Trust Boards-in-Common approved the Modern Slavery Statements for NLaG & HUTH. It was agreed this would be signed as required.

5.3 Remuneration Committees-in-Common Terms of Reference – BIC(25)141

David Sharif referred to the report and noted key points of change within the Terms of Reference. It was confirmed this had also been discussed at the Remuneration Committees-in-Common.

The Trust Boards-in-Common approved the Remuneration Committees-in-Common Terms of Reference.

5.4 Strategic Programmes & Partnerships Committees-in-Common Terms of Reference – BIC(25)142

David Sharif referred to the report and noted key points of change within the Terms of Reference. He added that this would then mean that the Capital & Major Projects Committees-in-Common would cease. He further added that these new committees would also have oversight for research and innovation. He added that the wording would be strengthened within the responsibility section in reference to this.

Murray Macdonald agreed that the oversight for research and innovation should be strengthened. He asked if this could then be shared at the next Trust Boards-in-Common meeting for approval. Jane Hawkard asked if this could instead be updated through the committees and approved as a Chair's action. Murray Macdonald advised he would be happy with this. Dr Kate Wood agreed with the point and the agreed changes. Sean Lyons agreed he would be happy to sign this off as a Chair's action.

Gill Ponder as Chair of this committee advised that the oversight of research and innovation had not been discussed at the meeting. She advised that she would like more time for the committees to consider this. It was agreed this would be discussed further at the planned meeting next week. David Sharif noted that innovation had been discussed previously but Gill Ponder recognised that clinical research had not been discussed. It was agreed that once this had been discussed at the meeting, Sean Lyons would approve them as Chair's action.

Sue Liburd explained that the Quality & Safety Committees-in-Common currently had oversight of clinical research and that she would be concerned if this was not discussed at that meeting going forward. David Sharif agreed to convene a committees chairs discussion to resolve this aspect.

Action: 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.

5.5 Group Strategy – BIC(25)143

Amanda Stanford referred to the report and advised this had been through considerable discussion and scrutiny. She added that the communication plan had been added alongside the implementation of the Group Strategy. This had already started to be embedded through communications.

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

5.6 Research Innovation Strategy – BIC(25)169

It was confirmed that this item had been approved at item 3.7 earlier in the meeting.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 Items for Information / Supporting Papers

The following items for information were shared.

- Quality & Safety CiC Minutes – May & June 2025
- Medicines Management Annual Report
- Organ Donation Annual Report
- Performance, Estates & Finance CiC Minutes – June & July 2025
- Finance Report – Month 3
- Workforce, Education & Culture CiC Minutes – May & June 2025
- Medical Appraisal & Revalidation Annual Report
- Audit, Risk & Governance CiC Minutes – April & June 2025
- Audit, Risk & Governance CiC Annual Report
- Capital & Major Projects CiC Minutes – January 2025
- Health Tree Foundation Trustees' Committee Highlight Report
- Health Tree Annual Report & Accounts
- 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.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from members of the public in attendance.

John Palmer referred to an issue that had arisen in terms of appropriate communication with the GP Surgeries within the Goole area. He reported that some of the surgeries were not able to refer patients to Goole & District Hospital (GDH), instead they had to refer to SGH and the patients were then having to request to be referred back to GDH. He added that some of the issues had arisen following the new telephone system. Sean Lyons agreed that this was not acceptable for patients.

It was reported that a session had been held with the Governors, and it had been recognised that GP Practices should have one version of the directory for services. This was a fundamental issue that needed to be addressed. John Palmer advised that the Goole Group had recently paid for a page in the Goole Times to highlight what services were available at GDH to ensure this was highlighted. Sean Lyons agreed that there was a need to be clear about what services were offered at each site. Amanda Stanford advised there would be a piece of work undertaken by Ivan McConnell around outpatient transformation which would include this. It was recognised that it was not appropriate for Goole residents to be referred to SGH when services were offered at GDH. Councillor Kevin Woolas wanted to highlight that any information provided by the Goole Group would be factual and should be taken in that way.

Andy Haywood referred to the point made regarding the telephone system and wanted to note that it should not be assumed that those issues were specific to GDH, as there were issues at the other sites. He felt the issues may be due to a lack of external understanding of the Group. He planned to include within the partnership work actions to ensure colleagues in primary care understood how to use the directory of service.

Jackie Weavill queried how assured Emma Sayner was that the organisation was charging stakeholders the correct amount in terms of services offered for care. Emma Sayner felt assured that this was the case, however, agreed to speak about this outside the meeting.

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, 9 October 2025 at 9.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 13:20 hrs.

Cumulative Record of Board Director's Attendance 2025/26

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

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(25)172

BOARDS-IN-COMMON - PUBLIC ACTION TRACKER

2025 / 26

ACTION TRACKER - CURRENT ACTIONS - 9 OCTOBER 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

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

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)173

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9 October 2025**
Director Lead	Sean Lyons, Group Chair
Contact Officer / Author	Sean Lyons, Group Chair
Title of Report	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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Group Chair's Report

Leadership Changes

Group Chair Role

Since I announced my decision to step down, we have engaged with NHS England and the NLaG Council of Governors (CoG) regarding arrangements to cover the Group Chair role until a permanent replacement is appointed.

I am very pleased to say that both parties have agreed to appoint Murray Macdonald as Interim Group Chair from 10 October 2025. I am sure Board members will join me in congratulating Murray on his appointment, and we wish him every success in the role.

I would expect that several months will elapse before any process to appoint a new Group Chair is initiated, so this allows the focus on performance improvement, patient safety and staff wellbeing to continue.

Simon Parkes, Non-Executive Director

I am sorry to report that Simon Parkes has tendered his resignation as a Non-Executive Director (NED), although he has agreed to stay with us until December 2025. Simon Parkes has been with the organisation since September 2021 and has been a real asset to us and his contribution as a NED and Co-Chair of the Audit, Risk & Governance Committees and will be sorely missed.

Linda Jackson, Vice Chair – NLaG & Associate NED – HUTH

As mentioned in my last report, Linda Jackson concluded her time with the organisation at the end of September 2025 and we had the pleasure of presenting her with some leaving gifts and a Certificate of Appreciation on 25 September 2025.

Performance Improvement Plan & Winter Plan

As required by Region, the Group signed off and submitted the Performance Improvement Plan by the agreed date of 15 September 2025. We await feedback, but this will not be holding up actions within the plan, and the Interim Group Chief Executive will comment further on this in her report. Similarly, the Group has scrutinised and submitted the Winter plan as required.

Governor Elections

Governor Elections are to be held in the next few weeks, and the constituencies involved are East & West Lindsey with two vacancies, Goole & Howdenshire with one vacancy, North East Lincolnshire with three vacancies and North Lincolnshire with one vacancy.

I would at this point like to pay tribute to three of our Public Governors, Jeremy Baskett and Rob Pickersgill, who have served the maximum term allowed as a

Governors and Diana Barnes who has also decided to stand down, all have been excellent Governors, and we wish them well.

The usual Governor election roadshows are being held, and I personally attended the event at Goole & District Hospital (GDH), which attracted positive interest.

Integrated Care Board (ICB)

As mentioned in previous reports, our ICB continues to refine its plans to respond to the central requirements to reduce costs and refocus its attention to strategic commissioning as defined in the Model ICB Blueprint issued in May 2025.

Formal approval has not yet been given to the ICB's submitted plan, and some functions originally planned to be transferred to other providers will be retained by the ICB.

It is good to know that Jason Stamp, who has been acting in the ICB Chair role, will continue in that role for a further year.

Model Region

NHS England recently issued their Model Region Blueprint, which defines the intended roles and responsibilities of NHS Regions. The impact of this will emerge in due course, but this should not distract us from our improvement journey

Other Matters

I was delighted to attend the farewell celebration for Teresa Jackson who recently completed an incredible 62 years' service as a Nurse in the Grimsby area. We created a special certificate of appreciation, which Teresa was pleased to receive.

The shining lights awards continue to be a joyful process and I was lucky to be able to present awards to Karen Bibby, Harvey Mei and Rebecca Leggett in recent weeks.

Finally

I would like to thank everyone who has passed on their good wishes to me since I announced that I was stepping down. Serving as the Group Chair has been an enormous privilege, and I wish the Group every success in the future.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)174

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 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: • **Immediate Response** - SRO-led improvement trajectories in key National Oversight Framework areas; Improvement Plan due November with clinically led measures against standards. • **NHSE Priorities** - vaccination, waits, urgent care, winter readiness. • **CEO Engagement** - site visits, staff recognition, and national engagement reinforcing priorities of access, safety, culture, and winter preparedness.
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 ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other – please detail below:

Interim Group Chief Executive's Update

1. Immediate Response and Improvement Planning

In line with the recently published new National Oversight Framework (NOF) the Humber Health Partnership is taking forward a dual response, comprising both an Immediate Response and the development of a Sustainable Improvement Plan.

The Immediate Response focuses on grip and control in the highest-risk areas highlighted through the NOF. Each of these domains has been assigned an Executive Senior Responsible Officer (SRO), ensuring clear accountability.

For the immediate response, Executive SROs have developed improvement trajectories, which they are leading and delivering against while the Improvement Plan is developed in parallel. Delivery of the immediate response will be monitored through the Programme Management Office (PMO) with oversight through the Partnership's governance forums.

Running in parallel, the Improvement Plan is being developed as the Partnership's clinically-led roadmap for stabilisation, sustainability, and long-term improvement.

At the heart of the plan will be clinically led measures to achieve sustainable improvement against constitutional and other standards in the interests of patients and service users.

The plan is being structured around three anchors: Stabilise, Grow, and Connect. It builds on a bottom-up diagnostic and engagement process, ensuring that it reflects the real experiences of clinicians, patients, and service users across the Partnership.

Clinical ownership is central to this approach. Feedback from colleagues has made clear that the clinical voice has not always been strong enough in decision-making, and the new Improvement Plan is deliberately designed to address this. It is being informed and shaped by the Partnership's experienced clinicians and the lived experience of frontline teams.

The Improvement Plan will be finalised in November 2025 for submission to NHSE and Board approval. It will provide the Partnership's single framework for delivery, aligning immediate regulatory requirements with a clear longer-term trajectory for safe, reliable care.

This combined approach provides assurance that the Partnership is addressing immediate risks while laying the foundations for sustainable improvement, and aligns with the recent request from NHS England for all Trusts to undertake a mid-year (M6) review.

2. National NHS England Correspondence

The Partnership has also received two recent letters from NHS England which apply to all NHS providers:

- Campaign to Vaccinate All Frontline Healthcare Staff – calling for renewed focus on vaccination uptake among the workforce, with a clear expectation of provider leadership to protect patients and colleagues.

- Building on Our Progress in the Second Half of 2025/26 – setting out national priorities for the remainder of the year, including reducing elective and cancer waits, improving urgent and emergency care flow, preparing for winter, and leading with integrity and compassion.

These national priorities are directly aligned with the Partnership's Improvement Plan, reinforcing the focus on patient access, workforce engagement, financial discipline, and cultural change.

3. Chief Executive Engagement and Visits

As Interim Group Chief Executive I have continued my active programme of engagement across sites and with colleagues. Recent visits have included:

- Hull Women and Children's Hospital – where the Director of Midwifery, Yvonne McGrath, hosted a walkaround, including discussions with Maternity Patient Safety Specialist Matron, Matthew Proctor. I commended the progress made over the past three years in strengthening safety and colleague engagement, noting the clear commitment of teams to improving outcomes in maternity care.

- Goole Hospital – where the I met long-serving nurse colleague Pat, who retired in September after more than 40 years of service. Her continued enthusiasm for patient care and dedication to mentoring apprentices was highlighted as an outstanding example of professional commitment. At Goole, I also met the neurorehabilitation team, who described their ambitions to expand services, and the surgical team on Ward 6, who have achieved notable reductions in patient length of stay. The work of the cancellation avoidance team in supporting patients ahead of surgery was also recognised.

- Other engagement highlights included discussions with neonatal leads Preeti Gandhi and Aparna Manou, providing assurance on systems for supporting families and learning from incidents; congratulations to Practice Development Nurses for their national HSJ Patient Safety Award; and thanks to all colleagues involved in the recent CQC inspection of Hull Royal Infirmary's Emergency Department for their professionalism and responsiveness.

I also participated in the national provider CEO session with NHSE Chief Executive Jim Mackay and the Secretary of State for Health, Wes Streeting. The session reinforced the national priorities of reducing waits, preparing for winter, and leading differently rather than simply working harder. These themes were echoed in the Partnership's Top 100 leadership event, which focused on transforming outpatient care, building a stronger learning culture, and improving the staff experience as the national survey approaches.

Through these visits and engagements, the Chief Executive has reaffirmed the Partnership's commitment to listening to staff, promoting clinical leadership, and fostering a culture of safety, respect, and learning.

4. CEO Dashboard

Included with this report is the first 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

October 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

Ther Group is responding to the National Oversight Framework with an Immediate Response in key areas, each led by an Executive SRO with clear trajectories for improvement. Alongside this, a clinically-led Improvement Plan is being developed, structured around Stabilise, Grow, Connect. Its focus is sustainable improvement in patient access, safety, and quality.

- **People**

Clinical empowerment is central to change. Chiefs of Service now form part of the Senior Leadership Team, and a new Clinical Policy Group is being established to ensure decisions about resources and care are shaped collectively by clinicians. CEO visits across sites continue to highlight staff commitment, safety improvements, and professional achievements.

- **Population**

Work across sites is focused on reducing waits, improving patient flow, and preparing for winter - ensuring services are responsive to community needs, outcomes and access for our local populations.

MONTHLY TREND KEY

↑	Improvement on previous reported month
↓	Deterioration on previous reported month
↔	No change on previous reported month

SAFETY AND QUALITY PRIORITIES

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

OPERATIONAL PERFORMANCE (AUG 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)	**61.9%**	↑ 58.9% in July
62-day cancer (75% in March 2026)	***55.3.%**	↑ 48.1% in June
28-day FDS (80% in March 2026)	***50.8%**	↓ 52.9% in June
18-week RTT (65% in March 2026)	**56.7%**	↓ 57.9% in July
6 week wait (95% by March 2026)	**67.6%**	↓ 73.8% in July

*July 2025

NLAG

A&E 4hr wait (78% by March 2026)	**72.9%**	↓ 74.2% in July
62-day cancer (75% in March 2026)	***54.5%**	↑ 53.5% in July
28-day FDS (80% in March 2026)	***64.1%**	↑ 58.8% in June
18-week RTT (65% in March 2026)	**59.1%**	↓ 59.9% in July
6 week wait (95% by March 2026)	**61.3%**	↓ 64.9% in July

*July 2025

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- During Q1 at HUTH, Friends & Family Test responses declined by 13%, but positivity held at 92.7%; A&E scores remained below national target (73%). NLAG saw a 14% rise in responses, with positivity improving to 91.7%, and inpatient/outpatient scores above 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 shape our organisation. By bringing Chiefs of Service onto the Senior Leadership Team, our most experienced clinicians are increasingly involved in day-to-day decisions about priorities, resources, and delivery of care.
- To build on this, the Group is forming a new Clinical Policy Group, which will bring together senior clinicians from across specialties to make collective decisions on how services are organised and how resources are allocated. This will ensure that patient safety, quality, and clinical insight sit at the heart of strategic and operational decision-making, while also helping to develop a stronger culture of learning.

PEOPLE (AUG 25)

IPR

Group sickness absence	**4.8%**	↔	4.8% in June
Core Mandatory Training	**89%**	↔	89% in June
Role Specific Training	**80%**	↔	80% in June
Appraisal rate (AfC)	**81%**	↓	82% in June
Turnover rate (12 months)	**8%**	↔	8% in June
Agency spend YTD	**179.4 WTE**	↓	172.7 WTE in June
Job planning	**43%**	↑	39% in June

GROUP FINANCIAL POSITION (M5)

Finance. rep

Indicator	£M	%
I&E YTD against plan	(£3.0m)	(21%)
I&E Year end forecast	£0.0m	0%
Capital YTD against plan	£20.9m	66%
CIP YTD against plan	£37.3m	85.2%

DISCHARGE (Sept 25)

MH

HUTH

Bed occupancy classed as clinically ready for discharge (lower is better)
27.7% ↑ 29.5.% in Aug

NLAG

Bed occupancy classed as clinically ready for discharge (lower is better)
18.1% ↓ 15.4% in Aug

THEATRE UTILISATION

IPR

HUTH touch-time capped utilisation (Elective 85% standard)	**81.3%**	↑	80.2% in July
NLAG touch-time capped utilisation (Elective 85% standard)	**73.9%**	↑	72.5% in July

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)175

Name of the Meeting	**Trust Boards in Common**
Date of the Meeting	Thursday 9 October 2025
Director Lead	Amanda Stanford, Group Chief Nurse
Contact Officer/Author	Donna Pickering, Head of Risk and Patient Safety (HUTH) Kelly Burcham, Head of Risk and Patient Safety (NLAG) Richard Dickinson, Associate Director of Quality Governance
Title of the Report	**Quarterly Patient Safety Report and Triangulation plan.**
Executive Summary	The Board is asked to review and note the content of the report for the 3 elements of the report, Patient Safety, Triangulated themes and the Patient Safety section of the Board Assurance Framework. **Patient Safety Incident reporting and learning:** An overview of the Quarter 1 of 2025/26 is provided illustrating the overall reporting rates, ranking of highest reported incidents and thematic analysis. There is also a listing of investigation and casework being monitored for action completion. Safety actions identified from investigations is also provided to share. **Triangulation of identified themes:** The proposal has been to analyse the themes and issues arising from a range of sources, including incident reporting, patient safety profile, legal claims and inquests, patient complaints and clinical effectiveness is provided. **BAF – Patient Safety:** The summary overview of the Patient Safety Strategic Objective and associated risks are provided, including risk appetite, high level risk association, controls, assurances and gaps.
Background Information and/or Supporting Document(s) (if applicable)	This report with further detail was provided to the Quality and Safety Committees-in-Common in September 2025.
Prior Approval Process	A version of this report was provided to the Patient Safety & Learning Group and Quality and Safety Committees-in-Common.
Financial implication(s) (if applicable)	*None*
Implications for equality, diversity and inclusion,	*No negative impacts.*

including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval þ Assurance ☐ Discussion	☐ Information ☐ Review ☐ Other – please detail below

Quarterly Patient Safety Report (Q1)

The quarterly paper provides a summary of the patient safety incident and learning response activity within NLaG and HUTH and associated improvement work.

Main highlights are as follows:

NLaG

There are normal variation rates of reporting of incidents across care groups and for the overall reporting of patient safety incidents.

The themes of incidents reported have been analysed and the activities to investigate, identify learning and improve are summarised in the breakdown of the detail. The following are main themes highlighted from the patient safety incidents section as well as those identified in learning responses or previous investigations:

Pressure ulcers and Falls: Improvement plans under review which are led by the Chief Nurse Office. There have been 3 fall learning responses in total since transition to PSIRF in December 2023. There has been 1 learning response declared for a pressure ulcer incident in the last 6 months. Care Groups continue to implement safety actions identified from learning responses undertaken.

Discharge: One of the main themes in relation to incidents reported with numerous improvement activities and workstreams in place within the Trust and externally with the ICB.

Medications: Identified themes progressed through Safer Medications Group. Weight based prescribing is an ongoing quality priority project. The medication safety dashboard in place for the group (developed by the medicines safety team) brings together both data from Datix and Ulysses and is shared each month with the care groups. Group quality priorities in place in respect of medication safety relating to weighing of patients, time critical medication, insulin safety (to commence early 2026) and IV Oral switch. Local quality initiatives relating to medication recorded on AMaT.

Results not acted upon: Continues to be a theme, most notably for outpatients as identified from proportionate learning responses. There is planned roll out for results acknowledgement in outpatients although this is currently on hold until the version upgrade for WebV from 2 to 3 which is expected in Q2 25/25. The new system (Lorenzo) gives a more robust tracking process to try and mitigate any patients being missed and helping ensure their care plan is monitored. Audit of results being acted upon in line with policy to be undertaken across the group with the project at planning stage. A recent PSII has been declared (ref: STEIS 2025 3724) relating to a patient seen in an outpatient clinic and a CT scan urgent finding that was not escalated nor actioned for a referral to the specialty and MDT discussion.

Communication: A recognised triangulated theme. Communication with patients / families included within the Trust Quality priorities 2024/2025 as an associated qualitative KPI where appropriate.

Handover*:* Electronic solutions in place including handover documents on WebV in Acute Medicine and the introduction of an electronic handover tool on Symphony following a local QI project. However, uptake is unclear currently as ED are predominantly paper based. Web V version 3

handover tool expected to be released in Q2 2025/2026 to support more effective handovers between teams. It is planned to be piloted in August 2025 by ITU.

Paediatric Audiology: 1 further case has been identified in this quarter. Action plans are being monitored within the Head and Neck Care Group, and evidence collation in conjunction with central patient safety team.

Allergy recording: Identified by the Learning Response Panel as a priority area for a thematic review in relation to recording of allergy status. Currently in progress. AAR declared in January 2025 relating to medication given to a patient with known allergy. The outcome of the AAR will inform the thematic review. In April 2025 clinical nurse educators and members of medicine management team spoke to staff on as many wards and sites as possible about allergy recognition, medication related allergies and the importance of checking a patient's allergy status as part of allergy awareness week. Information and resources are available on Bridget including an allergy awareness poster as part of this campaign.

Theming of incidents and team capacity

The central patient safety team's ability to conduct thematic reviews has been significantly hindered due to a resource gap. The Patient Safety Project Officer position was vacant from November 2024, which has recently been appointed to (April 2025). The team's capacity to compensate for this vacancy has been limited, worsened by increased manual reporting requirements. This has strained resources and impacted the team's ability to perform critical thematic analysis. Priority will be given to reviewing learning responses and emerging concerns as part of a 6-month plan (April – Oct 2025).

Triangulation of themes

The following table provides an overview of the themes previously identified, with an appendix provided for further charts and details of plans to manage these activities.

Themes	**Lead/Process**	**Stage of workstream and baseline data.**
1. Reduction in the number of complaints received by each Care Group	Associate Director of Quality Governance (patient experience/ compliance/ risk)/ QI project	QI project initial meetings have taken place with each Care Group working through their priorities and plans at this stage.
a. Appointment waiting times		
b. Attitudes & Behaviours		
c. Clinical treatment delays/ waiting		
d. Clinical Treatment outcomes		
e. Communication with patients and relatives		
f. Nursing Care		
2. Communication improvement with primary care in OPD and discharge.	ICB & Patient Safety Team	There is some overlap and interdependence between these workstreams, so consolidated baseline information is provided.
3. Discharge medication safety and supply	Operational Medication Group	
4. Safer surgery and interventions	Safer Surgery and Interventions Group/ Working group has Deputy Group CMO, TACC Nurse Director, Associate Director of Quality Governance (patient safety/ clinical effectiveness/ legal/ QI)	Target is to have zero Never Events.

Themes	Lead/Process	Stage of workstream and baseline data.
5. Failure to act on results of tests, Radiology, laboratory	Patient Safety Team	Baseline data captured, with learning form specific incidents
6. Community Pressure Ulcer Prevention (NLAG Community)	Community PU group	The North Lincolnshire Community Nursing team have a regular pressure ulcer review process, supporting the casework and care homes they work with.
7. Hospital acquired Pressure Ulcer prevention	Acute PU Group/ Associate Chief Nurse.	There is a weekly review meeting for the group and a strategic oversight meeting held monthly.
8. Prevention of patient slips trips and falls	Falls Group/ Practice Development Mation - Falls	NLAG detail has been provided on page 13 and HUTH data on page 44.

NLAG OVERVIEW OF PATIENT SAFETY INCIDENTS REPORTED

Total Number of Patient Safety Incidents by Quarter

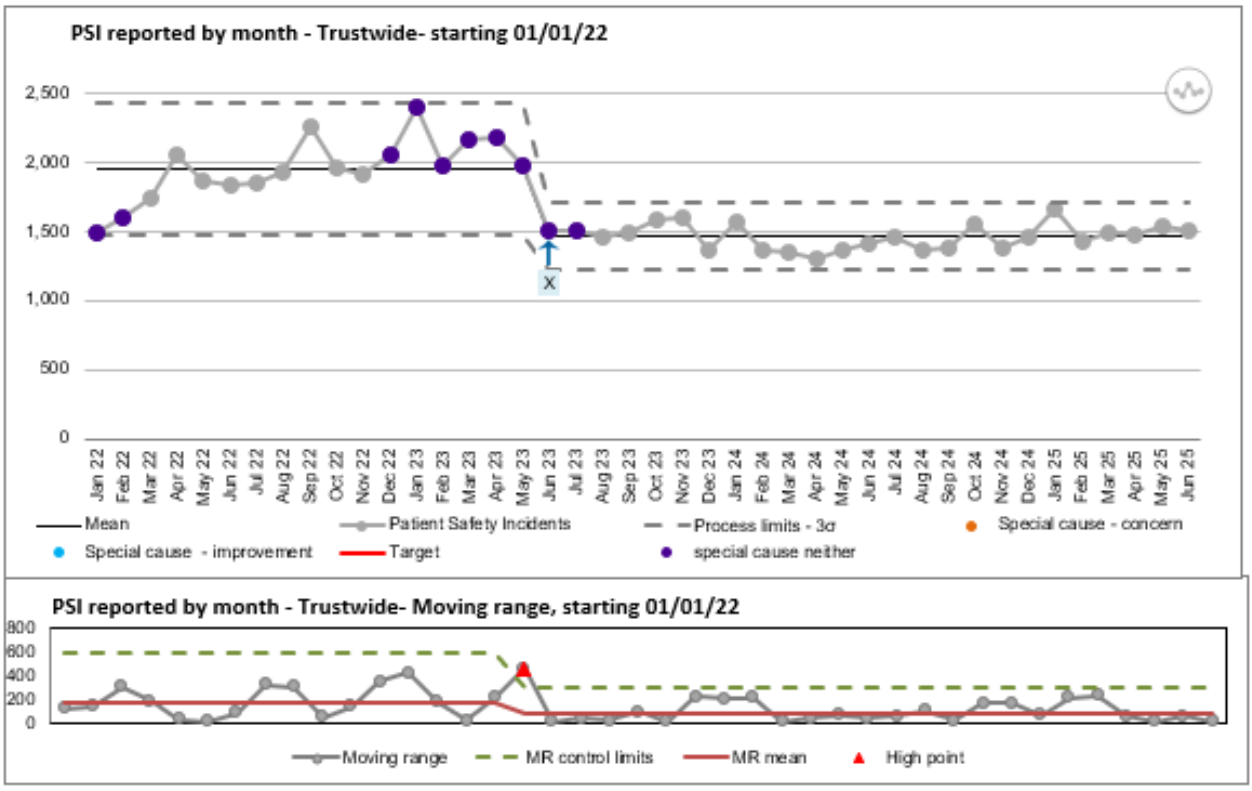
The following table provides the total Number of Patient safety incidents reported on Ulysses (excluding externally reported incidents) by Quarter (Trust-wide) including % breakdown of harm levels:

Quarter:	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Harm levels as of % of patient safety incidents reported by Quarter				
Total:	4205	4309	4568	4508
Near Miss	3.25%	3.09%	3.67%	2.90%
No Harm	70.02%	65.62%	68.56%	71.36%
Low	23.21%	28.65%	25.35%	23.27%
Moderate	3.09%	2.43%	2.21%	2.20%
Severe/Major	0.14%	0.13%	0.15%	0.20%
Fatal	0.09%	0.04%	0.04%	0.07%
% graded as Near Miss / No / Low Harm*	96.67%	97.38%	97.59%	97.54%

***>90% of total patient safety incidents indicates a positive safety culture in relation to incident reporting.**

Patient Safety Incident Reporting Rate

Total number of patient safety incidents reported by month:

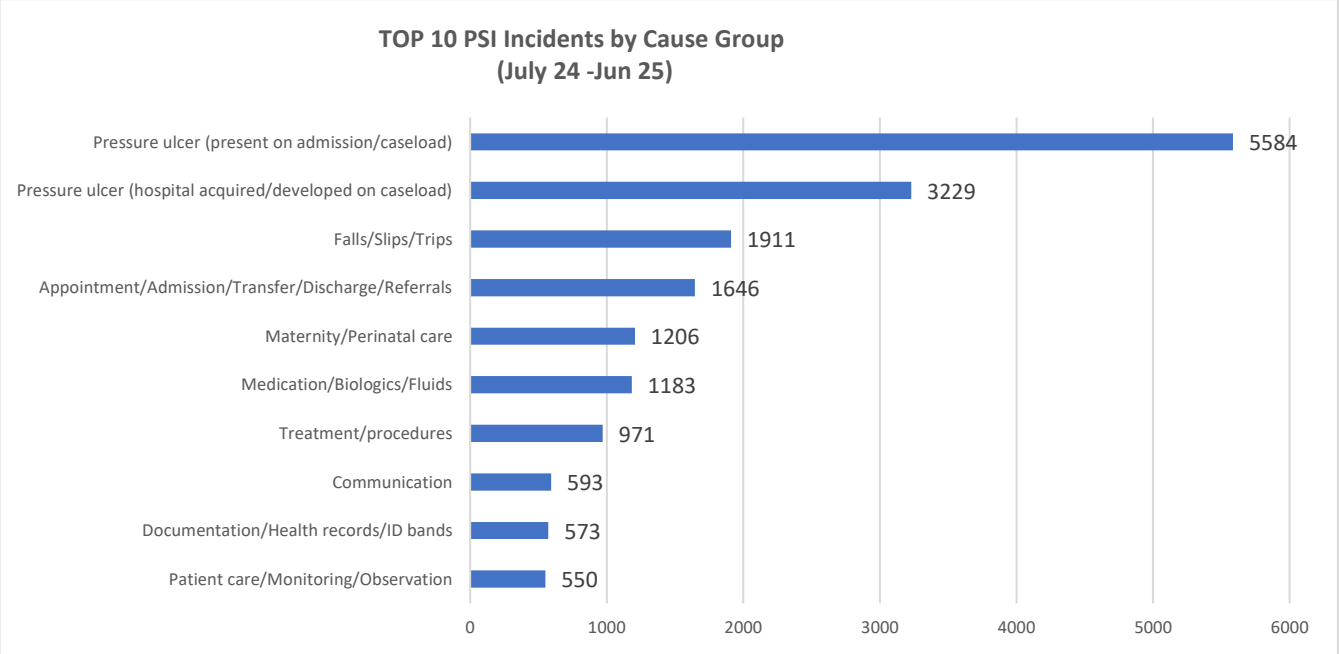


A change to the reporting on 12-hour trolley waits in the Emergency Departments (now a daily summary rather than each occasion) was introduced in June 2023 (marked x on the chart), unless there is harm evident, incidents are continued to be monitored via other workstreams across the Trust. There is common cause variation shown in the recent period.

The rate of incidents is 81.99 per 1000 bed days, for the last 12 months (Jul 24 to Jun 25), however this does not factor in the OPD activity and community services, so use with caution for direct comparison for other provider benchmarking (national benchmarking data not available since 2022).

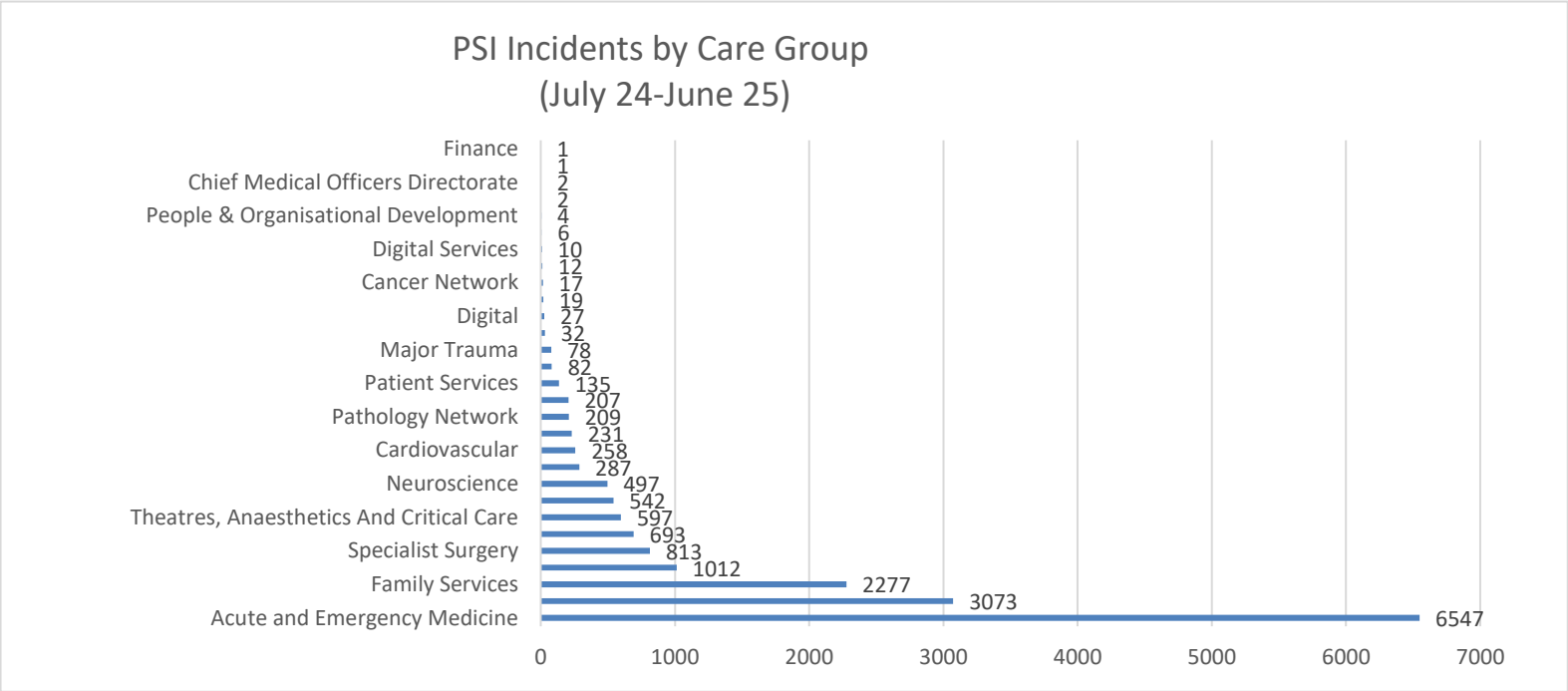
Top 10 Patient Safety Incidents by main Cause Group (12 months data)

Further analysis of these cause groups is provided later in the report under Patient Safety Incident Cause Group breakdown.



Patient safety incidents by Care Group (responsible)

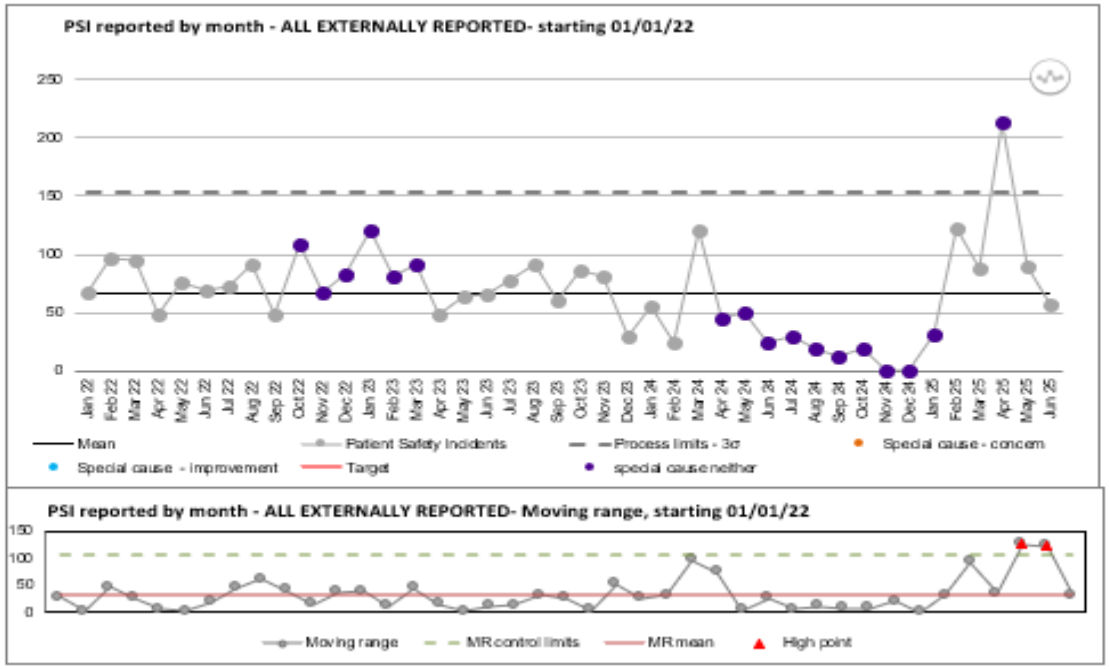
The following chart shows the breakdown of patient safety incidents by care groups from April 2024:



Pt Safety Incidents by Care Group (Top 10 Reported) (July 24 to Jun 25)	No. (%)
Acute and Emergency Medicine	6547 (37.04%)
Community, Frailty & Therapy Services	3073 (17.39%)
Family Services	2277 (14.01%)
Digestive Diseases	1012 (5.37%)
Specialist Surgery	813 (4.47%)
Specialist Medicine	693 (3.6%)
Theatres, Anaesthetics And Critical Care	597 (3.37%)
Specialist Cancer And Support Services	542 (2.97%)
Neuroscience	497 (2.32%)
Head and Neck	287 (1.74%)

OVERVIEW OF EXTERNALLY REPORTED PATIENT SAFETY INCIDENTS

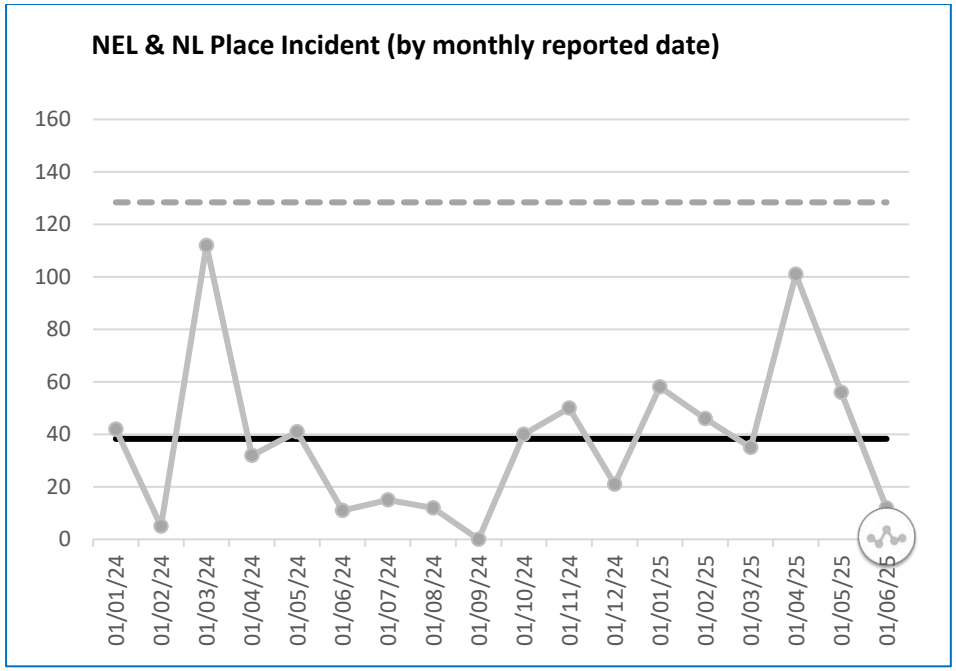
These incidents originate in primary care mainly, but other provider organisations also report incidents to the Trust. Note: these are **all** externally reported incidents (Jul 24 – Jun 25 *n=684.* NL and NEL ICB incidents account for 473 reported incidents).



There is common cause variation seen in this SPC chart. Whilst there are variances month on month it should be noted that the graph represents the dates *reported* and may not reflect the date of the incident. NEL ICB forwards incidents to the Trust in batches to upload to Ulysses (as can be seen with the highs and lows). At the time of writing this report there was a delay in uploading/reporting external incidents on Ulysses due to capacity within the central team. This backlog is now complete (as of June 2025).

Patient Safety Incidents by NEL and NL ICB *only from Jul 24 – Jun 25 (n=446)*

These incidents are collated, themed, and shared to gain further insights and mitigation / improvement work to provide assurance (previously separate reports provided feedback to ICB colleagues). A new process has been implemented from July 2024 with all incidents investigated via the normal incident management route.

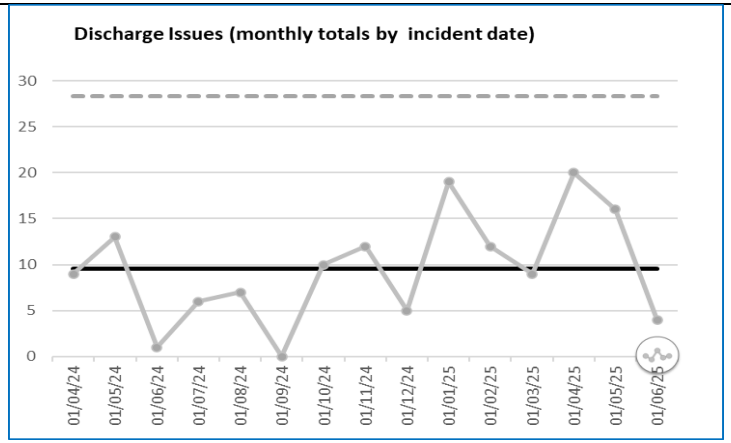


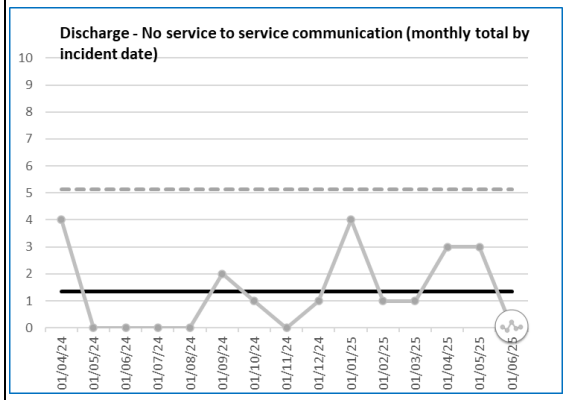
The number of incidents that have occurred over a 12-month period remains static (normal variation) and within the upper and lower control limits.

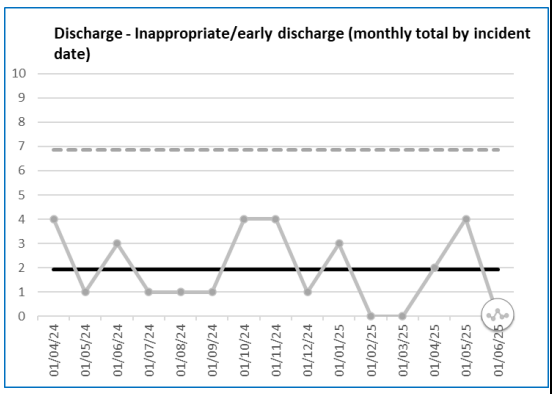
Discharge and Discharge Medication issues remain the top themes across NEL and NL reported incidents.

The table below provides a summary of these identified themes, mitigation and action taken to remedy the identified issues (as at June 2025). Any themes identified as an improving picture no longer feature in the report however are continued to be monitored via other workstreams across the Trust.

Theme: Discharge issues (*Rolling 12 months / date reported n=120 (prev 103*) ICB	
Incident data	**Mitigation/Improvement Activity**







Inappropriate/early discharge
Issues reported include patients discharged with ongoing medical issues that still require attention; cannula still in-situ; assessments / referrals not completed prior to discharge (including referral to District Nursing and Care Agencies).

Patient flow and discharge workstreams continue, reported through to the Performance and Financial Group. Weekly expert panel in place to review patients with multiple admissions, supported by Northern Lincolnshire system partners.

A new discharge lounge safety pathway, approved in February 2025, has been implemented. The pathway is for the ward areas to complete to ensure that all the relevant actions are taken prior to transferring the patient to the discharge lounge.

A weekly director level 'No Criteria to Reside' meeting is now in place which replaces weekly multiple admission meeting and is attended by external partners.

There is monthly Flow Forum with the Care Navigators from the wards where discussion is held regarding patient flow issues/processes. This meeting is a learning platform supporting education on patient discharge and forms part of the Flow campaign. This forum is well established with good attendance.

The Trust continues to monitor its readmission rates monthly (from locally available data) and compares these to the national rates to benchmark our performance. The Trust is below the England average for readmissions in patients aged over 16 years.

No service-to-service communication
Referrals to community nursing (including the administration of insulin; catheter and End of Life care) remain the main area of concern along with referrals to care services and referrals between hospital departments.

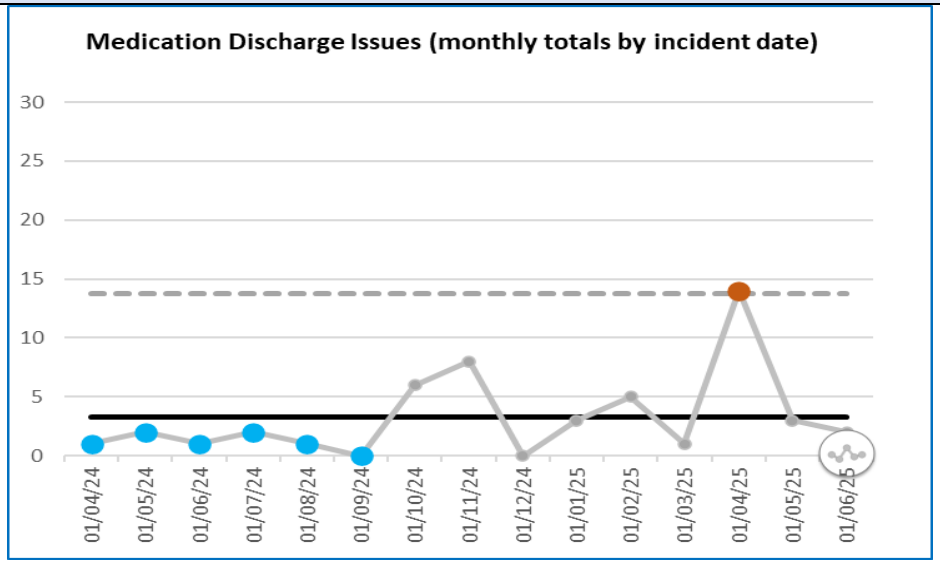
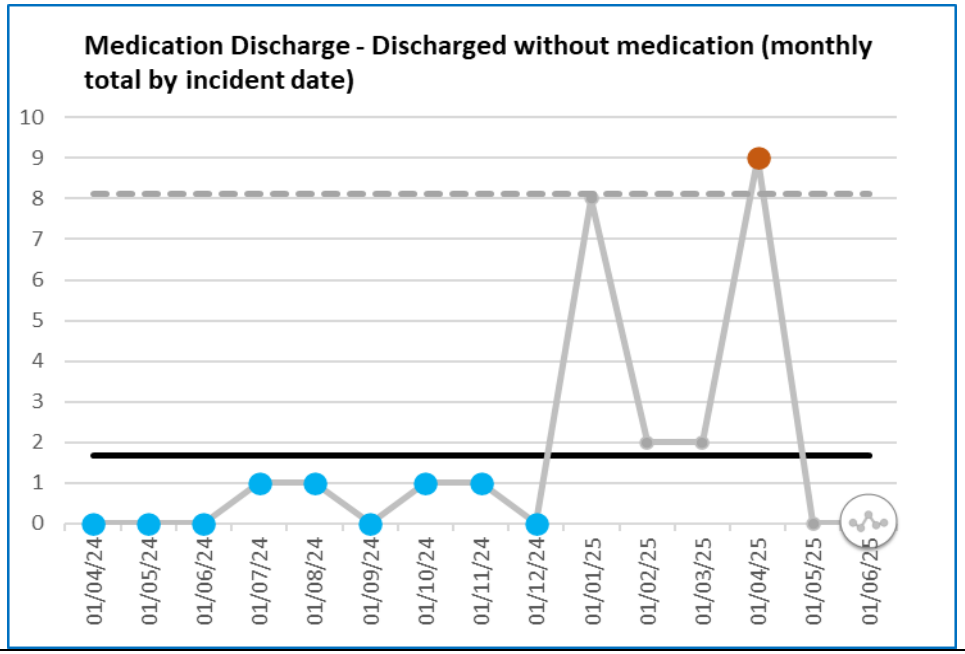
The Trust are implementing the OPTICA IT system for supporting with tracking patient pathways and discharge for in and out of hospital providers. OPTICA is used on all 3 sites – ward roll out is about to commence across SGH in the current phase of the project.

There are multi agency meetings being held monthly relating to discharge with the ICB and other external providers in attendance.

A transport coordinator role has been newly established and extended for another year in DPOW and a Transport Co-ordinator has now been appointed

	in SGH and commences in post August. This role is to improve the organisation of patient transport. A voluntary role has been implemented in both EDs and Discharge Lounges to support discharges/flow. The role will ensure that when discharged from ED/Discharge Lounge they will follow up patients at home to prevent admission to hospital. Meetings are being held with Lincolnshire and East Riding of Yorkshire ICBs to improve patient pathways for discharges.

Theme: Medication Discharge (*Rolling 12 months / date reported n= 45 prev month = 30*) ICB

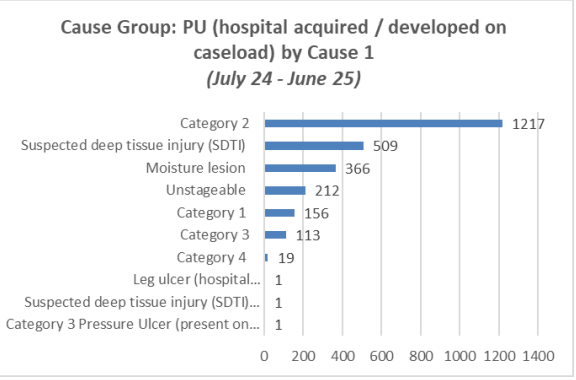
Incident data	Mitigation/Improvement Activity
 	**Discharged without or insufficient medication on discharge** Overall numbers remain low. All incidents reported under Cause Group 'Medication/Biologics/Fluid' are also reviewed/investigated by the Pharmacy Team (as well as within areas responsible) providing greater oversight (however most are outside pharmacy control). This theme also forms part of wider work ongoing across the Trust regarding the discharge process. The pharmacy team analyse weekly data ensuring themes can be identified by specialty/date. Incidents include no prescription/green sheet for Insulin; discharged without medications that should be prescribed by a specialist (not a GP); patients discharged without appropriate medications i.e. EOL patients discharged for best supportive care discharged without anticipatory medications (some have no referral made to community nursing / other services). **refer also Medication/ Biologics/ Fluid*

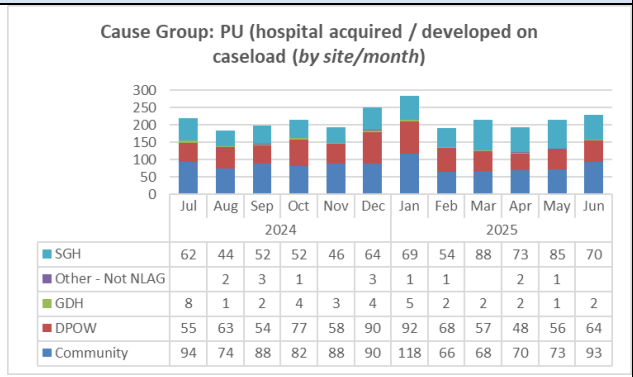
PATIENT SAFETY INCIDENT CAUSE GROUP BREAKDOWN

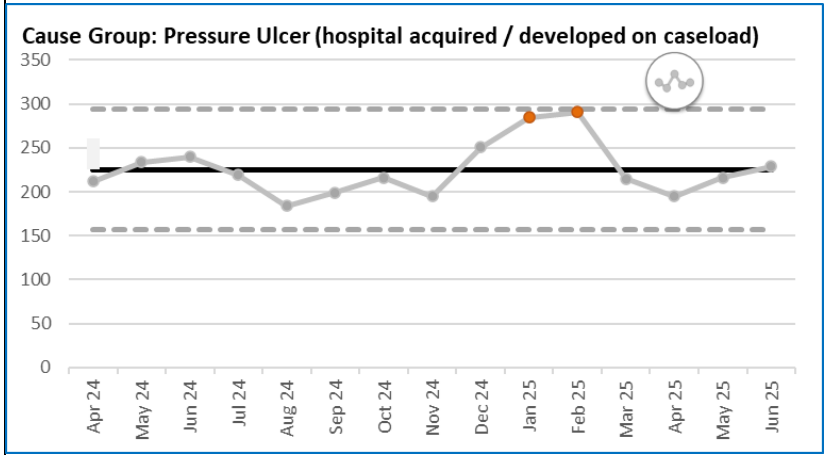
This section provides a breakdown of each of the top 10 cause groups (excluding Pressure Ulcer – present on admission / caseload) relating to patient safety incidents for the 12-month period **July 2024 to June 2025.**

Cause Group Pressure Ulcer (hospital acquired / developed on caseload) (*n= 2595*; prev. rolling 12-months *n=2641*)

Incident data







Note: Pressure Ulcers present on admission / on caseload are excluded from this analysis.

Specialty Responsible	Count
Acute Medicine	453
South Network	372
West Network	254
East Network	222
Trauma & Orthopaedics	190
General Surgery	156
Frailty	130
Respiratory / Thoracic Medicine	122
Critical Care	113
Community - Intermediate Care	103

Mitigation/Improvement Activity

New Group Pressure Ulcer Improvement Plan in development.

All pressure ulcer incidents (hospital and community acquired) are validated. Rapid review of Cat 3, Cat 4 and Unstageable are undertaken. If new learning identified an After Action Review (AAR) is conducted under PSIRF which would then inform the Improvement Plan with relevant actions. A Cat 4 / complex PU case would be considered for PSII by the Learning Response Panel. For Cat 1 and Cat 2, local manager review of the incident is undertaken for local learning.

CQUIN 24/25: Assessment and documentation of PU risk - 80% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. CQUIN Steering Grp reporting to PS&LG.

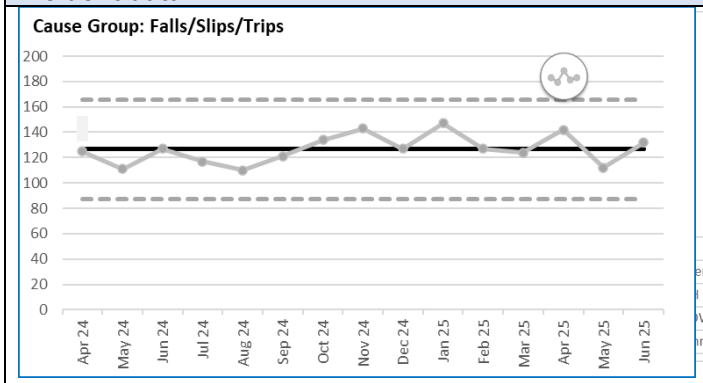
Ward Managers Weekly Assurance Tool (WAT) includes questions relating to pressure area care. Reported monthly to the Senior Nurse Forum. Locally developed action plans in place.

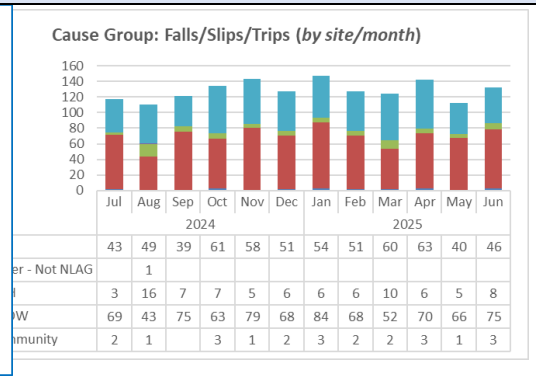
Pressure Ulcer KPIs are reported to QS CIC via the IPR. Group assurance programme 'A Commitment to Excellence' (ACE) commenced in March 2025. ACE provides ward-to-board assurance on quality of care, demonstrate compliance with key standards and identify themes for improvement. Reporting to PS&LG and quarterly highlight report to QS CIC.

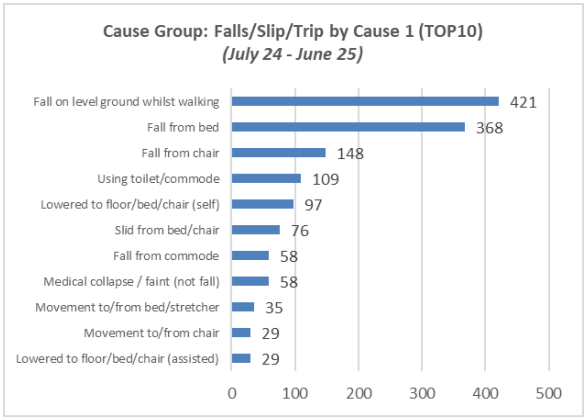
New pressure ulcer risk assessment rolled out at NLaG following a collaboration between WebV and the Tissue Viability team in Q4 24/25. The new way of working has replaced the former Skin Integrity Risk Assessment and Pressure Area Management Care Plan. This new system is based on the Pressure Ulcer Risk Assessment - Purpose T tool, which was developed by Leeds CRTU that is being used nationally. Referenced in PSIRF section of the report.

Cause Group: Falls/Slips/Trips *(n=1536; prev. rolling 12-month n=1513*

Incident data







Specialty Responsible (Top 10)	No
Acute Medicine	467
Frailty	155
Emergency Care	127
Stroke	123
Respiratory / Thoracic Medicine	91
Trauma & Orthopaedics	89
General Surgery	76
Gastroenterology	76
Cardiology	70
Endocrinology	57

Fall incident themes: Documentation (not completed / not followed: risk assessments / care plans / pathways / NEWS scores / AFLOAT Assessment). Lack of staff to support 1:1 care.
**Links also to Documentation Cause Group*

Mitigation/Improvement Activity

Group Falls Improvement Plan in place. Approved April 2025.

Incidents and learning responses reviewed by the Chief Nurse Office for themes and trends which are used to inform the improvement plan.

Falls training provided to areas/individuals as identified through investigative processes, incident review or Nursing Metrics.

Falls KPIs reported to Quality and Safety Committee in Common via the IPR.

Ward Managers Weekly Assurance Tool (WAT) includes questions relating to falls care. Reported monthly to the Senior Nurse Forum. Locally developed action plans in place.

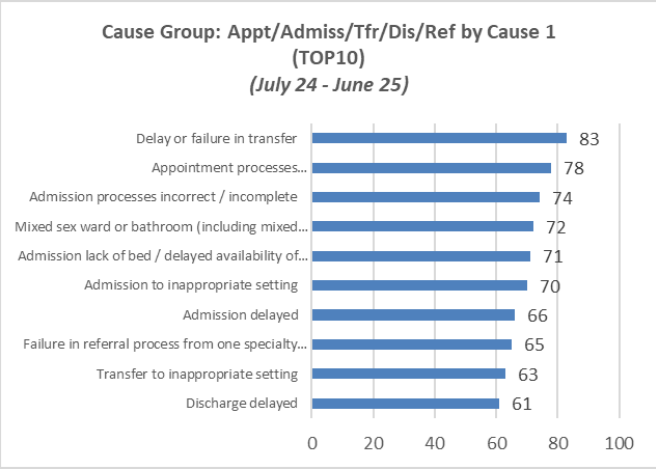
Group assurance programme 'A Commitment to Excellence' (ACE) commenced in March 2025. Reporting to Patient Safety and Learning Group and quarterly highlight report to QS CIC

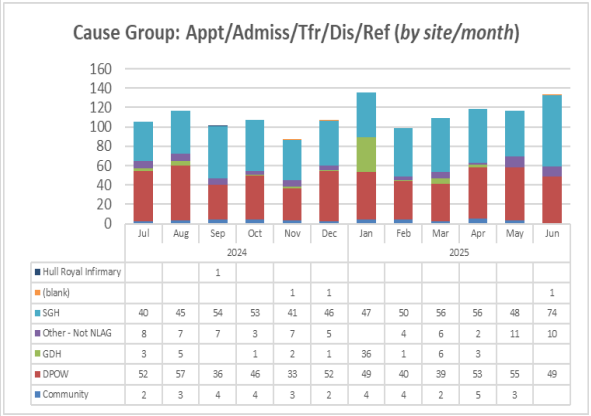
AFLOAT documentation went live in Q3 24/25 on WebV to improve documentation. Falls assessment on WebV is being presented to the Nursing Directors Group to remind nurses when assessment is due for patients, this has gone live April 25. This relates also to the documentation theme.

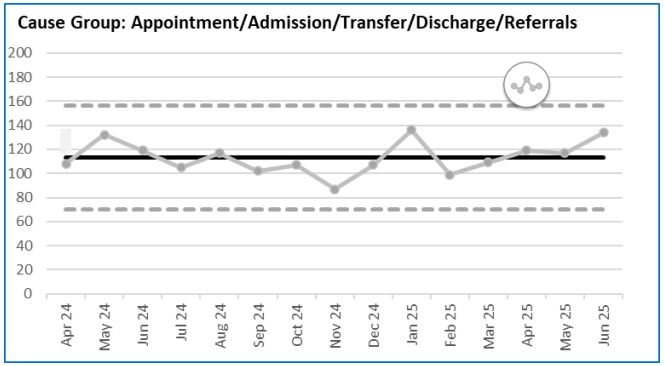
Referenced in PSIRF section of the report.

Cause Group: Appointment/Admission/Transfer/Discharge/Referrals *(n=1339; prev. rolling 12-months n=1328)*

Incident data







Specialty Responsible (Top 10)	No (%)
Acute Medicine	151
Operation / Site Team	150
Emergency Care	130
Paediatrics	125
Ophthalmology	103
Gynaecology	69
Other - Not NLAG	66
Obstetrics / Maternity	61
Stroke	60
Critical Care	39

*Discharge *Reference also in External Incidents section of the report.*
Ophthalmology delay in appointments (including the incidents reported from Sep-24) are being reviewed by the Senior Management Team to identify improvement work.

Mitigation/Improvement Activity

Discharge checklist for Paediatric Safety Netting developed in ECC to improve audit compliance. Discharge checklist implemented in 2023 (WQN 1757). Additional training is required to ensure full usage which is ongoing.

Discharge Improvement Group led by the ICB with all key stakeholders.

Audit undertaken within S&CC on the quality of electronic discharge summaries for 2023/24. Actions being agreed.

FLOW Champion Forums are held monthly with attendance from ward champions. The forums investigate problem areas and support with implementing improvements. These forums are fully established with good attendance. INR Management was included in the forum following a patient safety incident (investigated under PSIRF as an MDT), this is now incorporated into the discharge lounge safety pathway.

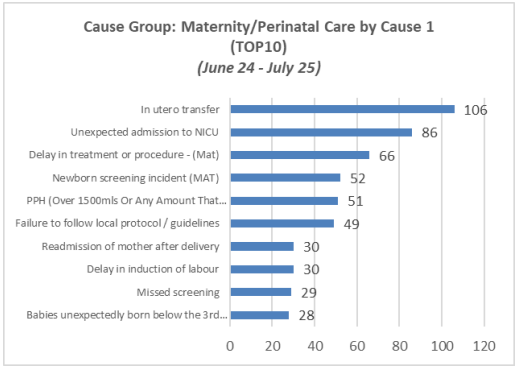
The FLOW workstream is reported through the Performance and Finance Improvement Board with the Site Nurse Director being the Senior Responsible Officer. The workstream incorporates patient pathways including board rounds and ward rounds and expansion of virtual wards.

Patient Services Care Group highlighted key learning from incidents in their March 2025 update to PSLG. Delayed appointments in Ophthalmology DPOW were due to low staffing resources, staffing backfilled over establishment to mitigate patient safety risk (staffing now at 100%, additional support to be withdrawn), SGH due to patient cancellations. Agreed process in place for clinical involvement when patients cancel their appts and current processes to be reviewed and improved. These incidents are now closed – processes were reviewed and improved.

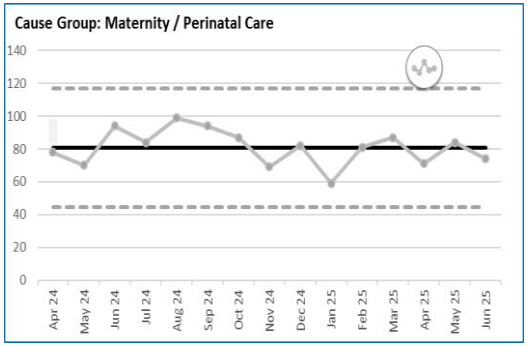
** See ICB Incident – Discharge issues section of the report for additional improvement work.*

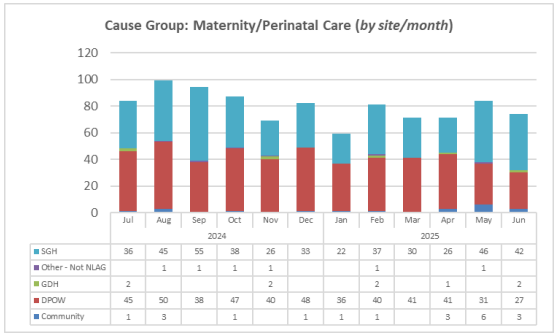
Cause Group: Maternity/Perinatal Care *(n=955* prev. rolling 12-month *n=968)*

Incident data



Specialty Responsible (Top 5)	No (%)
Obstetrics / Maternity	737
Neonatology (Newborn Intensive Care)	54
Community Midwife	46
Neonatal	37
Paediatrics	28





Mitigation/Improvement Activity

Weekly O&G incident meetings held to review reported incidents held at Specialty level. Avoiding Term Admissions into Neonatal units (ATAIN) reviews undertaken for appropriate incidents. Local Managers Review now undertaken for Post-Partum Haemorrhage (PPH) with thematic reviews undertaken within the Care Group.

PMRT review still births and neonatal deaths as part of the national standards.

Fetal monitoring and CTG training in place as part of the national standards.

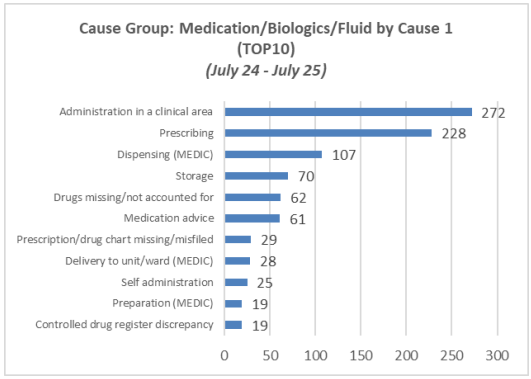
Ongoing projects undertaken to understand, drive and share learning to prevent future cases including Royal College of Obstetricians and Gynaecologists 'Each Baby Counts'; NHS England 'Saving Baby Lives Bundle' reported to the Trust Board.

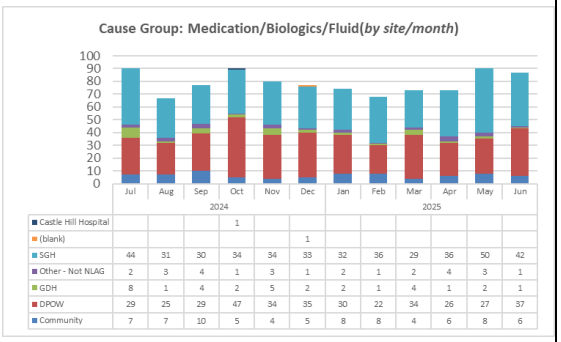
Quality Improvement Projects being undertaken in Family Services Care Group in relation to End of Life (neonates), Deteriorating Patient (paeds medicine; neonates); and Medication (paeds medicine).

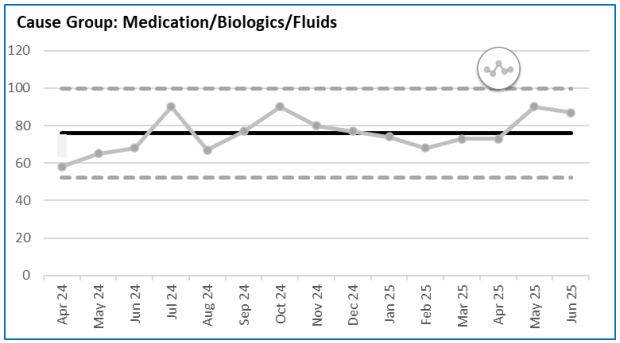
The Newborn Screening Coordinator reviews the incidents. Training happens if identified as an occurring issue with professional practice. All newborn screening samples are now undertaken by the neonatal nurses.

Cause Group: Medication/Biologics/Fluids (*n*= 946; prev. rolling 12-month *n=887)*

Incident data	Mitigation/Improvement Activity







Controlled drug register discrepancies (missing / not accounted for)
Failure / delay in prescribing / administering;
Incorrect dose / route; duplicate prescription.
Antibiotic / Penicillin / Paracetamol Prescribing
Transferring of medication with patient transfers.

Specialty Responsible (Top 10)	No (%)
Acute Medicine	205
Emergency Care	121
Pharmacy	100
Paediatrics	52
General Surgery	41
Frailty	40
Obstetrics / Maternity	39
South Network	28
Other - Not NLAG	27
Trauma & Orthopaedics	26

Safer Medication Group monitor all incidents with cause group 'medication' and review a monthly incident report of medication themes. Local management reviews of medication incidents occur at ward/dept level with additional incident oversight from the pharmacy team.

Safer Medicine Newsletter produced to act as an aide memoire and to highlight pertinent issues.

The Medicines Optimisation Annual Report from July 2025 provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year.

All controlled drug incidents are reported to the Trust CDAO and concerns shared with the NHSEI region Controlled Drug Local Intelligence Network (CD LIN). Quarterly audit on storge compliance undertaken. Each area of non-compliance is incident reported, investigated, and actions taken by the ward/area manager. These actions are reviewed by the CDAO, and any further support is offered to the ward /area manager through the medicine management nurses. Any trends are discussed at the Safer Medication Group, and Pharmacy Governance Group.

Allergy status theme identified October 2023 following SI. Thematic Review (PSIRF) for medication allergy incidents commenced July 2024. AAR declared Jan 24 for allergy incident that will inform the thematic review.

Weight based prescribing issue identified following SI in 2018. Medication Safety **Quality Priority (commenced 23/24)** to improve the safety of prescribing weight dependent medication to adults. Patient's weight is now automatically added to their weight in EPMA to support the weighing of medication.

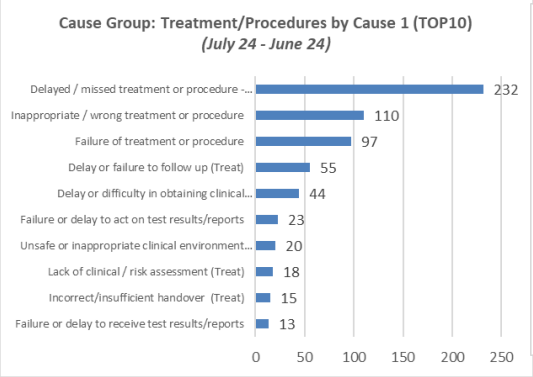
The Medication Safety Quality Priority incorporates the below 4 workstreams with engagement from the teams across the HHP:

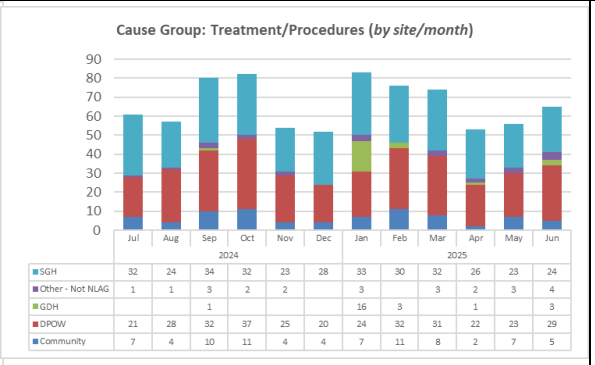
1. Weighing of patients
2. Time Critical Medications
3. Insulin Safety (to commence early 2026)
4. IV to Oral switch

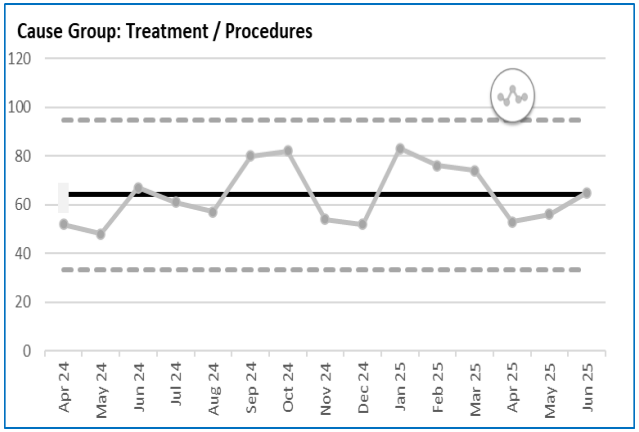
Progress is reported to the Patent Safety Learning Group.

Cause Group: Treatment/Procedures *(n=793; prev. rolling 12-months n=793)*

Incident data







Specialty Responsible (Top 10)	No (%)
Emergency Care	111
Acute Medicine	96
Obstetrics / Maternity	46
Trauma & Orthopaedics	43
Ophthalmology	43
Gynaecology	34
Paediatrics	33
General Surgery	33
South Network	31
Other - Not NLAG	23

Mitigation/Improvement Activity

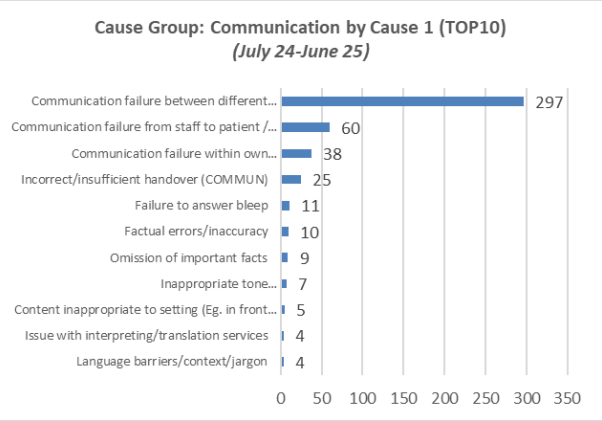
Audiology Services
**See PSIRF section of the report.*

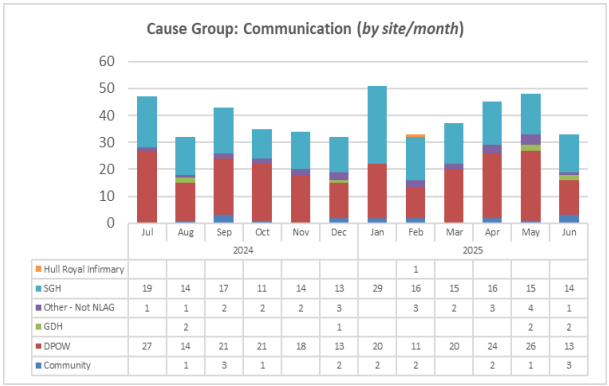
Results not acted upon (inpatient and outpatient radiology; pathology; histology; screening tool; observations and monitoring).
**See PSIRF section of the report.*

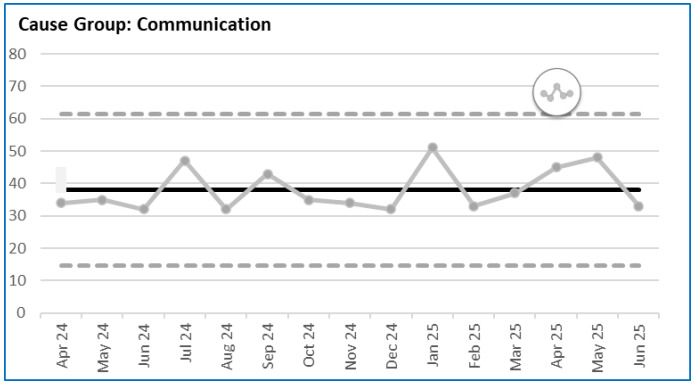
Delay in Ophthalmology appointments
***** See *Appointment/Admission/Transfer/Discharge/Referrals section of the report.*

Cause Group: Communication *(n=470; prev. rolling 12-month n=445)*

Incident data	Mitigation/Improvement Activity







Specialty Responsible (Top 10)	No (%)
Emergency Care	61
Acute Medicine	57
Paediatrics	35
Obstetrics / Maternity	33
General Surgery	30
Other - Not NLAG	24
Gynaecology	17
Trauma & Orthopaedics	15
Respiratory / Thoracic Medicine	14
Operation / Site Team	14

Communication is a recognised triangulated theme.
Discharge: including referral to community nursing services and external care agencies; accurate and appropriate discharge summaries
**Referenced also in Externally Reported Incidents section*
Handover: between shifts / teams / departments; incorrect / insufficient; written / verbal; Emergency Department and ambulance handovers

Communication included within the Trust Quality priorities 2024/2025 as an associated qualitative KPI where appropriate.

Local QI project undertaken relating to 'Handover in Emergency Department' which has seen the introduction of an electronic handover tool on Symphony (the electronic patient record) allowing all team members to document / view handover. Unclear as to the uptake currently of this electronic handover tool as ED are predominantly paper based. This tool is used within ED and enables the clinical staff to handover to the next shift– further developments are required and will be worked on to improve the usage and uptake to other specialities.

A roll out will commence after July 2025 for the WebV Version 3 Handover tool. This will improve quality of handovers. The progress in reported monthly at the EPR Operational Group. The role out will commence in ITU initially with a view for other areas to follow – it is expected that ITU will be fully operational with this tool within 2 months (October 2025).

Handover previously considered as a Trust Quality Priority for 2022/23 but there was lack of available reportable data for the KPI measurement from information services.

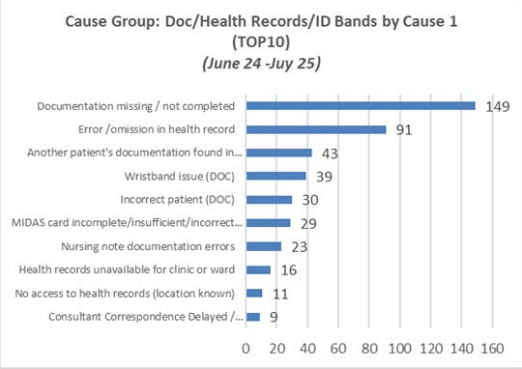
The EPR Operational Group are looking at digital solutions to enhance interfaces with the electronic systems which will support communication for staff. This is an ongoing agenda item on the EPR Operational Group – updates/developments will be ongoing as agreed.

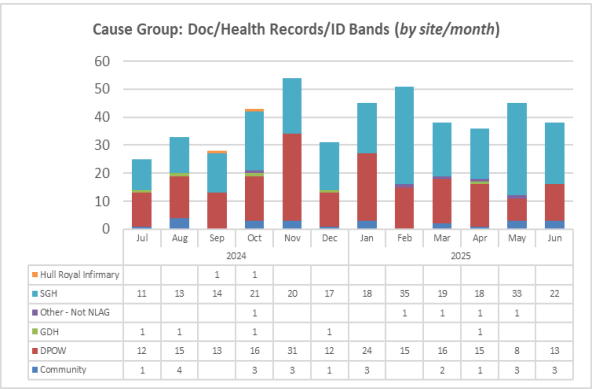
Web V electronic tool has seen 642,730 e documents completed in 2024/25 which is a 60% increase since 2023. 1,750 documents are completed daily within Web V with 250 live documents on the system including Assessment tools / admission documents.

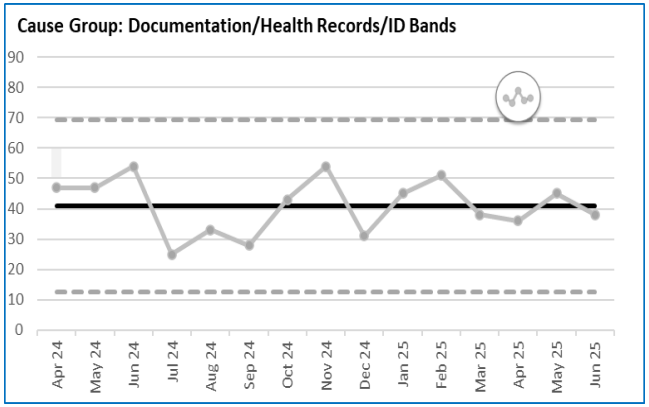
Quality Priority 24/25: Mental Capacity – Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording.

Cause Group: Documentation/Health Records/ID Bands (*n=467*prev. rolling 12-months *n=474)*

Incident data







Specialty Responsible (Top 10)	No (%)
Obstetrics / Maternity	117
Emergency Care	84
Acute Medicine	54
Paediatrics	21
Ophthalmology	12
General Surgery	12
Trauma & Orthopaedics	9
Neonatology (Newborn Intensive Care)	9
Cardiology	8
Other - Not NLAG	7

Missing / Incomplete Poor Quality Documentation. Key clinical information not documented including discussions between teams and decision making (including handovers – see also Communication) Incorrect entries in notes and discharge / clinic letters. Appropriate documentation not shared between settings. Checklists / assessments not completed or fully completed.

Mitigation/Improvement Activity

Highly dependent on a digital solution for long-term sustainability / improvement in recording of information.

Identified documentation issues would be addressed through improvement activities such as:

- Learning Responses under PSIRF.
- Mortality related improvement work.
- QI Projects where changes to documentation and recording requirements are part of the improvement work.

Nursing documents Avoiding Falls Level of Observation Assessment Tool (AFLOAT); Bed Rails & Falls; Intentional-Rounding, Malnutrition Universal Screening Tool (MUST) are being added to the WebV system to enable staff to record data more accurately and digitally.

All the above are available on the Web V system except for intentional rounding. This document consists of multiple assessment including fluid balance which is still under review. AFLOAT, Bed Rails & Falls, MUST are now in use on the Web V system. Work continues to bring Intentional Rounding document onto the Web V system.

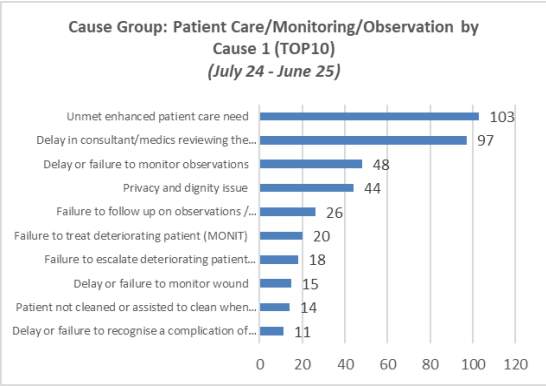
The nursing assessments will have reminders on WebV for the nursing team to complete. This is being presented for roll out to the Nursing Directors Group.

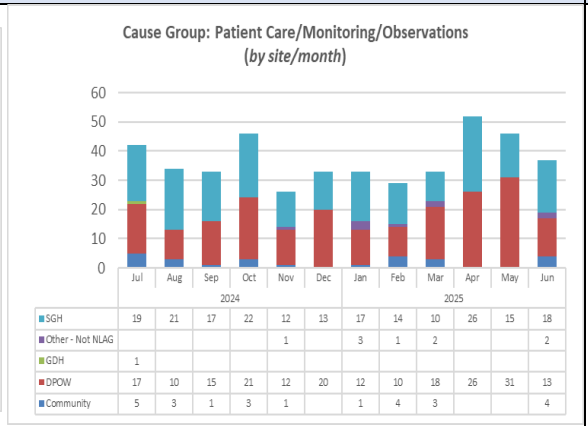
Requesting of diagnostic investigations electronically via WebV is planned for September 2025 in Endoscopy. This will eliminate “unknown/illegible referrers” due to the receiving team being able to clearly identify the requestor.

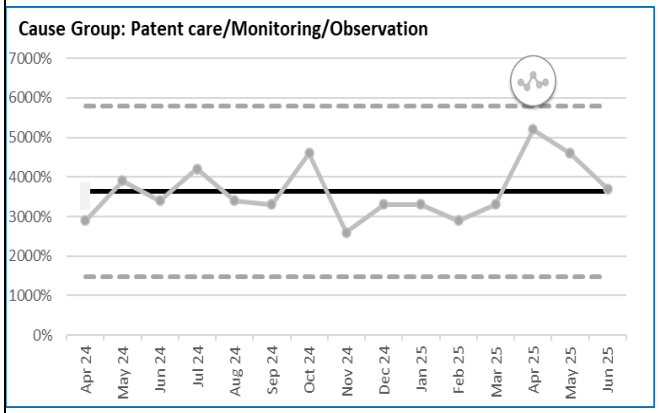
An electronic document management system (EDMS)/EPR is being procured by the Trust to enable a reduction in the need for a paper health record. This project is ongoing for North and South Bank. The EDMS will support all new records to be digital and older records to be scanned it the new system. This is an ongoing project in the early stages linked to the EPR project within the Trust. The Trust is currently at the procurement stage of the project with the evaluation process commencing late August.

Cause Group: Patient Care/Monitoring/Observation (*n=444*; prev. rolling 12-month *n=411)*

Incident data







Specialty Responsible (Top 10)	No (%)
Acute Medicine	75
Emergency Care	68
Gynaecology	45
Respiratory / Thoracic Medicine	28
Paediatrics	21
General Surgery	21
Obstetrics / Maternity	17
Trauma & Orthopaedics	17
Stroke	13
Frailty	13

Lack of / delayed observations / monitoring, delay in medics/consultants reviewing patients. Documentation/Health Records

Mitigation/Improvement Activity

Quality Priority 24/25: Deteriorating Patient / Sepsis – Improved recognition and responding to the deteriorating patient; Improved recognition and responding to sepsis in patients. Reporting to Patient Safety and Learning Group.

CQUIN 24/25: Recording of Paediatric Early Warning System (PEWS) for patients aged <18: 95% of all admitted paediatric inpatients having a Paediatric Early Warning System (PEWS) recorded within 1 hour of admission or arrival on the ward/unit. CQUIN Steering Group reporting to PS&LG.

CQUIN 24/25: Recording of and response to NEWS2 score for unplanned critical care admissions: 75% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes. CQUIN Steering Grp reporting to PS&LG.

A technical process error in the imaging department at NLAG occurred in October 2024. As a result, ultrasound reports with red or yellow alert flags on scans requested by primary care have not had an additional email notification sent out in line with our published practice. Primary Care were notified and the individual patients affected have now all had the email alert sent. There are no significant impacts to patients identified at this time. If any are identified the specific case will be escalated to the Weekly Learning Response Panel.

PSIRF / SERIOUS INCIDENTS

Background

The Patient Safety Incident Response Framework (PSIRF) is a significant transformative policy and cultural change. It sets out a new approach to achieving effective learning and improvement following patient safety incidents and embeds patient safety incident responses within a wider system of improvement and supports a significant shift in safety culture.

PSIRF LEARNING RESPONSES – NLAG
BACKGROUND
In June 2025 the daily navigation meetings ceased with Care Groups devising their own incident management process. This includes reviewing patient safety incidents and escalating if the incidents require a harm review or urgent clinical review and presentation at panel to decide if a PSII or other learning response is required. The central team at NLaG continue to review all incidents regardless of harm levels and ensure that the incidents response is applied against the Trust's Patient Safety Incident Response Plan (PSIRP) and that incidents are escalating if a serious concern is identified or there is potential Never Event. The Learning Response Panel (LRP) became a joint meeting with HUTH in December 2024. LRP is a decision-making group that meets weekly to: • Commission PSII and other proportional learning responses in line with the PSIRPs and patient safety risk profile. • Monitor the Urgent Clinical Review/ Harm review casework. • Prompt and explore Duty of Candour and engagement with patients/families and staff. The joint PSIRF Oversight Group launched in December 2024 meets on alternate weeks to: • Have oversight of all Patient Safety Incident Investigations (PSIIs) and thematic review reports ensuring they are of the highest standard leading to recommend for Group Chief Nurse or Group Chief Medical Officer sign off. • Receive proportionate learning response outcomes/reports for review particularly in relation to the safety actions identified. • Ensure implementation of safety actions through regular monitoring of any that are overdue actions and approval of proposed changes/amendments. The Patient Safety Team monitor safety actions with Care Groups to ensure both completion and robust evidence of completion is provided.
KEY UPDATES SINCE LAST REPORT
<u>Newly reported PSII/Learning Responses (since last reported):</u>

PSIRF LEARNING RESPONSES – NLAG

Patient Safety Incident Investigations (PSIIs):
5 incidents reported that required full investigation:

(ref 2025 3180– 344545) Patient was given nerve block the right side and noted to be the wrong site.

(ref 2025 3724– 345875) Patient presented to the vascular service as an emergency on the with signs and symptoms of a ruptured AAA, 2 reported imaging on the WebV as he was under the care of the Urologists for a rising PSA, presumed prostate cancer. Although there were no obvious lesions on his prostate to biopsy, and his bone scan was negative. Suggesting localised disease. He had an MRI on the 8/11/2024 which reported a large >8cm AAA, this was never escalated to vascular for review, he also went on to have a CT of his chest on the 8/4/25 which noted the same. Review of both the urology consultations after this time make no mention of the large AAA despite being reported and both these images should also be discussed in the Urology MDT with urgent referral to vascular services.

(ref 2025 3701– 346539) Notification received that a baby from North Lincolnshire had passed away on PICU at Royal Manchester Children's Hospital. When reviewing the records several concerns around care have come to light from both a midwifery and paediatric perspective.

(ref 2025 3835– 346639) Requested a trauma call due to the mechanism of injury. The patient was alert and responsive. Analgesia was given IV, due to complaining of pain and then patient was for a polytrauma CT scan. Patient handed over however the need to monitor patients GCS was not handed over. The patient was scanned and returned to Resus. When the CT report came through, patient had their GCS to find the patient had a GCS of 3, with pupils fixed and dilatated. Patient intubated and transferred to ITU. Following transfer to ITU, the patient condition deteriorated. Patient passed away on 30th June 2025.

(ref 2025 4419 – 349040) **Never Event** – Wrong Implant: Incorrect IOL inserted for left eye during bilateral cataract surgery.

Learning Responses: 13 incidents reported that required a proportionate learning response. Further details have been provided to the Quality and Safety Committees in Common.

There were 9 investigation/learning responses completed:
Areas for improvement/safety actions identified from these are set out in the following table.

Ulysses Ref	Areas for Improvement/Safety Actions
329929 Delay in diagnosis Specialist Cancer and Support Services (SCSS)	• Update the trigger list for reporting on Ulysses to include: Diagnosis – Misdiagnosis which results in a serious adverse outcome to the patient, failure/delay in diagnosis, incorrect diagnosis. Ensure the Radiologists are familiar with the update. • Share the quarterly audit report from Everlight with the ED Clinical Leads to give assurance that the Everlight reporters meet the required standards. • Share the learning from the incident with the Radiologists and Resident Doctors. • Clinical staff to be aware of the importance of providing detailed information in Radiology referrals to ensure that all potential injuries are considered by the Radiologist. A snapshot audit is to be completed on ten request cards following this. • Improve education within the ED team around re-examining a patient's hip if they reattend hospital following a recent discharge complaining of pain and knee swelling. • Share the report with ED staff for use in teaching platforms and Bitesize Learning Platform.
331801 Myotonic Dystrophy with Lorazepam Acute & Emergency Medicine (AEM)	• Raise awareness of the cautions of lorazepam prescription in patients with myotonic dystrophy at the ED Governance Meeting. • Share the Learning document with the Medical Team and Resident Doctors. • Education for the ED Team around the importance of good documentation on the Symphony System. A snapshot audit is to be completed on ten handovers/transfers following this. • Undertake a quality improvement project on WebV for patient handover. • Education for the ED Team around assessing a patient's level of consciousness to ensure it is correct, taking into consideration any new acute confusion. A snapshot audit is to be completed on ten observations following this.
333039 Delayed X-Ray, AEM	• Training session on identification of ankle injuries for ED/UCS Team • Explore the guidelines that exist in ED in relation to the examinations and investigations of an injured lower leg to confirm practise. Guidelines to be updated if required following the review.
335263 Missed Radiological Finding, SCSS	• Present the case at the next clinical governance webinar to emphasize the learning points and the importance of careful review for incidental findings and the importance of scrolling through multiple planes to distinguish lymph nodes from bowel loops. • Consider developing an artificial intelligence module to detect incidental enlarged lymph nodes within the abdomen and pelvis. • Improve knowledge around looking for malignancy in younger patients and that systematic review for incidental findings is important, and not to be swayed by presenting symptoms or patient age. • Present the case at the Quality and Safety Surgical Meeting and Colorectal MDT to raise awareness amongst clinicians of the need to provide a complete history, perform a clinical examination, and revisit the initial diagnoses to ensure that all possible causes are considered, to avoid missing significant findings when a patient represents to the ED; especially when the patient is symptomatic. • Improve knowledge that if there is an incidental finding on the CT report, this should be communicated to the patient and taken to the x-ray MDT for further discussion.

	• Improve knowledge that once a reasonable investigation has been done, the patient should be offered some symptomatic treatment to help alleviate their symptoms. • Include the case in the grand round presentations and radiology registrar teaching sessions for learning purposes. • Present the case at the Radiology Events and Learning Meeting (REALM) to emphasise the learning points.
336475 DKA, AEM	• Discussion to take place with counterparts at HUTH around the possible development of a streamlined pathway, with regards to the administration of insulin to run alongside WPG 508 Prescription Chart For Fixed Rate Intravenous Insulin Infusion (FRII) To Treat Diabetic Keto Acidosis (DKA) In Adults. • Distribute information to the ED Team about the necessity of continuing long-acting insulin for DKA patients while on an infusion. Ensuring no further incidents/events occur. • Consider implementing a timer system on patient's doors in the department to remind staff about time sensitive critical medications. • Highlight to Clinicians the importance of prescribing and administering critical medications on patients' arrival into the department.
336224 Wrong Site Surgery, SCSS	• Change the programming on the x-ray equipment so that the default projection for mandible x-rays is PA instead of AP. • Add a bright yellow neon sign to the x-ray equipment to indicate when AP is selected, prompting the radiographer to confirm the selection. • Replace the ball and chain markers with ribbon markers to prevent rotation and ensure correct usage. • Present the case for discussion at the Radiology REALM meeting with the Reporting Radiographers, where unusual or difficult cases are discussed.
335054 Fall in ED (Head Injury), AEM	• ED South Bank Matron is to link in with the ED North Bank Matron to review the processes that are in place at Hull in terms of preventing patients from falling within Emergency Departments. • To raise awareness and the availability of the use of sensor clips within the department. • Training slide that are covered within the Preceptorship Training to be shared with the ED Team. • Nurse in Charge to be made aware of the expectations in these situations and what routes should be followed if Site Team are unable to support.
335918 Cardiac Arrest, AEM	• Remind the Nursing Team in SDEC to complete a full set of observations on all patients and to repeat on arrival to SDEC when they have come from the UCS and ED to ensure the patient is stable and escalate any concerns if required. • Amend the shift leader daily checklist to incorporate the patient admissions and time of admission requested and also the listing allocation of staff. • Remind all staff in SDEC to print the WebV patient lists and cross reference with the shift leader daily checklist at the board round to ensure patients are not missed. This to be kept with the shift leader paperwork. • Issue the escalation of a deteriorating patient policy to the Nursing Team in SDEC and discuss at the daily shift huddles. • Allocate band 6 nurses to cover the shift leader shifts on SDEC to have a greater oversight of SDEC needs and escalation. • Amend the IAAU shift leaders checklist to incorporate the daily check-ins to see if the SDEC shift leader needs any additional support.

PSIRF LEARNING RESPONSES – NLAG	
	• Provide an additional nurse from IAAU to support with the increase in demand on SDEC during the day and also nights if they are not pulled and relocated by the site team.
336190 Delay Identifying #NOF, AEM	• Email all radiographers to make them aware of the EPIC bleep number so this can be used in the future to prevent a lack of/delay in communication between departments. • Presentation of the case and its learning, including the value of good, written, closed loop communication and handover is to be provided in a Middle Grade Teaching session.

DUTY OF CANDOUR

KEY UPDATES IN REPORTING PERIOD – Q1 25/26

Duty of candour compliance

The following table provides the overall performance for NLaG in relation to meeting its statutory obligations under regulation 20 of the Health and Social Care Act. This is for all patient safety incidents that have or could result in moderate or above harm.

NLAG Overall Performance			
Month	**No. Incidents DoC required in month**	**DoC completed**	**within 10 working days**
Apr-25	44	36 (82%)	31 (70%)
May-25	81	52 (64%)	37 (45%)
Jun-25	30	21 (70%)	17 (56%)

Subsequently to the initial production of this report the number of DoC completed overall has improved to 97%, 90% and 91.67% for the three months.

Duty of candour / Engagement with patients/families for all PSII and Learning Responses

When a PSII or other learning response is declared, a Family Liaison Officer is assigned to provide support to patients and/or families, and to act as the main contact during the investigation/review and following its completion. Engagement with patients and families is provided irrespective of the harm level so whilst the above section relates to incidents of moderate or above harm and whether the statutory obligations have been met, the following is compliance for all incidents identified for a learning response under PSIRF.

100% compliance in Q1 with duty of candour / engagement completed within 10 working days of a patient safety event declared for an investigation/learning response (1 was just one day over). Feedback of Learning Response outcomes to patients and families were all completed within 10 working days of approval.

Duty of candour is monitored at the Learning Response Panel, Care Group governance, and via the performance review meetings led by Site Directors. A weekly monitoring report is provided to Care Groups to show incidents where duty of candour is required.

QUALITY IMPROVEMENT WORKSTREAMS / ACTIVITIES

Under PSIRF the system for oversight should be designed in a way that allows the organisation to demonstrate improvement rather than compliance with prescriptive, centrally mandated measures. The Trust already has a range of quality improvement priorities and activities as outlined in the Patient Safety Incident Response Plan (PSIRP). Completed learning responses from December 2023 are thematically analysed to develop an insights profile which will be used to inform the review of the PSIRP as well as quality improvement workstreams/activities that already exist or that need to be

considered as a new priority area. Investigation and learning response outcomes are used to inform existing improvement activities as outlined below with some priorities noted for consideration of a planned improvement activity or as a themed PSII.

Insights / priority area	Investigation Type(s)	Local safety improvement actions	Linked quality improvement workstreams
Pressure Ulcers	AAR	Safety actions developed at local level by relevant senior management teams. Measures of compliance developed and monitored at local level.	New learning / areas for improvement to be added to the Pressure Ulcer Improvement Plan which is currently under review for the group context. For assurance, where AARs have been completed in the Community, actions are monitored through the Care Group's governance meetings. There is 1 AAR in progress for a Cat 4 PU in the Acute services. For all other PUs, the learning is captured and acted upon locally. Reported to QS CIC
Falls	SIs AAR (latest January 2025)	All remaining SI actions completed and signed off in January 2025. Safety actions developed at local level by relevant senior management teams. Measures of compliance developed and monitored at local level.	New learning / areas for improvement to be added to the Group Falls Improvement Plan. Reported to QS CIC
Weight based prescribing	SI (1) Inquest	SI actions completed. Inquest held May 2024	Quality Priority – prescribing weight dependent medication to adults. Reported to QS CIC Coroner confident with actions being taken by NLaG and did not issue a Regulation 28.
Results not acted upon - outpatient	MDT	Two related MDTs highlighting the same issues. Safety actions developed at local level by relevant senior management teams. Measures of compliance developed and monitored at local level. A total of four MDT learning responses undertaken in the past 12 months relate to results not acted upon in outpatient setting.	Limited wider quality improvement activity. Highly complex system which may warrant a PSII or specific quality improvement workstream. Under review whilst local safety actions are being implemented. It is noted that the new system (Lorenzo) gives a more robust tracking process to try and mitigate any patients being missed and helping ensure their care plan is monitored. Roll-out of results acknowledgement in outpatients with measurement planned through dashboard development (currently on hold until the version upgrade for WebV from 2 to 3 which is expected in July 2025). This workstream will not resolve all associated system safety issues. Audit of results being acted upon in line with policy is to be undertaken across the group. The project is at planning stage (May 2025).
Audiology	SI Overarching investigation.	Through the reviews from The British Academy of Audiology, Professor Begg	The alignment of the Audiology departments in the Head and Neck Care Group and proposals to ensure continuation of the service improvement, including training, governance arrangements, MDT arrangements, provides a roadmap for further

	Multiple patients impacted	and the Trust SI investigation, there remains a continued focus on the development of the NLAG Audiology services.	improvement as a group. Reporting on progress will continue to Patient Safety and Learning Group specifically and then as part of the Care Group highlight reporting.
Allergy Recording (Penicillin / Antibiotic Prescribing)	PSII (1) (penicillin allergic reaction) - inquest pending. Thematic review of incidents (declared July 2024) AAR Jan 25 (penicillin allergic reaction).	Investigation currently on hold due to police investigation. Previously declared SI but moved to PSII under PSIRF. Chief Medical Officer led meeting held October 2023 to identify immediate learning and cascade.	Initial thematic review of associated incidents undertaken and discussed at the Learning Response Panel. Limited wider quality improvement activity currently. Thematic review to take place to identify system safety improvements. Expected completion was 3-6 months following decision to undertake the review. AAR completed April 2025 will be used to inform thematic review.
PSA monitoring	Historical SIs MDT 1 x Harm review incident at time of writing this report.	SI actions fully implemented. Safety actions developed at local level by relevant senior management teams and currently being implemented.	Emerging theme requiring a deep dive analysis to understand recurrent issues. Risk 3421 in pending on the risk register in relation to PSA tests not being actioned (Patient Services) and one live risk 2691 (Specialist Surgery) in relation to staffing and knowledge impacting on the patient pathway for PSA (Low Risk). MDT Review relating to delay in monitoring PSA was presented by Clinical Lead for Urology at PSIRF Oversight in December 2024. They highlighted the risk of this happening again due to capacity and demand. The group chair advised for this to be considered for inclusion on the risk register.

Hull University Teaching Hospitals NHS Trust

PURPOSE OF THE REPORT

The purpose of this paper is to provide oversight of:

- Maternity and Newborn Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) investigations and all other proportionate learning responses that have been identified under the Patient Safety Incident Investigation Framework (PSIRF).
- Incident reporting
- System Learning and Cross System Investigations
- Duty of Candour compliance

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

BACKGROUND

The HUTH PSIRF Plan outlines the different response methods and tools available for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Learning Response Panel meets to review all HUTH incidents reported onto Datix that have resulted in patient harm in the previous week. The incidents are discussed to identify any themes and trends, learning and immediate actions.

KEY UPDATES IN REPORTING PERIOD

Patient Safety Incident Investigations (PSIIs) identified

During the reporting period (Quarter one 2025/26), there were 16 incidents reported that were identified to be PSIIs; four of the incidents met Never Event criteria.

PSII Ref	Care Group	Specialty	Details
2025/1996	Cardiovascular	Cardiology	Patient death following pneumothorax
2025/2119	Acute and Emergency Medicine	A and E	Patient death following allegation of kidnap from another hospital (Safeguarding)
2025/2121	Major Trauma Network	Major Trauma	Patient death following allegation of oxygen having been switched off (Safeguarding)
2025/2277	Digestive Diseases	Gastroenterology	Patient death following self-discharge against medical advice and intentional overdose at home
2025/2315	Specialist Surgery	Dermatology	NEVER EVENT: Wrong site surgery, incorrect lesion removed

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK			
2025/2316	Cardiovascular	Cardiology	Patient death following unwitnessed fall; subdural haematoma with midline shift.
2025/2320	Specialist Cancer and Support Services	Radiology	NEVER EVENT: Foreign body left in situ, cover of a 2mm senri ballon used in previous angioplasty
2025/2483	Acute and Emergency Medicine	A and E	Patient required manipulation under conscious sedation; incorrect amount of midazolam administered.
2025/2484	Theatres, Anaesthetics and Critical Care	Theatres	NEVER EVENT: Laparotomy on 20/04/25, readmitted 29/04/25, findings of abdominal scan show retained swab at the hepatic flexure.
2025/2929	Family Services	Obstetrics	Incident meeting MNSI criteria; MI-042322 - baby cooled
2025/3179	Theatres, Anaesthetics and Critical Care	Theatres	Patient death following post-operative reopening to remove central line, resulting in tear.
2025/3290	Family Services	Acute Paediatric Medicine	Child on fluid challenge overnight for poor oral intake and reduced urine output. Delay in receiving blood results confirming hyperkalaemia. Urgent Embrace transfer to Leeds for intubation and dialysis.
2025/3400	Family services	Obstetrics	Incident meeting MNSI criteria; MI-040973 - baby cooled
2025/3439	Specialist Surgery	Plastic Surgery	NEVER EVENT: Wrong site block. Wrong finger partially blocked. Identified, correct finger blocked and surgery completed as planned.
2025/3440	Neuroscience Specialist	Stroke Medicine	Delayed CT scan, response of stroke team and thrombolysis.
2025/3442	Cardiovascular	Cardiology	Patient death (severe aortic stenosis); patient referred to valve clinic in July 2022 for severe AS. No appointment given.

Patient Safety Incident Investigations (PSIIs) completed

There were no Patient Safety Incident Investigations completed in Quarter one 2025/26.
The learning responses for all PSIIs are shared through the governance committee structure and are available to view on Bridget (intranet).

Proportionate Learning Responses

During the reporting period, 15 incidents were identified for a proportionate learning response to be undertaken and facilitated by the Patient Safety Team. Further details have been provided to the Quality and Safety Committees-in-Common.
In the reporting period (Quarter one) 10 learning responses were facilitated and learning shared at the PSIRF Oversight Group.
Learning responses completed under PSIRF are available to view on Bridget (intranet).

DUTY OF CANDOUR

KEY UPDATES IN REPORTING PERIOD

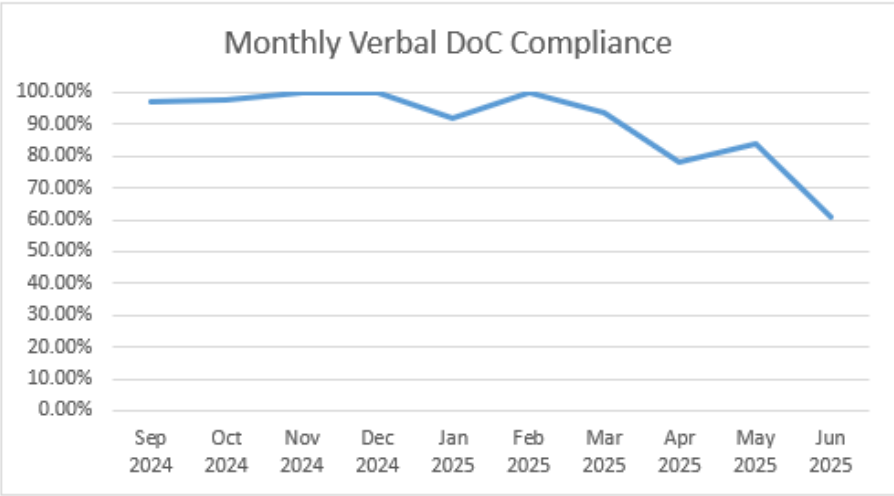
The monitoring of duty of candour was reset in September 2024 with responsibilities for completion of sending written apologies transferring to the individual wards/departments.

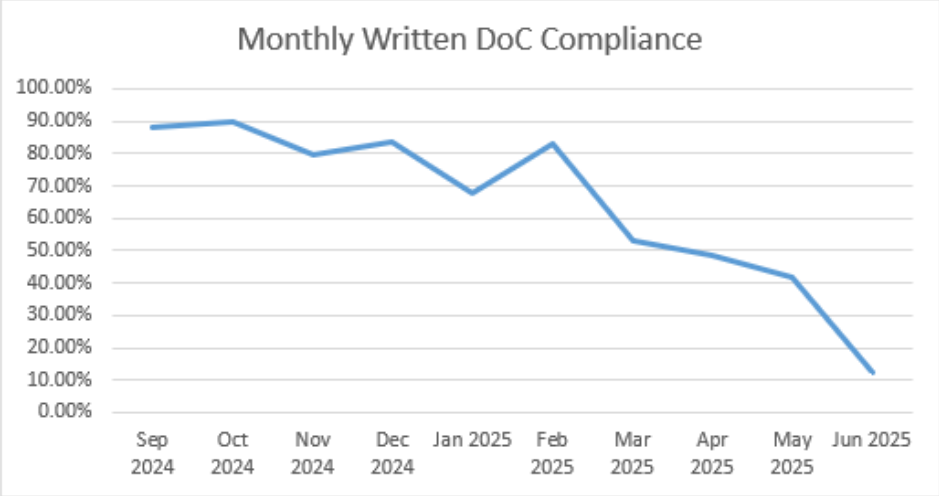
Barriers have previously been identified and actions implemented compliance remains below the expected level of 100%.

Barriers identified	Actions to address

Process of sending written apology - Care Group Quality Governance support of generating the letters within Datix ceased	• Review of processes being undertaken
	• Dedicated support being provided to areas with low compliance
	  • Raised awareness of roles and responsibilities of Ward Investigators
	  • Targeted training provided by Patient Safety Team

Process of sending written apology - responsibility moved to the Ward B7s (investigators) in most Care Groups	
Ward Investigators unaware of process of generating and uploading letters to Datix	
Technical issue identified – accessibility of all DoC fields not available to some staff therefore fields not being completed	Datix form reviewed and now accessible/visible to all staff. Validation checks





OVERVIEW OF PATIENT SAFETY INCIDENTS REPORTED

Total Number of Patient Safety Incidents by Quarter

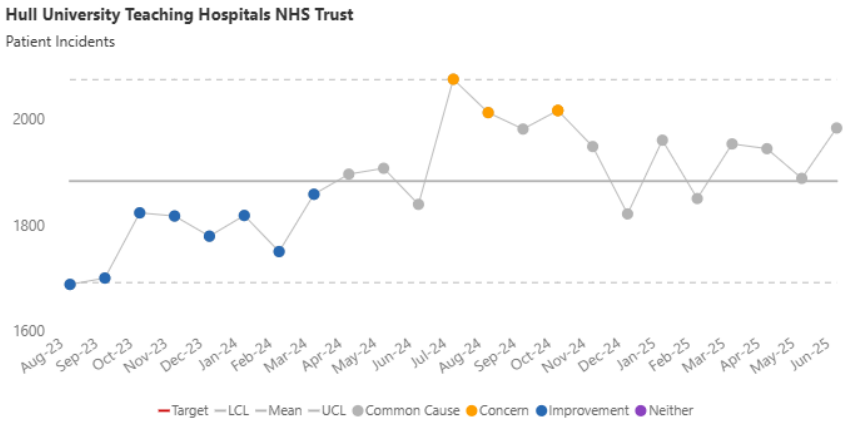
The following table provides the total Number of Patient safety incidents reported on Datix by Quarter (Trust-wide) including % breakdown of harm levels:

Total No. of patient safety incidents by Quarter					
Quarter:	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**
Total:	5642	6067	5785	5763	5816
Harm levels as a % of patient safety incidents reported by Quarter New definitions of harm as from June 2024 (in order to align North/South bank + match LFPSE criteria)					
Near Miss	10.32%	6.59%	6.62%	6.35%	6.4%
No Harm	71.69%	74.32%	74.48%	74.53%	73.74%
Low	13.56%	14.77%	16.53%	17.65%	17.9%
Moderate	3.93%	3.92%	2.04%	1.02%	1.44%
Severe/Major	0.21%	0.18%	0.14%	0.24%	0.38%
Fatal	0.28%	0.21%	0.19%	0.21%	0.14%
% graded as Near Miss / No / Low Harm*	95.57%	95.68%	97.63%	98.53%	98.04%

***>90% of total patient safety incidents indicates a positive safety culture in relation to incident reporting.**

Patient Safety Incident Reporting rate

Total number of patient safety incidents reported by month:



The number of all patient safety incidents reported monthly has steadily risen over the last 24 months to above the mean. The number resulting in harm to patients remains within control limits but is nearer the upper control limits. The Trust has a good patient safety reporting culture (high volume, low harm); the monitoring of reporting rates (benchmarking) nationally has been

paused whilst organisations transition to LFPSE; the benchmarking data was last published in July 2022.

National LFPSE Update

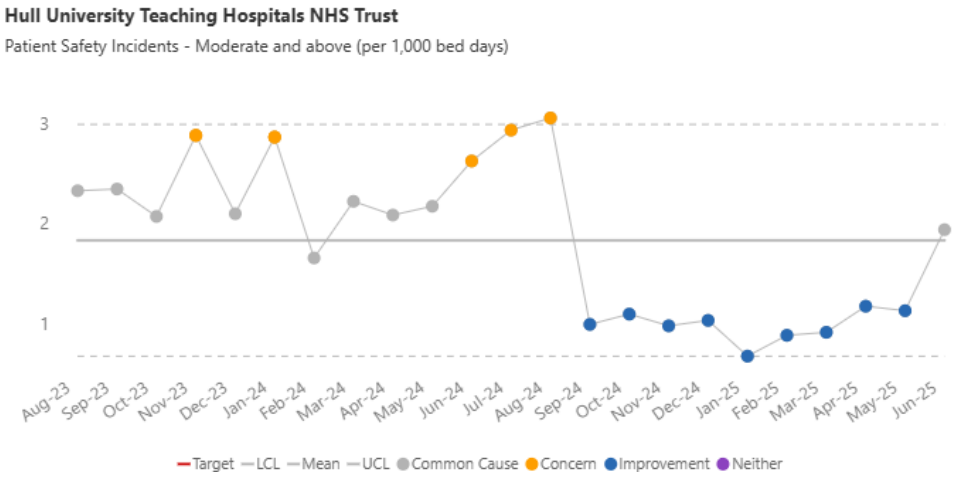
In December 2024 it was announced by the National Patient Safety Team that the new LFPSE Recorded Data Dashboard (RDD) would be a public facing BI application designed to enhance access and utilisation of aggregated LFPSE data, thereby fostering patient safety learning and improvement. The RDD facilitates filtering, grouping, and easy visualisation of near-real-time LFPSE data for all organisations recording patient safety events into LFPSE.

Prior to its full release providers have been asked to validate local data (Datix) with the LFPSE data to identify and resolve and data quality issues; this is ongoing at HUTH.

Once the RDD is fully released it can be used by providers, ICBs and regions for patient safety incident planning and for official statistics.

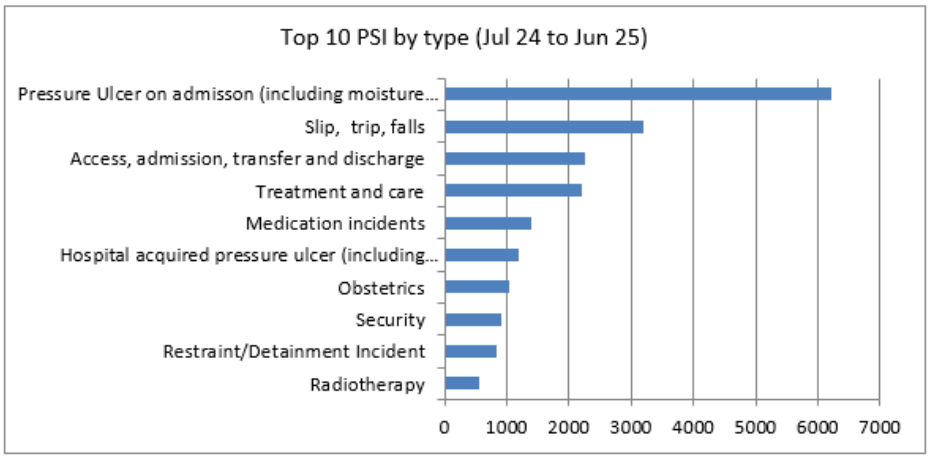
Patient Safety Incidents resulting in harm

Total number of patient safety incidents resulting in harm reported by month:



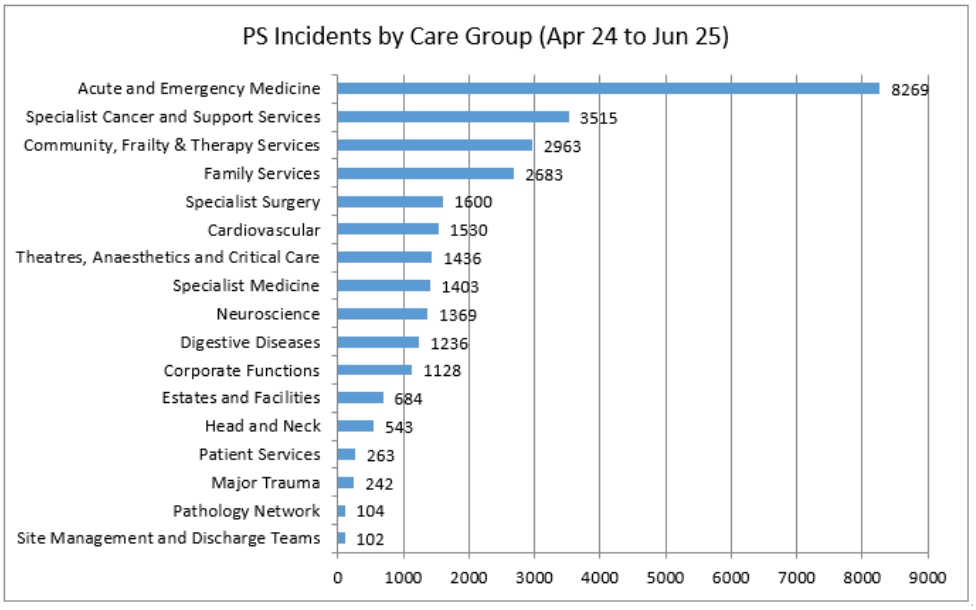
Since the change to the duty of candour process from September onwards there has been a marked decrease in the number of incidents resulting in harm being reported this can has decreased; this can be explained by the re-categorising of hospital acquired pressure ulcer definitions of harm in line with LFPSE i.e. a category two pressure ulcer does not automatically equate to moderate harm.

Top 10 Patient Safety Incidents by Type of incident (12 months data)



Patient safety incidents by Care Group (responsible) (6 months data April to September 2024)

The following chart shows the breakdown of patient safety incidents by Care Groups since the move from Health Groups in April 2024:



Pt Safety Incidents by Care Group (Apr 24 to Jun 25)	No.	%
Acute and Emergency Medicine	8269	28.45%
Specialist Cancer and Support Services	3515	12.09%
Community, Frailty & Therapy Services	2963	10.19%
Family Services	2683	9.23%
Specialist Surgery	1600	5.50%
Cardiovascular	1530	5.26%
Theatres, Anaesthetics and Critical Care	1436	4.94%
Specialist Medicine	1403	4.83%
Neuroscience	1369	4.71%
Digestive Diseases	1236	4.25%

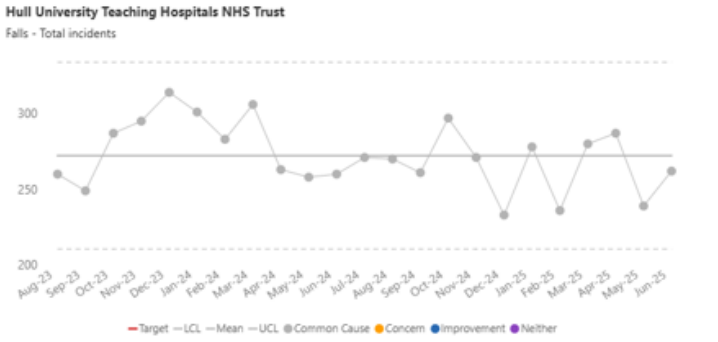
Corporate Functions	1128	3.88%
Estates and Facilities	684	2.35%
Head and Neck	543	1.87%
Patient Services	263	0.90%
Major Trauma	242	0.83%
Pathology Network	104	0.36%
Site Management and Discharge Teams	102	0.35%

Themes and Trends

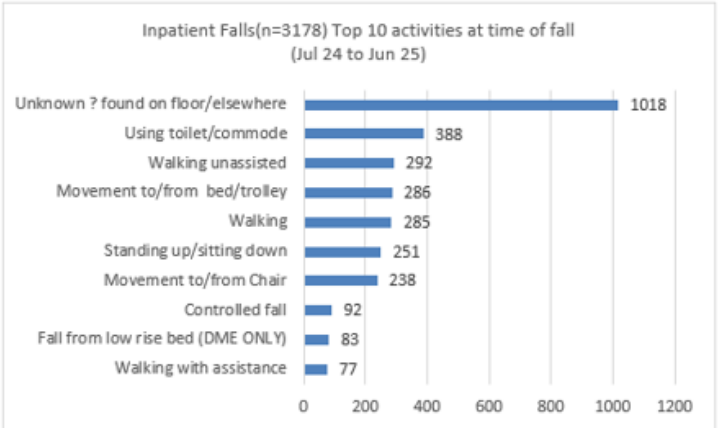
Below is a breakdown of the top reported Themes of patent safety incidents occurring within the Trust (12 months data July 2024 to June 2025). This shows the split down to category and sub-category levels harm levels and to which specialties / teams incidents relate.

Inpatient slips, trips and falls

Slips trips and falls are the highest reported type of inpatient incidents. There is currently a Falls committee that has a number of improvement workstreams that report into the Patient Safety and Learning Group – see their Quarterly Report for further information.



Falls by Speciality (Top 10)	No. (%)
Elderly Medicine	708 (22.3%)
Acute Medicine	309 (9.7%)
Clinical Oncology	272 (8.6%)
NCTR Elderly Medicine	196 (6.2%)
A and E (Accident and Emerg	178 (5.6%)
Cardiology	170 (5.3%)
Stroke Medicine	120 (3.8%)
Chest Medicine	119 (3.7%)
Diabetes and Endocrinology	114 (3.6%)
Orthopaedics (Trauma)	80 (2.5%)



Falls: Harm Level	No. (%)
Near Miss (due to intervention)	5 (0.2%)
No Harm	2462 (77.5%)
Low Harm	663 (20.8%)
Moderate Harm	25 (0.8%)
Severe Harm	20 (0.6%)
Fatal	3 (0.1%)

CiC ESCALATION REPORT

QUALITY AND SAFETY COMMITTEES-IN-COMMON – 26 June 2025

Humber Health Partnership

1.Matters for Reporting

A number of neonatal deaths had occurred and a neonatal bereavement officer has been put into place for families and staff. A review of all cases to be carried out and a review of the Group Neonatal services would also be explored.

179 CPE cases across the Group had been reported. Action plans were being developed to address the ongoing issues.

2. Positive assurances

Following the CQC visit to the ED at HUTH, positive feedback was received.

Martha's rule was being rolled out, the sepsis screening tool was being used and improvements were being seen. Reasonable assurance was given by the CIC.

3. Matters on which the committees have requested additional assurance

Never Events – Work was ongoing to promote the Never Event work to the Grand rounds and team briefings. Checklist compliance was being reviewed but there was a wider cultural piece to manage. Monitoring mechanisms and observations were being explored by the Safer Surgery Group.

Due to the amount of control and grip regarding the CQC action plan, reasonable assurance was agreed.

PSII timescales for completion are currently off track but work was ongoing to address the issues.

4. Decisions made

The CIC received an update regarding Echo Cardiography and requested further updates following the investigation.

Further assurance was requested for Duty of Candour performance at the October CIC.

Group Clinical Strategy was endorsed by the CIC and would be presented at the next Council of Governors meeting.

The IPC Annual Report was endorsed by the CIC.

5. Escalation to Trust Boards

SHMI scores were now acceptable and positive with 1.06 for HUTH and 1.02 for NLAG. Performance is also improving for Sepsis and secondary malignancies. A section 28 had been received and the team were responding to the Coroner.

TAVI – The CIC received an update regarding the culture in the department, the significant amount of work ongoing and the significantly improved performance. An external reviewer of TAVI deaths and pathway compliance had been commissioned. Significant assurance was given by the CIC.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	N/a	N/a	Assurance	N/a
2	Quality Priorities – deteriorating patient and sepsis	3	20	Assurance	● Reasonable
3	CQC Improvement Plan	3	20	Assurance	● Reasonable
4	Maternity and Neonatal Assurance Report	3	20	Assurance	● Reasonable
5	Children and Young People	3	20	Assurance	● Reasonable
6	Quarterly Quality Theme Triangulation, Learning and Improvement Report	3	20	Assurance	● Reasonable
7	Learning from Deaths Quarterly Report Q1	3	20	Assurance	● Reasonable
8	Equality and Quality Impact Assessment	3	20	Assurance	None to note
9	Safeguarding including MCA and DOLs	3	20	Assurance	● Reasonable
10	TAVI	3	20	Assurance	● Significant
11	IPC Annual Report	3	20	Review and endorse	Endorsed by the CIC
12	Clinical Strategy	3	20	Review and endorse	Endorsed by the CIC

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						
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						

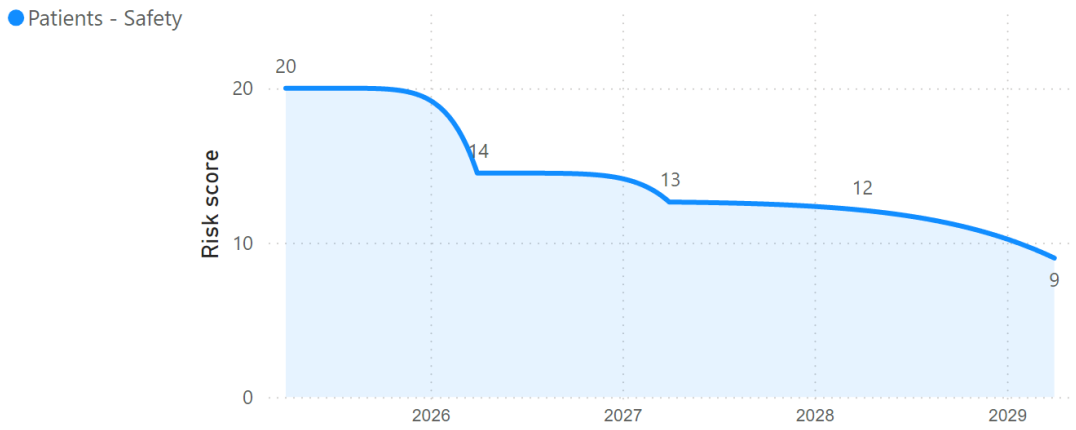
3. Patients - Safety

The strategic risk affecting our objective, 'Patients - Safety' is led by Amanda Stanford, Group Chief Nursing 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 12 September 2025. In full, the risk is:

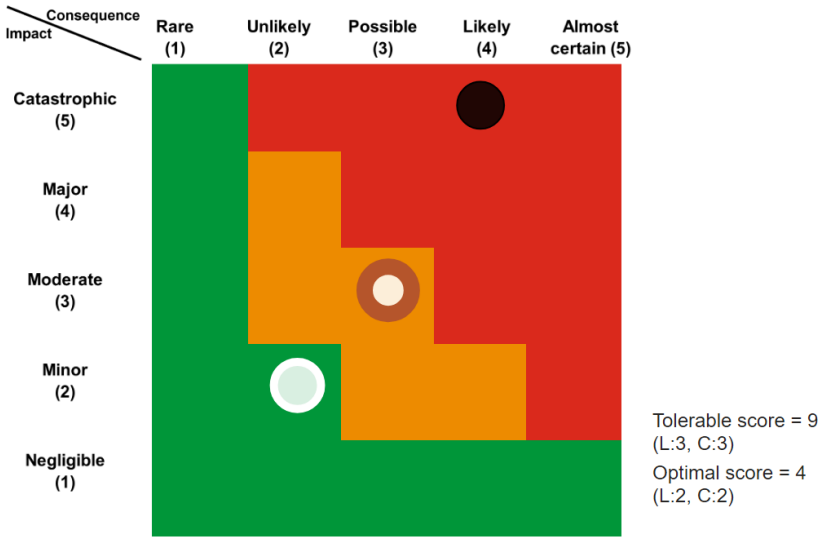
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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	Significant
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	Reasonable
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**
Weak quality governance from ward to board	1						**1**
Total	**2**	**2**	**2**	**1**	**3**	**1**	**3**	**14**

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)	11	12	13	15	Total
Absence of routine data quality monitoring and patient record validation	1				**1**
Poor regulatory status		1	1		**2**
Poor triangulation of KPIs across Care Groups, Corporate and locations	1				**1**
PSIRF Processes not fully embedded		1		1	**2**
Risk Management process not fully embedded	1				**1**
Total	**2**	**1**	**2**	**1**	**1**	**7**

3. Patients - Safety

NHS Humber Health Partnership

The table below details the 9 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
11	Develop and publish Risk Management strategy	01/05/25	31/03/26	Draft anticipated during October 2025, with copy to ARG before Nov meeting	12/09/25	Amanda Stanford, Group Chief Nursing Officer	Limited
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	Amanda Stanford, Group Chief Nursing Officer	Reasonable
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25		1st Draft to NMB end of Jan	04/02/25	Amanda Stanford, 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, Amanda Stanford, Group Chief Nursing Officer	Reasonable
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	Amanda Stanford, Group Chief Nursing Officer	Significant
39	CQC preparations for Care Groups	30/09/25	01/04/29		04/02/25	Amanda Stanford, Group Chief Nursing Officer	
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	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	12/09/25	Kate Wood, Group Chief Medical 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)176

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9th October 2025
Director Lead	N/A
Contact Officer / Author	Sue Liburd Non-Executive Director Maternity & Neonatal Safety Champion Northern Lincolnshire & Goole NHS Foundation Trust David Sulch Non-Executive Director Maternity and Neonatal Safety Champion Hull University Teaching Hospitals
Title of Report	**Maternity & Neonatal Safety Champion Report**
Executive Summary	• **Neonatal Service Pressures & Safety:** Escalation of risks due to regional and local neonatal capacity pressures; cluster of neonatal deaths at HUTH NICU reviewed with assurance on timely investigation and actions. • **Workforce & Staff Experience:** Concerns raised about high numbers of newly qualified midwives and limited support capacity, plus inadequate office space at DPOW for community midwives. • **Service User Voice & Engagement:** Positive Friends and Family feedback, however continued concerns over Badger notes functionality and limited choice of place of birth; MNVP engagement remains active. • **Good Practice & Innovation:** Launch of "Ask Me Anything" for staff to raise issues directly with the Director of Midwifery, review of midwifery rotation at DPOW, and launch of "Nest and Nurture" antenatal education programme are noted. • **Data & Assurance:** Progress with dashboards across the Group to support safety and quality monitoring, though some data quality issues remain unresolved; risks noted with MIS Year 7 compliance (Safety Actions 4, 5, 7, 8).
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)	Noted
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

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

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.

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between 01 August to 30 September 2025 have included the 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 (MNAG)
- 25 September Safety Champion Walkaround DPOW.

Northern Lincolnshire and Goole (NLaG)

- 11 August Meeting to discuss improvements in student midwives' clinical experience.
- 18 August NNEL MNVP 15 Steps visit and feedback meeting to SGH Neonatal Ward.
- 1 September Midlands NED Safety Champions Network Meeting.
- 10 September NNEL MNVP quarterly meeting.
- 18 September Maternity & Neonatal Assurance Group (MNAG).
- 25 September Safety Champion Walkaround DPOW.

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
The Safety Champions note the escalation and timely deep dive following a cluster of Neonatal Deaths at HUTH NICU. The Safety Champions are assured by the review undertaken and the actions put in place.	Positive feedback continues to be received through the Friends and Family Test, reflecting a good level of service user satisfaction. The MNVP Leads shared positive feedback and areas of concern. Badgernotes continues to be raised as an issue. Choice of place of birth not always being offered or available was also raised.	The Safety Champions noted that office space for the Community Midwives at DPOW is not sufficient for the numbers of staff during the walkaround and that space across office areas at DPOW could be utilised better. Midwives at DPOW in all areas raised concerns about high numbers of newly qualified midwives and concerns about being able to offer sufficient support.

	The Safety Champions are assured that these issues have been appropriately escalated.	5 new concerns raised by staff have added to the action plan since the last report and are currently being addressed. 7 concerns have been closed since the last report.

Good practice, improvements & innovation to share:

The Safety Champions continue to engage across sites and services, providing assurance that concerns are heard and acted upon, celebrating innovation and improvement, and escalating risks where necessary. Continued focus on user experience (both staff and service users), culture, and access to digital tools will remain priorities for the coming months.

The Safety Champions note:

- The launch of 'Ask Me Anything' a MS Forms where staff can send queries or concerns directly to the Group Director of Midwifery.
- Review of Midwifery Rotation at DPOW and the engagement with midwifery staff to find a sustainable and positive solution way forward.
- The launch of the 'Nest and Nurture' antenatal education event at NLAG. The first event takes place at DPOW on the 2nd of October.
- The excellent MNVP board in Antenatal Clinic Reception at DPOW.

Risks & concerns to escalate:

The Safety Champions note:

- The significant pressures on Neonatal services across not only the Group but the region as whole.
- The risks relation to MIS Year 7 delivery in relation to Safety Actions 4, 5, 7 and 8.
- Positively detailed dashboards are now in place across the Group, however, there are some data quality issues that still need to be resolved.

Activities planned next month:

- 14 October - LMNS Delivery Board.
- 16 October- MNAG.
- 30 October - Safety Champion Walkaround SGH.

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

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)177

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 9 October 2025**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery, Family Services Care Group**
Title of Report	**Maternity & Neonatal Assurance Report & Maternity Incentive Scheme year 7 Progress Report**
Executive Summary	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 · Service User Experience: o HUTH recorded 96% positive maternity feedback in June. o NLAG achieved 90% positive maternity and 100% neonatal feedback in July. · Recruitment & Workforce: o All long-term seconded posts at HUTH have been made substantive. o 15.28 WTE (HUTH) and 17.05 WTE (NLAG) newly qualified midwives have been recruited for autumn 2025. · Safety & Governance: o Robust governance with monthly MIS7 Delivery Group monitoring. o PMRT reviews completed in line with national requirements with strong external engagement. o Transitional care services and quality improvement projects under way to minimise separation of mothers and babies. Key Challenges · Workforce Planning & Staffing: o Ongoing pressure due to sickness, maternity leave, and supernumerary requirements, particularly within neonatal services. o Delay in workforce investment papers progressing to Board.

	- Vacancy rates: HUTH midwifery 4.1% (adjusted 2.4%); NLAG midwifery 6.8% (improving with new starters). - CNST MIS Year 7 Compliance Risks: - Safety Actions 4 (Clinical Workforce), 5 (Midwifery Workforce), 6 (Saving Babies' Lives v3), and 8 (Training) remain areas of concern. - Compliance trajectories set by LMNS for March 2026 at 100% remain challenging, particularly for pre-term birth optimisation and smoking cessation interventions. - Training Compliance: - Compliance has dipped due to the intake of new rotational doctors in August 2025; recovery plans in place to meet 90% target within 6 months. - Data Quality & Reporting: - Maternity dashboards are now in place across both Trusts but require continued work to resolve data quality issues. Safety, Outcomes & Risks - Red Flags (July 2025): HUTH reported 46 (mostly delays to induction of labour), NLAG reported 3. - Perinatal Mortality: - HUTH: 2 stillbirths and 1 neonatal death (July); 1 stillbirth, 1 neonatal death, and 1 infant death (August). - NLAG: 1 neonatal death (July); 1 stillbirth, 1 neonatal death, and 1 infant death (August). - Risk Registers: - HUTH: Key risks include consultant staffing, neonatal cot availability, and lack of AHP support. - NLAG: Key risks include antenatal clinic capacity, NICU equipment (incubators, CPAP drivers), and infrastructure constraints. Conclusion Both Trusts continue to demonstrate commitment to safe maternity and neonatal care through governance, staff training, service user engagement, and transparency. However, workforce fragility, data quality, and training compliance remain significant risks to achieving full MIS Year 7 compliance by March 2026. Immediate focus is required on: - Finalising and approving midwifery and neonatal workforce investment/action plans. - Strengthening training compliance trajectories for all staff groups. - Ensuring data quality improvements to underpin safe monitoring and reporting.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**Maternity & Neonatal Assurance Group and Quality & Safety**

	Committees in Common September 2025	
Financial Implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ü Assurance	☐ Information ☐ Review ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

September 2025

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1: Executive Summary & Highlight Report

This report outlines the progress, key achievements, and areas for improvement across maternity and neonatal services at Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG).

Key Achievements

- Service User Satisfaction:
  - HUTH reported 96% positive maternity feedback in June (July currently unavailable).
  - NLAG achieved 90% positive maternity and 100% neonatal satisfaction in July.
- Recruitment & Workforce:
  - All long-term seconded roles at HUTH are now substantively recruited.
  - 15.28 WTE and 17.95 WTE newly qualified midwives have been recruited and HUTH and NLAG respectively.

Challenges

- Delay in Workforce papers going to board.
- MIS Year 7 compliance with Safety Action 4, 5, 6 and 8.
- Dashboards for each site now in place- some data quality issues identified and currently being worked through.

Conclusion

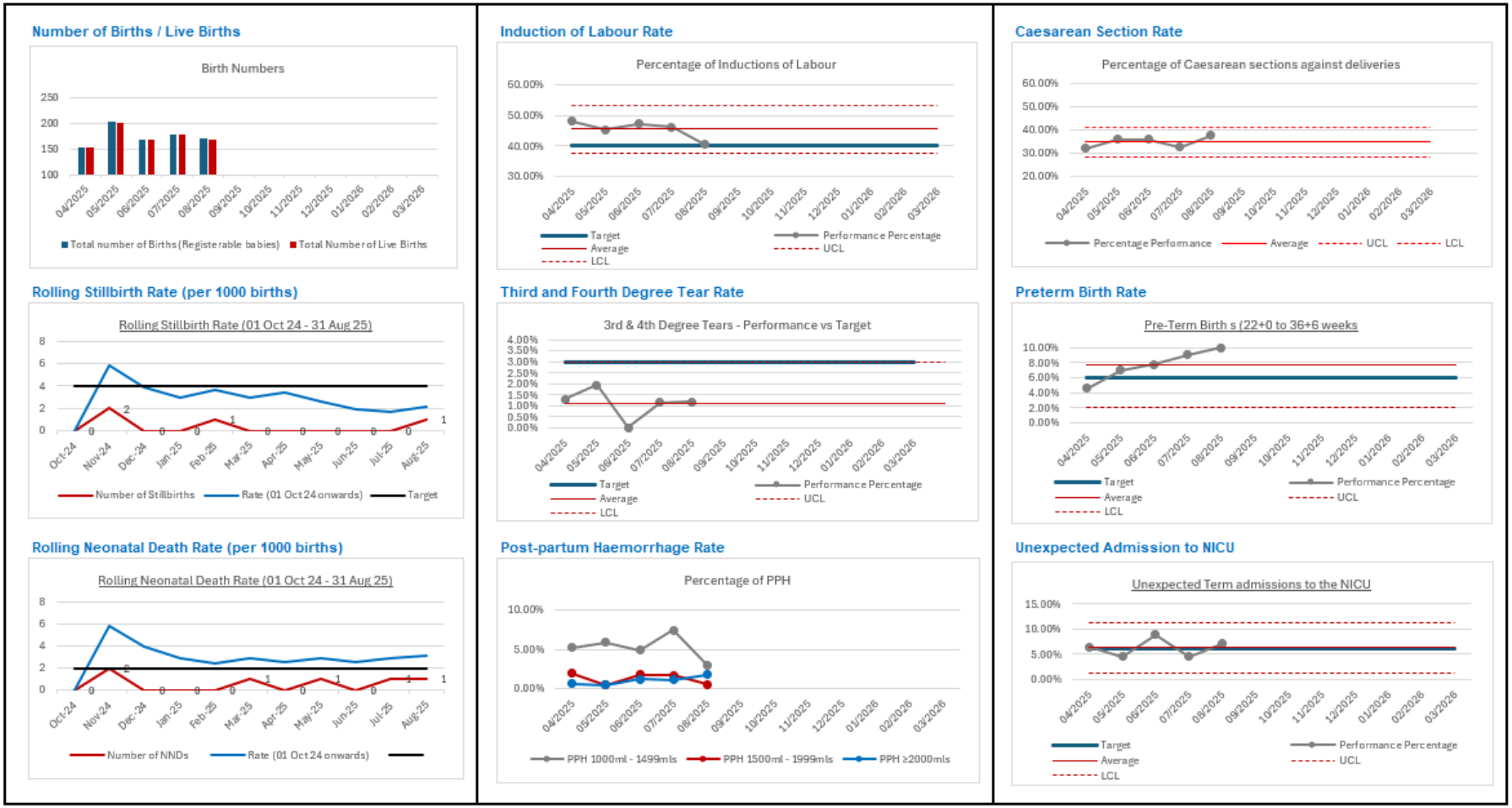
Both HUTH and NLAG demonstrate strong commitment to maternity and neonatal safety through robust governance, staff training, user engagement, and transparent reporting. While service user satisfaction remains high, efforts are ongoing to address workforce, cultural, and data quality challenges.

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)

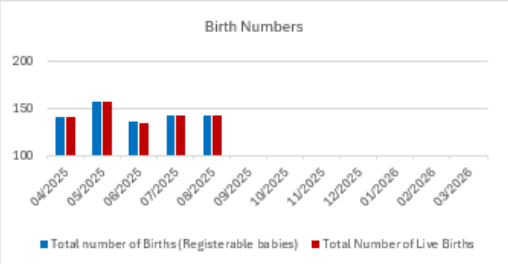
Latest Month: July 2025



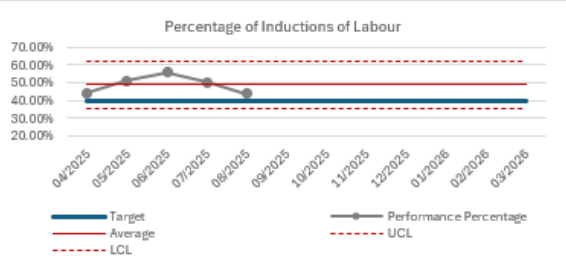
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: July 2025

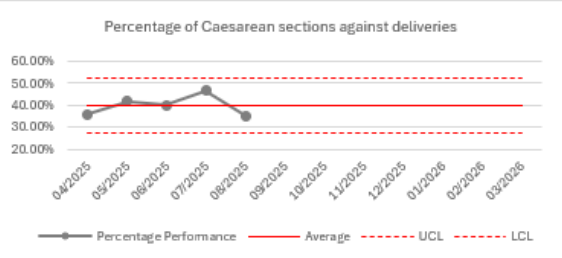
Number of Births / Live Births



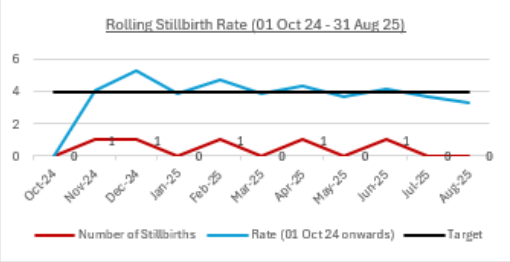
Induction of Labour Rate



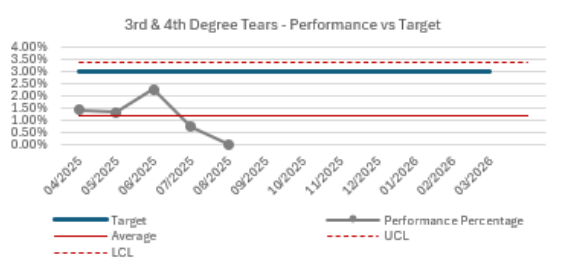
Caesarean Section Rate



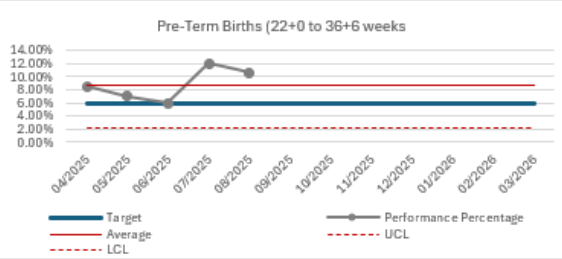
Rolling Stillbirth Rate (per 1000 births)



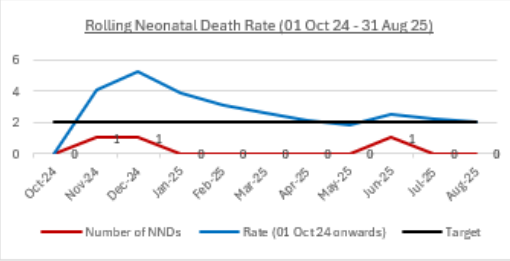
Third and Fourth Degree Tear Rate



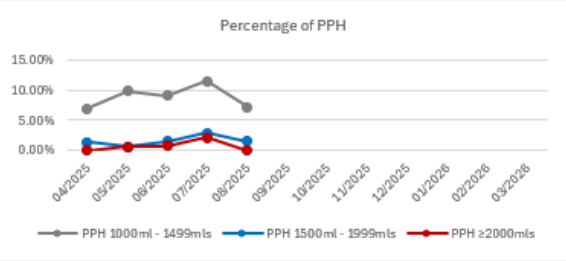
Preterm Birth Rate



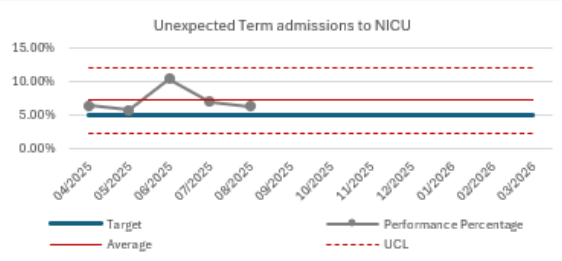
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU

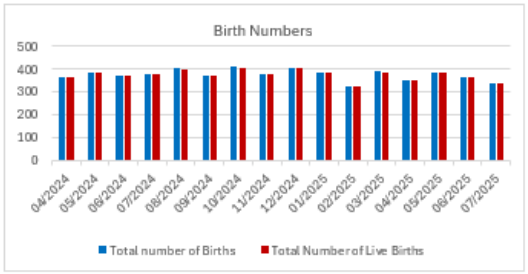


** The rolling stillbirth and neonatal death rates are based on births data extracted from Badgernet monthly reports. Issues noted in data reporting when comparing to Power BI sourced data.*

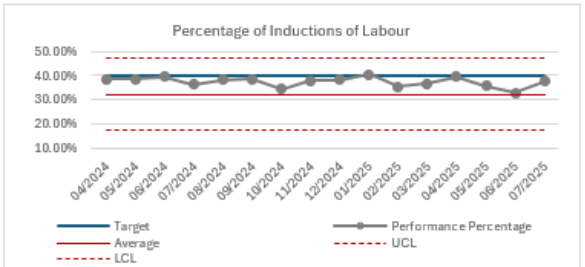
Maternity Overview - Hull University Teaching Hospitals (HUTH)

Latest Month: July 2025

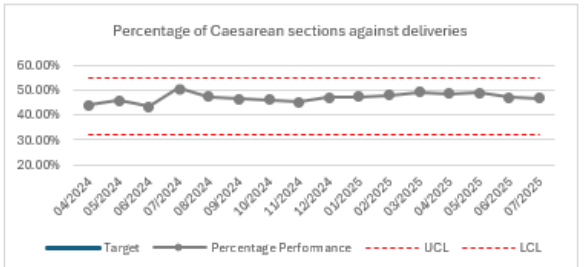
Number of Births / Live Births



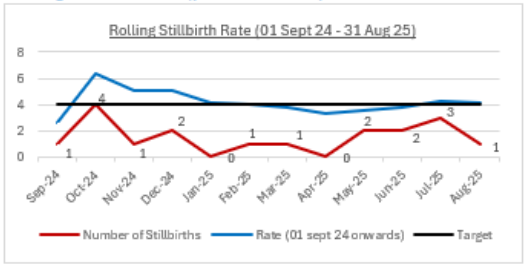
Induction of Labour Rate



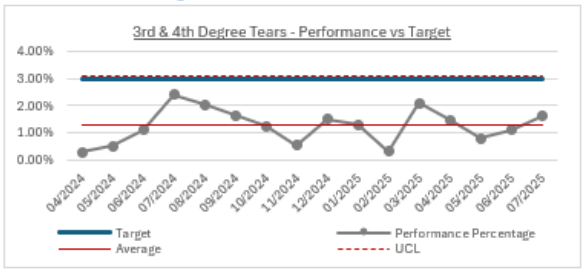
Caesarean Section Rate



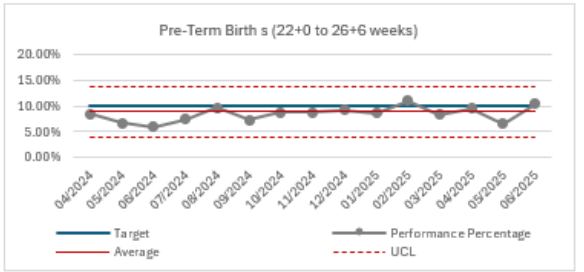
Rolling Stillbirth Rate (per 1000 births)



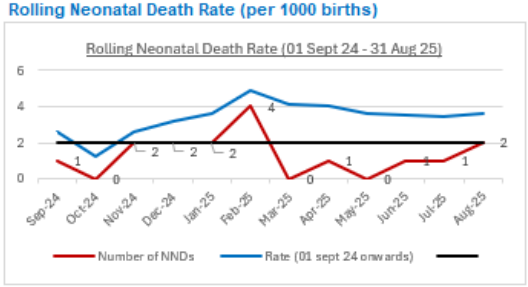
Third and Fourth Degree Tear Rate



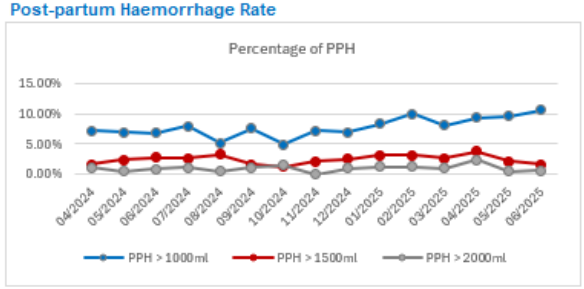
Preterm Birth Rate



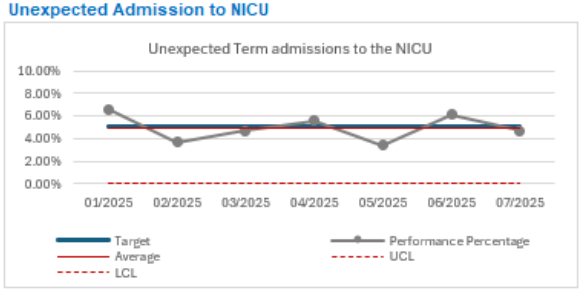
Rolling Neonatal Death Rate (per 1000 births)



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					
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 Plan					Outstanding staff members to book onto training.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**2**	**8**	**0**	**0**	

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	July 2025
Findings of reviews of all perinatal deaths using the real time data monitoring tool	PMRT reviews - meeting occurred on the 23rd July. External reviewers present. 97484 NND 22+6 – Care graded A/B/A. Moved to report writing stage 98792 IP SB 36+ - Care graded B/A. Known congenital abnormality. 97620 NND >28 days – Care Graded B/C/A Neonates aware to escalate their grading of a C to the LRP for further review in line with process. Joint case with Calderdale.
Number of cases referred to MNSI/ENS	Nil – 2 ongoing (see ongoing MNSI 5.1)
Findings of review of all cases eligible for referral to MNSI	N/A
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	Concerns raised regarding the open access to the hospital on evenings and difficult conversations on the postnatal ward when visiting hours are over.
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	July 2025
Findings of review of all perinatal deaths using the real time data monitoring tool	PMRT reviews - meeting occurred on the 1st July. External reviewers present. The following case was reviewed: 97389, 28+1 weeks antepartum stillbirth, care graded B/A. Not asked about domestic abuse, assessed as high risk but was not prescribed aspirin at booking (prescribed later on in pregnancy).
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	N/A
Number of patient safety incidents logged and what actions are being taken	191 maternity (1 moderate – unplanned return to theatre) / 38 neonatal (0 moderate/above).
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
Service User Voice – themes	Please refer to body of report
Staff feedback from frontline champions and walk-abouts - themes	Concerns raised about low use of Badger notes by service users- ongoing escalation to through various Digital forums.
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

- Information services- minimal support beyond statutory requirements for maternity due to gaps with the Corporate Information Team- in view of this in-house plans to develop a detailed maternity dashboard are ongoing. Progress has been made at HUTH, however, data quality continues to need review. Dashboards now in place as drafts due to the need to resolve data quality issues.
- Scunthorpe continues to offer significant support to Hull reflected in the induction of labour rates. Full reports on induction of labour across the Group to be shared at October MNAG.

	SGH Induction of labour rate total	SGH Induction of labour rate minus transfers from HRI
May	50.9%	43.2%
June	55.6%	50.4%
July	50.0%	35.7%

- In July 2025 DPOW received a notification of an outlier at alert level for a measure within the National Neonatal Audit Programme (NNAP) relating to the Breastmilk by day 2 of life (based on the 2024 data). This was acknowledged by our clinical lead in the specified time frame as requested by NNAP reviewed internally for improvement purposes which identified that there are potential documentation issues. There is evidence on the UNICEF Baby Friendly / Admission record on Badger of first human milk being given within 2 days of life that is only being picked up on the daily summary data the following day (day 3) in several cases. Findings are yet to be confirmed with the Ward Manager/Matron, however, if this is correct it would improve our compliance from 43.6% (as per outlier notification) to 56.4% and potentially within the control limits. The national report / outlier status cannot be changed retrospectively but this provides insight for ensuring data quality issues are eliminated prior to final submission in 2025.

Positive News

- Positive feedback continues for Golden Hour on Rowan
- Midwifery Diabetes team at HUTH fully recruited to from the 1st of September
- Positive review of the exit criteria from the MSSP for HUTH. Plans in place to write to the CQC regarding review of the Section 31

- Approach to addressing concerns regarding rotation at DPOW agreed and first workshop was very well attended with positive discussion.
- PMA Day held at the University of Hull on the 8th of September- with really encouraging feedback from PMAs invigorating the role and progress required to further develop the PMA role.
- Further staff attending Braver than Before in October
- A number of LWCO across the Group are attending the LWCO course at Teeside.
- The Midwifery Unit Project "Birth in Focus: Evidence, Physiology and Practice" commenced on the 11th and 12th of September with positive feedback from the midwives who attended.

Areas of Concern

- Delay in Workforce papers going to board
- Staffing has been challenging due to sickness and awaiting new starters particularly in the neonatal services. Although midwifery will be fully recruited to when the newly qualified midwives commence, due to high levels of maternity leave, supernumerary requirements and sickness it remains a challenge to staff rosters effectively. This is reviewed daily to maintain safety.

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 (August 2025)

	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	97%	N/A	90%	100% (prior 01/07) TBC (after 01/07)	N/A		N/A	N/A	N/A	N/A
PROMPT (MIS)	96%	94%	95%	67% (prior 01/07) SPR TBC * (after 01/07)	78%	75% (prior 01/07) 33% (after 01/07 – all booked)	N/A	N/A	N/A	N/A
MOS&T (SBLCB)	95%	60%	47%	TBC	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	92%	N/A	N/A	N/A	N/A	N/A	85%	82%	72%	40%
NLS (4 year MIS)	N/A	N/A	N/A	N/A	N/A	N/A	Requested	Requested	N/A	N/A

** MOS&T training was recently added to the mandatory training for medical staff.*

Northern Lincolnshire and Goole NHS Foundation Trust (August 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%	86%	N/A	N/A				
PROMPT (MIS)	96%	89%	93%	71%	83%	100%				

Personalised Care (SBLCB)	92%	94%	87%	79%	N/A	N/A				
Care during Labour & PN (SBLCB)	96%	N/A	93%	54%	N/A	N/A				
Neonatal Resus (1 year) (MIS)	96%	N/A	N/A	N/A	N/A	N/A	88%	93%	89%	100%
NLS (4 year) (MIS)	N/A	N/A	N/A	N/A	N/A	N/A	94%	82%	87%	100%

Training compliance is lower than usual during August following the intake of new doctors that are yet to complete their training. The above figures for 'other doctors' take into account new doctors and staff who are rotating out of Maternity Services in September 2025 who are out of compliance.

Item 6: Safe Staffing

6.1 Fill rates – planned versus actual

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Jul 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	3311.1	3075.0	92.9%	3300.6	3081.4	93.4%	1674.0	1639.5	97.9%	1426.0	1413.5	99.1%
SGH	2567.1	2390.9	93.1%	2567.1	2249.6	87.6%	713.0	607.1	85.1%	945.5	751.8	79.5%

Month: Jul 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	1782.5	1553.4	87.1%	1426.0	1337.1	93.8%	713.0	536.6	75.3%	713.0	423.3	59.4%
SGH	1426.0	1336.1	93.7%	1069.5	1136.5	106.3%	713.0	569.3	79.8%	713.0	671.4	94.2%

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

Hull University Teaching Hospitals (HUTH)

Month: Jul 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	9604.00	9094.42	96.36%	6602.50	5762.50	90.45%	3492.00	3074.00	88.02%	2741.00	2400.50	87.57%

Month: Jul 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	7111.50	5690.33	80.02%	6134.00	4980.58	81.20%	456.00	351.50	77.08%	341.00	206.00	60.41%

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

6.2 Midwifery Staffing Vacancy Rates (July 2025)

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH	Vacancy rate NLAG	Vacancy rate adjusted NLAG
Midwifery	4.1%	2.4%	6.8%	-7.5%
Midwifery Support Workers	-1.0%	-2.5%	-14.1%	-29.2%

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.15.28 WTE and 17.95 WTE newly qualified midwives are due to commence this autumn across HUTH and NLAG respectively.

6.3 Red flags, Actions and Mitigations (July 2025)

The most recent data available is for July 2025. During the month HUTH reported 46 red flags and NLAG reported 3. The details are shown in the table below.

	HUTH	NLAG
Delayed or cancelled time critical activity	21 (46%)	3 (100%)
Delay between admission for induction and beginning of process	25 (54%)	0
Total	**46**	**3**

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-040973	Romanian/ IMDD 1	Yes	Yes	Yes	Yes	Yes	Perimortem CS and cooled baby. AAR completed. Staff interview stage. MIRM review completed. ENS referral. DoC compliant. Draft received and FA complete. No safety actions. Awaiting final report.
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

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
W343585 – IUD 32 weeks with no FM	BA – IMDD 1	Obstetric	Fatal – (downgraded to moderate following MIRM). To receive DoC in line with PMRT. Verbal DoC provided.	What went well: - High level of AN and intrapartum care and documentation -GAP protocol and escalation Potential Learning: - system gap identified.

				-Having discussed over e-mail with Sonography, the images were of a reasonable nature but not detected as <10th during the AN period. Overall, the care received was of a high standard, but concerns raised that we do not have a pathway for a woman who conceives on an IUD. This lady remained on midwifery led pathway and was not referred to an obstetric clinic for further observation and plan. The IUD was identified at most of her scans but was reassured by the community midwife this can be located prior to delivery. An attempt to remove it was undertaken in EPAU but our obstetric colleagues in the meeting said ideally an attempt around 16-17 weeks but further observation would have been recommended also. This was a large topic of conversation as studies have identified a positive correlation between babies conceived with an IUD insitu and: • Growth restriction • Mid-trimester and early miscarriage (no evidence link specifically around still birth) • Pre-term labour • Increased neonatal mortality and morbidity • Cervical and uterine trauma • Infection • Sepsis Due to these factors and no clear system pathway to support referrals, discussion will take place at LRP (pre-empting that if the placental histology demonstrates infection changes) prior to full PMRT review for transparency. LRP – to follow PMRT

W343972 - postnatal day 4 following spontaneous vaginal preterm birth presented via TC where baby was cared for -unwell, Hb 47g/dl CT confirmed moderate hemoperitoneum IR standby Laparotomy and TAH bilateral salpingectomy for spontaneous rupture of pseudoaneurysm of uterine vessels extending into broad ligament tear and ongoing bleeding. EBL 7.5litres. ICU post op.	WB – IMDD 5	Obstetric	Severe – upheld after MIRM but no requirement for escalation to LRP. To receive DoC 2 and debrief with consultant. Verbal DoC provided.	Care reviewed and of a very high standard. Very unusual incident occurring approx. 1:30,000 births. X1 missed meows but did not affect care. Team including theatres, anaesthetics and Obstetric and Maternity MDT commended for their work.

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, progressing through MNSI investigation. Staff interviews underway (HUTH external support).

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
348972 (MNSI - 045011)	White British	Obstetric	Moderate	Rapid review undertaken. Immediate action taken – learning lessons disseminated via the huddle regarding CTG monitoring and the importance of co-ordinator review. Discussed at Learning Response Panel, agreed for investigation as per MNSI / early notification processes.
350129	White British	Obstetric	Moderate	Cardiac issues identified on NIPE screening, referred to Leeds for specialist review who felt this should have been recognised at the anomaly scan. To be discussed at Learning Response Panel (w/c 08/09/25) where further action will be determined.
350350	White British	Obstetric	Moderate (downgraded to low harm)	Antepartum stillbirth with antepartum haemorrhage. Rapid review and staff de-briefs undertaken. To be investigated through PMRT process.

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	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
Maternity / Obstetrics	Obs & Gynae Consultant staffing (effect on daily patient service and RCOG educational requirements)	Moderate
Neonatal	Frequent unavailability of neonatal cots	High
Neonatal	No AHP for support for high-risk babies on NICU	Moderate
Neonatal	Increased risk of drug administration errors without e-prescribing	Moderate

Northern Lincolnshire and Goole NHS Foundation Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity / Obstetrics	Antenatal clinic review capacity (TWD)	High
Maternity / Obstetrics	Inappropriate accommodation (community midwives)	Moderate
Maternity / Obstetrics	Obsolete diathermy machine	Moderate
Neonatal	Electricity supply failure in NICU	Moderate
Neonatal	CPAP drivers	Moderate
Neonatal	NICU incubators	Moderate

Item 8: Perinatal Mortality

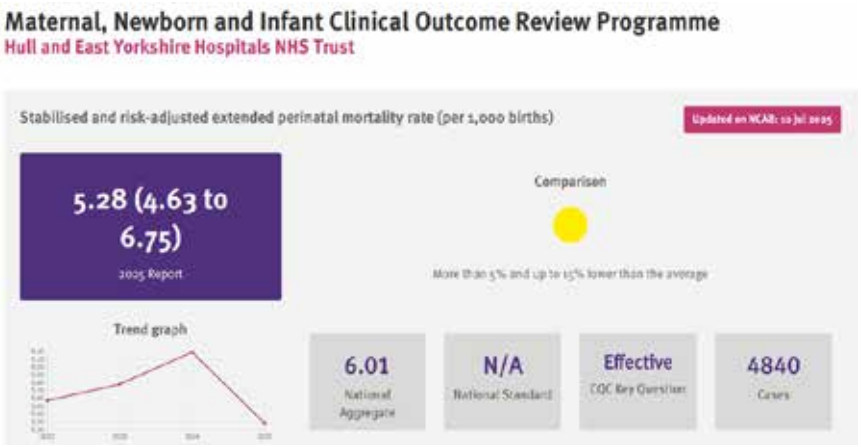
8.1 Perinatal Mortality Summary for the period

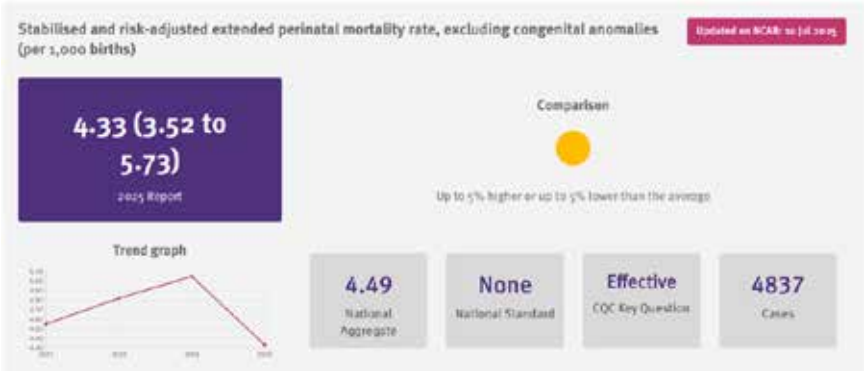
Perinatal deaths within month (July 2025)					
	Antenatal Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	2 (31+0 / 32+3)	1 (36+5)	0	1 (36+4)	0
NLAG	0	0	0	1 (22+0)	0

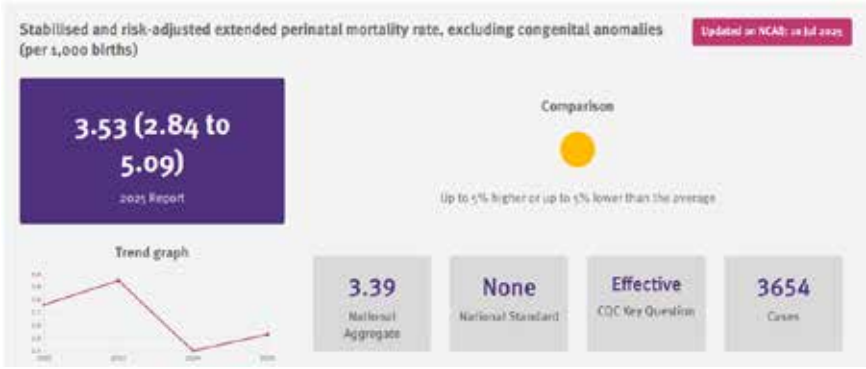
Perinatal deaths within month (August 2025)				
	Antenatal Stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	1 (32+4)	0	1 (22+6)	1 (29+3)
NLAG	1 (30+5)	0	1 (21+4)	1 (40+0)

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 (August 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
99280	A, A	N/A	N/A	Currently report writing
99072	A, awaiting NN review, A	N/A	N/A	Awaiting neonatal review of care
99338	A, awaiting NN review, A	N/A	N/A	Awaiting neonatal review of care

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
98007	C / B	Yes	21/08/25	Rapid Review undertaken. Learning identified and actions underway as per PMRT processes. Learning Response Panel satisfied with PMRT review and actions identified.
99711	B	N/A	N/A	Joint PMRT with South Tees, discussed at PMRT and graded B for care at NLAG, care yet to be graded by South Tees. Lessons learnt regarding commencement of Enoxoparin earlier in pregnancy.

Item 9: Listening to our staff

- Safety Champion Walkaround on the 24th July 2025 at Hull Royal Infirmary. Discussion was centred around behaviours of the general public and security and support for staff.
- Plans ongoing for a staff experience and maternity and neonatal culture workstream- mapping meeting planned for the 19th September 2025
- Ask Me Anything launched by the Director of Midwifery.
- First workshop at DPOW to find a collaborative solution to the necessity for midwifery rotation to effectively deliver the service was very well attended with positive contributions. A further two workshops are planned and then feedback will be undertaken and a fresh consultation launched

Item 10: Safety Champion Updates / Feedback

The last Safety Champion meeting took place in July 2025 the following were in attendance.

Role	Attendance		Attendance
Board Safety champion	Yes	Perinatal Neonatal lead	
Board Safety Champion	Yes	Perinatal Management team	
Perinatal Obstetric lead		MNVP lead	
Perinatal Midwifery lead	Yes	Perinatal Neonatal lead	

Item 10.1: Safety Champion Feedback

Feedback raised by staff	Action and progress
HUTH: Staff on Rowan Ward (HRI) have shared positive feedback regarding the recent improvements to the office space	No action required.
Ongoing staff feedback regarding the roll out of the Golden Hour initiative, which enables partners to stay with new mothers for the first hour post-transfer outside normal visiting hours.	Continue to monitor and action new risks identified.
NLAG: Eight actions raised through the Safety Mailbox, Shout Out Wednesday, or walkarounds have now been closed.	Continue to monitor and action new risks identified.
Visitor Interactions (HRI): Staff report challenges with difficult conversations involving visitors;	Discussions with the security team are planned to explore supportive interventions.
Triage Access (HRI): In response to staff concerns, an intercom system has been installed; work is ongoing to ensure secure overnight access.	Continue to monitor and action new risks identified.
Student Midwife Experience: Concerns raised about placements and training experiences.	A meeting with university representatives has occurred and an action plan with regular follow-up meetings has been established.
Additional safety champions intelligence	**Action and progress**
KPI Achievement: Sustained performance of 80% of women being triaged within 15 minutes across the Group is noted positively by the Safety Champions.	No action required.

Item 11: 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 24/25 is based on the benchmarking against the new interventions.

Northern Lincolnshire and Goole NHS Foundation Trust

% of interventions fully Implemented					Current
Review quarter	Q4 2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Assurance review date	10 June 24	19 Sept 24	11 Dec 24	14 Mar 25	06 Aug 25
Element 1: Smoking in pregnancy	70%	90%	80%	80%	80%
Element 2: Fetal growth restriction	90%	85%	90%	90%	95%
Element 3: Reduced fetal movements	100%	100%	100%	100%	50%
Element 4: Fetal monitoring in labour	80%	100%	80%	100%	100%
Element 5: Preterm birth	67%	74%	74%	78%	67%
Element 6: Diabetes	83%	83%	83%	83%	83%
TOTAL	**77%**	**83%**	**81%**	**84%**	**80%**

A drop in compliance has been observed in the Q4 self-assessment, partial compliance has been declared in several interventions to allow guideline updates. Further improvement work is required to reach full implementation by March 2026 as per the trajectories set by the LMNS, although it should be acknowledged that due to the nature of some interventions it will be difficult to achieve full compliance e.g. element 5 where it is not always possible to provide preterm optimisation due to the nature of presentation of the women. Data collection is ongoing for submission of Q1 (25/25) data for review in October 2025.

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	Q4 2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Assurance review date	10 Jun 24	18 Sept 24	11 Dec 24	12 Mar 25	30/07/2025
Element 1: Smoking in pregnancy	60%	70%	80%	90%	70%
Element 2: Fetal growth restriction	95%	100%	100%	100%	90%
Element 3: Reduced fetal movements	50%	50%	100%	100%	100%
Element 4: Fetal monitoring in labour	20%	40%	80%	60%	100%
Element 5: Preterm birth	70%	67%	89%	85%	77%
Element 6: Diabetes	83%	83%	100%	100%	67%
TOTAL	**73%**	**76%**	**91%**	**90%**	**81%**

A drop in compliance has been observed in the Q4 self-assessment, following changes with the update to Saving Babies Lives to Version 3.2. The main drop in compliance is around smoking training and the tobacco dependence treatment service, changes required in a guideline regarding symphysis fundal height and preterm birth due to the nature of women presenting. Peer assessment by the LMNS was completed place in July 2025. Further improvement work is required to reach full implementation by March 2026. Data collection is ongoing for submission of Q1 (25/25) data for review in October 2025.

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%

In view of the significant challenges of reaching 100% on each element of SBL a discussion with the LMNS is required as the trajectories are locally agreed and not cohesive across the Group.

Item 12: Avoiding Term Admissions to NICU target <5%

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	%
Jun 2025	168	155	15	8.9%
Jul 2025	175	162	8	4.6%
Aug 2025	171	154	12	7.0%

% 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	%
Jun 2025	135	127	14	10.3%
Jul 2025	138	125	10	7.2%
Aug 2025	142	127	9	6.3%

Themes and Trends in Q1

- Classification and escalation of CTG's have been highlighted and have generated the need for rapid reviews of admission of a baby to NICU to have a deeper look at cases for immediate learning.
- Documentation on Badgernet IT system, specifically neonatal resuscitation or specialist review of a baby that didn't go to NICU initially. Supported learning for neonatal staff from maternity.
- Cord gases not uploaded to Badgernet automatically and discussion taken to perinatal M&M re process for where cord gases should be entered.
- 1 case of admission for social circumstances which are unavoidable from the maternity/neonatal perspective.

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	%
Jun 2025	343	307	21	6.1%
Jul 2025	338	307	16	4.7%
Aug 2025	343	313	13	3.8%

The primary reason for separation of mother and baby in August was RDS. Late pre-term admission rate 2.65% (April onwards) and to be calculated monthly moving forward and initial NARLG meeting took place.

Item 13: Service User Feedback

9.1 Complaints Received (August 2025)

Hull University Teaching Hospitals NHS Trust

Complaints received – Maternity	
Number received	**Claimant concern**
3	Concerns regarding care provided / delay in decision making Treatment received during Caesarean section Delayed diagnosis.

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Complaints received – Maternity	
Number received	**Claimant concern**
1	Delay or failure to monitor obs - mother of patient has concerns regarding care in NICU and also concerns regarding her own care on maternity ward.

9.2 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 • Triage, seen quickly and efficiently • Caring midwives, going the extra mile • Doctors, especially during C-Sections • Golden hour on Rowan Ward • Parent education – carousel, classes *(project to improve further equitable offer)* • Ask a Midwife service **Not going so well** • Badger notes app – slow to load, not being used. *Project started to review all PILs by week* • Feeling dismissed/not listened to • Rowan ward 'chaotic' • IOL – less poor feedback but still a key theme • Complaints/PALs – not being responded to	**HUTH** **15 Steps ground floor Feb –** very positive especially ADU and Triage. Main outstanding actions on improving signage, welcome in different languages **15 steps NICU May –** very positive for NICU. Actions to improve TC **15 steps middle floor** – to be done this Autumn

9.3 Friends and Family Test (July 2025)

Hull University Teaching Hospitals NHS Trust

For June 2025 a total of 84 responses (40%) were received as part of the Friends and Family Test for Maternity Services. 96% of the feedback was positive.

MLU: “I had a very positive experience on the midwife led birthing unit. My midwife Liv was amazing, and all the staff were so helpful and reassuring. We are so so grateful thank you.”

Community Midwifery Team: “Every midwife we have seen has been amazing. They have been friendly, putting us at ease, answered all our questions and provided so much support. After the birth they have also helped ease my anxiety and I honestly can't thank everyone we have dealt with (including both trainee midwives) enough.”

Northern Lincolnshire and Goole NHS Foundation Trust

For July 2025 a total of 10 responses were received as part of the Friends and Family Test for NICU across the Trust. 100% of the feedback was positive.

For Maternity, 90 responses were received with 91% positive feedback, 1% poor and 8% very poor. All negative feedback related to the waiting times in the joint antenatal clinic at both DPOW and SGH.

NICU DPOW:
“They have been amazing with our baby and reassured us where possible. Although we have had a very traumatic experience giving birth, the nurses have ended this journey for us on a positive”.

NICU SGH
“The whole team on NICU have been amazing. All staff have been so friendly, supportive, helpful and patient. Very informative, knowledgeable throughout. A massive thank you to all”.

Maternity DPOW:
None received.

Maternity Goole:
None received.

Maternity SGH:
“All the staff were incredibly caring and supportive. I felt very well looked after throughout my stay. I'm extremely satisfied with the care I received on the postnatal ward. Thank You!”

Item 14: VTE Risk Assessment Performance

Northern Lincolnshire and Goole NHS Foundation Trust

August 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	42.8%	57.4%	69.7%	82.0%
DPOW	69.8%	79.8%	84.5%	84.5%

Hull University Teaching Hospitals NHS Trusts

August 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	84.2%	92.2%	93.4%	99.1%

Item 15: 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 16: Triangulation of Claims Scorecard Quarter 1 2025/26
16.1 Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 1

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 April 2014 –June 2024 (55 claims)

Top injuries by volume:	Top injuries by value:
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Brain damage (3) Cerebral palsy (2) Wrongful birth (1) Bladder damage (3) Fatality (9)
Top causes by volume:	**Top causes by value:**
Failure / delay in treatment (15) Failure / delay in diagnosis (8) Inadequate nursing care (3) Operator error (3) Intra-operative problems (3)	Failure / delay in treatment (2) Intra-operative problems (1) Other (1) Fail in antenatal screening (1)

Claims Breakdown Q1 25/26

Claims opened:

- Alleged failures in management of suspected ectopic pregnancy, resulting in removal of fallopian tube, infertility and unnecessary pain.
- Post-delivery of third baby bladder complications.
- Allegations of failings around post-delivery care and management of post-mortem and genetic testing of still born child resulting in psychiatric harm.

Existing claims:

25

Claims closed:

0

Incidents Q1 25/26

Top 5 incidents by volume:

- Unexpected admission to NICU **(24)**
- Potential breach of confidentiality **(17)**
- Documentation missing/not completed **(12)**
- Readmission of other after delivery **(11)**
- Delay in induction of labour **(10)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **430**

Complaints Q1 25/26

There have been 9 new complaints received relating to the following categories:

- Failure to provide adequate care / care needs not met (2)
- Delay or failure to diagnose (2)
- Delay or failure in treatment (1)
- Blood transfusion administration (1)
- Attitude of staff (1)
- Injury sustained during treatment (1)
- Wound dehiscence (1)

Clinical Audits Registered Q1 25/26

- Compliance with the capability standards – BAPM Neonatal Airway
- Consultant presence in Clinical Situations
- Saving Babies' Lives Care Bundle Version 3.2 (Elements 1 – 6)
- Avoiding Term Admissions to NICU
- Transitional Care Point Prevalence Audit
- VTE Risk Assessment and Prophylaxis (Antenatal & Postpartum)

Deep Dive Reviews Q1 25/26

In progress:

Induction of labour (SGH)

Completed:

Unexpected Admission to NICU (no themes identified).

Learning Q1 25/26
• Badgernet documentation for fetal monitoring in labour not completed appropriately at SGH • Bereavement checklist to be completed in its entirety in order to prompt staff to undertake all postnatal observations • The Trust needs to work towards allocating the recommended 30 minutes for growth ultrasound scans (from MNSI report) • The Trust does not have a SOP to guide sonographers with possible actions to take when there are difficulties obtaining good quality scan images • NEWTT2 Framework not used for paediatric care • Incorrect interpretation of antenatal CTG monitoring • Women assessed as high risk but aspirin not prescribed

Themes Q1 25/26
• Women not asked about domestic violence at booking appointment • Women / family members in the same household not offered referral to smoking cessation services • Deep Dive of Unexpected Admission to NICU being undertaken to identify any themes • Not all postnatal investigations undertaken for bereaved mothers • Bereavement checklist not always completed in its entirety

Action Plan Q1 25/26	Not started / In progress / Complete	
Deep dive to be undertaken at SGH to assess compliance with fetal monitoring standards and documentation on Badgernet. Results to be discussed with Labour Ward Co-ordinators and individual staff members.	June 2025	
Saving Babies' Lives newsletter / guidance for completing fetal monitoring (risk assessments, hourly fresh eyes) in Badgernet to be disseminated to all midwifery staff.	July 2025	
Training package to be implemented to upskill Midwifery Support Workers.	July 2025	
Discussions with individual staff members to take place regarding the 'opt out' referral to the Tobacco Dependency Treatment Advisors for smoking in pregnancy.	June 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	October 2025	
Immediately adopt NEWTT 2 and update all EMC documentation	October 2025	
Individual staff training in fetal monitoring	October 2025	
Reminder on Doctors huddle to ensure aspirin is prescribed where indicated	July 2025	

12.2 Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 1 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 April 2014 –June 2024 (90 claims)

Top injuries by volume:	Top injuries by value:
Fatality (16) Unnecessary pain (15) Additional / unnecessary operation(s) (13) Stillborn (11) Bladder damage (5)	Cerebral Palsy (4) Brain damage (7) Stillborn (13) Fatality (9) Cardiac Arrest (1)
Top causes by volume:	**Top causes by value:**
Failure / delay in diagnosis (11) Failure / delay in treatment/operation (11) Inadequate nursing care (6) Failure to recognise complication (6) Failure to act on abnormal test results (6)	Failure to monitor 1st stage of labour (3) Failure / delay in treatment (2) Failure / delay in diagnosis (1)

Claims Breakdown Q1 25/26

Claims opened:

- Alleged failure to escalate the deteriorating CTG and delay in performing the emergency caesarean section resulting in exposure to perinatal hypoxia-ischaemia and death
- Alleged failure to appropriately manage maternal infection during antenatal and perinatal period resulting in prolonged recovery, surgery to treat wound and psychological injury
- Alleged failures in management of instrumental delivery resulting in laceration to face and subdural and subarachnoid haemorrhages.

Existing claims: 35

Claims closed:

- Alleged failure to provide antenatal cervical length screening and subsequent inappropriate management of preterm labour resulting in stillbirth. **No damages paid.**
- Psychiatric injury claim linked to the birth of the individual's baby who suffered fatal spinal injuries during rotational forceps delivery. **Damages paid £45k.**

Incidents Q1 25/26

Top 5 incident by volume:

- In-utero delay in IOL **(47)**
- Term NNU admissions **(23)**
- Safeguarding concerns **(23)**
- Readmission to hospital **(21)**
- Post partum haemorrhage (PPH) >1500mls **(16)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **468**

Complaints Q1 25/26

There have been 6 new complaints received relating to the following

- Treatment- Medication error
- Historical review of care (baby requiring amputation of arm)
- Treatment delayed
- Treatment – not satisfied

Clinical Audits Registered Q1 25/26

- Antenatal and Newborn Screening – Health Inequalities Audit
  Fair Access to the "Screening Tests for You and Your Baby" Leaflet
- Consultant Attendance in Clinical Situations - Obstetrics

Deep Dive Reviews Q1 25/26

In progress:

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.*

Complete:

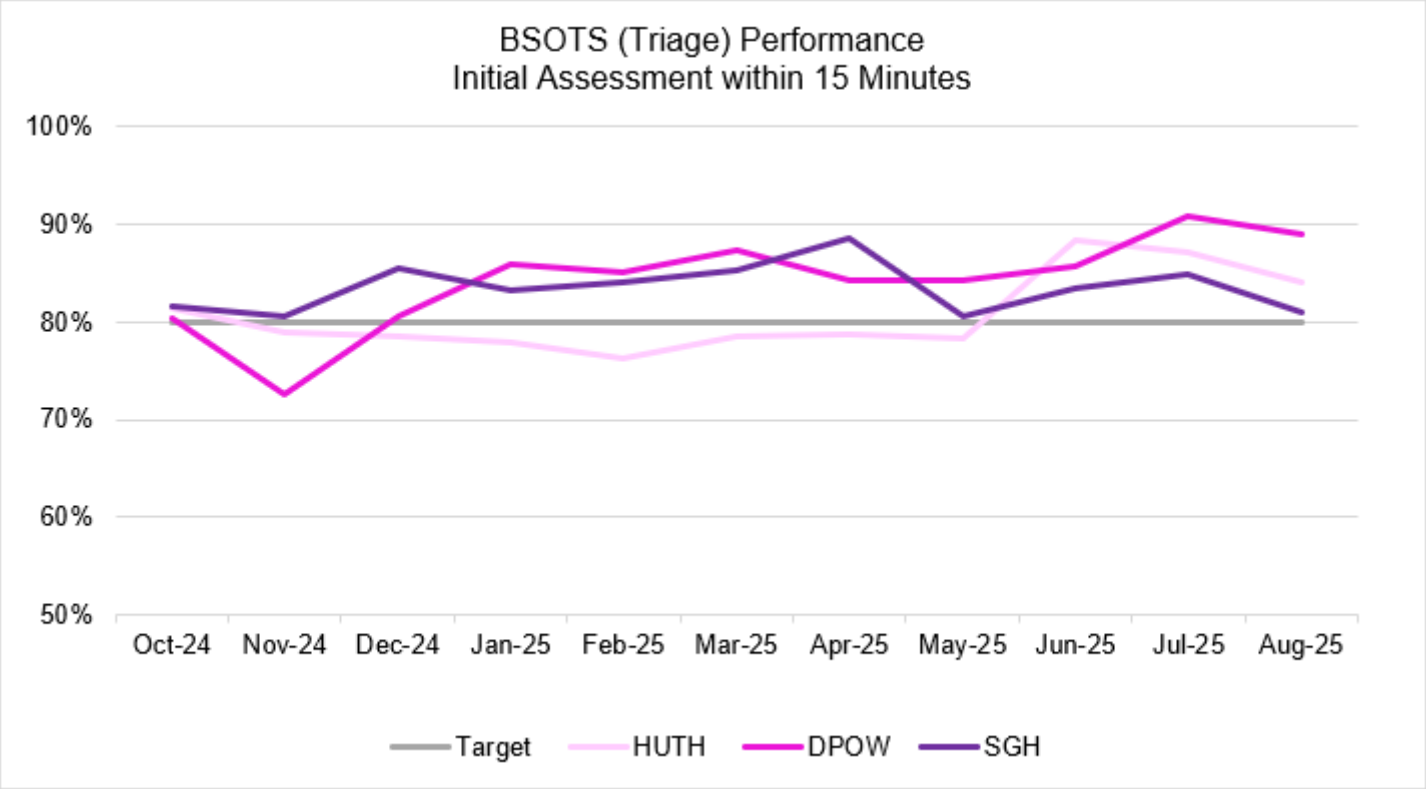
Perinatal Optimisation – *focusing on the pathway from presentation to delivery to assess if optimisation measures have been taken. Supported by the LMNS.*

Learning Q1 25/26
• PLGF/PCR not being sent when required • Abduction drill conducted • Failed instrumental deliveries – MDT thematic review commenced • CTGs not being classified during reviews • Emergency buzzer use (registered QI project)

Themes Q1 25/26
• ATAIN sustained decrease in hypothermic admissions continues • Delay in IOL and ARM >24hrs continue to be Datixed • Postnatal admission thematic review commenced • BadgerNet documentation standards much improved and risk lowered • VTE risk assessment non-compliance

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 17: BSOTS Performance



Item 18: 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 19: Progress with CQC Survey Action Plan

Following publication of the 2024 Maternity Care CQC Survey 19 actions were identified and incorporated into the MATNEOSIP tool for monitoring within the group.

The table below provides an update for the 16 open actions.

Action Numb	Site	Issues identified	Outcome Aim	Actions	By whom	Comments	Target date	Current RAG	Actual Completion Date	Evidence / Validation of Completio
C11	NLAG & HUTH	Not left alone when worried (during labour and birth)	All women and birthing people who 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	Birthrate plus review due Spring 2025			
D2	NLAG & HUTH	Discharged without delay.	Expected Discharge plans are discussed and all involved in plans and are kept up to date	Documented evidence that all are involved in discharge plans and unavoidable delays are minimised	HOM/Matrons	Ongoing work with Rowan ward. -Plans for discharge coordinator -Work with pharmacy to reduce TTO delays -Recruitment to Rowan ward manager	Sep-25			
F11	NLAG & HUTH	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 pangroup. 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.	May-25			
F12	NLAG & HUTH	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	As above	May-25			
F15	NLAG & HUTH	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-25			
B4	HUTH	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	As above Poster regarding local hospitals with QR code directing to hospital tours recently launched via LMNS.	Ongoing			

B6	HUTH	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	HUTH	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 pangroup. Community midwives direct women to these services. This information to be shared with community midwives and support services advertised widely.	Ongoing			
B17	HUTH	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	May-25			
C4	HUTH	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.	May-25			
F5	HUTH	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	As above with Badgernet introduction	Ongoing			
F14	HUTH	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	As above 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.	Ongoing			

F14	HUTH	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	As above 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.	Ongoing			
C12	NLAG	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		May-25			
D7	NLAG	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.	Ward Managers / Community Managers	Pain management included in Badgernet maternity records	May-25			
F13	NLAG	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	Ward Managers / 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 anytime also) - 'Fit for the Future'; suturing training to staff which 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.	May-25			

Item 20: 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 the recommendations is detailed in the table below.

Recommendation	Action / Milestone	Expected Impact	Lead	Forecast Completion Date	Progress	RAG
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	
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	31/10/2024	5 actions remain in process, 7 actions complete. Completed and plans in place for quarterly interface meetings between the trust and the Universities (Hull and Lincoln)	
NLAG Behaviour Charter for Maternity	Document includes, behaviour framework based on the organisational values. Refers to the Civility Saves Lives Campaign. Used the Capital Midwife Civility toolkit to	Provide information, educate/enhance knowledge and	Jennifer Buckley	August 2024	Needs update due to change in trust values following restructure and partnership with HUTH	

	guide aspects of the charter. Created MS form and displayed posters in clinical areas for staff to report concerns around psychological safety. RCOG civility posters displayed in clinical areas.	recognition of civility and incivility. Inform them of statistics: impact of incivility.	(Retention Lead Midwife)		**14/07/2025** New staff charter based on the Group Values in place.	
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	Complete. Student clinics been in place for over 12 months following concerns raised by students and the escalation process not being followed. PLF in seconded post has been extended for 2024. Pastoral support provided to students as required, walk rounds include speaking with students on shift. All students have access the trust student HUB page. SLEC launched in February 2024, this framework will guide support mechanisms the trust will work towards for students. No resources available on trust HUB. To discuss with PD team for nursing and AHPs to any work they have ongoing. 14/07/2025 Recent visit from NHSE- will request update on findings of visit and any actions recommended.	
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.	

EDI training on mandatory training	30 minute session on EDI, unconscious bias, equality, equity and the differences between these. Discussions around perceptions and beliefs and how these differ from person to person. Service user and student feedback are included in this session.	Refresh staff awareness of the topic and the impact of EDI inequalities for service users and colleagues.	EDI Lead Midwife/Clinical Educator Lead Midwife	01/02/2024	Ongoing. Sessions have been included on the personalised care day of mandatory training. **14/07/2025** – complete. 24 sessions completed at maternity mandatory training weeks across the trust over 12 months.	
NLAG People Strategy 2020-2024	The People Strategy builds on the vision and values of the trust to support the workforce and service users. The core drivers have come from the NHS People Plan 2020 and CQC action plan. The strategy highlights three themes: workforce, culture, and leadership.	Work towards improvements in areas identified nationally, regionally and locally.	CEO	01/06/2024	Due to restructure changes unsure of the progress. More information may be available at board level. **14/07/2025** New Group People Strategy 2025-2028 was implemented in April 2025.	
Group People Strategy 2025-28	Our new Group People Strategy (2025-28) launched this week. It covers how we will recruit locally, nationally and internationally, onboard, engage, manage, develop and recognise and reward staff. It covers flexible working to give people a better work/life balance, reasonable adjustments, new roles, new ways of working, speaking up, developing our leadership capacity and capability and, importantly, how all managers should lead and inspire staff in order to provide great care to patients. The strategy is our plan to improve our specific workforce challenges and improve our organisational culture, together with more specific actions in response to the Staff Survey.	Improved investment in training & development, career opportunities and pathways, quality of leaders and support available to all staff.	Simon Nearny Chief People Officer	12/05/2025	**14/07/2025** The People Strategy 2025-28 is available on Bridget for all staff to access.	
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. To form of the mapping work on 19/09. Minimal interest from staff- alternative strategies to be considered.	

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.		TBC	14/07/2025 Poster created, waiting for confirmation to share and display in clinical areas across the group. In place at HUTH to consider rollout at NLAG - reviewed in circle meetings monthly and actioned when received as required.	
Group Staff Charter	The Staff Charter sets clear, consistent standards for conduct, fostering a safe, compassionate, respectful, and productive work environment aligned with our core values. It promotes a harmonious culture by preventing conflicts and guiding professional, accountable behaviour across the workforce. As a reference point for addressing conduct concerns and managing disciplinary actions fairly, it supports managers and HR in maintaining consistency. Embedded in induction and training, the Charter helps all staff understand expectations and integrate effectively, nurturing a respectful, cohesive, high-performing culture.	Create a safe, respectful, and positive workplace by setting clear behavioural standards, reducing conflicts, and supporting consistent, fair management of conduct issues. It will align all staff with the organisation's values, improve professionalism and accountability, and help new and existing employees understand and meet expectations, contributing to a cohesive, high-performing culture.		12/05/2025	**14/07/2025** Group charter available on Bridget for all staff to access.	

Item 17: 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.

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Seven

HUTH & NLAG PROGRESS REPORT

September 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					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**	

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					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 Plan					Outstanding staff members to book onto training.
9 Floor to Board					
10 MNSI / Early Notification Scheme					
Total	**2**	**8**	**0**	**0**	

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 29th September 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 – 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 applicable – 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 applicable – not yet met	-
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)	1 applicable – 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%)	3/4 (75%) 1 not yet met (deadline 23/11/25)	1 applicable – 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	-

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 – Dec 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%)	4/4 (100%)	10/10 (100%)	-
Cases applicable for PMRT review are applicable to the following standards (n=24)						
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%)	6/9 (66% - 3 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%)	3/3 (100% - 1 N/A as baby born in a different trust)	7/8 (1 ongoing, 1 N/A as baby born in a different trust)	-
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3/3 (100%)	8/8 (100%)	2 complete, 1 in progress (on track, due Nov)	0 applicable in timeframe	-
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT.	**50%**	N/A	Not yet discussed at PMRT.	3/3 (100%)	2 met, all others after deadline	-
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	To be submitted	-

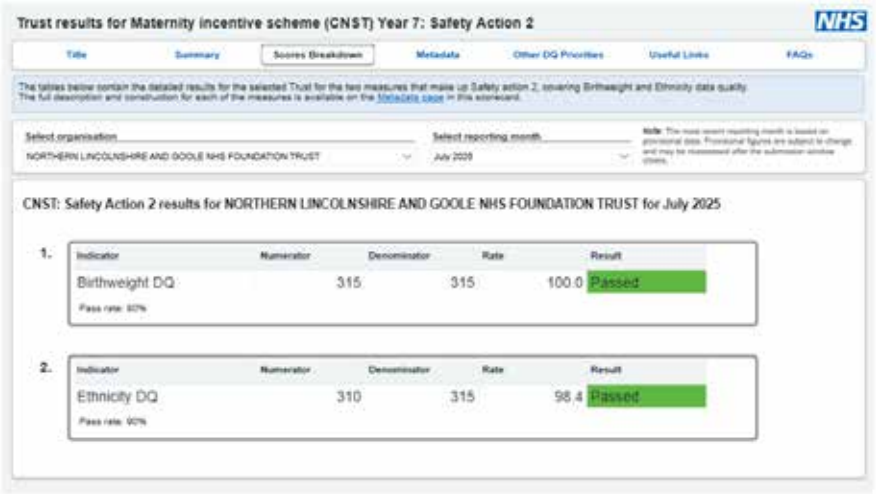
Action Required:

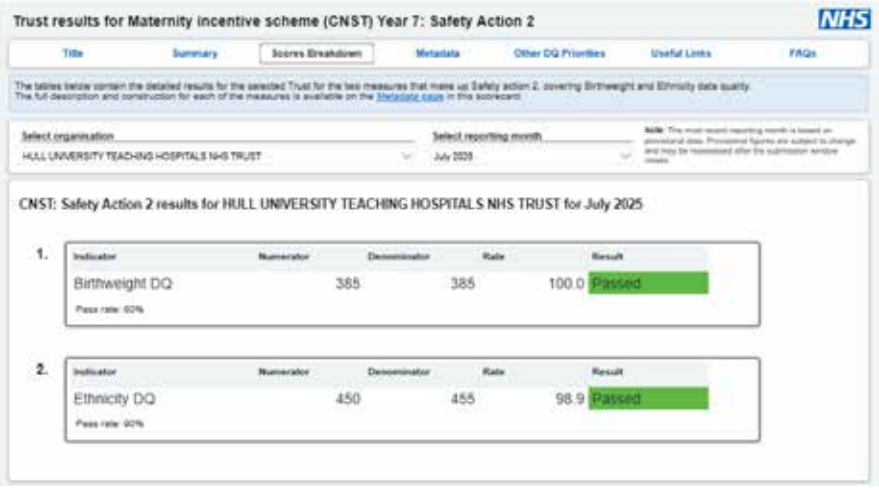
Quarter 2 2025/26 PMRT reports to be discussed at Trust Board and with the Safety Champions in November/December 2025.

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. Provisional data for July 25 indicates both HUTH and NLAG have passed the data quality checks. Finalised data is yet to be published (expected Oct 25).





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:

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.

Progress update:

- QIP data collection to continue at NLAG and commence at HUTH.
- Progress made with QIP shared at Maternity and Neonatal Assurance Group (18/09/25) with Safety Champions / LMNS representative in attendance. Written progress report also uploaded to NHS Futures (LMNS notified) and further update to be provided at LMNS Perinatal Forum in October 2025.

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?		

Locum Staffing Audit Findings

4.1, 4.2, 4.3 Northern Lincolnshire and Goole NHS Foundation Trust

During the audit period a total of 68 tier 2 or 3 rota shifts in Obstetrics and Gynaecology were covered by 8 external locum doctors on a short term basis (<2 weeks). The table below details the split between SGH and DPOW.

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
SGH	7	18
DPOW	5	50
TOTAL	**8***	**68**
*Please note that the same doctors covered shifts at DPOW and SGH during the audit period		

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the 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 Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
NLAG (n=8)	N/A	5	8
Achievement: 100% compliance			

4.4 Northern Lincolnshire and Goole NHS Foundation Trust

During the audit timeframe the Trust employed 0 external long term locums to cover middle grade rotas in Maternity or Gynaecology. Therefore, it was not possible to determine compliance against the standard. For the purposes of the MIS submission, compliance against this standard will be declared.

Long term locum staffing (>2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
SGH	0	0
DPOW	0	0

4.1, 4.2, 4.3 Hull University Teaching Hospitals NHS Trust

During the audit period a total of 8 tier 2 or 3 rota shifts in Obstetrics and Gynaecology were covered by 2 external locum doctors on a short-term basis (<2 weeks).

Short term locum staffing numbers (≤2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
HUTH	2	8

The table below demonstrates the criterion met in relating to standard 1 and the overall compliance for external locum doctors.

Standard Compliance			
EXTERNAL - Short term locum staffing (<2 weeks)			
Site	Currently work in their unit on the tier 2 or 3 rota	Have worked in the 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 Progressions (ARCP)	Hold a certificate of eligibility (CEL) to undertake short term locums
HUTH (n=2)	N/A	2	N/A
Achievement: 100% compliance			

In this time period, 2 locums covered a tier 1 shift but did not meet the criteria for the audit. Moreover, a consultant was employed for short-term locum who was on the GMC specialist register but again, did not meet the criteria for this audit.

4.4 Hull University Teaching Hospitals NHS Trust

During the audit timeframe the Trust employed 0 external long term locums to cover middle grade rotas in Maternity or Gynaecology. Therefore, it was not possible to determine compliance against the standard.

Long term locum staffing (>2 weeks)		
Site	**No. of locum doctors booked**	**No. of shifts covered**
HUTH	0	0

Consultant Attendance Audit Findings

4.6 Northern Lincolnshire and Goole NHS Foundation Trust

SGH & Goole - Compliance of Consultant Attendance for Clinical Situations
Total number of women delivered during Feb / March / Apr 2025: 400
Number of occasions where consultant was called to attend: 27/400 (6.8%)
Compliance: 26/27 (96%)

Clinical scenario requiring consultant to be present	Number of occasions	Consultant Attendance
Consultant requested to attend	12	100%
High levels of acuity (i.e. second theatre open / unit closure)	1	100%
Trial of instrumental delivery in theatre	3	100%
Any other scenario agreed prior to shift commencing in line with level of experience	3	100%
LSCS < 28/40	2	100%
LSCS for major placenta praevia	1	100%
LSCS birth for transverse lie	1	100%
PPPH>2 litres where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated	2	100%
LSCS at full dilatation	1	0%*
LSCS birth for a woman with a BMI >40	1	100%

*Declined by surgeon. Escalated to Obstetric Clinical Lead and Labour Ward Consultant Lead to discuss with individual doctor.

DPOW - Compliance of Consultant Attendance for Clinical Situations
Total number of women delivered during Feb / March / Apr 2025: 479
Number of occasions where consultant was called to attend: 40/479 (8.4%)
Exclusions: There were 2 occasions where the consultant did not attend for a Caesarean section in a women with a body mass index greater than 40, the operating doctor was deemed to be competent to undertake the procedure in line with RCOG guidance roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf There is clear documentation on Badgernet that the consultants have been informed and are happy for the doctor to progress with the procedure (grades: Specialty Doctor / Specialist Registrar).
Compliance: 38/38 (100%)

Clinical scenario requiring consultant to be present	Number of occasions	Consultant Attendance
Consultant requested to attend	12	100%
Trial of instrumental delivery in theatre	10	100%
Intrauterine death	1	100%
Caesarean section in a women with a body mass index greater than 40	3	100%
Placenta Praevia	2	100%
Pre-term delivery	4	100%
Abruption	1	100%
Fetal Abnormality	1	100%
LSCS for multiple pregnancy (twins and triplets)	3	100%
Cervical suture	1	100%

4.6 Hull University Teaching Hospitals NHS Trust

HUTH - Compliance of Consultant Attendance for Clinical Situations
Total number of women delivered during Jun / Jul / Aug 2025: 1026
Number of occasions where consultant was called to attend: 41/1026 (4%)
Compliance: 41/42 (98%)

Clinical scenario requiring consultant to be present	Number of occasions	Consultant Attendance
Trial of instrumental delivery in theatre	16	15 (94%) *
LSCS birth for a woman with a BMI >50	3	2 (67%) **
LSCS < 28/40	4	4 (100%)
PPPH>2 litres where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated	3	3 (100%)
Massive abruption	1	1 (100%)
Consultant requested to attend	2	2 (100%)
High levels of acuity (second theatre open)	2	2 (100%)
Any patient in Obstetrics with an EBL>1.5 litres and ongoing bleeding	1	1 (100%)
LSCS at full dilatation	8	6 (75%) *
LSCS birth for a woman with a BMI >40	1	0 (0%) *
LSCS < 32/40	2	2 (100%)
3rd degree perineal tear repair	6	3 (50%) *

**There was one case of BMI more than 50, where consultant attendance is required, but they were not present. Two registrars were present in theatre (operated by ST7 and assisted by ST3).

*There were 7 occasions where the consultant did not attend as they were busy in the labour and delivery suite. These cases have been classed as compliant as the operating doctor (Registrar) was signed off to be competent to undertake the procedure.

- *Trial of instrumental birth in theatre (1)*
- *Caesarean section in a woman with a body mass index greater than 40 (1)*
- *LSCS at full dilatation (2)*
- *3rd degree perineal tear repair (3)*

Progress update: Results of the Locum Staffing Audits and Consultant Attendance Audits detailed above are yet to be shared with the Trust Board, safety champions and LMNS (anticipated Oct 25).

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?		

Progress update:
The action plans for NLAG and HUTH have been reviewed and updated by the Clinical Lead for MIS year 7 the risk of non-compliance is also recorded on the Trust's risk register. To be approved by Trust Board (anticipated October 2025) and shared with the LMNS / neonatal ODN before 30/11/25.

Please see Appendix A and B for the action plans.

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 review in progress	Action plan review in progress
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:
Action plans for both NLAG and HUTH have been reviewed by the Director of Nursing for MIS year 7. To be approved by Trust Board (anticipated October 2025) and shared with the LMNS / neonatal ODN before 30/11/25. The risk around non-compliance is recorded on the Trust's risk register for NLAG.

Please see Appendix A and B for the action plans.

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:
BirthRate+ review undertaken for both HUTH and NLAG. Both Trusts demonstrate non-compliance with establishment levels. An action plan will be developed and presented to Trust Board in December 2025 following discussion of workforce papers submitted to Trust Board in October 2025.

No issues identified with supernumerary co-ordinator status and one to one care in labour to date. Monitoring continues within the group.

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) 100% by March 2026. Please refer to the tables below for a breakdown of compliance against the interventions.

Northern Lincolnshire and Goole NHS Foundation Trust

Currently for quarter 1 NLAG have achieved 83% (self-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%		0%
Element 2	Fetal growth restriction	Partially implemented	90%		0%
Element 3	Reduced fetal movements	Partially implemented	50%		0%
Element 4	Fetal monitoring in labour	Fully implemented	100%		0%
Element 5	Preterm birth	Partially implemented	73%		0%
Element 6	Diabetes	Partially implemented	83%		0%
All Elements	TOTAL	Partially implemented	83%		0%

Non-compliant areas:

Element	Intervention	Measure
1	1.6	a) Of the pregnant smokers with an opt out referral, 50% should set a quit date. b) Of the pregnant smokers who have a 4 week smoking status outcome recorded, 50% should be non-smokers at 4-week quit date target. c) Of the pregnant women identified as smokers at booking, 50% should be non-smokers at 36 weeks, or delivery if this is earlier than 36 weeks.
2	2.2	No. of women who are recommended vitamin D supplementation at booking.
	2.7	Number of women identified as high risk for FGR at booking who had a uterine artery doppler (UAD) assessment between 18+0 and 23+6 weeks gestation.
3	3.2 (3b)	No. of women with RRFM identified at a care contact who have a scan the next working day to assess fetal growth. *Would be compliant if could submit as a Trust (non-compliant at SGH).
5	5.1	Preterm birth multidisciplinary team in place.
	5.2 (2b)	No. of women who give birth to a singleton (liveborn or stillbirth) between 24+0 and 36+6 weeks. *N.B. If transfers in were not considered and were removed from the denominator the rate of pre-term labour for NLAG would be 5.7%.
	5.14	Patient information leaflet outlining the signs and symptoms of preterm birth and what to do.
	5.15	Patient information leaflet to help parents understand preterm birth and care options.
	5.16	Evidence of use of preterm birth parent information leaflets available in relevant languages for your local population as identified in your equity and equality plan.
	5.19	Percentage of [Mothers to] babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.
	5.23	Percentage of babies born below 34 weeks who have a first temperature between 36.5-37.5°C (within one hour of birth). * *Target is set at the stretch ambition of 85% but the implementation tool states minimum target as 70%.*
	5.24	Percentage of babies born below 34 weeks gestation who receive their own mother's milk within the first 2 days of life.
6	6.1	Separation of clinics for pre-existing / GDM.

Hull University Teaching Hospitals NHS Trust

Currently for quarter 1 HUTH have achieved 87% (self-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%		0%
Element 2	Fetal growth restriction	Partially implemented	90%		0%
Element 3	Reduced fetal movements	Fully implemented	100%		0%
Element 4	Fetal monitoring in labour	Fully implemented	100%		0%
Element 5	Preterm birth	Partially implemented	85%		0%
Element 6	Diabetes	Fully implemented	100%		0%
All Elements	TOTAL	Partially implemented	87%		0%

Non-compliant areas:

Element	Intervention	Measure
1	1.6	d) Of the pregnant smokers with an opt out referral, 50% should set a quit date. e) Of the pregnant smokers who have a 4 week smoking status outcome recorded (that set a quit date) 50% should be non-smokers at 4-week quit date target. f) Of the pregnant women identified as smokers at booking, 50% should be non-smokers at 36 weeks, or delivery if this is earlier than 36 weeks.
	1.8	Staff providing front line care who use CO monitors should have annual in date training compliance
	1.9	Staff Providing front line care should have annual in date training on the delivery of VBA, making an opt out referral and maternity pathway processes
2	2.6	Agree a plan so that all blood pressure monitors in use with pregnant women are complaint
5	5.1	Preterm birth multidisciplinary team in place.
	5.2	No. of women who give birth to a singleton (liveborn or stillbirth) between 24+0 and 36+6 weeks.
	5.16	Evidence of use of preterm birth parent information leaflets available in relevant languages for your local population as identified in your equity and equality plan.
	5.20	5C Percentage of [Mothers to] babies born before 30 weeks who receive magnesium sulphate within the 24 hours prior to birth

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.		
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.	N/A	N/A
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.		
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.		

Progress update:

- CQC action plan has been co-produced and was shared at September 25 Maternity and Neonatal Assurance Group (LMNS / safety champions present). Further updates to be added regarding free text feedback and shared in October 2025. Final version to be uploaded to NHS Futures evidence folder for further LMNS update by 01 November 25.
- Infrastructure in place as per MIS year 6, awaiting evidence to be uploaded to NHS Futures by LMNS. However, concerns raised nationally regarding the expectation to have a band 8 MNVP lead in post and the requirement for MNVPs to be quorate members of several Trust meetings. Paper to be developed by Director of Midwifery informing Trust Board of current infrastructure and resource available.
- Terms of reference developed for the required meetings with MNVP listed as core member.
- Evidence continues to be gathered to demonstrate MNVP engagement with local community groups.

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)		81%
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?	46% (please refer to breakdown below)	35% (please refer to breakdown below)
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	67%	88%
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?	50% (please refer to breakdown below)	21% (please refer to breakdown below)

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).		84%
8.10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	88%	88%
8.11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota.	75%	
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?	33%	0%
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.	SIMs planned within MIS timeframe	

Neonatal basic life support:			
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units		88%
8.16	90% of neonatal doctors (commencing with the organisation prior to 1 July 2025) who attend any births		84%
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?	N/A	70%
8.18	90% of neonatal nurses (Band 5 and above who attend any births)	82%	
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)	40%	
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.	Requested update.	82%

Progress update:
Training compliance/attendance is monitored closely by the MIS Delivery Group on a weekly basis with regular escalation where required. Trajectories and action plan for the MIS period have been developed and shared with the management team. Confirmation has been received from the Midwifery Clinical Educators that PROMPT Simulations will take place within the reporting period.

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.

Northern Lincolnshire and Goole NHS Foundation Trust – Update

Training Competence: PROMPT					
Staff Group: Obstetricians					
Site:	No. started Aug 25	No. started Sept 25	Training completed	Training Booked in MIS period	Training to be booked within 6 months of start date
DPOW	5	10	3	2	10
SGH	5	4	0	2	7

Training Competence: Fetal Monitoring					
Staff Group: Obstetricians					
Site:	No. started Aug 25	No. started Sept 25	Training completed	Training Booked in MIS period	Training to be booked within 6 months of start date
DPOW	2 applicable	10	2	2	8
SGH	1 applicable	4	1	0	4

Training Competence: Neonatal Resuscitation (1 yearly)					
Staff Group: Neonates					
Site:	No. started Aug 25	No. started Sept 25	Training completed	Training Booked in MIS period	Training to be booked within 6 months of start date
DPOW	7	7	10	0	4
SGH	0	4	4	N/A	N/A

Training Competence: Newborn Life Support (4 yearly)					
Staff Group: Neonates					
Site:	No. started Aug 25	No. started Sept 25	Training completed	Training Booked in MIS period	Training to be booked within 6 months of start date
DPOW	*1 applicable	*7 applicable	6	1	1
SGH	0	4	4	N/A	N/A

Hull University Teaching Hospitals NHS Foundation Trust - Update

Training Competence: PROMPT				
Staff Group: Obstetricians				
Site:	No. started after July 25	Training completed	Training Booked	Training to be booked within 6 months of start date
SHO	13	7	6 (1 in December)	0
Registrar	11	5	2	4

Training Competence: Fetal Monitoring				
Staff Group: Obstetricians				
Site:	No. started after July 25	Training completed	Training Booked in MIS period	Training to be booked within 6 months of start date
Registrar	11	5	3	4

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. Aim for all remaining staff to be booked in December and January.	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.		

Progress update:

- Awaiting evidence of collaboration with LMNS through PQSAG meeting to be uploaded to NHS Futures by the LMNS.
- Q2 25/26 scorecards to be shared with Trust Board and Trust Board Safety Champions in December 2025.
- Maternity and Neonatal Assurance Group is held on a monthly basis with attendance from the perinatal leadership team, Board Safety Champions and MNVPs. At least 3 have taken place in the MIS reporting period (June, July and September 2025). Additionally, safety champion walkabouts and meetings have taken place with attendance from the Board/Maternity Safety Champions. Evidence that Trust Board have been assured of meetings taking place required (October 2025).
- Progress with the culture improvement plan is monitored as part of the MATNEOSIP tool an update will be provided to Trust Board in October 2025.

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.

Confirmation of Claims reporting wizard completion for HUTH outstanding. Requested from the Trust's Claims Team.

Appendix A: BAPM Workforce Benchmarking (Nursing)

Northern Lincolnshire and Goole NHS Foundation Trust

CNST MIS Year Seven - Neonatal Nursing Workforce Action Plan

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal 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
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	N/A	N/A	N/A
There should be a 1WTE Band 7 Lead nurse for Transitional Care Services who are Supernumerary 100% of the roster period	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 – ODN supports this position	No further action required.	Deborah Bray, Emma Spicer / Jennifer Copley	-	Complete	Rosters
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	-	Complete	Job descriptions

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
There must be a supernumerary Band 6 Shift lead 24/7	To fully comply each neonatal unit needs to recruit 5.14wte Band 5 RN's per site to achieve 1 supernumerary Band 6 to be released to provide overall leadership of the shift. DPOW: establishment and funding in place at band 5 level to allow band 6 supernumerary. At present staffing vacancy position does not allow this to be a consistent feature of the rota. SGH: The realignment of the WTE allows the SGH neonatal unit to have 4 registered nurses on duty instead of 3. Neither unit achieve 24/7 band 6 supernumerary status, however, consistently strive to achieve this when acuity and activity allows.	This will continue to be highlighted through Chief Nurse establishment and is captured in the neonatal workforce paper that is waiting for review and consideration by Cabinet (Aug 25).	Deborah Bray, Emma Spicer / Jennifer Copley	Continuous review through Chief Nurse establishment review process	September 2025	Chief Nurse Establishment Review
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.	Job matching complete for Nurse Educator role, awaiting establishment control to provide code to progress post.	Emma Spicer Neonatal / Paediatric Matron	01 October 2025	In progress	Job Description e-Roster

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
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	Staffing levels and cot capacity/acuity data is entered in to BadgerNet on a daily basis for both sites and risk mitigated accordingly.	Continued submission to demonstrate compliance.	Emma Spicer & Jennifer Copley Matrons	-	Ongoing monitoring	Workforce Toolkit / BadgerNet data
		Additional resource to be found if acuity levels exceed workforce numbers.	Emma Spicer & Jennifer Copley Matrons	-	Ongoing monitoring	Rosters /Bank reports /Agency spend reports Escalation policy
	Workforce tools provided to Chief Nurse to inform establishment review process. Chief Nurse submitted overarching nursing and midwifery workforce review paper to the executive team - awaiting outcome.	Workforce toolkit reports to be reviewed and incorporated into Chief Nurse review and BC Planning around establishments. The neonatal establishment as part of the Chief Nurse review process. ODN review workforce tools and provide feedback / highlight any issues. Any issues identified will be fed into the workforce paper.	Emma Spicer & Jennifer Copley Neonatal / Paediatric Matrons	September 2025	In progress	
70% of the workforce should be Registered Nurses	Current staffing status is non-compliant as follows: DPOW: 74% SGH: 63%	To support HCAs to undertake further training including Nurse Associate and registered nurse training once funding is established. SGH: Supporting HCA to re-join the NMC register to take up a nurse vacancy (expected to commence October 2025). Continue to review quarterly.	Emma Spicer & Jennifer Copley Neonatal / Paediatric Matrons	Re-assess 01 January 2025	Ongoing	Rosters
30% of the workforce should be non-registered.	DPOW: 26% SGH: 37%					

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
80% of registered nurse workforce should be QIS 70% compliance with QIS standard to be maintained 100% of the time.	TWD: Rolling training programmed in place. DPOW: 59% SGH: 63% Due to acuity the shift lead may not always be supernumerary but should be able to have the lowest workload to do both. An incident form will be completed to evidence how often this occurs and the impact this has.	Continue with training plan in place to support appropriate staff to access the relevant training and educations modules to achieve the QIS. Trajectories in place across the Trust. New starters without QIS to commence free foundation after six months (if service allows).	Emma Spicer & Jennifer Copley Neonatal / Paediatric Matrons	Ongoing	Ongoing	Training compliance rates
Non-registered workforce should complete a minimum of NVQ level 3 training in neonatal care.	NVQ level 3 training in neonatal care not offered as part of training / development. Training plan in place to support the new starters to ensure the non-registered workforce are supported to complete the required academic and practical training.	Continue to monitor training rates to ensure that 100% of the non-registered workforce complete the required training within 1 year of employment. Monitoring of compliance against standard operating procedures / Calderdale competencies.	Emma Spicer & Jennifer Copley Neonatal / Paediatric Matrons	Ongoing	Ongoing monitoring	Training compliance
Neonatal Outreach must be available 7 days a week.	SGH has a 5 day service and DPOW have a 6 day service but work flexibly to facilitate discharge over 7 days. Current establishment does not facilitate 7 day cover when annual leave or study leave is taken.	Review of current model in line with new BAPM recommendations with potential consultation to allow maximum over the 7 day period within the restrictions of the WTE available.	Deborah Bray / Emma Spicer / Jennifer Copley	01 April 2026	Ongoing	Outcome of consultation

Hull University Teaching Hospitals NHS Trust

CNST MIS Year Seven - Neonatal Nursing Workforce – Benchmarking

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal 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
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	N/A	N/A	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.	95% Registered Nurses. 5% Unregistered Nurses (not included in baseline cot side nursing numbers).	No further action required.	Deborah Bray	N/A	N/A	N/A
A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS).	Including the new recruits and the 3 who have just completed the qualification, compliance is 55% (as of September 25). HUTH are meeting all the national guidance for QIS standards, for both QIS foundation and 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 we have been able to increase our staff completion of this. We now have a plan for 4 nurses to attend the QISS twice yearly.	Continue to review current training plan and send staff onto the QIS programme (no more than 8 staff at any one time in the year).	Deborah Bray / Jenny Hemingway	Quarterly review	Ongoing	Training compliance / Trajectories

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
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	-	-	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	Fully compliant.	No further action required.	Deborah Bray	-	-	Workforce Tool New tool required
There is a nursing co-ordinator on every shift in addition to those providing direct clinical care.	Fully Compliant Nurse Co-ordinator is supernumerary.	No further action required.	Deborah Bray	N/A	N/A	N/A
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.	No Nurse/Midwife with clinical leadership. Surgical Link Team in place with 1 x Band 7 Clinical Sister who has completed the specialist surgical course. Where possible, any baby due for delivery with a known surgical condition, a member of the link team will support the parents alongside the consultant. Once staff have been on the unit for 18 months, they should be trained in facilitating advanced ICU & surgery.	To develop a business case for a Band 7 Neonatal Surgical Specialist Nurse	Deborah Bray	April 2026	Ongoing	Business Case

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
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.	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. The unit works closely with the Specialist Lead Nurse in Leeds and can reach out for support/advice if needed.	To develop a business case for a Band 7 Neonatal Surgical Specialist Nurse	Deborah Bray	April 2026	Ongoing	Business Case
There should be an appropriately resourced clinical education team to support the training and education requirements of the cot side workforce. This team should consist of Nurse Educators at both band 6 and band 7 and have a WTE resource that provides 1 WTE educator per 50 staff members.	2 substantive and 1 on fixed term (funded with low risk of being discontinued). 100% compliant with current resource Current resource is 2 x FT B6 (1 funded from CPD monies on a fixed term basis for 12 months) and 1 x FT B7 (substantive).	Continue to monitor and re-assess. Review current budget to offer third educator substantive post.	Deborah Bray	April 2026	Ongoing	E-roster
There should be a 1 WTE Band 7 Lead Nurse for Transitional Care Services who are Supernumerary 100% of the roster period.	Fully compliant	No action required.	Deborah Bray	-	-	-

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
Neonatal Outreach must be available 7 days a week.	Fully compliant for a 7 day service.	No action required.	Deborah Bray	-	-	-
Non-registered workforce should complete a minimum of NVQ level 3 training.	Not applicable – non-registered workforce do not provide any clinical care.	No further action required.	Deborah Bray	-	-	

Appendix B: BAPM Workforce Benchmarking (Medical)

Northern Lincolnshire and Goole NHS Foundation Trust

CNST MIS Year Seven - Neonatal Medical Workforce Action Plan

Requirements for Safety Action 4:

3. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
4. 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><td>LNU activity</td><td>Tier 3</td></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></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.</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 and HASR.

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

CNST MIS Year Seven - Neonatal Medical Workforce Benchmarking

Hull University Teaching Hospitals NHS Trust

Requirements for Safety Action 4:

5. The neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards.
6. 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.	Non-compliant at present Complexities increased and SCBU Consultant supporting with these queries	Move under 1 year GP referrals to General Paediatrics.	Dr Peirce (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.	-	-	-	-
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.	-	-	-	-
BAPM standard requirement		**MIS Year 7 status**	**Action Required**	**Lead**	**Timescale**	**Status**	**Evidence**

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 Peirce (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 Peirce (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- request for long term locum appointment to this post was declined by Nick Cross with ad hoc locum cover in place.	Dr Peirce (Clinical Lead)	-	-	-
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.	Dr Peirce (Clinical Lead)	-	-	-
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.	-	-	-	-

BAPM standard requirement	MIS Year 7 status	Action Required	Lead	Timescale	Status	Evidence
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
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)178

Name of the Meeting	Trust Board - Public
Date of the Meeting	9th October 2025
Director Lead	Sarah Tedford, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer/Author	Chris Fry, Associate 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 Q2 for UEC, Cancer, Diagnostics and in addition for NLAG for RTT Summary Compliance:

Domain	GROUP	HUTH Performance	NLAG Performance
RTT Long Waits	August 2025	August 2025	August 2025
• 104 weeks	0	0	0
• 78 weeks	2	0	2
• 65 weeks	116	62	54
• 52 weeks	4,086	3,261	1,025
• % 52 weeks (target <1.3% March 2026)	3.6%	4.0%	2.6%
Diagnostics: 6ww Performance (target <5% March 2026)	August 2025 36.2%	August 2025 32.4%	August 2025 38.7%
Cancer: 28 Day FDS (target > 80% March 2026)	July 2025 55.3%	July 2025 50.8%	July 2025 64.1%
62-day Performance (all sources) (target > 63% March 2026)	55.1%	55.3%	54.5%
UEC: ED: 4-hour standard (Type 1&3) (target > 78% March 2026)	August 2025 67.7%	August 2025 61.9%	August 2025 72.9%
ED: 12-hour standard	12.1%	10.1%	14.2%

Update on BAF and mitigating actions:

- Extensive actions are in progress, alongside the review and augmentation of elective improvement plans.

Background Information and/or Supporting Document(s) (if applicable)	
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

Key messages

Referral to Treatment (RTT)

Waiting list (PTL) growth has been arrested at both Trusts, ending four years of c8% annual waiting list growth. This is a direct result of:

- Over delivery of RTT pathway completions versus plan.
- Lower than planned/historic referral levels in the latter part of 2024/25
- The inception of the national 'Validation Sprint' programme in 2025/26.

At HUTH these actions have resulted in a stable waiting list of 80,655 which is 1.2% below plan.

At NLAG the reduction is more pronounced, with the latest months volume of 39,698 being 3,848 pathways (9.7%) below trajectory.

Despite this stabilisation of the PTL, both Trusts have seen the percentage of RTT patients waiting less than 18 weeks return to start of financial year performance. At HUTH 56.7% shows a reduction and is 2.3% below the 25/26 trajectory. The change in compliance reflects a reduction in 0-18 week waiter and an increased tip in of >52-week waiters (+300).

In contrast to the significant improvement in waiting list volumes, the percentage of NLAG patients waiting less than 18 weeks has remained static with performance of 59.1% a 1% reduction on the previous month, and 6% below the planned improvement trajectory. This variance to plan has triggered NLAG being placed into Tier 1 oversight for RTT. The variation to plan is reflective of validation pathway completion outcomes 'negatively' influencing the compliance percentage (i.e. validation removals in the 0–18-week cohort). This mathematical relationship belies the positive benefits to patients of removal of inaccurate pathways of care remaining live of the RTT PTL.

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) has historically delivered at the Trust aggregated level by high volume / high compliance in tumour sites such as Breast. In recent months these key tumour sites have been challenged in FDS delivery due to outpatient demand / supply imbalances, in turn compromising aggregate compliance for both Trusts.

HUTH performance has decreased in year to 50.8% with significant delays due to radiology capacity, loss of CNS Alliance funding and Consultant shortfalls.

NLAG July performance 64.1% is an increase of 5.3% on the previous month, however, significantly below plan with additional capacity sought for Breast and Colorectal.

Cancer referral demand continues to grow on both sites. At HUTH both June and July saw 400 more referrals versus the same points last year and similar is observed at NLAG with a net 27% increase to date. 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.

Compliance against key stage of treatment targets in July	HUTH - from June to July	NLAG - from June to July
FDS	Decline - from 52.9% to 50.8%	Improvement - from 60.2% to 64.1%
31-day compliance	Decline - from 77.8% to 76.8%	Decline - from 96.5% to 93.7%
62-day compliance	Improvement - from 48.1% to 55.3%.	Static - from 54.2% to 54.5%

August (provisional) shows similar improvement.

Diagnostic Access

The Group is a national outlier for Diagnostic 6-week waits, with August data showing HUTH at 32.4% HUTH and NLAG at 38.7% versus the national expectation of <5%.

Total activity plan across all diagnostic modalities is being achieved, however notable reduction in August for HUTH of -11% versus July resulting in a negative 6.2% swing in perfromance. Underperformance is evident in key endoscopy modalities on both sides of the Group whilst increases in emergency, planned care and surveillance pathways are activity constricting waiting list (DM01) activity leading to associated waiting list growth of 17% at HUTH and 25% at NLAG since start of calendar year.

Notable in-month themes:

- An ongoing national issue with the **Auditbase** product has been corrected, resulting a Paediatric Audiology reporting correction of c500 breaches, taking compliance from 2.2% to 45.1%.
- Neurophysiology capacity contract awarded with mobilisation expected from October
- Utilisation of NLAG CDC Echo capacity for HUTH waiters has begun and should see impact during October

Unplanned & Emergency Care (UEC)

HUTH A&E 4 Hour standard (all types) was 61.9% in August 2025 (plan 72.8%). Type 1 performance of 46.3% was below the 25/26 operating plan target of 62.1%. Type 3 performance (HRI UTC) was 95.8% against the 95% target. Type 1 attends were below plan whilst Type 3 attendances were also below planned levels.

NLaG combined type 1 and 3 performance was 72.9% against a target of 75%. Type 1 performance = 54.6% (Target 58.9%) and Type 3 performance = 99.2% (Target 99%). Type 1 and Type 3 attendances were lower than planned levels in August 2025.

Update on key actions

- Interim Group Chief Delivery Officer has absorbed operational leadership for Elective Care
- Recruitment of 2 x Directors of Operational Transformation to Interim Chief Delivery Officers senior team to lead operational improvement of UEC and Elective Care respectively.
- Delivery of Flow model as part of UEC improvement plans
- Fundamental review of existing risks and action plans relating to Elective Care.
- Revised recovery trajectories being developed for elective care, with Cancer 28 Day and 62 Day improvement plans agreed by Board in September
- Development of enhanced reporting commenced comprising Foundation Scorecards, National Oversight Framework dashboards, pathway staging reports, etc.
- Refresh of HUTH bed model to incorporate NLAG forecast bed need requirements.

Key changes to regulatory oversight

Changes made to national Tiering oversight arrangements relating to the Group:

- **UEC** - Current Tiering status relates to ICB system. The Group has been notified this will end with immediate effect and be replaced with Acute Provider specific tiering meetings. As part of this revision HUTH and NLAG will be subject to separate Tiering meetings.
- **NLAG** has triggered Tier 1 oversight for RTT
- **Cancer and Diagnostics** remain in Tier 1 oversight.

CiC ESCALATION REPORT

Humber Health Partnership

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 2 September 2025

1. Matters for Reporting

The **Group finance** report noted a month 4 year-to-date deficit position of £12.2m which was ***£3m adverse to plan***. This also included £7.5m of non-recurrent balance sheet support. The Group had delivered £28.5m in CIP against a target of £34.3m; ***£5.8m behind target***. A £65.4m gap was expected based on the current adjusted run-rate.

The CIC agreed limited assurance due to the significant work required to reduce the unidentified CIP gap and given the 'high' risk profile of the overall plan. The committee requested a recovery action plan to include the Care Groups. The CIC acknowledged the amount of work and actions in place to address the issues, improved visibility in the transformation plans and additional care group support and interventions put in place.

On **Performance**, the CIC agreed limited assurance due to ongoing unsatisfactory performance delivery. It was acknowledged that whilst high quality plans were being developed and implemented, these were not yet embedded or sustained. Positive movement was noted on patient list total numbers and urgent care across July and August 2025. The move towards understanding future performance targets through trajectories was also welcomed.

The Winter Plan 2025/26 report was presented to the CiC. The CIC agreed reasonable assurance due to the robust plans in place despite the lack of funding. There was increased focus on maintaining flow, earlier discharges and reducing the number of patients with No Criteria To Reside by working with system partners which was having a positive impact.

2. Positive assurances

The CIC gave significant assurance to the **Estates and Facilities General Update** due to the grip and control being displayed. The CIC noted a delayed spend in comparison to planned spend. However, spend was expected to accelerate within the next six weeks.

3. Matters on which the committees have requested additional assurance

The Board Assurance Framework (including Risk Register Report) was presented to the CIC and further assurance was required regarding the high-level risks. The Group would ensure that responsible action owners were providing updates on the BAF actions.

The committee requested additional assurance around the ability to meet the financial plan targets for the year. A recovery plan was requested that balances back to the committed position.

4. Decisions made

The **Group Fire Annual Report and Workplan** was presented and **approved**. With some minor updates, the CiC were assured that the HRI Tower Block and fire warden provision was adequately covered. Work was ongoing to address the issues raised around the HRI Tower Block and it was advised that the Annual Report refer to the current issues. Further investigations have not increased the risk rating of this issue.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework (including Risk Register Report)	-	-	Assurance	n/a
2	Winter Plan 2025/26	2	20	Assurance	Reasonable
3	Group Finance Report – Month 4	6	16	Assurance	Limited
4	Transformation Programme	2	20	Assurance	Limited
5	Integrated Performance Report	2	20	Assurance	Limited
6	Estates and Facilities – General Update including Risks	6	16	Assurance	Significant
7	Group Fire Annual Report and Work Plan	6	16	Approval	n/a
8	HUTH Catering Services	6	16	Assurance	n/a

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 30 September 2025

NHS Humber Health Partnership

1. Matters for Reporting

The **Group finance** report for month 5 reflected a **£47m risk and £25m gap** to plan. Concerns were raised regarding delays in decision making by the leadership team as pace was needed to build on the early signs of improvements in run rates at Month 5.

As such, the Committees in Common gave limited assurance due to the level of risk, whilst recognizing positive improvements including focus on run rates, transparency and intervention with the Care Groups. The Committees acknowledged the significant improvement in overall grip and control and identification of further opportunities, However, the slow pace of change was flagged as a concern alongside the delay in gaining control on increasing agency spend.

Transformation Programme - a review of WLI and agency spend was being carried out by doctor, speciality, site and Care Group. Stock control and ward reviews are being worked through to reduce the risk gap. The CIC gave Limited assurance, although noted the amount of work being carried out which would increase assurance if results reflect activity in Months 6-7.

On **Performance**, RTT additional breaches noted on 52 week waits due to not tackling the waiting list in chronological order; LUNA ROVA will be instrumental in ensuring the lists are appropriate. Although the waiting lists had reduced there were still issues around diagnostics with a focus on ENT and CDC performance to address this.

Cancer 28-day performance flagged as a risk due to focus on clearing the back log

Urgent and emergency care 4hour standard performance had improved and was 61.9% although non-admitted performance was still a key concern as was pull out of the department. The CIC gave Limited assurance although noted the improvement in quality of plans. Areas of focus such as ambulance handovers were showing sustained improvement.

2. Positive assurances

Cancer 62-day performance had improved across the Group.

The CQC had visited the ED in September and positive feedback was received due to team identification of the deteriorating patient and the department being less chaotic than previously observed on inspections.

The Estates update noted that the closure of the 13th Floor at HRI was giving rise to decant opportunities, which had previously not been possible and flagged as a high risk for HRI .

The CIC gave Significant assurance over the EFD plans due to the grip and control being displayed.

3. Matters on which the committees have requested additional assurance

Monthly updates required with regards management of Tower Block fire risk and communications with Humberside Fire and Rescue.

Additional assurance still required around the ability to meet the financial plan targets for the year. A recovery plan has not yet been received that balances back to the committed position. An update on CIP programme progress and latest view of the financial gap will be covered at Board.

4. Decisions made – the Security LSMS report and workplan was **endorsed for approval.**

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Annual Business Plan - Timetable	-	-	Approval	n/a
2	Group Finance Report – Month 5	6	16	Assurance	Limited
3	Update and transformation Programmes	6	16	Assurance	Limited
4	Costing and benchmarking	6	16	Assurance	Limited
5	Group Performance Report	2	20	Assurance	Limited
6	UEC Improvement – LOS and Bed Modelling	2	20	Assurance	Limited
7	Estates and Facilities and Development Update	6	16	Assurance	Significant
8	Security LSMS Annual Report and Workplan	6	16	Review and Endorse	Approved
9	NHSE Self-Assessment on Provider Capabilities	-	-		Not Presented

5. Escalation to Trust Boards

Although the CIC gave limited assurance for the Month 5 Finance Position, it was noted that improved results were being delivered and continued improvements into Month 6 would suggest the assurance level could be moved to reasonable assurance.

6. Comments on the effectiveness of the meeting

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

7. Escalation to CiCs

The Committees in Common received the operational/financial timetable and it was recommended that the Workforce plans be presented to the Workforce, Education and Culture Committees in Common.

The lack of weekend cover for consultants and senior staff was also referred to the WEC. This is deemed to be a barrier to delivering optimal patient care and performance standards.

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	✓	✓	✓	✓					
Philippa Russell	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓					
Andy Haywood	Chief of Strategy, Partnerships and Digital	-	-	-	✓	x	x	x					
Tom Myers	Group Chief of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓					
Simon Parkes	Non Executive Director	✓	✓	✓	✓	✓	x	✓					
Jane Hawkard	Non Executive Director	✓	✓	✓	✓	✓	✓	✓					
Kate Wood	Group Chief Medical Officer	✓	✓	✓	✓	✓	✓	PS					

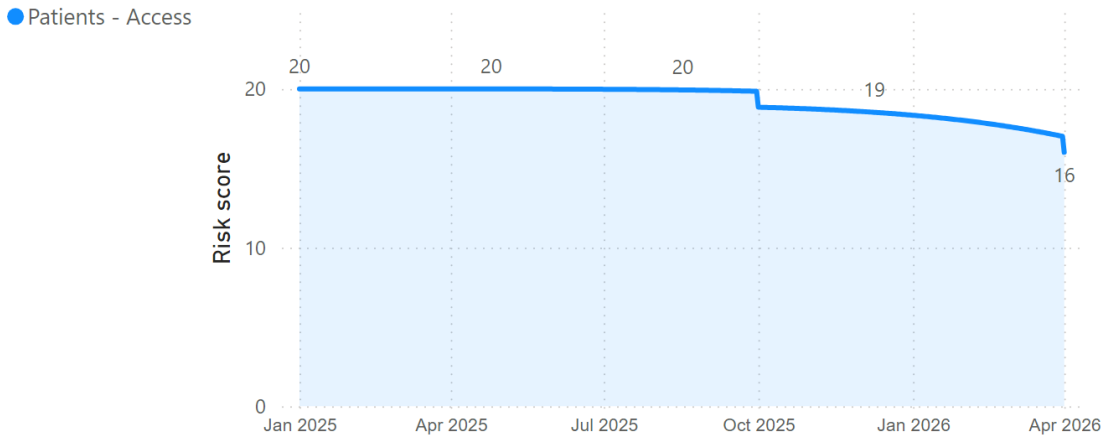
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Sarah Tedford, 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 17 June 2025. In full, the risk is:

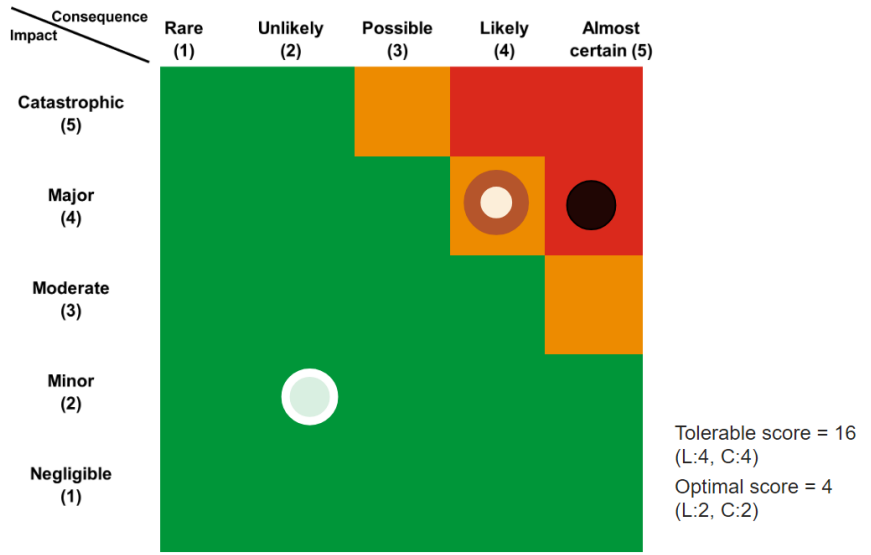
We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.

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	Reasonable
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	Reasonable

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 timely / realtime performance reporting (eg weekly dashboard)				1		1
Lack of trajectory setting to support robust performance management					1	1
Weak culture of improvement/change management and siloed working	1		1			2
Total	**1**	**1**	**2**	**1**	**1**	**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 and assurance
External
Acute Provider collaboration reports
GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients
ICU Network review
NHS tiering arrangements and support or freedoms
Internal
2025-26 Operational Plan Assurance Statement
Integrated Performance Report
Planned Care Board reporting to Performance, Estates & Finance CiC
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
Total	**1**	**1**	**1**	**1**	**4**

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	01/04/26	Deep dive LOS and bed work in progress report presented to PEF on 4/3/25. PA Consulting to undertake a bed utilisation review (ahead of developing in-house modelling capacity)	04/03/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Adam Creeggan, Group Director of Performance, Sarah Tedford, Group Chief Delivery Officer	Limited
21	Embed QI Methodology		01/04/26			Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Heather McNair, Interim Group Chief Nurse	
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, Sarah Tedford, 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, Sarah Tedford, Group Chief Delivery Officer	Significant

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)179

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October, 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 within Humber Health Partnership that we are seeking to address to improve our organisational culture, so our people feel engaged, valued and motivated and have the skills and knowledge to provide great care to our patients and their families The Group People Strategy (2025– 2028) was launched in April 2025 and aims to transform the workforce experience through five strategic themes: People and Partnerships, Workforce Systems Transformation, Health and Wellbeing, Leadership, Learning and Talent Development, and Culture and Engagement. In addition, the Putting People First - culture transformation programme commenced in April, 2025 which leads us into the National Staff Survey for our staff to complete which opened on Monday 29th September.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce, Education and Culture Committees-in-Common August/September 2025 highlight report is 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 ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other – please detail below:

Humber Health Partnership

Trust Boards-in-Common

9th October, 2025

Our People

1. Purpose

The purpose of the report is to provide the Boards-in-Common with an overview of the key people issues across the Group that we are seeking to address to improve our organisational culture, so our people feel engaged, valued and motivated and have the skills and knowledge to provide great care to our patients and their families.

2. Background

NLaG and HUTH have been placed in the National Operating Framework (NOF) segment 4. This is the lowest division in the NHS league tables. 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 Committee at the end of each quarter. 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 has continued throughout Quarter 2, with a focus on Aid – health and wellbeing. Executive-led manager sessions are ongoing. These sessions encourage all attendees to consider how they can improve the wellbeing of their teams and asks them to commit to three key actions at a local level. The Q2 Health and Wellbeing focus has seen three Fit4Life Fairs take place at Hull, Scunthorpe and Goole. Castle Hill and Grimsby will follow. These information events offer staff-led advice and support to our people and the public on managing their own health. The Quarter 2 CARE package is now available on Bridget detailing all aspects of health and wellbeing from clubs and social activities, to family, financial and practical support. In addition, the new group Reasonable Adjustment (REACH) policy and approach were launched to improve the reasonable adjustment process for staff so adaptations can be made quickly and equipment ordered. Initial feedback is that this has landed well with staff and networks.

4.2 National Staff Survey

Staff Survey communications began in earnest during September. The survey will run between 29 September – 28 November. After one day of fieldwork 1200 staff across the group completed a survey. Weekly care group and directorate response rates will be communicated to all staff.

Posters, screensavers and videos have been created in an attempt to reach a total return rate of 60%. HR and OD teams are carrying out roaming staff survey clinics to different areas in an attempt to encourage more people to complete their surveys.

3.9 Communications and Engagement

Since July, and in response to staff survey feedback, the Communications team has implemented a number of significant changes to corporate communication:

- Re-launch of Bridget, the group intranet, including contact details for all wards and departments – in response to a robust staff engagement exercise
- Launch of Chief Executive-led team brief, to all staff, merged with Ask the Executives online session
- Assessed and changed the 'drumbeat' of corporate comms and briefings following discussion with the executive team and care groups

In April 2025 prior to the relaunch of Bridget an average of 9,000 unique users accessed Bridget every day. In September, following the changes made, this number increased to 14,000 unique users each day, a 55% increase. Information about the flu vaccination programme has also been widely shared across the group. This includes details of all static clinics, as well as FAQs about the vaccine.

5. Health & Wellbeing

5.1 Flu Vaccination

The HHP (HUTH and NLAG) staff influenza vaccination campaign has commenced on the 1st of October. The initial launch is with the static hubs one on each of the main sites running through October. This is a joint approach with support from roving teams, Occupational Health and Corporate nursing. There is a strong communication program running alongside the campaign including incentives for high/improved team uptake. There will be close monitoring of uptake throughout the campaign to permit a focused roving approach through the winter period to capture any areas of low uptake. The 25/26 vaccination target is 75% locally, building on an average delivery rate of 51% across the group in 24/25. Progress will be reported every 2 weeks.

5.2 Staff Health and Wellbeing (HWB)

Health and Wellbeing remains a top priority within the People Strategy, with Year 1 focusing on embedding healthy workplace practices and ensuring timely access to support. Project delivery is marginally ahead of plan at 55.4% for Q2, with the "Aid Quarter" programme completed in full, seeing strong engagement across a range of wellbeing activities and leadership seminars. Pulse survey results indicate improvements, particularly in work-life balance, and both MSK and psychological-related sickness absence are in decline and correlate with increases in HWB activity from 1st April 25. Psychological sickness reduced from 21.6% to 19%, keeping on track to meet the year-end target of 18%. Newly appointed HWB practitioners are now working at team level to provide local support and HWB clinics. New initiatives such as the Sports & Social Society and widening support for the unregistered workforce projects will commence in Q3, alongside the continued growth of the ELE self-help video library are helping broaden provision. The organisation also gained national recognition, winning the HSJ Award for Health and Wellbeing for its International Nurse Wellbeing initiative.

6. People & Partnerships

6.1 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 5 was £12.2m. At end Month 5 agency spend is £4.3m off target.

With effect from 22nd September 2025 agency authorisation processes were strengthened further so that no new agency worker (for over 1 week or more) or contract extension of an agency worker is permitted unless approved by an Executive Director. If services believe they should have an agency worker for patient safety reasons, then an exemption can be requested that will be

considered by the Executives on a weekly basis. An agency request process and associated form has been developed which covers all staff groups. The Care Group and Site Management teams can continue to fill rota gaps by approving additional hours, bank usage and short-term agency of less than 1 week.

Other key actions include the appointment of 218 Newly Qualified Nurses to start Q3 onwards (133 HUTH, 85 NLaG), a focus on recruiting to long term medical and dental vacancies and the conversion of Standard Placement Agency bookings to Direct Engagement bookings to achieve tax efficiencies over and above that available via Standard Placement bookings. Care Groups have been advised no new Standard Placement bookings or extensions to current bookings will be authorised. All current Standard Placement bookings must end or be converted to Direct Engagement bookings by 31st October 2025. Any exceptions to this must have Executive Team approval. 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.

6.2 Health Care Support Worker Band 2 / 3

Unison and all other trade unions have accepted the Group's offer to re-band our Healthcare Support Workers from band 2 to band 3. This has been confirmed at both JNCC staff side forums. A Memorandum of Understanding (MOU) will be signed by parties and staff will be moved to band 3 from October 2025 and begin working to the new Group Healthcare Support Worker and Senior Healthcare Support Worker job descriptions. Some staff have indicated they would like to remain as Healthcare Support Workers - band 2. Back-dated payments to April 2021 will begin from November 2025 onwards and it is likely to take 12 to 15 months to complete. Staff and trade unions are aware of this position.

6.3 NLaG Pay Dispute (Consultants)

The Group Chief Medical Officer and the Group Chief People Officer continue to work with NLaG LNC colleagues to reach agreement on Extra Contractual Payments linked to additional periods of on-call over and above those contained in job plans. Whilst working towards an agreement, LNC Staff Side have requested medical colleagues consider recommencing extra contractual work if they are able to do so. NLaG consultants are being balloted on the current offer.

7. Workforce System Transformation

7.1 Key workforce metrics – current position

Metric	Group current Position	Target
Sickness	**4.8%**	**4%**
AFC Appraisals	**80.4%**	**85%**
Vacancy Rate	**5.4%**	**7%**
Turnover	**7.8%**	**10%**
Core Mandatory Training	**89.2%**	**85%**
Role Specific Training	**81.3%**	**85%**
Job Planning	**51.9%**	**100%**
Medical Appraisals	**84.1%**	**90%**

7.2 Medical Consultant Workforce

- 91 Consultants were appointed and started in the last 12 months, with 16 starting in August 2025
- A further pipeline of 33 Consultants are currently awaiting a start date
- There are now 37 Specialists in role working autonomously to offset the Consultant vacancy position, with Care Groups exploring opportunities for further conversion of posts where appropriate
- There are currently 4 Specialists appointed in the pipeline awaiting start
- Recruitment activity for Consultants has increased, with 3 roles currently with Royal Colleges

for approval, 15 in advertising, 27 in shortlisting, and 9 in interview stages

The overall vacancy rate across the group is currently 5.8%. The vacancy rate for Registered Nursing and Midwifery stands at 2.5%, excluding Operating Department Practitioners (ODPs) and Nurse Associates. However, the Consultant vacancy rate has risen to 18%, an increase from 14% in previous board papers. This rise is not reflective of a deterioration in recruitment or turnover, which remains positive and stable, but rather due to a change in the source data. From April 2025, Staff in post and whole time equivalent (WTE) reporting has shifted from the finance ledger to direct ESR reporting, which has altered role groupings and provides a more accurate picture of Consultant and SAS grades. While this has improved accuracy, it does mean figures are not directly comparable with previously reported data.

8. Leadership, Learning & Talent Development

8.1 Organisational Development

Care Group Programmed Support

Below are the key services that require input from Organisational Development. The team is working with teams in all Care Groups on interventions that range from supporting timeout activities, restorative practice, team coaching and use of psychometrics to support team dynamics.

Care Group	Service/ Department	Intervention	Senior Leadership Sponsorship
Family Services	Maternity (Groupwide/ HUTH)	• Behaviours and leadership • Leadership development Band 7 up • Leadership coaching • Departmental cultural action plans (Sister owned) supported by OD • Tea trolleys to support cultural transformation • Incivility reporting tool and circle group • Facilitation of SLT timeouts	Sponsorship from DOM, Creation of steering group to create accountability
Family Services	Neonatology (DPOW)	• Leadership development workshops	Sponsored by Matron and Band 7
Family Services	Paediatrics (Medicine and Surgery) HUTH	• Circle meetings using restorative practice • Relationships • Inter relationships	Clinical Director Sponsorship
Cardiovascular	Cardiology in HUTH	• Behaviours • Supporting leadership meetings • Leadership development • Facilitated team meetings • Incivility reporting tool and circle group	Care Group Tri sponsorship
TACC	Anaesthetics (NLaG)	• Behaviours • Intervention proposed awaiting approval from Chief of Service	Clinical Director, Ops Manager. Awaiting Tri Sponsorship
TACC	Theatres HUTH	• Ongoing support for cultural transformation • Quarterly group coaching meetings with teams	Theatre Sisters
TACC	ICU (HUTH)	• Ongoing maintenance of cultural transformation work. • Quarterly group coaching sessions • Leadership development	ICU Matron

The support and interventions of OD are much more impactful when senior leaders take ownership of the challenges and also provide that strong compassionate leadership at the same time as the interventions. Improved behaviours and new ways of working need to be managed and regularly reinforced.

8.2 Leadership Development

Leadership development programmes are taking place across the group including a Great Leaders - leadership programme which is a pilot for middle/senior operational managers.

The group have piloted an approach that combined the best of the HUTH and NLaG existing programmes of Be Remarkable (HUTH), and Values Based Leadership (NLaG). The programme ran from January-June 2025 and consisted of 6 units over 6 months with one unit being a Leadership Impact Project. There were two cohorts one at NLaG and one at HUTH. 17 participants in total, 10 from NLaG and 7 from HUTH.

The units were:

- Introduction and Insights
- Leadership Attributes and Yourself as a Leader
- Leadership Impact Project
- Team Dynamics
- Talent Management

All participants were asked to submit reflections after each unit. They are also required to present their impact project at a celebration event at the end of the programme.

Key Lessons from pilot so far (as the participants are yet to present their impact projects) are

- Submission of reflections are a useful way to measure impact of workshops and encourage using learning in work settings
- Criteria and parameters for projects to be more specific to ensure maximum impact on team
- There needs to be a greater emphasis on the correlation between effective people management and increase in performance.
- Using a multi-rater feedback tool alongside one psychometric evaluation
- Spend less time in the classroom and more time self-directed and experiential learning

This learning is being restructured into a more performance focused approach, so delivery of constitutional standards, quality metrics, finance and transforming services and people metrics are delivered alongside our need to ensure our leaders create cultures that are inclusive and compassionate.

In addition, the group is delivering Future Leaders programme, Leadership Essentials/Bitesize development for all managers, Leadership and Management Apprenticeships level 5, 6 and 7, a medical leadership programme and Braver than Before programme for nursing, midwifery and AHP managers. Leadership will be covered in more detail in December's Board report.

8.3 Mandatory Training: Progress, Harmonisation & Governance

The Humber Health Partnership (HHP) is undergoing a significant transformation of its mandatory training strategy, with a strong focus on harmonising national subjects across HUTH and NLaG. The alignment to the NHS England Core Skills Training Framework (CSTF) ensures that all staff, regardless of role or location, achieve a consistent level of competence in key areas such as infection control, safeguarding, fire safety, and information governance. This standardisation is crucial for patient safety and high-quality care. Aligning national core subjects with local mandated training and role specific training cleansing all will streamline and avoid duplication and ultimately reduce the burden of training.

Better Governance and the Role of MLOG

The establishment of robust governance structures, including the Required Learning Steering Group (RLSG) and the Mandatory Learning Oversight Group (MLOG)—is central to the new approach.

These groups oversee and approve training proposals, scrutinise training needs analysis, outcome metrics, and the investment of staff time, and ensure alignment with organisational goals and regulatory requirements.

Benefits of Improved Governance:

- Structured Decision-Making: The RLSG provides a forum for evaluating new mandatory training proposals, ensuring only necessary and relevant topics are escalated to MLOG.
- Outcome-Focused Evaluation: MLOG oversees the delivery and effectiveness of both national and local training, using NHS England templates and outcome-based criteria to ensure relevance and necessity.
- Annual Review and Cleansing: All locally mandated training is subject to annual review cycles, with the ability for both SMEs and learners to request removal or adjustment of training that is no longer current or beneficial.

8.4 GMC Medical Education Survey

The 2025 GMC National Training Survey highlights an urgent need for sustained action, especially at Scunthorpe General Hospital (SGH), which reported 12 "red" outliers compared to Diana Princess of Wales Hospital's 7. Widespread concerns were noted in patient safety across several specialties: Gastroenterology, Cardiology, Respiratory, Anaesthetics, Diabetes and Endocrinology, as well as trust-wide cultural issues. NLaG will submit their action plan early October to address the concerns raised.

Chiefs of Service are responsible for these specialty plans, with progress ongoing to meet the deadline. Planned interventions include reviewing medicine rotas, forming a Medicine Steering Group, providing weekly two-hour Self Development Time for Resident Doctors starting October 2025, conducting facilitated listening sessions, and updating supervision standards to ensure all Resident Doctors have an Educational Supervisor. The action plan is being led by NLaG's Director of Medication Education with Executive sponsorship from the Group Chief Medical Officer.

With the National Education Training Survey launching in October 2025, NHSE expects improvement; otherwise, affected specialties may face Enhanced Monitoring and possible suspension of training.

9. Recommendation

The Board-in-Common is requested to note the content of the report and provide any feedback.

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 27 August 2025

Humber Health Partnership

1. Matters for Reporting

Job Planning compliance had improved by 11% from the last WECC meeting and the target of 90% was still on track for achievement in October 2025. Work was ongoing with the Care Groups to ensure the HUTH/NLAG licencing issues were resolved.

Learning and Organisational Development – work is ongoing to support Care Groups despite the reduction of staff in the OD Team.

2. Positive assurances

Health Care Support Workers/Unions have agreed the offer to move from band 2 to band 3. Implementation planned for October and pay back to commence shortly after.

Positive discussions continue with the NLAG consultants regarding WLI and emergency pay rates.

3. Matters on which the committees have requested additional assurance

The CIC will receive monthly updates regarding Job Planning.

The EDI Steering Group TOR would be presented to the CIC once agreed. Health Inequalities would be separated and discussed and monitored at the Strategic Programmes and Partnerships CIC.

4. Decisions made

Consideration was given to the triangulation of performance and workforce data. It was agreed that due to the amount of capacity required, Execs would escalate any workforce issues to the CIC.

5. Escalation to Trust Boards

Medical staff mandatory training compliance still needed addressing in relation to the CQC outstanding actions. Line managers are required to take responsibility to allow staff to have the time to carry out this training.

Quarterly Pulse Survey – Overall staff engagement results had slightly improved as at QTR 2. The CIC discussed transformation and the need for a more focussed effort. Reasonable assurance was given due to the halted decline and comparison with the national picture

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework	N/a	N/a	Approval	N/a
2	National Quarterly Pulse Survey Q1 and Q2 Report	1	20	Assurance	● Reasonable
3	Guardian of Safe Working Hours - HUTH	1	20	Assurance	● Reasonable
4	Guardian of Safe Working Hours – NLAG	1	20	Assurance	● Reasonable
5	Job Planning Monthly Update	1	20	Information	N/a
6	Learning and Organisational Development: August 2025	1	20	Assurance	Further review of reports
7	EDI Steering Group Time Out Update	1	20	Information	N/a
8	People Data Triangulation Discussion Paper	1	20	Assurance	

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 24 September 2025

Humber Health Partnership

1. Matters for Reporting

Band 2/3 Health Care Support Workers – all unions had agreed the payment and the back pay offer and a MOU was being developed. Payments would commence in October 2025 and would be phased.

2. Positive assurances

Improvement Team were in place and there was a statement of intent regarding clinical engagement and new ways of working in place.

Nursing Education – NHSE had visited NLAG and had given positive feedback regarding the processes in place for the student nurses. The CIC noted the HSJ award for the Practice Nurses relating to Health and Wellbeing.

Medical Education - HUTH Team have been nominated for a Medical Educator Award.

3. Matters on which the committees have requested additional assurance

Agency spend and the 30% reduction target was currently off plan. A strengthened authorisation process is now in place to address this. Due to the risk of achievement limited assurance was given.

Job Planning – 49% compliance. Clinical leads to take responsibility to sign off Job Plans. The target is 90% by the end of October 2025. Limited assurance was given due to current compliance and the risk to achievement of the target.

4. Decisions made

WRES – there are issues around patient and staff bullying and harassment, but zero tolerance was operating across the Group with support from the Circle Group. The composition of the Board was discussed and escalated for further Board discussion. The WRES was endorsed by the CIC.

WDES – Zero tolerance is in place across the Group and reporting was highlighting any issues. The WDES was endorsed by the CIC.

5. Escalation to Trust Boards

Nursing safe staffing paper highlighted gaps in general nursing, midwifery and neonatal to the level of approximately £14m. This investment was required to maintain compliance and would be a phased programme. This figure did not include any consultant investment. Limited assurance was recommended by the CIC due to the investment required.

NLAG Medical Education/supervision had been flagged by the GMC due to poor survey results. An action plan was in place to address the issues and support the resident doctors. Minimal assurance was recommended.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Workforce Integrated Performance Report	1	20	Assurance	N/a
2	Registered Nursing and Midwifery Staffing HUTH/NLAG	1	20	Assurance	Limited
3	Nursing, Therapies and Midwifery Education Progress Report	1	20	Discussion	N/a
4	WRES	1	20	Approval	Endorsed
5	WDES	1	20	Approval	Endorsed
6	Staff Lottery Committee – Annual Report 2024-25	1	20	Information	N/a
7	Medical Education Annual Report HUTH	1	20	Assurance	Reasonable
8	Medical Education Annual Report NLAG	1	20	Assurance	Minimal
9	Guardian of Safe Working Hours Annual Report HUTH	1	20	Assurance	Reasonable
10	Guardian of Safe Working Hours Annual Report NLAG	1	20	Assurance	Reasonable
11	Health and Well-Being Progress Report Q2	1	20	Assurance	Significant
12	Temporary Staffing – Agency Usage	1	20	Assurance	Limited
13	Job Planning Monthly Update	1	20	Assurance	Limited
14	Mandatory Learning	1	20	Discussion	N/a
15	NLAG Resident Doctors GMC National Training Survey Results and Progress update	1	20	Assurance	Covered in Medical Education Report
16	NHSE Self-Assessment on Provider Capability	1	20	Discussion	N/a

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
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	✓						
Kate Wood	Group Chief Medical Officer	✓	PS	✓	✓	✓	x						
David Sulch	Non-Executive Director (HUTH)	x	✓	✓	✓	✓	✓						
Sue Liburd	Non-Executive Director (NLAG)	x	✓	✓	✓	✓	x						
Laura Treadgold	Non-Executive Director (HUTH)	✓	✓	✓	✓	x	x						
David Sharif	Group Director of Assurance	✓	✓	✓	✓	✓	✓						

Tony Curry, Chair of the Workforce, Education and Culture Committees-in-Common
Julie Beilby, Chair of the Workforce, Education and Culture Committees-in-Common

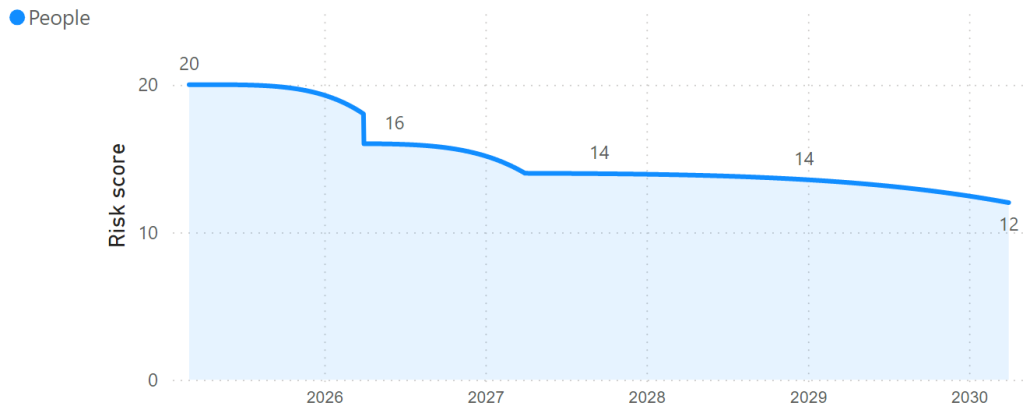
1. People

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:

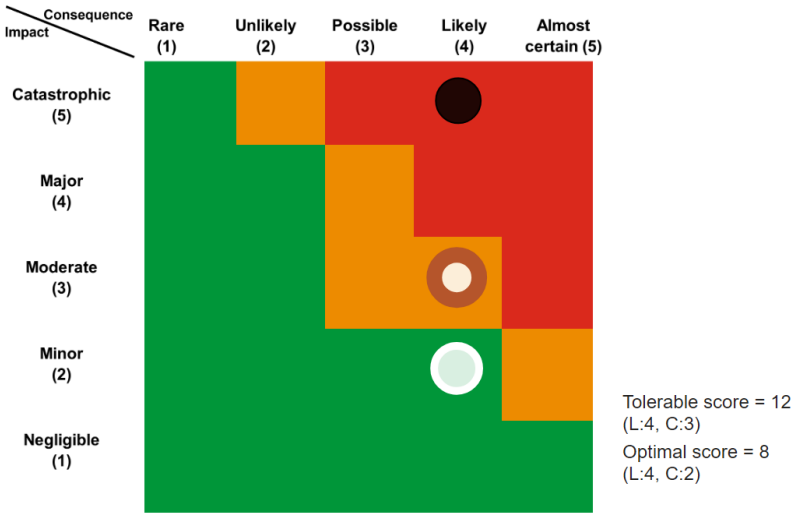
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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

Gaps in control (and Action ID)	5	6	7	8	38	Total
Hard to recruit roles in medical specialities	1	1	1			3
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	1		4
Total	**2**	**2**	**2**	**2**	**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	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Integrated Performance Report	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited

Assurance gaps (and Action ID)	5	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
Total	**2**	**1**	**4**

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 detrimaentla 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)180

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 9 October 2025**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	Linsay Cunningham, Group Deputy Director of Strategy and Partnerships
Title of Report	**Population**
Executive Summary	Key messages: • There are significant inequalities in health outcomes within the population our hospitals serve. These inequalities drive 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 the health outcomes for our population. • Initial work has been undertaken to scope and agree an approach to developing this element of our Group Strategy. This work will be undertaken over the coming 12 to 18 months to enable teams to focus their efforts on the immediate improvement priorities of the organisation.
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Population

Key messages

There are significant inequalities in health outcomes within the population our hospitals serve. These inequalities drive 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 the health outcomes for our population.

Initial work has been undertaken to scope and agree an approach to developing this element of our Group Strategy. This work will be undertaken over the coming 12 to 18 months to enable teams to focus their efforts on the immediate improvement priorities of the organisation.

Background and context

The Group Strategy, agreed in August 2025, sets a clear direction for the organisation with a focus on three key areas – our Patients, our People and our Population.

As the organisation continues on its improvement journey, the immediate focus for teams must remain on the most pressing challenges facing the organisation. This focus on performance against constitutional standards, financial recovery and staff wellbeing and engagement will support delivery over the longer term of our first two strategic goals:

- ✓ our **patients** get the best care
- ✓ our **people** feel proud to work here

In addition, work has commenced to develop our approach to delivering the third of our key strategic goals:

- ✓ our **population** live more years in good health.

This is an important goal for our organisation, working as part of a wider health and care system, in close collaboration with our Local Authority, voluntary, community and social enterprise (VCSE) sector, public and private sector partners. Working together with wider system partners we can begin to address the underlying factors that lead to such disparate outcomes for our population and drive higher than average levels of demand for the services we provide.

Key developments – Health Inequity Action Plan

Initial scoping work has been undertaken to formulate an approach to developing this element of our Group Strategy.

As detailed in the Group Strategy, we will focus on three core strands of work to deliver this strategic goal that address different aspects of the population health agenda:

- Tackling inequity in care delivery
- Taking action on prevention
- Addressing wider determinants of health

Tackling inequity

Initially, this work has focused on the first of these areas – tackling inequity in the delivery of our services. The way in which our services currently operate does not always deliver equitable care to our population and some of our ways of working can inadvertently increase, rather than address, underlying health inequalities.

For example, analysis undertaken to support this scoping work has shown a higher rate of missed appointments from patients living within the most deprived communities across most specialties.

Addressing health inequity requires us to take a systematic approach across our organisation that is clear about and focused upon the areas we can influence or control. By working with partners and key stakeholders, we will design a Health Inequity Action Plan that will set out key actions we can take to address inequity within our current services. This will focus on inequalities for those who use our healthcare services viewed across three lenses:

- Access
- Experience
- Outcomes

Developing a Health Inequity Action Plan will support wider efforts to transform our services so that they are built around the needs of those who use them and deliver the best possible care for all our patients, recognising the different starting points and barriers some within our communities face.

An action plan will be co-produced with key internal and external stakeholders. This action plan will include SMART objectives that will support delivery of the Group Strategy. It is proposed that this work will be undertaken over the coming 12 to 18 months, to enable teams to focus their efforts on the immediate improvement priorities of the organisation.

Taking action on prevention

Through our People strategy, we are already taking action to improve the health and wellbeing of our teams across the organisation. The Putting People First programme is delivering a range of initiatives aimed at improving staff wellbeing across the group.

Over the coming months we will develop, in parallel, action plans to ensure we are maximising the impact of every contact we have with a patient and family member and doing all we can to equip our patients and their loved ones to live healthier lives.

Addressing the wider determinants of health

The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there. One of the goals of our Group Strategy is to leverage this influence, work closely with partners across each of our places to maximise the benefits we can bring to the health and wellbeing of the populations we serve.

As we seek to implement our Partnerships strategy over the medium term, we will continue to develop strong relationships in each of our places and communities to ensure we maximise our influence on the wider factors that impact the health of our population.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)181

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	9 October 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 5 is included in detail for information at agenda 6.2.2 and has been discussed extensively through the most recent PEF on 30 September 2025. A deep dive on CIP / Transformation to cover the previous referral made by PEF is scheduled on the private Board agenda on 9 October 2025. It is really encouraging to see the stabilization in deterioration / run rate in the month 5 position but it is important to recognize the financial challenge from a CIP / transformation programme perspective gets increasingly challenging as the year progresses so maintaining grip and control and focus on the run rate is crucial (on a week by week basis in some cases), especially in relation to the use of variable pay. There have been some further changes that have been implemented since the last Board which it is anticipated will have a positive impact on the run rate as we progress through the year including enhanced weekly variable pay controls that commenced in mid-September, the closure of ward 130W at HUTHT, increased CIP for corporate services, as well as the intensive support programme with the care groups in most financial distress which has seen significant work on detailed financial recovery plans. The discussion at PEF on 30 September 2025 included a lot of detail on the risk and actions the Group is taking, and I was particularly pleased to hear the members describing a situation where there is no additional actions, they would advise we could be doing to further de-risk the plan and delivery from their experience. We do, however, continually seek ideas and review various data to ensure no stone is unturned in this regard. In terms of the wider system HHP have been working with finance colleagues across the ICS and Region and whilst this is not absolutely confirmed it is anticipated that given the position at Month 5 (of which HHP makes a significant proportion) the system will be recommended to keep the Q3 deficit support funding (the full year income for this is £22m so equates to a PYE of c£6m), this is not only important from a revenue perspective but also in relation to cash.

	Work is underway to prepare for the mid-year review process that has been set out in the recent letter from Sir Jim Mackey. As is usually the case the team are keeping a close eye on the capital plan which is ambitious given the scale of change and development the Group is enacting, and thanks go to all for pulling out the stops on making sure we deliver the plan and achieve maximum value for money. The most notable risk on capital remains the profiling of the allocation for the EPR programme and we are engaging regularly with NHSE colleagues on this. The final update for this month is a very brief heads up on the work the national and regional teams have been doing on the "deconstruction of the block". This is an exercise to really understand what activity and value is being derived through contracts that have been post COVID very much handled on a block basis. Data quality and counting and coding challenges have a significant bearing on this work especially for specialized, community and mental health services where data sets have not been in place. It is not anticipated that this will be used to move allocation around but is important for the Group to understand the detail and will be a tool for benchmarking and identification of further opportunities for financial sustainability. This will be a topic of discussion in the coming months.
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

CiC ESCALATION REPORT

Humber Health Partnership

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 2 September 2025

1. Matters for Reporting

The **Group finance** report noted a month 4 year-to-date deficit position of £12.2m which was ***£3m adverse to plan***. This also included £7.5m of non-recurrent balance sheet support. The Group had delivered £28.5m in CIP against a target of £34.3m; ***£5.8m behind target***. A £65.4m gap was expected based on the current adjusted run-rate.

The CIC agreed limited assurance due to the significant work required to reduce the unidentified CIP gap and given the 'high' risk profile of the overall plan. The committee requested a recovery action plan to include the Care Groups. The CIC acknowledged the amount of work and actions in place to address the issues, improved visibility in the transformation plans and additional care group support and interventions put in place.

On **Performance**, the CIC agreed limited assurance due to ongoing unsatisfactory performance delivery. It was acknowledged that whilst high quality plans were being developed and implemented, these were not yet embedded or sustained. Positive movement was noted on patient list total numbers and urgent care across July and August 2025. The move towards understanding future performance targets through trajectories was also welcomed.

The Winter Plan 2025/26 report was presented to the CiC. The CIC agreed reasonable assurance due to the robust plans in place despite the lack of funding. There was increased focus on maintaining flow, earlier discharges and reducing the number of patients with No Criteria To Reside by working with system partners which was having a positive impact.

2. Positive assurances

The CIC gave significant assurance to the **Estates and Facilities General Update** due to the grip and control being displayed. The CIC noted a delayed spend in comparison to planned spend. However, spend was expected to accelerate within the next six weeks.

3. Matters on which the committees have requested additional assurance

The Board Assurance Framework (including Risk Register Report) was presented to the CIC and further assurance was required regarding the high-level risks. The Group would ensure that responsible action owners were providing updates on the BAF actions.

The committee requested additional assurance around the ability to meet the financial plan targets for the year. A recovery plan was requested that balances back to the committed position.

4. Decisions made

The **Group Fire Annual Report and Workplan** was presented and **approved**. With some minor updates, the CiC were assured that the HRI Tower Block and fire warden provision was adequately covered. Work was ongoing to address the issues raised around the HRI Tower Block and it was advised that the Annual Report refer to the current issues. Further investigations have not increased the risk rating of this issue.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Board Assurance Framework (including Risk Register Report)	-	-	Assurance	n/a
2	Winter Plan 2025/26	2	20	Assurance	Reasonable
3	Group Finance Report – Month 4	6	16	Assurance	Limited
4	Transformation Programme	2	20	Assurance	Limited
5	Integrated Performance Report	2	20	Assurance	Limited
6	Estates and Facilities – General Update including Risks	6	16	Assurance	Significant
7	Group Fire Annual Report and Work Plan	6	16	Approval	n/a
8	HUTH Catering Services	6	16	Assurance	n/a

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 30 September 2025

NHS Humber Health Partnership

1. Matters for Reporting

The **Group finance** report for month 5 reflected a **£47m risk and £25m gap** to plan. Concerns were raised regarding delays in decision making by the leadership team as pace was needed to build on the early signs of improvements in run rates at Month 5.

As such, the Committees in Common gave limited assurance due to the level of risk, whilst recognizing positive improvements including focus on run rates, transparency and intervention with the Care Groups. The Committees acknowledged the significant improvement in overall grip and control and identification of further opportunities, However, the slow pace of change was flagged as a concern alongside the delay in gaining control on increasing agency spend.

Transformation Programme - a review of WLI and agency spend was being carried out by doctor, speciality, site and Care Group. Stock control and ward reviews are being worked through to reduce the risk gap. The CIC gave Limited assurance, although noted the amount of work being carried out which would increase assurance if results reflect activity in Months 6-7.

On **Performance**, RTT additional breaches noted on 52 week waits due to not tackling the waiting list in chronological order; LUNA ROVA will be instrumental in ensuring the lists are appropriate. Although the waiting lists had reduced there were still issues around diagnostics with a focus on ENT and CDC performance to address this.

Cancer 28-day performance flagged as a risk due to focus on clearing the back log

Urgent and emergency care 4hour standard performance had improved and was 61.9% although non-admitted performance was still a key concern as was pull out of the department. The CIC gave Limited assurance although noted the improvement in quality of plans. Areas of focus such as ambulance handovers were showing sustained improvement.

2. Positive assurances

Cancer 62-day performance had improved across the Group.

The CQC had visited the ED in September and positive feedback was received due to team identification of the deteriorating patient and the department being less chaotic than previously observed on inspections.

The Estates update noted that the closure of the 13th Floor at HRI was giving rise to decant opportunities, which had previously not been possible and flagged as a high risk for HRI .

The CIC gave Significant assurance over the EFD plans due to the grip and control being displayed.

3. Matters on which the committees have requested additional assurance

Monthly updates required with regards management of Tower Block fire risk and communications with Humberside Fire and Rescue.

Additional assurance still required around the ability to meet the financial plan targets for the year. A recovery plan has not yet been received that balances back to the committed position. An update on CIP programme progress and latest view of the financial gap will be covered at Board.

4. Decisions made – the Security LSMS report and workplan was **endorsed for approval.**

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Annual Business Plan - Timetable	-	-	Approval	n/a
2	Group Finance Report – Month 5	6	16	Assurance	Limited
3	Update and transformation Programmes	6	16	Assurance	Limited
4	Costing and benchmarking	6	16	Assurance	Limited
5	Group Performance Report	2	20	Assurance	Limited
6	UEC Improvement – LOS and Bed Modelling	2	20	Assurance	Limited
7	Estates and Facilities and Development Update	6	16	Assurance	Significant
8	Security LSMS Annual Report and Workplan	6	16	Review and Endorse	Approved
9	NHSE Self-Assessment on Provider Capabilities	-	-		Not Presented

5. Escalation to Trust Boards

Although the CIC gave limited assurance for the Month 5 Finance Position, it was noted that improved results were being delivered and continued improvements into Month 6 would suggest the assurance level could be moved to reasonable assurance.

6. Comments on the effectiveness of the meeting

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

7. Escalation to CiCs

The Committees in Common received the operational/financial timetable and it was recommended that the Workforce plans be presented to the Workforce, Education and Culture Committees in Common.

The lack of weekend cover for consultants and senior staff was also referred to the WEC. This is deemed to be a barrier to delivering optimal patient care and performance standards.

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	✓	✓	✓	✓					
Philippa Russell	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓					
Andy Haywood	Chief of Strategy, Partnerships and Digital	-	-	-	✓	x	x	x					
Tom Myers	Group Chief of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓					
Simon Parkes	Non Executive Director	✓	✓	✓	✓	✓	x	✓					
Jane Hawkard	Non Executive Director	✓	✓	✓	✓	✓	✓	✓					
Kate Wood	Group Chief Medical Officer	✓	✓	✓	✓	✓	✓	PS					

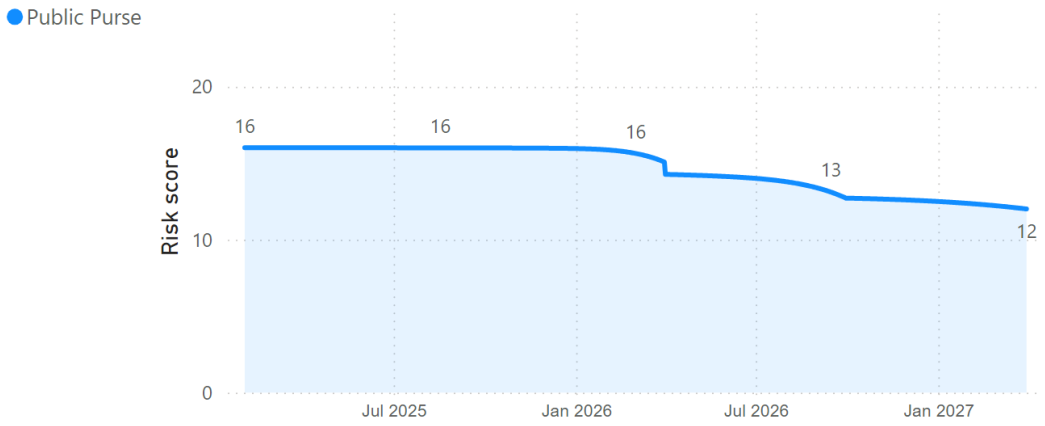
6. Public Purse

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 23 June 2025. In full, the risk is:

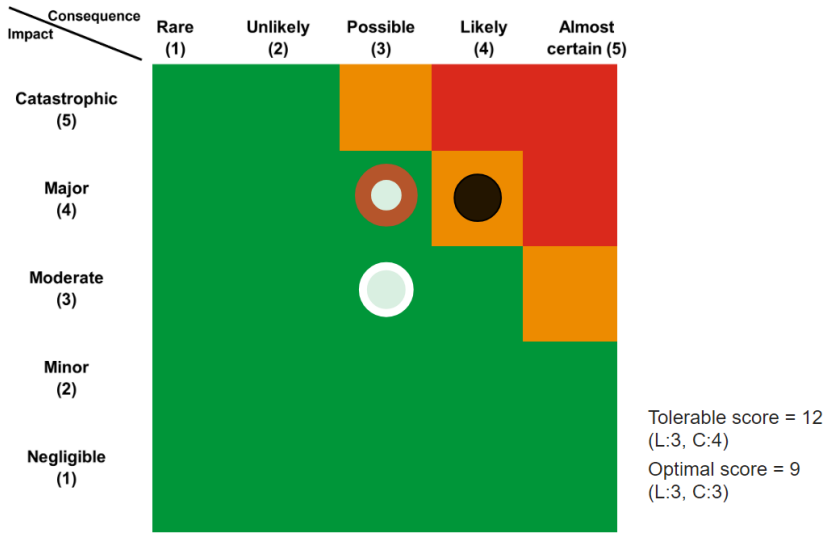
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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



Tolerable score = 12 (L:3, C:4)

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

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	Reasonable
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 Group Finance Strategy founded on clinical and estates strategies		1	1					2
Lack of understanding of current financial pressure and need to live within means				1	1			2
Out of date Long Term Financial Model	1							1
Weak culture of improvement/change management and siloed working				1	1	1	1	4
Total	**1**	**1**	**1**	**2**	**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 and assurance
External
Internal audit review of key financial systems
NHSE external assurance reviews
Internal
2025-26 Operational Plan Assurance Statement
Budget control reports
Exception reporting on Standing Financial Instructions and Standing Orders compliance
FPIB and PMO reporting on transformation and run-rate
In-year operational plan progress
Service Line Reporting
Vacancy control and Discretionary Spend Panel
Workforce planning updates

Assurance gaps (and Action ID)	Total
Total	

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	Sarah Tedford, Interim Site Chief Executive - North, Sarah Tedford, 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, Sarah Tedford, 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

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)182

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**09 October 2025**
Director Lead	**Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer**
Contact Officer / Author	Linsay Cunningham, Group Deputy Director of Strategy and Partnerships
Title of Report	**Partnerships**
Executive Summary	Key messages: • Development of Neighbourhood Health and healthcare delivery at place continues at pace. • The North East Lincolnshire Health and Care Partnership (of which HHP is a member) was successful is gaining a place on the National Neighbourhood Health Implementation Programme (NNHIP). • Continued uncertainty within our local health and care system continues to 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. Update on BAF and mitigating actions: • Partnerships Strategy – draft strategy is complete, to be reviewed by Execs and new Strategic Programmes and Partnerships CiC once formally in place. Additional actions underway: • Stakeholder mapping • Review of representation and internal feedback mechanisms • Review of group policy for clinical service change
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 ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Partnerships

Key messages

Work is ongoing with partners to develop our approach to delivery of Neighbourhood Health across the Humber area, as one of the core elements of implementing the government's Ten Year Health Plan (10YP).

Within our system in Humber and North Yorkshire, there continues to be a level of uncertainty regarding the future shape of collaborative arrangements, system leadership and the size, structure and function of the Integrated Care Board (ICB) due to a number of factors. Uncertainty and change within our local health and care landscape presents a potential risk to delivery of our emerging partnership strategy. This risk is being mitigated through ongoing engagement with health and care partners, maintaining good relationships with key stakeholders and active involvement in collaborative arrangements at place and system.

Key developments – Neighbourhood Health

Neighbourhood Health is a core component of the government's plan for the future of the NHS. The National Neighbourhood Health Implementation Programme (NNHIP) is a large-scale change programme, which aims to accelerate existing partnership working in places to deliver integrated care and the shift from hospital to community-based care.

All four Places within the Humber submitted an expression of interest to join the programme. The North East Lincolnshire Health and Care Partnership (of which HHP is a member) was successful is gaining a place on the programme.

This will support the partnership to accelerate delivery of more integrated health and care services, designed to shift the focus of care from hospitals to communities. Our local focus will start with developing a Neighbourhood Health Team across Meridian PCN population focusing on adults with multiple long-term conditions with rising risk.

Additionally, mechanisms are being put in place to capture and share learning from the North East Lincolnshire pilot across the other Places in Humber and North Yorkshire, ensuring each area can continue to develop Neighbourhood Health models at pace.

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.

Key developments – Local Government Reorganisation

Local Authorities across the Greater Lincolnshire combined authority area have been invited to participate in the local government reorganisation across Greater Lincolnshire. It is anticipated that newly vested unitary organisations will be established by April 2028.

The primary objective of this reorganisation is to eliminate the two-tier system across counties and districts. However, the two existing unitary authorities in North Lincolnshire and North East Lincolnshire are also included within the scope of the exercise.

All councils have the opportunity to submit a proposal. North Lincolnshire and North East Lincolnshire have submitted a proposal in favour of continuing the existing unitary authority boundaries. Alternative proposals have been put forward by a number of the district councils, which would see amalgamation of some of the existing authorities. The Ministry of Housing, Communities and Local Government (MHCLG) will review all submitted proposals from December 2025 onwards.

It is important to HHP that, whatever the eventual makeup of local authorities within the Greater Lincolnshire area, we are able to maintain and build upon the strong working relationships we have

with local government partners across Northern Lincolnshire. These partnerships are vital to ensuring we deliver our strategic goals, ensuring our patients get the best care and our population can live more years in good health.

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

- Draft strategy has been developed through ongoing engagement with internal and external stakeholders.
- Draft strategy is undergoing further review to ensure alignment with Ten Year Plan and the organisational Improvement Plan that is in development.

59. Align partnership reporting to governance arrangements

- Changes to Committees in Common – Capital and Major Projects to become Strategic Partnerships and Programmes – will ensure greater visibility of partnerships working going forward.

Update on other key work and actions underway:

- Review underway of approach to clinical service change. This will include developing a Group-wide policy for service change (existing NLaG policy is in place, however, no equivalent within HUTH). This will ensure a consistent approach is followed across the Group, in particular, in our engagement with stakeholders and partners in local government.

- Detailed stakeholder mapping exercise underway to review stakeholder landscape and develop a prioritised stakeholder engagement strategy aligned to delivery of the Group Strategy. This will involve gap analysis to identify areas where new or different strategic partnerships need to be explored in addition to confirming relationship management approaches for existing partners and key stakeholders.

- Review of representation on place and partnership forums, supported by work to strengthen internal feedback mechanisms, ensuring consistency of voice and impact of involvement is maximised.

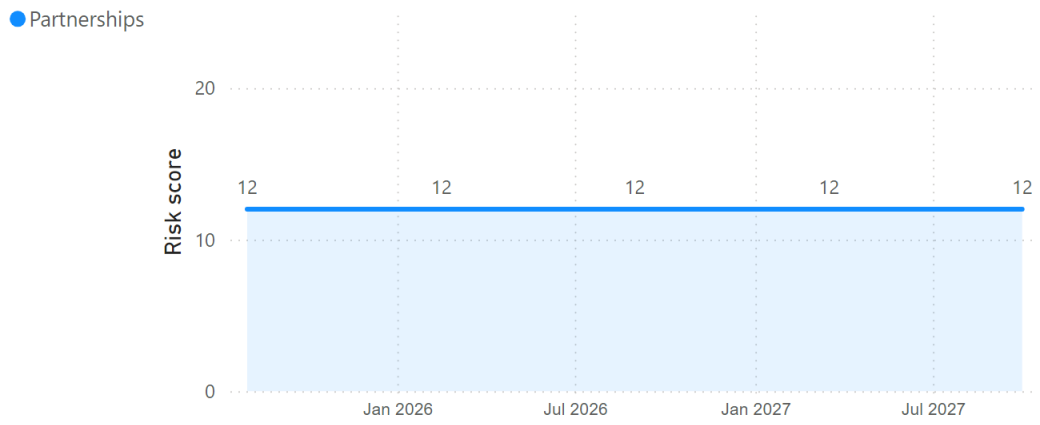
5. Partnerships

The strategic risk affecting our objective, 'Partners' is led by Amanda Stanford, Acting Group Chief Executive and reported to the 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 30 June 2025. In full, the risk is:

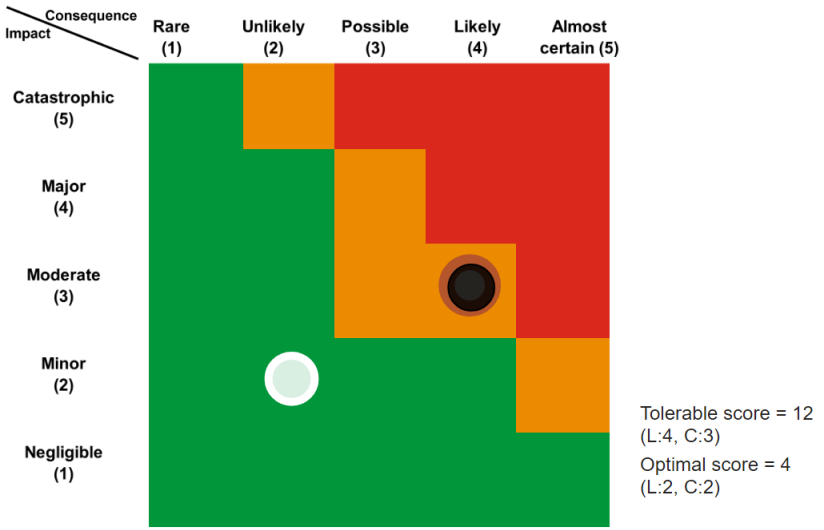
We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

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



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
Total	**2**	**2**

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 and assurance
External
Establishment of operational CDC (vs strategic build) and financial delivery through PFIB
Positive Task and finish participation from Place Boards

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	30/06/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Significant
59	Align partership reporting to governance arrangements internally	30/09/25	31/03/26		30/06/25	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)183

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer (Programme SRO) Andy Haywood, Group Chief Strategy, Partnerships & Digital Officer
Contact Officer / Author	Andy Haywood, Group Chief Strategy, Partnerships & Digital Officer
Title of Report	Electronic Patient Record (EPR) update
Executive Summary	The Group is currently evaluating supplier submissions for its new EPR, with a preferred supplier due to be named on 30 November with contracts due to be signed in January 2026. The Frontline Digitisation Programme, which provides circa £30 million (Capital) funding to HHP, ceases this financial year, therefore it is imperative to conclude contract signatures asap. This will require providing up-front payment to the successful supplier, therefore our procurement teams, supported by NHS England, NHS London Procurement Partnership (LPP) and our delivery partner are exploring options for mitigations such as clawback clauses. Given the timescales involved, the Full Business Case (FBC) for the EPR will need to be reviewed and approved iteratively to ensure it can be approved in time to sign contracts, therefore the following timescale is suggested: 13 November – Initial review of draft FBC (bid moderation concludes on 14 November) TBC – Chair's action to approve for submission to NHS England Electronic Patient Record Investment Board (EPRIB) on 1 December 11 December – Update on final draft submitted and discussion. By 30 January – National approval and contract signature
Background Information and/or Supporting Document(s) (if applicable)	Latest EPR highlight report attached, including plan on a page.
Prior Approval Process	EPR Programme Board
Financial Implication(s) (if applicable)	Requirement to broker Capital funding between financial years, to mitigate challenge of up-front payment to supplier.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	EQIA will be completed as part of FBC.
Recommended action(s) required	☐ Approval ☐ Information ✓ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Electronic Patient Record Programme

Month Ending: Sept 2025 **Overall Project RAG**

On track | Risk of minor delay to project timescales | Risk of major delay to project timescales | Not yet started | Completed

Deliverable Status

Ref	KEY MILESTONES	DUE	STATUS
1	Tender Evaluation complete	26 September	
2	Tender Moderation complete	14 November	
3	Issue intent to award	15 December	

Achievements to date

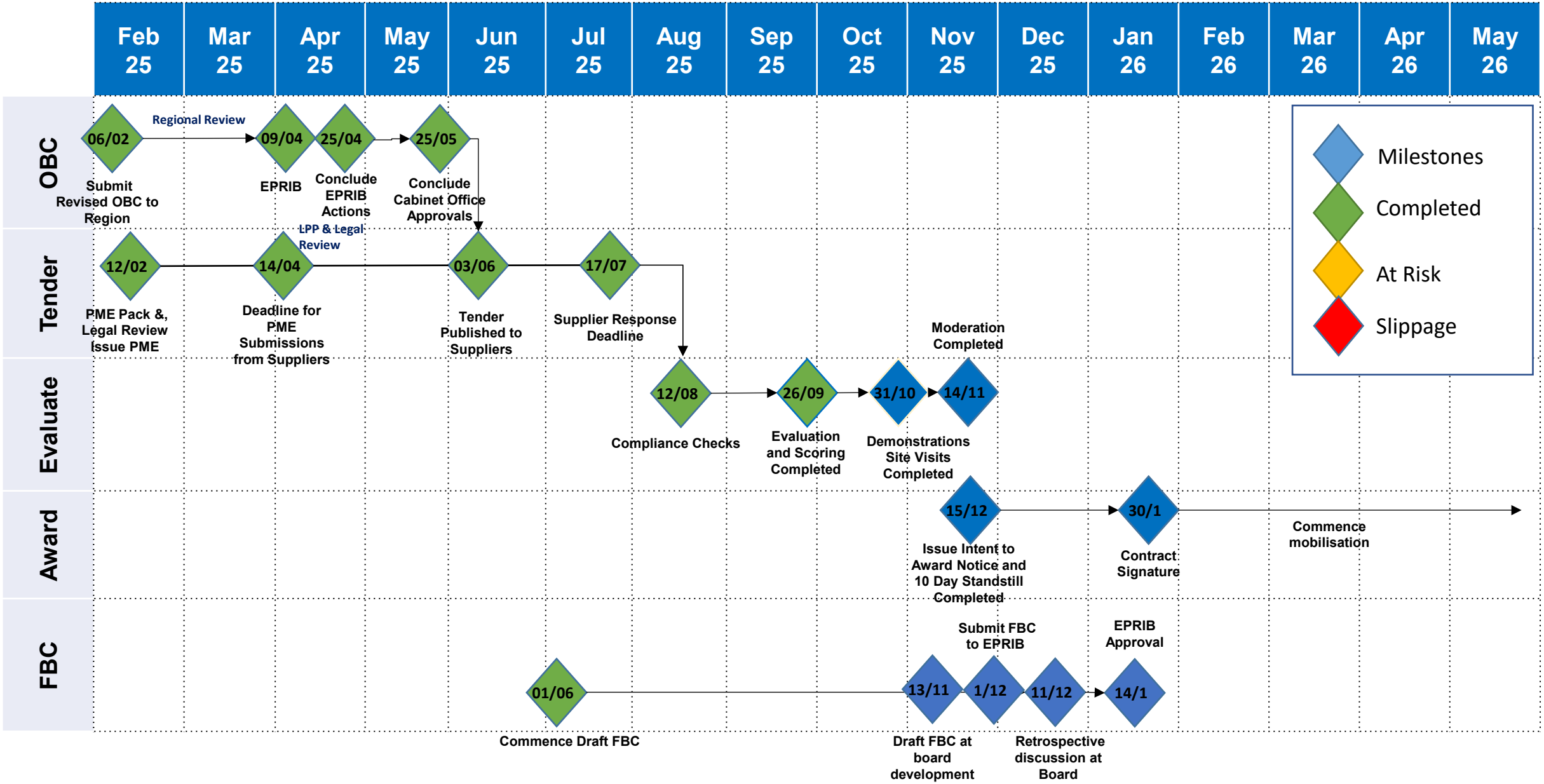
1. Evaluation complete.
2. EPR Programme Director appointed, joins 22 October.
3. Meeting held with Frontline Digitisation (FD) Programme Director around financial brokerage and procurement mitigation.
4. Recruitment underway for other team roles.
5. Initial conclusions shared from operational and clinical readiness workstream.

Planned Activities

1. Complete scoring of demonstrations and commence bid moderation.
2. Confirm Board Approval route for FBC
3. Complete KPMG review of programme and project management.
4. Commence pathway redesign.

Ref	TOP RISKS & ISSUES	RAG	UPDATE	DUE
1	In the event of there not being enough time, there is a risk that the procurement will not be completed in time to use the capital available from NHSE in FY25/26 [Risk 002]		Risk flagged with NHSE. Meeting requested with head of FD.	ongoing
2				
3				

Ref	ESCALATIONS TO PROGRAMME BOARD	RAG	DECISIONS AGREED	DUE
1	Availability of key staff to complete procurement evaluation and readiness activity.			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Milestones
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Slippage
06/02
Submit Revised OBC to Region
Regional Review
09/04
EPRIB
25/04
Conclude EPRIB Actions
25/05
Conclude Cabinet Office Approvals
LPP & Legal Review
12/02
PME Pack &, Legal Review Issue PME
14/04
Deadline for PME Submissions from Suppliers
03/06
Tender Published to Suppliers
17/07
Supplier Response Deadline
12/08
Compliance Checks
26/09
Evaluation and Scoring Completed
31/10
Demonstrations Site Visits Completed
Moderation Completed
14/11
15/12
Issue Intent to Award Notice and 10 Day Standstill Completed
30/1
Contract Signature
Commence mobilisation
01/06
Commence Draft FBC
13/11
Draft FBC at board development
Submit FBC to EPRIB
1/12
11/12
Retrospective discussion at Board
EPRIB Approval
14/1

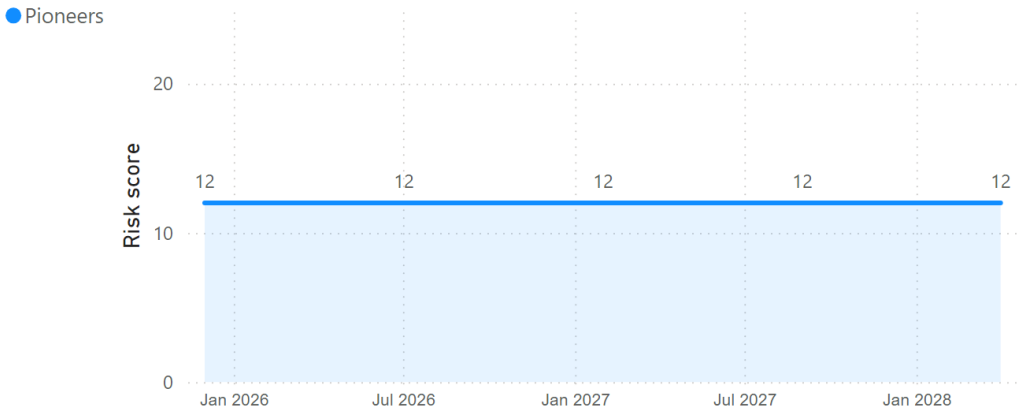
4. Pioneers

The strategic risk affecting our objective, 'Pioneers' is led by 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 Pioneers, the risk's current score is 12 and its score last changed on 05/09/2025. The actions were last reviewed on 05 September 2025. In full, the risk is:

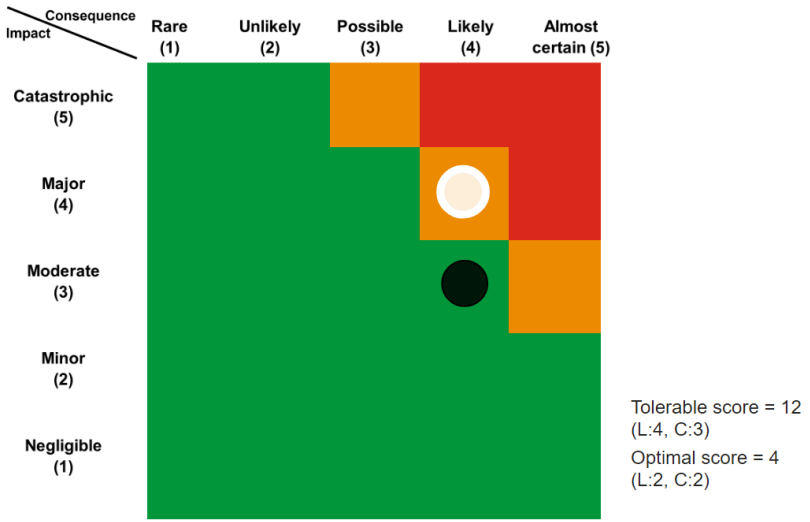
We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit 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

NHS Humber Health Partnership

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	Reasonable
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	Limited
Senior digital leadership team	Reasonable
Senior research team	Reasonable

Gaps in control (and Action ID)	29	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				2
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**	**1**	**2**	**2**	**2**	**2**	**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
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)	29	56	57	Total
Gaps in financial tracking and funding	1			1
Lack of available protected time for research		1	1	2
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**	**1**	**2**	**1**	**7**

4. Pioneers

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), awaiting start.	05/09/25	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

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)185

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Lucy Vere, Group Director of Learning & Organisational Development Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing & Improvement
Title of Report	**Workforce Disability Equality Standard (WDES)**
Executive Summary	The purpose of this report is to update Trust Board on progress against the Workforce Disability Equality Standard (WDES) Indicators, and: • To update on the trust submission and information as per trust contractual requirements. • To highlight key priorities and actions required during 2024/25, to make improvements against the WDES. A summary is provided in the Appendix of the report. Committee members are asked to: • To note the contents of this report against the NHS Workforce Disability Equality Standard. • Approve the data content which we are required to share with NHS England and trust commissioners. • To note the actions proposed for 2024/2025 and to monitor progress of those actions and wider culture transformation programme through the Committee.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce Disability Equality Standard (WDES) was introduced and forms part of the standard NHS contract. From April 2019 is also part of the inspection framework under the "Well Led" domain.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	As outlined in the report
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review

	☐ Assurance	☐ Other – please detail below:

Workforce Disability Equality Standards 24/25

NHS Humber Health Partnership
Hull University Teaching Hospitals NHS Trust

Planning, Recruitment, Wellbeing and Improvement

Workforce Intelligence

nlg-tr.twworkforcedatareqs@nhs.net

Introduction

As set out in the National Health Service (NHS) Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare. The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS.

The WDES follows the NHS WDES as a tool and an enabler of change. The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.

The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain. It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation. The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

Disabled staff feel less valued within the organisation than last year

The percentage of disabled staff receiving all categories of bullying and abuse is down from last year

The number of unknown responses for declaring a disability has decreased since last year, across all staff groups

Most staffing bands have around 5% disabled staff.

The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process is 7.1 times more likely

14.4% of disabled applicants were appointed from shortlisting in 2024/25

Non-Disabled staff are 1.5% more likely to be appointed from shortlisting compared to Disabled staff

Disabled staff are still 11% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff

Disabled staff felt 8.7% more pressured to attend work than non disabled staff

The engagement score for disabled staff has worsened since last year and is also below the national averages

There is currently zero disabled representation on the HUTH board - however when we take into account the joint board the representation picture is more positive.

Disabled staff are 9% more likely to experiencing harassment, bullying or abuse from staff compared to non disabled staff

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	WDES 24/25 Performance Comparison and Summary	23/24	24/25
1	Percentage of disabled staff	3.64%	4.20%
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.36	1.10
3	Relative likelihood of disabled staff entering the formal capability process (excluding ill-health related proceedings) compared to non-disabled staff	-	7.1
4a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	32.7%	30.1%
4b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months	17%	15.3%
4c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	27.1%	26.0%
4d	Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work	45.3%	47.5%

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	WDES 24/25 Performance Comparison and Summary	23/24	24/25
5	Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion	54.5%	47.2%
6	Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties	29.3%	29.9%
7	Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work	29.7%	27.7%
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	76%	75.4%
9	Staff engagement scores	6.2	6.0
10	Disability representation among board members	0	0

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WDES Indicator 1

Table 1: Composition of HUTH Staff

	Clinical	Non-Clinical	Overall Percentage
Disabled	293	141	4.2%
Non-Disabled	6883	2437	92.1%
DIsability Unknown	377	12	3.7%

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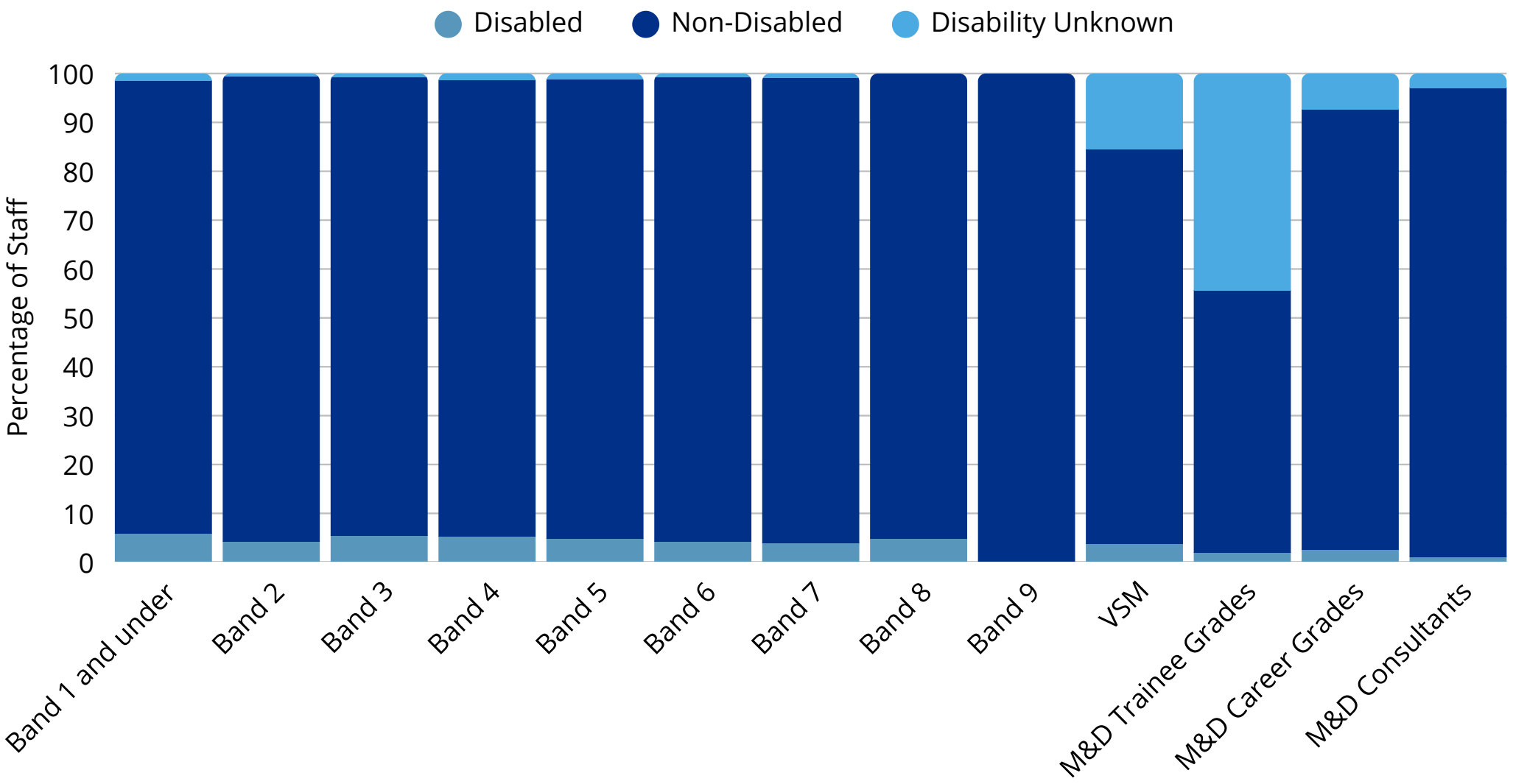
WDES Indicator 1

Figure 1: Composition of HUTH Staff



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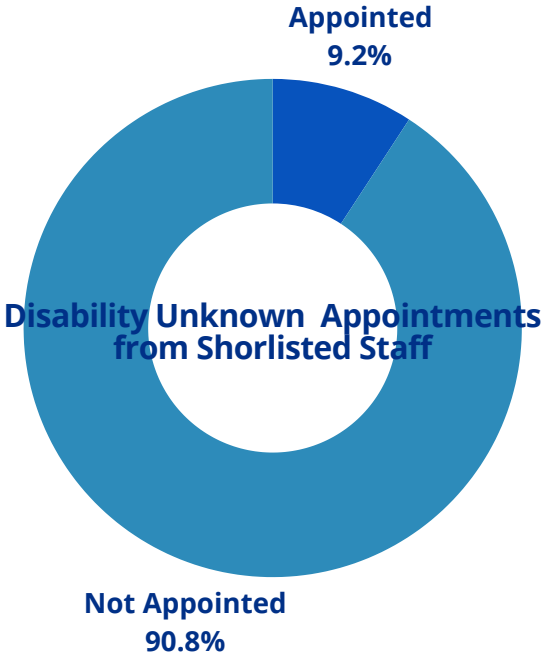
WDES Indicator 2

Figure 2: Appointment from Shortlisting for all staff groups



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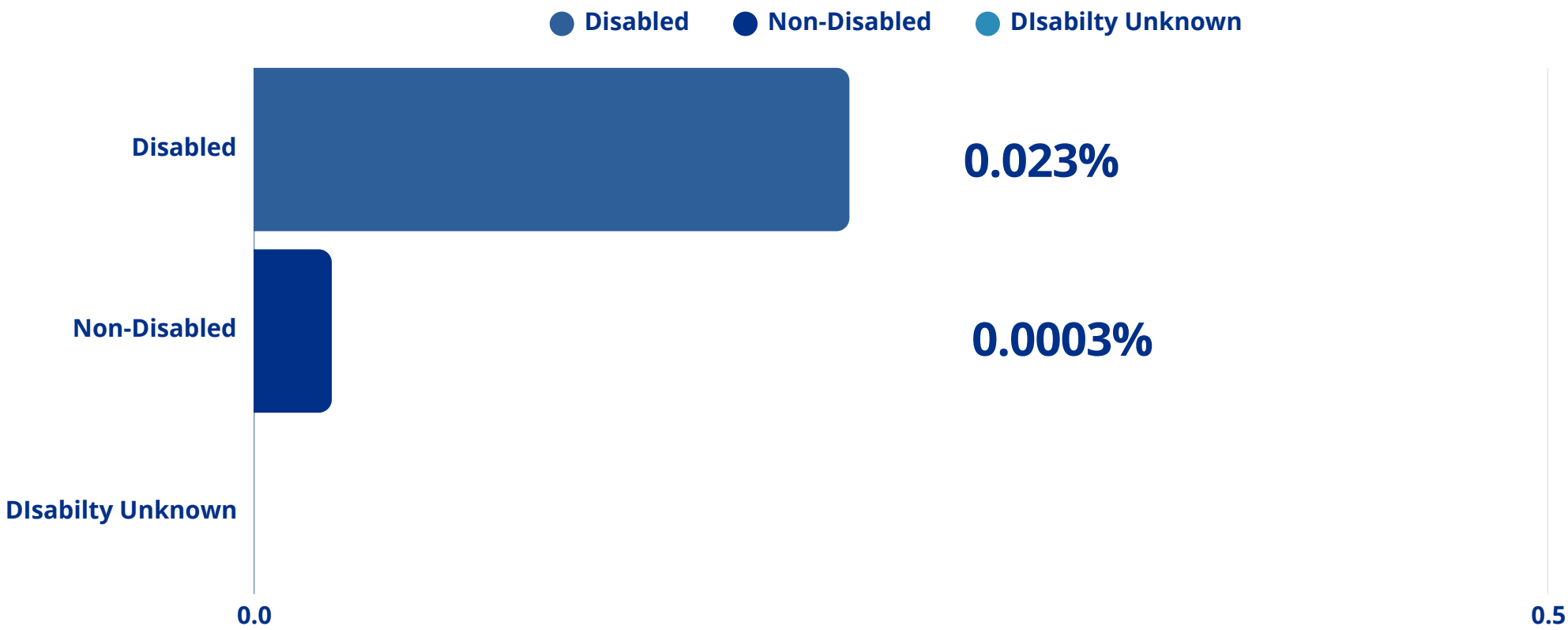
WDES Indicator 3

Figure 3: Likelihood of Staff entering formal disciplinary procedure



The relative likelihood of disabled staff entering the formal disciplinary process compared to non-disabled staff is 7.1. This is extremely small values for all categories.

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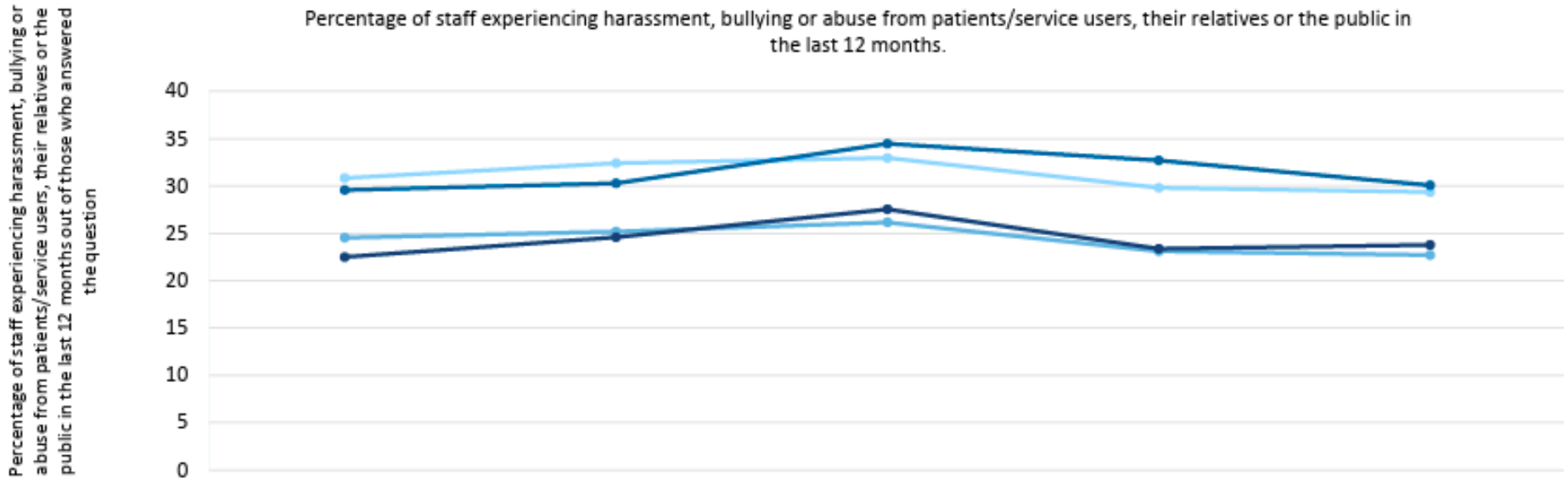
WDES Indicator 4a

Figure 4 : Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	29.58%	30.29%	34.48%	32.71%	30.09%
Staff without a LTC or illness: Your org	22.50%	24.59%	27.55%	23.38%	23.79%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%

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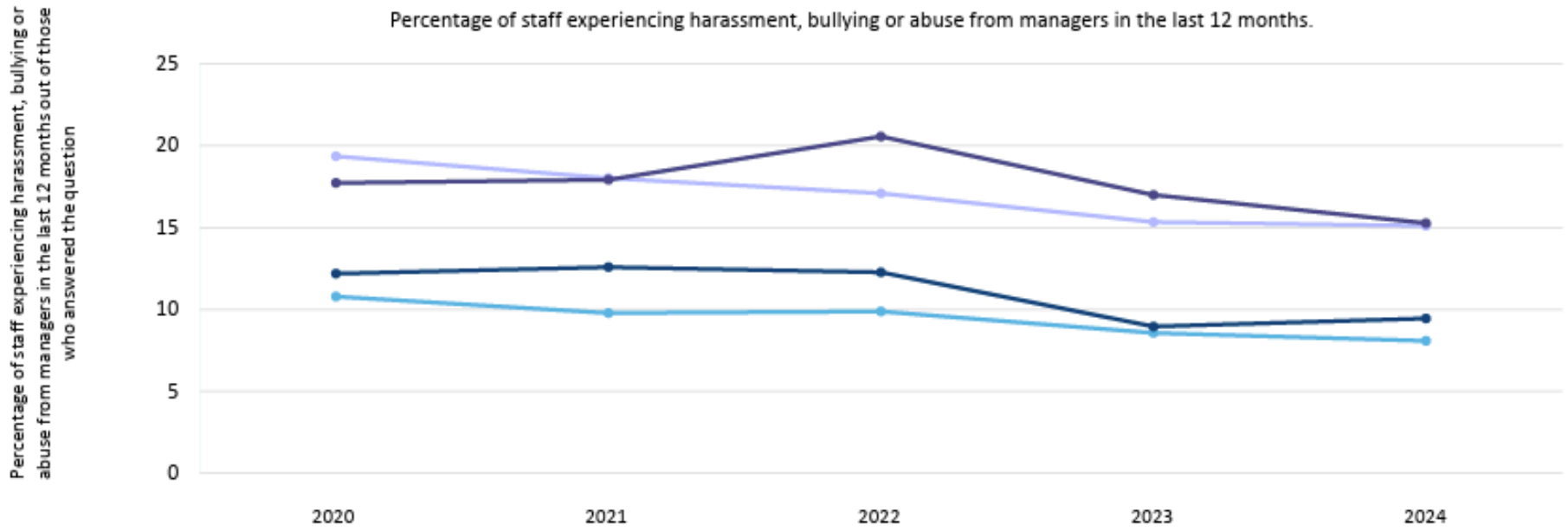
WDES Indicator 4b

Figure 5 : Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	17.72%	17.91%	20.56%	16.99%	15.27%
Staff without a LTC or illness: Your org	12.19%	12.58%	12.27%	8.95%	9.45%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%

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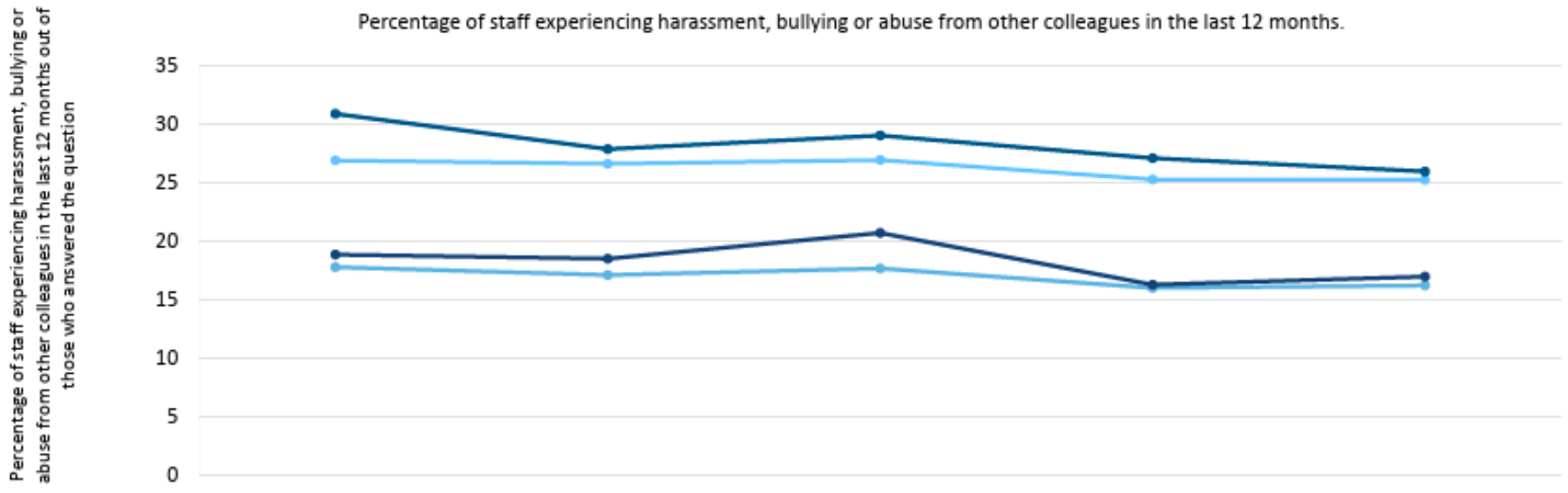
WDES Indicator 4c

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	30.87%	27.87%	29.03%	27.08%	25.96%
Staff without a LTC or illness: Your org	18.85%	18.51%	20.71%	16.28%	16.97%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%

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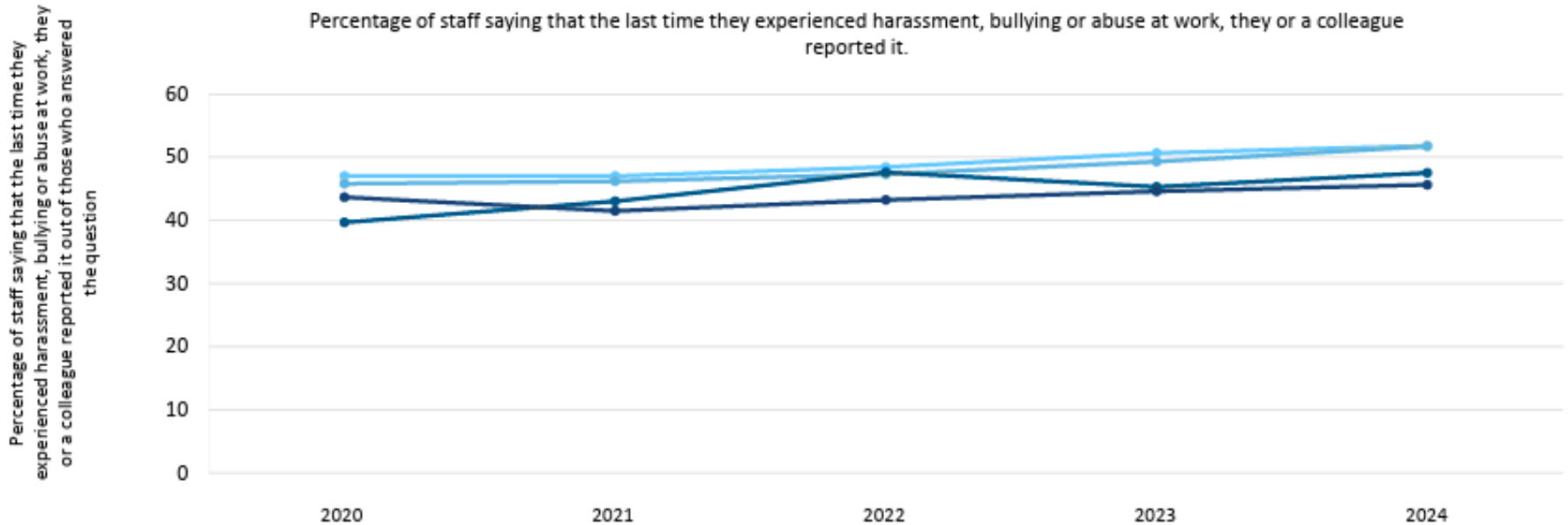
WDES Indicator 4d

Figure 7 : Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	39.68%	43.02%	47.59%	45.30%	47.52%
Staff without a LTC or illness: Your org	43.65%	41.49%	43.24%	44.60%	45.64%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%

47.5% of employees with a disability have reported an incident of harassment, bullying, or abuse at work. This reveals that disabled staff members are more inclined to report incidents compared to their non-disabled peers. The Trust has seen an increase over the past three years in indicator 4d regarding reporting incidents, which is encouraging as it suggests people feel more empowered to speak up. This progress aligns well with the introduction of the zero tolerance reporting tool. This emphasises the importance of fostering a workplace culture that encourages reporting, ultimately contributing to a more supportive and inclusive environment.

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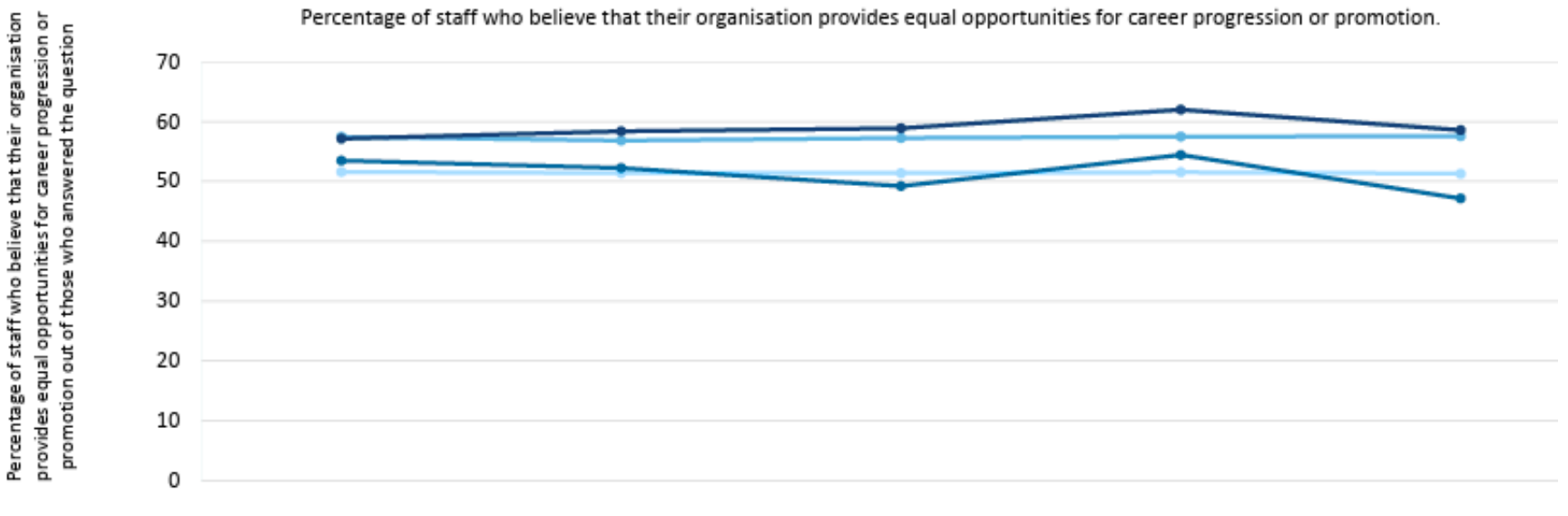
WDES Indicator 5

Figure 8 : Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	53.51%	52.25%	49.24%	54.45%	47.16%
Staff without a LTC or illness: Your org	57.16%	58.38%	58.89%	62.01%	58.57%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%

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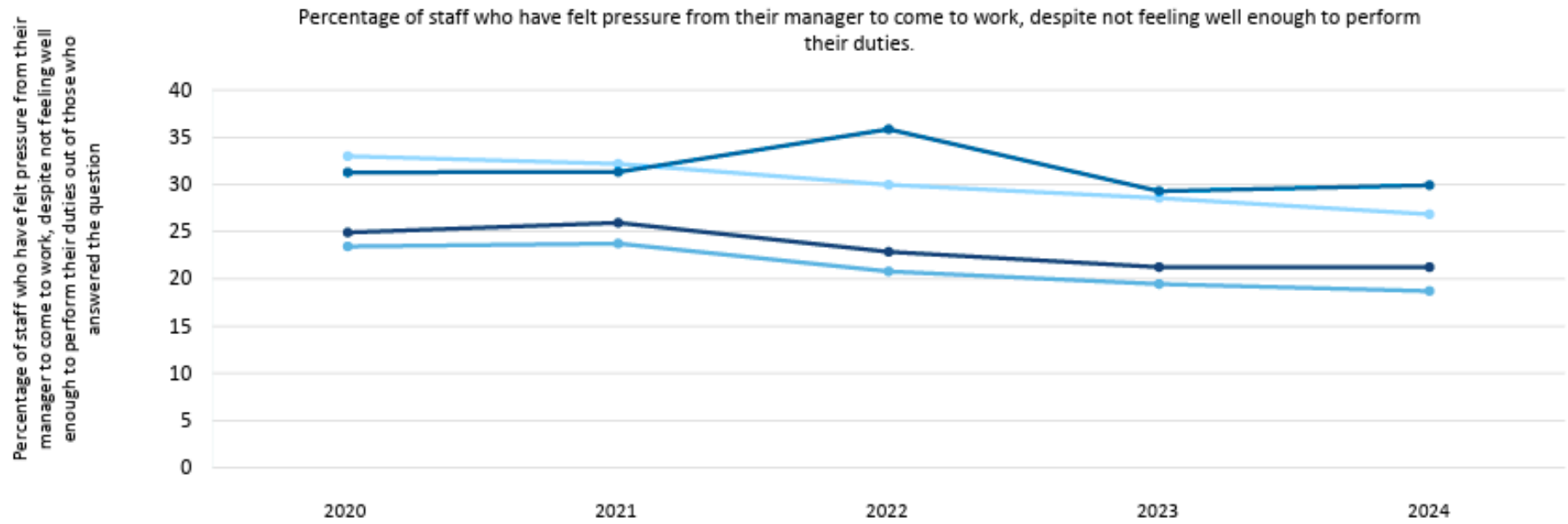
WDES Indicator 6

Figure 9: Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	31.26%	31.33%	35.85%	29.29%	29.92%
Staff without a LTC or illness: Your org	24.92%	25.94%	22.87%	21.24%	21.24%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%

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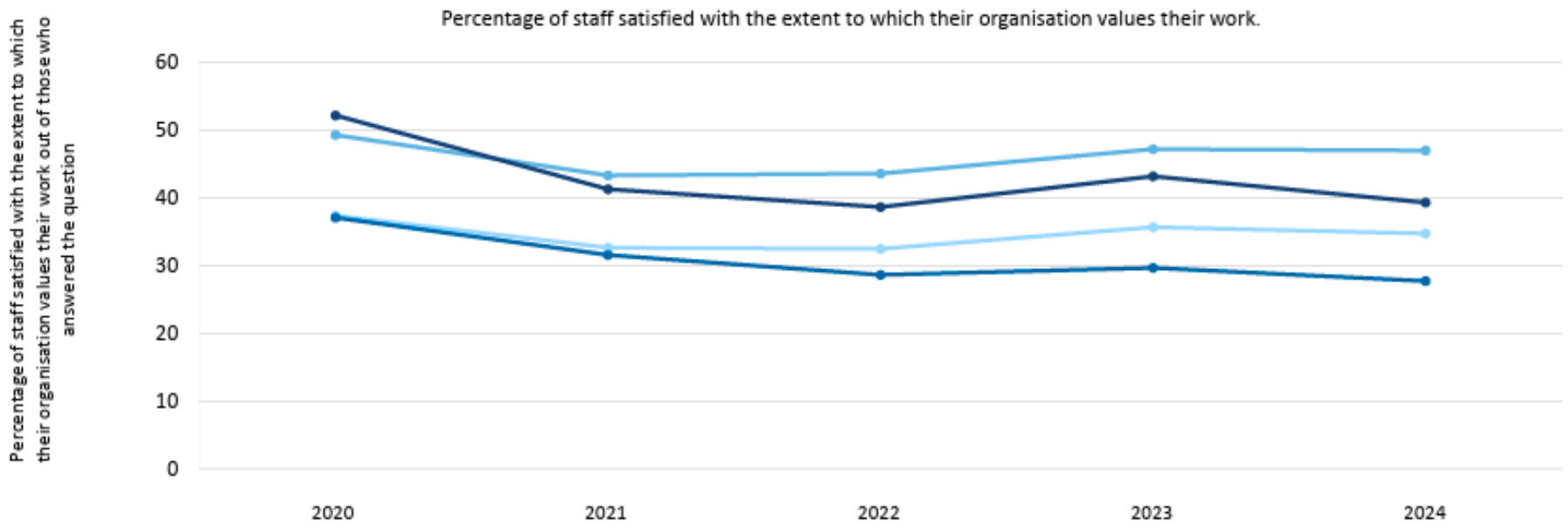
WDES Indicator 7

Figure 10: Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	37.07%	31.57%	28.61%	29.67%	27.70%
Staff without a LTC or illness: Your org	52.17%	41.26%	38.64%	43.17%	39.32%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%

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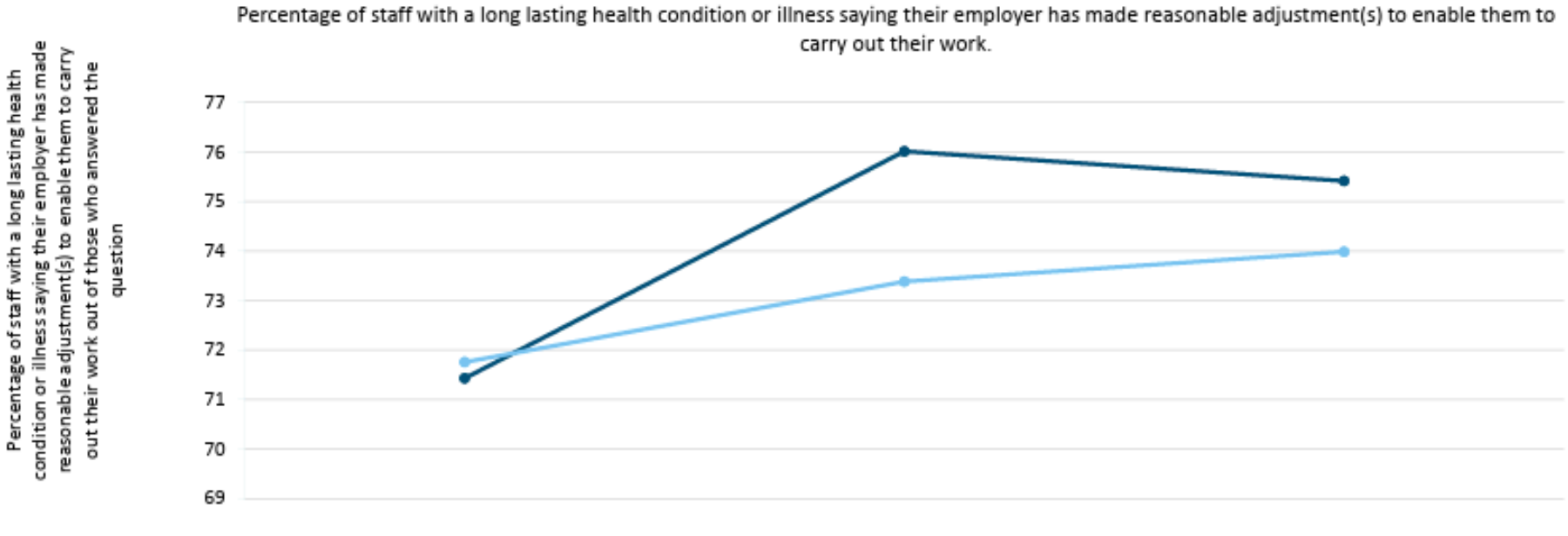
WDES Indicator 8

Figure 11: Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work



	2022	2023	2024
Staff with a LTC or illness: Your org	71.43%	76.01%	75.41%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%

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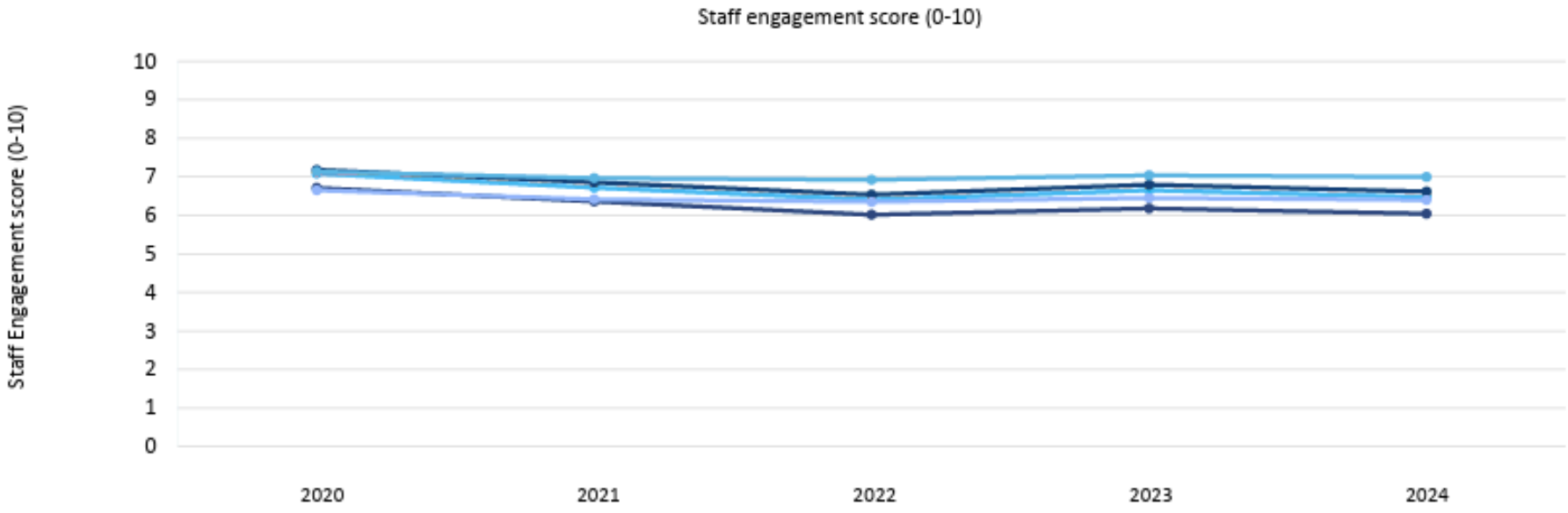
WDES Indicator 9

Figure 12: Staff engagement scores



	2020	2021	2022	2023	2024
Organisation average	7.09	6.72	6.41	6.65	6.47
Staff with a LTC or illness: Your org	6.71	6.37	6.02	6.18	6.04
Staff without a LTC or illness: Your org	7.18	6.86	6.54	6.80	6.62
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00

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WDES Indicator 10

Figure 13: Disability representation among board members

Figure 13: Total Board Composition

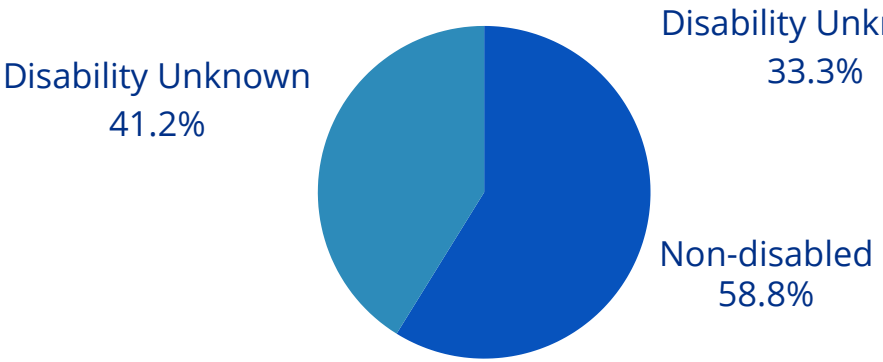


Figure 14: Voting Board Members

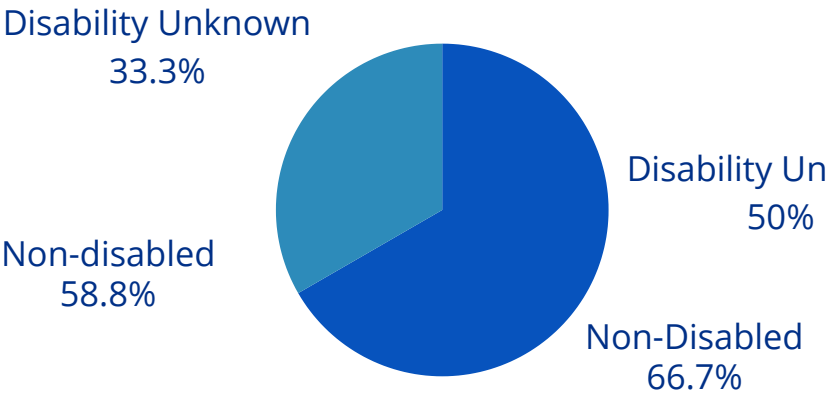
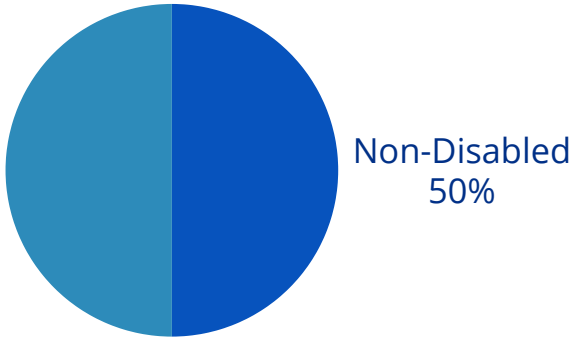


Figure 15: Non-Exec Board members



There is currently no disabled representation on the board either at Exec or Non-exec level. However this position changes when taking into account the joint board.

HUTH is part of NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

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Existing Networks and Programmes

Embedding of the Zero Tolerance to Ableism Framework and Reporting tool. The tool is playing a significant part to assisting how we support equality, to tackle all forms of discrimination and in particular support our disabled staff.

Engagement Events
This year's disability events included a successful conference and a number of drop-in sessions to celebrate Disability History Month.

Reasonable Adjustments
The groundwork and approvals for the centralised were done for a Reasonable adjustments for Equity, Accessibility and Confidence Hub (REACH) to provide a dedicated service advocating for individuals asking for reasonable adjustments if they are needed.

Governance
An Equality, Diversity, and Inclusion Steering Group has been formed chaired by an executive director. This group is able to challenge and give the Trust Board assurance in terms of meeting our equality duties.

Education and Development
All new staff receive face to face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a managers leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination and equip leaders to have open and honest conversations with their staff.

In addition the network Chair regularly meets with the Group CEO to help for development and to help frame Trust policies.

Sunflower Lanyard Scheme
The chair of Huth Disability staff network successfully launched the Sunflower Lanyard scheme across Huth originally and has since worked the NLaG staff network to spread across the group.

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Action Plan

The Action Plan has been developed, based on the 24/25 WDES technical data results, to help close the gaps in workplace experience between Disabled & Non-disabled staff.

Action	Metric	Delivery Timescale	Lead Responsibility
1. Continue the Zero Tolerance to Ableism framework ○ Ensure staff are aware of this framework ○ Establish links with the staff network ○ Ensure that the term Ableism is communicated and fully understood throughout the Group	3, 4a, 4b, 8, 9a, 9b EDS 2022 2B	Ongoing	EDI Team

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Action	Metric	Delivery Timescale	Lead Responsibility
2. Introduce an Inclusive Recruitment Project **Stage One Data Analysis:** ○ **Data Analysis Importance:** Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. ○ **Disaggregation by Characteristics:** They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. ○ **Promotion Analysis:** Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	1a, 1b, 2 EDS 2022 2D, 3	February 2026/ Ongoing	EDI Team, Recruitment

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Action	Metric	Delivery Timescale	Lead Responsibility
3. Launch Reasonable Adjustments for Equity, Accessibility and Confidence Hub (REACH) ○ Raise the profile of Access to Work and support staff to apply and make the application for adjustments via Access to Work simpler and explore the feasibility of introducing a centralised process ○ Explore using reasonable adjustment case studies. ○ Enable and promote Line Managers to introduce simple adjustments quickly. ○ Explore with HR how adjustments in relation to disability related leave and absence can be incorporated into HR processes ○ Introduce a “Disability Passport” for colleagues across the Trust.	6, 7, 8, 9a EDS 2022 2A	Dec25/ Ongoing	EDI Team, HR

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Action	Metric	Delivery Timescale	Lead Responsibility
4. Supporting staff who are Neuro Divergent ○ Through the staff network provide support to this group of staff. ○ Explore various support interventions ○ As part of EDI training make managers aware of neuro divergence. ○ Explore reasonable adjustments and how they better support neuro divergent staff.	All EDS 2022 2A, 2B, 2C	April 2025/ Ongoing	EDI Team, Disability Staff Network
5. EDI Education ○ Deliver EDI training on all Corporate Induction Course ○ Deliver a range of EDI course each month ○ 'Embracing the Challenges of Inclusive Leadership' ○ Leading without Limits programme group wide bespoke programme for disabled colleagues or with a long term condition in partnership with T2	All EDS 2022 2B, 2C	October 2025/ Ongoing	EDI/OD Teams

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Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	1 *	6,3 %	15 *	93,8 %	0 *	0 %	16
Band 2	50 *	4.7 %	1006 *	95.1 %	2 *	0.2 %	1058
Band 3	40 *	6.4 %	580 *	93.4 %	1 *	0.2 %	621
Band 4	18 *	6.6 %	252 *	93 %	1 *	0.4 %	271
Band 5	13 *	6,4 %	190 *	93,1 %	1 *	0,5 %	204
Band 6	4 *	3 %	131 *	97 %	0 *	0 %	135
Band 7	5 *	5 %	96 *	95 %	0 *	0 %	101
Band 8a	5 *	8,2 %	56 *	91,8 %	0 *	0 %	61
Band 8b	2 *	3,9 %	49 *	96,1 %	0 *	0 %	51
Band 8c	1 *	5,9 %	16 *	94,1 %	0 *	0 %	17
Band 8d	1 *	10 %	9 *	90 %	0 *	0 %	10
Band 9	0 *	0 %	2 *	100 %	0 *	0 %	2
VSM	1 *	3,8 %	21 *	80,8 %	4 *	15,4 %	26
Other e.g. Agency and/or any other groups, please specify	0 *	0 %	14 *	82,4 %	3 *	17,6 %	17

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	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	109	5.5 %	1853	94.3 %	4	0.2 %	1966
AfC Bands 5, 6 and 7	22	5 %	417	94.8 %	1	0.2 %	440
AfC Bands 8a and 8b	7	6.3 %	105	93.8 %	0	0 %	112
AfC Bands 8c, 8d, 9 and VSM	3	5.5 %	48	87.3 %	4	7.3 %	55

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	0 *	0 %	1 *	100 %	0 *	0 %	1
Band 2	35 *	3.2 %	1049 *	96.1 %	8 *	0.7 %	1092
Band 3	24 *	5.1 %	438 *	93.8 %	5 *	1.1 %	467
Band 4	9 *	4.7 %	179 *	92.7 %	5 *	2.6 %	193
Band 5	106 *	4.9 %	2027 *	94.1 %	22 *	1 %	2155

Band 6	48 *	4,4 %	1043 *	95,2 %	5 *	0,5 %	1096
Band 7	29 *	4,2 %	662 *	95 %	6 *	0,9 %	697
Band 8a	7 *	3,2 %	211 *	96,8 %	0 *	0 %	218
Band 8b	3 *	5,7 %	50 *	94,3 %	0 *	0 %	53
Band 8c	1 *	5,9 %	16 *	94,1 %	0 *	0 %	17
Band 8d	0 *	0 %	2 *	100 %	0 *	0 %	2
Band 9	0 *	0 %	2 *	100 %	0 *	0 %	2
VSM	0 *	0 %	15 *	75 %	5 *	25 %	20
Other e.g. Agency and/or any other groups, please specify	3 *	6,7 %	42 *	93,3 %	0 *	0 %	45

Medical & Dental Staff, Consultants	7	*		%	512	*	1	%	10	*		%	529
Medical & Dental Staff, Non-Consultants career grade	2	*		%	85	*	1	%	9	*		%	96
Medical & Dental Staff, trainee grades	19	*		%	518	*	1	%	312	*		%	849
Total clinical	265			%	5737		1	%	56			%	6058
Total medical & dental	28			%	1115		1	%	331			%	1474
Total clinical & non-clinical	434			%	9289		1	%	399			%	1012

clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	68	3.9 %	1667	95.1 %	18	1 %	1753
AfC Bands 5, 6 and 7	183	4.6 %	3732	94.5 %	33	0.8 %	3948
AfC Bands 8a and 8b	10	3.7 %	261	96.3 %	0	0 %	271
AfC Bands 8c, 8d, 9 and VSM	1	2.4 %	35	85.4 %	5	12.2 %	41

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	708 *	7870 *	141 *
Number appointed from shortlisting	102 *	1251 *	13 *
Likelihood of shortlisting/appointed	0.14	0.16	0.09

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts: 1.10

Notes

Metric 3

Metric 3 – Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	434	9289	399
Average number of staff entering the formal capability process for any reason *	1	3	0
Of these, how many are on the grounds of ill health only? *	0	0	0
Likelihood of staff entering the formal capability process	0,002304	0,000323	0,000000

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff: 7.133127

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report, The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 – Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

* ◉ Yes
* ○ No

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

Disability Circle Group *

Notes

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2023.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	10 *	7 *	17
How many are voting members?	0 *	6 *	3 *	9
Number of non-voting members	0	4	4	8
How many are Exec Board members?	0 *	6 *	3 *	9
Number of non-exec members	0	4	4	8
Number of staff in overall workforce (from Metric 1)	434	9289	399	10122

Total Board members - % by Disability	0 %	58,82 %	41,18 %
Voting Board members - % by Disability	0 %	66,67 %	33,33 %
Non-Voting Board Member - % by Disability	0 %	50 %	50 %
Executive Board Member - % by Disability	0 %	66,67 %	33,33 %
Non-Executive Board Member - % by Disability	0 %	50 %	50 %
Overall workforce - % by Disability	4,29 %	91,77 %	3,94 %
Difference % (Total Board - Overall workforce)	-4,29 %	-32,95 %	37,24 %
Difference % (Voting membership - Overall Workforce)	-4,29 %	-25,1 %	29,39 %
Difference % (Executive membership - Overall Workforce)	-4,29 %	-25,1 %	29,39 %

Notes

Please note we operate a shared board with Northern Lincolnshire and Goole Foundation Trust and the board are hosted across both organisations.

Workforce Disability Equality Standards 24/25

NHS Humber Health Partnership
Northern Lincolnshire and Goole NHS Foundation Trust

Planning, Recruitment, Wellbeing and Improvement

Workforce Intelligence
nlg-tr.twworkforcedatareqs@nhs.net

NHS
Humber Health
Partnership

Introduction

As set out in the National Health Service (NHS) Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare. The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS.

The WDES follows the NHS WDES as a tool and an enabler of change. The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.

The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain. It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation. The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

The Trust's WDES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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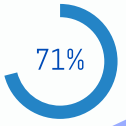
Key Findings

Reasonable adjustments in the workplace have decreased since 2023: 71% of disabled staff reported the trust made necessary adjustments in 2024



The percentage of disabled staff in the non-clinical and clinical workforce stands at 5.4% of the total workforce: up from last year

The number of unknown responses for declaring a disability has decreased since last year, across all staff groups

Most disclosures of disabilities are from staff from bands 2-5

The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process is 5.5 times more likely

Only 5.6% of disabled applicants were appointed from shortlisting in 2024/25

Non-Disabled staff are 1.6 times more likely to be appointed from shortlisting compared to Disabled staff

Disabled staff are still 5.5% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff

Disabled staff felt 13% more pressured to attend work than non disabled staff

The engagement score for disabled and non disabled staff has worsened since last year and is below the national average

The percentage of the board and executive team who classify themselves as having a disability or long-term condition stands at 14.3%

Disabled staff are 11% more likely to experience harassment, bullying or abuse from colleagues compared to non disabled staff

	WDES 24/25 Performance Comparison and Summary	23/24	24/25
1	Percentage and Number of disabled staff	4.5%	5.4%
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.1	1.6
3	Relative likelihood of disabled staff entering the formal capability process (excluding ill-health related proceedings) compared to non-disabled staff	0	5.5
4a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	27.2%	28.9%
4b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months	15.3%	15.1%
4c	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	26.9%	28.1%
4d	Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work	51.8%	54.8%

	WDES 24/25 Performance Comparison and Summary	23/24	24/25
5	Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion	52.8%	48.8%
6	Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties	29.6%	29.6%
7	Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work	31.2%	27%
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	73.6%	70.9%
9	Staff engagement scores for staff with a disability or long term condition	6.3	6
10	Disability representation among board members	14.3%	14.3%

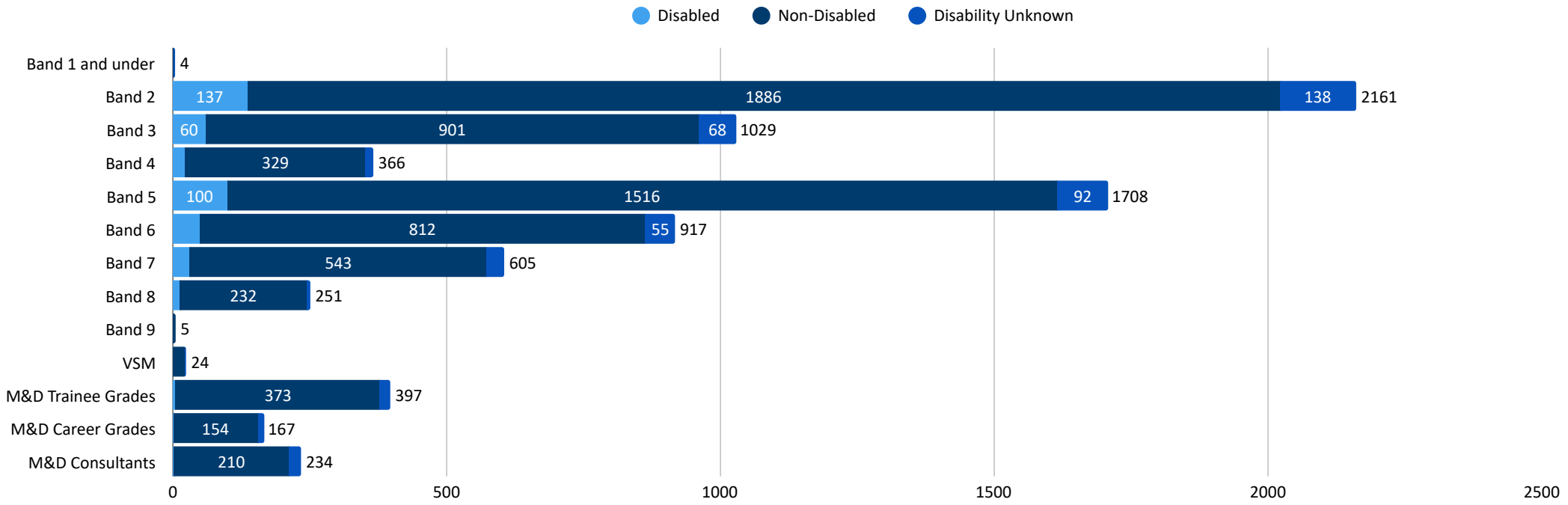
WDES Indicator 1

Table 1: The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric is a snapshot as at 31 March 2024.

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff
Disabled	5.4%	5.7%	6.2%
Non-Disabled	88.8%	88.4%	88.3%
Disability Unknown	5.8%	5.9%	5.5%

WDES Indicator 1

Figure 1: The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric is a snapshot as at 31 March 2024.



Almost 1 in 4 NHS staff now have lived experience of a disability or long-term condition (NHS England). The bar chart above highlights a disparity in the representation of staff with disabilities across the trust. The percentage of disabled staff in the non-clinical and clinical workforce stands at 5.4% of the total workforce: up from last year.

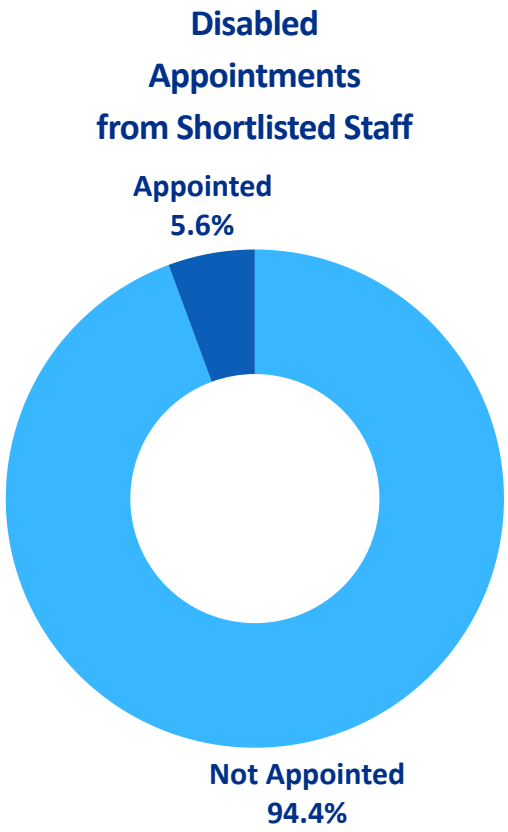
It is evident that the overall number of staff who have disclosed a disability on the Electronic Staff Record (ESR) remains low across the trust. However, the data also reveals that the highest proportion of these disclosures is concentrated in specific categories, notably among staff in bands 2-5. This suggests that while there is an underrepresentation of staff with disabilities generally, there are particular areas within the trust where individuals with disabilities are more prevalent.

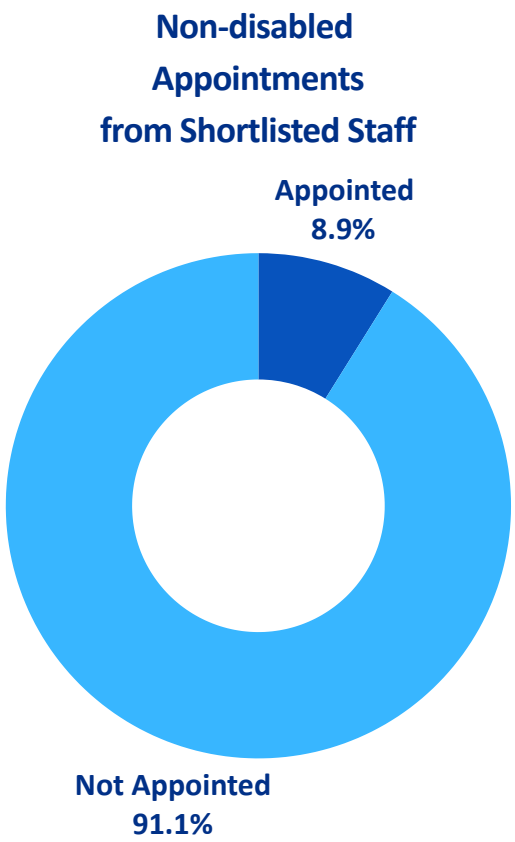
When comparing this data with the trust's most recent national staff survey responses regarding the disclosure of long-term health conditions or disabilities, it is evident that employees are hesitant to disclose or update their disability status on ESR. The staff survey responses indicate a greater number of employees with disabilities than the ESR data suggests.

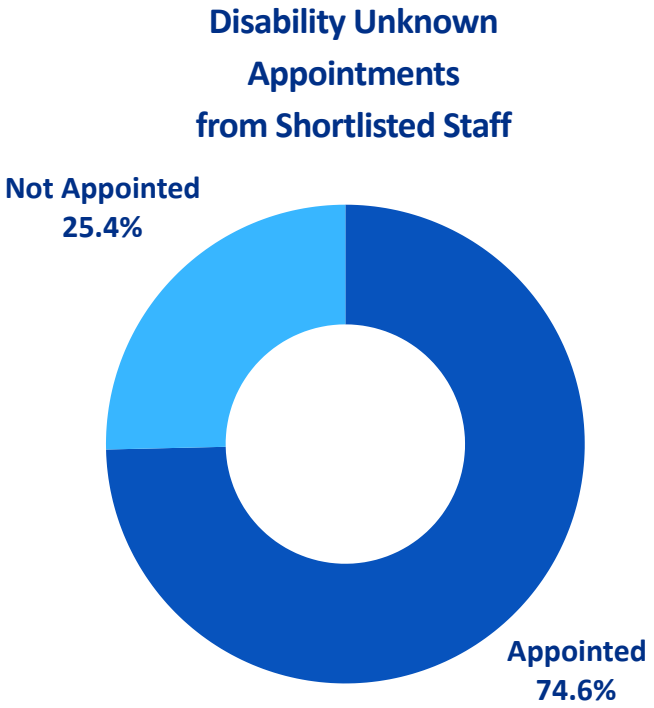
**VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)*

WDES Indicator 2

Figure 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.





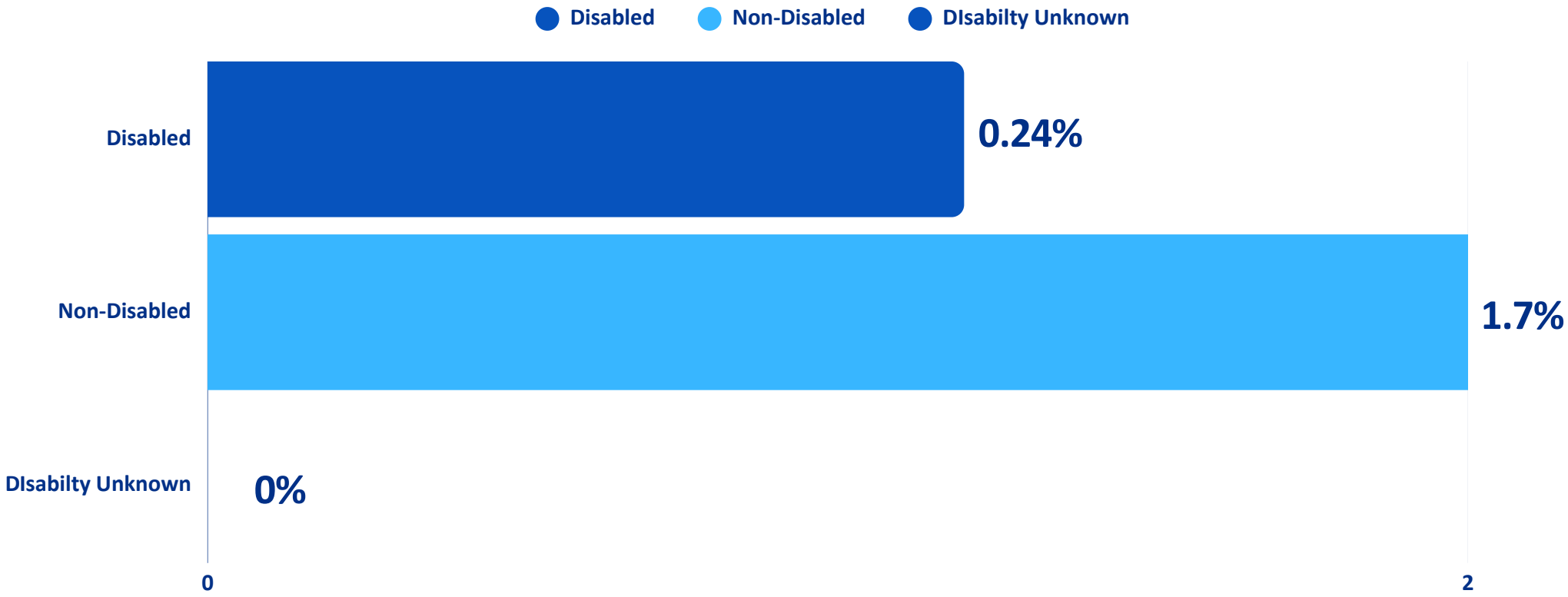


The relative probability of non-disabled staff being appointed from the shortlist, compared to disabled staff, stands at 1.6. This statistic encompasses both external and internal positions. This ratio has declined over the current year. The data collected over the past two years is too limited to provide any meaningful statistical insight.

It is important to highlight that the trust, as part of the Department of Work and Pensions initiative, is recognised as being a Disability Confident Employer and offers a guaranteed interview scheme for disabled applicants who fulfil the minimum person specifications. For all organisations that adopt a guaranteed interview scheme, the data may not be directly comparable to those from organisations that do not have such a program. This information will be recorded on the WDES online reporting form to ensure consistency across organisations.

WDES Indicator 3

Figure 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.



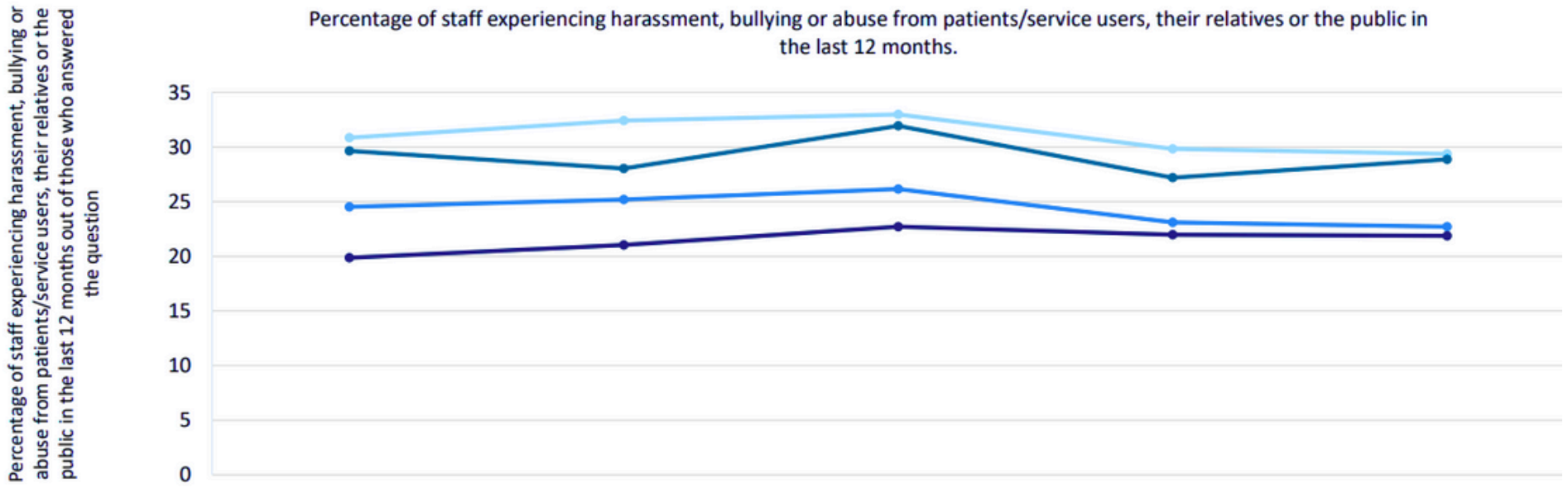
The Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff 5.5. Metric 3 explores the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the number of staff entering the formal capability procedure from a two-year rolling average of the current year and the previous year. This metric applies to capability on the grounds of performance and not ill health.

The bar chart indicates the likelihood of disabled staff compared to non-disabled staff entering the capability process reveals: non-disabled staff are more likely to enter this procedure. It's crucial to note, however, that the overall number of capability cases reported remains very low. This suggests that while there is a relative difference in likelihood between the two groups, the figures are not substantial.

WDES Indicator 4a

Metrics 4a-9 represent unweighted question level responses to key findings in the NHS for NLaG staf and the staff survey results surrounding the disabled workforce in 2024.

Figure 4 : Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



	2020	2021	2022	2023	2024
f with a LTC or illness: Your org	29.64%	28.04%	31.94%	27.20%	28.88%
f without a LTC or illness: Your org	19.86%	21.04%	22.71%	21.97%	21.87%
f with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
f without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
f with a LTC or illness: Responses	506	560	526	818	800
f without a LTC or illness: Responses	1767	1792	1814	2259	2350

Disabled employees face a 7% higher likelihood of encountering harassment, bullying, or abuse from patients, relatives, and the public when compared to their non-disabled counterparts. This marks an increase from the previous year, highlighting a decline in workplace conditions.

WDES Indicator 4b

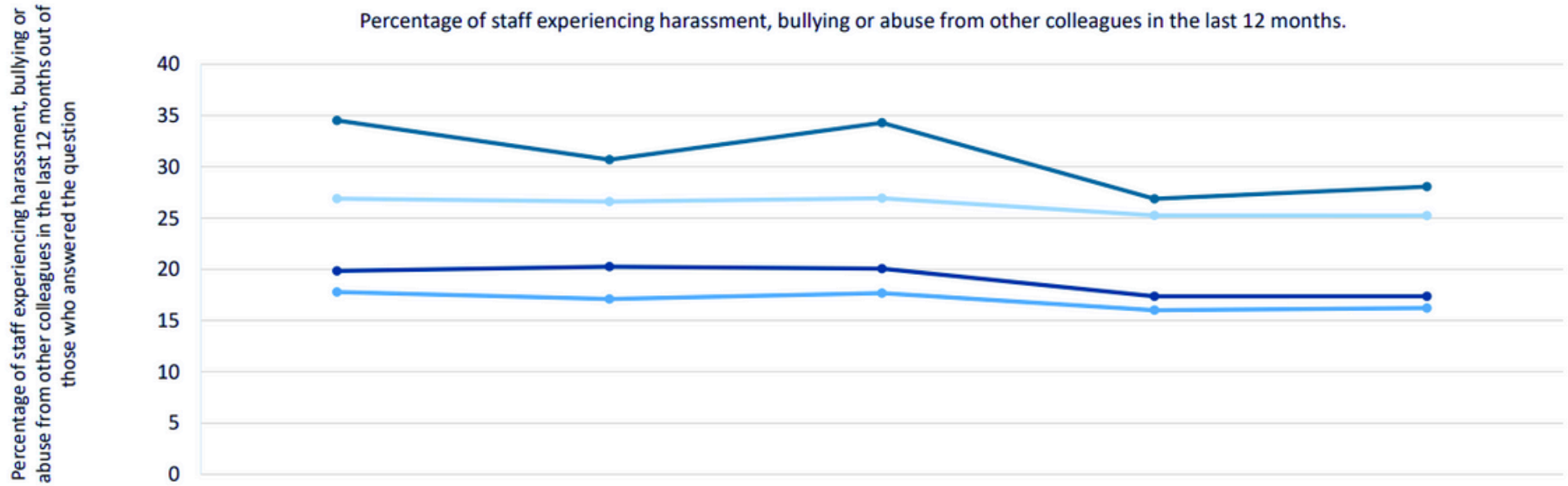
Figure 5 : Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	26.53%	22.48%	20.31%	15.33%	15.13%
Staff without a LTC or illness: Your org	13.11%	11.86%	12.58%	8.35%	8.07%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	505	556	522	811	793
Staff without a LTC or illness: Responses	1769	1779	1797	2234	2318

Disabled employees are 7.1% more likely to experience harassment, bullying, or abuse from their managers compared to their non-disabled peers. This represents an decrease from the previous year, indicating an improvement in workplace conditions.

WDES Indicator 4c

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

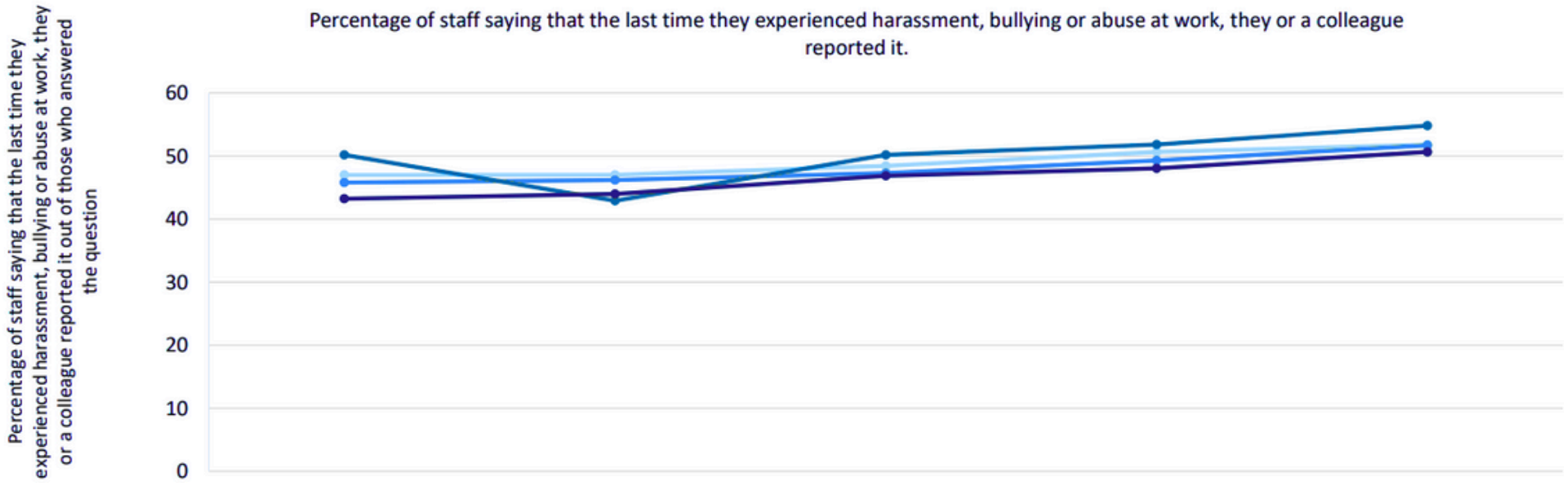


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	34.52%	30.69%	34.30%	26.88%	28.07%
Staff without a LTC or illness: Your org	19.85%	20.26%	20.07%	17.37%	17.37%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	504	554	519	809	791
Staff without a LTC or illness: Responses	1773	1777	1794	2229	2309

Disabled employees are 11% more likely to face harassment, bullying, or abuse from colleagues compared to their non-disabled counterparts.

WDES Indicator 4d

Figure 7 : Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	50.19%	42.91%	50.19%	51.84%	54.82%
Staff without a LTC or illness: Your org	43.23%	43.98%	46.89%	48.05%	50.67%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%
Staff with a LTC or illness: Responses	259	268	257	328	332
Staff without a LTC or illness: Responses	576	573	595	639	675

54.8% of employees with a disability have reported an incident of harassment, bullying, or abuse at work. This reveals that disabled staff members are more inclined to report incidents compared to their non-disabled peers. The Trust has seen an increase over the past three years in indicator 4d regarding reporting incidents, which is encouraging as it suggests people feel more empowered to speak up. This progress aligns well with the introduction of the zero tolerance reporting tool. This emphasises the importance of fostering a workplace culture that encourages reporting, ultimately contributing to a more supportive and inclusive environment.

WDES Indicator 5

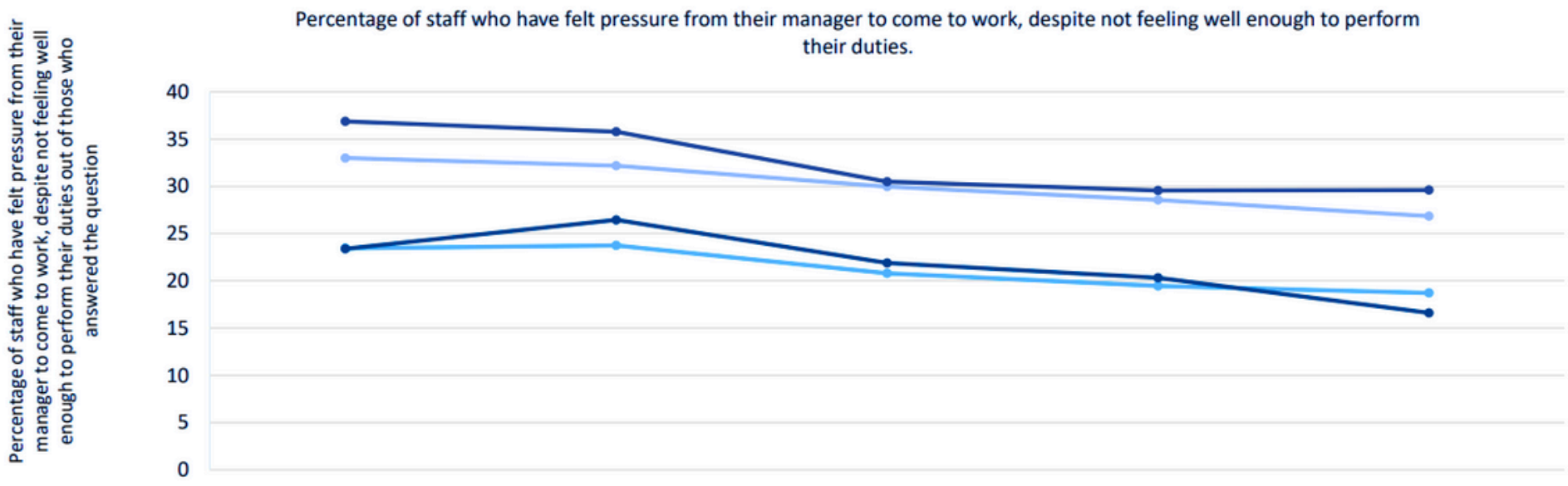
Figure 8 : Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	45.74%	47.25%	43.98%	52.75%	48.81%
Staff without a LTC or illness: Your org	53.32%	53.91%	56.31%	55.33%	54.34%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	505	563	523	874	799
Staff without a LTC or illness: Responses	1806	1816	1806	2514	2337

Less than half of disabled staff who completed the staff survey believe that their trust provides equal opportunities for career progression or promotion. Disabled staff are still 5.5% less likely to believe that the trust provides equal opportunities for career progression or promotion compared to non-disabled staff.

WDES Indicator 6

Figure 9: Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties



	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	36.87%	35.79%	30.48%	29.56%	29.61%
Staff without a LTC or illness: Your org	23.40%	26.45%	21.89%	20.31%	16.61%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%
Staff with a LTC or illness: Responses	339	380	397	636	591
Staff without a LTC or illness: Responses	735	828	964	1221	1204

Disabled staff felt 13% more pressured to attend work than non disabled staff, highlighting a concern in workplace inclusivity and support. This disparity suggests that disabled employees may not be receiving the necessary accommodations or understanding from management, which could impact their overall well-being and job satisfaction.

WDES Indicator 7

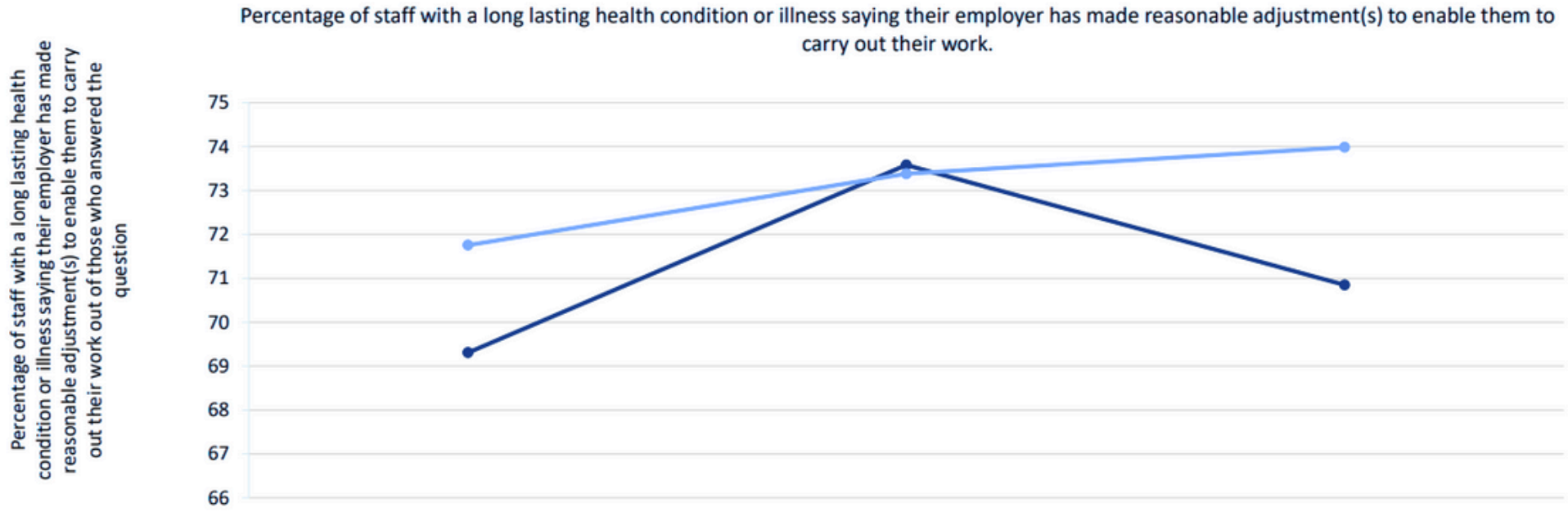
Figure 10: Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work

	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	28.01%	26.71%	28.36%	31.17%	26.99%
Staff without a LTC or illness: Your org	42.31%	36.84%	36.99%	41.36%	36.56%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%
Staff with a LTC or illness: Responses	507	569	529	879	804
Staff without a LTC or illness: Responses	1808	1846	1814	2522	2352

Disabled employees are 9.6% less likely to feel appreciated by the organisation for their workplace contributions. This highlights a gap in workplace inclusivity and recognition.

WDES Indicator 8

Figure 11: Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work

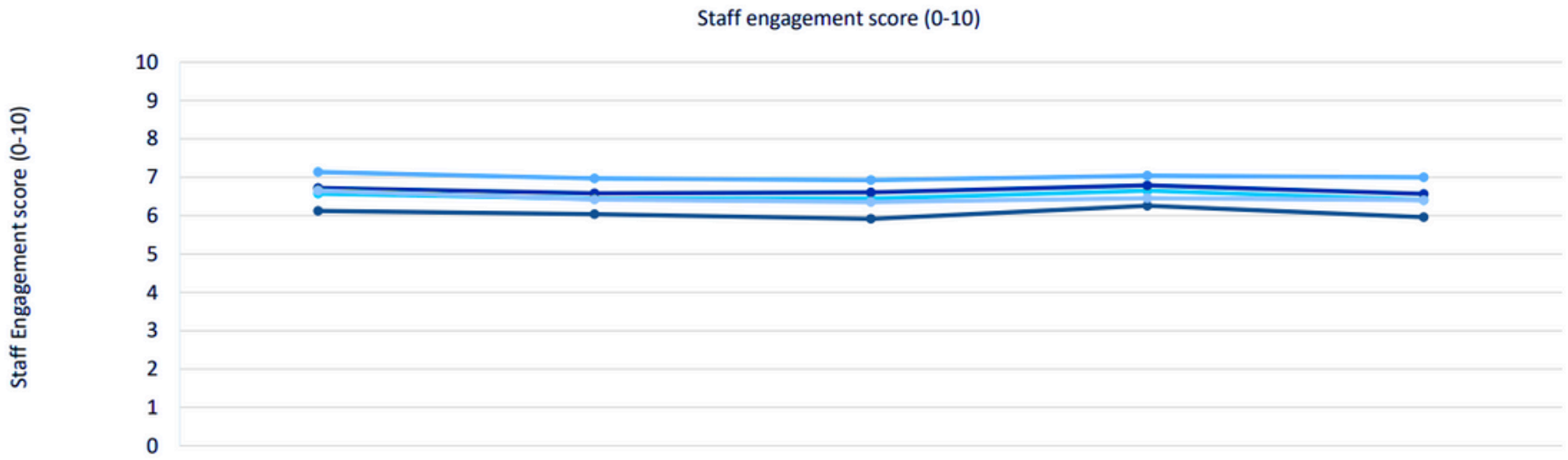


	2022	2023	2024
Staff with a LTC or illness: Your org	69.31%	73.58%	70.85%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%
Staff with a LTC or illness: Responses	303	511	494

In the recent staff survey, 70.9% of disabled employees expressed that the trust has made adequate adjustments to help them perform their duties. This figure reflects a decline compared to 2023/24, indicating a negative trend for disabled employees.

WDES Indicator 9

Figure 12: Staff engagement scores



	2020	2021	2022	2023	2024
Organisation average	6.57	6.44	6.44	6.65	6.41
Staff with a LTC or illness: Your org	6.12	6.04	5.91	6.26	5.96
Staff without a LTC or illness: Your org	6.72	6.58	6.60	6.79	6.57
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	510	573	529	883	805
Staff without a LTC or illness: Responses	1817	1847	1818	2536	2360

The engagement score for employees with disabilities has declined to 5.96, falling below the national average of 6.4 for disabled staff members.

WDES Indicator 10

Disability representation among board members

Figure 13: Total Board Composition

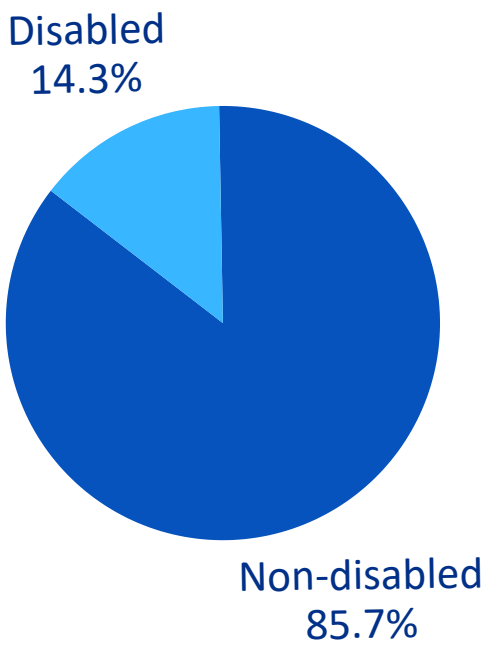


Figure 14: Voting Board Members

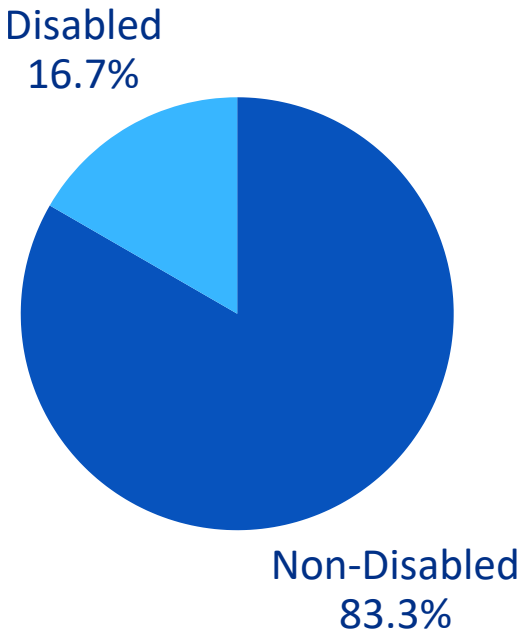
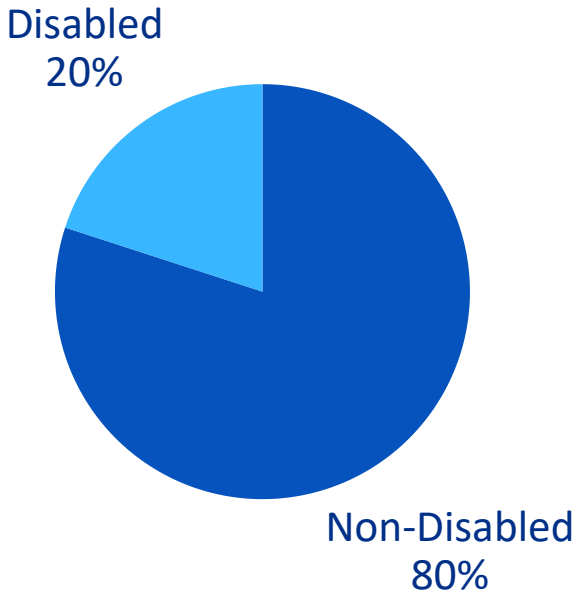


Figure 15: Non-Exec Board members



Northern Lincolnshire and Goole NHS Foundation Trust is part of the NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

The disabled board representation on the South Bank stands at 14.3%.

Progress to Support Disabled Staff

The advancements made in the past year to assist disabled staff within the workforce are outlined below.

1

Launched a Zero Tolerance to Ableism Framework

NLaG have introduced a Zero Tolerance to Ableism Framework and Reporting tool. The tool is playing a significant part assisting how we support equality, to tackle all forms of discrimination and in particular support our disabled staff.

2

Grown the Disability Staff Network & introduced Engagement Sessions

The Disability Staff Network has successfully recruited a Chair and Deputy Chair. These roles were advertised and formally recruit to. Each role has an agreed job description and person specification. The network now benefits from having an executive sponsor. Additionally, the network Chair regularly meets with the Group CEO to help develop and frame Trust policies. This year's disability events included a successful conference and a number of drop-in sessions to celebrate Disability History Month.

3

Reasonable Adjustments

In addition, significant efforts have been made to assist staff who may need reasonable adjustments. NLAG has launched the Reasonable Adjustments for Equity, Accessibility, and Confidence Hub (REACH) to offer a specialised service that advocates for individuals requesting necessary adjustments.

4

Sunflower Lanyard Scheme

The chair of the Huth Disability staff network has successfully implemented the Sunflower Lanyard scheme throughout Huth and has collaborated with the NLAG staff network to extend its reach across the group.

5

Governance

An Equality, Diversity, and Inclusion Steering Group has been established, with an executive director serving as the chair. This group is empowered to challenge and provide assurance to the Trust Board regarding our compliance with equality obligations.

6

Education and Development

New employees will receive face-to-face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination and equip leaders to have open and honest conversations with their staff.

Action Plan

Although this year's national WDES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of disabled employees within the trust. To address this, an Action Plan has been created based on the 24/25 WDES technical data results, aimed at bridging the gap in workplace experiences between disabled and non-disabled staff.

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
1. Embed the Zero Tolerance to Ableism framework • Ensure staff are aware of this framework • Establish links with the staff network • Ensure that the term Ableism is communicated and fully understood throughout the Group	3, 4a, 4b, 8, 9a, 9b EDS 2022 2B	Ongoing	EDI Team
2. Develop and Grow the Disability Staff Network • Develop a full engagement plan in partnership with the EDI team • Ensure appropriate governance arrangements are in place.	All EDS 2022 2B	September 2025/Ongoing	EDI Team

Action Plan

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
3. Introduce an Inclusive Recruitment Project Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	1a, 1b, 2 EDS 2022 2D, 3	February 2026/Ongoing	EDI Team, Recruitment

Action Plan

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
4. Embed the Reasonable Adjustments for Equity, Accessibility and Confidence Hub (REACH). • Raise the profile of Access to Work and support staff to apply and make the application for adjustments via Access to Work simpler and explore the feasibility of introducing a centralised process • Explore using reasonable adjustment case studies. • Enable and promote Line Managers to introduce simple adjustments quickly. • Explore with HR how adjustments in relation to disability related leave and absence can be incorporated into HR processes • Introduce a “Disability Passport” for colleagues across the Trust.	6, 7, 8, 9a EDS 2022 2A	December 25/Ongoing	EDI Team, HR
5. Supporting staff who are Neuro Divergent • Through the staff network provide support to this group of staff. • Explore various support interventions. • As part of EDI training make managers aware of neuro divergence. • Explore reasonable adjustments and how they better support neuro divergent staff.	All EDS 2022 2A, 2B, 2C	April 2025/Ongoing	EDI Team, Disability Staff Network

Appendix

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	0 *	0 %	1 *	100 %	0 *	0 %	1
Band 2	75 *	6.3 %	1044 *	87.4 %	76 *	6.4 %	1195
Band 3	24 *	5.1 %	417 *	88 %	33 *	7 %	474
Band 4	10 *	5.4 %	168 *	91.3 %	6 *	3.3 %	184
Band 5	11 *	6.6 %	151 *	91 %	4 *	2.4 %	166
Band 6	6 *	8.1 %	65 *	87.8 %	3 *	4.1 %	74
Band 7	5 *	6 %	75 *	90.4 %	3 *	3.6 %	83
Band 8a	2 *	6.3 %	29 *	90.6 %	1 *	3.1 %	32
Band 8b	6 *	19.4 %	25 *	80.6 %	0 *	0 %	31
Band 8c	1 *	5.9 %	16 *	94.1 %	0 *	0 %	17
Band 8d	0 *	0 %	11 *	100 %	0 *	0 %	11
Band 9	0 *	0 %	1 *	100 %	0 *	0 %	1
VSM	1 *	8.3 %	11 *	91.7 %	0 *	0 %	12
Other e.g. Agency and/or any other groups, please specify	0 *	%	0 *	%	0 *	%	0

Total non-clinical

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	109	5.9 %	1630	87.9 %	115	6.2 %	1854
AfC Bands 5, 6 and 7	22	6.8 %	291	90.1 %	10	3.1 %	323
AfC Bands 8a and 8b	8	12.7 %	54	85.7 %	1	1.6 %	63
AfC Bands 8c, 8d, 9 and VSM	2	4.9 %	39	95.1 %	0	0 %	41
	141	6.2 %	2014	88.3 %	126	5.5 %	2281

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	0 %	1 *	50 %	1 *	50 %	2
Band 1	0 *	0 %	0 *	0 %	1 *	100 %	1
Band 2	62 *	6.4 %	842 *	87.2 %	62 *	6.4 %	966
Band 3	36 *	6.5 %	484 *	87.2 %	35 *	6.3 %	555
Band 4	13 *	7.1 %	161 *	88.5 %	8 *	4.4 %	182
Band 5	89 *	5.8 %	1365 *	88.5 %	88 *	5.7 %	1542
Band 6	44 *	5.2 %	747 *	88.6 %	52 *	6.2 %	843
Band 7	25 *	4.8 %	468 *	89.7 %	29 *	5.6 %	522
Band 8a	3 *	2.5 %	116 *	95.9 %	2 *	1.7 %	121
Band 8b	1 *	4.2 %	20 *	83.3 %	3 *	12.5 %	24
Band 8c	0 *	0 %	12 *	100 %	0 *	0 %	12
Band 8d	0 *	0 %	3 *	100 %	0 *	0 %	3
Band 9	0 *	0 %	4 *	100 %	0 *	0 %	4
VSM	0 *	0 %	11 *	91.7 %	1 *	8.3 %	12
Other e.g. Agency and/or any other groups, please specify	0 *	%	0 *	%	0 *	%	0

Notes

Medical & Dental Staff, Consultants	2 *	0.9 %	210 *	89.7 %	22 *	9.4 %	234
Medical & Dental Staff, Non-Consultants career grade	2 *	1.2 %	154 *	92.2 %	11 *	6.6 %	167
Medical & Dental Staff, trainee grades	5 *	1.3 %	373 *	94 %	19 *	4.8 %	397
Total clinical	273	5.7 %	4234	88.4 %	282	5.9 %	4789
Total medical & dental	9	1.1 %	737	92.4 %	52	6.5 %	798
Total clinical & non-clinical	423	5.4 %	6985	88.8 %	460	5.8 %	7868

Clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	111	6.5 %	1488	87.2 %	107	6.3 %	1706
AfC Bands 5, 6 and 7	158	5.4 %	2580	88.8 %	169	5.8 %	2907
AfC Bands 8a and 8b	4	2.8 %	136	93.8 %	5	3.4 %	145
AfC Bands 8c, 8d, 9 and VSM	0	0 %	30	96.8 %	1	3.2 %	31

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. Note:
i) This refers to both external and internal posts.
ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	728 *	3971 *	414 *
Number appointed from shortlisting	41 *	520 *	309 *
Likelihood of shortlisting/appointed	0.06	0.09	0.75

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts: 1.58

Notes

We have seen an increase in applications therefore, this has resulted in double the number of shortlisted applicants. Particularly an increase in overseas applications.

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	423	6985	460
Average number of staff entering the formal capability process for any reason	1 *	3 *	0 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process	0.002364	0.000429	0.000000

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff: 5.510490

Notes

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts: 1.58

Notes

We have seen an increase in applications therefore, this has resulted in double the number of shortlisted applicants. Particularly an increase in overseas applications.

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	423	6985	460
Average number of staff entering the formal capability process for any reason	1 *	3 *	0 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process	0.002364	0.000429	0.000000

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff: 5.510490

Notes

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

* Yes
* No

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

Staff Disability Network
Introduced a Zero Tolerance framework

Notes

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2023.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	1 *	5 *	0 *	7
How many are voting members?	1 *	5 *	0 *	6
Number of non-voting members	0	1	0	1
How many are Exec Board members?	0 *	2 *	0 *	2
Number of non-exec members	1	4	0	5
Number of staff in overall workforce (from Metric 1)	423	5985	460	7868
Total Board members - % by Disability	14.29 %	85.71 %	0 %	
Voting Board members - % by Disability	16.67 %	83.33 %	0 %	
Non-Voting Board Member - % by Disability	0 %	100 %	0 %	
Executive Board Member - % by Disability	0 %	100 %	0 %	
Non-Executive Board Member - % by Disability	20 %	80 %	0 %	
Overall workforce - % by Disability	5.38 %	88.78 %	5.85 %	
Difference % (Total Board - Overall workforce)	8.91 %	-3.07 %	-5.85 %	
Difference % (Voting membership - Overall Workforce)	11.29 %	-5.45 %	-5.85 %	
Difference % (Executive membership - Overall Workforce)	-5.38 %	11.22 %	-5.85 %	

Notes

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)186

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Lucy Vere, Group Director of Learning & Organisational Development Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing & Improvement
Title of Report	**Workforce Race Equality Standard (WRES)**
Executive Summary	The purpose of this report is to update the Trust Board on progress against the Workforce Race Equality Standard (WRES) Indicators, and: • To update on the trust submission and information as per trust contractual requirements. • To highlight key priorities and actions required during 2024/25, to make improvements against the WRES. A summary is provided in the Appendix of this report. Committee members are asked to: • To note the contents of this report against the NHS Workforce Race Equality Standard. • Approve the data content which we are required to share with NHS England and our commissioners. • To note the actions proposed for 24/25 and to monitor progress of those actions and wider culture transformation programme through the Committee.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce Race Equality Standard (WRES) was introduced by the NHS Equality and Diversity Council (EDC) and forms part of the standard NHS contract. From April 2016, it has also formed part of the inspection framework under the "Well Led" domain.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	As outlined in the report
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review

	☐ Assurance	☐ Other – please detail below:

Workforce Race Equality Standards 24/25

NHS Humber Health Partnership
Hull University Teaching Hospitals NHS Trust

Planning, Recruitment, Wellbeing and Improvement

Workforce Intelligence

nlg-tr.twworkforcedatareqs@nhs.net

Introduction

The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).

The WRES seeks to prompt enquiry to better understand why BAME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BAME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BAME staff in the NHS.

The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator. The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

The BAME Staff within the organisation have remained fairly static.

The composition of Medical and Dental Workforce that is BAME stands at 54.5%

White staff are 1.75 x as likely to be appointed once they have reached the shortlisting stage compared to BAME staff

BAME Staff are less likely to enter the formal disciplinary process

BAME Staff experiencing bullying from other staff has increase by 3.1% this year

BAME Staff experiencing discrimination at work has increased by 1.3% in year

In last 12 months, BAME staff report a 8.0% higher negative experience than white colleagues in relation to harassment, bullying or abuse from patients, relatives or the public

BAME Staff are more likely to access non-mandatory training and CPD than White Staff

The percentage of BAME Staff in Bands 8-9 and VSM compared to total staff in these bands is 6.6%

The staff survey results are much more negative than previous years. This may be impacted by the timing of the Survey which was immediately after the Hull Riots

51.4% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion

6.4% of non-clinical staff are BAME

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	Wres 24/25 Performance Comparison and Summary	23/24	24/25
1	Percentage of BAME staff in NHS trusts by ethnicity	21.0%	21.1%
2	The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	1.19	1.75
3	The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	0.82	0.71
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff	0.96	0.88
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	30.4%	32.1%
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	28.5%	31.8%
7	Percentage of BAME staff believing that their trust provides equal opportunities for career progression or promotion	54.1%	51.4%
8	Percentage of BAME staff experiencing discrimination at work from other staff in the last 12 months	17.7%	19.1%
9	Percentage difference of BAME representation between Board Membership and overall workforce	-10%	-15.3%

WRES Indicator 1

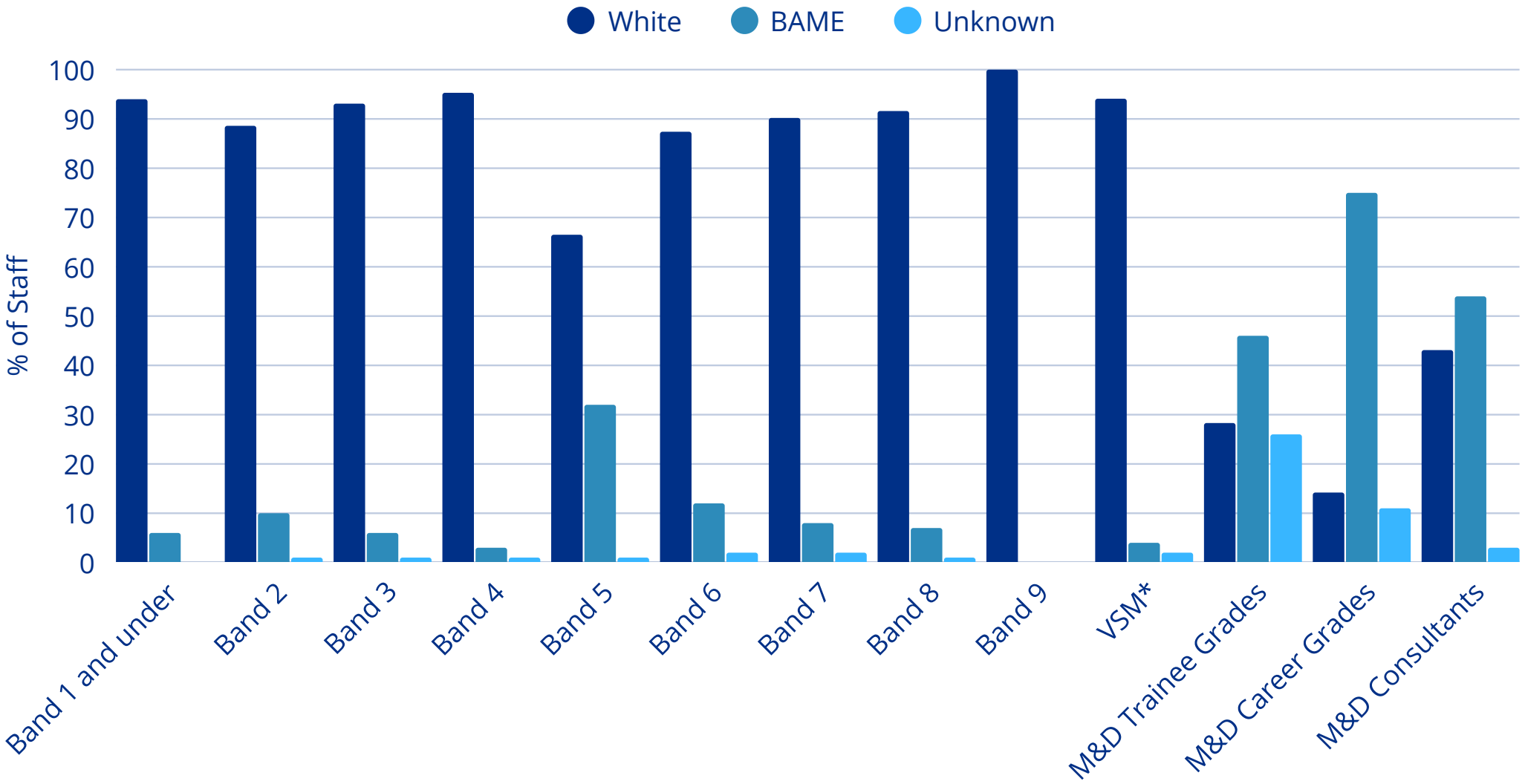
Table 1: Ethnic Composition of HUTH Staff

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff	Composition of Medical and Dental Staff
BAME	21.1%	26.2%	6.4%	53.2%
White	76.0%	70.1%	92.7%	32.2%
Not Stated	2.9%	3.7%	0.9%	14.6%

The complement of our BAME staff has remained relatively static year on year with an increase in 'not-stated' ethnicity. There has been a slight increase in non-clinical BAME staff.

WRES Indicator 1

Figure 1: Proportional Ethnic Composition of HUTH Staff



There is a significant percentage of 'unknown' ethnicity within trainee grades. This needs to be worked on to show a fuller picture.

*VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)

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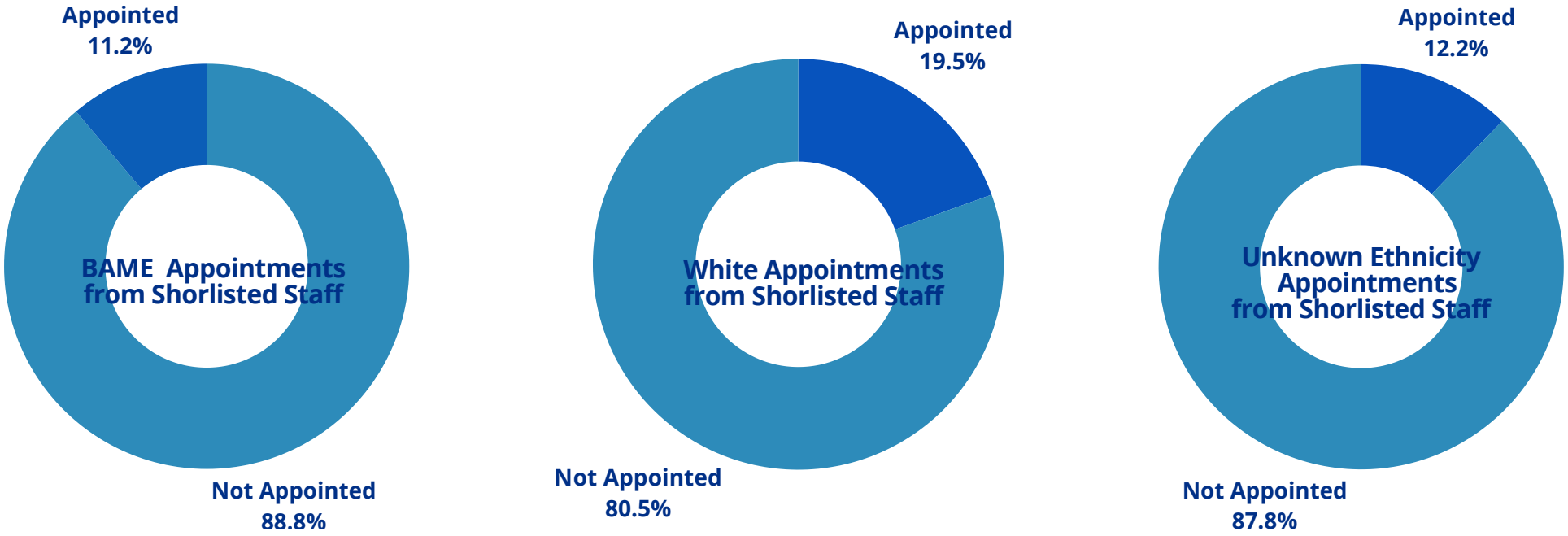
WRES Indicator 2

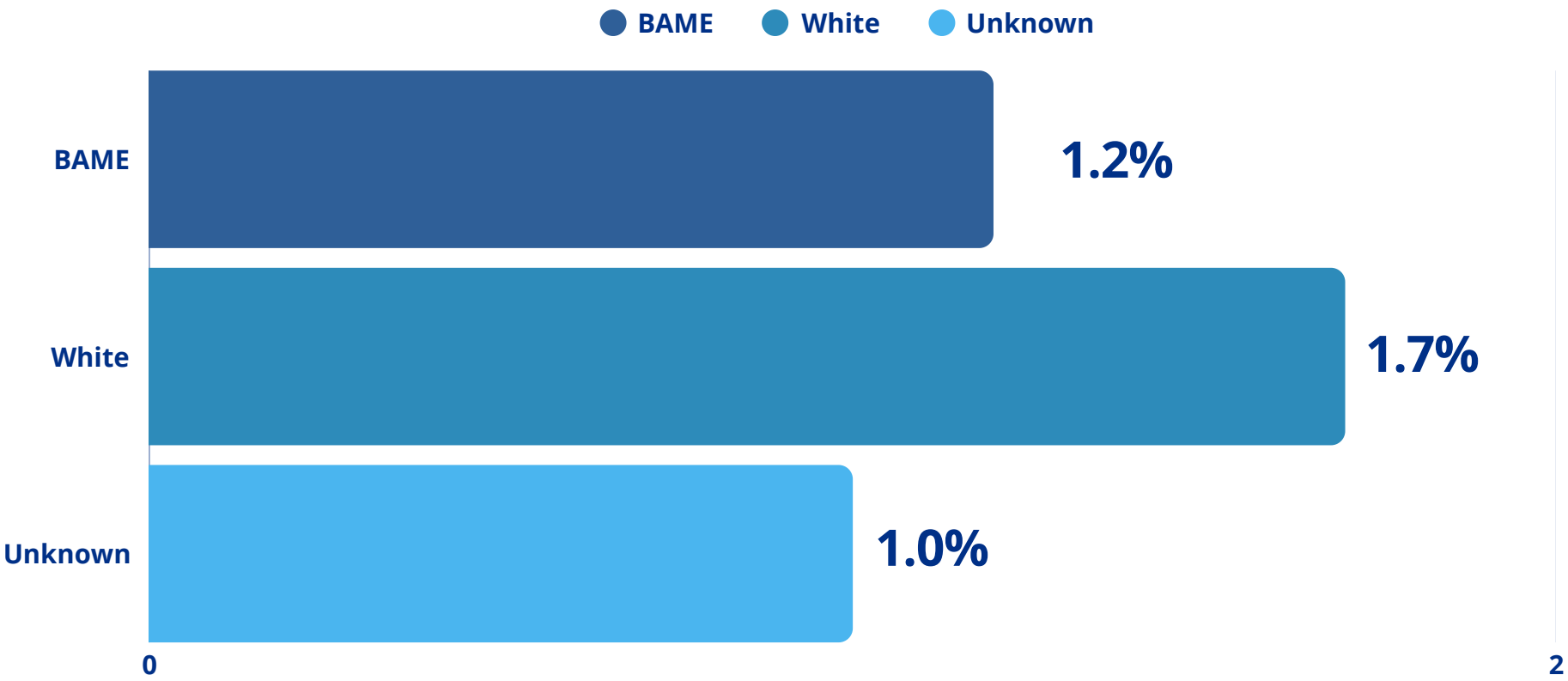
Figure 2: Appointment from Shortlisting for all staff groups



This indicator has a noteable negative increase, though some of that may be due to the sheer number of BAME staff shortlisted which nearly doubled in the year.

WRES Indicator 3

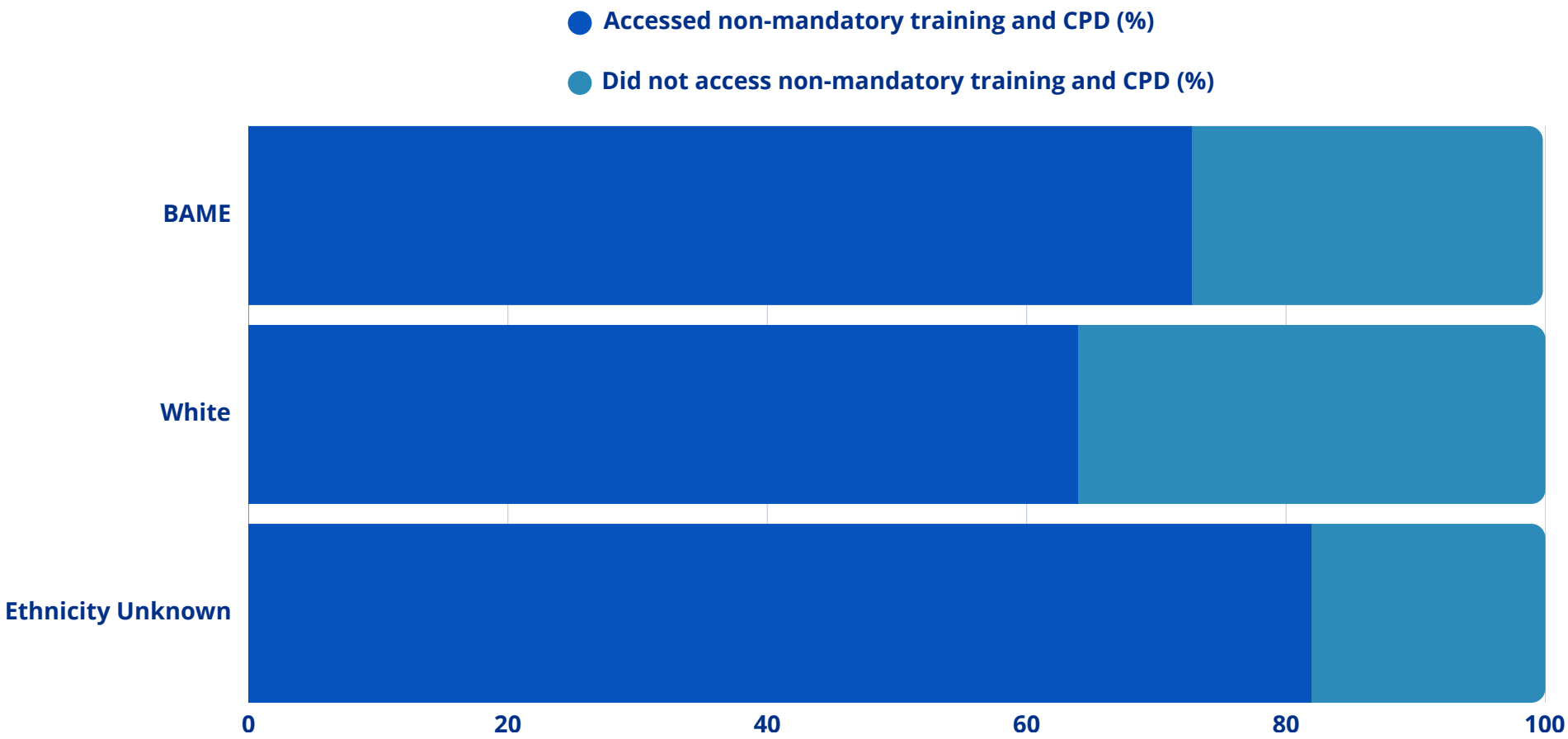
Figure 3: Likelihood of Staff entering formal disciplinary procedure



The relative likelihood of BAME staff entering the formal disciplinary process compared to White staff is 0.71. This is an improvement on last year's information. This is getting back towards historical information of BAME staff being less likely to go through formal disciplinary process.

WRES Indicator 4

Figure 4: Likelihood of Staff accessing non-mandatory training and CPD



The relative likelihood of White Staff accessing non-mandatory training and CPD is 0.88 this is an improvement on last year's position however the Ethnicity unknown staff have a higher access rate.
This metric should reflect the offering of personal development and whilst it is a positive it doesn't appear to reflect through to development of BAME staff within the organisation.

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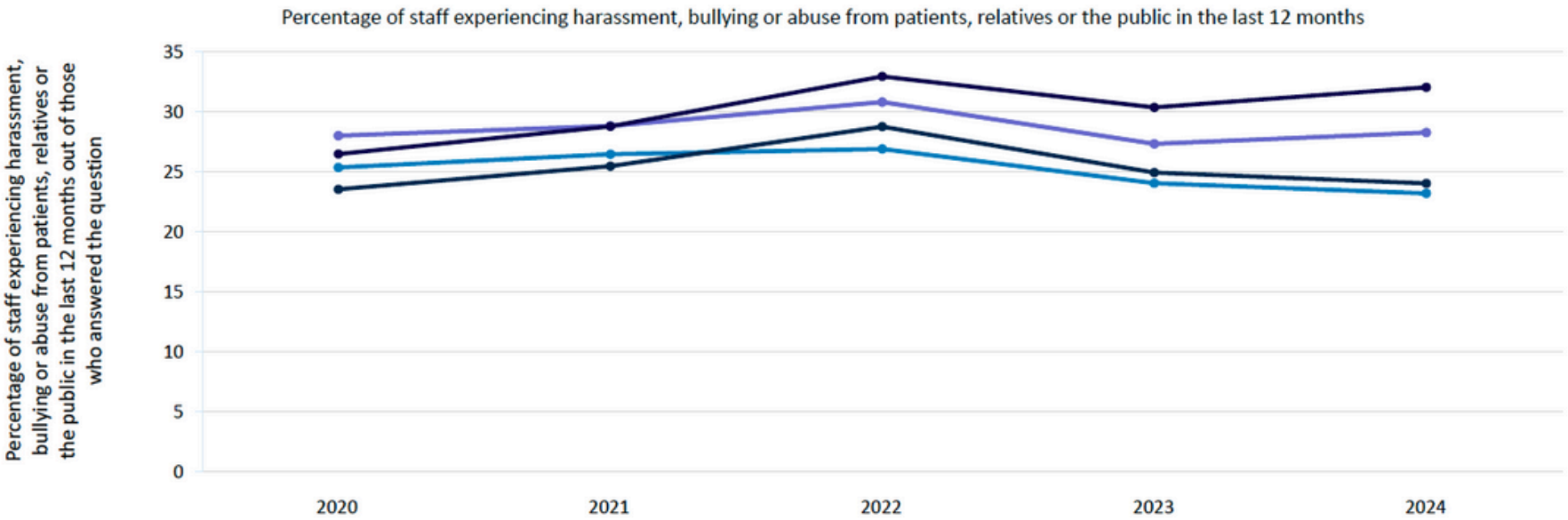
WRES Indicator 5

Figure 5 : Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	23.55%	25.47%	28.77%	24.93%	24.04%
All other ethnic groups*: Your org	26.49%	28.79%	32.95%	30.37%	32.06%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%

Unsurprisingly this indicator deteriorated in 2024 given the proximity of the Staff Survey to the Hull Riot and the negative impact this had on staff.

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WRES Indicator 6

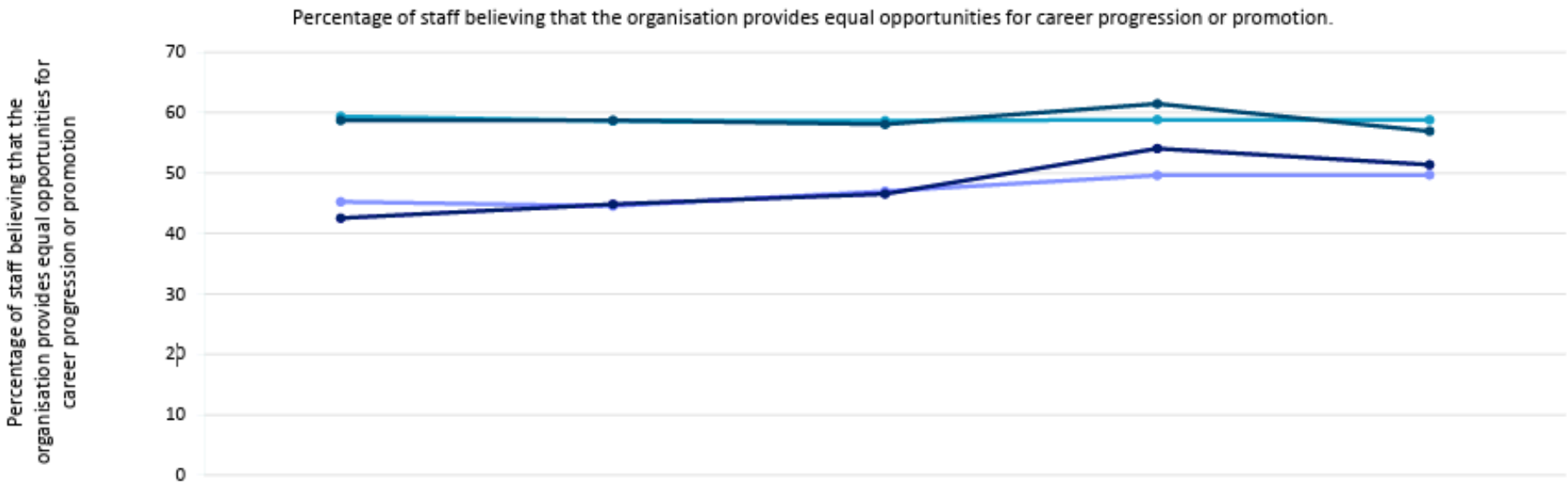
Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	2020	2021	2022	2023	2024
White staff: Your org	26.81%	26.04%	26.47%	22.55%	22.20%
All other ethnic groups*: Your org	34.14%	31.28%	35.61%	28.47%	31.78%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%

This fell back for BAME staff only in 2024 but the root of this is likely to be the August riot in Hull and the percieved reactions of some White colleagues.

WRES Indicator 7

Figure 7 : Percentage of staff believing that their trust provides equal opportunities for career progression or promotions



	2020	2021	2022	2023	2024
White staff: Your org	58.73%	58.72%	58.06%	61.47%	56.92%
All other ethnic groups*: Your org	42.54%	44.85%	46.55%	54.06%	51.37%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%

This metric saw a significant improvement in 2023 and has fallen back in 2024 but not as much as that of White staff.

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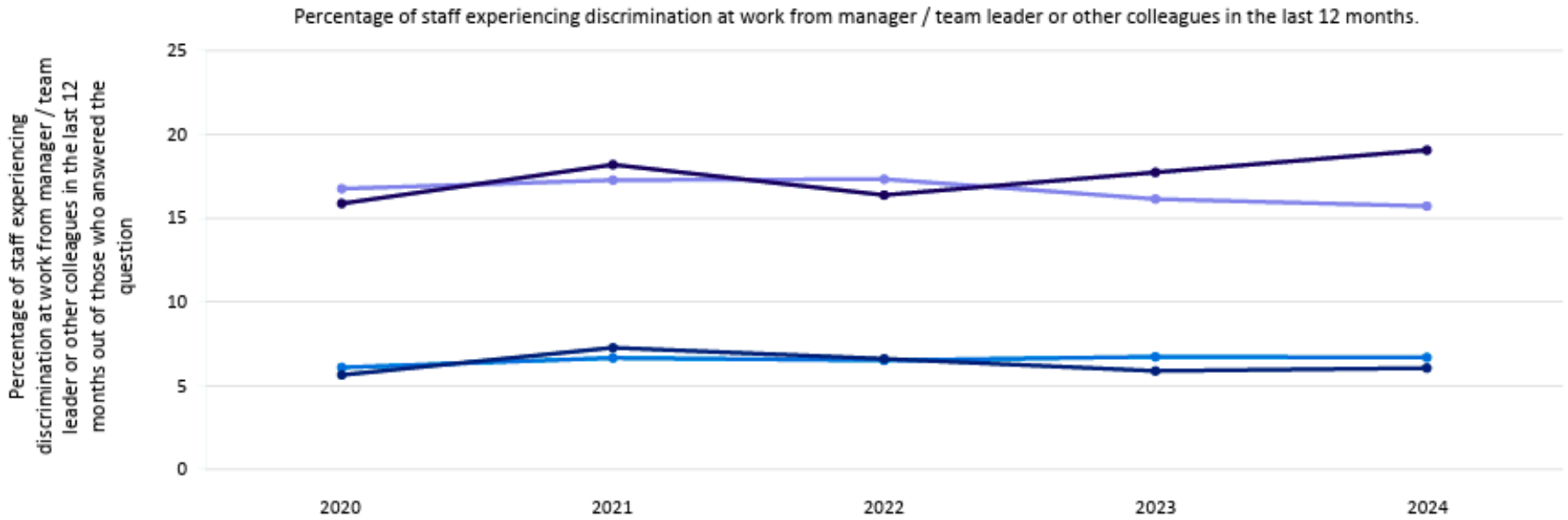
WRES Indicator 8

Figure 8 : Percentage of staff experiencing discrimination at work from other staff in the last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	5.65%	7.27%	6.61%	5.89%	6.05%
All other ethnic groups*: Your org	15.88%	18.20%	16.38%	17.74%	19.07%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%

There needs to be some focus on this metric in the upcoming year

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WRES Indicator 9

Figure 9: Total Board Composition

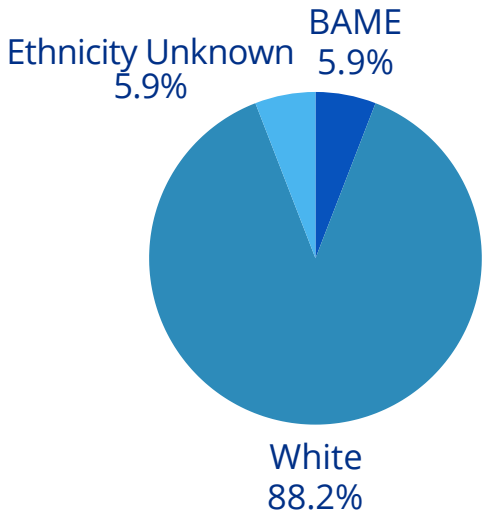


Figure 10: Voting Board Members

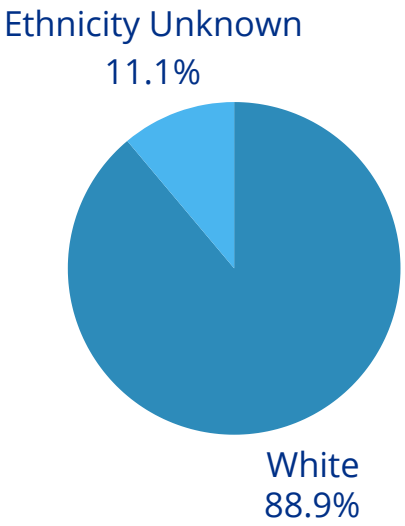
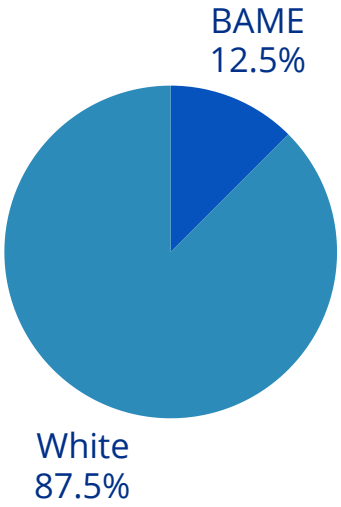


Figure 11: Non-Exec Board members



The BAME representation at board level has is nor reflective of the proportion of BAME staff we have in the organisation. Of the Voting Board members we are currently showing no BAME representation.

Huth is part of NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

There has been a negative impact since last year's report - BAME representation at Board level is down to one individual.

Progress to date to Support BAME Staff

The advancements made in the past year to assist BAME staff within the workforce are outlined below.

1

Continue to ember the Zero Tolerance to Racism Framework

This has now become a groupwide framework and Reporting tool. This tool is playing a significant part to assist in creating an anti-racism stance, to tackle all forms of racism and in particular support our Black, Asian and Minority Ethnic (BAME) staff.

2

Continued support for Internationally Educated Staff

We have and are continuing to support our International Educated Staff and have an established a Stay and Thrive group which drives this agenda. Some of the positive steps we have taken to support our internationally educated staff includes; a staff survey to help understand their needs, developing career conversations to support retention and progression, a focus on community out-reach to encourage putting down roots and working with community partners such as Health Gospel. This work has received national recognition through the Health Service Journal awards where we are currently a finalist.

3

Developed and Grown the BAME Staff Network

The BAME Staff Network has successfully recruited a Chair and Deputy Chair. These roles were advertised and formally recruited to, and they each have an agreed job descriptions and person specifications. This network now also benefits from having an executive sponsor.

4

Engagement Events

This year BAME events included a successful conference and various drop-in session to celebrate black history month.

5

Governance

An Equality, Diversity, and Inclusion Steering Group has been formed which is chaired by an executive director. This group is able to challenge and give the Trust Board assurance in terms of meeting our equality duties. In addition the network Chair regularly meets with the Group CEO to help for development and to help frame Trust policies.

6

Education and Development

All new staff receive face to face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a managers leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination, and equip leaders to have open and honest conversations with their staff.
A cohort of the WithStand programme in collaboration with BRAP successfully concluded the course.

The new appraisal system has been introduced and will be able to allow the cascading of Equality objectives

Action Plan

Although this year's national WRES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of BAME employees within the trust. To address this, an Action Plan has been created based on the 24/25 WRES technical data results, aimed at bridging the gap in workplace experiences between BAME and White staff. A comprehensive workplan accompanies the Action Plan.

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
1. Continue to develop the Zero Tolerance to Racism Framework and Reporting tool • Support the Trust to tackle all forms of racism • Support our BAME Staff	Indicators 5, 6, 8 EDS 2022 2B	2025/26 Ongoing	EDI Team
2. Develop and Grow the BAME Staff Network • Develop a full engagement plan in partnership with the EDI team • Ensure appropriate governance arrangements are in place.	All EDS 2022 2B	September 2025/Ongoing	EDI Team

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
3. Support Internationally Educated Staff • Engage with the NHSE Step Up programme (Start to Elevate your Professional Career) for our Nursing & AHP colleagues • NHSE initiative started in South West now being rolled out nationally	Indicators 1, 2, 7 EDS 2022 2B, 2C	Ongoing	EDI Team / Nursing
4. Introduce an Inclusive Recruitment Project & Toolkit Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	Indicator 2, 7 EDS 2022 2D	March 26/Ongoing	EDI Team/Recruitment

Your paragraph text

Appendix

Please exclude all NHS held bank worker data from your submission. Bank workers are defined as workers who in your organisation work solely on a zero hour/'bank only' contract.

Guidance and additional information can be viewed here: Guidance (Link:)and Additional Information (Link:)

- Our information governance notice can be viewed here: Information Governance Notice (Link:)
- Web form technical support queries and queries about your account and password should be sent to: Data Collections Framework (DCF) - Customer Support (Link:)
- Requests for additional users to access the web form should be sent to: england.wres@nhs.net (Link:)
- Any queries about how to populate this data collection should be sent to: england.wres@nhs.net (Link:)

Indicator 1a - Non-Clinical Workforce

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Under Band 1				6	0	0	Have included apprentice grades
Band 1				14	1	0	
Band 2				990	98	11	
Band 3				596	38	2	
Band 4				267	7	1	
Band 5				195	9	0	
Band 6				126	6	1	
Band 7				90	6	5	
Band 8A				56	4	2	
Band 8B				48	2	0	
Band 8C				17	0	0	
Band 8D				10	0	0	
Band 9				2	0	0	
VSM				23	1	0	have included other board level staff in this

Indicator 1b - Clinical Workforce

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Under Band 1				33 *	1 *	0 *	Have included apprentice level staff
Band 1				1 *	0 *	0 *	
Band 2				958 *	126 *	14 *	
Band 3				420 *	37 *	5 *	
Band 4				180 *	11 *	5 *	
Band 5				1361 *	760 *	19 *	
Band 6				950 *	150 *	11 *	
Band 7				632 *	59 *	7 *	
Band 8A				189 *	22 *	3 *	
Band 8B				54 *	1 *	0 *	
Band 8C				16 *	1 *	0 *	
Band 8D				2 *	0 *	0 *	
Band 9				2 *	0 *	0 *	
VSM				15 *	0 *	0 *	

Indicator 1 – Medical and Dental Consultants

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Medical & Dental Consultants				236 *	279 *	16 *	
Of which Senior Medical Manager				9 *	1 *	0 *	
Non-consultant career grade				20 *	66 *	10 *	
Trainee Grades				199 *	454 *	186 *	
Other				0 *	0 *	0 *	

Indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Number of Shortlisted Applicants				5112 *	3515 *	98 *	
Number Appointed from Shortlisting				997 *	392 *	12 *	
Relative likelihood of appointment from shortlisting	%	%	%	1! %	1! %	1: %	
Relative likelihood of White staff being appointed from shortlisting compared to BME staff				1,75			

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on yearend data.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Number of staff in workforce				7708	2139	298	
Number of staff entering the formal disciplinary process				132 *	26 *	3 *	
Likelihood of staff entering the formal disciplinary process	%	%	%	1 %	1 %	1 %	
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff					0.71		

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Number of staff in workforce				7708	2139	298	
Number of staff accessing non-mandatory training and CPD				4950 *	1558 *	244 *	
Likelihood of staff accessing non-mandatory training and CPD	%	%	%	6 %	7 %	8 %	
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff				0.88			

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

Note: Only voting members of the Board should be included when considering this indicator.

	Last Year			This Year			
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null	Comments
Total Board members				15 *	1 *	1 *	
of which: Voting Board members				8 *	0 *	1 *	
Non-voting Board members				7	1	0	
Exec Board members				8 *	0 *	1 *	
Non-exec Board members				7	1	0	
Number of staff in workforce				7708	2139	298	
Total Board Members - % by Ethnicity	%	%	%	8 %	5 %	5 %	
Voting Board Members - % by Ethnicity	%	%	%	8 %	0 %	1 %	
Non-voting Board Members - % by Ethnicity	%	%	%	8 %	1 %	0 %	
Executive Board Members - % by Ethnicity	%	%	%	8 %	0 %	1 %	
Non-executive Board Members - % by Ethnicity	%	%	%	8 %	1 %	0 %	
Overall Workforce - % by Ethnicity	%	%	%	7 %	2 %	2 %	
Difference (Total board - Overall workforce)	%	%	%	1 %	-' %	3 %	

Workforce Race Equality Standards 24/25

NHS Humber Health Partnership
Northern Lincolnshire and Goole NHS Foundation Trust

Humber Health Partnership

Planning, Recruitment, Wellbeing and Improvement

Workforce Intelligence
nlg-tr.twworkforcedatareqs@nhs.net

Introduction

The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).

The WRES seeks to prompt enquiry to better understand why BAME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BAME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BAME staff in the NHS.

The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator. The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

The increase in BAME representation in-year is largely due to an increase in BAME staff within the clinical workforce

The composition of Medical and Dental Workforce that is BAME stands at 74.2%

White staff are twice as likely to be appointed once they have reached the shortlisting stage compared to BAME staff

BAME staff are 1.83 times more likely to enter a formal disciplinary process compared to white staff. Although this has improved slightly since last year

The Trust Board BAME representation has increased in-year from 11.2% in 2024 to 14.3% in 2025

The percentage of BAME Staff in Bands 8-9 and VSM is 8.6%, an improvement on last year

In the last 12 months, BAME staff report a 12.3% higher negative experience than white colleagues in relation to harassment, bullying or abuse from patients, relatives or the public

White and BAME staff have equal opportunities to engage in non-mandatory training and CPD

The percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months is 31.2%

The percentage of BAME Staff in the overall workforce stands at 18.4%

46.3% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion

The composition of Non Clinical Staff that are BAME stands at 3.2%

	WRES 24/25 Performance Comparison and Summary	23/24	24/25
1	Percentage of BAME staff in NHS trust by ethnicity	17.9%	18.4%
2	The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	1.83	2.04
3	The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.91	1.83
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff	1.01	1
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31.4%	34.1%
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	31.4%	31.2%
7	Percentage of BAME staff believing that their trust provides equal opportunities for career progression or promotion	45.8%	46.3%
8	Percentage of BAME staff experiencing discrimination at work from other staff in the last 12 months	21.9%	21.8%
9	Percentage difference between Board Membership and overall workforce	-6.7%	-4%

WRES Indicator 1

Table 1: Ethnic Composition of NLAG Staff

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff	Composition of Medical and Dental Staff
BAME	18.4%	24.6%	3.2%	74.2%
White	79.2%	72.7%	95.1%	18.9%
Not Stated	2.5%	2.8%	1.7%	6.9%

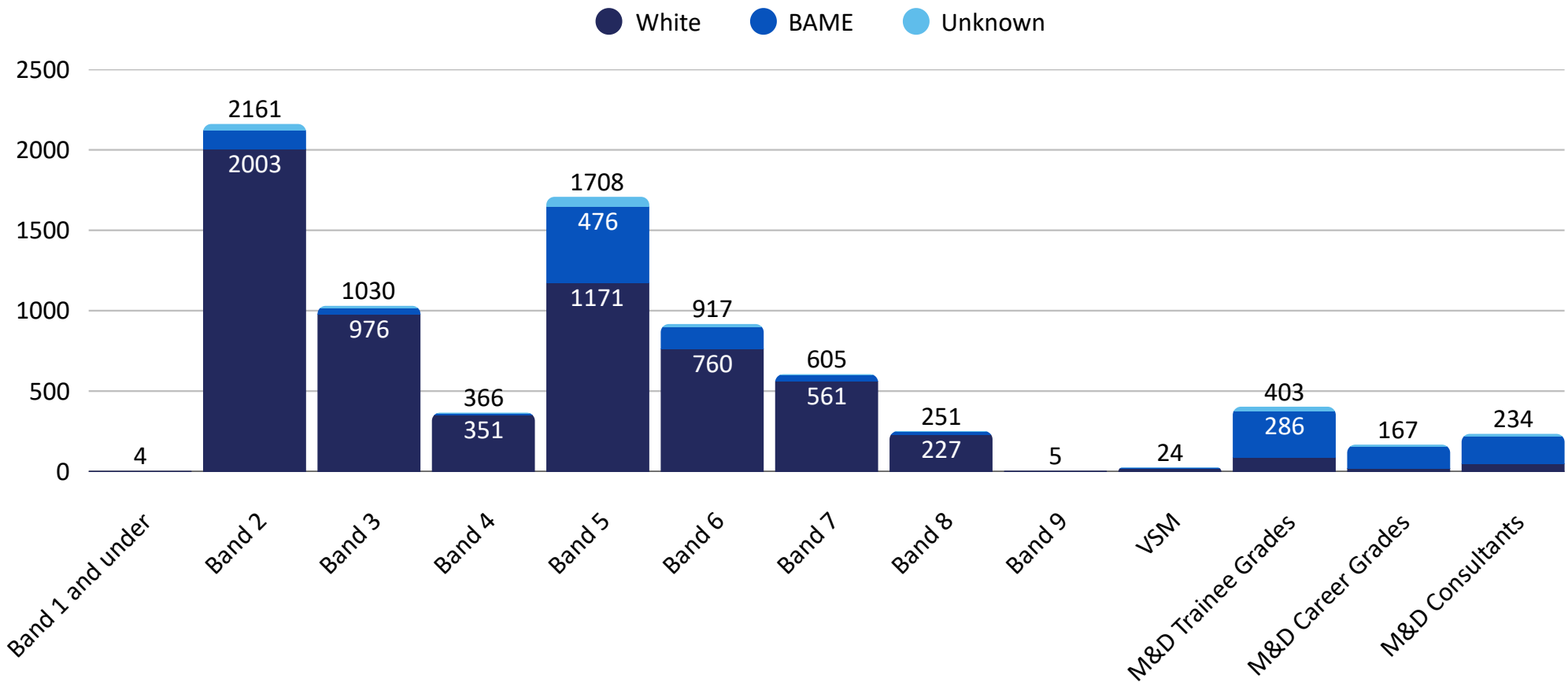
As shown above, BAME staff are more prevelant in the clinical and medical workforce. In contrast, the non-clinical workforce—which includes roles such as estates, administration, domestic staff, and management—exhibits a lower representation of BAME individuals.

The overall percentage of ethnic minority staff within the NHS as a whole, increased to 28.6% in 2024, rising from 26.4% in 2023 and 17.7% in 2016 (NHS Providers 2024). NLAG falls below the national average for BAME representation. It is essential to acknowledge that this varies across different regions and reflects the diversity within local populations.

Moreover, the percentage of staff who have not disclosed their ethnicity is 2.5% of the total workforce, which marks an improvement in declaration rates compared to the previous year. However, there remains a small percentage of 'unknown' ethnicity among medical and dental staff, with 6.9% not disclosing their ethnicity.

WRES Indicator 1

Figure 1: Ethnic Composition of NLAG Staff



The bar chart illustrates the distribution of individuals identified as white, BAME, and those with an unknown ethnicity, categorised by band. BAME representation is lowest within Bands 3-4 and again at Band 8 and above.

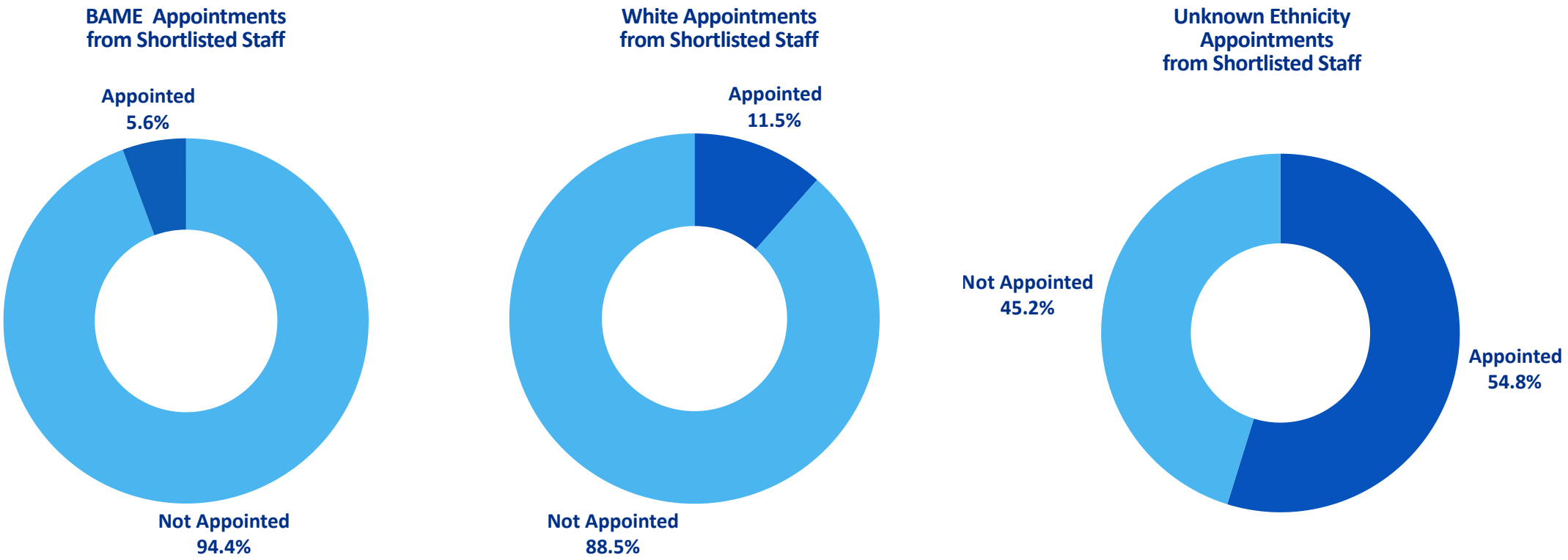
When considered by Agenda for Change (AfC), band 5 continues to see the highest percentage of staff from an ethnic minority, which is similar across all trusts (NHS Providers, 2024).

The percentage of BAME Staff in Bands 8-9 and VSM is 8.6%, an improvement on last year. Although, there is a lower percentage of BAME staff in Bands 8-9 and VSM compared to BAME representation within the overall workforce (18.4%). Following NHS England's recommendations, Medical and Dental Grades (including Trainee Grades) are excluded from the Bands 8-9 and VSM figures, as these categories typically have a much higher proportion of BAME staff.

**VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)*

WRES Indicator 2

Figure 2: Appointment from Shortlisting for all staff groups



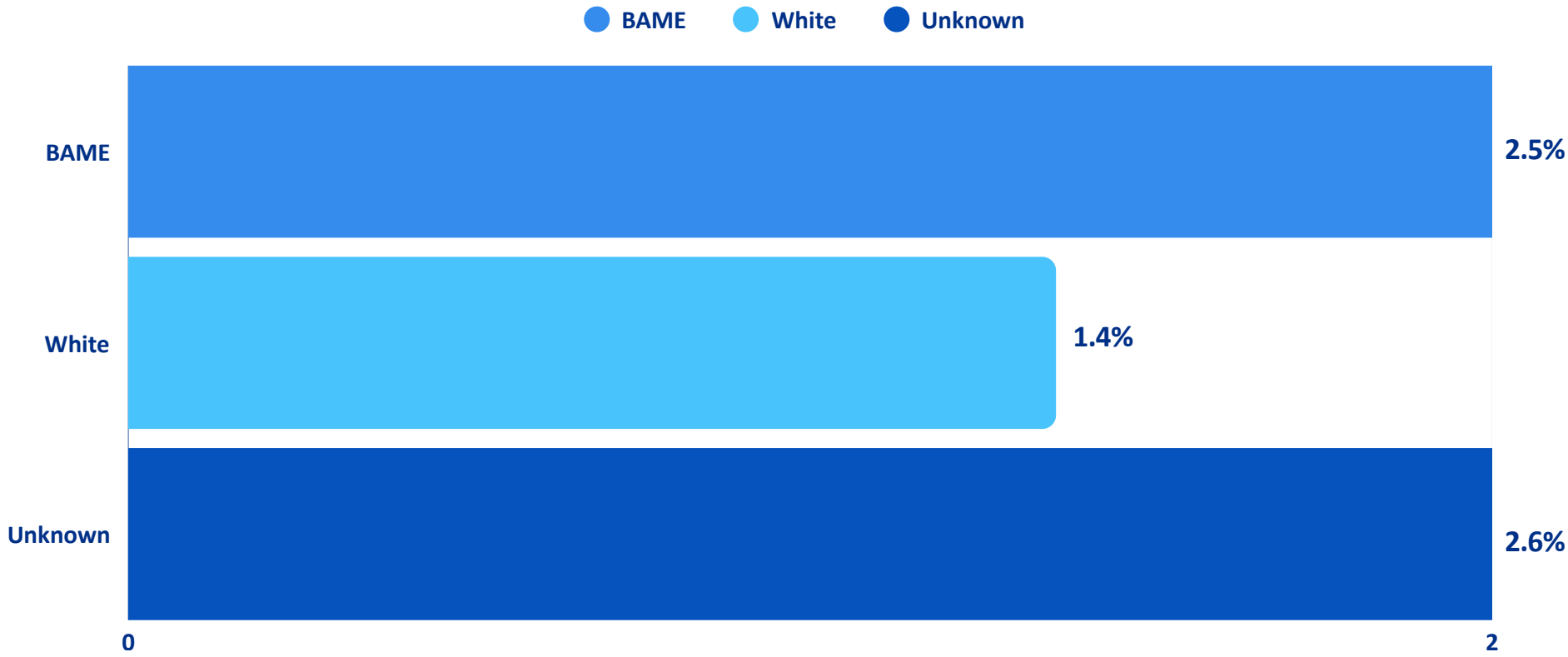
The charts above illustrates the likelihood of staff being appointed from shortlisting, categorised by ethnicity. BAME staff have a 5.6% chance of being appointed at the shortlisting stage, whereas White staff have an 11.5% likelihood of being shortlisted. Additionally, candidates with unknown ethnicity have a 54.8% chance of appointment, indicating a need for more transparent demographic data collection during the early recruitment stages.

The relative likelihood of White staff being appointed from shortlisting, compared to BAME staff, is 2.04. This indicates that White staff are twice as likely to be appointed once they reach the shortlisting stage when compared to their BAME counterparts.

The national relative likelihood has remained broadly unchanged since the inception of the WRES in 2016, meaning that this metric is proving the most difficult to improve on across the whole of the NHS (NHS Providers, 2024).

WRES Indicator 3

Figure 3: Likelihood of Staff entering formal disciplinary procedure

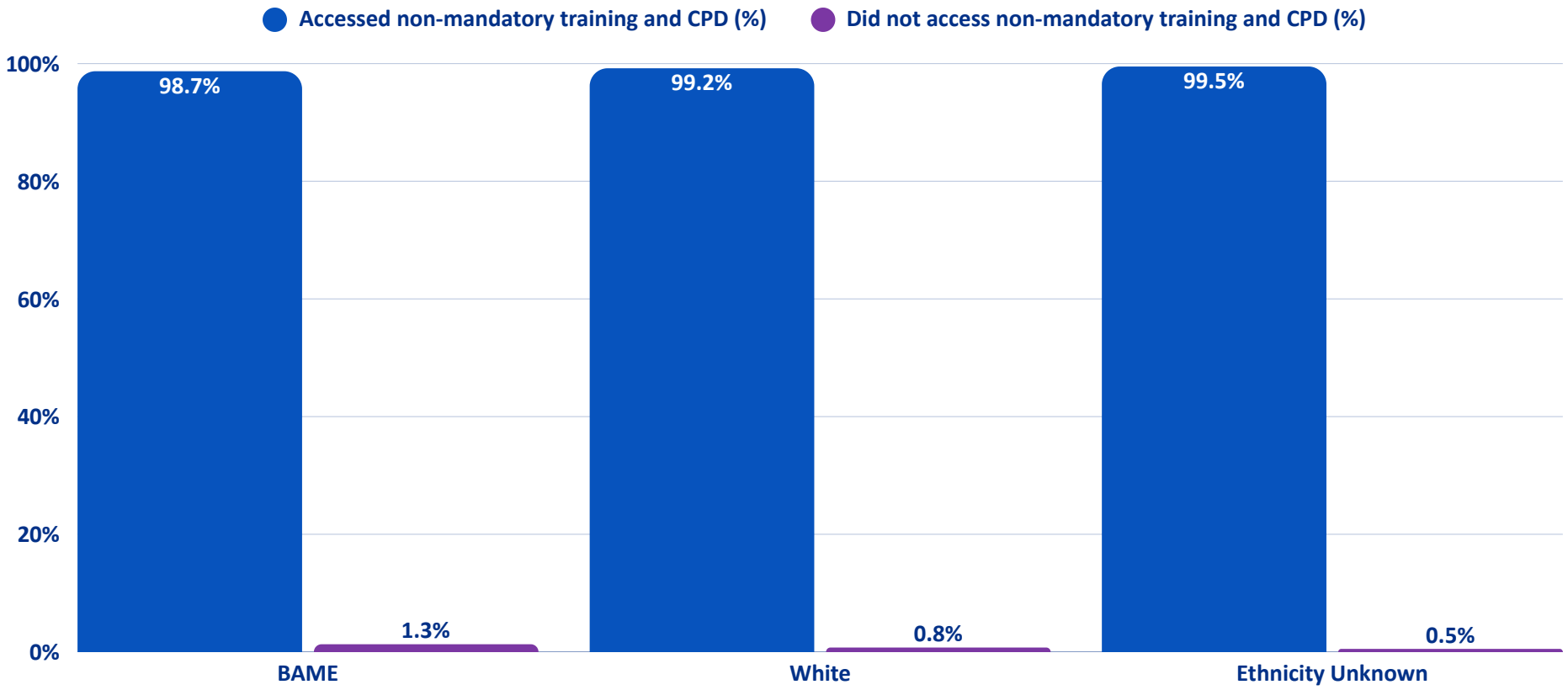


The bar chart presented above illustrates the comparative likelihood of BAME staff entering a formal disciplinary process in relation to their white counterparts.

Currently, BAME staff are 1.83 times more likely to face a disciplinary process, showing an improvement from last year's figure of 1.91. While these numbers remain proportionately low within the overall workforce, they do indicate a disparity; BAME staff are more inclined to enter the formal disciplinary process compared to white staff.

WRES Indicator 4

Figure 4: Likelihood of Staff accessing non-mandatory training and CPD

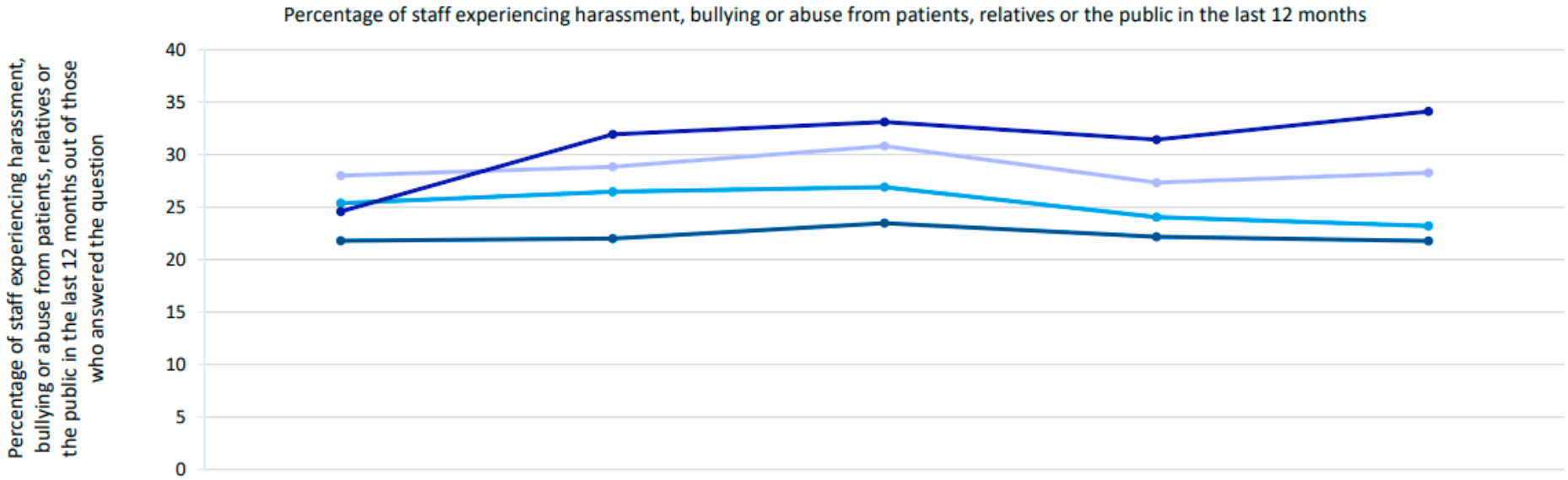


The probability of White staff participating in non-mandatory training and continuing professional development (CPD) remains at 1, mirroring last year's results. This suggests that both White and BAME staff have equal opportunities to engage in non-mandatory training and pursue additional professional development. Consequently, the probability is the same, signifying that accessibility for all staff, irrespective of race, is equal.

WRES Indicator 5

Figure 5 : Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

The WRES indicators 5, 6, 7, and 8 reflect unweighted responses to essential findings from the NHS staff survey conducted among the staff of the Northern Lincolnshire and Goole NHS Foundation Trust. Additionally, it provides average scores for acute Trusts for comparison purposes.



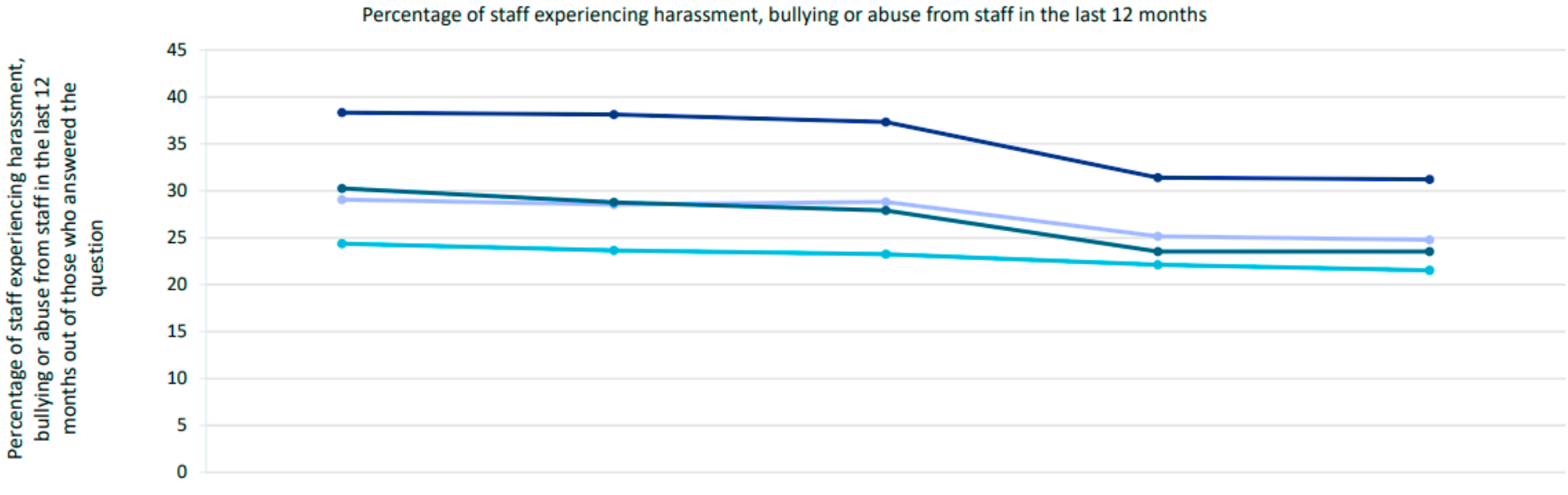
	2020	2021	2022	2023	2024
White staff: Your org	21.79%	22.01%	23.47%	22.18%	21.78%
All other ethnic groups*: Your org	24.58%	31.94%	33.12%	31.43%	34.12%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	2065	2131	2024	2718	2668
All other ethnic groups*: Responses	179	216	311	400	510

*Staff from all other ethnic groups combined

BAME staff report a 12.3% higher negative experience than their white colleagues, an increase from 2023. This is above the average acute Trust score for the BAME staff, emphasising the importance of creating an inclusive and supportive environment for all employees.

WRES Indicator 6

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

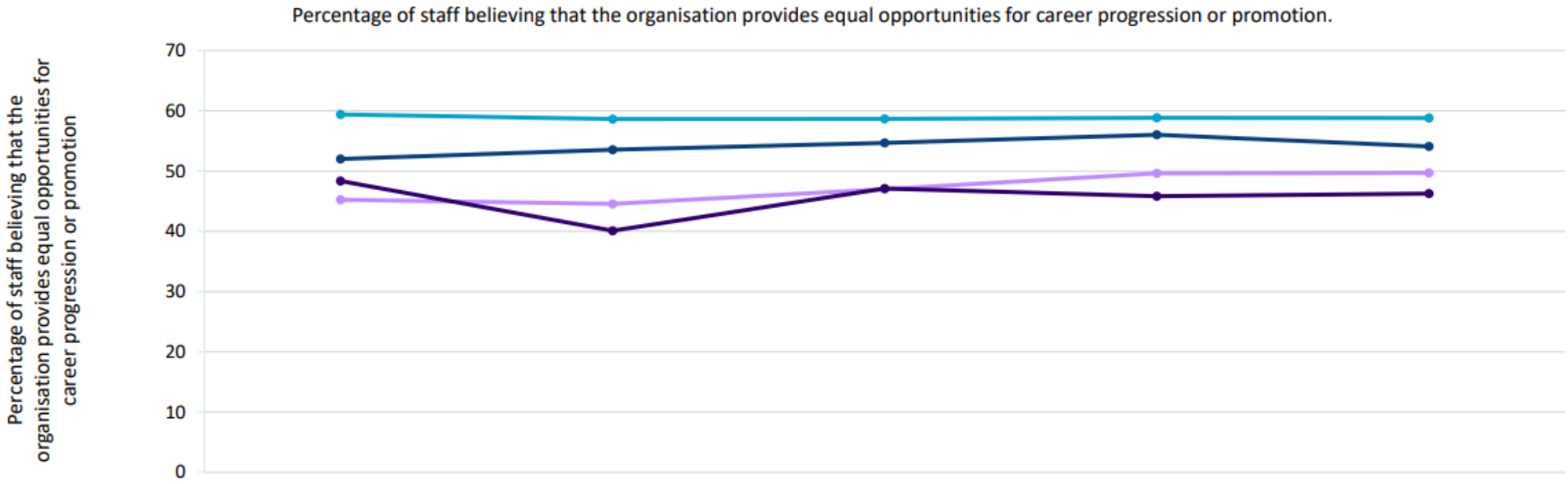


	2020	2021	2022	2023	2024
White staff: Your org	30.26%	28.77%	27.92%	23.54%	23.53%
All other ethnic groups*: Your org	38.33%	38.14%	37.34%	31.40%	31.23%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	2072	2127	2024	2709	2652
All other ethnic groups*: Responses	180	215	308	394	506

There has been a minor decline in the number of staff facing harassment, bullying, or abuse from colleagues across the board. However, the situation remains considerably more challenging for our BAME staff, with a notable gap of 7.7% between white and BAME employees, although there has been a slight improvement in year. This figure is 6.5% above the national average for BAME staff.

WRES Indicator 7

Figure 7 : Percentage of staff believing that their trust provides equal opportunities for career progression or promotions

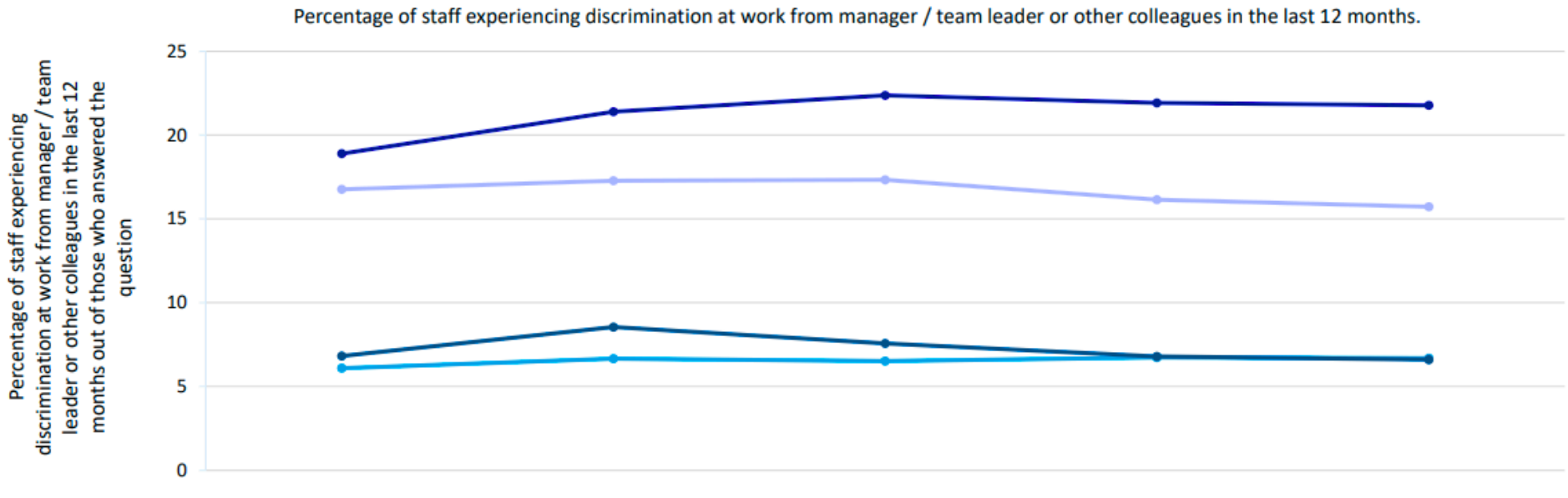


	2020	2021	2022	2023	2024
White staff: Your org	52.01%	53.54%	54.67%	56.02%	54.10%
All other ethnic groups*: Your org	48.35%	40.09%	47.10%	45.81%	46.26%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	2094	2161	2014	2940	2656
All other ethnic groups*: Responses	182	212	310	489	508

In 2024, 46.3% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion. This figure shows an increase compared to last year which is positive.

WRES Indicator 8

Figure 8 : Percentage of staff experiencing discrimination at work from other staff in the last 12 months



	2020	2021	2022	2023	2024
White staff: Your org	6.82%	8.55%	7.57%	6.79%	6.60%
All other ethnic groups*: Your org	18.89%	21.40%	22.37%	21.93%	21.78%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	2098	2176	2022	2944	2635
All other ethnic groups*: Responses	180	215	304	488	505

In 2024, BAME staff felt 15.2% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. This remains higher than the reported national average for BAME staff.

WRES Indicator 9

Figure 9: Total Board Composition

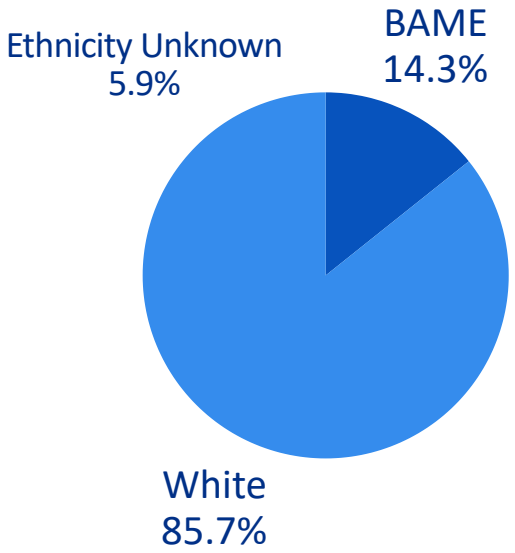


Figure 10: Voting Board Members

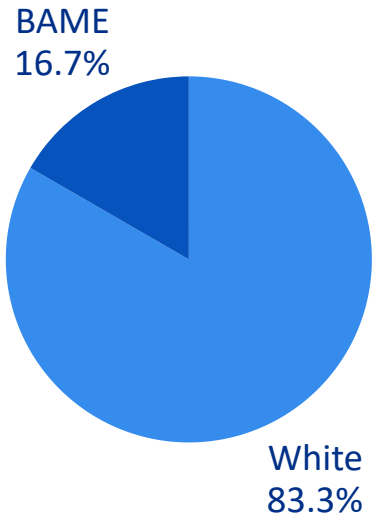
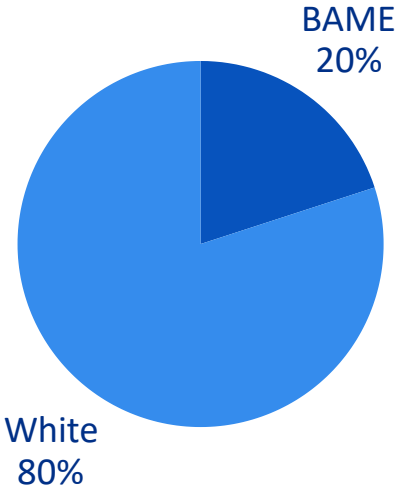


Figure 11: Non-Exec Board members



Northern Lincolnshire and Goole NHS Foundation Trust is part of the NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

The BAME representation at board level has is partially reflective of the proportion of BAME staff we have in the organisation. Trust Board BAME representation has increased in-year from 11.2% in 2023 to 14.3% in 2024. Therefore, there has been a positive impact since last year's report.

Progress to date to Support BAME Staff

The advancements made in the past year to assist BAME staff within the workforce are outlined below.

1

Launched a Zero Tolerance to Racism Framework

NLaG have introduced a Zero Tolerance to Racism Framework and Reporting tool. This tool is playing a significant part to assist in creating an anti-racism stance, to tackle all forms of racism and in particular support our Black, Asian and Minority Ethnic (BAME) staff.

2

Continued support for Internationally Educated Staff

Established a Stay and Thrive group to support our International Educated Staff. Positive steps we have taken includes; a staff survey to help understand their needs, developing career conversations to support retention and progression, a focus on community out-reach to encourage putting down roots and working with community partners such as Health Gospel. This work has received national recognition through the Health Service Journal awards where we are currently a finalist.

3

Engagement Events

This year BAME events included a successful conference and various drop-in session to celebrate black history month.

4

Developed and Grown the BAME Staff Network

The BAME Staff Network has successfully recruited a Chair and Deputy Chair. These roles were advertised and formally recruited to, and they each have an agreed job descriptions and person specifications. This network now also benefits from having an executive sponsor.

5

Governance

An Equality, Diversity, and Inclusion Steering Group has been formed which is chaired by an executive director. This group is able to challenge and give the Trust Board assurance in terms of meeting our equality duties.

6

Education and Development

All new staff receive face to face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a managers leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination, and equip leaders to have open and honest conversations with their staff.

Action Plan

Although this year's national WRES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of BAME employees within the trust. To address this, an Action Plan has been created based on the 24/25 WRES technical data results, aimed at bridging the gap in workplace experiences between BAME and White staff. A comprehensive workplan accompanies the Action Plan.

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
1. Continue to develop the Zero Tolerance to Racism Framework and Reporting tool • Support the Trust to tackle all forms of racism • Support our BAME Staff	Indicators 5, 6, 8 EDS 2022 2B	2025/26 Ongoing	EDI Team
2. Develop and Grow the BAME Staff Network • Develop a full engagement plan in partnership with the EDI team • Ensure appropriate governance arrangements are in place.	All EDS 2022 2B	September 2025/Ongoing	EDI Team

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
3. Support Internationally Educated Staff • Engage with the NHSE Step Up programme (Start to Elevate your Professional Career) for our Nursing & AHP colleagues • NHSE initiative started in South West now being rolled out nationally	Indicators 1, 2, 7 EDS 2022 2B, 2C	Ongoing	EDI Team / Nursing
1. Introduce an Inclusive Recruitment Project & Toolkit Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	Indicator 2, 7 EDS 2022 2D	March 26/Ongoing	EDI Team/Recruitment

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
5. Engagement Events • Celebrate Black History Month • General EDI engagement events	All	October/November 2025/Ongoing	EDI Team
6. Introduce a Six-Monthly Review of Disciplinary Data • NLaG WRES indicator 3 needs addressing to reflect that of HUTH	Indicator 3	February 2026	EDI team /HR team

Appendix

Collection name: **Workforce Race Equality Standard (WRES) Data Collection**

For: **NorthernLincolnshire and Goole NHS Foundation Trust (RJL)**, FY2024/25

Submitted: **Fri,May 23, 2025, 11:18 AM** by **Marie Hill (marie.hill12@nhs.net)**

Status: **Completed**

Welcome to the WRES 2025 Data collection

Please exclude all NHS held bank worker data from your submission. Bank workers are defined as workers who in your organisation work solely on a zero hour/'bank only' contract.

Guidance and additional information can be viewed here: Guidance (Link:)and Additional Information (Link:)

- Our information governance notice can be viewed here: Information Governance Notice (Link:)
- Web form technical support queries and queries about your account and password should be sent to: Data Collections Framework (DCF) - Customer Support (Link:)
- Requests for additional users to access the web form should be sent to: england.wres@nhs.net (Link:)
- Any queries about how to populate this data collection should be sent to: england.wres@nhs.net (Link:)
-

Indicator 1a - Non-Clinical Workforce

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Under Band 1				0	0	0	
Band 1				1	0	0	
Band 2				1142	30	23	
Band 3				450	18	5	
Band 4				174	7	3	
Band 5				159	4	3	
Band 6				63	10	1	
Band 7				82	1	0	
Band 8A				32	0	0	
Band 8B				30	1	0	
Band 8C				16	0	1	
Band 8D				11	0	0	
Band 9				1	0	0	
VSM				9	2	1	

Indicator 1b - Clinical Workforce

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Under Band 1				2	0	0	
Band 1				1	0	0	
Band 2				861	91	14	
Band 3				526	21	8	
Band 4				177	5	0	
Band 5				1012	472	58	
Band 6				697	131	15	
Band 7				479	39	4	
Band 8A				105	15	1	
Band 8B				19	4	1	
Band 8C				11	1	0	
Band 8D				3	0	0	
Band 9				4	0	0	
VSM				11	1	0	

Indicator 1 - Medical and Dental Consultants

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Medical & Dental Consultants				49	170	15	
Of which Senior Medical Manager				4	7	0	
Non-consultant career grade				19	136	12	
Trainee Grades				83	286	28	
Other				0	0	0	

Number of staff in Workforce

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
				6229	1445	194	

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Number of Shortlisted Applicants				5311 *	2395 *	407 *	We have seen an increase in applications therefore, this has resulted in double the number of shortlisted applicants. Particularly an increase in overseas applications.
Number Appointed from Shortlisting				612 *	135 *	223 *	
Relative likelihood of appointment from shortlisting	%	%	%	11.52 %	5.64 %	54.79 %	
Relative likelihood of White staff being appointed from shortlisting compared to BAME staff				2.04			

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data.

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Number of staff in workforce				6229	1445	194	
Number of staff entering the formal disciplinary process Likelihood of staff entering the formal disciplinary process				85 *	36 *	5 *	
Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff	%	%	%	1.36 %	2.49 %	2.58 %	
					1.83		

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Number of staff in workforce				6229	1445	194	
Number of staff accessing non-mandatory training and CPD				6182 *	1426 *	193 *	
Likelihood of staff accessing non-mandatory training and CPD	%	%	%	99.25 %	98.69 %	99.48 %	
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff				1.01			

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

Note: Only voting members of the Board should be included when considering this indicator.

	Last Year			This Year			
	White	BAME	Ethnicity Unknown/ Null	White	BAME	Ethnicity Unknown/ Null	Comments
Total Board members				6 *	1 *	0 *	Northern Lincolnshire and Goole NHS Foundation Trust is part of the NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double-counted.
of which: Voting Board members				5 *	1 *	0 *	
Non-voting Board members				1	0	0	
Exec Board members				2 *	0 *	0 *	
Non-exec Board members				4	1	0	
Number of staff in workforce				6229	1445	194	
Total Board Members - % by Ethnicity	%	%	%	85.7 %	14.3 %	0 %	
Voting Board Members - % by Ethnicity	%	%	%	83.3 %	16.7 %	0 %	
Non-voting Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %	
Executive Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %	
Non-executive Board Members - % by Ethnicity	%	%	%	80 %	20 %	0 %	
Overall Workforce - % by Ethnicity	%	%	%	79.2 %	18.4 %	2.5 %	
Difference (Total board - Overall workforce)	%	%	%	6.5 %	-4.0 %	-2.5 %	

How would you describe your trust's preparedness in measuring and monitoring Ethnic Pay Gap (EPG)?

Other: Please specify.

The tool on ESR BI is not yet adequately developed to provide the relevant information required.

NHS
Hull University Teaching Hospitals
NHS Trust

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)187

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9th October 2025
Director Lead	Sarah Tedford, Interim Chief Delivery Officer
Contact Officer / Author	Jeevan Gill, Director of Operational Transformation
Title of Report	Winter Plan 2025 – 26
Executive Summary	This paper provides a copy of the final winter plan including the board assurance statement that was submitted to NHS England. Winter is defined within this plan as the period 1 December 2025 – 31 March 2026. The Plan has been created with the assumption that no additional funding will be available to increase capacity. Therefore, focus remains on the admission avoidance and discharge pathways, both of which will require system working to be successful and ensure a sustainable impact. The Plan has been approved at the Trust's Executive Group and Performance, Estates and Finance Committees in Common, and Trust Board on the 11 September.
Background Information and/or Supporting Document(s) (if applicable)	The Board Assurance Statement is attached as supporting document which has been submitted to NHS England on the 30 September.
Prior Approval Process	Trust Executive Group and Performance, Estates and Finance Committee in Common and Trust Board on the 11 September.
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:

1 Introduction and Purpose

1.1 The paper and the associated appendices provide an organisational winter plan on behalf of NHS Humber Health Partnership. This outlines the key principles by which we will deploy resources to ensure that the services are delivered in a safe and timely manner. The winter period is defined within the Trust as being between 1 December 2025 up to and including 31 March 2026.

1.2 All current national and regional guidance relating to winter planning has been incorporated.

1.3 The plan is complementary to existing Trust plans and should be read in conjunction with Trust's Operational Pressures Escalation Levels Framework (OPEL), Severe Weather Plan, Major Incident Plan, Business Continuity Plans and the Pandemic Influenza Plan.

2 Trust Plan

2.1 The Trust's plan was developed collectively with Care Groups and support services. Several assumptions were made taking into consideration the desired outcomes from the actions within the UEC Programme Plan. These are:

- No additional funding is available therefore the plans focused on improving patient flow across all sites. Should funding become available a number of schemes have been developed which will either increase capacity or support patient flow during the winter period
- The plans include a 0.5% reduction in length of stay by bringing forward discharges before lunch. Work with ECIST is ongoing with two of the wards at Hull Royal Infirmary site. The plan is once these processes are embedded the learning will be rolled out across the wards and Hull Royal Infirmary. In September ECIST undertook site visits at Scunthorpe General Hospital and Diana Princess of Wales Hospital and have agreed workstreams which include extending the ward and board round work on the southbank.
- Embedding the continuous flow model across all hospital sites
- Introduction of a digital bed management system to ensure efficient use of bed stock
- A GIM rota embedded
- Introduction of surgical and frailty SDEC (same day emergency care)
- Increase in facility assessment (FAB) capacity
- Reduce the number of NCTR (No Criteria to Reside) patients
- A robust staff vaccination programme in place

2.2 There are several risks associated with winter which require close monitoring and working closely with system partners to minimise and ensure patients are in the right place, at the right time. A comprehensive risk log will be monitored via the Urgent and Emergency Care delivery group fortnightly with clear escalation and mitigation actions. NHS England Region have nominated an ICB Winter Director who will work across the system to try and support services. This individual is also responsible for the reporting to the regional and national team.

3 Key National Requirements

3.1 NHS England requires each system to address the below, therefore winter plans have incorporated actions to:

- Improve vaccination rates
- Increase the number of patients receiving care in primary, community and mental health settings
- Meet the maximum 45-minute ambulance handover time standard
- Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
- Set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays or more than 48 hours in all settings

3.2 Clarification as to the national sit rep requirement is not yet known although arrangements will be put in place to meet these.

4 Conclusion and Recommendations

4.1 It is recommended that the Trust Board note the winter plan and the Board Assurance Statement. It should be acknowledged that as more information and further national / regional guidance is issued the plan will be subject to further evolutionary changes.

NHS
Humber Health
Partnership

HHP Winter Plan

October 2025

Version 1.0

Winter Planning

NHS Humber Health Partnership

Plans

- With no winter funding available, the plans are focused on improving flow across the sites
- The plans include a **0.5% reduction in LOS** by bringing forward patient discharges to before lunch
- Embedding continuous flow model across all Care Groups
- Introduction of digital bed management to ensure efficient use of bed stock
- GIM Rota embedded
- Introduction of Surgical and Frailty SDEC – reducing bed occupancy
- Increase Frailty and Fab capacity
- Reduce NCTR patients
- Introduce staff Vaccination Programme

Risks

- Inability to discharge patients timely into community beds resulting in underutilisation of community capacity
- Increase in UEC activity during the winter period
- Increased IPC issues
- Staff availability and sickness
- Financial constraints – requirement to open unfunded inpatient capacity

Mitigation

- Potential to increase beds to be confirmed
- Extensive use of Temporary Escalation Spaces (TES)

Measures – Proposed Metrics

NHS Humber Health Partnership

- Improve patient flow to allow timely access to the most appropriate inpatient space – reducing medical outliers
- Ambulance handover at 30 minutes
- 30% ED demand via SDEC(s)
- Mitigation of risk of 4-hour patient delays
- Mitigation of risk of 12-hour trolley waits
- Maintain Cancer Elective and RTT delivery plan. Overview of activity & cancellations
- AM discharges against predicted
- Pathway utilisation
- Community capacity
- IPC (to include beds closed)
- Discharge lounge utilisation
- Vaccination rates
- Sickness levels

Improvement of Flow

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- Continuous Flow model embedded to improve early discharges and flow out of ED
- Integrated Discharge teams work closely with inpatient wards to facilitate timely discharges of P1 – 3 across 7 days
- Introduce digital bed management platform to monitor and manage flow and discharge at HRI
- Greater utilisation of POC testing to minimise infection risks across all EDs and SDECs
- Establish GIM Rota and processes for managing ward outlier including criteria and clinical ownership (HRI)
- Establish GIM as Care Group speciality at NLaG with dedicated inpatient ward areas by September
- Review implementation of TES and escalation spaces
- Move discharge lounge to support expansion of SDEC(s). Ensure sustainable model for discharge lounge
- Maintain GI bed for emergency pathway at HRI
- Daily review of next days elective activity at Site Meetings to avoid cancellations

Outputs	Measurables
• Reduction in crowding in ED • Efficient discharge planning processes • Early decision making at ward level	• Reduction in admitted lodged patients in ED • Reduced LOS • Great percentage of AM discharges

Ambulance Handover

NHS Humber Health Partnership

1. Continue embedding Transfer of Care SOP to facilitate ambulance handovers within 30 minutes – national target of 45 minutes
2. Agree cross-site divert request model, managing activity across sites
3. Work closely with ambulance providers to enable alternative to ED pathways. Working with Place to support Category 4 patients to avoid ED where clinically appropriate
4. Launch ED RAG-rated risk assessments to identify overall safety risks

Outputs	Measurables
• Transfer of Care SOP for ambulance handovers • Direct access to SDEC pathways for YAS and EMAS	• Average ambulance handover times 30 Minutes • Increased activity through SDEC pathways

Improve 4hr A&E Performance to Deliver 78%

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- Strengthen leadership arrangements across all sites to allow dedicated focus on non-admitted performance
- Optimise GP pathways
- Optimise FAB SDEC, Surgery SDEC, Gynae Ambulatory pathways
- Re-commence frequent attenders meeting with partners with a view to manage these patients in the community
- Maintaining conversion rate from ED to inpatient wards at 30%
- Review admitted patients from ED with 0 LOS
- Standardise ward handover/assessment from ED

Outputs	Measurables
• Reduction in crowding in ED • Continuous flow of out ED for admitted	• 4 hour performance • 12 hour DTA breaches • Improved time for Dr 1st seen – 60mins

Increase Capacity of SDEC(s) – HRI

NHS Humber Health Partnership

- Expand surgical SDEC capacity
- Expand frailty SDEC capacity
- Expand opening hours for medical SDEC
- Maintain cardiology SDEC
- Paediatric SDEC in place across all sites
- Ensure direct access pathways to SDEC from ED & community services (ambulance services, primary care)
- Align local dashboards to national SDEC standards

Outputs	Measurables
• Expand SDEC capacity and amend SOP to enable direct access for community providers	• % of patients attending SDEC • Utilisation of direct SDEC • SDEC conversion to inpatient rate

Care Groups

NHS Humber Health Partnership

- In-reach into SDEC or ED to provide timely reviews and avoid admission where appropriate
- Bed base review to be completed to ensure right capacity for specialist demand
- Continue implementation of the Humber Acute Services Review
- Maintain elective and outpatient delivery plan
- Progress the frailty front door model on the South
- Development of stroke assessment unit
- Paediatrics escalation and mutual aids plans reviewed and in place – plans in place to manage RSU increased activity
- Refocus >21-day LOS meetings to review management plans for the top 100 LOS patients
- Ensuring effective board / ward rounds and use of EDD, discharge planning and proactive management of LOS. All staff understanding the importance of Flow principles

Outputs	Measurables
• Expand capacity at Care Group through efficiency and improved pathways to support flow • IPC SOP	• 4 hour standard • Utilisation of SDEC • Cancer & RTT delivery against plan in winter

IPC Risk Management

Humber Health Partnership

- Strengthen flu planning and IPC protocols to reduce bed closures and mitigate winter pressures
- Data from Southern Hemisphere suggests trends in influenza will be like last year
- Ensure full compliance with NHSE IPC guidance, with regular audits and staff briefings to reinforce best practice
- Clear SOP and training for IPC to ensure appropriate management for all wards and departments
- Working closely with site management teams and attendance at site meetings
- Implement Point of Care testing in ED for respiratory viruses, COVID-19, and flu to support timely triage and safe patient placement
- Promote uptake of workplace vaccination programmes, targeting all eligible staff to reduce transmission risk
- Track and respond to outbreak-related impacts on NCTR numbers, using real-time data to adjust operational plans

Outputs	Measurables
• Vaccinations drop-in clinics	• High rate of vaccination take up • NCTR levels

Paediatrics

Humber Health Partnership

- Hospital at home on South to expand clinical pathways (e.g. fevers of unknown origins, respiratory). Re-promote service for primary care & ambulance service
- Trial hospital at home on North (depended on workforce)
- Working closely with mental health partners to minimise discharge delays

Outputs	Measurables
• Improve patient outcomes and satisfaction • Right care, right place	• Reduced length of stay • Admissions avoidance

Critical Care

NHS
Humber Health
Partnership

- Ability to increase ICU capacity during winter (if funding allows)
- To increase ICU capacity, the plan is to surge into additional beds. This can we achieved by either (these actions would require approval & risk assessment to maintain safety):
  - Open additional beds with appropriate funding
  - Utilising theatre staff which would result in cancelling elective activity (In hours option only)

Outputs	Measurables
• Reduction in mortality, as right patient receives correct care in a timely manner • Flow improvements in and out of critical care	• Reduction in length of stay • Reduction in admissions through early detection and intervention • Improved patient satisfaction

AHP / Pharmacy

NHS Humber Health Partnership

- Maintain patient flow, discharge and pharmacy's priority plan. Enact business continuity arrangements if demand exceeds capacity to maintain the above if no additional funding is available
- Embed proactive identification of patients requiring therapy at NLAG & HUTH continuing success of QI project at SGH
- Maximise use of digital resources to embed electronic referral and assessment processes
- Review of trusted assessor process agreed across the Trust and with system partners

Outputs	Measurables
• Promote alternative pathways into community • Reduce deconditioning with earlier access to short term equipment	• Supporting admission avoidance • Reduce length of stay

Staff Health and Wellbeing Plan

NHS Humber Health Partnership

- Access to occupational health
- Promote vaccination programme
- Pastoral in-reach programmes for wards/departments
- Ensure robust on-call arrangements in place patterns - clarify roles and responsibilities
- Review communication strategies to ensure all staff are aware of current site position
- Encourage staff to take annual leave periodically throughout the year to ensure staff are rested
- Use of volunteers to support patient and staff experience
- Review staff facilities access out of hours

Outputs	Measurables
• Clear staff vaccination communication plan • Vaccinations drop-in clinics • Enhanced staff wellbeing package	• Increase rate of vaccination take up from 24/25 • Reduced staff absence levels from 24/25 • Monitor staff wellbeing through monthly capacity meetings

Staff Vaccination Programme

NHS
Humber Health
Partnership

The Trust aims to have 75% of staff vaccinated. The programme includes a robust communication plan which has already commenced. Staff communication will detail access to a number of drop in and bookable clinics to meet the needs of our staff. The programme will involve:

- Static hubs for staff drop in from October in line with national scheme at HRI, CHH, DPOW and SGH
- From end of October – January ‘pop up’ clinics across all sites and clinical areas
- Bookable sessions available through occupational health
- Peer vaccination programme in clinical areas where teams have the appropriate resource and training to facilitate

System Enablers Plan

Humber Health Partnership

- Timely in-reach from mental health providers
- 2UCR delivering against all 9 clinical conditions
- Increase operating hours at HRI of UTC
- Reduce NCTR patients across all sites
- Additional social work capacity ED(s) to avoid admission (requires funding)
- SPA within Hull and East Riding to avoid ED attendances from community providers

Outputs	Measurables
• Detailed communication Plan with targeted staff communications. • Vaccinations drop-in clinics • Enhanced staff wellbeing package	• High rate of vaccination take up • Staff sickness and absence levels • Monitor staff wellbeing through monthly capacity meetings

Command and Control

- The Executive Winter lead has been identified and will work closely with the Care Groups and ICB Winter Director
- Winter will be managed and monitored via the UEC Delivery Group on a fortnightly basis
- A robust on call structure is in place including Director of the Day senior leader in place to support patient flow for the North and South Bank
- Escalation from strategic will be to the Trust Executive on call

Risk and Mitigation

NHS Humber Health

Risk	Likelihood	Impact	Score	Mitigation
There is a risk that delivery of the care group's winter plans may be compromised if system partners are unable to coordinate and implement the necessary enablers. This could result in adverse impacts on patient flow, including challenges to admission and discharge profiles across our services.	3	4	12	• Active engagement with system partners through winter planning forums to ensure alignment of capacity and escalation plans. • Regular monitoring of system-wide demand and flow metrics to identify emerging pressures early. • Escalation routes agreed with ICB and place-based partners for rapid decision-making where capacity gaps arise. • Internal surge and escalation plans in place within the care group to provide resilience if system enablers are delayed or insufficient. • Ongoing communication with discharge teams, community services, and social care partners to maintain safe and timely patient flow.
There is a risk that delivery of the care group's winter plan actions will be compromised due to financial constraints. This includes reliance on additional funding that may be delayed in allocation, insufficient in scale, or provided on a non-recurrent basis. These factors pose particular risks to the timely recruitment and retention of staff required to deliver safe and effective winter capacity.	3	4	12	• Early identification of financial requirements and submission of detailed winter funding bids. • Phased planning of winter actions to enable prioritisation should full funding not be secured. • Close liaison with Finance teams to track allocation timelines and model scenarios for delayed or partial funding. • Exploring use of flexible staffing models, including bank, agency, and redeployment, to mitigate recruitment risks linked to non-recurrent funding. • Clear escalation route if funding delays or shortfalls materially impact delivery of safe services. • Development of contingency plans to safeguard critical patient flow and safety priorities if funding is not secured in time.
There is a risk that delivery of the care group's winter plan actions will be undermined by insufficient cross–care group engagement and coordination. This risk is particularly relevant to ensuring therapy services are aligned to support RTT and CWT performance, and to the UEC interface with AEM, the Site and Discharge Team. A lack of joined-up planning could result in delays to patient flow, compromised performance standards, and increased operational pressures.	3	3	9	• Establishment of joint planning meetings with other care groups to ensure alignment of actions and priorities. • Named leads from each care group identified and accountable for delivery of shared winter actions. • Use of shared demand and capacity modelling to inform therapies input into RTT and cancer performance planning. • Regular escalation to the Care Group Triumvirates where cross–care group dependencies are at risk.

Risk and Mitigation

NHS Humber Health Partnership

Schemes	Risk	Likelihood	Impact	Score	Mitigation
Theatre capacity for same day surgery for acute surgery	Due to pressure on acute theatre stock the inability to provide enough capacity for SDEC patients.	3	3	9	SOP agreed with all care groups and overarching decision managed by floor anaesthetist.
Surge for critical care beds	Inability to staff additional capacity robustly	3	3	9	DPI and excess hours agreement, ensuring all maternity leaver is backfilled and supported, and vacancy factor covered with no delay.
Increase critical care outreach capacity to enable step down earlier and identification of deteriorating patients in a timely fashion.	Inability to staff required support above baseline	3	3	9	DPI and excess hours offered to team, cover all vacancy gaps with minimal delay.
Review HDU Nursing gaps at NLAG and develop a workforce force plan to meet winter demand					
Increase respiratory bed base, to manage increased higher acuity patients	Inability of respiratory to enact	4	4	16	
SOP for paediatrics within Critical Care Partnership wide	The management of critical care paediatric pts while either awaiting EMBRACE or until improvement in acuity, the management of these pts within adult ICU environment.	4	4	16	
Zero tolerance of cancellations due to bed pressures.	Recovery becomes overwhelmed while beds become available	3	3	9	Assurance of beds being ringfenced and moving to improved LoS and same day discharge for elective care across all speciality reducing the reliance on the bed base.

Risk and Mitigation

NHS
Humber Health
Partnership

Schemes	Risk	Likelihood	Impact	Score	Mitigation
Maintaining elective activity	High levels of urgent and emergency demand may lead to reduced availability of beds, staff, and theatre slots for elective care, resulting in cancellations, extended RTT waits, and impact on cancer treatment pathways.	3	3	9	Ring-fence elective beds and theatre slots with daily oversight to prevent unplanned work impacting elective activity.
Delivery of acute neurosurgery activity	Lack of access to acute theatres	3	4	12	Working closely with TACC

Winter Schemes*

The below schemes require additional funding:

Scheme	Care Group	Funding Requirement
Paediatric Consultant winter locum	Family Services	£65,600
Paediatric consultant (HRI) & Tier 2 doctor (SGH & DPOW) for PAU	Family Services	£64,000
Implement Hospital @ Home pilot of North	Family Services	£85,600
Enhance therapies presence in assessment & SDEC	CFT	£44,000
Several schemes worked up from the AEM team for North and South	AEM	£1.4m (based on Oct – March)
Expand OPAT service (HUTH)	CFT	£93,000
Implement frailty NCTR winter ward on C20 CHH	CFT	£800,000
Implement additional 10 NCTR beds at Google W3	CFT	£400,000
Virtual ward COPD expansion to NLAG	SMCG	£120,000

Winter Schemes*

The below schemes require additional funding:

Scheme tbc	Care Group	Funding Requirement
ICU surge plan – 10 additional beds	TACC	£1, 176,215
Increase critical care outreach capacity	TACC	£230,000
Increase clinical psychologist for TACC wards	TACC	4,000
Additional vascular Resident / Tier 2 doctor to support flow and in-reach into ED	Cardiovascular	£39,265
Additional 1.0wte registrar to support SDEC weekend and extended day cover	Cardiovascular	£39,265
Additional prescribing and dispensing capacity	Specialist Cancer & Support Services	£218,000
Queen's Centre surge plan	Specialist Cancer & Support Services	£76,000
Additional imaging	Specialist Cancer & Support Services	£56,000
Extra two RSU beds (HRI and SHG)	SMCG	£189,300

Winter Schemes*

The below schemes require additional funding:

Scheme	Care Group	Funding Requirement
H.S.A support into ED 24 hours December – March 2026 – Scunthorpe General	Estates, Facilities & Development (EF&D)	£56,900
H.S.A support into ED 24 hours December – March 2026 – Diana, Princess of Wales	Estates, Facilities & Development (EF&D)	£56,900
Porter support into ED 24 hours December – March 2026 – Scunthorpe General	Estates, Facilities & Development (EF&D)	£56,900
Porter support into ED 24 hours December – March 2026 – Diana, Princess of Wales	Estates, Facilities & Development (EF&D)	£56,900
Domestic support into ED 24 hours December – March 2026 – Hull Royal Infirmary	Estates, Facilities & Development (EF&D)	£56,900
Porter support into ED 24 hours December – March 2026 – Hull Royal Infirmary	Estates, Facilities & Development (EF&D)	£56,900
Patient Feeding into ED 24 hours December – March 2026 – Hull Royal Infirmary	Estates, Facilities & Development (EF&D)	£9,100

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Humber Health Partnership

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Humber Health Partnerships, comprising: Hull University Teaching Hospitals NHS Trust Northern Lincolnshire and Goole NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Group Executive - 26 August Performance, Estates and Finance Committees-in-Common - 2 September Trust Boards-in-Common - 11 September
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	A number of workshops were held with Trust operational teams as well as system partners which formed the Winter Plan
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	A regional workshop took place on the 3rd September which colleagues from the Trust attended
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Executive Accountable Director for winter is the Interim Chief Delivery Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	

Provider:	Humber Health Partnerships, comprising: Hull University Teaching Hospitals NHS Trust Northern Lincolnshire and Goole NHS Foundation Trust

The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	It was acknowledged at the regional winter work that all systems are challenged, the priority remains delivery of the NHS constitutional standards, patient safety and risk. Following discussion at the Trust Board, the overall view was that the existing elective commitments could be delivered, and constitutional standards improved upon, but that full assurance could not be provided.

Provider CEO name	**Date**	**Provider Chair name**	**Date**
Lyn Simpson	30 September 2025	Sean Lyons	30 September 2025

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	The Trust's vaccination programme incorporates the staff communication plan. These messages will be strengthened by clinical and operational teams to promote uptake of the vaccination
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	As mentioned above it is acknowledged that no additional winter funds are available this year to support winter or increase capacity from commissioners therefore the priority in times of escalation will be to maintain patient safety
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	See above comment
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Continuous flow in place and revised standard operating procedure and discharge numbers in place
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	
Infection Prevention and Control (IPC)		

6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	IPC were involved in the initial workshops during the development of the winter plan and remain engaged to support patient flow
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)188

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9 October 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 – July 2025
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 24/7/25
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 25/9/25
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:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 24 July 2025 at 9.00am to 12.30pm in the Boardroom, HRI and 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)
Dr Kate Wood	Group Chief Medical Officer
Heather McNair	Interim Group Chief Nurse
David Sharif	Group Director of Assurance
Julie Beilby	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)

In Attendance:

Sarah Tedford	Interim Group Chief Delivery Officer
Yvonne McGrath	Care Group Midwifery Director
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Rebecca Thompson	Deputy Director of Assurance
Dr Nick Cross	Site Medical Director (South)
Miss Preeti Gandhi	Consultant Obstetrician & Gynaecologist/Chief of Family Services
Kevin Allen	Governor Observer
Jo Palmer	PA to Trust Board Committees (Minutes)

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. There were no apologies for absence, however Dr Kate Wood advised that she needed to leave the meeting at 9.30am for a short while.

1.2 Staff Charter & Values

The committee Chair asked all attendees to be mindful of the Staff Charter & Values throughout the course of 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 meetings held on 26 June 2025**

The minutes of the meetings held on 26 June 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

No items were raised.

1.6 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

April 25 1.10 – item to be closed
May 25 1.7 – David Sulch to refer to Performance, Estates & Finance (PEF) CiC
May 25 2.0 – Dr Kate Wood advised that NLaG remains in arbitration with ACAS and positive discussions continue. Consultants continue to undertake extra contractual cover
May 25 3.1.1 – David Sharif advised that there was a placeholder in the BAF which would be picked up with Dr Kate Wood and Heather McNair. Item to be closed
May 25 3.2 - item to be closed
May 25 4.1.b – Dr Kate Wood advised that the Quality Strategy would be brought back to a future meeting, however item can be closed
May 25 4.5.1 – Item to be brought back to the September meeting
June 25 3.1a – David Sharif updated that there was to be a briefing at the CoG meeting on 12 August 2025 therefore item to be closed
June 25 3.1b – item to be closed as per previous item
June 25 3.1.c – Update to be provided at the September meeting
June 25 3.2 – item to be closed
June 25 4.4 – David Sulch advised that this was discussed at the previous Board meeting, therefore item can be closed
June 25 4.4 – item can be closed as per previous item
June 25 4.6 – Dr Kate Wood advised that a Group policy was now available and there had been no further incidents reported. Summary of progress to date to be provided at the September meeting
June 25 7.1 – Michela Littlewood advised that Marie Stern was happy to attend the HRI-based meetings and that enquires had been made regarding other representatives. Sue Liburd noted that they needed to have lived experience and welcomed an introductory meeting with them once recruited

1.7 **Operational Pressures Update**

Dr Kate Wood confirmed that the resident doctors were striking with effect from 25 July 2025 for five days and the directive was to ensure continuity of service across elective and planned care areas, in addition to emergency cover. She shared that there was good communication with the Care Groups to ensure that emergency departments were covered and considered that the Group was in a better position of resilience than ever before ahead of strike action and thanked all colleagues involved for their support.

Dr Kate Wood acknowledged that delays in planned care can lead to harm and as an acute NHS provider, the Group is allowed to ask for derogation if there is a likelihood of a patient coming to harm and she was actively reviewing the cancer waiting lists. However, guidance suggests that an application for derogation can only be made on the first day of the strike action and the decision is made by the NHSE and subsequently the BMA. If a procedure had to be cancelled, then this would potentially be due to the lack of medical ward cover to

provide that care. Dr Nick Cross added that he had been pleased to note how well the teams had collaborated with each other. Dr Kate Wood was pleased to update that communication through to primary care had been well received and those colleagues felt part of the solution rather than the opposite, which was evidence of good progress and teamwork.

Tony Curry asked if there was an awareness of how many patients would be involved but Dr Kate Wood replied that this work was still underway. She acknowledged the potential psychological impact on patients having their care delayed and on behalf of the Group, apologised to any patient that would be affected. Tony Curry asked for reassurance that any patients who were affected would be reprioritised as soon as possible, and it was confirmed that this indeed would be the case.

In relation to TAVI, Dr Kate Wood referred to the recent media coverage around the historic issues and the number of deaths that were reviewed and confirmed that the Group continues to support the police on any information requests and thoughts remain with the families affected but also with the staff in the service who the Group continues to support. Meetings with the TAVI team are held monthly and oversight continues through the Quality Improvement Group.

ACTION: Further update on TAVI to be provided at the meeting in September 2025

1.8 **CPE Update**

Heather McNair was pleased to advise that there were now minimal numbers of patients affected with CPE at SGH. There was a planned visit to DPoW by UK HSA and NHSE on 6 August 2025 to review the work that has been ongoing in managing the outbreak and how future infection outbreaks would be managed. For current new cases, there was a mix of new infections, readmissions and hospital transmissions.

Tony Curry was pleased to see the downturn in infections and asked what the position was in terms of Infection Control generally across the Group. Heather McNair considered there was still a lot to do in terms of reinforcing the message around the basics, such as bare below the elbow, frequent handwashing, correct uniform, but also the visibility of the leadership team across the seven days a week service. It was recognised that there needed to be a cultural change to remove the complacency and staff should feel comfortable in challenging others and that there would be consequences in non-compliance.

Julie Beilby reflected that the topic of getting the fundamental basics right came up time and time again and patients deserved the right to come into hospital and have minimal risk of contracting an infection. She suggested the idea of a Freedom to Speak Up campaign to strengthen the message that staff would be supported in challenging a member of staff and to draw attention to the potential impact of not doing so.

Sue Liburd confirmed that this Committee supported the idea of a Back to Basics campaign and asked that this be picked up by the Group Chief Nurse's team.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The committee Chair reported that the NLaG Consultants LNC issue had been referred previously by the Workforce, Education & Culture Committee and was featured on the action tracker.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

David Sharif shared a presentation on the current position and a full update would be provided at the September meeting once the BAF had been realigned to the new strategic objectives. There were currently no changes to the risk scores or appetite and there had been progress in the rating of controls. He shared that the team were working to improve the content of the narrative and was pleased to update that he considered the BAF was where it needed to be at this point. A method of providing an executive review and commentary of each high level operational risk was being explored on the risk register system.

There was concern that the ED risk was still at 25 and unfortunately the upcoming Performance & Accountability meeting had been postponed, which would have been an opportunity for check and challenge to review the score.

David Sulch noted that the narrative had improved, along with descriptions of issues and risks but there was still a need for better clarity on the mitigations to reduce the risks. David Sharif clarified that the intention was to highlight the top high risks within the executive summary, along with a clear indication of the mitigating actions.

3.2 Risk Register Report Q1

Michela Littlewood updated that whereas there were normally two monthly meetings for North and South, due to operational challenges, these had been cancelled but there was an upcoming meeting to discuss the corporate risks. Work was underway with colleagues on why certain risks were overdue. Ulysses, the current inhouse incident reporting system, was also to be used to produce reports going forward and it was anticipated this would contribute to the efficiency and quality of the reporting. Work was underway to align the process across the Group, as currently the processes were different at HUTH and NLaG.

Michela Littlewood welcomed feedback on the level of detail.

Heather McNair queried the number of risks and noted that this included issues. Michela agreed and explained the rationale behind it, in that there had been an instance at a recent Risk & Compliance meeting where the issues had not been addressed and the Nurse Directors were unhappy about it. Heather McNair responded that as an assurance paper, the issues should not be included and there be clear evidence on how the risks were being managed.

Michela Littlewood asked the Committee to confirm what was expected from this report and David Sulch responded that he considered it was important to understand the issues but with a clear indication of what actions were being taken to lower the risk.

Heather McNair was of the view that it was important to be able to see how the risk score had changed over a period of time and David Sulch clarified that he would like to see an overview of how the scores were changing but in addition, an appendix noting the high risks and as agreed at the June meeting, risks of 20 and above to be reviewed monthly and risks of 15-20 reviewed quarterly.

Tony Curry agreed with the comments and said that he would expect to see a mitigation strategy, and if a risk could not be fully mitigated, a statement to support this would show

that an appropriate decision had been made. He stated that he preferred to see the issues as he considered them to be unmitigated risks.

Dr Nick Cross considered that the current format of the report created questions, and too much narrative took the focus away from the actual risk.

David Sharif asked for clarification on data relating to overdue risks in that the paper indicated there were 506 Care Group risks which were overdue for review and the data he had was that there were 16 overdue. Michela agreed to check this.

Sue Liburd thanked Michela Littlewood and her team for their work on the Risk Register.

Yvonne McGrath and Miss Preeti Gandhi joined the meeting at 9.50am

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

CQC Action Plan

Michela Littlewood summarised the report and explained that there were several task and finish groups in place to address actions more closely. CQC enquiries were referenced in the directors' briefing and she welcomed some feedback on the level of detail.

Tony Curry was of the view that there was too much detail but was pleased with the approach to the expectation of an action being fully or partially resolved.

David Sulch accepted the level of detail but with the undelivered actions being noted on an appendix and Julie Beilby agreed and commented that it was important to have a clear executive summary which signposted to the detail if required.

Heather McNair considered that this needed to be integrated into an improvement plan focussed on quality and safety.

Conversation continued in that the outstanding actions needed completing as it was two years on and if CQC visited at this point, it would be difficult to justify why matters were still outstanding. Michela Littlewood pointed out that the timings had been reset on the formation of the Group approach and she also advised that there had now been some recruitment into the team which would help with the updating of the plan.

3.4 **Review of Relevant External Report, Recommendations & Assurances**

There were no external reports, recommendations or assurances to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Quality & Safety

4.1 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)**

Yvonne McGrath gave an overview of the paper and reported that there were still challenges around mitigation on NICU acuity and staffing across the Group. For MIS Year 7, safety actions 6 and 8 on Saving Babies Lives and training were a risk.

Tony Curry referred to the fact that training continued to be an issue. Yvonne McGrath advised that there was a training clerk in post at NLaG and this would be replicated at HUTH as it was proving helpful in maintaining focus on compliance.

Tony also asked whether alternative methods of training were being considered along with staffing options, to achieve the balance of complying with training requirements and meeting clinical needs. Yvonne McGrath responded to say that they were calling staff in for renewing their training earlier than anticipated so they did not fall out of compliance and hoped that this would bring about a change in culture in how training was viewed.

Miss Gandhi was aware that short staffing had an impact on compliance and currently, consultants were working on the Waiting List Initiatives rather than renewing their mandatory training. Clinicians that were not active in undertaking their training before expiry were escalated to her.

David Sulch referred to safety action 6 and asked whether the 100% trajectory was a local measurement and Yvonne McGrath replied that it was. Heather McNair suggested that the Group make it clear as to why attainment was not reached despite the work that was undertaken.

Sue Liburd questioned the section on screening and KPIs across the Group and Yvonne McGrath advised that the team were working with individuals in doing some 1:1 training.

The Committee agreed on a level of reasonable assurance in respect of both HUTH and NLaG as there was evidence of an awareness of the issues and what the mitigations were to resolve these.

4.2 **Establishment Review of Safe Staffing**

Heather McNair explained the CQC Section 31 had noted issues around staffing. The maternity paper on staffing was now complete but there were still issues in neonatal and obstetric staffing. Miss Gandhi was in attendance to present papers on consultant requirements at both HUTH and NLaG and neonatal nursing, due to non-compliance with BAPM (British Association of Perinatal Medicine) standards. A Board-approved plan was needed due to non-compliance.

Yvonne McGrath presented the maternity paper and shared with the Committee that the total investment for full recruitment for 2025/26 would be around £2m. Dr Kate Wood fully supported the request and believed that Yvonne had clearly demonstrated the challenges faced and aligned them to the current requirements across the Group. She clarified that there would be a further request for investment for 2026/27 but with a close review of how the service was being managed.

Heather McNair pointed out that if CNST was not achieved, there would be a loss of £1m.

Julie Beilby referred to the discussion at the recent Workforce, Education & Culture Committee, where in terms of financial challenge, it was accepted there were two areas. The first one related to future years' planning which would be reviewed through the budget setting cycle, but the immediate challenge was the in-year growth, which she considered needed to be a separate discussion at Board and possibly the Performance, Estates & Finance Committee and whether it was possible to include an interim option. Yvonne McGrath was not keen to continue with secondments and preferred, if possible, to defer for another six months. She referred to the fact that bank and agency spend was high.

Miss Gandhi presented the three papers on medical staffing. She noted that within the NHS long-term plan, there was an ask for maternity services to be safe. Following a capacity and demand process, for HUTH there was a request for twelve consultants to enable division of

the obstetric and gynaecology rosters. This would be at a cost of around £2.9m. Currently, £1.1m was being spent on WLI (Waiting list Initiative) work and a separate reference to spend was detailed on the executive summary of each paper. Twelve consultants and four SAS recruitment would adequately cover our current PA deficit gap and significantly improve patient safety, compliance and workforce sustainability.

For NLaG, the request was for five consultants, at a cost of just less than £1m in total. This would address compensatory rest for obstetric consultants following overnight on-calls as per CNST requirement and cover the gaps in capacity for obstetrics and gynaecology. Total cost would be around £4m for medical staffing for obstetrics and gynaecology across the Care Group.

From a neonatal perspective, maintaining the current footprint and to achieve the required BAPM standards requires £2.9m over 5 years for nursing workforce and £3.8m for medical workforce. Some reduction may be achieved by reconfiguration of levels of units.

Dr Kate Wood reflected that there had been a significant amount of under- investment for medical and nursing and maternity colleagues for a long time, particularly at HUTH and the current way of working, such as reliance on WLI, bank and agency staffing, was not sustainable long-term and did not deliver a quality service. She considered it was important that executive colleagues were totally briefed on the challenges.

David Sulch referred to neonatal underfunding and Heather McNair replied that it had never been properly funded.

David Sulch asked if the Board could be provided with a breakdown of how the money would be allocated and where money would not need to be spent. He recognised that there were some imperatives within the papers, for example, without the midwifery investment, MIS Y7 would not be achieved, he was of the view that obstetrics and gynaecology needed to be split. David Sulch also referred to the Legal paper to be presented later in the meeting which stated that gynaecology was 121 out of 123 Trusts on the North Bank relating to the cost of claims, which implied that gynaecology was being deprioritised due to obstetrics. He also was of the view that neonatologists should be fully committed to the neonatal service. Overall, he was supportive of the papers and noted that the Board needed to carefully consider the options for the South bank in terms of how the neonatal units were structured.

Heather McNair remarked that WLI money was not in the budget and directed the overspend so there was a need for new money.

Julie Beilby noted the very detailed papers and agreed with David Sulch's comment on the need for a summary of requests and savings would be helpful. She also asked whether the paper had been submitted to Executives and what the feedback had been. Heather McNair responded that it had, and the request was to bring it to this Committee and then take back to Board for a discussion and a decision. Julie asked whether it also should go to the PEF Committee. The Committee agreed with this and for it then to be presented at the August Board meeting.

ACTION: David Sharif to ensure paper is presented to the PEF Committee prior to discussion at the August Board meeting

Tony Curry commented that in summary, the expectation was to deliver a quality, safe service 24/7 and the papers certainly highlighted the underinvestment in staffing and the reliance on WLIs.

Heather McNair added that it also prompted the Group to review how the service was structured and clarified that originally it had been part of the HASR review but was taken out.

Dr Kate Wood reiterated the need for urgent action now on this subject.

Sue Liburd drew the conversation to a close and concluded that the paper needed a significant amount of discussion at Board and asked that it was amended to reflect the need for a summary giving clarity to the request.

Sue Liburd thanked both Yvonne McGrath and Miss Gandhi and acknowledged the significant underinvestment in the service over the years.

The meeting paused for a 10-minute break at 10.55am

Sarah Tedford joined the meeting at 11.05am

The running order of the meeting was changed at this point

4.4 **Deep Dive Quality Priority –**

- **Medicines Safety**

Jo Goode summarised the report and advised that the approach to the safer medication quality priorities had been agreed at the Safer Medications Committee and they related to insulin safety due to an increase in insulin-related incidents being reported on Datix and the IV to oral switch which would support the Group anti-microbial stewardship work. There was some work ongoing around the areas where patient weight was not being recorded. Work on the insulin safety was on hold until early 2026 due to the new EPMA system installation which would be part of the new EPR but the IV to oral switch was underway with good engagement.

Heather McNair commented that it was a good report and Tony Curry agreed.

Dr Kate Wood added that it showed the good progress made and a clear trajectory on the work ahead, along with the reason for the phased approach. She also highlighted there were opportunities for additional staff to support the work and was pleased to note there was currently safe mitigation in place.

Sue Liburd thanked Jo Goode for the excellent report.

Assurance was noted as reasonable.

4.6 **<u>Quality & Safety</u>**

Deep Dive –

- **Elective Surgery Waiting Times**

Sarah Tedford shared a slideshow of her presentation, focussing on harm reviews. She acknowledged that there was work to do and highlighted that currently there were two different processes in place across the Group, and this was to be aligned over the coming six weeks. This was causing confusion as the Care Groups worked across site, therefore working with two different processes and were unaware of which parameters they should be working to. For example, at HUTH for patients on a cancer pathway who had breached 104 days, an incident was reported and then reviewed. At NLaG, any patients breaching 104 days were reviewed by the cancer team. Clinical harm data was also reviewed at the Care Group governance meetings, performance meetings and ultimately Risk & Compliance meetings and through to this Committee. Sarah Tedford did point out that at

no point in any of the review feedback, was there an indication of what had been done in connection with the patient.

Sarah Tedford stated that a summary page for patients over 52 weeks needed to be reflected in the new policy. In summary, there was a low incidence of clinical harm or no harm, with a few of moderate harm and there was a clear variation in implementation between sites and specialities. In developing a new single policy, it was evident that actions needed to be standardised across the Group, work undertaken to ensure clinicians have time to see patients, and for escalations of high-risk pathways and capacity shortfalls where necessary.

Heather McNair asked whether Duty of Candour was performed when harm was evident. Richard Dickinson confirmed that affected patients were discussed in the weekly response panel meetings where it was ensured that this was undertaken. Michela Littlewood added that if a trend in complaints and referrals to PALS has been identified, the nurse director for that Care Group is approached to discuss further. Sarah Tedford was of the view that there needed to be a review of the threshold at which harm reviews were undertaken

Dr Nick Cross was encouraged to see from the slideshow the suggestion of proactiveness in looking for harm, by way of involving patients in looking out for deterioration or change of condition and feeling able to contact the speciality rather than wait for the hospital to contact them when they reach a point on the waiting list. This could be done as soon as the patient was added to the waiting list by way of good conversation or patient leaflet.

Richard Dickinson shared with the meeting that by October 2025, there would be one incident reporting system across the Group, which would instigate a need for alignment from all sites.

David Sulch agreed that the waiting lists needed to be more dynamic and commented that decisions on prioritisation can only be made on what is presented to the Committee and it is for the Care Groups to highlight any concerning issues appropriately.

Dr Kate Wood commented that it was clear a Group approach was needed in how waiting lists were managed and how the patients are supported whilst waiting for their procedures.

ACTION: Update as to how the Committee should be updated to be discussed at the September meeting

<u>Quality & Safety</u>

4.5 **Operational Update Flow (HUTH)**

Sarah Tedford shared with the Committee that work on flow started around 12 weeks ago in ensuring that the Care Groups had appropriate plans in place that would allow receipt of patients from EDs more efficiently and the short stay ward was opened. Changes were being seen but albeit slowly. The anticipated ‘push back’ from wards was visualised and there was a clear need for a more efficient discharge process. ED performance was improving but not significantly.

Sarah Tedford updated the meeting that Jeevan Gill had joined the Group as the Director of Transformation and would be overseeing the UEC work.

Sue Liburd thanked Sarah Tedford for her update.

6. ANNUAL REPORTS

6.1 Medicines Optimisation Annual Report & HUTH Controlled Drugs Annual Report 2024

Joanne Goode presented the annual report and advised that the year had been spent aligning the two pharmacy services along with the management of medicines. She highlighted the key achievements for the year as the decommissioning of piped nitrous oxide at HRI, which was now also required at NLaG. There was now a single system prescribing committee. Pharmacy staff at NLaG was now fully recruited. There was a concern around the integration of systems, and it was hoped that the EPR would help with this. Medicine reconciliation was an outstanding CQC action on the South bank and there was still no access to that data. In the previous report was a noted unease at the AMS standards at NLaG and the risk of outbreaks, which this year did then come to light with the CPE outbreak. A business case had been prepared for extra staff at NLaG.

All meetings were now aligned across the Group and there was a review underway on licensing in respect of the storage of drugs at a single site and on resilience and whether the Group was working in the most cost-effective way should one of the units close temporarily.

Tony Curry noted the level of administration errors, but Jo Goode replied that this was related to nurse administration of the drugs and not office administration.

Dr Kate Wood referred to item 3.3.3 in that medicine reconciliation was not being reported as a core standard and asked when this would resume as it was a mandatory requirement. Jo Goode responded that the department was waiting for HDigital and information support as there was a planned move to new systems. Dr Kate Wood asked if there was a known timeline as the Committee would need to be assured on this.

ACTION: Dr Kate Wood to contact HDigital for a timeline on resuming the reporting of medicine reconciliation.

Dr Kate Wood also asked regarding theatre-controlled drug record keeping and whether there was a specific audit ongoing related to this. Jo Goode was awaiting an update but did note that changes already put into place with the new controlled drugs registers which had improved practice.

Dr Kate Wood's final point on the HUTH Controlled Drugs paper was that a green rating reflecting 80%+ correct meant that 20% was incorrect and was this concerning. Jo Goode responded that a controlled drugs group was being resurrected, and she would ask the controlled drugs lead pharmacist to benchmark this against the region and then consider what other organisations were doing and through this process reflect on appropriate benchmarking metrics.

Dr Nick Cross referred to the incident report and noted a downward trend and asked whether Jo Goode was happy with the system of incident reporting, to which she replied that the aim was for high reporting and low harm. A slight drop had been noted at HRI and she was unsure whether this related to the pressures being identified there and it had been raised at the medicines management meeting.

The Committee approved the report.

Jo Goode left the meeting.

6.2 **Organ Donation Annual Report**

Dr Kate Wood advised that there was a requirement to provide a report to Board and highlighted that although HUTH and NLaG were separate organisations, they were both included in the one report for ease of comparison. However, it was noted that Hull was a tertiary centre for major trauma, therefore there was a large contrast in the number of organ donations that were possible. She was pleased to note that both HUTH and NLaG were working well in managing donations and identifying possible donors, and the specialist nurse was present for most conversations with families which was known to improve the acceptability for the family in allowing the donation. Organ Donation week was planned for September 2025 and a selection of venues were to be lit up pink. Work was underway to improve the awareness and education for organ donation to staff. Dr Kate Wood did highlight the fact that she was acting as the interim Chair for NLAG and there needed to be a permanent appointment as soon as possible to someone who could give the time and commitment to supporting the cause. She gave thanks to Barbara Hoggarth who was the HUTH chairperson who had been recognised nationally for the great work she had done and to Lorraine McLeavy, who had been the previous chair, but who had sadly passed away last year.

The Committee approved the report.

6.3 **Legal Service Annual Report**

Richard Dickinson focussed on the additional information on contributions, costs and benchmarking data from GIRFT. It was recognised that there were some quartile 4 performance issues specifically on the HUTH site but also some on the NLaG site. Work was underway on quartile 3 and quartile 2. The nature of claims received that could not be defended were fed back to the clinical teams and these had been well received and some good feedback provided. There was a noted increase at HUTH as opposed to NLaG in relation to CNST premiums. There were opportunities in how some areas could be improved and this included learning from non-clinical claims, improving on risk assessments and how to defend cases better.

Richard Dickinson pointed out that for inquest case work, the rate of enquiries was slightly higher. There was a clear need to invest time to prepare for inquests which would be a local cost, so it was important to use the inhouse legal team wherever possible.

David Sulch noted that maternity had not been given a ranking in the GIRFT table and Richard replied that it was not in this cycle.

David Sulch also referred to inquests and when required to give evidence, staff should be encouraged and supported to be able to be open and honest and speak as confidently as possible as this gives a good impression. Richard confirmed that the team do meet staff in advance of the inquest.

Heather McNair raised the point that it was unclear whether actions against the recommendations had been completed and whether the issue was a recurrence, and Richard responded that this was followed up at the Mortality & Improvement Group. Sue Liburd suggested that a statement to cover this detail be included in future reports.

Julie Beilby suggested it may be an idea for Internal Audit to do some checking on actions completed against recommendations. Richard Dickinson advised that this report would be presented at the Audit, Risk & Governance Committee (ARG) next week.

ACTION: Committee to request that, through the ARG Committee, Internal Audit perform some checks on actions completed against recommendations

Tony Curry referred to delayed treatments being a heavy factor in the complaints and Richard Dickinson acknowledged that there was indeed many incidents reported where there was no follow up, no results given and so on, but reassured him that there was a recognition of working differently and clinical teams were now receiving guidance on avoiding these incidents arising from their daily contact with patients.

The Committee approved the report.

6.4 **Infection Control Annual Report & Workplan**

This item was deferred to the September meeting.

6.5 **Annual PROMS Report**

Richard Dickinson advised that this was a deferred paper from March 2025 and highlighted a gap in how Hull issued their comparative questionnaires, but this was now resolved, resulting unfortunately in no data to show the comparison. A different process was in place at NLaG which was managed effectively.

The Committee approved the paper, acknowledging there was no HUTH data.

7. HIGHLIGHT REPORTS

7.1 **Patient Safety & Learning**

The meeting on 16 July 2025 was cancelled due to operational changes, therefore no report provided.

7.2 **Patient Experience**

Heather McNair commented on the very poor complaints performance in that the responses were poor, and the timing of the responses was poor and would be escalating this to the Interim Chief Executive Officer.

Michela Littlewood highlighted that some changes to processes had been made which had affected the figures and advised that the Group had come to an end of a HUTH FFT contract and it was having to look at other options. NLaG's contract with an external provider expired in June 2026.

Action: Update to be provided at the September meeting

Julie Beilby commented that she considered the way in which complaints are handled is very poor and this had been discussed at previous meetings and at Board and it was very important to get a more efficient process in place.

7.3 **Infection, Prevention & Control**

No comment.

7.4 **Maternity & Neonatal Assurance Group**

No comment.

7.5 **Risk & Compliance**

The North/South meeting on 15 July 2025 was cancelled due to operational changes, and a corporate meeting was due to be held on 25 July 2025, therefore no report provided.

The meeting returned to earlier deferred items

4.3 **Integrated Performance Report (IPR): quality & safety metrics**

Michela Littlewood again reiterated that as per the Patient Experience Highlight Report update, the new process had caused an issue with delays in responding to complaints but was pleased to share that the amount of subsequent complaints had reduced, which was because of the work undertaken on improving the quality of the response going out to patients. As part of the check and challenge process with the Care Groups, there was more focus on ensuring that actions are followed through.

The work with VTE risk assessments was ongoing and Dr Kate Wood highlighted that the presented data showed an improvement in VTE performance over the last year, but it was found that the Group were not measuring against national targets. This was advised to the national team and corrected but resulted in the data now showing poor performance. The process used by NLaG allowed better compliance to that of HUTH, but work was ongoing to improve the function.

Heather McNair questioned why there were minimal/no targets on the dashboard relating to pressure ulcers, falls and so on. Heather was of the view that Quality Improvement needed to feature and was concerned as to the position on IPC at this stage of the year and expected that, based on this, there will be considerable issues in the winter period, unless action was taken immediately. Sue Liburd suggested this be highlighted to Board and focus on as a Deep Dive at a future meeting.

Julie Beilby referred to the previous Board meeting where the Interim Chief Executive Officer was to pick up on several themes that had been brought to the the Board's attention with Adam Creeggan, the Group Director of Performance.

Sue Liburd thanked Heather McNair for raising the issue and confirmed that a decision would be made to include as a Deep Dive on the workplan for 2025.

ACTION: Deep Dive on IPC to be added to the workplan

5. STRATEGY

5.1 **Clinical Strategy – Update**

Dr Kate Wood commented that the paper provided an overview of what work had been undertaken regarding the development of the clinical strategy and the final draft would be presented to a future meeting.

8. ITEMS FOR INFORMATION

8.1 **Draft Workplan**

This item was deferred to the September meeting.

9. ANY OTHER URGENT BUSINESS

9.1 Any Other Urgent Business

There were no items of any other business raised.

10. MATTERS TO BE REFERRED BY THE COMMITTEES

10.1 Matters to be Referred to other Board Committees

It was agreed that the following matter required referral to other board committees, as follows:

- Establishment of Safer Staffing paper to be referred to PEF CiC
- IA to perform checks on actions completed against recommendations within Legal Services

10.2 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:

- Industrial action
- TAVI update
- CPE update
- Complaints process
- C Difficile and MRSA infection rates
- Risk Register for further assurance
- CQC actions
- Maternity – NICU acuity and staffing challenges
- Obs/Gynae neonatal medical staffing issues
- Medicines management Deep Dive received
- Harm review process received
- Annual Reports received and approved
- FFT contract expiration
- Organ donation Annual Report received and approved

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 25 September 2025 at 9.00am-12.30pm in the Boardroom, DPoW.

The committee Chair thanked Heather McNair for her involvement and support to the CiC in her role as Interim Group Chief Nurse. The meeting was closed at 12.32pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2024/2025

***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								
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y								
Tony Curry	Non-Executive Director (HUTH)	N	Y	Y	Y								
Julie Beilby	Non-Executive Director (NLaG)	N	Y	Y	Y								
Dr Kate Wood	Group Chief Medical Director	Y	D	Y	Y								
Heather McNair	Interim Group Chief Nurse	N	Y	D	Y								
Clive Walsh	Interim Chief Executive (North)	Y	N	D									
Sarah Tedford	Interim Chief Executive (South)	N	N	D	Y								
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y								
Yvonne McGrath	Care Group Midwifery Director	N	N	Y	Y								
Rebecca Thompson	Group Deputy Director of Assurance	Y	Y	Y	Y								
Murray MacDonald	Non-Executive Director of Assurance	N	N	Y	N								
Richard Dickinson	Associate Director of Governance (NLaG)	Y	Y	Y	Y								
Michela Littlewood	Associate Director of Governance (HUTH)	Y	Y	Y	Y								
Kevin Allen	Governor Observer			Y	Y								

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)189

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 9 October 2025**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Wendy Millard, Deputy Director of Infection Prevention & Control**
Title of Report	Infection Prevention & Control & Cleanliness (IPCC) Annual Report 2024-25
Executive Summary	Infection Prevention Control and Cleanliness (IPCC) Annual Report reports on infection prevention and control activities within Humber Health Partnership (HHP) incorporating; Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) from April 2024 to March 2025. Author: Wendy Millard Deputy Director of Infection Prevention & Control
Background Information and/or Supporting Document(s) (if applicable)	All background information relevant to this report is included in this report, including contributions received from IPC, Estates, Facilities, Pharmacy and Sepsis Team.
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 ü Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

HUMBER HEALTH PARTNERSHIP
INCORPORATIING
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST (HUTH)
&
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST (NLAG)

INFECTION PREVENTION CONTROL & CLEANLINESS (IPCC)

ANNUAL REPORT 2024-25

Written by Wendy Millard, Deputy Director of Infection Prevention and Control

Contributions from: IPC, Estates, Facilities, Pharmacy, Sepsis team.

Humber Health Partnership

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1 Executive Summary

Executive Summary

The Infection Prevention Control and Cleanliness (IPCC) Annual Report for 2024-25 provides a comprehensive overview of infection control activities within the Humber Health Partnership (HHP), which includes Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Trust (NLAG). This report covers the period from April 2024 to the end of March 2025.

Key Achievements:

- **Restructure of IPC Team and Service:** The Infection Prevention and Control (IPC) team has been restructured across the Group, enhancing the alignment and delivery of infection prevention activities.
- **Antimicrobial Stewardship (AMS):** An AMS lead was established for NLAG, and a strategic action plan was developed to meet national standards. HUTH reported a continued reduction in the use of broad-spectrum antibiotics.
- **Data Alignment:** Data collection for Healthcare Associated Infections (HCAIs) and Surgical Site Infection (SSI) reporting has been aligned across the Group.
- **National Standards of Cleanliness:** NLAG successfully introduced national standards of cleanliness, resulting in improved cleaning practices.
- **Collaborative Relationships:** Effective working relationships were established with services related to IPC, such as Estates & Facilities and Occupational Health.

Areas of Concern:

- **Education and Training Compliance:** New national education and training frameworks for IPC have been published, and the IPC team is working towards compliance. Improved understanding of IPC's role in patient safety is essential.
- **CPE Outbreak:** A significant outbreak of Carbapenemase-Producing Enterobacteriaceae (CPE) was identified at NLAG, requiring focused efforts to manage and contain the outbreak.
- **HCAI Incidence:** Both HUTH and NLAG reported an increase in HCAI incidence above threshold levels.
- **Surgical Site Infections (SSI):** HUTH was identified as an outlier for SSI in hip and knee surgeries, with early data indicating similar concerns at NLAG.

Recommendations for 2025-26:

- **Reduce HCAIs:** Focus on reducing harm from preventable healthcare-acquired infections.

- **Improve IPC Practices:** Enhance adherence to IPC practices across the Group.

- **Address Outbreaks:** Continue efforts to manage and contain outbreaks, particularly CPE.
- **Enhance Education and Training:** Ensure compliance with new IPC education and training frameworks.
- **Focus on Surgical Site Surveillance (SSI):** a focus on improving practice standards and outcomes for patients undergoing surgical procedures, particularly orthopaedic surgery.
- **Strengthen Collaborative Efforts:** Foster collaborative relationships with related services to improve IPC outcomes.

Conclusion: The report highlights the significant achievements and ongoing challenges in infection prevention and control within the Humber Health Partnership. The recommendations for the upcoming year focus on reducing HCAIs, improving IPC practices, managing outbreaks, enhancing education, and training, and strengthening collaborative efforts. The board is requested to take note of this report and consider the recommendations for 2025-26.

2.1 Introduction and purpose of the report

Effective infection prevention, control and cleanliness is fundamental to the delivery of high quality, safe and effective patient care. This remains a significant priority for the Group with an objective for engagement and ownership of infection prevention and control throughout the organisation at all levels from Ward to Board.

The Health and Social Care Act 2008: `Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections` in conjunction with the Care Quality Committee (CQC) regulations, clearly outline Trust Boards responsibilities in providing a collective agreement and overarching strategic direction for IPC, including approval of the Director of Infection Prevention & Control Annual Report.

The following annual report provides a comprehensive overview of infection prevention and control activities within the Humber Health Partnership (HHP), which includes Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). This report covers the period from April 2024 to March 2025.

2.2 Governance arrangements

2.2.1 Team structure

The Chief Nurse (Amanda Stanford) is the Trust **Director of Infection Prevention and Control (DIPC)** with executive responsibility for leading and managing the Trust's Infection Prevention, Control and Cleanliness (IPCC) 24/25 plan. The **Group Deputy Director for Infection Prevention and Control (Deputy DIPC) Wendy Millard** is responsible for the Strategic Leadership of the Group Infection Prevention, Control and Cleanliness service. During 2024-25 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist at HUTH and Dr Shaktijit Dave, Consultant Microbiologist at NLAG. The remaining infection control team structure is illustrated in **appendix 1.**

2.2.2 Infection Prevention, Control Group Structure

The infection team has a robust set of meetings to ensure that the Group is meeting it is mandatory and statutory requirements for IPCC. There are the strategic and operational infection reduction committees, which report via the Quality and Safety Committees in Common ultimately to the Trust board. There are several supporting committees and meetings which feed into Strategic Infection Reduction Committee (SIRC) and Operational Infection Reduction Committee (OIRC), including the Antimicrobial Stewardship Committee (ACAT), HHP Water Safety Group, HHP Group Ventilation, and HHP Decontamination Group.

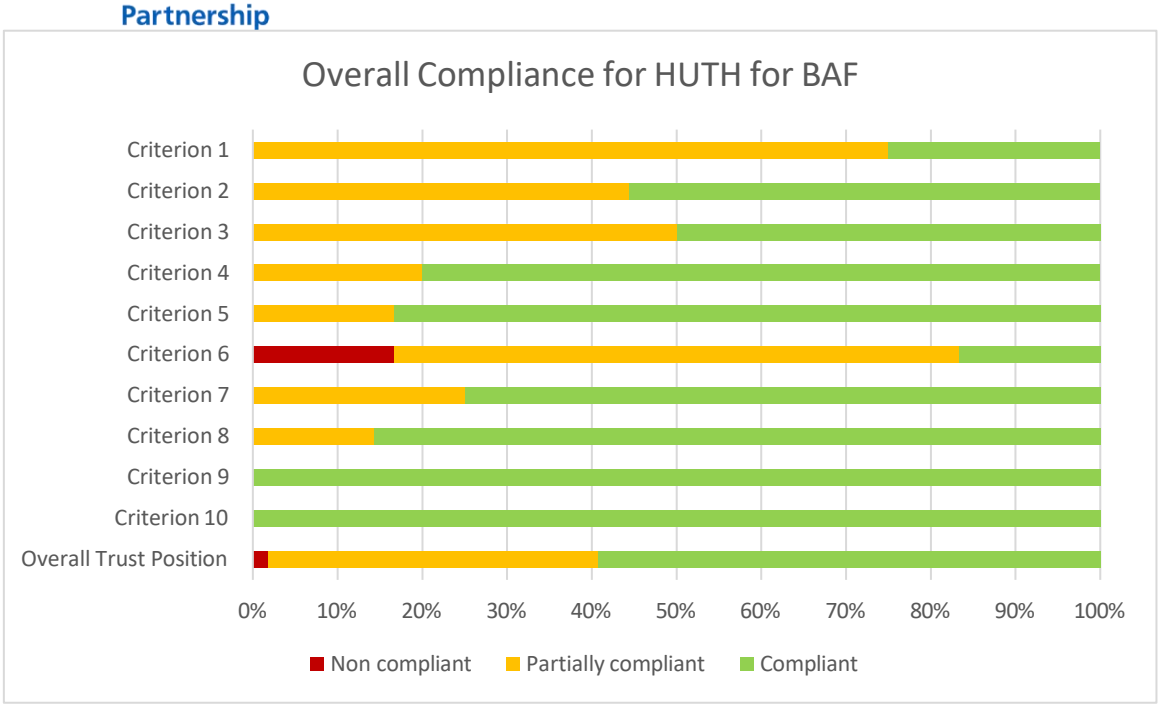
2.2.3 Reporting to the Trust Board and Board Assurance Framework (IPC BAF)

The IPCT has maintained a relationship with the Trust board, when there are issues of concern that require escalation, they have been given the opportunity to raise these in a timely manner to appropriate committees. The HUTH IPC BAF is maintained as a live document, with action plans to support improvements where gaps in compliance or risks have been identified. The NLAG BAF has been established during 24/25. An update on progress of the BAF was presented to the Quality and Safety Committees in Common on a Quarterly basis during 2024-25.

Board Assurance Framework BAF for IPC

The BAF relates to the Ten Criterion identified in the Health and Social Care Act, 2008. The key lines of inquiry (KLOEs) are made up of fifty-four elements within this. The Group has rated itself against these KLOEs based on the National Infection Prevention and Control (NIPC) Framework. Below figures illustrate compliance with the NIPC Framework.

Figure 1: Overall Compliance for HUTH

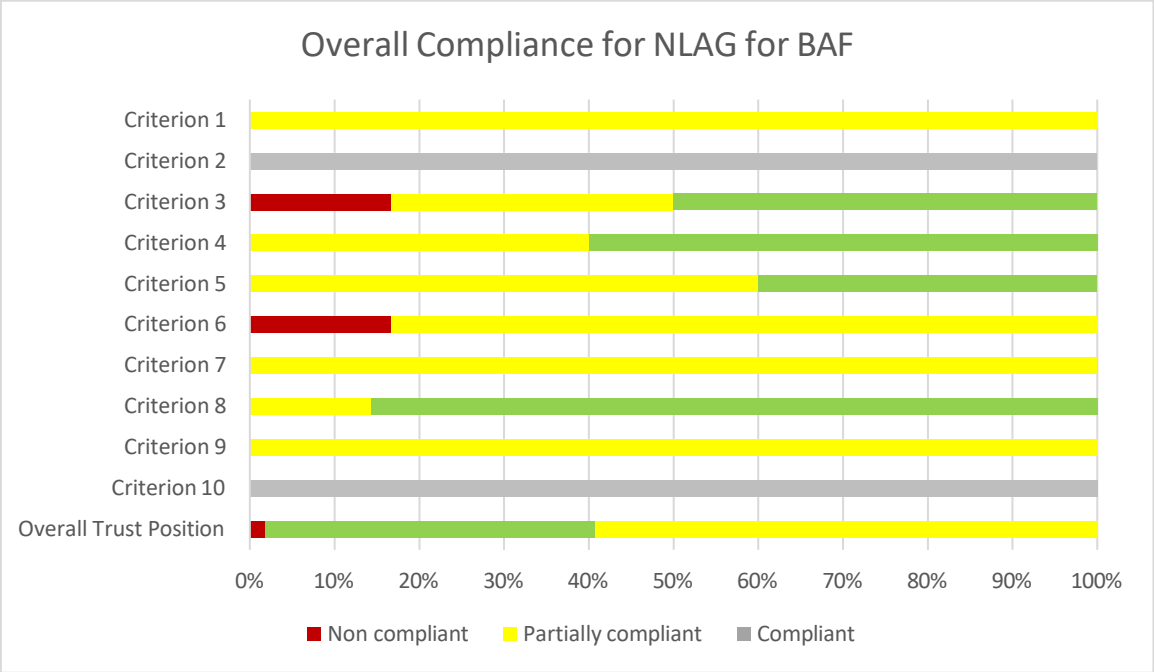


HUTH was 61% compliant within the IPC BAF by the end of March 2025; thirty-three out of fifty-four elements within KLOEs completed, 37% partially compliant twenty-one out of fifty-four progressed against, and 2% non-compliance one out of fifty-four KLOEs, this relating to the education and training requirements. Therefore, HUTH overall has 98% compliant/partially compliant at present and 2% non-compliance. This is illustrated as above.

An overview for NLAG BAF is illustrated below in Figure 2. This overview commenced when the IPCC service established joint working as a Group in September 2025. Initially working through the core IPC elements, then linking in with appropriate departments, such as Estates, Facilities, Laboratories, Pharmacy and Occupational Health.

For the Group once an overall position has been formulated and established, further progress work will be undertaken to look at continuously improving against all KLOEs within the NIPC Framework.

Figure 2: Overall Compliance for NLAG



NLAG was 24% compliant within the IPC BAF by the end of March 2025; thirteen out of the fifty-four elements within KLOEs completed, 50% partially compliant twenty seven out of fifty-four progressed against, and 4% non-compliance two out of fifty-four KLOEs, this relating to face fit testing and service provisions. Therefore, NLAG overall has 74% compliant/partially compliant at present and 4% non-compliance. However, there are two KLOEs, Criterion Two and Ten, still requiring review, representing 22% of compliance not currently assessed against. The plan for this review will take place during Q1 of the next financial year.

2.2.4 Policy and Procedures

There has been a full review and refresh of all the IPC policies and procedures during 2024-25, such that policies are now in date and aligned with current national guidance and the Infection Prevention and Control Manual (NIPCM) where applicable. Some policies have included significant changes, impacting clinical teams, they have required a process of operationalisation, to ensure compliance. The priority for 2025-26 is alignment of IPC policies across the Group.

2.2.5 Infection Control Risk Register

The established IPCC risk register at HUTH highlights risks directly held by the IPCT, equally reflecting risks owned by other departments which are relevant to IPCC. These are reviewed regularly with the risk management team and discussed at OIRC and escalated to SIRC when appropriate. Key risks include; those relating to the aging estate and environment including the ventilation and water systems,

isolation room capacity, healthcare acquired infections (HCAIs) and multi-drug-resistant organism transmission. Similarly, NLAG risk register has held risks relating to IPCC. Since moving to, Group model, the review and alignment of risks have been a priority for IPCC, where appropriate. There have been several risks identified to be added to NLAG risk register, including risks associated with increased incidence of HCAIs, risk of CPE outbreak, and face fit testing service provisions.
All high risks within the Group are further reviewed by the Chief Nurse at The Risk and Compliance Group Meeting.

2.2.6 External inspections / visits

There have been no external inspections or assessments specific to IPC during 2024-2025.

2.3 Overview of infection control activities during 2024-25

The IPC Service has a significant and broad remit. Both HUTH and NLAG are reviewing policies and practice to align across the Group. The NLAG team model has undergone a restructure, with the recruitment of new inexperienced IPCNs. The senior members of the team are supporting the team and the new structure with new ways of working. The team has developed a work plan, to ensure clear focus on key priorities. Whilst much of the work for IPCT is reactive, including:

- providing advice to care groups and clinical teams on the management of individual patients to prevent onward spread of transmissible infections
- managing outbreaks of infection
- investigating healthcare acquired infections
- supporting Occupational Health in staff vaccination campaigns and promoting staff health and safety

However, the team plays a more critical role in the proactive prevention of infection and moving forward, this needs to be the greater focus for IPCT. This work includes, but not limited to:

- supporting estates to ensure the environment is safe and fit for purpose, in relation to water safety and ventilation
- advising to capital project colleagues on aspects of new builds related to IPC
- working closely with facilities to maintain the cleanliness of the environment
- working with the microbiology department to ensure effective screening of patients at risk of multi-drug-resistant organisms
- improving antimicrobial stewardship to reduce antimicrobial resistance
- education and training of staff in all aspects of IPC and antimicrobial stewardship
- winter planning for both organisations
- working with external partners and agencies in managing IPC related issues

The remaining report will highlight in more detail some key aspects of this work.

2.3.1 Healthcare Associated Infections (HCAI's)

2.3.1.1 Surveillance organisms

The NHS Standard Contract 2024/25 includes quality requirements for NHS Trusts and NHS Foundation Trusts to minimise Clostridioides difficile (C. difficile) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England. Healthcare-associated infections (HCAIs) remain a significant challenge across NHS England, with evidence pointing to multifaceted drivers behind the rising incidence of GNBSIs, other resistant infections, and antimicrobial resistance (AMR). Contributing factors include variations in antimicrobial stewardship (AMS), diagnostic practices, and application of infection prevention, control, and cleanliness (IPCC) measures. Health and social care providers have obligations set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, to undertake steps to keep patients and staff safe and to provide assurance to Trust Boards about the risks and outcome. These requirements support the delivery of the AMR National Action Plan (NAP) 2024-2029 which includes a target to prevent any increase in all GNBSIs from the 2019/20 baseline by 2029 and is not limited only to HCAIs.

Preliminary projections of the aging population between now and 2029 means that this could represent a 17% reduction in underlying trends. The NAP includes a target to prevent any increase in a specified set of drug-resistant infections in humans from the 2019/20 baseline by 2029. Whilst not part of the Standard Contract requirements, as in previous years, this document sets out the thresholds included on a guidance/advisory basis for equivalent thresholds for sub-ICBs (at ICB level previously), reflecting that the prevention of infections requires preventative, pathway-based approaches. Having targets within the new NAP focussed upon all GNBSIs, not just healthcare-associated, supports this approach.

The 2024-29 NAP targets mean that appropriate thresholds to support achievement will not be comparable to those set in previous years. Therefore, there is a need to support Trusts and sub-ICBs to transition to the new targets. Workstreams are being developed and supported in a Partnership approach to support these targets. This features in the annual work plan and reported through OIRC and SIRC. These include workstreams focused on; the Built Environment, Personal Protective Equipment (PPE), Basic IPC Practice Campaign (Where's the Harm), Antimicrobial Stewardship (AMS), Surgical Site Infection Surveillance, reduction of gram-negative bacteraemia's and management of indwelling devices.

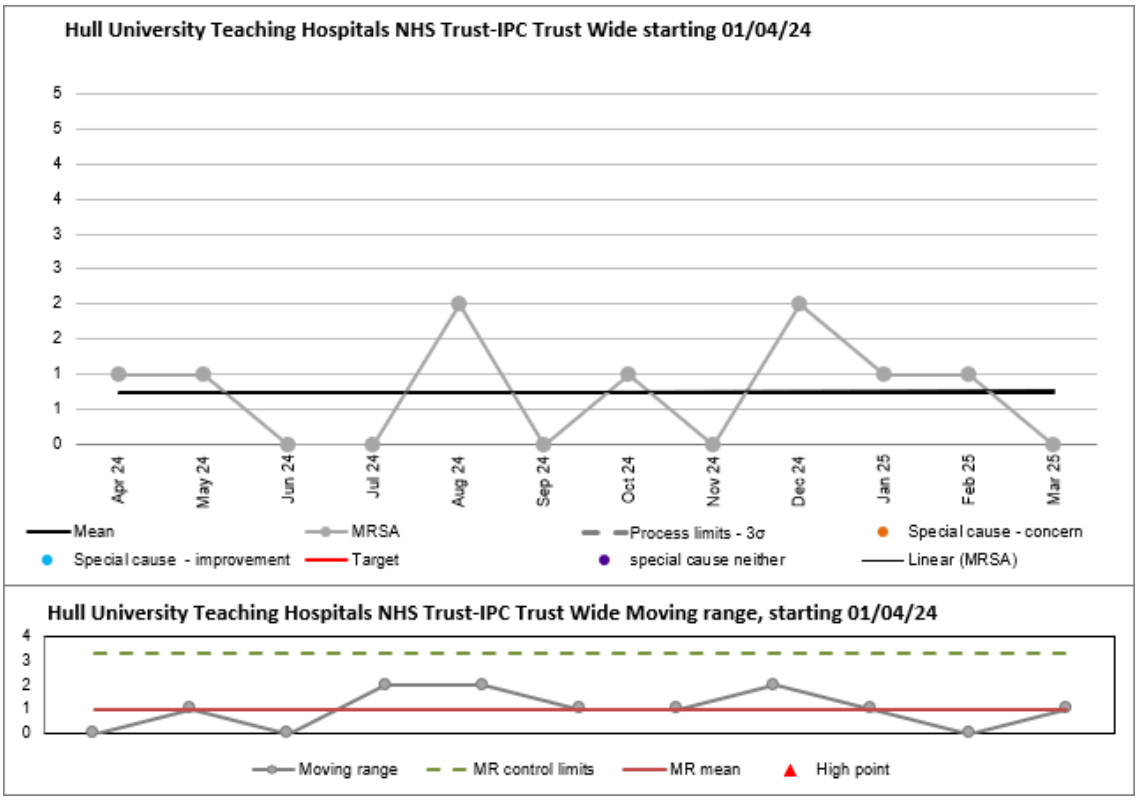
2.3.1.1.1 methicillin resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI)

Over the last ten years the Department of Health & Social Care have monitored Trust apportioned MRSA Blood Stream Infections (BSIs) against a policy of 'zero tolerance of avoidable infection.' It was accepted that there would continue to be, a small number of infections seen, and that the national aim was to reach an 'irreducible minimum.' National and Regional figures support this contention (Figure 5, shows Trusts position against others in the region). The numbers of total and hospital onset MRSA BSI diagnosed in the Trust for the last year are shown in the graphs below.

HUTH:

During 2024-25, there were nine MRSA bacteraemia's; eight hospital onsets, healthcare associated (HOHA) cases were reported, and one Community Onset Hospital Acquired (COHA) in total.

Figure 3: **HUTH Figures**



All nine cases were investigated via Post Infection Reviews (PIR) by both the Trust and System Partners. Learning from the PIRs is shared at the time of the meeting with the associated care group. The learning is shared at OIRC through the care group reports for learning across the Partnership. Recurring themes and trends are picked up in the IPCC improvement work.

There were no reported outbreaks of healthcare acquired MRSA infections.
Of the five reported HOHA MRSA bacteraemia cases, all represent patients with complex past medical histories and multiple comorbidities. Many of the cases had a history of MRSA colonisation and/or previous infection, who had received timely treatment, however some of the cases, did highlight compliance with the MRSA policy could be improved. The MRSA/MSSA policy has been updated and will be shared across the Partnership.

NLAG:
During 2024-25, there were 6 hospital onset healthcare associated (HOHA) cases were reported in total. Learning from the PIRs included similar finding to HUTH, some patients had a history of MRSA with timely treatment and were unavoidable, equally, some cases require learning lessons, as patients received, sub-optimal peripheral cannula care and antibiotic prescribing not in line with guidance.

Figure 4: NLAG Figures

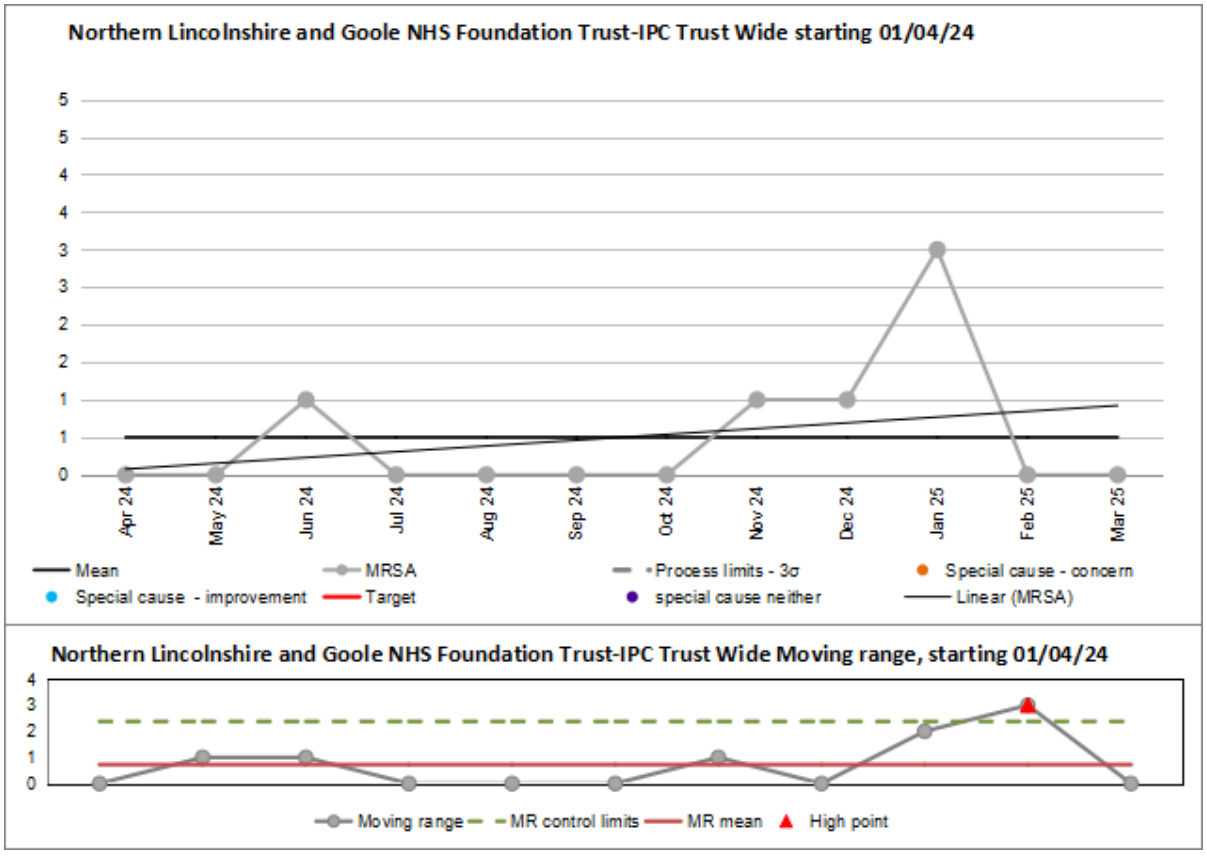
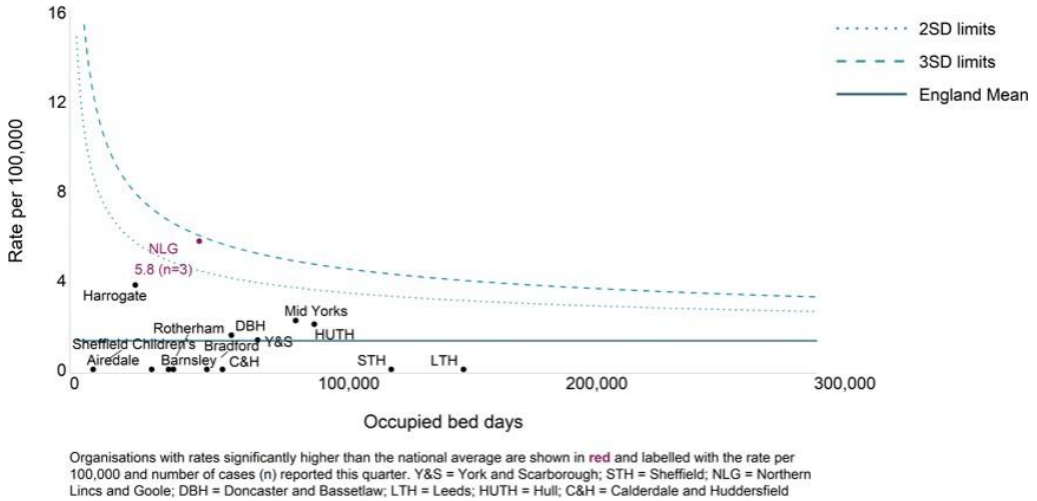


Figure 5: Regional MRSA Figures

Healthcare associated MRSA bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025.



Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. Y&S = York and Scarborough; STH = Sheffield; NLG = Northern Lincs and Goole; DBH = Doncaster and Bassetlaw; LTH = Leeds; HUTH = Hull; C&H = Calderdale and Huddersfield

Concerningly NLAG is an outlier for MRSA BSIs in the last financial year, this is being addressed through review of harm ratings, and new measures to review all MRSA BSIs with support from the Group governance team, to ensure lessons learned are implemented into clinical practice.

2.3.1.1.2 Meticillin sensitive Staphylococcus aureus (MSSA) bloodstream infection (BSI)

Currently there are no national threshold for MSSA bacteraemia. During 2024-25 the HUTH cases reduced from the previous year by 10 cases at 80 cases. NLAG increased from 23 to 36 cases for 2024-2025.

Figure 6: HUTH Figures

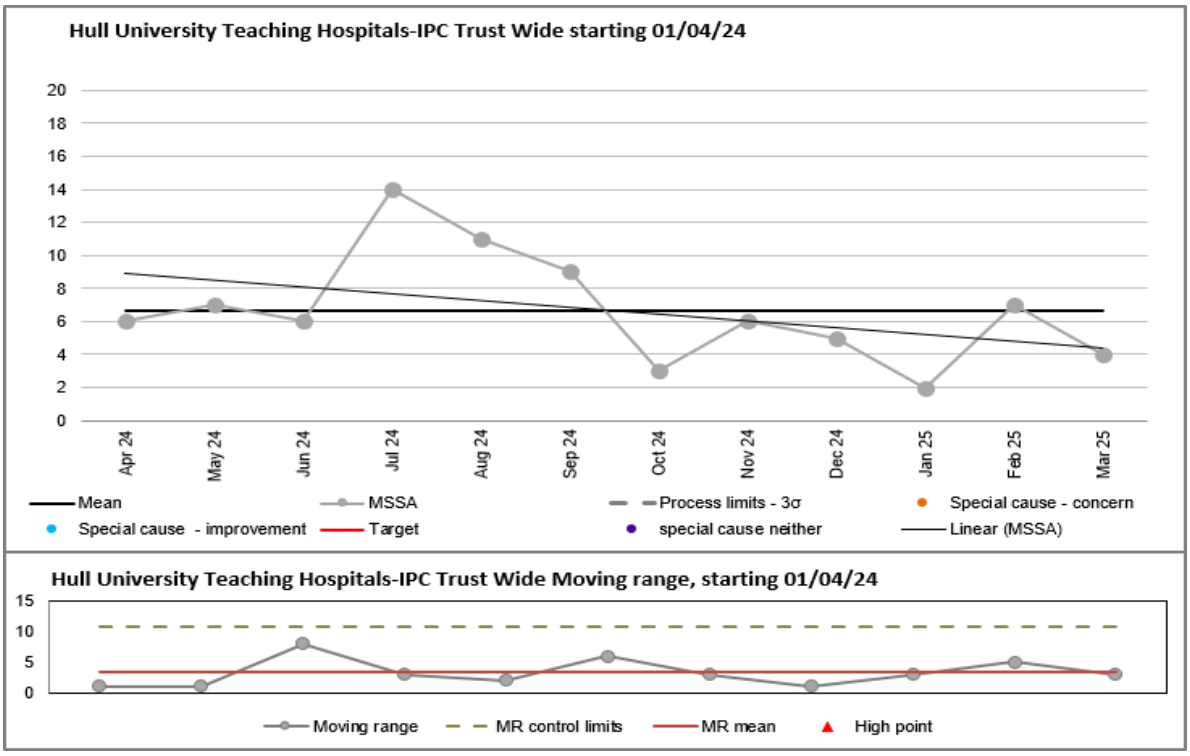


Figure 7: NLAG Figures

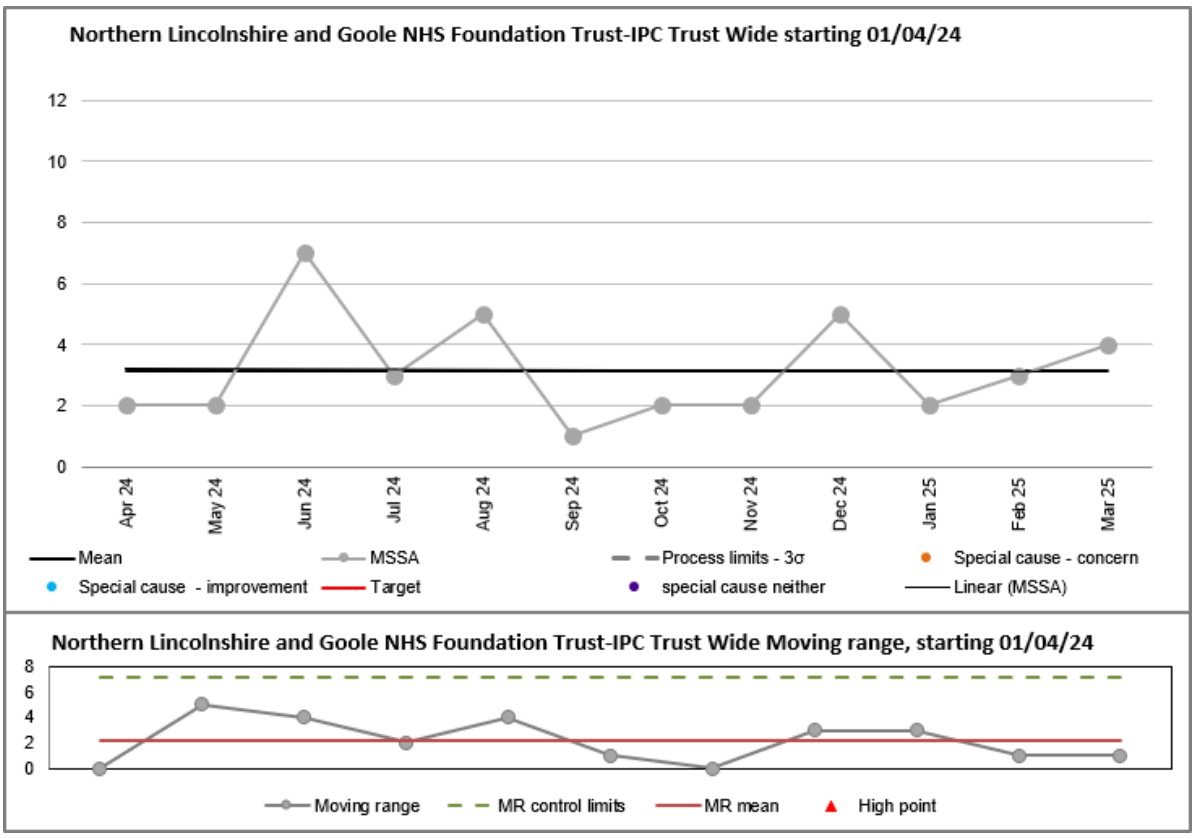
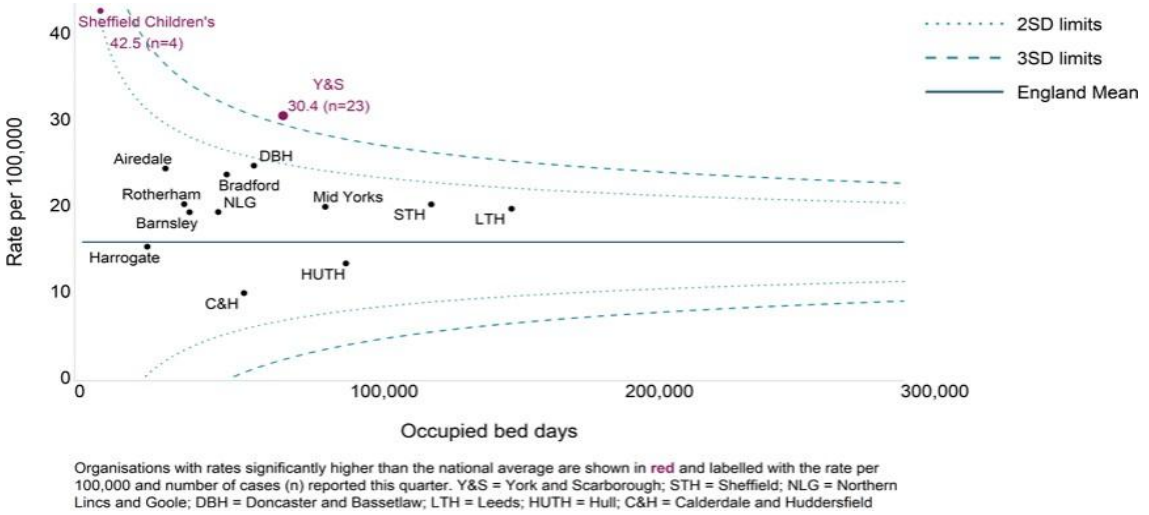


Figure 8: Regional MSSA Figures

Healthcare associated MSSA Bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025.



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There were no reported outbreaks of MSSA during 2024-25.

During 2024-25, NHSE were concerned about the rise in MSSA BSIs across England and requested NHSE regional teams to further investigate MSSA BSI, as a result the Trust completed and submitted a survey in January 2024. The results of the survey across the North of England, where shared during the last financial year, these mirrored findings in the Trusts; with risk factors associated with chronic wounds and wound care, intravenous devices and management, people who injection drugs (PWID's), skin colonisation and diabetic patients being at greater risk. Reduction strategies are centred on intravenous devices insertion and management, Aseptic Non-Touch Technique (ANTT), screening and decolonisation protocols, effective documentation, and education.

During 2024-25, a regional workshop on preventing MSSA BSI was held, and current projects are being implemented across the Region including recommendations to form a Partnership MSSA BSI reduction strategy. There needs to be an ongoing focus on vascular device insertion and management with an aim of creating a vascular access service across the Partnership to support and facilitate best practice and patient care. This is currently being worked up across the Group with a business case submitted for review by the executive team for the formation of a vascular access service for the HUTH site.

2.3.1.1.3 Gram negative organism blood stream infections (GNBSIs)

For the operational period 1st April 2024 to 31st March 2025, UKHSA and NHS England required NHS Trusts to continue to report cases of BSIs due to E coli, Klebsiella species and *Pseudomonas aeruginosa (P. aeruginosa)*. These were

based against set threshold targets outlined by NHSE, the below Table 1 and 2 show the NHSE thresholds set for HUTH and NLAG, and the performance against these thresholds for 2024-25.

Table 1: HUTH: Gram Negative National Thresholds

Blood stream infection	**2024-2025 upper threshold as per standard contract (HOHA* & COHA* cases combined)**	**Year-end actual reported case total (HOHA* & COHA* cases combined)**	**Performance**
E coli	216	220	Exceeded threshold
Klebsiella species	88	74	Below threshold
Pseudomonas aeruginosa	36	26	Below threshold

Table 2: NLAG: Gram Negative National Thresholds

Blood stream infection	**2024-2025 upper threshold as per standard contract (HOHA* & COHA* cases combined)**	**Year-end actual reported case total (HOHA* & COHA* cases combined)**	**Performance**
E coli	57	69	Exceeded threshold
Klebsiella species	34	32	Below threshold
Pseudomonas aeruginosa	5	13	Exceeded threshold

<u>E. coli bloodstream infections</u>

The threshold for HUTH was 216 cases and 220 cases were reported. This was 4 cases above threshold, however, 4 cases reduction on last year's performance.
The threshold for NLAG was 57 cases and 59 cases were reported. This is both an increase in reported cases, and poorer performance, the IPCT going forward will be reviewing themes and trends at NLAG. NLAG are involved in the Group Deteriorating Patient (DP) and Sepsis Quality Improvement Programme (QIP) aimed at reducing gram-negative BSIs, specifically E. coli, through improvement work relating to care of catheter and management of urinary tract infections.

Figure 9: HUTH Figures

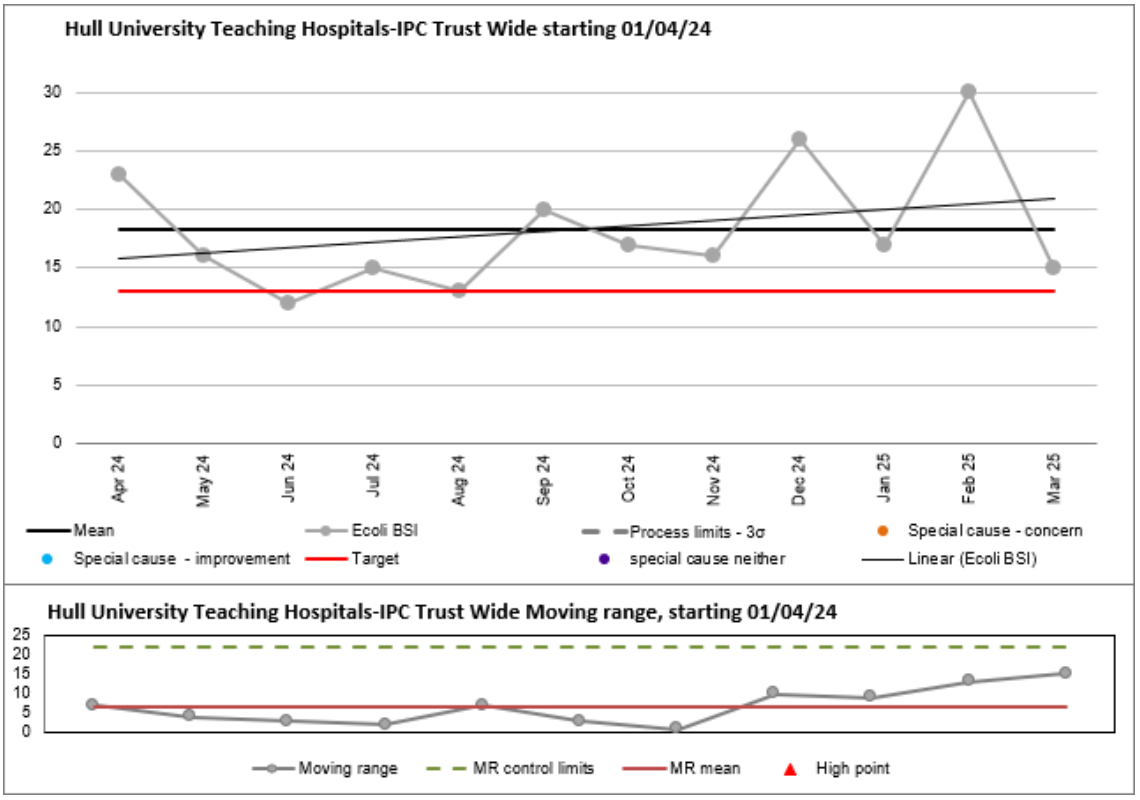
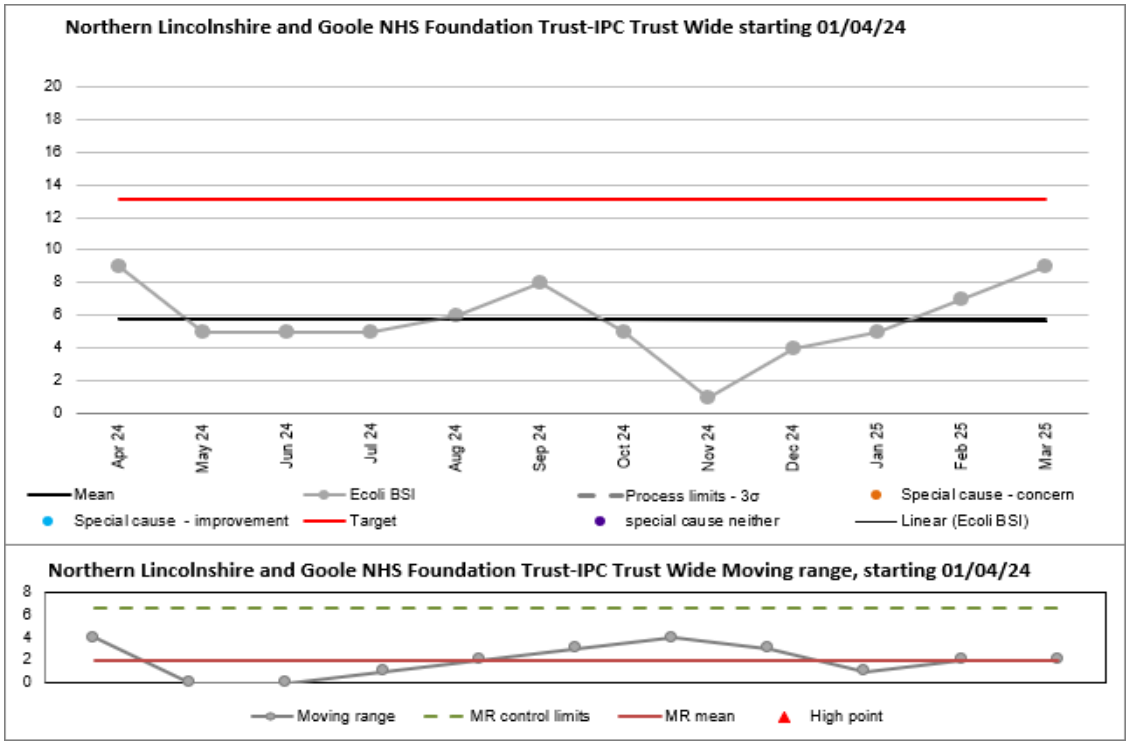


Figure 10: NLAG Figures

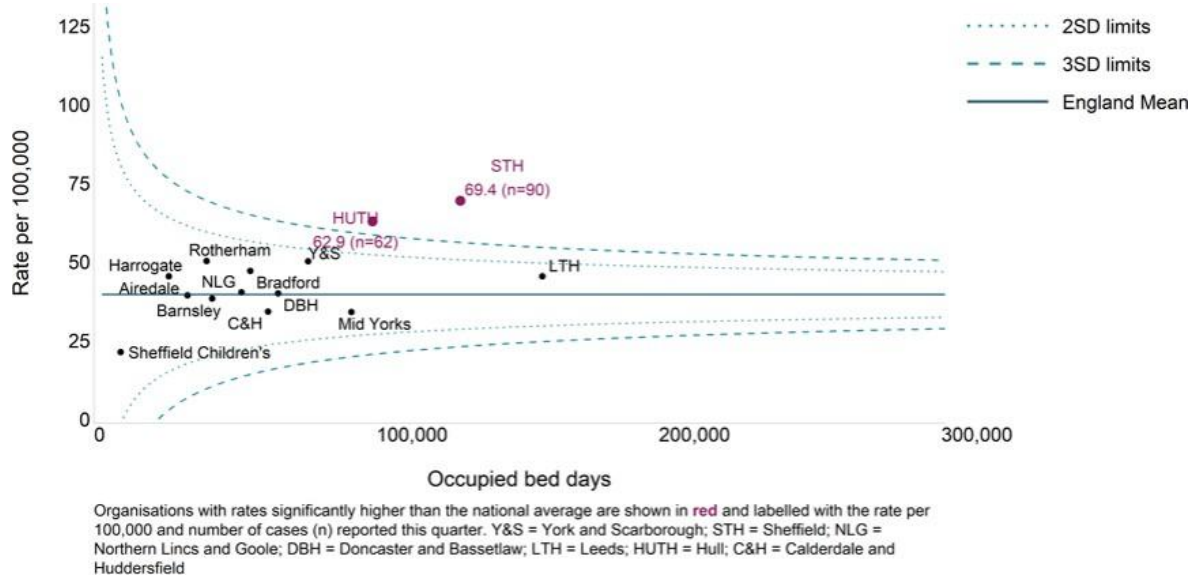


During 2024-25, NHSE focused on reducing healthcare associated *E. coli* bloodstream infections because they represent 55% of all gram-negative BSIs. Approximately three-quarters of E. coli BSIs occur before people are admitted to hospital, reduction requires a whole health economy approach. To commence this key work, stream the IPCT completed a GNBSI self-assessment intended to assist organisations or systems to produce a focused and effective action plan for reducing E. coli BSIs. To effectively reduce the number of E coli BSIs, there will need to be coordinated work across the Group looking at improvements in patient hydration, the use and care of urinary catheters and reduced delays in infection source control e.g. delayed interventional procedures.

The Deteriorating Patient (DP) and Sepsis: Infection Reduction Task and Finish Group, are currently working towards implementing a plan for reduction in catheter related infections, following a comprehensive audit during March 2025 in conjunction with BD and the IPCT for HUTH and NLAG; collating data on all inpatient areas for those patients with indwelling catheters. This has resulted in a robust action plan, focused towards addressing areas of concern highlighted in the audit, including hand hygiene, Aseptic Non-Touch Technique (ANTT) on catheter insertion, gaps in documentation and care of patients with catheters. Progression will be monitored through the above task and finish group.

Figure 11: Regional E. coli Figures

Healthcare associated *E. coli Bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025.*

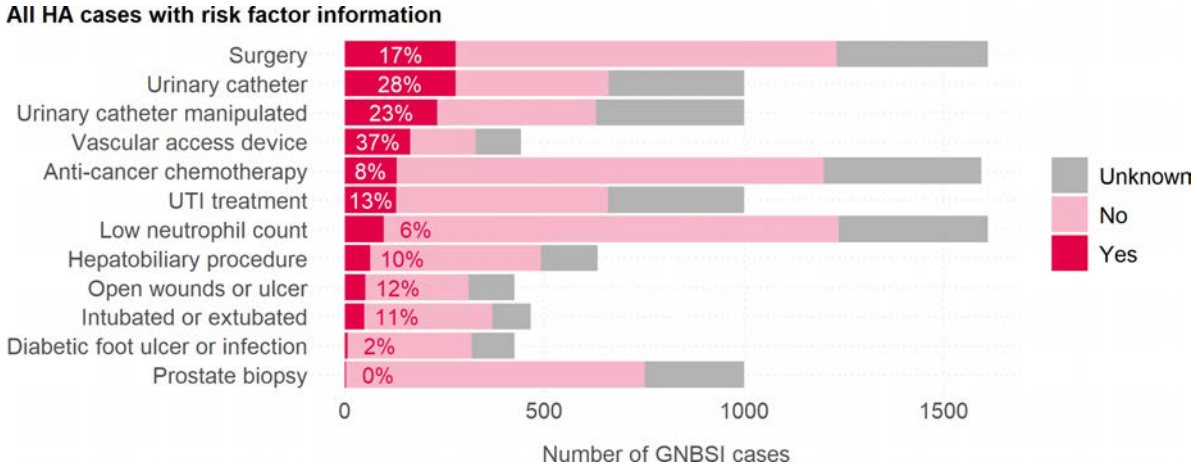


Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. Y&S = York and Scarborough; STH = Sheffield; NLG = Northern Lincs and Goole; DBH = Doncaster and Bassetlaw; LTH = Leeds; HUTH = Hull; C&H = Calderdale and Huddersfield

HUTH remains a regional outlier, similar to NLAG is undertaking the Group DP and Sepsis QIP, to improve overall performance.

Risk factors reported for healthcare-associated (HA) *E. coli* bacteraemia cases reported from Yorkshire and Humber NHS acute trusts, April 2024 to March 2025
Exposures in the 28 days prior to GNBSI onset except for surgery (30 days or 12 months for prosthetic material); % = exposed proportion of all cases with risk factor field completed (includes Unknown).

Figure 12: Causation Risks



Klebsiella species bloodstream infections

The threshold for HUTH was 88 cases and 74 cases were reported; this is below threshold and an improvement on previous year's performance. The threshold for NLAG was 34 cases and 32 cases were reported; this is below threshold and improvement last year's performance.

Figure 13: HUTH Figures

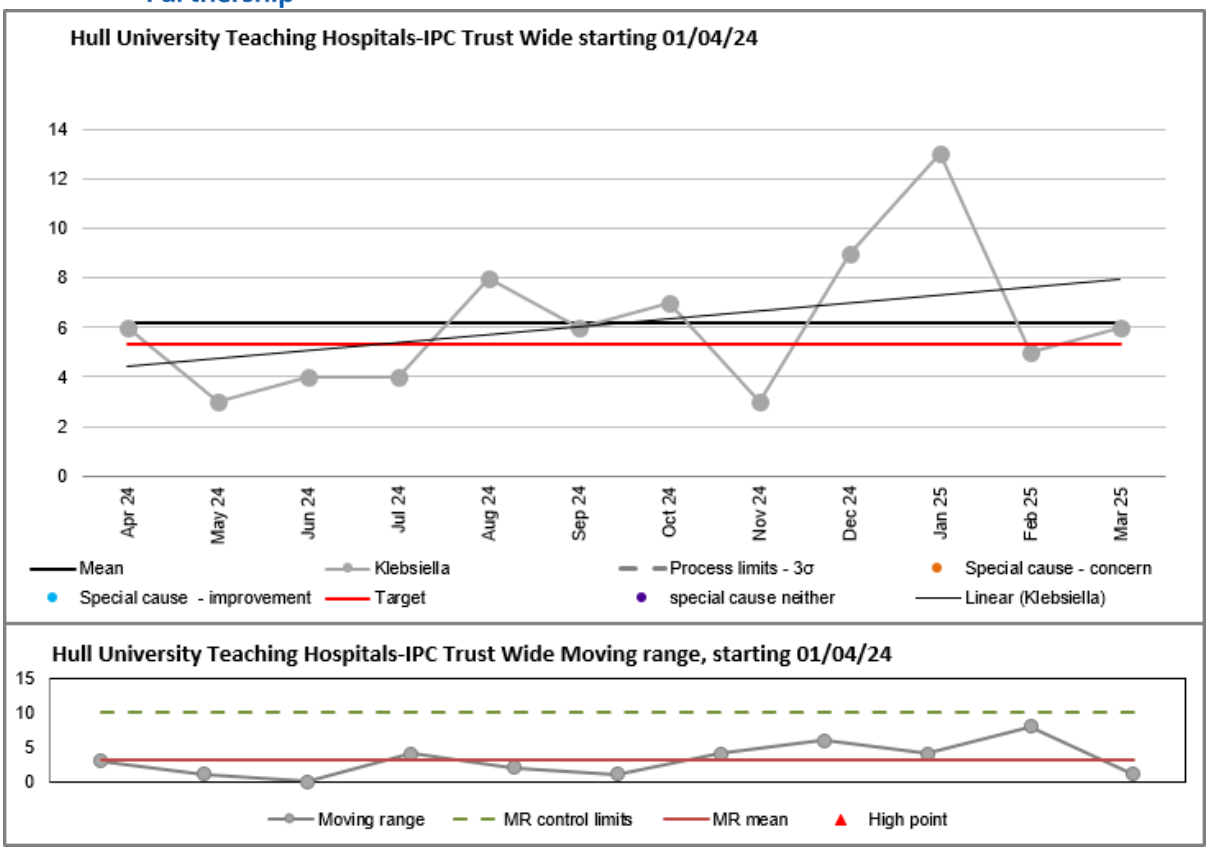
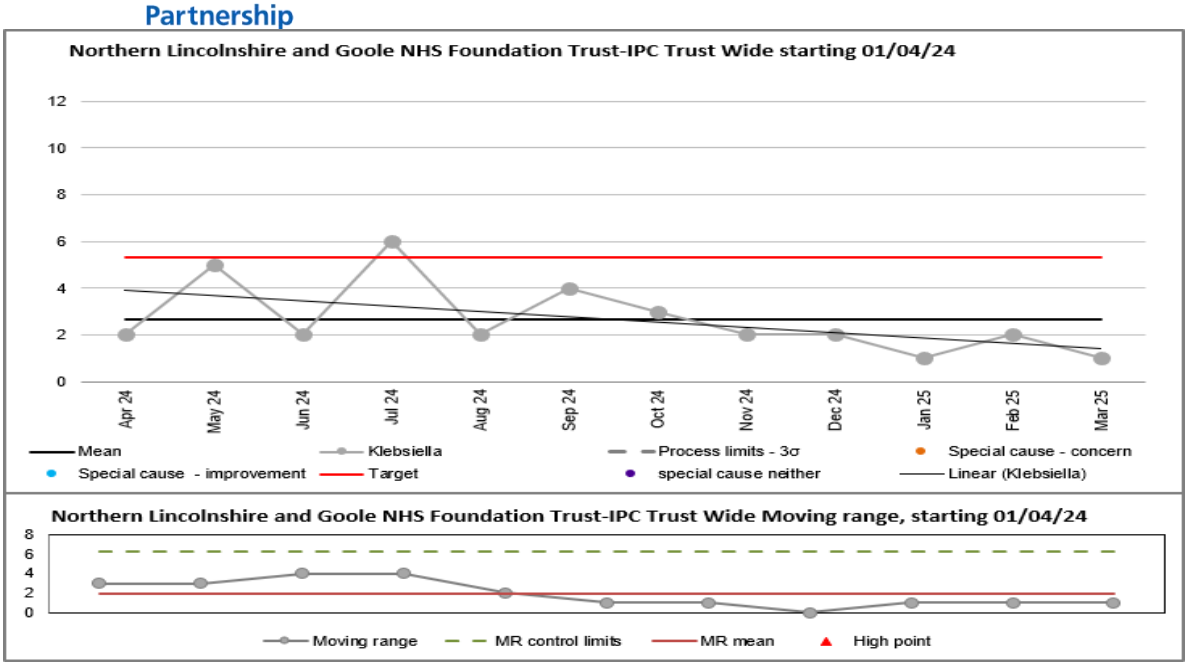


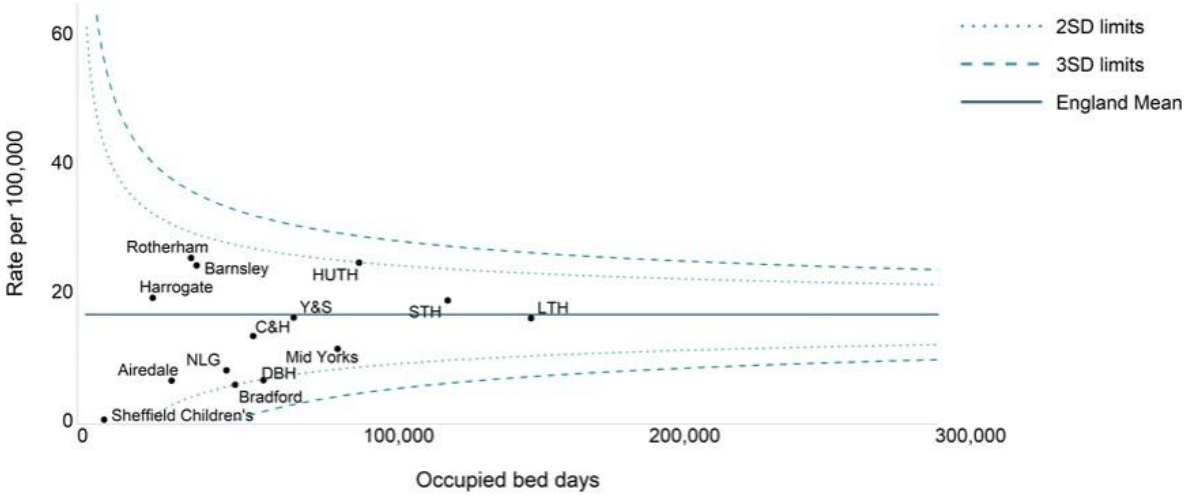
Figure 14: NLAG Figures



The same trends and risk factors apply for Klebsiella as per E coli, i.e. most infections are of urinary or intra-abdominal focus and although some are unpreventable, improvements in hydration, catheter care and surgical source control are all likely to give beneficial improvement. These are focuses for the IPCT work plan for the next financial year.

Figure 15: Regional Klebsiella Figures

Healthcare associated *Klebsiella spp*. Bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025.



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<u>Pseudomonas aeruginosa bloodstream infections</u>

HUTH has improved in the number of reported pseudomonas BSIs during 2024-25 and did not breach national threshold target. Overall pseudomonas cases were 26 which was 10 under the threshold of 36. NLAG reported 13 cases having a threshold of 5, this is a significant breach of the national threshold, with more than double the number of cases set as a target. Whilst these totals remain quite low, the IPC workstreams planned and supported for 2025/26 are aimed to have a positive impact on these rates, and going forward IPCT will be reviewing themes and trends at NLAG, to inform future improvement work

Figure 16: HUTH Figures

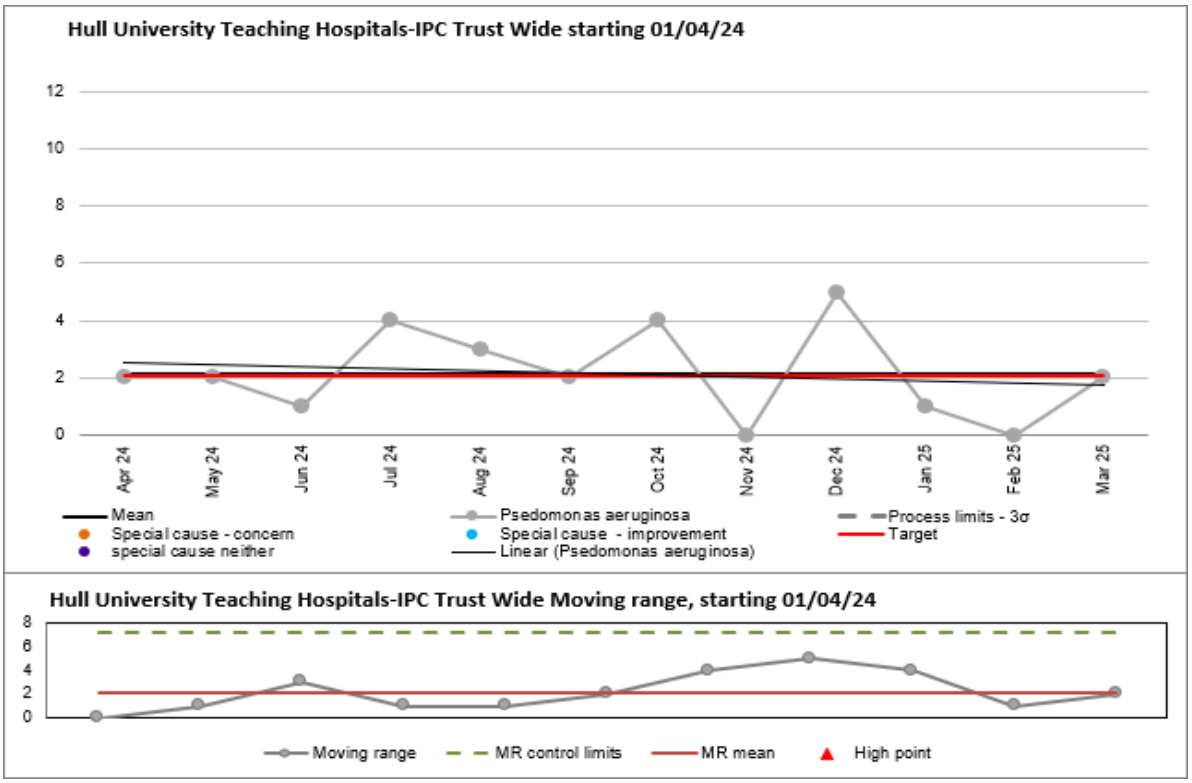
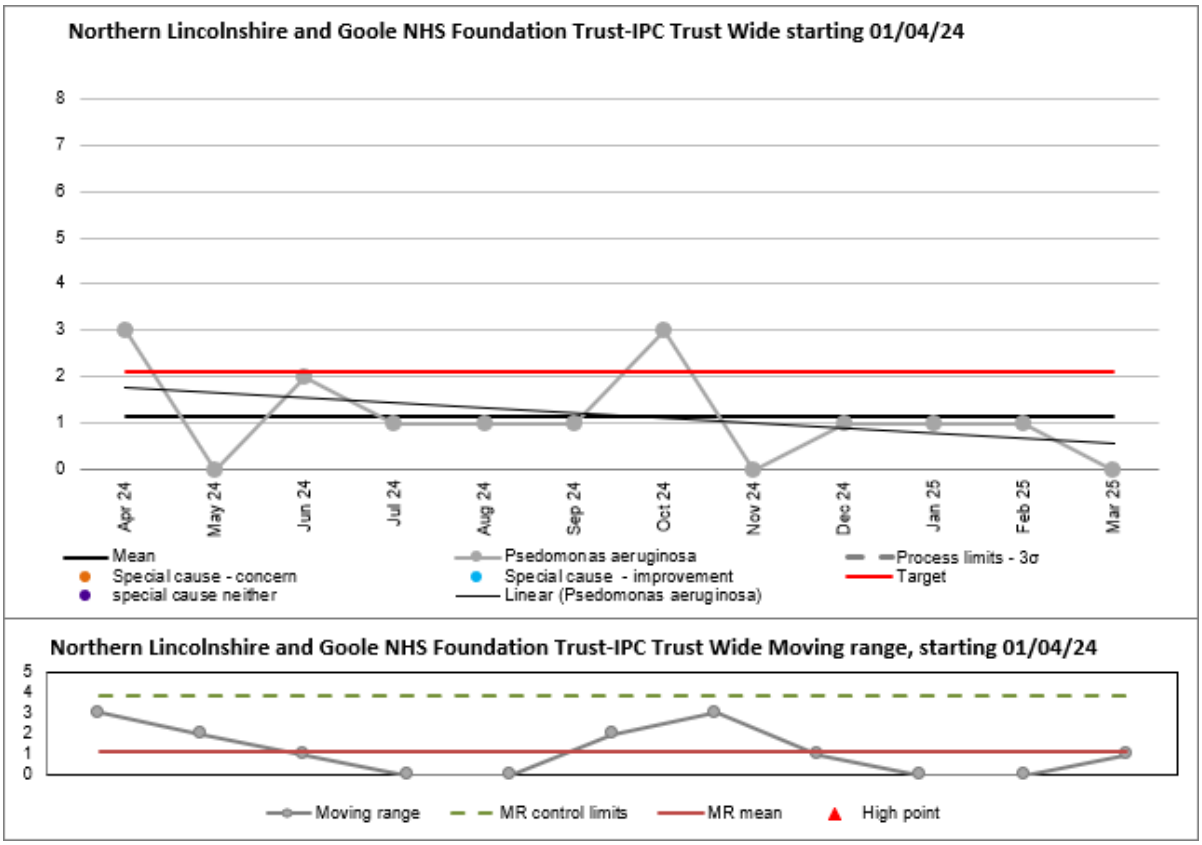


Figure 17: NLAG Figures

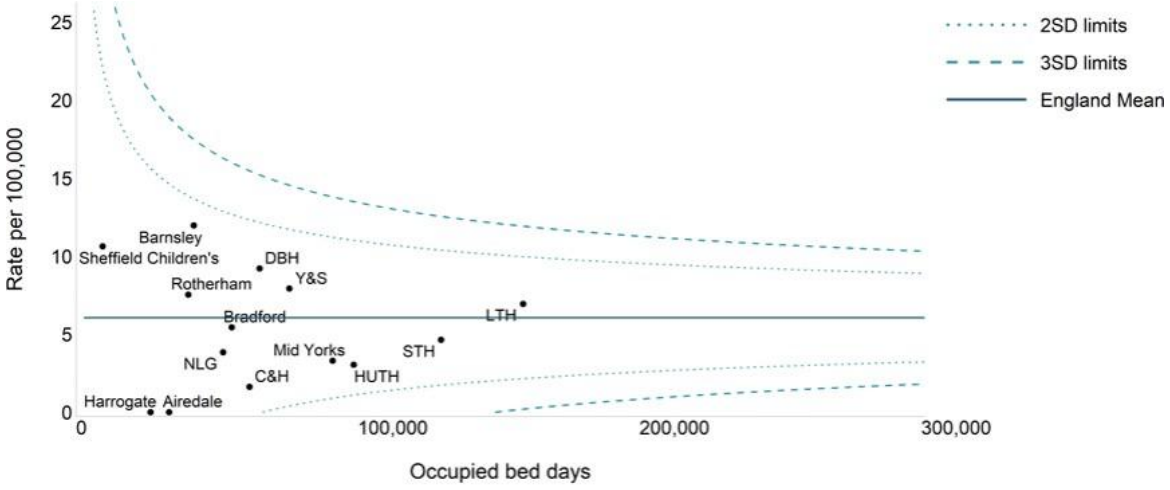


Understanding reasons for the significant increase at NLAG during 2024-25. Initial analysis of the causation for the increase has identified differences in the reporting mechanisms between NLAG and HUTH for UKHSA data submission. These have now been standardised across the Group and are in accordance with the UKHSA recommendations, to ensure robust reporting.

Figure 18: Regional Pseudomonas Figures

Healthcare associated *Pseudomonas aeruginosa* bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average,

January to March 2025.



Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. Y&S = York and Scarborough; STH = Sheffield; NLG = Northern Lincs and Goole; DBH = Doncaster and Bassetlaw; LTH = Leeds; HUTH = Hull; C&H = Calderdale and Huddersfield

There were no reported outbreaks of Pseudomonas aeruginosa BSI, although monitoring of cases in augmented care areas continued during 2024-25 due to the risk correlation associated with the environment, especially water.

Causation was associated with hospital, community and/or ventilator associated pneumonia, skin and soft tissue infections, biliary and neutropenic sepsis.
Babies on the neonatal intensive care unit (NICU) in HUTH, are routinely screened for Pseudomonas carriage due to the significant risk of infection in this group and new isolates are sent to the reference laboratory for typing.

2.3.1.1.4 Clostridioides Difficile Associated Diarrhoea (CDAD)

During 2024-25 both HUTH and NLAG have significantly deteriorated in performance for the number of reported CDI cases. Both Trusts have breached their thresholds, however neither Trust is a regional outlier. There has been a national increase in CDI cases, which has resulted in NHSE commissioning a deep dive review as to the causation for this. The results of this work have not been published to date.

Following individual reviews of CDI cases, we have a number of cases which could be avoidable, and link to delays in sampling, timely implementation of treatment plans, poor compliance with IPC practices and AMS. As a result of these reported concerns, HUTH has introduced a weekly review of all CDI cases by the IPCT, to ensure effective management plans are in place for all patients with CDI. The plan is to replicate this process in NLAG throughout Q3. NLAG has introduced AMS ward rounds following the successful appointment of a Lead AMS pharmacist in October 2024.

Figure 19: HUTH Figures

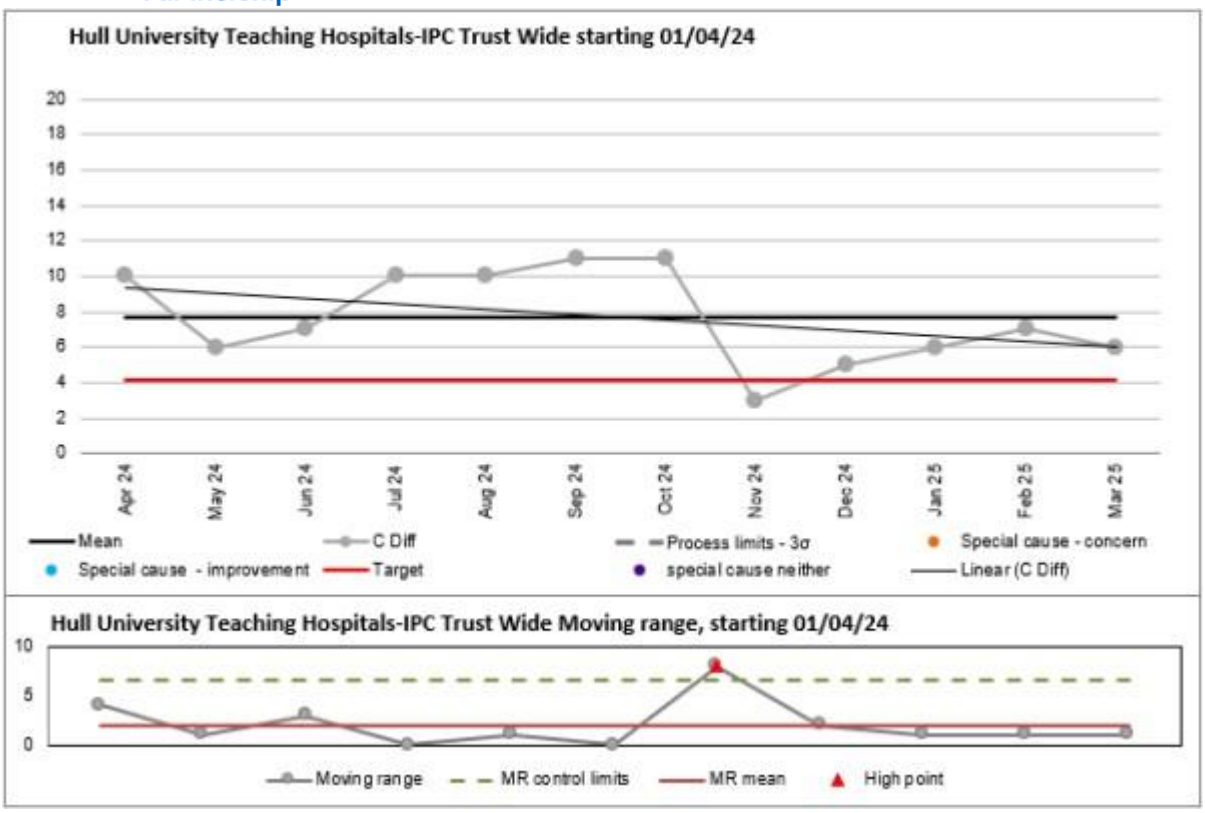


Figure 20: NLAG Figures

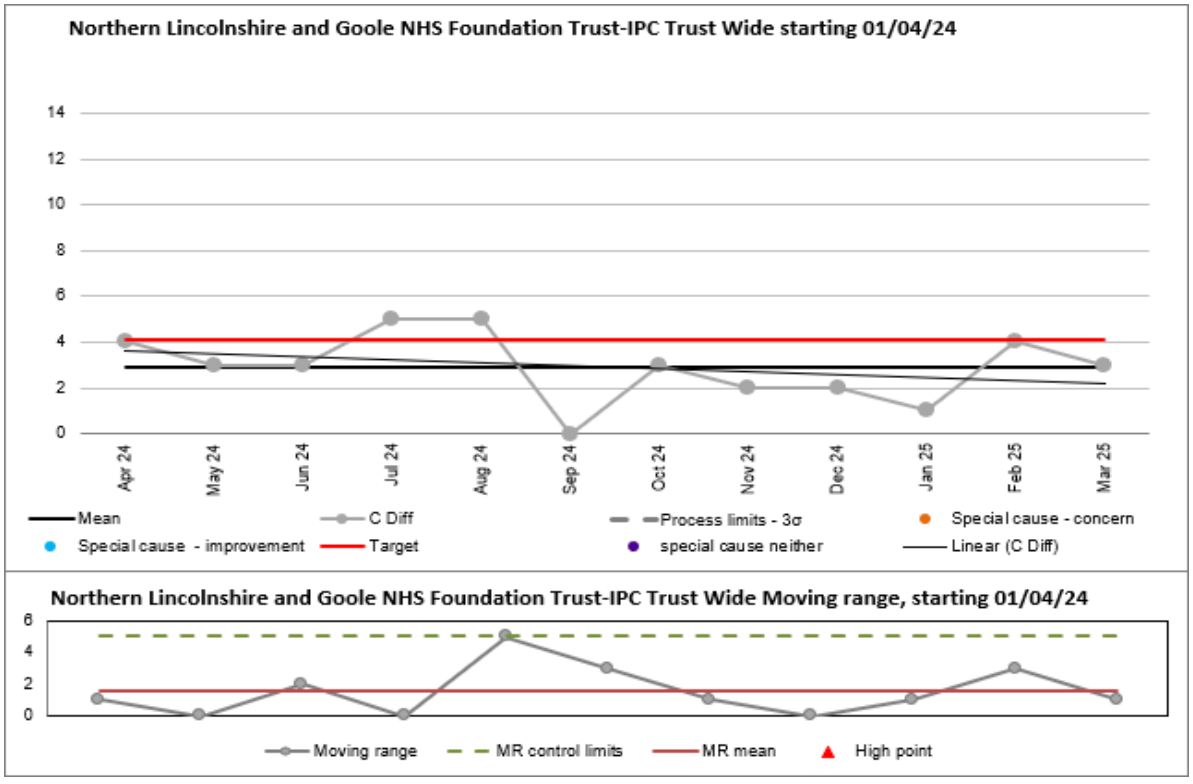
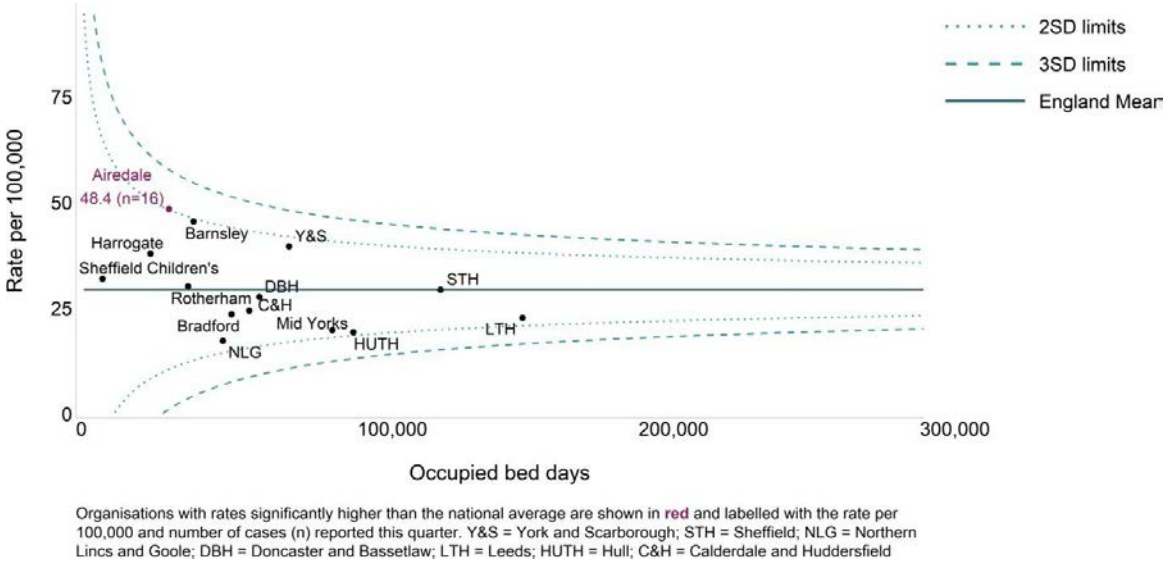


Figure 21: Regional C.diff Figures

Healthcare associated CDI rates in patients over 2 years of age per 100,000 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025



Organisations with rates significantly higher than the national average are shown in red and labelled with the rate per 100,000 and number of cases (n) reported this quarter. Y&S = York and Scarborough; STH = Sheffield; NLG = Northern Lincs and Goole; DBH = Doncaster and Bassetlaw; LTH = Leeds; HUTH = Hull; C&H = Calderdale and Huddersfield

Both HUTH and NLAG CDI rates fall below the mean for England, although improvement work for CDI is a key focus for IPCT during the next financial year.

2.3.1.2 multi-drug-resistant organisms Carbapenemase producing Enterobacterales (CPE) and Vancomycin Resistant Enterococci (VRE)

Carbapenemase producing Enterobacterales (CPE)

HUTH has continued to progress the multi-drug-resistant organism (MDRO) screening for CPE and VRE. This has resulted in the roll out of screening provision in all high-risk services such as, oncology, renal, non-elective ICU to allow the Trust to move towards compliance with the National Framework of Actions to Contain CPE. This ongoing proactive screening has so far identified single cases of CPE who have been managed in accordance with Trust policy and did not result in onward transmission.

During Q4, it was noted of an increased incidence of CPE within DPOW, resulting in two known CPE BSIs. A CPE outbreak was declared in February 2025 at DPOW. In response to this, a ‘Gold command’ structure was established chaired by the Chief Nurse, with membership of all internal and external stakeholders. Five ‘Silver’ workstreams were established under this, focusing on the key elements of the UKHSA Framework for the management of CPE: AMS, Estates & Facilities, Screening and Microbiology, Education and Operational Outbreak management. Following this a look back exercise was commenced from December 2024 reviewing all patients screened for CPE in NLAG, this has become an ongoing outbreak, which currently continues to be managed in accordance with the framework.

Vancomycin Resistant Enterococci (VRE)

During 2024-25, HUTH continued to see several VRE cases, in the vascular services. In addition to the concern impacting individual patients this has resulted in the loss of surgical capacity, and therefore the cancellation of patients on elective and non-elective pathways. The ICD and IPCT have worked in conjunction with the vascular services to address the above issues, with the introduction of a cleaning matrix and guidance for theatres for the management of low-risk patients that are VRE positive to reduce lost theatre time due to enhanced cleaning between patients.

During 2024/25 a VRE outbreak was reported on Ward 22 at Scunthorpe hospital. This was discovered following molecular VRE screening at HUTH for patients transferred across the Trusts, three patients were identified to be VRE colonised, and an outbreak was declared. An incident group was commenced including system partners. All patients were screened, and discussions took place across the Group. The ward was closed to admissions during April 2024 and strict IPC measures put in place. The IPCT measures included; enhanced cleaning, weekly screening of all patients, enhanced IPC audits including hand hygiene, environment and personal protective equipment use, when no onward transmission occurred and all patients were discharged. The ward was deep cleaned and reopened. Additional specialist cleaning was carried out using Hydrogen Peroxide Vapour and Ultraviolet light therapy in areas unable to have HPV misting. This was a service provided by an outside company with significant cost to the organisation. This process is now being reviewed by facilities, finance, and IPCT to find a timely and cost-effective solution going forward across the Group.

2.3.1.3 Respiratory viruses

Influenza

Both Trust sites identified increased cases of Influenza reported for Quarter 3 peaking in December 2024 at HUTH and January 2025 at NLAG site. This resulted in 625 cases at HUTH and 350 cases at NLAG being reported overall. These were amongst patients acquiring infection in the community, although unfortunately there was significant transmission in ward areas once patients were admitted due to the volume of admissions, and minimal isolation facilities. The overall rise in Influenza A was comparable with other acute Trusts regionally and nationally. The Trusts saw a lower number of Influenza B infections, matching the national picture for influenza B with lower reported numbers, peaking in March 2025.

Patients were tested for influenza, along with COVID-19 on admission, in line with national guidance based on symptoms compatible with respiratory viral symptoms. At HUTH key admission areas including ED, AMU, Queens oncology, and

paediatrics performed viral testing by Point of Care Tests, allowing for timely accurate diagnosis and subsequent isolation and management. In NLAG respiratory testing is supported by PathLinks pathology.

For appropriate management of patients presenting with infective respiratory conditions, maintenance of up-to-date face fit testing for staff is vital to enable them to use appropriate PPE. When rates of infection increased, additional measures were introduced such as, clinical staff wearing respiratory protection following a risk assessment, additional enhanced cleaning and cohort areas identified to manage patients safely. For further information please see the FIT Testing section in 2.4.5.

COVID-19

Covid-19 remained a challenge for the organisation, during Quarter 3, both Trusts had increased activity, resulting in ongoing small outbreaks and bay closures. The Trusts continue to follow national guidance for the management of respiratory viruses, including Covid-19, it had minimal impact in comparison to previous years since the pandemic. Cases of COVID-19 during 2024-25 were due to different COVID-19 variants which resulted in peaks and troughs of the infection.

2.3.1.4 Other outbreaks and infections of note

Norovirus

During Quarter 1 and Q2 from April to August both Trusts had seen an increase in Norovirus. This was in line with the national picture. HUTH had an increase in incidences in Q4 during February and March 2025. The wards were supported by the IPCT to ensure all IPC measures and cleaning requirements were adhered to. In accordance with national guidance the outbreaks were managed with partial restrictions and no complete ward closures were necessary. IPCT is working with business intelligence (BI) to establish a data collection tool for norovirus cases, to ensure accurate monitoring through-out the year, and support reporting to UKHSA on number of cases.

Scabies Outbreak C7 Castle Hill

During 2024-25, C7 declared a Scabies Outbreak amongst staff during the month of September 2024. There was an initial delay in diagnosis of scabies that resulted in a protracted significant outbreak. Following declaration of the outbreak, an incident meeting was convened and a decision made to treat all staff, and patient contacts. Other actions included a deep clean and full linen changes; communications team prepared statement with warn and inform letters for affected staff and patients, community partners and UKHSA were informed and invited to the outbreak meetings. As a result of this outbreak, Occupational Health (OH) and IPCT reviewed

the Trust scabies polices and updated the staff information leaflet. The outbreak was closed and no further issues raised in relation to this. There has notably been an increase in scabies cases/ outbreaks during 2024-25 regionally, and the IPCT has been linking in with system partners as required.

Measles

There were 2 identified cases of Measles in 2024/25 at HUTH. The first case was reported in April 2024. The patient had presented to SDEC at HUTH and was transferred to AMU. It was suggestive that the patient had had contact with another family member within the travelling community. The management of both staff and patients was completed in line with national guidance on the management of measles and measle contacts. The second case was an 8-month-old baby that had just arrived in the country on holiday from Romania. The baby was managed as a suspected Measles, so all IPCC policies adhered to, and baby was isolated appropriately on admission. Both cases were managed in accordance with the national guidance, and all relevant community partners were informed, including, Public Health.

2.3.1.5 Surgical Site Surveillance

Trusts continue to participate in mandatory surveillance of surgical site infection (SSI). In 2024/25 results received for HUTH for orthopaedic surveillance fractured neck of femurs and total knee replacements, conducted Q4 in 2023-24 indicated the Trust remained an outlier for SSI. Due to HUTH being an outlier, a group was convened to look at potential improvements to reduce the infection rates in orthopaedic surgery. This group has progressed work and implemented several changes, to improve patient outcomes in relation to SSI, including reviewing theatre practices, changes to lay up preparation and review of pre-operative decolonisation treatments. It continues to work on preventative measures across HUTH.

There have been no SSIs declared for NLAG during this period. However, following the formation of the Group, and alignment of process for the completion of SSI surveillance, it has become apparent that the follow up surveillance has not been captured accurately and therefore not reported, resulting in a zero return for NLAG. The process has now been aligned with results submitted for Q4 January to March 2025, resulting in a Notification of concern to the Trust, NLAG being an outlier, the future focus will be to bring NLAG in line with the work already undertaken in HUTH.

2.3.2 Infectious Diseases and Public Health

The Trust continues to work closely with UKHSA and the local health protection teams. There is an organised weekly huddle for the regional IPCC senior nurse's

lead by Integrated Care Board (ICB). This is a good forum to discuss regional issues and any emerging themes. It provides senior IPCN support and has improved communication and relationships across the region. There is a monthly infection control and antimicrobial stewardship collaborative forum which discusses healthcare acquired infection's themes, trends and required actions. The Trust ICD and Deputy DIPC are members of the Humber & North Yorkshire Integrated Care System (ICS) Antimicrobial Stewardship steering group and The HUTH ICD is a member of the ICS AMR and IPC Programme Board, representing the ICS acute Trusts. A quarterly report is produced for both Hull and North Lincolnshire Health Protection Board.

The Group supports UKHSA in urgent actions required to protect patients and the public from infectious diseases, for example, supporting the supply and delivery of urgent interventions, such as immunoglobulins for post exposure prophylaxis in varicella zoster (chicken pox) cases.

2.3.3 Built Environment

2.3.3.1 Isolation facilities

The provision of isolation facilities for both HUTH and NLAG remains an issue as with many other NHS trusts with older estates. There is a general shortage of single rooms suitable for isolating patients with potentially infectious conditions. This is reflected on the Trust corporate risk register.

Both HUTH and NLAG have had a lack of a decant facilities to enable a proactive, rolling deep clean programme. The ability required to close a ward in the event of an outbreak is equally an issue for the organisations and must be considered alongside the requirement to increase isolation facilities.

To mitigate the risk the following initiatives have been introduced. During 2024-25 HUTH have had several of the 10-bedder bays in the HRI tower block wards having been fitted with floor to ceiling partitions to help reduce infection transmission, through containment of the shared airspace. Currently, NLAG utilise the Redi-rooms which were purchased during the pandemic to facilitate and increase isolation facilities. Recently, a review completed by IPC and Care groups considered the number of Redi-rooms required overall, following the upgrades to the current building, as both Trusts have increased the number of single occupant rooms.

2.3.3.2 Other Estate issues

There are some areas in both Trusts that are being used for purposes other than their original design, which poses potential risks to patients and staff. The ventilation Group is in the process of identifying, which areas of the Trust should be identified

as critical ventilation, this has highlighted some issues. The IPCT will be raising these issues as risks with the relevant clinical services, so that mitigations and alternative plans can be made. An example of this in HUTH, is the acute hand trauma service is using a room as a theatre environment, that does not meet the relevant standards for ventilation for a clinical use, therefore a plan was taken forward to reduce this risk and increase the ventilation of the room, making required improvements.

2.3.4 Water safety

The national guidance on water safety, Health Technical Memorandum (HTM) 0401: Safe water in healthcare premises provides guidance on the legal requirements; design, maintenance and operation of hot and cold-water supply, storage, and distribution of all water systems in healthcare premises. During 2024-25, water safety continues to be monitored by the Water Safety Group (WSG), which is required to report into OIRC & SIRC. Due to the formation of the Group model, this water safety group needs to be further developed to work collaboratively across the Group. Both Trusts have a Water Safety Plan (WSP) which provides a risk-management approach to the safety of water and establishes good practices in local water usage, distribution, and supply. Water safety management is shared by everyone in the Trust. Estates continue to improve internally to ensure the message gets portrayed, either via communications or by delivering presentations to mixed cohorts.

At NLAG the Authorising Engineer (Water) 2024/5 audit confirmed that all three of the sites had appropriate Pre-Planned Maintenance (PPM), with other records present and well completed, there was limited identified exceptions and records where in accordance with current task standard operating policies (SOPs).

Estates continued employment of a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients. Any positive water samples culturing Legionella and/ or Pseudomonas are reported by UKHSA to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

The water sampling regime at HUTH has been reviewed to focus not only on augmented care areas but also other areas identified as high-risk by IPCT. A full suite of SOP’s has been developed that cover all aspects of water systems maintenance tasks both planned preventative maintenance, reactive activities, and water sampling.

During December 2024, legionella pneumophilia sampling was conducted as part of routine testing, this showed a significant count in C20 Castle Hill Hospital (CHH), this initiated a rapid review of the area, water system, and practices. The area was closed to patient admissions for a period of four weeks. Patients were decanted into alternative areas, to support completion of the required works. Prior to reopening full water sampling was undertaken and results obtained for assurance.

Both organisations have had blockages due to inappropriate use of waste outlets, this has increased, with numerous foreign objects pulled from blockages in the waste system. Blockages in clinical hand wash basins (CWHB) create slow draining sinks which are a risk factor in CPE management, this has been picked up as part of the ongoing CPE outbreak management work, along with a sluice room audit, carried out by IPCT, estates and microbiology, in conjunction with improvement works for the CPE outbreak.

All blockages are now reported on the Trust risk management system and escalate to IPCT and the respective area to allow investigation and tracking. A trial of maceratable wipes has been undertaken, feedback was extremely positive, which has helped reduce the number of blockages to the drains. A paper is to be presented to Cabinet for the use of maceratable wipes, across the Group.

2.3.5 Ventilation Safety

The Group now has a well-established ventilation safety committee, which is chaired by the estates team and supported by the IPCT, an external Authorising Engineer (AE) and other relevant services are engaged, such as lead for Private Finance Initiative (PFI) buildings within the Trust. The group is working towards understanding where the Trusts are compliant with the relevant HTMs, whilst recognising there are significant risks due to the aging estate and aging ventilation plants. These risks remain on both Trusts risk registers and are regularly monitored and reviewed.

2.3.6 Decontamination of medical devices and Equipment

The Decontamination Group met during 2024-25 to provide assurance for the processes in place across the Group in ensuring appropriate decontamination of re-useable medical devices, surgical instruments, and endoscopes. The Decontamination Group has been chaired by the Allied Health Professional (AHP) Care Group Director for Theatre, Anaesthetics and Critical Care (TACC) with deputy chair Digestive Diseases Nurse Director. The Group conducts a monthly meeting; The Trust Endoscopy group, Sterile Services and Theatre, Anaesthetics and Critical

care group report into this group, escalation of concerns are reported via this Group into SIRC.

A continued focus has been the development of an asset register to document patient care equipment and the required decontamination, including; responsibility, process, frequency, and traceability. An asset register will need to encompass all patient care equipment, where decontamination is required and as such during 2024-25 it was evident decontamination of patient care equipment was taking place across the all the sites by multiple teams and differing disciplines. The continuation of this work, with an asset register, methods of decontamination and audit of processes and practices will form the basis of the committee's direction for 2025-26 and as such, will remain a priority.

Cleanliness audits for patient care equipment, such as, blood glucose monitors are undertaken through the Trusts Accreditation Clinical Excellence (ACE) programme and manufacturers in reach, with results fed back to the wards and departments, with immediate effect should equipment found to be contaminated. In some cases, individual nurses and clinicians who last used the equipment can be identified with appropriate training and education provided. This is facilitated by the Point of Care Team with support from the IPCT and completed at regular intervals during the year.

During 2024-25, an Endoscopy User Group (EUG) met bimonthly with input from the infection prevention & control team. This input is pertinent given the challenges of there being no onsite decontamination for endoscopes on the HRI site. The Trust is reliant on Central Sterile Services Department (CSSD) to provide a timely turnaround of scopes. IPC continued to provide advice and support for the requirements for the new endoscopy suites within the Allam Digestive Health Building at HUTH. Estates in conjunction with CSSD have started the replacement of older endoscopy washers with new models, this programme is ongoing. This should improve the resilience of the washer disinfectors. The Endoscopy service at HUTH continues to work towards JAG accreditation, whilst NLAG have this status.

CSSD service is outsourced to Steris for all NLAG equipment, and they follow the same required standards for practices as outline below.

CSSD continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008. For moist heat and gas plasma sterilisation of theatre trays, procedure packs, and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only). Clinical team's complete incident reports

should sterile equipment fall short of the required standards and investigated by CSSD accordingly. During 2024-25, embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued with the additional development of a SOP for management of surgical instruments.

2.3.7 Facilities

2.3.7.1 Cleaning

Cleaning services have two systems in place, HUTH have an outsourced service with OCS and NLAG have an in-house managed service.

NLAG Cleaning Services:

1. 1 Over the past twelve months, cleaning services across NLAG have been reviewed, so understanding across the Group could be achieved. Working in partnership with IPCC and Facilities Management (FM) teams across the Group has achieved a focused approach to the challenges faced.

1.2 In an attempt to gain control and get ahead of CPE prevalence, areas affected by CPE have seen the FR Rating raised (see below table). By raising the FR rating, the standard to achieve 5* is raised, as a result additional and enhanced cleaning has been provided. IPCC have created the Nursing, HCA Standard Cleaning Checklist NLAG.

Functional Risk	Audit Target Score	Audit Frequency
FR1	98% and above	Weekly
FR2	95% and above	Monthly
FR3	90% and above	Bi-Monthly

1.3 Inpatient Ward areas are defined in the standard as being a FR2 (95% & Monthly Technical Audits), CPE effected Ward areas are now defined at IPCC request as FR1 (98% and Weekly Audits).

1.4 Many areas across the Trust are seeing 3* ratings and below being achieved, due to the new ways of assessing, this is due to cleaning across domestics and nursing requiring improvement, and the fabric of the building can and does impact on the star rating being achieved. All Estates related issues are reported by the FMOs with job numbers being received. Audit findings are shared with Ward Managers, Deputies and Matrons with improvement plans provided.

1.5 A simplified discharge clean request guidance document has been developed as part of the review and rolled out across NLAG. This document clearly lays out the

three types of clean required, breaking down responsibilities and provided clear guidance to achieve. It utilises a colour coded system:

HPV Clean / Enhanced Clean	Tristel Fuse Clean / Infectious Clean	Clinell Clean / Non-Infectious Clean

1.6 With the increasing prevalence of challenging infections including CPE, this has required a full review of current cleaning products and implementation of the use of Tristel Fuse, a chlorine-dioxide (ClO_2) chemical. In addition, Hydrogen Peroxide Vapour (HPV) is in use and will be utilised going forward as standard, for pathogens identified by IPCC and in line with recommendations from the NIPCM.

1.7 Facilities on the NLAG sites are currently reviewing transferring from traditional re-usable socket mops and move towards disposable flat mops. To achieve this, investment in trolley systems that support this cleaning technique is required. This move is fully supported by IPCC and product reviews are being completed.

2. Deep cleaning

1.1 NLAG operates a yearly deep clean schedule with areas categorised in priority and cleaned at the appropriate frequency. This programme continues to remain challenging due to restricted access to wards and associated bed pressures. Areas are frequently out of compliance due to lack of decant facilities for a deep clean to takes place.

2.2 To support this to be achieved, the Capital development team are supporting the refurbishment of closed wards on both acute hospital sites (DPOW & SGH). There is a plan for the refurbishment of Ward 24 on Scunthorpe site, and this will provide a decant facility for a programme of cleaning and required works. This is a positive step to aid the recovery of the deep clean programme. This programme requires full support of Senior Operations teams and the Care Groups.

2.3 There is a requirement to review the Deep Clean team's establishment to ensure it is fit for purpose and in a position to react to enhance, infectious and routine programme deep clean requirements 24/7, including the use of HPV. This is currently being reviewed.

2. Patient Catering Services – Food safety specialist (RFS Ltd) has supported NLAG through continued advice and recommendations which have helped with further investment in the patient catering services. Environmental Health Officer

(EHO) inspections have occurred across the three sites (SGH, DPoW & GDH), they have all retained their 5-star awards.

4. Capital Investment – Our Capital Investment Programme 2024/25 ensures that cleaning/IPCC concerns remains a priority as the hospital environment evolves. The facilities team continues to be well support with a £120k temperature control environment project being delivered within the reporting period at SGH, replacing two walk-in industrial freezer units and three walk-in industrial fridge units that are used to maintain the correct and safe storage temperature for patient and staff catering services.

5. Linen

The Linen Assistants at NLAG are utilising a ruggedised tablet to input linen volumes delivered to wards and departments. This allows the management of linen stock, working more efficiently and allowing understanding for areas of high usage, thus delivering a tailored approach to achieving service delivery. It supports maintenance for the correct stock holding, should we need to implement Business Continuity Plans (BCP).

Following HTM 01-04, NLAG continues to manage and segregate linen, ensuring its categorised accordingly. We continue to work in partnership with the external laundry service Synergy LMS who deliver to us six days per week. A review of this contract is underway, with the introduction of some new key performance indicators (KPIs) to ensure we are receiving the absolute best service.

6. HUTH Cleaning Services

HUTH has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals, this is now a key element of how each hospitals performance is judged, and it is assessed in several ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2024-25, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for HUTH. Healthcare demand post pandemic and a rise in reported resistant organisms have brought challenges with regards cleaning services, especially during surges of infection. Enhanced cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract have been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV).

During the financial year the IPCT attended monthly operational meetings, facilities, in addition to the Ops meetings hold a 6-monthly review meeting, and an annual contract review meeting, as well as ad-hoc meetings to share information with regards to risk and / or issues related to respiratory infections, HCAIs and outbreaks, equally to acquire assurance that hospital cleanliness remained a priority. Support and flexibility have been shown collaboratively between the IPCT and facilities in times of high demand. The below table shows the number of discharge cleans across the 2024/25 year.

Clean Type	Total Number
Green (Clinell)	5588
Amber (Tristel)	6156
Purple (HPV)	330

National Standards of Healthcare Cleanliness (2025) apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007, with amendments published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations, and good practice. HUTH continues to be compliant with these standards, initiating local enhancements to cleaning as needed in collaboration between OCS, HUTH Facilities and IPCT.

Environmental auditing remains a priority for both the Trust, facilities team, OCS, and IPCT to ensure the Trust remains compliant with the standards. All clinical areas display ‘Our Commitment to Cleanliness Charter’ and cleanliness ratings. Efficacy auditing is required annually for all patient facing areas with remedial action and re-auditing needed when areas fall below a score of 80% on the efficacy audit.
We take a collective Multi-Disciplinary Team approach for any improvement plans that are identified as necessary across the audits that take place. All improvement plans are placed onto a tracker that is reported to the (EFD) Group Governance Committee. These are reported into both OIRC and SIRC where facilities have attended and are engaged.

During 2024-25, due to an increase in resistant infections affecting patients both at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH), additional specialist cleaning and decontamination processes were required. These processes involved primarily the use of HPV and were delivered on an ad-hoc call out basis by Sanondaf, who have facilitated this since January 2023. There is a significant cost

burden associated with this, regardless of provider which year on year has increased as per table below.

Company Name	Dates	Cost
Inivos	From April 2022 – January 2023	£220,000
Sanondaf	From 1ST April 2023 – 31st March 2024	£134,629 (ex. VAT)

At the time of drafting this annual report an options appraisal paper to scope acquiring a Trust HPV decontamination service, enabling reactive and proactive decontamination has been placed on hold. This is due to the new Group working direction and the uncertainty surrounding the infrastructure at NLAG and environment compatibility with the HPV cleaning method.

2.3.7.2 Linen HUTH

During 2024-25, Synergy Linen Management Services has been responsible for providing linen services for HUTH since 1st of August 2021. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained. Regular reports are submitted regarding linen to the (EFD) Group Governance Committee and to the Decontamination Group Meeting to ensure that linen remains safe and up to standard for our patients.

During the 2024-25 year, members of the HUTH Facilities Hotel Services team alongside members from the IPCT conducted an audit and site walk of the Synergy Sheffield laundry factory to ensure the correct procedures were followed and that high standards were upheld and followed.

During 2024-25 ongoing construction work at both HRI and CHH, resulted in the need for prudent pest control by both the IPCT, Estates & Facilities teams and external pest control contractors and this will be monitored as ongoing construction continues into 2025-26.

2.3.8 Audit Programme

2.3.8.1 Place inspections

The 2024 PLACE assessments were undertaken at CHH between 20th September and 10th October 2024 and at HRI between 21st October and 12th November 2024 by a multidisciplinary Trust Team and trained patient assessors. The two pertinent

PLACE inspection elements to include within the DIPC Annual Report are Cleanliness and Condition, Appearance and Maintenance.

For Cleanliness, the Trust score (98.88%) is above the national average (98.31%) at both sites and above the average cleanliness scores of our peers. This does not just relate to domestic cleaning. The cleaning of some 'patient equipment' i.e. fans, commodes and ventilation grilles that sit with the nursing and estates teams respectively, contribute to the cleanliness score. The implementation of bespoke cleaning checklists identifying cleaning responsibilities has contributed to an improved cleaning score.

For Condition, Appearance and Maintenance Trust score (98.33%) is above the national average (96.36%) and the average of our peers. A decant facility at both sites to allow for annual repairs, decorating and upgrades to be carried out would further improve this score as the estate and infrastructure, particularly at HRI is challenging due to the ageing infrastructure.

While the age of the estate is challenging, the scores achieved show a significant improvement has been made. HUTH have introduced the PLACE Lite programme in 2024-25 to further assess the patient environments and make positive changes wherever possible. HUTH have used our MDT alongside the patient assessors to conduct one audit per site per month since April 2024 and have created action plans for the wards and departments to make improvements.

The most significant challenges faced across both organisations remains the aging infrastructure and the ability to clean this effectively; however, our teams work hard to ensure any maintenance jobs are reported. Despite significant pressures the facilities teams remain positive and will react to any challenge they face with continued dedication and professionalism.

2.3.8.2 Fundamental standards and audit

An annual programme of audit is agreed as part of the annual IPCT/ Fundamental Standards programme. The audit programme is a combination of policy and general IPCC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2024-25 audits were presented to the respective OIRC by the reporting Health Group, summarising all the audit activity and high-level findings.

During 2024-25, the IPCT focused on the timely completion of IPC Fundamental Standards audits and audit documentation with an updated audit form to reflect introduced electronic nursing records. By year end IPC Fundamental Standards were up to date whilst ongoing challenges faced with the reactive nature of the service, dealing with outbreaks and incidents.

Thematic audit analysis is a regular element and highlights an improvement in audit compliance and associated scoring with exceptions including lack of storage facilities resulting in cluttered environments, gaps in cleaning checklists especially at weekends/ bank holidays, lack of compliance with effective hand hygiene/use of PPE and gaps in electronic nurse documentation.

At ward / departmental level audit processes utilised an updated audit format and audit schedule via MyAssurance Tool alongside a live dashboard, thereby allowing care groups and the IPCT to identify trends and required action to improve compliance and practice. Audit processes were slow to embed at ward level. Self-assessment can result in positive scoring.

NLAG have used the fifteen-steps model for audit of IPC, and bespoke Point Prevalence Survey's (PPS) for IPC specific audit. Similar to HUTH they found gaps in knowledge, skills and behaviours, were often in relation to bare below elbow, correct hand decontamination, appropriate use of PPE and poor compliance with documentation. The Group have now developed a Quality audit known as ACE which IPC were involved in developing. ACE commenced in March 2025 and will provide information in relation to IPCC audit across the Group going forward.

2.3.9 Education and Training

The Infection Prevention and Control (IPC) education framework was published in March 2023 by NHS England. It sets out a vision for design and delivery of IPCC education and sets core requirements for clinical and non-clinical staff working in healthcare settings in 6 core standards:

Standard: 1. IPC Practitioners must inform the development of IPC learning and practice development

Standard: 2. Applying standard IPC Precautions (SICPs) and evidence-based practice for preventing HCAI associated with invasive devices and procedures will be incorporated into all health and social care related education programmes

Standard: 3. Antimicrobial resistance (AMR) and Antimicrobial Stewardship (AMS) is an integral part of education programmes.

Standard: 4. Transmission based IPC precautions (TBPs), screening programmes, Hierarchy of controls (HOC) and IPC risk assessment will be incorporated into relevant education programmes

Standard: 5. IPC will be appropriately incorporated into all health and social care related education programmes in a contextually relevant approach. This will support the promotion of appropriate IPC in the delivery of care.

Standard: 6. Management, maintenance and planning of the built environment is incorporated into related education programmes.

The overall aim is to strengthen IPCC knowledge, skills, and behaviours, and to provide a standardised approach to IPC education. Once fully implemented, the framework will deliver clear individual objectives for IPCC learning and development; strong IPC leadership at Board and Executive level; IPCC training developed with IPC experts. The new introduction is Levels 1, 2 & 3 (previously only known as level 1 & 2); Level 1 is for everyone working in health and social care setting; Level 2 is for all staff working directly with/ providing care to patients and / or who work in the patient environment; and Level 3 is for all staff who are responsible for an area of care.

The IPC Educational GAP analysis has been completed and is awaiting implementation across the group as per NHS England Education framework 2023. The two funded IPCC Practice Development Matron posts will work together in ensuring this in embedded effectively across the Group. This will involve a substantial education programme for all staff ensuring education compliance to improve any gaps in knowledge and improve practice standards. The training will be at levels 2 & 3 dependant on the staff level of training required. This training will be monitored and records of compliant staff recorded in readiness to report in for 2025/26 report. The monitoring for this development programme and implementation is reported into OIRC and SIRC.

The IPCC have been delivering face to face training for many groups of staff across both HUTH and NLAG, and HUTH continue to utilise Skills for Health continuing online and face-face on both sites. The face-to-face training includes new overseas recruits, non-registered staff new to the Trust and working in clinical areas, newly qualified nurses, and apprentices The IPCT have delivered an IPC link day last year and plan to arrange a link day for later this year. Members of the IPCT have continued face to face training booked with ward Housekeepers and Hygienists, and the IPCT are linking in with OCS in relation to the education of the new NHS cleaning standards. IPC have worked closely with staff in facilities to continue to deliver IPC training specific to the roles worked.

The IPC team will be commencing the IPC training with the “Let’s get started” for newly qualified nurses in October when the new cohort of RN’s qualify and bespoke training for Junior and Senior sisters in the clinical areas. The training provided to date has received positive feedback from all staff groups.

In NLAG link worker meetings have taken place through the year with good attendance. These are now presented face – face with also the option to join by Teams if unavailable to physically attend. The Annual Bugs R Us event originating from NLAG as now been reviewed and opened across the Partnership. This is an excellent day with attendances around 70-80 staff from many different staff groups. The content includes currently local and national IPC updates and training. Speakers include colleagues from NHSE and UKHSA previously.

During 2024/25, training and educational opportunities were offered regionally and nationally by NHS England & UKHSA inclusive of IPC practices, tackling GNBSIs, CPE and antimicrobial stewardship. Non-registered staff at the Trust benefitted from a bespoke IPCC course again funded by the national team, places were limited regionally. Limited numbers of staff completed the course and found the content helpful and clinically applicable.

2.3.10 Antimicrobial Stewardship (AMS) NLAG & HUTH

2.3.10.1 NLAG

Antimicrobials stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.

Within the Trust the antimicrobial stewardship agenda is predominately led by the Lead Antimicrobial Pharmacist (Consultant Pharmacist post), who works closely with Pharmacy staff, the IPCT, PathLinks Microbiologists, PathLinks Microbiology Operational Manager & Laboratory Manager and with clinicians. This includes working with the ePMA (electronic prescribing medication and administration) implementation team to incorporate appropriate antimicrobial stewardship into the prescribing and administration system. The AMS work is delivered by stretched teams, there are staff limitations to implement AMS activities, gaps in audit, data and education and increased expenditure on antimicrobials due to the CPE outbreak

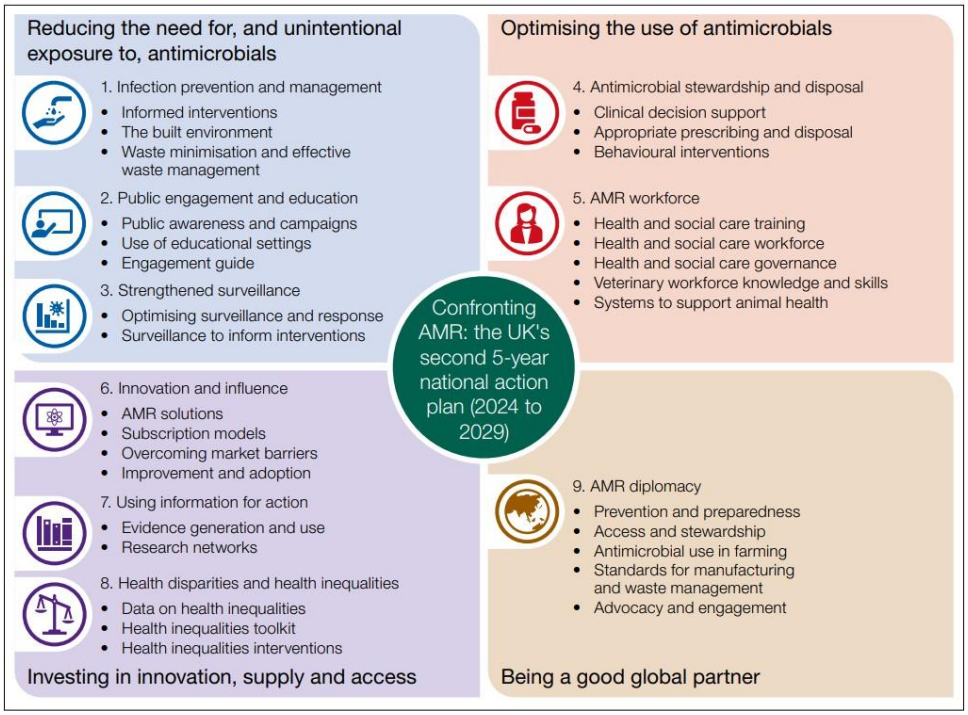
leading to more complex infections requiring expensive intravenous (IV) antimicrobials and increased length of stay.

The current Trust's Antimicrobials Stewardship Strategy incorporates all elements of the national 'Tackling Antimicrobial Resistance 2019 – 2024: The UK's five-year national action plan'. The strategy aims to:

- Ensure the optimal use of antimicrobials in the Trust
- Minimise the risk of causing Healthcare Onset, Healthcare Acquired infections (HOHAs), antimicrobial related adverse effects, and the development of antimicrobial resistance, whilst maximising their clinical and cost effectiveness.
- This report outlines the antimicrobial activities and progress with the action plan made in 2023/24 and activities related to antimicrobial stewardship

The UK 5-year National Action Plan (NAP) for Antimicrobial Resistance 2024 to 2029 Confronting antimicrobial resistance 2024 to 2029 was updated and published in May 2024 to be effective from April 2025. The NAP 2024/29 has 9 strategic outcomes organised under 4 themes as per summary below:

Figure 1: summary of the 2024 to 2029 NAP



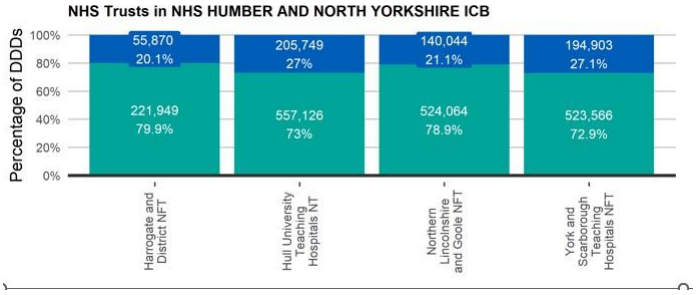
The following figure shows the new human health targets.

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary. Education and training are facilitated both on the wards and in a classroom setting for pharmacists, junior doctors, and nurses where capacity allows. The aim is to ensure appropriate antimicrobial prescribing as per 'Start smart then focus toolkit' Start smart then focus: antimicrobial stewardship toolkit for inpatient care settings - GOV.UK and optimise treatment for patients through an effective stewardship programme. The Trust antimicrobial strategy is due for review and update by March 2026 to incorporate the updated NAP 2024/29. The pharmacist staffing levels continue to be challenging. The antimicrobial pharmacist post was vacant between April 2024 and October 2024. On appointment, the new Lead Antimicrobial Pharmacist focus was on setting up the NLAG Antimicrobial Stewardship Group and updating the NICE Baseline Assessment tool for AMS (NICE Medicines Practice Guideline NG15 Overview | Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use | Guidance | NICE) to evaluate if current practices at the Trust are in line with national recommendations. This helped identify gaps and challenges and therefore, informed the need and development of an improvement plan to meet the recommendations and give assurance to the Trust Board and commissioners of activities being undertaken to ensure best practice and compliance with current legislation. To support improve Trust performance and compliance with legal requirements in relation to AMS, a couple of business cases (Pharmacist and Pharmacy Technician) were submitted in December 2024 to establish an NLAG AMS Pharmacy team.

Audit and surveillance of antimicrobial use

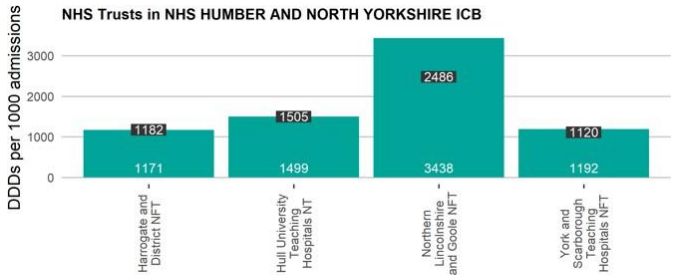
The following data from NHSE Antimicrobial Resistance Reporting NHS Humber and North Yorkshire ICB March 2025 report shows NLAG is in an advantageous position with regards to antibacterial oral to IV ratio. However, the data does not show appropriateness. Digital systems have been identified as tools that would enable prioritisation of patients for AMS reviews to ensure appropriate prescribing and best outcomes for the patients. It is planned for the ICNET system to be utilised when the new laboratory system is in place for HUTH.

Antibacterial oral to IV ratio (DDD%) (Secondary Care) in the 12 months ending January 2025



NLAG has been consistently identified as an outlier with regards to broad spectrum antimicrobial prescribing. This has been the focus of the improvement plan for the Trust.

Watch & Reserve DDDs per 1,000 admissions (Standard Contract 24/25). For the four quarters ending Q2 24/25.



NLAG performance against national targets still requires improvement and this will continue to be the focus of the improvement plan for next financial year 2025/26. Although the Trust did not achieve the 5% reduction in total antibiotic use from the 2019 calendar year baseline, our internal data shows that the last two months of 2024/25 usage was below target line for 5% reduction.

Performance against agreed trajectories in CQUINs, NHS Standard Contract & NAP										
Topic	Trajectory agreed by	KPI	KPI Target	2023/24 Figure	2024/25 YTD Figure	Difference from last year	Difference from KPI	Current SPC Status	Current KPI Status	Benchmarking
Overall Antibacterials for systemic use usage (DDDs/1000 Admissions)	NAP 2024-2029 Health Targets	5% reduction in total antibiotic use from the 2019 calendar year baseline.	5043.55	5215.15	7729.81	2514.66	2686.26	Statistically Decreasing	Fail	6th highest in the region for antibacterials for systemic use usage.
			Monthly Average DDDs per 1000 Admissions							
WHO Access, Watch, Reserve (AWaRe) classification for the UK	NAP 2024-2029 Health Targets	70% of total use of antibiotics from the Access UK AWaRE category by 2029, across the Human Healthcare System.	70%	41.74%	42.23%	0.49%	-27.77%	No Significant Change	Fail	Lowest in the region for % of antibiotics from the ACCESS UK AWaRE category usage.
			% of total use of antibiotics from the Access UK AWaRE category.							
	NHS Standard Contract 2024/25	10% reduction in the Watch and Reserve category from the 2017 baseline.	No current measure	25658.68	25582.67	-76.01	No current measure	No Significant Change	Not known	Highest in the region for combined WATCH and RESERVE category usage.
			Monthly Average DDDs per 1000 Admissions							
IV vs Oral Antibiotic use	NHSE MO Priorities, Operational Planning Guidance	Significant Reduction in IV antibiotic usage.	Significant reduction	21.25%	20.23%	-1.02%		No significant change	Pass	In the lowest half for IV antibiotics use in the region
			% of IV antibiotics with regards to IV and Oral antibiotic usage (DDDs per 1000 Admissions)							

The trust antimicrobial reports include specific data of three broad spectrum antimicrobials to monitor: co-amoxiclav, piperacillin/tazobactam and meropenem. The data shows that there is no change to co-amoxiclav prescribing however, piperacillin/tazobactam and meropenem prescribing is statistically decreasing.

Antibiotics to Monitor					
Antibiotic	(DDDs per 1000 Admissions)			Current SPC Status	Benchmarking
	2023/24 Monthly Av.	2024/25 YTD Monthly	Difference from last year		
Co-Amoxiclav	1492.54	1746.27	253.73	No Significant Change	2nd highest user in the region
Piperacillin/Tazobactam	140.90	150.20	9.29	Statistically Decreasing	Top half of the region for usage
Meropenem	73.97	67.37	-6.60	Statistically Decreasing	3rd highest user in the region

Emergency departments on both sites have been identified through the data reports as highest users of co-amoxiclav and this should be considered an area to focus targeted work, however capacity to deliver the work is a limitation. Penicillin DE labelling has been identified as an intervention that would support the reduction of broad spectrum (Watch) agents and increase narrow spectrum (Access) ones. NLAG is consistently one of the highest users of meropenem within the region. Meropenem is a broad-spectrum antimicrobial with high resistance potential. Data shows that usage appears to have decreased slightly from April 2023. Statistical Process Control (SPC) methodology is used within the Trust AMS reports. SPC charts shows statistically decreasing and that change is happening at DPOW site.

The data shows that DPOW site has a higher financial year to date usage of meropenem and piperacillin/tazobactam than Scunthorpe site. Targeted work in relation to CPE, including the review of prescribing, review of current Trust policy and the review and removal of ward stock, with a developed restriction process in place this targeted focus has continued since the CPE outbreak was declared in February 2025.

The Trust continued to collect data each quarter on Start Smart then Focus Indicators. The **Antibiotic Prescribing Standards Audit** is currently under review to

reduce duplication with IPCN audits. The table below shows the data and current SPC status.

Antibiotic Prescribing Standards				
Key	Less than 80%	in between 80%-90%	90% or over	
Standard	22/23 Average	23/24 Average	24/25 Average	Current SPC Status
Standard 1. The allergy box is complete on antibiotic prescriptions	95.1%	99.5%	98.8%	No Significant Change
Standard 2. The Nature of an Allergy is recorded on all Antibiotic Prescriptions excluding NKDA	40.0%	76.0%	52.5%	Improvement
Standard 3. Antibiotic Prescriptions have an indication on start date	97.4%	99.9%	97.9%	No Significant Change
Standard 4. The Antibiotic choice follows Trust guidelines	72.5%	65.7%	71.6%	No Significant Change
Standard 5. Antibiotic Prescriptions have evidence of a review within 72 hours of commencing treatment	72.5%	65.7%	71.6%	Improvement

Result of a clinical team review 72 hours after initiating therapy	% of prescriptions FY 2024/25
Antibiotic **stopped**	0.39%
De- escalated antibiotic treatment with no review / stop date	1.95%
De-escalated antibiotic treatment WITH review/stop date	0.78%
Escalated antibiotic treatment with no review / stop date	3.13%
Escalated antibiotic treatment WITH NO review/stop date	0.39%
Escalated antibiotic treatment WITH review/stop date	3.91%
No change with no review/stop date given	17.19%
No change WITH review/stop date given	35.55%
Route changed from IV to oral WITH review/stop date given	31.64%
Route changed from IV to PO with no review / stop date given	2.34%
Route changed from oral to IV WITH review/stop date given	1.95%
Route changed from po to iv with no review / stop date given	0.78%

Data in relation to omitted doses of antibiotics is included within NLAG AMS report however, more time and resources are needed to investigate this and implement any actions identified.

Omitted Doses of Antibiotics				
Administration Status	12 Month Average	6 Month Average	Last Month %	Current SPC Status
Administered	91.3%	90.9%	91.3%	Statistically Decreasing
Omitted	8.7%	9.1%	8.7%	Not monitored
Omitted with Avoidable Causes	6.1%	6.5%	6.0%	Statistically Increasing

The NLAG AMS report also includes i**ncidents** reported involving antimicrobials. There have been recent incidents regarding patients with documented penicillin allergies receiving penicillin-containing antibiotics. An Allergy Awareness T&F group led by Medicines Management Nurses was set up as a patient safety 'Allergy Aware Project' to raise awareness and prevent incidents.

Other activities undertaken not already mentioned:

- Adult antimicrobial guidelines moved from Micro guide to Eolas app and communications sent out.
- Posters displayed in clinical areas to raise awareness of Eolas app and provide easy direct access via QR code.
- Appointment of the Lead Antimicrobial Pharmacist following resignation of post holder in 2023/24.
- Inclusion of the Lead Antimicrobial Pharmacist in the antimicrobial formulary task and finish group led by PathLinks Microbiologists and Consultant Pharmacist Antimicrobials at United Lincolnshire Hospitals NHS Trust.
- New doctors' corporate induction including AMS and IPC.
- Induction training for pharmacy staff.
- Presentation at Grand Round during World Antibiotics Awareness Week (WAAW) and European Antibiotics Awareness Day (EAAD) delivered by the Microbiology consultant and a Clinician in Acute Medicine.
- Daily AMS messages during WAAW/EAAD.
- CPE key control measures - messages sent via Trust Communications team.
- Presentation at ground round to inform of the CPE outbreak and promote AMS delivered by Microbiologist.
- Restrictive practices agreed, it started with carbapenems in response to the CPE outbreak.
- Introduction of restriction of carbapenem policy.
- Review of carbapenem prescribing and monitoring incidents following the removal of stock from wards. No incidents have been reported to date.
- Review of capability of the current Trust EPMA system in relation to supporting correct antibiotic prescribing.
- Contribution to strategic planning of the NHS workforce for antimicrobial stewardship in England.

The role out of the OPAT (Outpatient antimicrobial therapy) last financial year 2023/24 and job description banding for an OPAT pharmacist and OPAT pharmacy

technician in 2024/25 was successful however, the recruitment process has been delayed due to issues with locating the funding allocated.

The following **key gaps** have been identified:

- Unable to fully meet expectations, NHS targets set by NAP 2024/29
- 5% reduction in total antibiotic use
- 70% reduction for access agents
- Outlier in carbapenem use with subsequent CPE outbreak
- Maintain oral to intravenous ratio requirements
- Difficulty to flexibly respond to shifting epidemiology due to limited workforce
- Data collection
- Antimicrobial prescribing reviews
- Guideline updates and development
- Education and training strategy on AMS and capacity to deliver it
- Risk of non-compliance with statutory requirements

Legal obligations under the Health and Social Care Act – criterion 3: safe staffing and skill mix. The Trust AMS Pharmacy team is formed solely by the Lead Antimicrobial Pharmacist. Significant variation in workforce capacity and skill mix across regions and healthcare settings in the NHS in England was identified in an AMS baseline survey carried out in 2022.

NHS contract 2024/25 SC21 21.1.6 ‘have regard to the Antimicrobial Stewardship Toolkit for English Hospitals. The Provider (if it is an NHS Trust or an NHS Foundation Trust) must use all reasonable endeavours, consistent with good practice, to minimise its Broad-Spectrum Antibiotic Usage in accordance with the requirements of the National Action Plan for Antimicrobial Resistance.’

CQC expectations to provide safe care and deliver effective outcomes for patients.

There have been workforce gaps identified, and with the potential investment requested, the following solutions and return of investment have been identified:

- Safer care and prescribing for improved patient safety, reduced risk of mortality, lower length of stay, reduced deconditioning, improved patient flow.
- Reduction of healthcare associated infections and antimicrobial resistance resulting in fewer complex infections, better patient outcomes.
- Long term cost savings as service demands increase.
- Strengthened CQC compliance.
- Lower litigation for AMS and sepsis.

2.3.10.2 HUTH

AMR rates are increasing. This has been seen locally, regionally, and nationally. It is particularly evident in gram negative isolates. Over the last couple of years, HUTH has had several outbreaks of highly resistant pathogens. Although multifactorial, antimicrobial prescribing is vitally important in the prevention and management of such outbreaks. Prudent antimicrobial prescribing is vital, both to reduce the risk of AMR but also to optimise best care and outcomes for our patients.

This section of the report provides an overview of antimicrobial usage and antimicrobial stewardship work within HUTH, between April 2024 to March 2025. Usage data is included for both local and regional use (when appropriate). Usage is calculated in Defined Daily Doses (DDDs) per 1000 bed days. DDD is a statistical measure of drug consumption as defined by the WHO that allows for usage comparisons across different clinical areas / trusts. It is the assumed average maintenance dose per day for a drug used for its main indication in adults. The usage data listed within this report is reported as DDDs per 1000 bed days. In addition, some of the data is presented as Lorenzo ePMA administrations, which is a total value not relative to trust bed days. Both values have their limitations, however, will give a picture of current antibiotic prescribing trends within HUTH.

2.3.10.1 National Action Plan 2024 to 2025

In May 2024, the UK 5-year Action Plan for Antimicrobial Resistance (2024-2029) was published. This plan made several recommendations and listed some specific antibiotic usage reduction targets, as outlined below:

The two main targets set within the action plan are;

- Reduce the total amount of antibiotics used within human healthcare by 5% compared to 2019 baseline
- Increase the proportion of ACCESS Agents to 70% within human healthcare.
- Antibiotics are categorised as either ACCESS, WATCH or RESERVE. ACCESS agents are antibiotics that may have a narrow spectrum of activity and/ or a lower risk of driving resistance/ HCAI. WATCH agents are those agents that can drive resistance/ HCAI and are often broader-spectrum antibiotics. RESERVE agents are antibiotics that should be restricted for use only when clearly indicated or resistance necessitates their use.

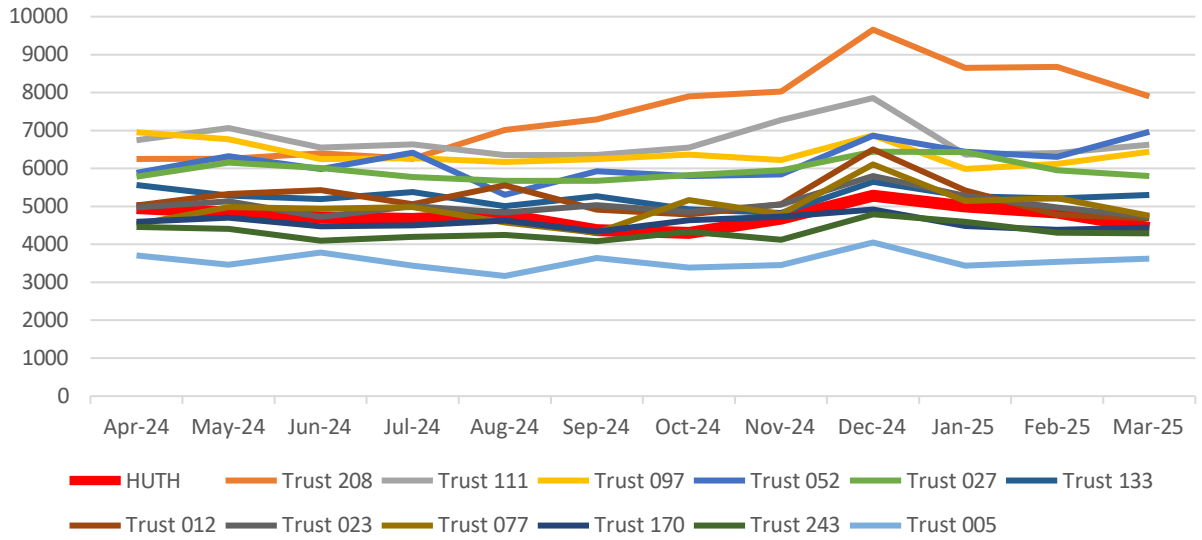
TOTAL ANTIBIOTIC USE

- At the end of 24/25, HUTH was using 2% more antibiotics (measured as DDDs per 1000 patients) compared to the 2019 baseline.

- Figure 1 has the regional breakdown of antibiotic usage (systemic use) across the region. HUTH usage was stable throughout the 24-25 financial year and is

in the lower using Trusts for overall antibiotics within the Yorkshire & Humber region:

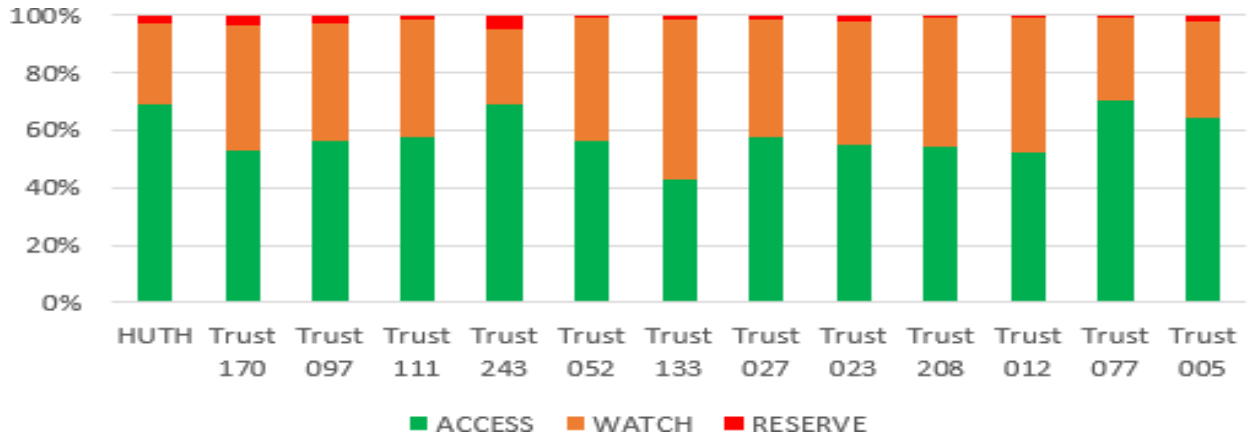
Fig 1: Antibiotic Total Usage (Systemic agents) - DDDs per 1000 patient admissions (incl Day case) - DEFINE data



ACCESS AGENTS

- At the end of 24/25, the proportion of ACCESS agents used in HUTH was 67.4%.
- Regionally HUTH is one of the highest users of ACCESS agents. Figure 2 shows the proportion of ACCESS/ WATCH/ RESERVE agents used between April 2024 to March 2025 for the acute hospitals within the Yorkshire & Humber region:

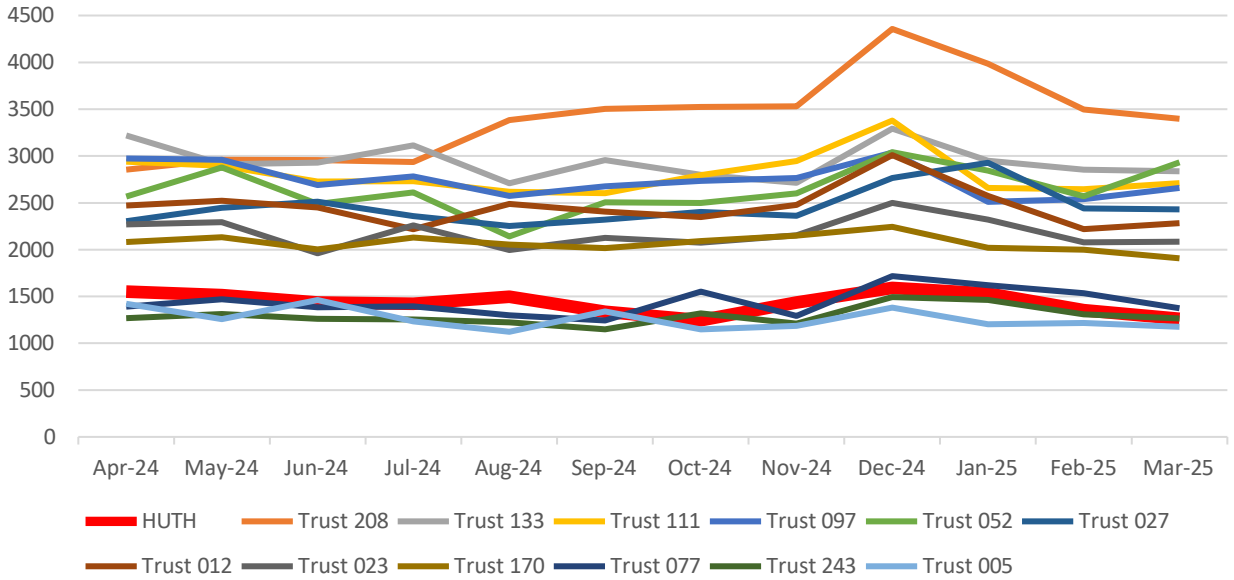
Fig 2 (Access, Watch and Reserve Regional usage):



WATCH/RESERVE AGENTS

- At the end of 24/25, HUTH was using 17.8% less WATCH/ RESERVE agents than it was in 2019.
- Regionally HUTH is one of the lowest users of WATCH/ RESERVE agents.
- Figure 3 shows the DDDs per 1000 patient admissions for WATCH/ RESERVE agents between April 2024 to March 2025 for the acute hospitals within the Yorkshire & Humber region:

Fig 3 - UK AWaRe WATCH/ RESERVE DDDs/ 1000 total admissions (incl Day Case) - DEFINE Data



CARE GROUP ACCESS/ WATCH/ RESERVE Breakdown

At the end of 24/25, ACCESS agent use across the trust was higher than WATCH and RESERVE (Figure 4). There was some variation across care groups with use of WATCH agents highest in critical care/ theatres, specialist cancer, infectious diseases, ENT/ breast surgery, and gynaecology. RESERVE agent use is highly variable but at the end of 24/25 was highest in critical care.

Figure 4: ePMA administrations - ACCESS/ WATCH/ RESERVE use end 24/25 (OP/ Discharge/ FP10 data excluded)

Care Group	ePMA wards included	% ACCESS agents	% WATCH agents	% RESERVE agents
Acute & Emergency Medicine	AMU, H36, H5, SDEC, H1, ED	67%	33%	0%
Cardiovascular	C5DW, C26, C27, C28, CMU, H39, H7	72%	25%	3%
Community Frailty & Therapy	FAB, H8, H80, H9, H90, C20, H130E/W	81%	17%	2%
Digestive Diseases	H6, H60, C10, C11, C14, H100	72%	24%	4%
Family Services	H30	57%	43%	0%
Head and Neck	C16 (incl breast surgery)	44%	54%	2%
Major Trauma Network	C1, H38	59%	34%	7%
Neuroscience	H4, H40, H11, H110	64%	29%	7%
Specialist Cancer & Support Services	C7, C29, C30, C31, C32, C33/TYAC, CAU	54%	40%	5%
Specialist Medicine	H10, H50, H500, H37, H70	69%	30%	1%
Specialist Surgery	C9, H12, H120, C15	71%	27%	2%
Theatres & Critical Care	CICU1, CICU2, HICU1, HICU2	35%	48%	17%
Trust Total		66%	30.5%	3.5%

2.3.10.2 NHS National Contract Reduction in Watch & Reserve Agents

No specific targets set for 24-25.

2.3.10.3 CQUIN Improvements

For 2024-25, there were no mandatory CQUIN improvements for antimicrobial stewardship.

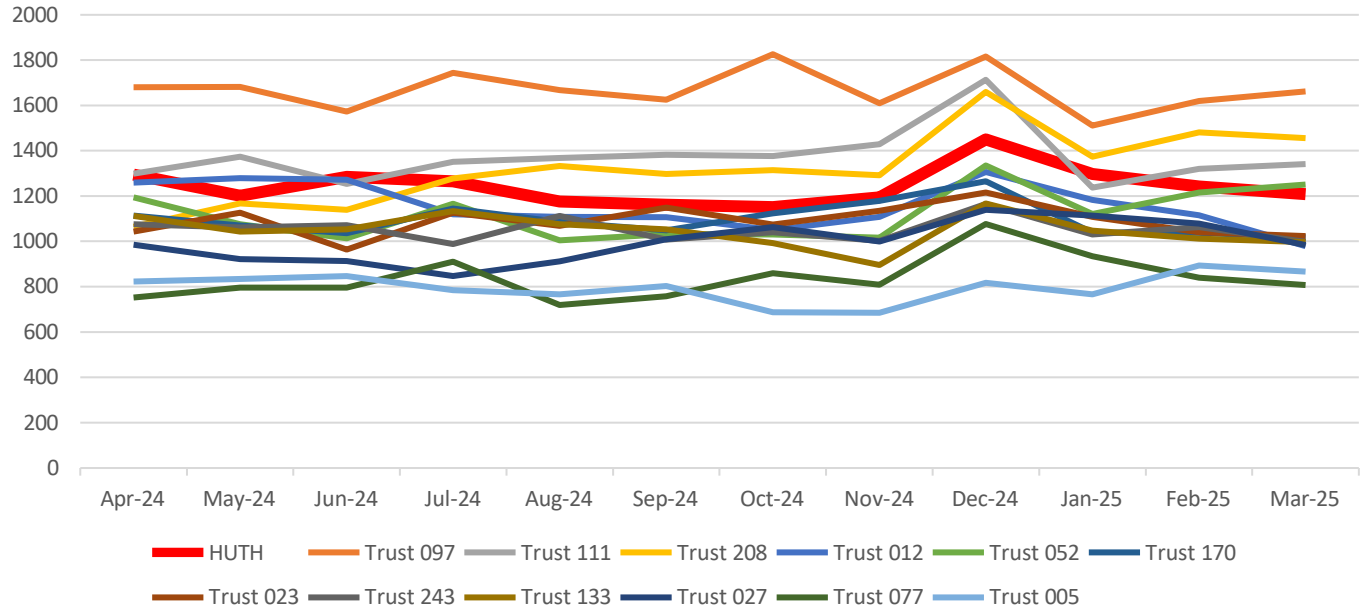
2.3.10.4 IV Antibiotic Use

At the end of 2024/25, IVAB usage was 27% of all antibiotics (59% of inpatient ePMA administrations) given or supplied from HUTH. Across the region, HUTH remains a high user of IV antibiotics.

Figure 5 details the use across the region as % of IV antibiotics relative to total antibiotics use (including Outpatients/ Discharges and FP10 prescriptions).

Figure 6 shows IV antibiotic use as DDDs per 1000 patients (i.e. data that is more reflective of usage relative to patient admissions) OBJ

Fig 6 - IV Antibiotic DDDs/ 1000 total admissions - DEFINE data



CARE GROUP IV ANTIBIOTIC BREAKDOWN

There is variable IV antibiotic use across the care groups (Figure 7). High usage is seen within critical care/ theatres, acute and emergency medicine, digestive diseases (includes acute surgery), gynaecology, ENT, and specialist surgery. Higher usage within some of these areas is expected, due to the nature of the patient group.

Fig 7: ePMA administration IV doses over 24/25 (OP/ Discharge/ FP10 data excluded)

Care Group	ePMA wards included	% IV doses (24/25)
Acute & Emergency Medicine	AMU, H36, H5, H38 (<2025), SDEC, H1, ED	**64%**
Cardiovascular	C5DW, C26, C27, C28, CMU, H39, H7	**43%**
Community Frailty & Therapy	FAB, H8, H80, H9, H90, C20, H130E/W	**42%**
Digestive Diseases	H6, H60, C10, C11, C14, H100	**69%**
Family Services	H30	**66%**
Head and Neck	H36SDEC (ENT area), C16 (incl breast surg)	**70%**
Major Trauma Network	C1, H38 (>2025)	**32%**
Neuroscience	H4, H40, H11, H110, HASU	**64%**
Specialist Cancer & Support Services	C7, C29, C30, C31, C32, C33/TYAC, CAU	**58%**
Specialist Medicine	H10, H50, H500, H37, H70	**44%**
Specialist Surgery	C9, H12, H120, C15, HPLA	**61%**

Theatres Anaesthetic & Critical Care	CICU1, CICU2, HICU1, HICU2	**87%**
Trust Total		**59%**

2.3.10.5 Antibiotic Prescribing Audits – Care Groups (Jan – March 2025)

In 2024/25, each care group was audited against antibiotic prescribing standards (Figure 8). This audit looked at how many patients were prescribed antibiotics on each ward; was the indication and duration/review date documentation on drug chart; was antibiotic prescribing in line with HUTH antibiotic guidance and if this was not aligned with trust guidance was there a documented/ evident rationale for prescribing against guidance.

This was the first audit since the Care Group changes. Please see below information.

Figure 8: Audit RESULTS: Target >80% 70-79% 60-69% <60%

Care Group	Wards reviewed	Indication documentation on drug chart	Duration/ review date documentation on drug chart (Note: Automatic ePMA reviews excluded)	Antibiotic prescribing as per HUTH guidance	Antibiotic prescribing with rationale if against HUTH guidance, or no HUTH guidance available	Overall antibiotic prescribing appropriateness (i.e. as per guidance or with clinical rationale if against guidance)
Specialist Medicine	H10, H37, H50,	**81%**	**45%**	**58%**	**54%**	**75%**

	H500, H37					
Specialist Surgery	C9, C15, H12, H120, C16 (breast/plastics)	**76%**	**56%**	**60%**	**38%**	**68%**
Theatres & Critical care	GICU2, CICU1, HICU1, HICU2	**61%**	**29%**	**47%**	**89%**	**93%**
Neuroscience	H4, H40, H11, H110	**73%**	**40%**	**56%**	**80%**	**87%**
Family Services	H30, H31, H33, H34, H200, H20, NICU	**85%**	**48%**	**68%**	**62%**	**80%**
Major trauma	C1, H38	**75%**	**58%**	**50%**	**78%**	**83%**
Head & neck	C16 (ENT)	**75%**	**75%**	**50%**	**67%**	**75%**
Digestive diseases	C10, C11, C14, H6, H60, H100	**73%**	**30%**	**68%**	**52%**	**81%**
Community & Frailty	FAB, H8, H80, H9, H90, H130E, H130W, C20	**79%**	**56%**	**50%**	**62%**	**78%**
Cardiovascular	H39, C26, C27, C28, CMU, H7	**79%**	**53%**	**71%**	**95%**	**98%**
Acute & EM	AMU, H36, H5, ED	**89%**	**26%**	**74%**	**42%**	**84%**
Cancer & SS	C7, C29, C30, C31, C32, C33	**72%**	**40%**	**64%**	**66%**	**78%**
HUTH	All above	**78%**	**41%**	**63%**	**63%**	**81%**

Indication documentation on drug charts was 78%, with all CG over 70% except the critical care wards. Duration/ review date documentation was 41%, with all CG (except H&N) having documentation on <60% of drug charts. Prescribing was as per HUTH guidance in 63% of drug charts reviewed, but when considering other factors (e.g. microbiology results, ID/ Micro approval, previous exposure) the overall appropriateness was 81%, with most CG above 80%.

Compared to previous audits, improvements were evident in prescribing as per HUTH guidance/ overall prescribing appropriateness. The target of above 80% was met for overall appropriateness trust wide which was a significant achievement and reflective of the improved awareness and compliance with HUTH antibiotic prescribing guidance following the introduction of Micro Guide/ Eolas. Indication and in particular duration/ review date recording on drug charts showed a decline in this audit compared to previous audit results.

2.3.10.6 Eolas Launch

At the end of November 2024, the Micro Guide app, where HUTH antimicrobial guidance was viewed, moved to the Eolas Medical platform. This is now rolled out across the HHP. Since its launch over 1,600 users have downloaded the app. Usage data for Dec 2024 – March 2025 is as follows:

	Dec 2024	Jan 2025	Feb 2025	March 2025
Sessions	**11,192**	**11,569**	**10,508**	**10,855**
Users	**933**	**801**	**838**	**854**

2.3.10.7 Summary

HUTH continues to perform well against national targets. One year into the national action plan, HUTH has almost achieved 70% ACCESS agents. This is following significant improvements since 2022 that have resulted in ~18% less usage of broad spectrum and restricted (WATCH/ RESERVE) antibiotics.

Ongoing work should consider the high IV antibiotic use within HUTH but with an appreciation of the cohort of patients managed in HUTH and the limitations of the data when compared to other hospitals within the region. Total antibiotic use is constant within HUTH, but to achieve the target of ~5% reduction in use (compared to 2019 baseline) some work needs to focus on promotion of timely antibiotic reviews and appropriate treatment durations.

The introduction of an app-based platform for trust antimicrobial guidance has been vital in improving prescribing audits and guidance accessibility and utilisation.

2.3.10.8 Antimicrobial Stewardship Action Plan and Key Priorities for HUTH 2025/26

The antimicrobial stewardship team request the support of the executive team to ensure the ongoing improvements continue in the use of antimicrobials. The suggested plan includes the following key points, but its success is dependent on the buy-in of clinical teams, which can be promoted by Antimicrobial Stewardship being seen as a clinical priority area.

The following recommendations form the key actions and priorities for antimicrobial stewardship at HUTH between April 2025 and March 2026

1. Promotion of principles of good anti-microbial prescribing. Follow recommendations in national strategy 'Start Smart then Focus.' Detail available at: Antimicrobial stewardship: start smart then focus - GOV.UK (www.gov.uk)

2. Reduce broad spectrum/ restricted antibiotic use (WATCH/ RESERVE classification) and maximise appropriate use of these agents.

   This forms part of the NHS National Contract 2025/26 NHS England » 2025/26 NHS Standard Contract. HUTH will use all reasonable endeavours, consistent with good practice, to minimise its broad-spectrum antibiotic usage, in accordance with the requirements of the new national action plan. No specific percentage targets for annual reductions set in the 25/26 contract.

3. Reduce total antibiotic use, aiming towards the national action plan target of a 5% reduction (compared to 2019 baseline). Reduction in overall use should focus on encouraging timely antibiotic reviews within 48-72 hours of initiation and promotion of shorter durations, in line with the recommendations in HUTH guidance.

4. Reduce the amount of IV antibiotics prescribed and administered at HUTH
   a. Promote appropriate IV antibiotic initiation to ensure those who require IV therapy are initiated on IV and those who do not require IV therapy are initiated on PO treatment
   b. Promote timely IV to PO switches (IVOS) in patients who are on IV antibiotic treatment and meet the criteria for switching to oral therapy. These switches should be encouraged as soon as the IVOS criteria is met.
   c. Support improvement work within clinical areas to reduce the amount of IV antibiotic prescribing
   d. Target areas of high IV antibiotic use as part of weekly AMS ward rounds

   There are several benefits in reducing the amount of IV antibiotics given. The risk of blood stream infections/ local reactions is reduced, and most patients prefer oral administration of medication. Nursing time is released as the time to prepare and administer an oral antibiotic is significantly

shorter than that of an IV. The organisation benefits through earlier discharges, reduced carbon footprint, and reduced costs.

5. Continued promotion and awareness of HUTH Antimicrobial Prescribing Guidance accessible via Eolas app and Bridget.

6. Promote and improve access to the COPAT (complex outpatient antibiotic therapy) service.
   Expansion of the treatment approaches to meet the needs of the changing patient population:
   a. Provision of IV outpatient antibiotics in an COPAT setting for HUTH
   b. Expansion of the provision of education and training of patients/ carers to self-administer prolonged IV antibiotic courses at home
   c. Provision of continuous infusions (changed in the COPAT clinic or at home by appropriately trained patients/ carers)
   d. Monitoring of patients on complex oral treatments with tolerability concerns e.g. linezolid, co-trimoxazole.

7. Monitoring of prescribing practices.
   a. Utilise antimicrobial usage business intelligence report and pharmacy EMIS system to produce regular review of inpatient prescribing. The focus for 25/26 will be proportion of IV antibiotics used within clinical areas.
   b. Regular review of all inpatient prescribing areas to review indication/ duration/ adherence to HUTH guidance and if not as per guidance, review if there is justification to go against guidance. Planned frequency: every 6 months per care group.
   c. Ad hoc review(s) as per clinical need.

8. Dissemination of information.
   a. Regular production of antimicrobial reports for each care group for discussion at appropriate business/ governance meetings.
      Discussions should lead to individual action plans for clinical areas and care groups that can be reported back at the local Infection Reduction Committee's and Antimicrobial Stewardship committee meetings (Advisory Committee on Antimicrobial Therapy, ACAT).
   b. Monthly reports for IRC against national action plan/ national contract and any other relevant targets.

9. Restriction policies - promotion of the agents restricted for use within the trust and support pharmacy to manage appropriate supply

10. Trust wide campaign on key antimicrobial stewardship priorities to coincide with World Antimicrobial Awareness Week in November.

11. Education programme to be agreed and supported for clinical staff, including medical, nursing and pharmacy staff. This is required as per NHSEI as part of the Infection prevention and control education framework, standard 3 'Ensure antimicrobial resistance (AMR) and Antimicrobial Stewardship (AMS) is an integral part of education programmes. The National Action for AMR 2024-2029 has a target set to increase healthcare professional's knowledge on AMR by 10% (using 2019 baseline data).

12. Pursue the role of antimicrobial champions within clinical specialities that can link in with the wider anti-microbial stewardship (AMS) agenda and ACAT team.

13. Quality improvement project work to support AMS. ACAT and AMS champions to work with the trust QI team to develop project work with clinical teams and identify improvement strategies.

14. Improve diagnostics in sepsis – in particular, target the improvements around the blood culture pathway as per NHSEI recommendations. Re-audit compliance and raise awareness with clinical teams, nurse educators, and other appropriate colleagues.

15. Support Infection Prevention & Control work, through ongoing and outbreak-directed AMS work.

2.3.11 Laboratory Reports

Laboratory report NLAG

In relation to NLAG PathLinks was able to directly transition to United Kingdom Accreditation Service (UKAS) ISO15189:2022 following inspection during Spring 2024 and has retained our accreditation following inspection in March-April 2025. Path Links, as part of the ME2 (East Midlands 2) laboratory network of UKAS-accredited Microbiology laboratories is working collaboratively through an Operational Group of Microbiology Managers and Working Group of Microbiology Managers and Clinical Microbiology Leads. All ME2 Microbiology laboratories, whilst distinct entities, work together to support each other's services whenever possible if there are service and/or supply disruptions to enable continuity of service. The ME2 laboratories are in the early stages of a phased joint procurement of new analysers, assays, and equipment due to be completed 2026-27. This will mean most analysers will be standardized across the East Midlands allowing for greater comparability of service provision and patient results, as well as providing the potential opportunity to expand local testing, and improve referred testing turnaround times by offering a more regional based service within ME2.

The Microbiology Directorate is working to ensure that we are supporting the improvements to the pathway with work to address the key pre-analytical targets of collection to receipt of less than 4 hours of all blood cultures by working to procure analysers for Grimsby as well as other non-Microbiology sites within Lincolnshire, and the current national recommendation of two sets of blood cultures per adult patient.

The Directorate is submitting audits every six months to the Yorkshire and Humber AMR group on collection to receipt times, and the volume of blood in blood cultures, which is recommended to be 8-10ml per adult bottle. Much work has been undertaken with Lincolnshire ICB which will provide a useful template for improvements especially at the clinical end. The analyser procurement includes a requirement for the successful solution to be able to calculate this blood fill volume for all adult blood cultures and the tender should be going out very shortly through ME2 Phase 2 procurement. The Directorate also takes part in the NLAG AMS group.

In June 2024, we were able to implement molecular testing for a range of viruses and bacteria in Cerebral Spinal Fluid (CSF) by PCR was introduced and this has cut the time for CSF PCR from 7-10 days down to a day from receipt. This was very timely as a national shortage of acyclovir was announced and our previous reference laboratory suffered a cyber-attack. The CSF PCR service is supporting antimicrobial stewardship including prevention of antimicrobial resistance through rapid results allowing early intervention of management of patients with results from a significantly more sensitive test than traditional microbiology and allows the standing down of any empirical treatment for suspected meningitis/encephalitis where negative PCR results align with clinical details post-admission and review.

Dr Reena Rambani has taken on the clinical leadership of the Microbiology Directorate from October 2024 and is working very closely with the laboratories to improve and develop all aspects of the service. The consultant team has recruited Dr Murugesh Jagadeesan back to the team and will be in post from May 2025 based at Boston Microbiology. Dr Jagadeesan had formerly worked with the team at Boston and Grimsby Hospitals; this will allow the team to deliver more clinical advice and support to clinical colleagues. Further recruitment is on-going for substantive consultant posts, in the meantime locum consultants are working with the team to ensure full clinical cover. The consultant team are actively involved with ward

rounds, MDTs and a variety of meetings supporting both NLAG and acute ULTH trust, ICBs, AMS and sepsis groups, and currently, the CPE outbreaks.

The Microbiology Clinical Lead and the Path Links Microbiology Operational Manager are now much more involved with the work of the ICB, NLAG, ULTH and LCHS, including key workstreams such as AMS, sepsis, and IPC, supporting a more integrated and responsive service from the Microbiology Directorate. This allows for more effective understanding of service requirements and to allow improved use of resources and future planning and developments.

Since the beginning of 2025 Microbiology at Scunthorpe have been supporting the IPC response to outbreaks of CPE. The directorate successfully submitted a business case for CPE PCR. Temporary analysers are already in use at Scunthorpe providing some CPE PCR testing, procurement of permanent equipment is in hand and recruitment of additional staffing completed and awaiting start dates. The conventional CPE screening continues but has had an incredibly significant impact on the staff workload, especially the Biomedical Scientists. The business case also included VRE PCR, and the validation and verification work will be undertaken shortly. The Operational Manager contributed a presentation on laboratory diagnosis of CPE at the recent NLAG IPC annual Bugs R Us day.

Laboratory report: HUTH

The Microbiology laboratory services for HUTH are delivered by the Scarborough, Hull, and York Pathology Service (SHYPS) network, which is hosted by York and Scarborough teaching Hospitals NHS FT. The Microbiology and Virology laboratories based on the Hull Royal Infirmary site deliver a clinically focused and led diagnostic service for the Trust and surrounding primary care providers. The service has successfully transitioned to United Kingdom Accreditation Service (UKAS) ISO15189:2022 following inspection during Spring 2024 and has retained our accreditation following inspection in March-April 2025. We use the latest technology ensuring that testing pathways deliver meaningful, accurate results in a timely manner. The lab delivers a 24-hour service for key urgent samples and blood culture incubation, to ensure compliance with the national requirement to incubate blood cultures within 4 hours of collection. SHYPS point of care testing (POCT) team, the clinical microbiology and virology team support the clinical services in the delivery of a point of care respiratory virus testing service to ensure timely isolation and treatment of patients with infections such as Covid-19 and influenza. The laboratory is currently working towards the implementation of a new laboratory information management system (LIMS) which will enable improved inter-network laboratory connectivity. The laboratory service supports the IPCT and Anti-microbial stewardship teams with data requirements.

The clinical microbiology service is delivered by the Department of Infection. The clinical director for Infection and Immunology is Anda Samson, and the SHYPS network lead for Microbiology is Dr Debbie Wearmouth. The Department of Infection deliver an infection advisory service, in-reach to clinical areas with ward rounds and MDTs, a bacteraemia service, support antimicrobial stewardship and have an active research department.

2.3.11.1 SEPSIS

Since becoming the Humber Health Partnership, the sepsis team consists of 3 nurses.

Sepsis and severe infection are one of the most common reasons for admission to hospital and the cause of inpatient deterioration. Many patients who develop sepsis have underlying medical conditions, the elderly and frail and those approaching the end of natural life.

The Group is working to reflect the 2024 update of the NICE guidelines (NG51) on sepsis. The recommendations in this are taken from the 2022 Academy of Medical Royal College's statement around appropriate and timely administration of antimicrobials. This work is in conjunction with the Partnership AMS plans.

Both NLAG and HUTH have a lead nurse and work collaboratively to replicate the same way of working, offering the same team services across the Group. The reporting channel is the DP, Sepsis, and Resuscitation Steering Group chaired by CMO Austin Smithies. This steering group meets monthly. The team continue to work collaboratively, and the following are workstreams completed and currently in progress within The Sepsis Team.

Completed

- Standardised sepsis audit (case note reviews) for all patient population through the organisation for compliance in comparison to patient outcome.
- Standardised sepsis related performance data (electronically generated) for HUTH & NLAG for wards/departments to use to make own improvements.
- Support wards in practice clinically, bespoke ward education, regular feedback to use on notice boards (data) use of link nurses.
- Engage with patient stakeholders and conduct patient surveys to establish needs for improvement.

In Progress

- Update sepsis guidelines for Humber Health Partnership to reflect Jan (2024)

NICE guidance (adults, children, pregnancy & community)

- Update clinical screening and management tools (paper, WEB V Nerve Centre & Badgernet) according to updated local guidelines.
- Collaborate with Consultant Pharmacist for HUTH & NLAG to ensure empiric antibiotic prescribing guidance for sepsis is accessible to staff and to ensure sepsis criteria is accessible (EOLAS).
- Work with clinical coders to accept screening tool outcomes for coding to ensure sepsis cases are captured.
- Promote sepsis team services to support QIPs: bespoke education, clinical support, resources, advice, and insight.
- Update current E-learning package and create in house E-learning by April 2026, this has been delayed due to financial constraints.
- Distribute information & safety netting leaflets clinical areas, via test, and via IDL's.
- Continue post sepsis follow-up clinics for adults in HUTH. Commence follow-up clinics for NLAG adults and HUTH children.
- World sepsis day: Raise awareness in the community. Public awareness campaign sharing of symptoms checker for use in the community.
- Improve Team PR& profile. Advertise service.

There is now a Deteriorating Patient, and Sepsis- Infection reduction task and finish group working with colleagues across the Group as part of a Quality Improvement Project. This work focuses on required improvements identified following a Urinary Catheter audit which was performed across the Group. The Trust sepsis action plan is appended.

2.3.12 Risk Register

HUTH have sixteen risks open in Datix relating to IPC, nine of those specifically are owned by IPC. Two of which are high risk, Risk 4225 Relating to cross infection due to environment which is no longer fit for purpose, relating to the HRI tower block, bed spacing, hygiene facilities. Risk 4229 Risk of health care associated infections, and failure to meet national thresholds due to both practices and environmental factors.

NLAG have two risks open in Ulysses relating to IPC, both owned by IPC. One of the risks is high risk, Risk 3279 Relating to decontamination of both the environment and cleaning, this has been addressed in terms of the CPE outbreak and changing of the cleaning products, along with several other actions. Since moving into a group model, it has been identified NLAG require some further risks adding to the risk register, the most recent relates to long term effects of a CPE outbreak.

Both Trusts regularly review and update the risks to ensure appropriate mitigations are in place, and they are shared with the Quality and Safety Committee in Commons as part of the monthly update for IPCC.

2.4 Local service improvements

2.4.1 Infection Prevention, Control and Cleanliness Bridgett Page

The IPCC Bridgett page provides updated resources, access to Patient Information Leaflets (PILs), policies and guidelines and IPCC links, these are available for staff to access and have been reviewed since adopting the Group. This page remains under review and plans to update as the continued alignment of services develops in the Group.

2.4.2 Multi-Drug-Resistant Organism (MDRO) (CPE, VRE, MRSA) Screening

At HUTH rapid diagnostics are utilised to support the timely identification of multi-drug-resistant organisms, reducing the risk of onward transmission, through early identification. This with combined improvement in initial patient assessment, aims to prevent outbreaks in the first instance. HUTH is maintaining a watching brief in terms of patients moving across the Group from NLAG to HUTH with regards to patients directly under the care of NLAG, who access HUTHs tertiary services, particularly considering the current CPE outbreak at NLAG. Following approval of the business case for MDRO screening, NLAG is currently planning and developing a roll out programme for MDRO screening during the next financial year.

2.4.3 IPC Simulation training

The IPCC have utilised the experience and expertise of the simulation team to introduce novel and innovative ways of training staff in IPC. This led to high satisfaction scores from those involved in the training. This method of education is resource intensive, although highly effective and resource to expand this programme across the Group would be beneficial. The development of this method of training is planned to be further extended when the IPC Practice Development Matron’s are recruited and commence post during the next financial year.

2.4.4 Patient Infection assessments

The Trusts across the Group have different patient electronic records systems. Web V is used at NLAG, and nerve centre electronic patient assessment is in practice at HUTH, both remain a key priority for improvement in terms of IPCC. IPCC are working with digital teams in the Group to improve assessment methodology for IPCC practices, and in terms of patient tagging, when they are classified as

'infectious.' This is to reduce risk of transmission when patients are admitted and discharged across the Group. The IPCC electronic system, ICNET, has been previously purchased for HUTH and is planned to be introduced following the LIMS laboratory system launch later 2025. This system will provide a more robust method for identifying, monitoring, and reporting for all patients identified as having an infection or with a positive microbiology result and will enhance IPCC information.

2.4.5 FFP-3 mask fit testing service

HUTH have an established robust system for assessing staff, appropriately face fit testing and recording the results for face fit testing via an electronic database.

The national guidance recommends staff are tested for Filtered Face Piece (FFP3) in standard healthcare settings, to protect them against respiratory viruses (airborne pathogens) whilst working in the healthcare setting. Health and Safety Executive (HSE) recommend retesting clinical staff every two years. Unfortunately, due to a back log in testing of staff from the gap in service testing during 2023, there remains some issues with compliance across HUTH. As a result, HUTH have temporarily extended the testing period for staff to every three years for low-risk areas; and continue to prioritise high risk areas every two years, such as, ICU, theatres, infectious disease, ED, and maternity. HUTH compliance to FFP3 face fit testing sits at 45% of clinical staff are in date with testing (this is based on more than 6000 clinical staff). Face fit testing remains a risk, on the risk register whilst compliance remains low. The plan is to continue to progress service provision and increase compliance during the next financial year, whilst acknowledging the service remains under resourced to meet demand.
Similarly, since commencing a group model, and noting the increase in influenza case during winter 2024/2025, NLAG have recommenced testing amongst staff through the CPD team. There are large gaps in terms of how these records are saved and the testing methodology uses qualitative testing at present. A case of need has been prepared for the executive board for presenting establishment of a small robust service, mirroring the system set up in HUTH. These plans prepare to move NLAG testing in line with HUTH using quantitative testing methodology, 'gold-standard,' and to provide a Face Fit Testing team which will manage this service and centrally capture the data on all staff tested, providing a safe and effective system for the Group.

2.4.6 Blood culture pathway

The Microbiology laboratory for HUTH has made changes to the capacity and access to the blood culture machines to enable 24-hour-a-day loading. This work is now being developed at NLAG for implementation during the next financial year. It is

to note that the two Trust have a different laboratory group within the regional network. NLAG works with Path Links and HUTH are affiliated to SHYPS. The IPCC wider team include microbiology and laboratory key members to promote Group inclusive working. Work has been undertaken with the sepsis team and clinical teams to increase awareness of the requirements of the recommendations for blood culture collection. This has seen a significant improvement in the proportion of patients' samples attaining the required standards, although there remains room for improvement. This will be a key focus for improvement across the Group for the next financial year; and should impact improvement work in reducing HCAI BSIs.

2.4.7 Community & Therapies Services NLAG

NLAG cover Community services within the Trust portfolio, these provisions are supported by IPCC, whilst sitting separately to the acute Trust, IPCC continue to provide a service to community colleagues including:

- Best practice standards support, relating to provisions for Infection Prevention, Control and Cleanliness, continued to be reiterated and supported with our community teams with the support of a 0.6 WTE Band 6 IPC nurse.
- IPCC have supported with promoting the Community prescribers to use EOLAS, a new system that guides best practice relating to antimicrobial stewardship. Shared access details to EOLAS to all community prescribers https://app.eolasmedical.com/. is now available
- IPCC work alongside community leads, supporting with IPC best practice review of documents, policies, and community IPC best practice.
- Community environmental audits are conducted on all premises in which are staff provide a service. This can be a challenge as often the building does not belong to the Group. The audits are recorded and if issues arise this is escalated through contracting.
- FIT testing – All new staff to be fit tested & re fit tested as required. IPCT are looking into teams being provided with cascade fit test training to enable staff to fit test their own teams to aid IPCC & compliance with best practice IPC & personal protection equipment (PPE). This will be included in the current planning of FIT testing for the Group.
- Lindsey Lodge Hospice remains part of the Community IPCC Agenda, a service level agreement for 7.5 hours per month is provided. This includes, clinical audit, support with best practice relating to IPCC, training, education, support with reviewing of guidelines and policies.
- The Group have now aligned with the use of the same cleaning products and information regarding this has been communicated to community colleagues and the building premises.

- Practice Development Nurse for community is being supported by IPCC with gaining access to / developing cleaning schedules for staff aiding best practice and quality assurance for community services.
- Goole Hospital Outpatients & Neuro Rehabilitation is part of the Community IPCC Team and is included in the Community IPCC agenda.
- The team are currently working with ICB colleagues and Laboratory colleagues to develop timely and effective ways to share organism results with community providers, due to not all GP practices and community providers using the same electronic systems.
- The IPCC Nurse attends monthly community governance meetings, review community policies, guidelines and provide expert IPCC advise and support.
- The Surgical site infections best practice is reiterated by IPCC to the community Nursing teams; to support the improvements made in SSI reporting Including that, patients discharged within a 30-day period of surgery need to be referred to the named consultant for further care management
- IPCC now attend weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) Service meetings with leads of the service, clinicians & consultant microbiology. This supports best practice relating to IPCC, microbiology, antimicrobial stewardship, and aiding patient safety.

2.5 Conclusion

IPCC encompasses an immense variety of patient, environment and behavioural aspects that are vital to patient safety. Much of standard patient care undertaken throughout the Trusts has implications for infection prevention, control, and cleanliness, and as such this needs to be a priority area for all staff. The Board is asked to accept this report and review the recommendations for the following years improvement.

3 Recommendations

1. *Improvements in the rates of MSSA BSIs and GNBSIs will need to be a priority for 2025-26. These are linked to significant morbidity, mortality and patient bed days and a proportion are preventable. This will require significant resource and multi-disciplinary working, with leadership from the senior management teams.*

2. *The Trust is the highest placer of vascular lines in the region and with it the increased risk of suboptimal management and ensuing line related infections – rationalising the use of IV access and improving care once lines are in situ must be a priority for 2025-26.*

3. *Review of the use of other medical devices, the association with healthcare acquired infections and ensuring best practice is always maintained. A particular focus on urinary catheters, their placement and care. This workstream is currently in development following the external audit completed across the Group.*

4. *A focus on surgical care is suggested, due to concerns around surgical site infections. Clinical teams need to take ownership of patient outcomes associated with surgical site infections, supported by the multi-disciplinary team including IPCC.*

5. *Support for raising awareness of the importance of antimicrobial stewardship in reducing anti-microbial resistance and complications such as C difficile and CPE, including introduction of mandatory training for all prescribers.*

6. *Support for improvement work to reduce the total amount and proportion of IV antibiotics used, by encouraging IV to Oral Switch (IVOS) which will bring substantial benefits for patients, including reduced hospital stay, reduced risk healthcare acquired infections and reduced time factors for nurses completing the IV preparations in the clinical areas.*

7. *Improvements in patient hydration to ensure the risk of dehydration and subsequent sepsis needs to be a focus of work. This is currently in development across the Group.*

8. *Continued focus on the identification of sepsis and prompt actions to positively impact on morbidity and mortality is an ongoing priority 2025-26. Including the supporting of the 5 Year Sepsis Strategy – see appendix*

9. *The identification and management of resistant infections with the propensity to cause outbreaks, including the completion of the rollout of CPE screening.*

10. *Support the work of the IPCT with capital and estates colleagues to prioritise improvements in the estate to maximise the patient environment with the focus on patient safety. Including Water safety training for Ward/Department leads.*

11. *Embedding learning from incidents involving HCAIs and outbreaks of infectious diseases enabling staff to understand risks and the requirement of good IPCC practice. A piece of work has been commissioned in conjunction*

with the Governance team to ensure the Group is reporting harm in accordance with National guidance.

12. *Ongoing utilisation of the national IPCC BAF during 2025-26 to provide assurance to the Group and Stakeholders.*

13. *Support to ensure that the Group moves towards compliance with the national framework for IPCC education and training, including supporting the recruitment of 2x WTE IPCC Practice Development Matrons.*

14. *The HHP IPCC will continue to work alongside York and Scarborough Teaching Hospitals NHS Foundation Trust, Integrated Care Boards, NHS England, UKHSA and other system partners during 2025-26*

15. *Continue the review of the Group IPCC team structure, meetings, and governance structures to support the HHP.*

16. *The Deputy DIPC to work in conjunction with Pharmacy to look at innovative ways for the IPCC team to address the AMS agenda.*

17. *IPCC to continue work in conjunction to support the delivery of the Group winter plan.*

Wendy Millard Deputy
Director of Infection Prevention and Control
Humber Health Partnership
July 2025.

4. Glossary

ACAT - Advisory Committee on Antimicrobial Therapy, clinical staff with expert knowledge, advising on best practice guidelines, and Trust improvement programmes for AMS.
ACE – Accrediting Excellence – is referring to achieving a recognized standard of quality and performance, and an ACE audit takes place to check and monitor performance standards.
AE – Authorising Engineer is a person external to the organisation who advises on best practice guidance which should be followed. They provide an unbiased opinion on elements of the estate.
AHP's - Allied Health Professional is a registered health professional affiliated with the following; Operating Department Practitioner (ODP), Physiotherapist, Occupational Therapist, Speech and Language Therapist, Radiographer, and Paramedic.
AMR – Antimicrobial resistance relates to an organism which is resistant to a medication designed to kill the organism e.g. antibiotics.
AMS – Antimicrobial Stewardship is an effort led to promote judicious use of antimicrobials to combat AMR.

ANTT – Aseptic Non-Touch technique, is standardised clinical practice framework for preventing infections during a clinical procedure, such as, insertion of an indwelling device e.g. catheter.

BAF – Board Assurance Framework is there to assist healthcare providers in conducting self-assessment against compliance against the criteria set out within the key lines of enquiry.

BCP – Business Continuity Plan is a documented strategy outlining the specific steps an organization will take to ensure its critical functions and essential operations can continue, or be quickly resumed, during and after a disruptive event such as a natural disaster, cyberattack, or pandemic.

C.DIFF - Clostridioides difficile is a bacterium that, when it overgrows in the gut produces toxins leading to inflammation and symptoms like diarrhoea, fever, and abdominal pain.

CHH – Castle Hill Hospital, an acute hospital site within Hull University Teaching Hospitals.

COHA – Community onset, Hospital Acquire, a definition to determine when a patient developed symptoms for a reportable organism

CPE – Carbapenemase-Producing Enterobacterales, a family of bacteria resistant to carbapenem antibiotics and can cause serious, difficult to treat infections

CQC – Care Quality Commission, independent quality inspector.

CQUIN - stands for Commissioning for Quality and Innovation. It is a national payment framework in England's NHS that links a portion of healthcare providers' income to the achievement of specific quality improvement and innovation goals set annually by the commissioners.

CSSD - Central Sterile Supply Department, also known as Central Sterile Services Department, and is responsible for collecting, cleaning, sterilizing, and distributing reusable medical equipment and instruments to prevent healthcare-associated infections (HAIs).

DIPC - A Director of Infection Prevention and Control (DIPC) is a senior, executive-level leader in UK healthcare organizations responsible for overseeing and implementing strategies to prevent and control healthcare-associated infections (HCAIs).

DPOW – Diana Princess of Wales Hospital, an acute hospital site within Northern Lincolnshire and Goole NHS Trust.

E. COLI - An E. coli infection is caused by certain harmful strains of Escherichia coli bacteria.

EF&D - Estates, Facilities & Development within the NHS, a department responsible for the physical infrastructure of hospitals and healthcare sites.

EHO - Environmental Health Officer protects public health by ensuring environments and workplaces are safe, healthy, and hygienic, especially in areas like food safety, housing, and noise pollution.

EOLAS - Eolas Medical is a knowledge management and communication platform for healthcare professionals that consolidates and provides instant access to critical medical information, clinical guidelines, and educational content on a single web and mobile platform.

ePMA - Electronic Prescribing and Medicines Administration in the healthcare sector, a digital system for managing prescriptions and medications to improve patient safety and efficiency.

FFP3 - Filtering Facepiece 3, a European standard for disposable respirator masks that provides the highest level of protection among the FFP classes, filtering at least 99% of airborne particles such as dust, viruses, and bacteria.

FR - FR rating (Functional Risk rating) is part of the NHS's National Standards of Healthcare Cleanliness, a system used to assign cleaning frequencies to different areas within healthcare facilities.

GDH - Goole District Hospital, an district hospital site within Northern Lincolnshire and Goole NHS Trust.

GNBSI's - refers to a group Gram-negative bacterium such as Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa are the leading causes of healthcare associated bloodstream infections.

GROUP – Group refers to both Northern Lincolnshire and Goole NHS Trust and Hull University Teaching Hospitals. The Group is named Humber Health Partnership.

HCAIS - HCAI stands for Healthcare-Associated Infection, which is an infection a patient contracts while receiving healthcare in a hospital, care home, or other clinical setting, or as a direct result of a medical procedure.

HHP - Humber Health Partnership, incorporating two Acute NHS Trusts, Northern Lincolnshire and Goole NHS Trust and Hull University Teaching Hospitals.

HOHA - infection refers to Hospital-Onset Healthcare-Associated, a classification for an infection that occurs in a hospital setting after a patient has been admitted.

HPV - A brand of hydrogen peroxide vapour (HPV) decontamination equipment used in hospitals for high-risk areas following discharge of infectious patients.

HRI – Hull Royal Infirmary Hospital, an acute hospital site within Hull University Teaching Hospitals, providing tertiary services.

HTM - Health Technical Memorandum, which provides comprehensive guidance on the design, installation, and operation of specialised building and engineering technology within healthcare settings. HTMs are essential for ensuring that healthcare facilities adhere to best practices, meet regulatory standards, and function safely and effectively throughout their lifecycle.

HUTH – refers to Hull University Teaching Hospitals NHS Trust, combining two sites, HRI & CHH.

ICB - CB stands for Integrated Care Board within the NHS in England. ICBs are NHS organizations that replace the former Clinical Commissioning Groups (CCGs) and are responsible for planning and managing health services for their local populations.

ICD – Infection Control Doctor, they are experts in managing both healthcare-acquired and community-acquired infections, and their role combines clinical, laboratory, and epidemiological skills to investigate outbreaks and determine the most effective treatments. They hold overall responsibility for Infection Control in a Hospital setting.

ICNET – a software platform designed to support infection control and antimicrobial stewardship programs, ICNET software is a clinical surveillance tool.

INFLUENZA - is a respiratory virus, known as/ or flu, is a sudden viral illness affecting the nose, throat, and lungs, marked by symptoms like a fever, cough, headache, muscle aches, and tiredness.

IPCC - Infection Prevention, Control and Cleanliness is the practice of implementing measures to stop the spread of infectious micro-organisms, while cleanliness is the state of being free from dirt, marks, and other impurities, crucial for effective IPC and patient/staff safety.

IPCT - team is a group of specialist nurses and other healthcare professionals responsible for preventing the spread of infections in healthcare settings and communities, protecting patients, staff, and visitors.

IVOS - intravenous-to-oral switch (IVOS), is change in the method of treating infection.

KLEBSIELLA - Klebsiella species are a Gram-negative rod-shaped bacteria belonging to the Enterobacteriaceae family, that can cause HAIs.

KLOES - refers to the Key Lines of Enquiry used by the Care Quality Commission (CQC) to assess whether a care service is providing good, safe care, these are incorporated into the IPC BAF.

KPI - Key Performance Indicator is a quantifiable measure of performance used to evaluate progress toward achieving specific business objectives.

LIMS - laboratory Information Management System, a software-based solution used to manage and track laboratory samples, tests, and results to improve efficiency, data quality, and operational workflows.

MDRO SCREENING - involves swabbing a patient's armpit and groin, or sometimes using rectal swabs, to detect the presence of multidrug-resistant organisms (MDROs) like MRSA or VRE upon hospital admission.

MEASLES - Measles is a highly contagious viral infection causing cold-like symptoms (fever, cough, runny nose, red eyes) followed by a characteristic rash, which can lead to serious complications like pneumonia and brain inflammation.

MRSA - Meticillin-resistant Staphylococcus aureus is a type of bacteria that usually lives harmlessly on the skin. But if it gets inside the body, it can cause a serious infection.

MSSA - Meticillin-Sensitive Staphylococcus aureus, known as, Staphylococcus aureus (often shortened to “Staph,” “Staph aureus” or S. aureus) is a type of bacteria

(germ) which lives harmlessly on the skin and in the noses, in about one third of people.
NAP (TARGETS) - national action plan for confronting antimicrobial resistance 2024 to 2029.
NHSE - stands for NHS England, the national leadership and statutory body for the National Health Service in England.
NICE - stands for the National Institute for Health and Care Excellence. It is an independent, government-funded body that provides evidence-based guidance to improve health and social care in England and Wales.
NIPC FRAMEWORK - The National IPC Board Assurance Framework (BAF) is available to support organisations to effectively self-assess compliance with the code of practice.
NIPCM – National Infection Prevention and Control Manual. This is an evidence-based practice manual for use by all those involved in care provision in England.
NLAG - refers to Northern Lincolnshire and Goole NHS Trust, combining three sites, GDH, SGH, DPOW and community service provision.
NOROVIRUS - also called the winter vomiting bug, is a stomach bug that causes vomiting and diarrhoea.
OCS - is a global company that provides integrated facilities management and support services across various sectors, including retail, government, and media. Their services include cleaning, security, catering, and hard facilities services like maintenance. OCS provides cleaning facilities for HUTH.
OIRC – Operational Infection Reduction Committee – monitors IPC practices across the Group at an operational level.
OPAT - Outpatient Parenteral Antimicrobial Therapy in the NHS. It is a service that allows medically stable patients who need intravenous (IV) antibiotics or other antimicrobials to receive treatment at home or in an outpatient clinic instead of staying in the hospital.
PFI - Private Finance Initiative in the NHS involved private companies designing, building, and financing NHS infrastructure, primarily hospitals, until 2018.
PLACE - Patient-Led Assessment of the Care Environment. PLACE assessments provide assessment on the clinical environment and advice on how to enhance the service/ care environment.
POCT - stands for Point of Care Testing, a type of medical testing performed at or near the patient's location, such as a hospital ward or community pharmacy, rather than in a conventional laboratory.
PPE - stands for Personal Protective Equipment, which includes garments and equipment like aprons, goggles, and masks designed to protect the wearer from hazards such as infection.
PPS – Point prevalence survey, a survey carried out as a snapshot that measures the proportion of a population (e.g., hospitalized patients) with a specific condition,

like healthcare-associated infections (HCAI), or receiving a treatment, such as antimicrobials, at a single, specific point in time.
PSEUDOMONAS - Pseudomonas is a genus of bacteria, with Pseudomonas aeruginosa being the most well-known species that causes opportunistic infections in people with weakened immune systems,
QIP - stands for a Quality Improvement Project, a structured initiative to enhance patient safety, quality of care, and efficiency through systematic changes and data-driven measurement.
SCABIES - is an intensely itchy skin condition caused by tiny mites, the Sarcoptes scabiei, that burrow into the skin.
SGH Scunthorpe General Hospital, an acute hospital site within Northern Lincolnshire and Goole NHS Trust.
SHYPS – Scarborough, Hull, York Pathology Services.
SICP - Standard Infection Control Precautions (SICPs) are essential measures to prevent the spread of infectious agents in healthcare and care settings by applying them to everyone, regardless of whether an infection is known to be present.
SIRC – Strategic Infection Reduction Committee – monitors IPC practices across the Group at a strategic level, escalating to Board where necessary.
SOP's - refer to the general concept of Standard Operating Procedures (SOPs) in healthcare, which are detailed, written instructions for carrying out specific tasks to ensure quality, safety, efficiency, and legal compliance within healthcare
SSI - surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues.
TBP's - transmission-based precautions may be required when caring for patients with known / suspected infection or colonisation.
UKAS (LABS) - the United Kingdom Accreditation Service. This accreditation demonstrates that the laboratory has been independently assessed and found to meet international standards, like ISO/IEC 17025, ensuring the accuracy, impartiality, and reliability of its test results and data.
UKHSA - UK Health Security Agency (UKHSA) prevents, prepares for, and responds to infectious diseases, and environmental hazards, to keep all our communities safe, through health protection and surveillance monitoring.
VRE - stands for Vancomycin-Resistant Enterococci, a type of bacteria, often found in the gut, that is resistant to the antibiotic vancomycin, making it harder to treat infections they cause.
WSG – Water Safety Group – a group of experts meeting to discuss all aspects of the water systems at the Group.
WSP – Water Safety Plan is a proactive, comprehensive risk management strategy that ensures safe water by assessing hazards, implementing control measures, and monitoring quality throughout the entire water system.

APPENDIX 1 -Definitions of health care acquired infections

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days (COHA)
- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)
- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 84 days (COCA)

APPENDIX 2

1 INFECTION PREVENTION & CONTROL ARRANGEMENTS

Amanda Stanford was the Trust **Director of Infection Prevention and Control (DIPC)** and was responsible for leading and managing the Trust's Infection Prevention Control & Cleanliness (IPCC) plan during 2024-25, with executive responsibility for infection prevention and control during 2023-24. Wendy Millard as **Group Deputy Director for Infection Prevention and Control (Deputy DIPC),** strategically leading the Group Infection Prevention Control and Cleanliness service. Jo Ledger, Group Deputy Chief Nursing Officer, holds the Infection Prevention and Control portfolio during 2024-25. During 2024-25 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist at HUTH and Dr Shaktijit Dave, Consultant Microbiologist at NLAG.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act (2008): code of practice on the prevention and control of infections. During 2023-24, **Strategic Infection Reduction Committee (SIRC)** continued to meet, in two formats - a business SIRC and a developmental SIRC meeting, meeting every other month respectively providing the opportunity to discuss key areas for improvement such as antimicrobial stewardship and managing gram negative blood stream infections (GNBSIs). SIRC is a performance management and assurance committee, responsible for holding the Care Groups and Directorates to account for their performance in preventing and

managing healthcare associated infections/ infectious diseases and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. Attendance by the senior HG representatives has been good, and most meetings were quorate with the exception of some medical directors.

The **Operational Infection Reduction Committee** (OIRC), continued to meet monthly. During 2024-25 this committee was chaired by the Infection Control Doctor. The Committee is a forum for the Care Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the Trust Board and Care Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, the Department of Infection, Occupational Health, the Estates & Facilities Directorate, and Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding infection prevention and control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to infection prevention and control and the decontamination of medical and surgical equipment.

Other relevant committees

The Trust has specific committees responsible for decontamination, ventilation safety and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. Attendance by the care groups and departmental representatives has improved as the meeting as evolved across both sites.

The formation of a Command Structure to support the Partnership during peaks of infection and operational challenges with associated meetings such as operational weekend planning meetings has further supported the IPC with either the DIPC and/or ICD in attendance, to inform and advise.

The wider infection prevention and control team

The clinical IPC team is composed of an Infection Prevention and Control Doctor, two Heads of Infection Prevention Control and Cleanliness, covering the five hospitals and community services in the Group model, there are a team of specialist Infection Prevention and Control nurses and supporting secretarial and administrative staff for both HUTH and NLAG. During the past 12 month there has

been significant changes to the IPC team at NLAG including the Lead nurse taking the Mutually agreed Redundancy scheme. During 2024-25. A full review of the team structure has taken place and the new posts at Band 6 have been appointed to. The new staff that are in post are currently completing training and development within their new roles, supported by the senior nurses. Members of the IPCT continue to be aligned to Care Groups to ensure in reach, education and support are provided to assist clinical teams with day-to-day management of patient care and maintaining a safe clinical environment.

Continuing to deliver an effective IPC proactive and reactive service continued during 2024-25 with support from the Consultant Microbiologist/ Infection Control Doctor, Infectious Diseases Consultants, Corporate Nursing team and site team. There is currently no system analyst, data manager, or epidemiological/ SSI surveillance support for the team.

The clinical IPC teamwork in unison with the wider **Department of Infection clinical team** inclusive of Consultant Infectious Disease physicians, Consultant Microbiologist, Virology Consultant Clinical Scientist and Clinical Scientists in Medical Microbiology. The nursing team consists of Specialist Nurses in HIV, viral hepatitis, sepsis and Outpatient Antibiotic Therapy (OPAT), as well as a team of ward-based nurses managing the infectious disease ward at Castle Hill Hospital (CHH), these individuals currently are managed by a Matron within the Support Services Division, Clinical Support Care Group.

In addition to the core clinical IPC team, an increasing number of other clinicians were recruited to support the Trust's efforts including the Quality Team and clinicians with a special interest in the quality-of-care patients receive and delivering prudent infection prevention & control practice.

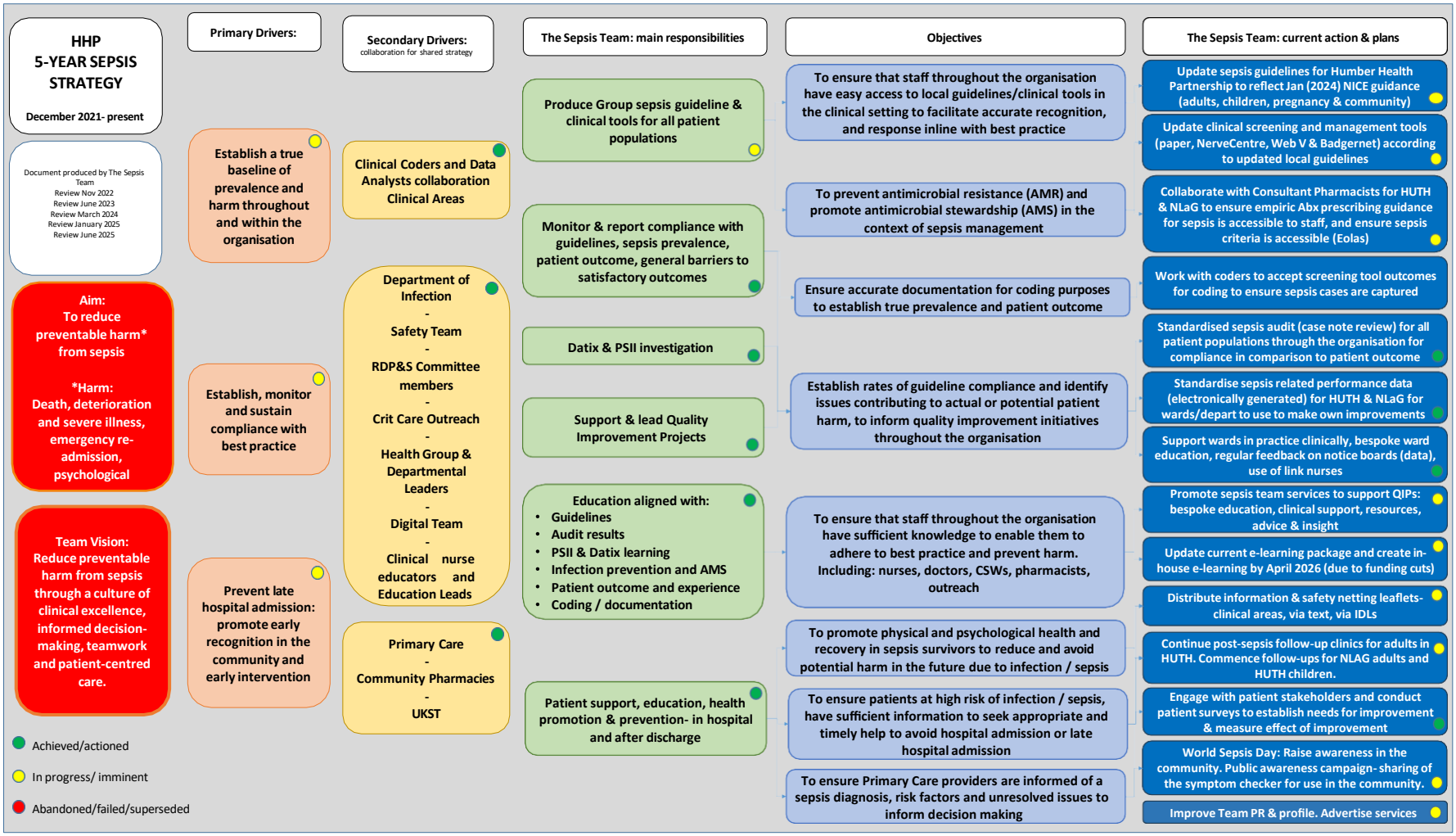
The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Education is facilitated by the Infection Prevention and Control Team (IPCT) and Link Practitioners continued to be supported by the IPCT to be proactive in implementing guidance and maintaining IPC standards in their workplace.

Access to infection prevention and control information can also be obtained from the Bridget page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required. In addition, a global IPC team email address remained

available for staff to access and email the team with queries, concerns and/or requests for advice or assistance for both HUTH and NLAG.

Humber Health Partnership

APPENDIX 3 - HHP SEPSIS 5 YEAR STRATEGY PLAN



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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)190

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9th October 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 5th August, Thursday 7th August and Tuesday 2nd September 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 2nd September and 30th September 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

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PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 5th August 2025 at 09:00 to 12:00 hours in The Boardroom, Alderson House, Hull Royal Infirmary

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)
Dr Kate Wood	Group Chief Medical Officer
Sarah Tedford	Interim Group Chief Delivery Officer
Emma Sayner	Group Chief Finance Officer
Simon Parkes	Non-Executive Director (NLaG) (Virtual)
Jane Hawkard	Non-Executive Director (HUTH)
Murray MacDonald	Vice Chair (HUTH)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Director of Transformation
Philippa Russell	Deputy Director of Finance
Tom Myers	Group Director of Estates
Adam Creeggan	Group Director of Performance
Leah Coneyworth	Head of Quality Compliance and Patient Experience - HUTH (item 3.1) – (Virtual)
Victoria Marshall	Operations Director for Acute and Emergency Medicine (item 4.3)
Edd James	Director of Procurement (item 4.5.1) – (Virtual)

Observers

Ian Reekie	Lead Public Governor (NLaG)

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. No Apologies for absence were noted.

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 01 July 2025

The minutes of the meeting held on 01 July 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
4.3	Deep Dive: Length of Stay and Beds	Adam Creeggan to provide an update with clarity on bed modelling progress for the May CiC.	**The existing bed model was refreshed and the Group planned to develop a more complex model which was subject to recruitment of the business insights team. Action closed.**
4.7	Premises Assurance Model (PAM)	Tom Myers to review further mitigations around Anti-ligature risks.	**The Group recruited Mark Watson, who undertook an exercise on the South Bank, to review properties and consolidate them under EFD. This process had now commenced on the North Bank. Action closed.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Emma Sayner updated that a referral was received from Workforce Education and Culture (WEC) CiC to review how the investment for the undergraduate medical school income was used. A response paper was undertaken by Michelle Scott and a background was provided around the history and establishment of Hull York Medical School (HYMS). The school was established in 2023 and both HUTH and NLaG received income provided for students to support the costs associated with clinical placement. The new consultant contract came into operation around that time which gave an opportunity to ensure training time for students on placements was incorporated into job plans and funded accordingly. Four additional consultant posts were established at HUTH and £250k income was provided for clinical teaching fellows. She explained that income for HUTH grew in 2021/22 to 2024/25 and then declined, however continued on a slight upward trajectory for NLaG.

The way income was captured had changed in terms of monitoring and returns. A formal return was required into Health Education England by each organisation however that was no longer a requirement. The analysis in the report detailed a breakdown of spend regarding direct teaching across the Group. There was a national challenge around data sourcing and obtaining the granular detail. A further review of systems for recording data was essential.

Dr Kate Wood shared that it was crucial to understand the granularity from a medical education perspective due to the expected increase in students and income. This provides an opportunity to explore utilisation of the money. She highlighted that the report did not provide the level of granular detail that WEC CiC required.

Emma Sayner mentioned that income was utilised by clinical job planning and the ongoing work around job planning would provide an opportunity for the Group to be more specific around the teaching elements and what the financial attribution looked like. Dr Kate Wood explained that work was undertaken historically at NLaG to align that and proposed building on that work.

The Committees-in-Common agreed to refer this matter back to WEC CiC, noting the requirement for more comprehensive tracking of how that income was spent going forward.

3. RISK & ASSURANCE

3.1 CQC Actions Report – Group

Leah Coneyworth joined the meeting at 10:10 hours.

Leah Coneyworth took the paper as read and provided an update. There were 5 actions currently open for NLaG, two were rated red and had been escalated to the Planned Care Board meeting on 21 July 2025. Caroline Hibbert was leading work around the harm reviews relating to the waiting times. An update would be provided to the CQC around how the Group were mitigating against the actions acknowledging that they were currently not achieving targets.

The amber-rated action regarding the End of Life (EOL) data was expected to progress to a green-rating in August 2025 and close within 3 months once assurance was provided. A dashboard was implemented and quality checks were carried out. The Group action around the strategy was rated green. Deadlines were in place for the clinical and finance strategy to be completed by September 2025. Two HUTH actions were in the process of closure.

Leah Coneyworth escalated that Infection, Prevention and Control were experiencing challenges with estates issues and did not have a planned completion date which impacted the delivery of their CQC action.

Action: Leah Coneyworth to pick up the Estates issues with Tom Myers outside of this meeting.

Helen Wright wondered when the Group would conclude on levels of patient harm in relation to the waiting list and when PEF CiC would expect to see the outcome of that. Leah Coneyworth shared that a separate Task and Finish Group had been established, led by Caroline Hibbert and the Group policy was near to finalisation. Sarah Tedford explained that Scott Fitzgerald-Becker was finalising the policy with an expected completion date of next week. Work would be undertaken to review how the policy would be implemented and further feedback would be provided at a future PEF CiC meeting.

Gill Ponder noted that it felt like the Group should demonstrate making progress towards the actions and it would be helpful to demonstrate this through the paper. Sarah Tedford shared that the volume of patients referred on an urgent and 2 week wait (2WW) referral had significantly increased. Long waiting times for first appointments was a challenge nationally. Work was ongoing to review how to resolve this with primary care colleagues and for Care Groups to understand their capacity across patient pathways in totality. Anomalies were seen that revealed fluctuating outpatient activity. The Group would review this and expect it to take a few months to understand the gaps.
Adam Creeggan mentioned that the national conversion rate of cancer referrals was 3.5% and the Group were seeing 5-7%. Although conversations were taking place with Cancer Alliance primary care partners, there was a sense that the Group would receive further cancer referrals which provided a risk.

Leah Coneyworth left the meeting at 09:25 hours.

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.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Finance Report: Month 3

Emma Sayner shared that there was further work required to understand the full scale of the financial challenge that the group faced. The Month 3 position did not show the required improvement in the run-rate and there was slippage on the Cost Improvement Plan (CIP) in Care Groups. She recognised that it would take time to overcome the cultural challenges and get the support of Care Groups. The NLaG balance sheet was reviewed in detail during the Month 4 close-down however there was insufficient time to review the HUTH balance sheet, as it was significantly larger in size in comparison to NLaG. This review would take place next month.

Philippa Russell provided an update on month 3 which saw an in-month deficit of £5 million with an adverse variance of £2.9 million. The year-to-date deficit was £10.2 million. She shared that the greatest financial challenge was CIP delivery which was fundamentally driving the deficit position. The Group were £6.4 million below plan at month 3 which was expected to be a continued challenge due to the significant volume of opportunity required to transfer into delivery and recurrent CIP. Based on the current run-rate, the Group forecast was a £65 million deficit, offset to some extent by an assumed £44 million improvement in CIP delivery and £8.9m of other mitigations including £6.8 million unidentified income which was part of the risk share arrangement with the ICB. This would leave a £12 million gap to fill. Philippa explained that although the underlying position is a £44.9 million deficit, this assumes recurrent delivery of CIP opportunity that is currently only at the scoping stage of development.

Helen Wright queried the reason why the Group were significantly behind on Capital. Phillippa Russell explained that this was due to an assumed £12 million for a Community Diagnostic Centres (CDCs) lease in month 3 and the Group had no concerns in terms of the overall programme and Capital spend. Emma Sayner shared that recent challenges regarding the Tower Block may affect the prioritisation of Capital spend**.**

Gill Ponder noted the significant bandwidth of Care Groups and Corporate areas between the extent to which they were on or off-plan and wondered whether the Group undertook bandwidth analysis. Emma Sayner shared that the Group were reviewing that level of granularity and the targeted work around CIP would provide an opportunity to cross-examine the in-year run rate work.

4.1.1 Update on Transformation Programme

Ivan McConnell updated that the Group had received feedback from the NHS England and the Integrated Care Board (ICB) assurance review which was positive and had identified areas for development.
They recognised the effective governance process in place and noted that the Group understood the risks however recommended an increased traction on managing those risks. Challenges around the demand and capacity elements within job planning were highlighted and ongoing work was being undertaken around this. Communications and Engagement was highlighted and that the Group had recruited into a Communications and Engagement role.

Ivan McConnell shared that there would be focus on tactical work. A 2026/27 planning process would commence from next week and potentially lead into 2027/28. The Group would consider resources and skillsets for the planning process as there were currently 6 people in place and 20 people were required. Wider schemes were highlighted. There was currently £12 million of unidentified schemes which included £32 million of risk. The Group were £2.4 million above plan on agency spend however overtime had increased and the Group would review this. Establishment had increased which was partially attributed to CDC posts. There was a £9.7 million gap identified within Care Groups and six Care Groups would be placed into intensive support which would include: Family Services, Specialist Medicine, Community, Frailty and Therapy, Cancer Network, and Digestive Diseases. Outpatients would be included however would run as a separate outpatient programme with support from an intensive team. There was significant work undertaken in Outpatients and the Group needed to accelerate the delivery to ensure a significant return on investment.

Work was ongoing in Pathology to review the future options for Scarborough, Hull and York Pathology Service (SHYPS) and Path Links. A workshop would commence led by Ivan McConnell with an aim to identify two potential options to review what both teams had done so far. Cardiovascular had overdelivered almost £2million however a significant proportion of that was non-recurrent VAT. The Group would refresh and revise how the Care Groups operated and joint teams would be developed with support from the planning team.

There were further opportunities to provide additional income. Work was ongoing to review the mechanism of a vacancy freeze for corporate admin and clerical which would provide a further £2 million income. The Group had agreed working principles on Waiting List Initiatives (WLIs) and needed to review further finances and the impact on the Patient Tracking List (PTL). There were additional opportunities within Estates, Facilities and Digital. Ivan McConnell recognised that the Group were not where they needed to be; however the Group was in a much improved position in comparison to 2024/25.

Emma Sayner addressed the size of the transformation team and the continued challenge around how to divert teams into the Transformation Programme. People were not aligning to the Group priorities and the Group needed to address cultural and behavioural issues and would adapt staff from their current day jobs. Ivan McConnell noted that utilising the infrastructure was crucial.

Emma highlighted that there would be a targeted focus to ensure the run rate did not deteriorate.

David Sharif joined the meeting at 09:53 hours.

Jane Hawkard queried when the Group would take difficult decisions around the opportunities and whether there were enough decisions to take. Ivan McConnell explained that a significant amount of the £32 million was underway and the opportunity around WLI required further work. He highlighted being mindful of the conversations taking place. The Group needed to improve their understanding around the correlation of Getting It Right First Time (GIRFT) standards and work through the mechanisms.

Helen Wright queried how special measures would appear to the Care Groups and whether recovery plans were required to provide assurance on meeting the targets. Ivan McConnell explained that the intention was for Care Groups to provide recovery plans and additional weekly challenge sessions would commence with the Care Group Directors. Sarah Tedford shared that there were opportunities that had not been taken and the Group would review how to manage that. Emma Sayner noted that career conversations would take place with individuals.

Simon Parkes highlighted that he did not have a sense of which decisions should be taken and how much savings could be made therefore he was not confident that the Group would achieve the recurrent results that were required. He shared concerns that the Boards-in-Common were losing the ability to influence this.

Gill Ponder suggested escalating this to the Private Boards-in-Common for a conversation around the immediate steps being taken and noted that a major focus was crucial.

Sarah Tedford mentioned the level of scrutiny at Care Group level and work was ongoing to ensure there were clear actions going forward which would be monitored.

Emma Sayner shared that difficult decisions were being taken every day and decisions to stop spend had already made an impact, particularly stopping using the Independent Sector which saved the Group £12 million.
Gill Ponder recognised that decisions were ongoing however this was not evidenced in the numbers.

Jane Hawkard suggested further information be provided around the decisions, the impact, and expected delivery timescales.

Murray MacDonald noted that it would be helpful to highlight when NED intervention was required and to provide clarity on numbers within the report.

Action: Decisions taken and decisions to meet improvement trajectories to be provided in the next report.

The Committees-In-Common agreed limited assurance, nothing the month 3 position, CIP position and the decisions taken to get the Group on track, as well as the requirement for visibility of the timescales for strategic decisions required to get back on track and deliver the financial plan

4.2 Group Performance Report

Adam Creeggan provided an update.

RTT
There were currently 40k patients on the PTL at NLaG which was a 15% reduction in comparison to nine months ago. NLaG expected to enter into Tier-1 due to the variance around 18-week RTT compliance against plan. There was a reduction seen in the PTLs below 18-weeks which was slightly less than the PTLs between 18 to 52 weeks, however the RTT position remained the same which

provided an anomaly. HUTH had seen significant improvement in RTT compliance.

Diagnostics
Adam Creeggan confirmed that the non-obstetric ultrasound activity was on plan. He mentioned the national reporting issue relating to specific software used for Audiology reporting. A local solution was in place to enable the Group to report quicker to the National Programme, however performance had deteriorated significantly from 2% to 47% due to the historic reporting errors.

Cancer
Cancer compliance had improved for five of the six key metrics across the Group in May to June 2025, with the exception of Faster Diagnosis Standard (FDS) at HUTH.

UEC
A continuation of substandard UEC performance was seen in June 2025. HUTH saw a 67% improvement which was attributed to increased compliance from the industrial action.

4.2.1 Operational Performance Metrics

Sarah Tedford updated that Tier-1 meetings were ongoing once every fortnight for UEC which covered both NLaG and HUTH,. The Tier-1 fortnightly cancer performance meeting for Humber Health Partnership (HHP) also covered diagnostics. There will now be a third Tier 1 meeting which was for RTT but for NLaG only.

NHSE had raised concerns around the activity in CDCs and queried the reason for the lack of activity. It was anticipated that HUTH would enter into Tier-1 for RTT. NHSE were satisfied with the UEC programme however shared concerns around the pace of delivery. The Group made the decision to separate the North and South Bank and implement two management teams which would provide greater on-site oversight of what was taking place. The recruitment of Jeevan Gill, Director of Operational Transformation would provide additional oversight.

Cancer performance was insufficient and the Group were working on clear demand and capacity plans with teams to ensure optimisation of current resources. Phil Calvert was developing recovery trajectories which would be utilised to ensure monitoring against plans. There was a clear plan to manage the FDS for Breast and get back on track by the end of March 2026. A Cancer Board would be implemented to develop the cancer strategy.

Sarah Tedford explained that there were concerns nationally that the RTT waiting lists were not reducing as required and the Group would anticipate further scrutiny going forward.

Jane Hawkard noted that the Faster Diagnosis Standard had reduced and wondered whether there was capacity. Sarah Tedford explained that once the trajectories were complete this could be addressed. A significant area of concern was Breast and extra clinics would commence in August 2025.

Gill Ponder mentioned a report that was published for the Collaborative of Acute Providers (CAP). There were a small number of measures that were critical to how the Group would be judged. She proposed streamlining the Group's reports to focus on those critical measures and determining whether there was anything that could be adopted from the CAP report formats.

Action: PEF CiC to review the Collaborative of Acute Providers report in the Extra-Ordinary PEF CiC session on 07 August 2025.

Helen Wright queried when Luna Rova would commence. Adam Creeggan shared that discussions were ongoing however the Group discovered £50-70k which was not initially planned for. The Group expected go-live within 4-5 months providing that the discussions and finances were resolved.

Gill Ponder noted the difference between NLaG and HUTH regarding late theatre starts and queried whether the Group were reviewing bandwidths between individual surgeons. Ivan McConnell explained that this was being reviewed.

The Committees-In-Common agreed limited assurance, noting that plans were in place however they were not providing results. However, there was increased transparency on the detailed actions being taken and the CiC welcomed the development of improvement trajectories for all critical performance measures.

4.3 Deep Dive: Urgent Care

Victoria Marshall joined the meeting at 10:50 hours.

Victoria Marshall took the report as read and provided an update. The Group agreed a challenging target with the ICB and NHSE to achieve 78% combined 4-hour performance by April 2026. Type-1 activity was currently 42% across the Group with a combined performance at NLaG of 73.75% in July 2025 against a trajectory of 74%. HUTH achieved 58.66% combined performance against a trajectory of 71.54%. Work was ongoing with the Yorkshire Ambulance Service (YAS) and East Midlands Ambulance Service (EMAS) around ambulance handover times. HUTH had consistently achieved an ambulance handover time of 24 minutes over the last 3 months. NLaG had achieved a 30-minute ambulance handover time with different constraints around capacity. There was a current medical staffing gap in ED and the Group recruited 5 Specialty and Specialist (SAS) doctors to support those gaps. A further 7 roles were being reviewed given the financial constraints. Overnight consultant cover on a Monday to Thursday was implemented in ED. Overnight consultant cover on a Friday to Sunday would be covered from October 2025 once the recruitment was finalised. £8 million worth of Capital works for a multi-specialty assessment area would support the transfer of patients to be assessed by other specialties and a reduction in 4-hour performance.

The flow programme revealed a reduction in the time patients were in ED. Emergency Care Improvement Support Team (ECIST) supported wards and saw a significant increase in discharges and a reduction in length of stay by 2 days. A short stay ward was implemented which contributed to a reduction in length of stay with a current average length of stay of 2 days. There were challenges at NLaG around frailty cover in ED and work was underway with the Frailty team to

resolve this. Acute and ED pathways at NLaG were robust however there was a challenge around flow and a business case was underway to re-introduce general internal medicine at NLaG with a more managed focus on patients which would support flow in ED. Work was ongoing to review a change in the Acute Assessment footprint at NLaG which would support an improvement in 4-hour performance and reduced waiting times.
The most significant challenge at HUTH was non-admitted performance which was 55% in comparison to 80% at NLaG. Victoria Marshall explained that performance remained unchanged irrespective of attendances and increased staffing. She shared that a mind-set shift was being worked through with the team with an aim to improve performance. Type-3 performance had improved at HUTH however there was further work required to achieve the target.

Jane Hawkard noted that increased consultant capacity did not impact performance. Victoria Marshall explained that consultant overnight cover was implemented to support quality and safety standards rather than performance. Dr Kate Wood shared that the impact of the resident doctors industrial action revealed that the presence of senior consultants in ED improved the performance and quality of care.

Helen Wright queried whether the improvements made were embedded and sustainable. Victoria Marshall clarified that the consistent improvement in ambulance handovers was a prime example of sustainable change and improvement. The trial of two separate management teams on the North and South Bank would attribute to a more developed plan for the General Internal Medicine (GIM) and Acute footprints.

Gill Ponder noted that type-1 attendances at NLaG were lower than planned however performance had still not improved which indicated no correlation between the attendance numbers and performance. She noted that it felt like there was a focus on the wrong thing. Sarah Tedford shared there was a reluctance from specialist teams to accept patients from ED until required tests were carried out which caused delays and an impact on ED. Direct pathways and management of those teams were being reviewed to address this.

Victoria Marshall left the meeting at 11:15 hours.

The Committees-In-Common agreed limited assurance, noting a sustained improvement on ambulance handover times on the North Bank, benefits starting to be seen on the South Bank, and the changed way of working in the management teams on the North and South Bank.

4.4 Directorate of Estates, Facilities and Development Update

Edd James joined the meeting at 11:17 hours.

Tom Myers updated that there was significant work ongoing to develop the Estate and smaller schemes were underway which related to estates safety funding. The acute theatre refurbishment programme at Hull Royal Infirmary (HRI) was ongoing. Work was underway to resolve ongoing challenges with the lifts at HRI. Additional options were being considered to refurbish two service lifts in the HRI Tower Block. The Lift B refurbishment was complete and defects to Lift A were

resolved. All lifts were monitored regularly to ensure maintenance. Work was ongoing with the Wish Foundation regarding the Well-being Centre at HUTH. Castle Hill Hospital (CHH) infrastructure works were underway and two generators were due to be installed in August 2025.

The HASR scheme work commenced in ITU at Diana, Princess of Wales Hospital (DPoW) and there was ongoing work around the planning and design of that. The Group were considering moving medical records to Ward B1. There were staff changing facility improvements on the main industrial corridor. Solar PV work was ongoing on the roofs at DPoW and Scunthorpe General Hospital (SGH). Improvement works were underway at Goole Hospital to clean gutters, main grounds and gardens. Retail catering at HUTH continued to lose revenue. The Group would go out to tender and an expression of interest would be published this week. The retail teams were informed and there would be an opportunity for them submit an internal bid by October 2025 if they could provide a robust plan with evidence to improve profit.

The Starbucks coffee shop at DPoW was established in Family Services, and Costa was expected to open in mid-September 2025. An increase in car parking charges for visitors and patients was being reviewed at HUTH which would be aligned with current charges at NLaG, and a paper would be presented to Group Executive next week. Car parking charges for staff would also be reviewed in January 2026. There were significant decisions to be considered around improving decontamination efficiency. The Group were looking to bring this in-house, and a further paper would be presented to the PEF CiC in September 2025.

Dr Kate Wood noted the improvements to Wayfinding at CHH and queried whether this would be considered on the South Bank. Tom Myers confirmed this and shared that work was ongoing to review the overall quality access and the clinical teams were linked in to provide feedback.

David Sharif thanked the Estates, Facilities and Development team for addressing concerns raised by Governor Colleagues at Goole Hospital.

The Committees-In-Common agreed significant assurance over business-as-usual activity, noting that work was ongoing to address significant issues in the Tower Block, ongoing issues around catering at HUTH losing income and the plans to address this, the scale of capital works underway across the Group and progress with the sustainability agenda.

4.5 Contract Approvals

4.5.1 Contract Approval: Radiology Reporting

Edd James updated that the Radiology team were requesting to extend the existing two contracts for NLaG and HUTH to March 2026. This would enable them sufficient time to undertake a procurement process in the meantime for a new contract in April 2026.

Gill Ponder noted that extending contracts after they expired did not feel like good practice and queried whether the Group were close to being caught up on

overdue contracts. Edd James noted that there was still a significant volume of overdue contracts and catching up while further contracts were incoming provided a challenge. The Group continued to work towards the target to get on top of contracts by October 2025. He mentioned that the Group were awaiting Radiology teams to finalise ongoing challenges with the Imaging Network which had delayed the contracts whilst they worked through that process. The Radiology team decided to go ahead with a Humber Health Partnership-only contract from April 2026 which would make the process simpler.

Gill Ponder noted that it would be helpful to indicate whether the costs were in the budget and whether the Group could afford the contract. Edd James explained that the only contract that had increased in cost was £4.5k on the TMC contract and the finance business partner has signed-off on the contracts. Emma Sayner mentioned that the contracts would drive additional value and efficiency. She further noted that work ongoing around the business partner model for procurement was robust however the Group expected it to take time due to the significant scale of the processes.

The Committees-in-Common endorsed the contract for Boards-in-Common approval.

5.3 Contract Approval: Managed Theatre Services at Castle Hill Catheterisation Labs

The Agenda was taken out of order at this point.

This contract was shared for information.

Edd James left the meeting at 11:37 hours.

4.5.2 Contract Approval: SGH – PSDS 3C Energy Centre (Phase 1) Shell, Core and Fit out

The Agenda returned to the correct order.

Tom Myers updated that the contract value was £3.9 million. The Group went out to tender and 7Formation was revealed to be the most advantageous tender.

Gill Ponder mentioned that there was a reference in the report to 7Formation only being able to meet the timescales if they could complete phase 1 and phase 2 concurrently. Tom Myers confirmed that timescales were agreed with 7Formation.

The Committees-in-Common approved the contract.

4.5.3 Contract Approval: HRI Solar Car Port Installation

Tom Myers explained that this contract was to install solar car ports on the Argyle Street Carpark at HRI and the Group were reviewing how to phase these with the contractor. RenEnergy Ltd was revealed to be the most advantageous from a quality and cost perspective, they were also working on the car ports on the SGH pit car park which was progressing well and ahead of programme. The scheme was expected to deliver 2.1 MW in terms of car ports solely, with an opportunity

to further deliver 2.8 to 3.1 MW at HRI. The Group reviewed the disruption to staff car parking due to the works that would take place and central car parking areas were considered to be a key redevelopment piece of work. The contract value was £4.29 million.

Emma Sayner shared that she was assured the Group were not limiting their ability to carry out other work as a result of this work.

Jane Hawkard mentioned that the contract value was greater than £5 million with the inclusion of VAT. Tom Myers shared that the scheme of delegation had authority to sign contracts to revenue or Capital at £3 to 5 million excluding VAT. Jane Hawkard noted that it did not make sense to exclude VAT from the contract as the Group were still required to pay it.

Simon Parkes shared that VAT was a treated as a transfer payment in economic terms and whilst it had a real budgetary impact for the Group, it did not for Government which was the reason to exclude it from approval limits.

Action: Emma Sayner and David Sharif to review changes made to the scheme of delegation and clarify the position on VAT.

The Committees-in-Common approved the contract.

4.6 Emerging Issues

Emma Sayner shared that discussions were being held with Sean Lyons to review the Provider Selection Regime (PSR) and Procurement at the next Board Development Session.

Gill Ponder proposed a review of contract management due to the historical challenges seen.

Ivan McConnell suggested considering PSR regulations which were different to the previous ones and explained the non-obstetric ultrasound for CDCs.

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.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

None to note.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

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:

An Extra-Ordinary PEF CiC will take place on Tuesday 02 September 2025, 09:00am to 12:30pm in The Boardroom, Diana, Princess of Wales Hospital, Grimsby.

The meeting closed at 11:49 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 30/09	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08				
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08				
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08				

									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				
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Andy Haywood	Group Digital Information Officer		N	N	N	N	N	N	N 05/08 N 07/08				
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08				
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08 Y 07/08				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the Extra-Ordinary meeting held on Thursday, 7th August 2025 at 09:00 to 10:00 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)
Dr Kate Wood	Group Chief Medical Officer
Emma Sayner	Group Chief Finance Officer
Jane Hawkard	Non-Executive Director (HUTH)
Murray MacDonald	Vice Chair (HUTH)
Jeevan Gill	Director of Operational Transformation (attending for Interim Group Chief Delivery Officer)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Adam Creeggan	Group Director of Performance
Philippa Russell	Deputy Director of Finance
Tom Myers	Group Director of Estates
Julie Beilby	Non-Executive Director (NLaG)
Linda Jackson	Associate Non-Executive Director (HUTH) and Vice Chair (NLaG)

Observers:

Ian Reekie	Lead Public Governor (NLaG)

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. No apologies for absence were noted.

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.

2.1 Deep Dive: NHSE National Oversight Framework

Adam Creeggan explained that the revised National Oversight Framework had been through an extensive consultation period. The data had now been published but was currently embargoed. He highlighted its complex methodology and the subjective process for determining segmentation scores. Organisations would require interventional support as part of segment 5, and The Group were unclear on whether they would be placed in segment 4 or 5. There was a delay in determining the segmentation scores which appeared to be due to NHSE confirming resource availability for associated interventions.

Key areas of focus for the Group were Finance, RTT, 62 days for cancer, and Urgent and Emergency Care (UEC). Critical areas of non-compliance for the Group were infection control metrics, the overarching financial position and the staff satisfaction survey.

Adam Creeggan explained that over time the number of metrics being reviewed through the Performance and Assurance meetings with the Care Groups had expanded significantly, however this posed the risk of losing oversight on assurance. A refocus on a smaller group of critical metrics was required to ensure appropriate oversight of quality, finance, and performance. Work was ongoing to determine whether the Group would benefit from moving to a pack based on the National Oversight Framework, with an associated exception template to streamline the engagement process and improve oversight.

Jane Hawkard queried when the Group would expect to see the key detail around metrics. Adam Creeggan explained that work was ongoing around UEC trajectories. An extensive process was underway to review all delivery plans for Elective Care and the Group had repeated an operational planning process to determine robust trajectories for elective care with a deadline of mid-September 2025.

Julie Beilby queried whether the Group would be separated into individual Trusts during the Tiering system and noted that individual Trusts being in different Tiers would provide challenges.

Julie Beilby further queried whether there was a requirement to report metrics as a Group or individual Trusts. Adam Creeggan explained that the Group were expected to report and be performance managed as separate sovereign organisations, however there were clearly Group level consequences of any component Trust triggering segment 5.

Adam Creeggan explained that the Group were currently building a performance tool which would contain every metric within the Group broken down into four key domains. This would enable the Group to access every metric and further explore Care Group performance. Each Care Group would be given a weighted score based on the compliance of each individual metric which would ultimately feed through into a heat map and would allow the Group to see specific key areas of concerns in that specialty.

Gill Ponder queried how staff would be trained to utilise the tool efficiently without being intimidated by the volume of information and ensuring focus on key priorities. Adam Creeggan recognised the cultural challenges and the journey the Group was on and he clarified that the tool would identify the essential metrics.

Gill Ponder shared that it was crucial to support staff to use the tool in order to drive improved performance. Adam Creeggan clarified that the tool would help staff to familiarise themselves with the system which would improve data access.

Helen Wright mentioned that it would be helpful to show the top 5 fallers and risers each month in terms of score to monitor exceptions, noting that turning data into insight was key. Adam Creeggan explained that the Group were in the process of building a business insights team to build complex forecast models with an aim of optimising the current Group resource to improve delivery. Until recruitment was completed the Group were constrained by the capability to undertake sophisticated data science programs to maximise efficiency identification.

Jeevan Gill emphasised the importance of ensuring Care Groups have effective governance and quality arrangements in place to measure against metrics.

Gill Ponder wondered how to get the Care Groups to focus on the metrics without compromising quality and patient safety. Jeevan Gill suggested engaging with Care Groups to understand their demand, capacity and skillset in order to deliver against metrics which would get buy-in and ensure sustainability.

Dr Kate Wood mentioned how performance interlaces with the quality and patient experience. She emphasised the importance of reviewing how the Group were impacting on the health and care delivery for patients.

Action: Gill Ponder agreed to share the Collaborative of Acute Providers presentation with the CiC outside the meeting to see if there were any ideas the Group could adopt.

Gill Ponder queried whether the daily reports currently being produced would focus on the critical measures as part of the national oversight framework parameters and the scores would be allocated based on the two outliers. Adam Creeggan confirmed this.

2. DATE AND TIME OF THE NEXT MEETING

2.1 **Date and time of the next PEF CiC meeting:**

Tuesday 02 September 2025, 9:00am to 12:30pm in The Boardroom, Diana, Princess of Wales Hospital, Grimsby.

The meeting closed at 09:45 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 30/09	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08				
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08				
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08 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				
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Andy Haywood	Group Digital Information Officer		N	N	N	N	N	N	N 05/08 N 07/08				
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08				
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08				
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08 Y 07/08				

***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, 2nd September 2025 at 09:00 to 12:30 hours in The Boardroom, Diana, Princess of Wales Hospital, Grimsby

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)
Dr Kate Wood	Group Chief Medical Officer
Sarah Tedford	Interim Group Chief Delivery Officer
Jane Hawkard	Non-Executive Director (HUTH)
Philippa Russell	Deputy Director of Finance (Attending for Group Chief Financial Officer)

In Attendance:

Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Adam Creeggan	Group Director of Performance
Ivan McConnell	Group Director of Transformation
Tom Myers	Group Director of Estates

Observers

Ian Reekie	Lead Public Governor (NLaG)

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 Emma Sayner, Group Chief Finance Officer, Rebecca Thompson, Deputy Director of Assurance, and Simon Parkes, Non-Executive Director (NLaG).

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 05 August 2025 Extra-Ordinary meeting held on 07 August 2025

The minutes of the meeting held on 05 August 2025, the Private minutes from the meeting held on 05 August 2025, and the Extra-ordinary meeting held on 07 August 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
3.1	CQC Actions Report – Group	Leah Coneyworth to pick up the Estates issues with Tom Myers outside of this meeting.	**The discussion still needs to take place and an update will be provided at the next meeting. Carry forward.**
4.1.1	Update on Transformation Programme	Decisions taken and decisions to trajectories to be provided in the next report.	**Update provided within agenda item. 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 Board Assurance Framework to include Risk Register Report

David Sharif took the report as read. He explained that the Board Assurance Framework (BAF) contained strategic risks against objectives scoring the Patient Access risk at 20 and the Public Purse risk at 16. He reported a slight improvement regarding the completion of aspects of the BAF and work underway and planned to add the strength of controls and assurance to all the BAF risks, and to bring items up to date. David Sharif also highlighted the controls around

flow, care boards, the actions in place through the tiering meetings, and the actions to transform and address the financial risks.

Gill Ponder mentioned that the information within the report appeared to be outdated in several places. She noted that several actions were last updated in February 2025 and wondered what would drive the Group to achieve delivery assurance. David Sharif explained he was reviewing the cycle of meetings and their sequencing to refreshing the BAF ahead of the Trust Board.

Action: David Sharif to review and update the timing and sequence of Board Assurance Framework to align with CiC and Board-in-Common meetings.

Action: David Sharif to ensure responsible action owners are providing updates on the BAF actions.

Gill Ponder wondered whether the tolerable risk score on page 6 for finance was appropriate and whether it is right to tolerate a catastrophic risk level.

Action: Philippa Russell to discuss the tolerable risk score on page 6 with Emma Sayner and determine whether the score needed adjusting.

Gill Ponder noted that the Group listed service line reporting as an assurance source, however service line reporting data was not presented to the CiC. David Sharif noted that he would review this as he believed that it should have an assurance gap against it, explaining that the Group did not routinely process service line reporting. Philippa Russell shared that there was an intention to re-introduce and embed routine service line reporting.

Jane Hawkard mentioned the action on page 8 of the report around developing a comprehensive financial strategy and highlighted that there was confusion between the financial strategy and the financial plan. Philippa Russell recognised that the strategy and plan were separate. The intention was to present the financial strategy at the next PEF CiC.

Helen Wright queried whether the Group had now implemented the tactical bed utilisation review. Adam Creeggan confirmed that the Group had refreshed the existing bed model which covered all data across the Group, and a workable model was in place which was comparable with models other organisations used. The model was at the simpler end of the available modelling techniques available in the NHS. A delay to improvement was expected until recruitment of the business insights team which was expected to be in place by the end of the financial year.

Helen Wright noted that the tolerable score of 16 for Patient Access appeared high and suggested a refresh in order for the CiC to understand the reason for the tolerable score. David Sharif explained that he would review this alongside the other tolerable scores.

Helen Wright queried whether there would be a wider review on Care Group performance. Sarah Tedford confirmed that work with Executive colleagues was

ongoing to review the current process the Group were following and this would take place over the next two weeks. Updates would be provided within the BAF. David Sharif highlighted that there was a limitation in the current process that covered 14 Care Group Accountability Groups.

David Sharif updated that an extract from the risk register of the applicable high-scoring risks was submitted and he apologised for its raw format. He expected a more comprehensive high-level risk report to be available by November 2025 which would be presented to the CiC when the next BAF quarterly update was due. Work was ongoing to ensure Care Groups and directorates were reviewing the risks on a timely basis.

Jane Hawkard queried whether the high-level risks were tolerable which linked to the risk appetite. Helen Wright mentioned that it would be helpful to understand the risk appetite in future reports. David Sharif confirmed that he would pull the tolerable risk scoring through as part of the next reporting phase.

Gill Ponder queried why the patient safety risk due to typing backlogs and accessing cardiology services was referred to PEF CiC rather than Quality and Safety CiC. She wondered whether it was an alignment issue. David Sharif suspected it was due to picking up the referrals and proposed reviewing this detail outside of this meeting.

Gill Ponder further noted risk 4368 and that the action was updated however the risk score had not reduced. David Sharif noted that several actions were associated with that risk.

The Committees-In-Common noted that some progress was made and further assurance was required around the high-level risks.

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.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Winter Plan 2025/26

Sarah Tedford took the paper as read and provided an update. There was no winter funding available and the Group needed to focus on using resources efficiently to ensure an upward trend in morning discharges. Work around the continuous flow model was progressing well and would be a key-driver throughout the winter period. The Group were working to implement teletracking with new systems and processes being reviewed and it was expected to be up

and running by December 2025. The Group were out to consultation to reintroduce the General Internal Medicine rota. Consultation was expected to commence for HUTH in September 2025 with an expectation to implement the rota by October 2025. However, this was dependent on the agreement of what the new rota would look like. If agreements were not made, the Group would end up in mediation and discussions would take place with finance teams to review how to support by utilising Locum Consultants in the interim.

Dr Kate Wood confirmed that changes to the job plans would cover nights and weekends versus days currently. Weekly meetings were taking place around introducing the Surgical SDEC (Same Day Emergency Care). Sarah Tedford shared that current issues around the Tower Block at HRI (Hull Royal Infirmary) had an impact on the initial plan for SDEC. The Group expected that the Surgical SDEC would be in place by Christmas 2025. Systems and processes were being reviewed to determine how many patients could be supported. The Group planned to increase and optimise the current frailty assessment beds and were working closely with community teams. There was a focus on re-providing staff into other bedded areas to support a reduction in the run-rate and medical staffing being deployed. Monitoring NCTR (No Criteria To Reside) numbers was critical as the Group entered the winter period. A winter testing meeting took place with Integrated Care Board (ICB) colleagues to review various scenarios around managing performance in the event of staff sickness which proved to be a productive exercise.

Sarah Tedford shared that work was ongoing to develop a dashboard that covered primary care, secondary care and community which would enable the Group to review capacity and performance. She emphasised the importance of ensuring that adequate medical staff were in place to support decision making and timely discharges. It was critical that the Group were not cancelling elective activity.

A big drive was required on IPC and vaccination rates internally. The Group would review how to improve the response to OPEL framework.

Helen Wright mentioned a previous request for additional funding and wondered how much was spent in 2024/25. Philippa Russell confirmed that £1million was spent, however the Committee queried whether this delivered any improvement to performance and this could not be quantified.

Gill Ponder mentioned the historical NCTR challenges and wondered what would be different and why the Group were confident that it would work this year. Sarah Tedford shared that good working relationships were in place and monitoring patients on a daily basis was crucial.

Gill Ponder noted that staff vaccination rates had decreased in 2024/25 and wondered how the Group would encourage an uptake in vaccination rates without spending money. Sarah Tedford mentioned that the Group were currently reviewing how to incentivise individuals and teams with an aim of increasing vaccination rates.

Helen Wright wondered whether there was a direct correlation level with vaccinations and absence. She agreed to refer this to Workforce, Education and Culture Committees-in-Common to provide further information.

Jane Hawkard queried whether the challenges around the discharge lounge at HRI had been resolved. Sarah Tedford shared that as part of the work to introduce the surgical SDEC there would be a temporary discharge lounge in place which was planned to commence in November 2025. Plans were in place to move the discharge teams from the 3rd floor to the 13th floor. Temporarily the surgical SDEC would go on the 1st floor while the 3rd floor was refurbished, and then would move back into the 3rd floor. The Group were looking to expand the 1st floor for frailty and the discharge lounge would be relocated into the new block.

Jane Hawkard noted that IPC was mentioned frequently in the report however there was no mention of a decant facility in place. Tom Myers clarified that there were decant facilities in place at DPoW (Diana, Princess of Wales Hospital) and SGH (Scunthorpe General Hospital). However, HRI provided a challenge. Sarah Tedford shared that although the Group currently did not have a decant facility at HRI, it would be reviewed.

Helen Wright queried whether the Group were confident that data fully captured all NCTR patients. Sarah Tedford confirmed that she believed it did and a significant amount of earlier referrals into the NCTR system was seen.

The Committees-In-Common agreed reasonable assurance, noting the robust plans in place despite lack of funding and movements seen in No Criteria To Reside.

4.2 Group Finance Report: Month 4

Philippa Russell took the report as read and provided an update. She highlighted a year-to-date deficit of £12.2 million which was £3 million adverse variance to plan. The Group utilised significant balance sheet support which meant that the underlying position was significantly worse. Improvement was seen in the Care Group delivery of CIP (Cost Improvement Plan) however that revealed an underlying overspend. Whilst the £12 million CIP gap did not change, the unmitigated gap increased to £18 million. The level of risk had increased and was reported externally. The risk adjusted forecast had increased to £51 million in comparison to the £38 million reported for month 3, this was due to the growth in unmitigated recovery requirements and the significant amount of opportunity that was still to be developed in the CIP plan. Philippa Russell highlighted that the scale of the CIP opportunity was diminishing partly due to the requirements of the Winter Plan as whilst there had been ambition around bed-closures, some were not viable and the Group would need to look elsewhere for the opportunity. The Group was forecasting a £65 million gap based on the current adjusted run-rate. Significant work was required to reduce that gap both through the Group level recovery action plan and Care Group recovery actions and CIP delivery.

Gill Ponder queried what the Executive team were doing to improve grip and control on the financial position. Sarah Tedford shared that transforming cultural behaviours was a challenge. Performance challenges were occurring and work was ongoing to ensure the right people were in the right places to take this

forward. Meetings were taking place with Operations Directors to review their finances and ensure recovery plans were in place. She recognised that some people appeared not to know how to stop spending money and it was crucial to hold people to account. The Group needed to see changes in individual behaviours and regular monitoring would take place.

Helen Wright mentioned that cash performance was better than planned however I&E performance was significantly worse and she wondered how the Group were managing that. Philippa Russell shared that there was a level of cash received in Month 12 that would be spent later in the year, a significant increase in the balance sheet accruals was seen at Month 12, and Capital was behind plan which further supported the Group cash position. She highlighted that deficit support funding was secured for Q1 and Q2 and unless a significant improvement was seen in Month 5, the Group may not receive deficit funding for Q3 and Q4. Philippa Russell mentioned that without a significant improvement in the financial position, the Group was likely to face the challenge of running out of cash possibly around Q4. She noted that there was no guidance released from NHSE for revenue support funding in 2025/26 on the basis that nobody should need it.

4.2.1 Update on Transformation Programme

Ivan McConnell updated that following an afternoon session with Care Groups, challenges were identified within family services, specialist medicine, specialist surgery and patient services, however patient services provided a significant opportunity in terms of change and delivery. The Group appointed a dedicated project manager to work with Care Groups and traction was seen through that work. Several still-to-be-defined key areas of work were identified and a dedicated workplan would be produced by December 2025. There were potential significant savings anticipated, however those savings were associated with significant costs. There was a drive to increase the speed of schemes progressing through gateways and Equality Impact Assessments (EQIAs). The Group had undertaken a greater scale of work throughout the transformation programme in comparison to 2024/25. A greater focus on service transformation would be required in 2026/27. The corporate services target had increased from 4% to 6% with a further opportunity to increase the target and the Group planned to enhance the corporate services processes. Work was ongoing with Sarah Tedford around potential area closures. Efforts were underway to review data around WLIs (Waiting List Initiatives). Agency spend had increased and was above plan. Work was underway to review Pathology alongside Pathlinks and SHYPS (Scarborough, Hull and York Pathology Service). Following a workshop that took place on 28 August 2025, a business case was in place to review next steps. Theatres at Goole Hospital were currently the highest performing Theatres within the Group, which provided an opportunity to repatriate patients. He highlighted that any strategic service changes would take 12 months for the Group to implement. Work was underway to implement centralised booking and scheduling which expected to provide both a significant opportunity and an associated risk.

Helen Wright queried whether there were any ramifications that would require Boards-in-Common involvement in the decision making. Ivan McConnell clarified that any form of strategic service change would; the Goole programme had some perceived risks, and Pathology would require Boards-in-Common involvement.

A discussion took place around which Committees were providing assurance to the Boards-in-Common around particular investments. Helen Wright emphasised the importance of being mindful of the processes coming through different Committees-in-Common and Boards-in-Common.

Ivan McConnell shared that currently the Group allow people to undertake WLIs who did not meet the required standards and consequently the Group were potentially committing additional funding for core capacity. However, if the Group did not improve efficiency reducing these WLIs would have a consequence on the waiting list. Helen Wright recognised that making a change would always pose a consequence, however that should not stop the Group from making difficult decisions. There was a concern raised around the pace of decision making, which needs to significantly increase.

Jane Hawkard queried whether there was traction outside of the core PMO (Project Management Office). Ivan McConnell shared that traction had improved and the work undertaken with the Care Groups and Care Group Directors contributed to that. He recognised that further work was required.

Helen Wright queried the timeframe for finalising the plans for Corporate and Estates,given that the Group were off-track. Ivan McConnell confirmed that the plan was to get something concrete in place by the end of September 2025. There were no concerns and it was a work in progress.

Gill Ponder shared that ultimately the Group would be judged by the outcomes achieved and that part of the cultural shift would be to get people to start to think and value outcomes more than effort, which would be a significant challenge.

The Committees-In-Common agreed limited assurance, recognising the amount of effort and hard work taking place, visibility in the transformation plans and Care Group support. However, results are not coming through quickly enough and decision making pace is too pedestrian. This will be followed up further at the next meeting and escalated to the Boards-in-Common.

4.3 Group Performance Report and Cancer Trajectories

Adam Creeggan shared that 12% of lost days was due to cough and flu and 50% of those absences occurred on a Monday and Tuesday.

UEC

UEC performance at month 4 for HUTH was 58.9%, and 74.4% at NLaG which was near plan.

RTT

The Patient Tracking List (PTL) had stabilised at HUTH and there was a decrease seen in the PTL at NLaG. The Group had seen the benefit of a reduced referral demand and the percentage compliance was suppressed in the sustainability of the PTL. Conversations with Jim Mackey suggested suppressing the RTT target would instead promote an accelerated reduction of wait time.

Gill Ponder wondered whether anything could be done further to reap the additional income of £33 per clock stop that would benefit RTT in the process. Adam Creeggan explained that this was being explored and it was determined that it was not the right approach. He provided clarity that the £33 additional income was provided for a closed pathway, not for validation.

Gill Ponder further wondered whether there was a correlation between late starts and list over runs, and whether the Group had undertaken analysis to review this which would be positive for productivity and patients. Sarah Tedford explained that the Group were reviewing a wide range of theatre metrics including cancelled on the day patients, overruns and early finishes through the theatre productivity group. It was determined that early finishes provided a more significant challenge and there was a focus on optimising the list times and reviewing dropped sessions within specialties. There were key areas identified with biggest pressure points and which were not optimising support efficiently.

Helen Wright queried whether there was progress made on accelerating timings regarding Luna Rova. Adam Creeggan clarified that progress had not been made and everything the Group could do to accelerate timings had been done.

Cancer

Sarah Tedford updated that the Group had produced a proforma for every tumour site to ensure they were clear on where they were starting from and where they needed to get to. A detailed programme of work was produced that reviewed the actions required to get cancer back on track which included ensuring trajectories were in place for each tumour site and meeting the 62-day standard. A number of tumour sites required further work or a different direction of travel. Following changes that had taken place in the cancer team, the service would be re-reviewed. An external review was ongoing and work would take place following this to review systems and processes that required development. Concerns were raised around inconsistencies with how MDTs (Multi-disciplinary Teams) were running and the Group would review this.

Due to the current Governance challenges, efforts were underway to re-establish a cancer board and develop a cancer strategy. The Group secured £1.4 million of external funding and would receive external support through the Cancer Alliance team to ensure efficient use of the funding. Significant work was required around referral management to reduce inappropriate referrals and introduce digital triage. A significant increase in patients awaiting scopes was seen following the pay disputes with Consultants at NLaG. The Group would review pathways in greater detail with an aim to enhance them.

Gill Ponder noted the significant difference between the end of year predicted trajectory between Colorectal and Urology and wondered whether there was an opportunity for mutual aid to smooth that performance out. Sarah Tedford explained that generally it was a work in progress, however it was dependent on individual specialties and the Group were unsure at this stage whether that was possible. Dr Kate Wood shared an example of the Urology prostate work that could only be done at CHH due to access to the robot, which meant the work was predicated on weekend working.

Helen Wright queried the difference between core capacity and extra capacity. Sarah explained that core capacity was the number of people the Group expected to have and extra capacity was capacity that could be put into the system to support the core capacity.

Helen Wright further queried the reason for the uptake in core capacity for Breast. Adam Creeggan explained that it contributed to restoration of normal base-line activity.

Gill Ponder noted the deteriorating picture on diagnostics which was an enabler for the cancer work taking place as it was dependent on diagnostics. Sarah Tedford explained that the tiering meetings covered both cancer and diagnostics. A detailed work plan and proformas for each modality were in place.

Gill Ponder wondered whether there would be an increase in the use of Community Diagnostic Centres (CDCs). Sarah Tedford shared that dedicated management was in place with the intention of increasing the use of CDCs.

The Committees-In-Common agreed limited assurance due to the performance position and having not seen the results delivered yet. Noting that high quality plans were in place however that were not yet embedded or sustained. The granularity within the trajectories was welcomed. They acknowledged the positive growth seen around the patient list, total numbers and urgent care across July and August 2025.

4.4 Directorate of Estates, Facilities and Development Update

Tom Myers updated that from a managing the estates perspective there was a focus on ensuring Group compliance through the role of an AE (Authorised Engineer, an independent external engineer). It was a mandatory requirement for them to review areas of compliance for fire, medical gas, water services, electrical, pressure systems, heating and ventilation, and decontamination. No areas of high risk were outstanding at HUTH, however six areas of high risk were outstanding at NLaG regarding medical gases, pressure systems and LV power. A plan was in place to resolve the medical gas risk at SGH with an interim measure in place to the control panels and vaporisers in 2025/26 while longer term plans to upgrade the VIE plant and systems are being worked up. Work was ongoing to resolve challenges at Goole Hospital regarding the medical gas and air plant. The Group aimed to resolved these within 12 months dependent on the outcome of the future of theatres at Goole.

An Enforcement notice was issued on the 16 July 2025 and published on 29 August 2025 regarding the Tower Block at HRI.

There were pressure system challenges ongoing at DPoW in relation to the medical gas systems and efforts were underway with the multi-disciplinary team to establish a plan and put something in place for 2026. Emergency shut down procedures for DPoW were being worked through. Work was ongoing to resolve challenges regarding LV at Goole Hospital and DPoW.

A number of small schemes were in place to develop the future estate and the Group expected to see a significant increase on orders and spend within the next

six weeks. Work would commence to implement the solar carports in the Argyle Street Car Park at HRI. Works on the pit car park at SGH were progressing well. The planned handover for Hull CDC saw challenges with the Hull City Council Contractor due to outstanding warranties.

Costa works at NLaG were progressing well and was expected to be operational by 09 September 2025. The Starbucks coffee shop saw an increase in service. The HPV trial for cleaning was extended to allow further training for in-house staff, and the Group would review how to roll this out across the Group if successful. Work was ongoing around the accommodation and property non-compliance issues at HUTH. The outstanding PAM (Premises Assurance Model) items required input from the Lead Mental Health Nurse regarding the Anti-ligature risks to resolve challenges around policy and procedures.

The Group were required to make a decision by December 2025 regarding extending the sterilisation contract. Work was underway to review options including the possibility of bringing the sterilisation service in-house and a following update would be presented to the CiC.

The Committees-In-Common agreed significant assurance, highlighting delayed spend in comparison to planned, however this was expected to accelerate within the next six weeks.

4.4.1 Group Fire Annual Report & Work Plan

Tom Myers mentioned that the annual report contained a number of minor corrections which the estates team would rectify.

Fire warden numbers were being monitored and the number of wardens was increasing across the Group. Work was ongoing to review fire training compliance. Staffing challenges had resolved and the Group recently recruited a Fire Officer. Efforts were underway in terms of compartmentation in the HRI Tower Block and compartmentation surveys at NLaG. Estates funding would support fire alarm upgrades at HRI which would be carried out across the 2025/26 financial year. The Group continued to monitor the errors on the fire alarm system at Goole Hospital which was still a cause for concern, however parts were being utilised in the meantime following the upgrade of the SGH fire alarm system. The Humber Fire Rescue Service (HFRS) raised an issue around the Womens and Childrens corridor at HRI regarding an increase of beds stored across the corridor. A temporary bed store would be put in place at the back of UTC to resolve this.

Jane Hawkard noted that the Fire report did not include the Tower Block risks that were present at HRI however these were present last year and the report should reference this.

Dr Kate Wood wondered whether it was possible to ensure that the Group would not accept the low number of fire wardens they previously had. Tom Myers confirmed that work was ongoing to review the system.

The CiC were comfortable that the Tower Block and fire warden provision was adequately covered. Work was ongoing to address the issues raised around the

HRI Tower Block and recent detailed investigations into the structure of the building had not increased the level of risk; as such timeframes for mitigation remain unchanged. The level of effort and focus around the detailed mitigations was commended.

4.4.2 HUTH Catering Services

Tom Myers shared that an expression of interest was published to the private sector market for catering services which were running in-house and continued to make a loss, despite mitigations and price increases being implemented. The Group were unable to subsidise catering service and were looking at alternative options. Significant interest was received and a positive response was expected. The Group were reviewing in-house mitigations with the intention of an in-house bid however the retail teams would have two months to provide a robust plan which would improve the position before the Group considered an in-house bid. Following a discussion at Group Executive, a decision was in the process of being made around closing Nourish at HRI over the weekends which continued to make a loss.

Gill Ponder wondered what the differences were between the Group just opening an in-house provision at NLaG and Nourish making a loss that the Group were unable to turnaround. Tom Myers explained that as the South Bank were half-way through a 15-year contract, charges had increased steadily and the Group were trying to introduce competition and an alternative option for patients, staff and visitors. In addition, Costa at NLaG provided a guaranteed income and introducing our own in house offer enabled the Group to challenge on the pricing.

Gill Ponder further queried whether the Group could utilise that same model used at NLaG. Tom Myers clarified that the Group were challenging the teams on the North Bank however a loss was seen across CHH and HRI in 2024. Work was ongoing to increase profits at HRI however this was not achieved.

4.5 Contract Approvals

None to note.

4.6 Emerging Issues

Nothing to raise.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

Action: Helen Wright and Gill Ponder to review Deep Dives on the Workplan in relation to diagnostics and trajectories.

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)

None to note.

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 Committees-in-Common around how much effort should go into pushing vaccination in order to reduce staff absence.

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.

Action: Limited assurance on CIP to be considered and reviewed by Boards-in-Common.

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 30th September in the Boardroom, Castle Hill Hospital.

The meeting closed at 12:25 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 30/09	Oct No meeting	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			
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09			
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	D 02/09			
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09			
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08 N 07/08	N 02/09			
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			
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09			
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09			
Andy Haywood	Group Chief Strategy, Partnerships & Digital Officer		N	N	N	N	N	N	N 05/08 N 07/08	N 02/09			
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08	Y 02/09			
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09			
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08	Y 02/09			

									Y 07/08				

***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)191

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	9 October 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Philippa Russell, Deputy Director of Finance
Title of Report	Finance Report – Month 5
Executive Summary	This report highlights the reported financial position at month 5 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Finance Report Month 5
August – 2025/26

Finance Overview

In-month I&E Performance – page 3

(£0.0m)

The Group reported an in-month deficit for month 5 of (£1.9m), (£0.0m) adverse to plan.

Year to Date I&E Performance – page 3

(£3.0m)

The Group reported a (£14.1m) year to date deficit for month 5, (£3.0m) adverse to plan. This also includes £8.5m of non-recurrent balance sheet support.

I&E Forecast Outturn – page 4

(£17.1m)

The Group is forecasting a deficit of (£61.8m) based on an adjusted straight-line projection. Mitigating actions are forecast to reduce the deficit leaving an unidentified gap of (£17.1m) across the Group.

YTD Cost Improvement Plan – page 5 to 6

(£6.5m)

The Group has delivered £37.2m in CIP against a YTD target of £43.8m, (£6.5m) behind target. The Group are forecasting CIP delivery of £114.6m, (£15.4m) adverse to plan. High risk schemes have reduced from £52.3m to £40.0m.

Underlying I&E – page 7

(£74.0m)

The Group's underlying position is estimated at a deficit of circa (£74.0m). Recurrent CIP and FYE of in year schemes will be the key variable to the Group's underlying position.

System Performance – page 8

(£3.2m)

The ICS reported a YTD deficit of (£20.3m), (£3.2m) adverse to plan at month 5. The ICS is forecasting a break-even position as planned.
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Capital Expenditure – page 9

(£10.9m)

The Group has spent £20.9m on capital expenditure against a plan of £31.8m, (£10.9m) behind plan.

Balance Sheet & Cash – pages 10 to 11

£55.2m

The Group's cash balance at the end of month 5 was £55.2m. CIP delivery will be the key variable in determining if external cash support will be required in year. This will be monitored closely.

Elective Recovery Performance – page 12

£1.3m

The Group is currently over-performing against ERF baselines by £1.3m. Due to the block income arrangements so additional income or penalties have been assumed year-to-date.

Temporary Staffing – pages 13 to 16

(£0.3m)

The Group has spent £29.0m on agency and bank pay YTD. This is (£1.0m) more than the same period in 2024/25.

Key Risks

- ❑ Unidentified CIP and reliance on Non-Recurrent schemes.
- ❑ ICS Risk share arrangement for CDC and HCDs growth.
- ❑ Winter pressures / unfunded Escalation Beds.
- ❑ 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.
- ❑ Reduce underlying run rate spend within Care Groups.

Financial Performance Summary

The Group ended August with a year-to-date (YTD) deficit at month 5 of (£14.1m), (£3.0m) in adverse to plan.

£million	HUTH £m						NLAG £m						Group £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	74.7	76.1	1.4	376.7	379.0	2.3	46.6	46.8	0.2	232.8	232.8	0.0	121.3	122.9	1.6	609.4	611.8	2.3
Other Income	6.9	18.3	11.3	44.9	45.0	0.0	6.7	6.0	(0.6)	31.1	26.5	(4.6)	13.6	24.3	10.7	76.1	71.5	(4.6)
Total Operating Income	**81.7**	**94.4**	**12.7**	**421.6**	**423.9**	**2.3**	**53.2**	**52.8**	**(0.4)**	**263.9**	**259.3**	**(4.5)**	**134.9**	**147.2**	**12.3**	**685.5**	**683.3**	**(2.2)**
Pay Costs																		
Clinical Pay	(39.2)	(40.5)	(1.4)	(196.0)	(202.5)	(6.6)	(27.8)	(28.8)	(1.0)	(140.2)	(142.1)	(1.9)	(67.0)	(69.3)	(2.3)	(336.2)	(344.6)	(8.5)
Other Pay	(8.4)	(8.4)	(0.0)	(41.4)	(42.0)	(0.6)	(7.3)	(7.1)	0.2	(36.4)	(35.6)	0.8	(15.7)	(15.5)	0.2	(77.8)	(77.7)	0.2
Total Pay Costs	**(47.5)**	**(49.0)**	**(1.4)**	**(237.4)**	**(244.6)**	**(7.2)**	**(35.1)**	**(35.9)**	**(0.7)**	**(176.6)**	**(177.7)**	**(1.1)**	**(82.7)**	**(84.8)**	**(2.2)**	**(414.0)**	**(422.3)**	**(8.3)**
Clinical Non Pay	(18.3)	(19.2)	(0.9)	(91.2)	(97.0)	(5.8)	(7.3)	(7.0)	0.3	(37.3)	(38.1)	(0.8)	(25.6)	(26.3)	(0.6)	(128.5)	(135.1)	(6.6)
Other Non Pay	(12.0)	(11.3)	0.7	(63.8)	(57.6)	6.2	(7.4)	(7.0)	0.4	(34.9)	(34.4)	0.5	(19.3)	(18.3)	1.1	(98.7)	(91.9)	6.8
Total Non Pay Costs	**(30.3)**	**(30.5)**	**(0.3)**	**(155.0)**	**(154.6)**	**0.4**	**(14.7)**	**(14.0)**	**0.7**	**(72.2)**	**(72.4)**	**(0.2)**	**(45.0)**	**(44.5)**	**0.4**	**(227.2)**	**(227.0)**	**0.2**
Total Operating Expenditure	**(77.8)**	**(79.5)**	**(1.7)**	**(392.4)**	**(399.1)**	**(6.8)**	**(49.9)**	**(49.9)**	**(0.1)**	**(248.8)**	**(250.1)**	**(1.3)**	**(127.7)**	**(129.4)**	**(1.7)**	**(641.2)**	**(649.3)**	**(8.1)**
EBITDA	**3.9**	**14.9**	**11.0**	**29.2**	**24.8**	**(4.4)**	**3.4**	**2.9**	**(0.4)**	**15.1**	**9.2**	**(5.9)**	**7.2**	**17.8**	**10.6**	**44.3**	**34.0**	**(10.3)**
Depreciation	(2.5)	(2.5)	0.0	(12.3)	(12.2)	0.1	(2.1)	(1.9)	0.2	(10.4)	(9.5)	0.8	(4.6)	(4.4)	0.2	(22.7)	(21.7)	1.0
Non Operating Items	(1.4)	(1.4)	0.0	(7.0)	(6.8)	0.2	(0.7)	(0.6)	0.1	(3.4)	(3.0)	0.3	(2.1)	(1.9)	0.1	(10.3)	(9.8)	0.6
Surplus/(Deficit)	**(0.0)**	**11.1**	**11.1**	**9.9**	**5.8**	**(4.1)**	**0.6**	**0.5**	**(0.1)**	**1.4**	**(3.3)**	**(4.7)**	**0.6**	**11.5**	**11.0**	**11.3**	**2.5**	**(8.8)**
NHSE Allowable Adjustments	(0.9)	(12.0)	(11.0)	(14.8)	(13.5)	1.3	(1.5)	(1.4)	0.1	(7.5)	(3.1)	4.5	(2.4)	(13.4)	(11.0)	(22.3)	(16.6)	5.7
Adjusted Surplus / (Deficit)	**(1.0)**	**(0.9)**	**0.0**	**(4.9)**	**(7.7)**	**(2.8)**	**(0.9)**	**(1.0)**	**(0.1)**	**(6.2)**	**(6.4)**	**(0.2)**	**(1.9)**	**(1.9)**	**(0.0)**	**(11.0)**	**(14.1)**	**(3.0)**

- **The Group reported a (£1.9m) deficit for August 2025, (£0.0m) adverse to plan. However, an extra £1.0m of non-recurrent technical balance sheet was released in month to support the financial position. £8.5m 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 (£6.5m). The programme has £40.0m of schemes rated as high risk with £35.7m rated as an opportunity or unidentified.
- The Group cash balance decreased by £10.5m in month to £55.2m (£30.3m HUTH / £24.9m NLAG). CIP delivery will be the key risk to cash flow for the remainder of the year and will be monitored closely.

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 (£61.8m) based on an adjusted straight-line projection. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£17.1m) across the Group.

A straight-line forecast based on the M1-5 deficit position would leave the group with a £33.8m 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 £61.8m, a £3.5m improvement vs the M4 forecast.

To achieve the planned break-even position, the group will need to:

- Significantly improve efficiency delivery including delivery of £20.2m of 'opportunity' that is yet to progress to in year delivery.
- Identify a further £15.4m of efficiency that is currently unidentified and unmitigated.
- Develop recovery plans of at least £6.6m to offset the additional pressure in the run-rate due to Care Group overspends.
- Secure £6.8m of unidentified income.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	Group £'m
YTD deficit (M5)	(7.7)	(6.4)	(14.1)
Straight line forecast	**(18.4)**	**(15.4)**	**(33.8)**
Seasonality	(4.9)	(1.5)	(6.4)
Industrial Action	1.0	0.3	1.2
CDC	(3.6)	-	(3.6)
Daycase Unit	(0.9)	-	(0.9)
CPE & Opthalmology (Ironstone/Freshney)	-	(1.4)	(1.4)
Expected changes to run-rate	(5.1)	0.5	(4.6)
Non Recurrent Flexibility in YTD position	(9.7)	(1.4)	(11.1)
Depreciation, Interest Received & PDC	-	(1.3)	(1.3)
Adjusted Run Rate	**(41.6)**	**(20.2)**	**(61.8)**
Forecast CIP delivery (improvement in run-rate)	19.4	7.2	26.6
Non recurrent mitigation	3.2	1.6	4.7
Care Group Recovery Plans	6.6		6.6
Income target	3.4	3.4	6.8
Unidentified Gap	9.0	8.0	17.1
Reported Forecast deficit	**-**	**-**	**-**
Plan	**-**	**-**	**-**
Variance	**-**	**-**	**-**

Financial Performance – Forecast Outturn (FOT) - RISKS

At Month 5 the Group reported a net risk to delivery of the forecast break-even position of £39.8m.

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)	(500)	(4,500)	ICS Risk Share: Growth		(1,300)
Additional cost risk - CDC 15% cost reduction	(3,000)	(1,840)	0	(1,840)	ICS Risk Share: CDC		0
Additional Cost risk - emerging			(2,389)	(2,389)	CPE outbreak, Esclation beds, Medical staffing pressures		(750)
Additional Cost risk - Industrial Action		0	0	0	Assumes no further risks		0
Additional cost risk (NP inflation)	(3,500)	(1,000)	0	(1,000)	Inflationary pressures above CUF		(200)
Efficiency risk	(47,072)	(6,398)	(9,030)	(15,428)	Unidentified CIP		(15,428)
Efficiency risk		(13,226)	(5,031)	(18,257)	very high risk - including potential double counts		(10,632)
Further recovery actions to be identified		(6,400)		(6,400)	Additional unmitigated gap to recover due to: YTD cost pressures, Pay Award funding gap and Industrial action		(6,400)
Income risk	(13,950)	(3,400)	(3,400)	(6,800)	Income target - not yet indentified		(5,100)
Income risk - Contract Dispute		0		0	Lincs ICB (now included in core forecast)		0
Mitigations/benefits:							
Additional cost control or income	7,050	0	0	0	Opportunity to review costs not yet fully implemented / income generation (Growth)		0
Transformational / Pathway changes	8,000	0	0	0	Utilisation of additional capacity to facilitate repatriation of Independent Sector activity (subject to agreement of funding mechanism)		0
Total Provider Net Risk	**(47,072)**	**(36,264)**	**(20,350)**	**(56,614)**			**(39,810)**

Financial Performance – CIP Delivery

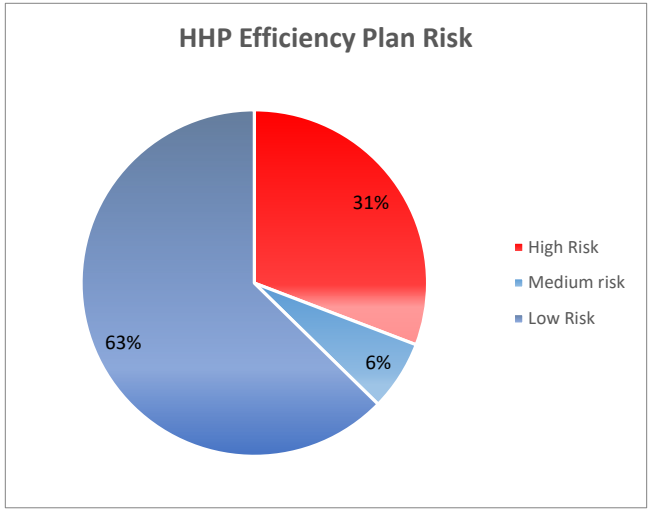
The Group has delivered £37.2m CIP year-to-date against a target of £43.4m, (£6.5m) adverse. The Group is forecasting CIP delivery of £114.6m, (£15.4m) adverse to plan. However, the forecast is inherently high risk an heavily reliant on NR schemes.

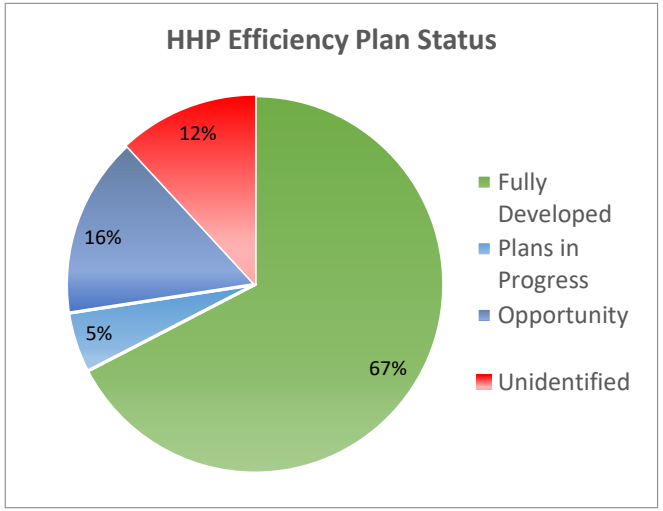
		HUTH						NLAG						Humber Health Partnership					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute And Emergency Medicine	693	343	(350)	1,376	1,122	(254)	1,918	1,797	(121)	4,068	4,285	217	2,612	2,141	(471)	5,444	5,406	(37)
	Cancer Network	69	38	(31)	166	99	(66)	52	51	(1)	125	122	(3)	121	89	(32)	291	221	(69)
	Cardiovascular	624	1,268	644	1,453	2,863	1,410	175	415	239	433	650	217	799	1,683	884	1,886	3,513	1,627
	Chief Delivery Officer	16	8	(8)	38	20	(18)	15	117	102	37	149	113	31	126	95	75	169	95
	Community, Frailty & Therapy	423	225	(198)	1,016	1,114	98	1,028	858	(169)	2,253	2,184	(69)	1,451	1,084	(367)	3,269	3,298	29
	Digestive Diseases	338	52	(286)	812	415	(396)	1,088	1,229	141	1,785	2,531	746	1,426	1,281	(145)	2,597	2,946	350
	Family Services	1,018	1,101	83	2,191	2,026	(165)	1,173	1,348	175	2,495	2,145	(351)	2,191	2,449	258	4,687	4,170	(516)
	Head & Neck	784	672	(112)	1,709	1,311	(398)	315	464	149	730	1,181	451	1,099	1,135	36	2,439	2,492	53
	Major Trauma Network	49	110	61	117	265	148	29	7	(21)	69	18	(51)	77	117	40	185	283	97
	Neuroscience	245	551	306	589	1,165	577	142	135	(7)	310	212	(98)	387	685	298	899	1,378	479
	Pathology Network Group	231	258	27	521	529	8	899	803	(96)	2,120	2,098	(23)	1,130	1,061	(69)	2,641	2,627	(14)
	Patient Services	398	21	(377)	955	194	(761)	346	102	(244)	830	445	(385)	744	123	(621)	1,785	639	(1,146)
	Site Management & Discharge Teams	44	12	(32)	101	41	(60)	110	103	(7)	229	170	(59)	154	115	(39)	330	211	(119)
	Specialist Cancer And Support Services	2,749	2,959	210	6,598	6,567	(31)	969	1,035	66	2,325	2,675	350	3,718	3,994	277	8,923	9,241	318
	Specialist Medicine	657	603	(55)	1,395	1,199	(195)	438	390	(48)	836	755	(81)	1,095	993	(103)	2,231	1,955	(276)
	Specialist Surgery	553	470	(83)	1,262	955	(307)	249	531	282	608	734	126	802	1,001	199	1,870	1,689	(181)
	Theatres, Anaesthetics And Critical Care	1,265	1,173	(92)	2,842	3,332	490	662	467	(195)	1,728	1,546	(182)	1,927	1,640	(287)	4,570	4,878	308
Total Operations		**10,157**	**9,864**	**(293)**	**23,138**	**23,216**	**78**	**9,607**	**9,852**	**245**	**20,981**	**21,899**	**918**	**19,764**	**19,716**	**(48)**	**44,119**	**45,115**	**996**
Corporate	Chief Executive	22	21	(1)	52	40	(12)	19	15	(5)	46	38	(8)	41	35	(6)	98	78	(20)
	Chief Medical Officer	390	244	(145)	935	641	(295)	325	485	160	781	1,015	234	715	729	14	1,716	1,655	(61)
	Chief Nurse	184	223	39	442	496	54	162	314	153	388	614	227	346	537	192	829	1,110	281
	Director Of Assurance	5	0	(5)	11	0	(11)	19	5	(15)	46	11	(35)	24	5	(19)	57	11	(46)
	Director Of People	276	335	59	662	707	44	244	430	186	586	932	346	520	765	245	1,249	1,639	390
	Finance - E&F	1,087	772	(315)	2,873	2,851	(22)	618	508	(111)	1,219	1,588	369	1,705	1,279	(426)	4,092	4,439	347
	Finance - Finance	167	227	60	401	455	54	117	146	29	280	269	(12)	284	374	90	681	724	42
	Strategy And Partnerships	155	258	104	371	515	143	99	291	192	237	598	361	254	549	296	609	1,113	504
Total Corporate		**2,285**	**2,080**	**(204)**	**5,748**	**5,704**	**(44)**	**1,603**	**2,193**	**590**	**3,583**	**5,065**	**1,482**	**3,888**	**4,273**	**385**	**9,331**	**10,768**	**1,437**
Total Allocated CIPCore Programme		**12,442**	**11,944**	**(498)**	**28,886**	**28,920**	**34**	**11,210**	**12,045**	**835**	**24,564**	**26,963**	**2,400**	**23,652**	**23,989**	**337**	**53,450**	**55,883**	**2,433**
Trustwide	Reserves	4,543	5,300	757	12,053	12,946	894	4,436	7,244	2,808	10,647	16,398	5,751	8,980	12,545	3,565	22,700	29,344	6,645
	Technical	263	304	41	630	671	41	194	194	0	466	466	0	456	498	41	1,096	1,137	41
	Unallocated	6,067	183	(5,884)	26,751	19,385	(7,367)	4,604	29	(4,575)	26,003	8,815	(17,188)	10,672	213	(10,459)	52,755	28,200	(24,555)
Total Technical & Unallocated		**10,873**	**5,787**	**(5,086)**	**39,434**	**33,002**	**(6,432)**	**9,235**	**7,468**	**(1,767)**	**37,116**	**25,679**	**(11,437)**	**20,108**	**13,255**	**(6,853)**	**76,550**	**58,681**	**(17,869)**
TOTAL		**23,315**	**17,731**	**(5,584)**	**68,320**	**61,922**	**(6,398)**	**20,445**	**19,513**	**(932)**	**61,680**	**52,642**	**(9,038)**	**43,760**	**37,244**	**(6,516)**	**130,000**	**114,564**	**(15,436)**

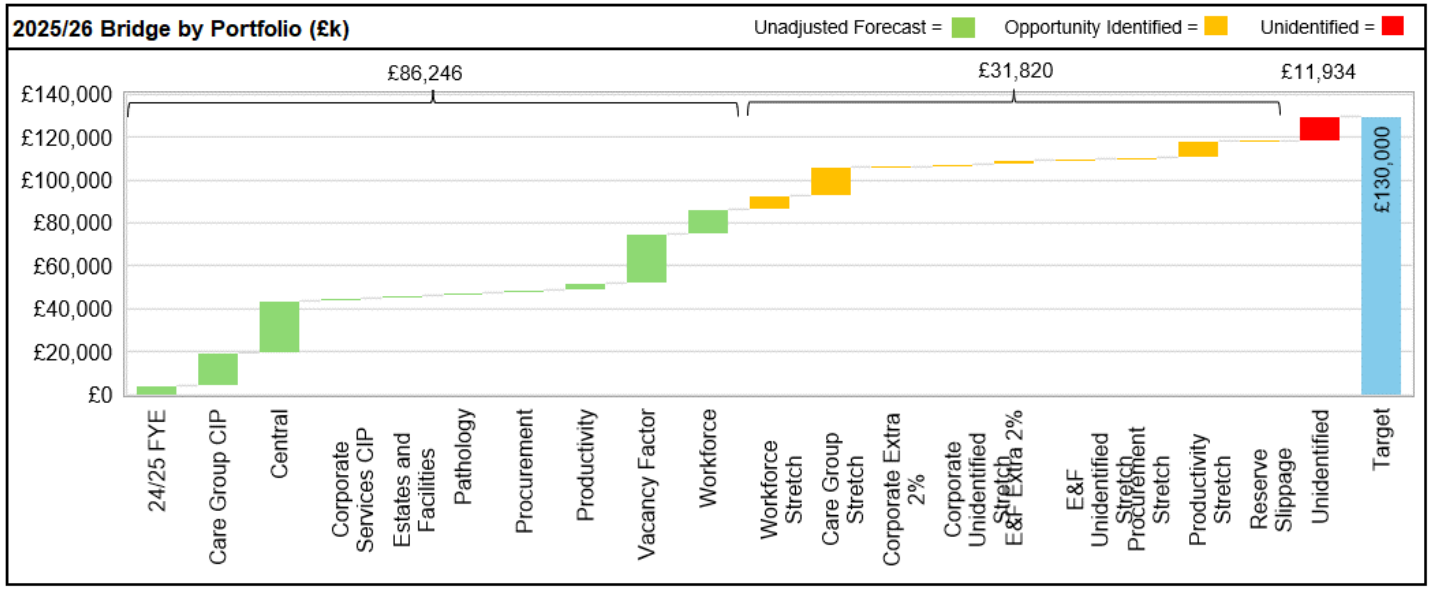
Financial Performance – CIP Planning Progress

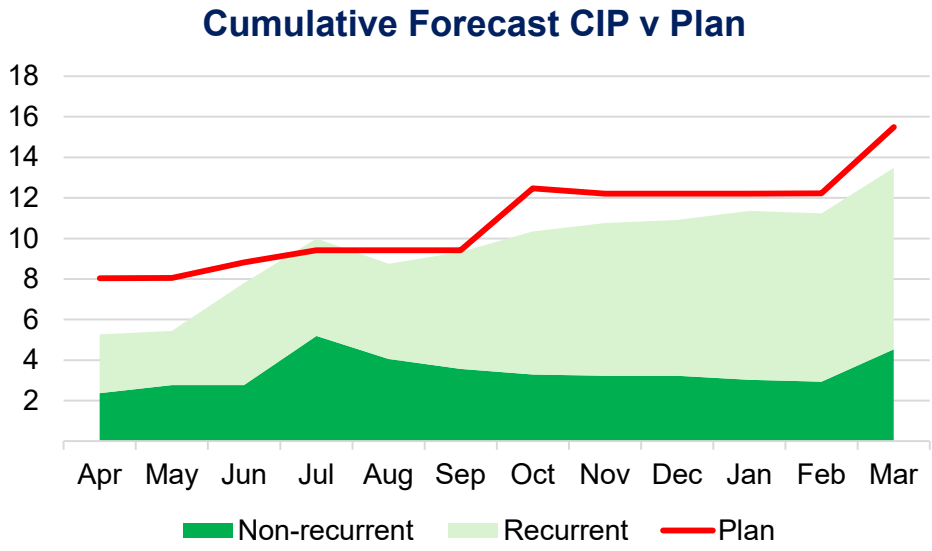
Efficiency Plan Status	HUTH	NLAG	HHP
Fully Developed	42,313	45,310	87,622
Plans in Progress	4,259	2,462	6,721
Opportunity	15,350	4,879	20,229
Unidentified	6,398	9,030	15,428
TOTAL	**68,320**	**61,680**	**130,000**

Efficiency Plan Risk	HUTH	NLAG	HHP
High Risk	26,055	13,983	40,038
Medium risk	5,235	3,256	8,491
Low Risk	37,031	44,441	81,471
TOTAL	**68,320**	**61,680**	**130,000**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£74.m)

- The Groups estimated underlying deficit is estimated to be (£74.0m).
- 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 (£29.6m) 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 (£15.4m).
5. The in year CIP schemes have a potential FYE of £32.2m if delivered in full in year.

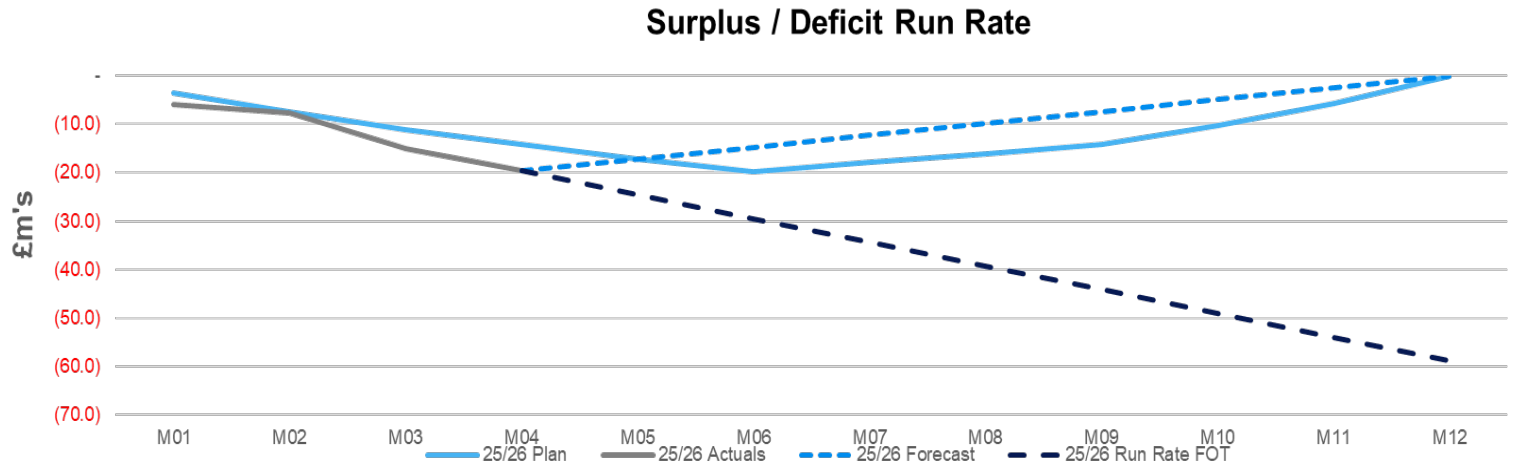
CIP delivery will be the key driver for the Trust's underlying financial position both in year and the potential full year effects of in year schemes. These are currently high risk and therefore the full year effects have been risk adjusted resulting in a risk adjusted underlying deficit of (£94.6m).

£million	NLAG	HUTH	Group
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)	(15.5)	(14.1)	(29.6)
Undidentified CIP (Forecast)	(9.0)	(6.4)	(15.4)
FYE 25/26 CIP	9.8	22.4	32.2
NR Flexibility	0.0	(5.1)	(5.1)
Underlying Deficit	**(31.0)**	**(42.9)**	**(74.0)**

System Financial Performance – August 2025

The ICS reported a YTD deficit of (£20.3m), (£3.2m) adverse to plan. The ICS is forecasting a break-even position as planned.

	YTD			Forecast		
Care Group	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Harrogate And District NHS Foundation Trust	(4.5)	(7.3)	(2.9)	0.0	0.0	0.0
Hull University Teaching Hospitals NHS Trust	(4.9)	(7.7)	(2.8)	0.0	0.0	0.0
Humber Teaching NHS Foundation Trust	(0.8)	2.2	3.0	0.0	0.0	0.0
Northern Lincolnshire And Goole NHS Foundation Trust	(6.2)	(6.4)	(0.2)	0.0	0.0	0.0
York And Scarborough Teaching Hospitals NHS Foundation Trust	(0.9)	(1.2)	(0.2)	0.0	0.0	0.0
Humber & North Yorkshire ICB	0.0	0.0	0.0	0.0	0.0	0.0
Total	**(17.2)**	**(20.3)**	**(3.2)**	**0.0**	**0.0**	**0.0**



Capital Expenditure

The Group has spent £5.3m on capital expenditure against a plan of £26.0m plan, (£20.8m) behind plan.

£million	NLAG Year to Date			HUTH Year to Date			GROUP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	0.3	0.0	(0.2)	0.0	0.0	0.0	0.3	0.0	(0.2)
Day Surgery CHH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Theatres & IRT	0.0	0.0	0.0	1.2	0.2	(1.0)	1.2	0.2	(1.0)
Community Diagnostic Centres	0.0	0.0	0.0	1.7	1.4	(0.3)	1.7	1.4	(0.3)
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	0.0	0.0	0.0	0.0	0.0
Total Estates Major Schemes	**0.3**	**0.0**	**(0.2)**	**2.9**	**1.6**	**(1.3)**	**3.2**	**1.6**	**(1.5)**
Other Estates Schemes	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	(0.0)
IM&T Programme	0.3	0.1	(0.2)	0.3	0.3	0.0	0.6	0.4	(0.1)
EPR	0.4	0.0	(0.4)	0.0	0.1	0.1	0.4	0.1	(0.3)
Equipment Renewal	0.4	0.1	(0.3)	0.5	0.0	(0.5)	0.9	0.1	(0.8)
Facilities Maintenance	1.0	0.1	(0.9)	0.3	0.4	0.1	1.3	0.5	(0.8)
Other Capital Expenditure	5.7	1.9	(3.7)	14.0	0.6	(13.4)	19.7	2.6	(17.1)
Total Capital Programme	**8.0**	**2.2**	**(5.8)**	**18.0**	**3.0**	**(15.0)**	**26.0**	**5.2**	**(20.8)**
Funded By:									
Internally Generated	2.3	0.3	(2.0)	4.2	1.4	(2.7)	6.5	1.8	(4.8)
PDC Funded	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated	5.2	1.9	(3.2)	1.5	1.5	(0.0)	6.6	3.4	(3.2)
IFRS16	0.5	0.0	(0.5)	12.4	0.1	(12.3)	12.9	0.1	(12.8)
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**8.0**	**2.2**	**(5.8)**	**18.0**	**3.0**	**(15.0)**	**26.0**	**5.3**	**(20.8)**

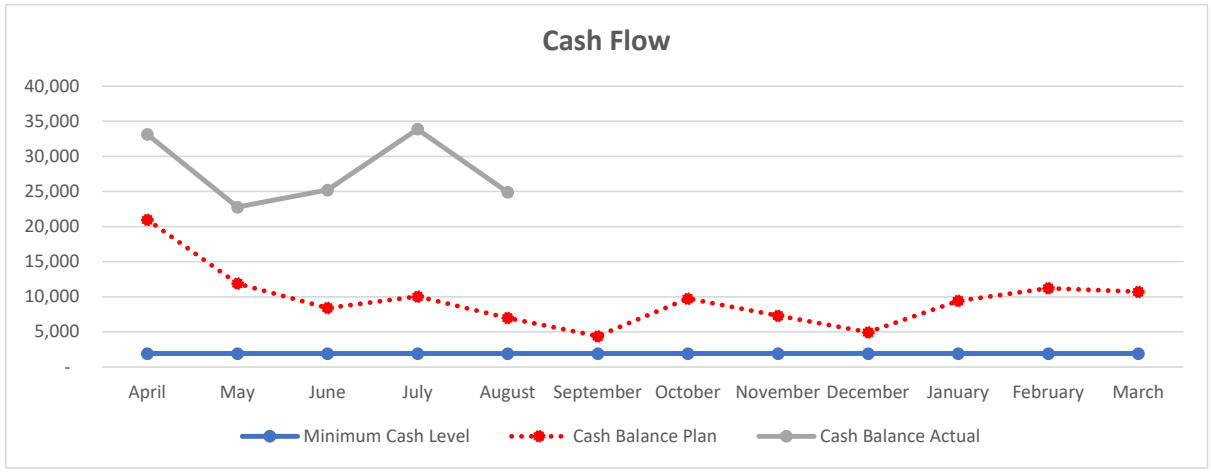
Balance Sheet

£ million	NLAG			HUTH			GROUP		
	Actual 31-Jul-25	Actual 31-Aug-25	In month movement	Actual 31-Jul-25	Actual 31-Aug-25	In month movement	Actual 31-Jul-25	Actual 31-Aug-25	In month movement
Fixed Assets	295.3	295.5	0.2	477.6	488.9	11.3	772.9	784.4	11.5
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	4.3	4.4	0.1	20.9	21.1	0.2	25.2	25.5	0.4
Trade and Other Debtors	23.9	23.6	(0.3)	37.4	34.3	(3.1)	61.3	57.9	(3.4)
Cash	33.9	24.9	(9.0)	31.8	30.3	(1.5)	65.7	55.2	(10.5)
Total Current Assets	**62.1**	**52.9**	**(9.2)**	**90.1**	**85.7**	**(4.4)**	**152.2**	**138.6**	**(13.6)**
Current Liabilities									
Trade and Other Creditors	(51.9)	(42.5)	9.4	(72.9)	(60.6)	12.3	(124.8)	(103.1)	21.7
Accruals	(23.0)	(24.7)	(1.6)	(45.1)	(50.3)	(5.2)	(68.1)	(75.0)	(6.9)
Other Current Liabilities	(11.9)	(10.2)	1.7	(18.3)	(20.8)	(2.5)	(30.2)	(31.0)	(0.8)
Total Current Liabilities	**(86.8)**	**(77.4)**	**9.4**	**(136.3)**	**(131.7)**	**4.6**	**(223.1)**	**(209.1)**	**14.0**
Net Current Liabilities	**(24.7)**	**(24.5)**	**0.3**	**(46.2)**	**(46.0)**	**0.2**	**(70.9)**	**(70.5)**	**0.4**
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	(4.4)	(4.4)	0.0	(8.6)	(8.6)	0.0
Finance Lease Obligations > 1 Year	(7.8)	(7.7)	0.0	(72.8)	(73.2)	(0.4)	(80.5)	(80.9)	(0.4)
Provisions - Non Current	(3.6)	(3.6)	0.0	(2.3)	(2.3)	0.0	(5.9)	(5.9)	0.0
Total Assets/(Liabilities)	**255.7**	**256.2**	**0.5**	**354.8**	**365.8**	**11.1**	**610.5**	**622.1**	**11.5**
TOTAL CAPITAL & RESERVES	**255.7**	**256.2**	**0.5**	**354.8**	**365.8**	**11.1**	**610.5**	**622.1**	**11.5**

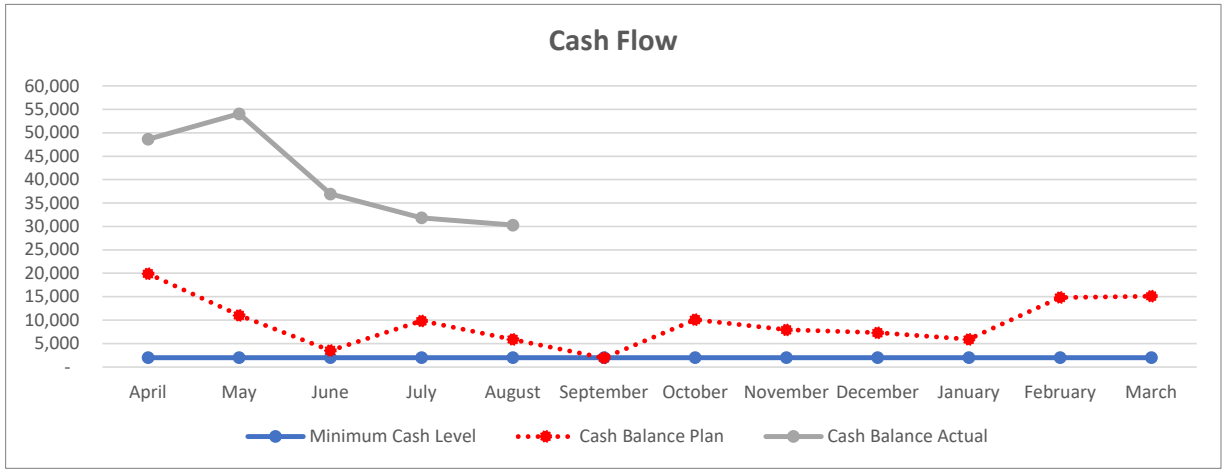
Cash Flow

The Group's cash balance at month 5 was £55.2m. 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 over-performing against ERF baselines by £1.3m. Due to the block income arrangements so additional income or penalties have been assumed year-to-date.

	YTD											
£000's	NLAG				HUTH				Group Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	29,729	31,598	1,869	106%	64,656	65,174	518	101%	94,385	96,772	2,387	103%
External Contracts	4,120	4,425	305	107%	1,180	1,123	(57)	95%	5,300	5,548	248	105%
Specialist	746	803	57	108%	18,809	17,370	(1,439)	92%	19,555	18,173	(1,382)	93%
Sub Total ERF	**34,595**	**36,826**	**2,231**	**106.4%**	**84,645**	**83,668**	**(977)**	**98.8%**	**119,240**	**120,493**	**1,253**	**101.1%**
A&G	375	375	0	N/A	1,550	1,550	0	N/A	1,925	1,925	0	N/A
Total	**34,970**	**37,201**	**2,231**	**106.4%**	**86,195**	**85,218**	**(977)**	**98.8%**	**121,165**	**122,418**	**1,253**	**101.1%**

	Forecast											
£000's	NLAG				HUTH				Group Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	72,322	76,511	4,189	106%	157,287	158,549	1,262	101%	229,609	235,060	5,451	102%
External Contracts	9,888	10,765	877	109%	2,832	2,731	(101)	96%	12,720	13,496	776	106%
Specialist	1,790	1,950	160	109%	45,142	42,257	(2,885)	94%	46,932	44,207	(2,725)	94%
Sub Total ERF	**84,000**	**89,226**	**5,226**	**106.2%**	**205,261**	**203,538**	**(1,723)**	**99.2%**	**289,261**	**292,763**	**3,502**	**101.2%**
A&G	912	912	0	N/A	3,771	3,771	0	N/A	4,683	4,683	0	N/A
Total	**84,912**	**90,138**	**5,226**	**106.2%**	**209,032**	**207,309**	**(1,723)**	**99.2%**	**293,944**	**297,446**	**3,502**	**101.2%**

Temporary Staffing Summary

The Group has spent £29.0m on agency and bank YTD. This is (£1.0m) more than the same period in 2024/25 and remains below the NHSE Target of 3.2% of total pay expenditure at 2.9%.

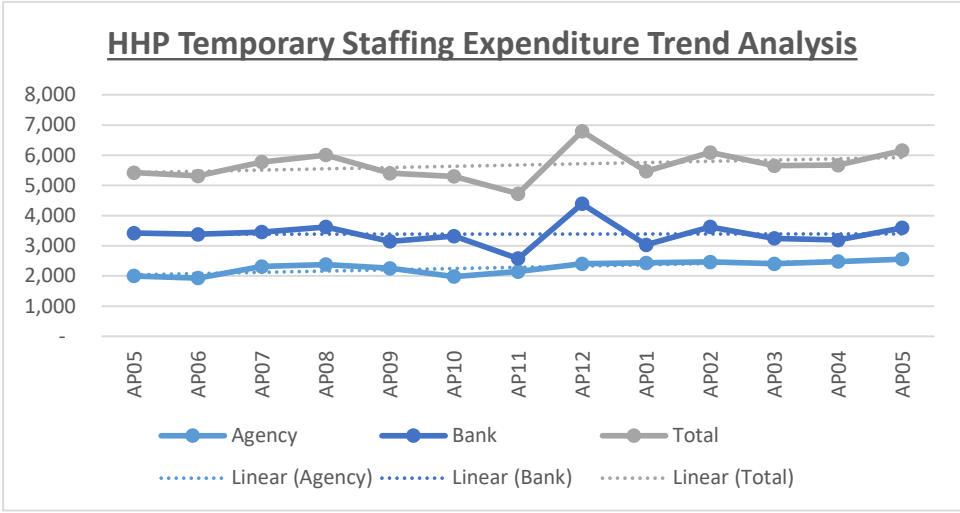
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Type	Subjective Sub category	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Agency	Medical Staff	3,950	3,817	133	4,830	5,559	(729)	8,780	9,376	(596)
	Nursing Staff	64	618	(554)	1,453	1,488	(35)	1,517	2,106	(589)
	Scientific, Therapeutic & Technical Staff	375	114	261	768	696	73	1,143	809	334
	Admin & Clerical Staff	202	(12)	214	166	34	131	368	23	345
	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)	1	2	(1)	1	24	(22)
Agency Total		**4,591**	**4,560**	**32**	**7,219**	**7,779**	**(560)**	**11,810**	**12,338**	**(529)**
Bank	Medical Staff	1,578	2,037	(459)	4,901	4,056	845	6,479	6,092	386
	Nursing Staff	2,125	1,874	251	5,119	5,406	(288)	7,244	7,280	(37)
	Scientific, Therapeutic & Technical Staff	190	308	(118)	485	607	(122)	675	914	(239)
	Admin & Clerical Staff	1	447	(445)	843	758	85	844	1,205	(360)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	23	74	(51)	945	1,137	(193)	968	1,212	(244)
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**3,917**	**4,739**	**(822)**	**12,292**	**11,964**	**328**	**16,209**	**16,703**	**(494)**
Grand Total		**8,508**	**9,299**	**(790)**	**19,511**	**19,743**	**(232)**	**28,019**	**29,042**	**(1,023)**

Agency Spend as % Total Pay (3.2% is the NHSE Target)	1.9%	4.4%	2.9%

Temporary Staffing Summary – Directorate / Care Group

The Group has spent £29.0m on all agency and bank pay YTD. This is (£1.0m) 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	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Cancer Network	0	22	(22)	19	23	(4)	19	45	(26)
	Cardiovascular	178	307	(128)	210	184	26	388	491	(103)
	Digestive Diseases	410	336	74	983	933	50	1,393	1,269	124
	Head & Neck	522	608	(87)	1,063	897	166	1,585	1,506	79
	Major Trauma Network	36	72	(35)	78	92	(14)	114	164	(50)
	Patient Services	4	365	(361)	493	442	51	497	807	(310)
	Specialist Cancer and Support Services	1,254	1,023	231	1,075	1,248	(173)	2,330	2,272	58
	Theatres, Anaesthetics and Critical Care	1,139	1,070	69	1,503	1,449	54	2,642	2,519	123
	Sub Total Operations North	**3,545**	**3,803**	**(259)**	**5,424**	**5,269**	**155**	**8,968**	**9,072**	**(104)**
	Chief Delivery Officer	0	0	0	9	0	9	9	0	9
	Acute and Emergency Medicine	1,849	2,065	(216)	5,533	5,915	(383)	7,382	7,981	(599)
	Community, Frailty & Therapy	675	1,318	(643)	1,573	1,526	48	2,249	2,844	(595)
	Family Services	880	590	290	2,245	1,911	334	3,124	2,500	624
	Neuroscience	524	253	271	489	525	(36)	1,014	779	235
	Pathology Network Group	4	6	(2)	429	373	56	433	379	54
	Site Management & Discharge teams	22	202	(181)	125	120	5	147	322	(175)
	Specialist Medicine	427	304	123	1,134	1,540	(406)	1,561	1,844	(283)
	Specialist Surgery	471	501	(30)	1,137	1,016	121	1,608	1,517	91
	Sub Total Operations South	**4,852**	**5,240**	**(388)**	**12,674**	**12,926**	**(253)**	**17,526**	**18,166**	**(641)**
Total Operations		**8,397**	**9,043**	**(647)**	**18,098**	**18,195**	**(98)**	**26,494**	**27,239**	**(745)**
Corporate	Chief Executive	12	0	12	7	0	7	19	0	19
	Chief Medical Officer	1	0	1	110	16	94	111	16	95
	Chief Nurse Office	1	26	(25)	48	57	(9)	49	83	(34)
	Director of Assurance	0	0	0	0	0	0	0	0	0
	Director of People	10	65	(55)	35	14	20	45	80	(35)
	Director of Finance, Estates & Facilities	210	83	127	967	1,145	(178)	1,177	1,228	(51)
	Strategy and Partnerships	0	3	(3)	42	52	(11)	42	55	(13)
Total Corporate		**235**	**177**	**58**	**1,208**	**1,284**	**(76)**	**1,443**	**1,461**	**(19)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(91)	79	(170)	61	263	(203)	(31)	342	(373)
	Reserves	(32)	(0)	(32)	145	(0)	145	113	(0)	113
Total Central Income, Reserves & Technical		**(123)**	**79**	**(202)**	**205**	**263**	**(58)**	**82**	**342**	**(259)**
Surplus / (Deficit)		**8,508**	**9,299**	**(790)**	**19,511**	**19,743**	**(232)**	**28,019**	**29,042**	**(1,023)**

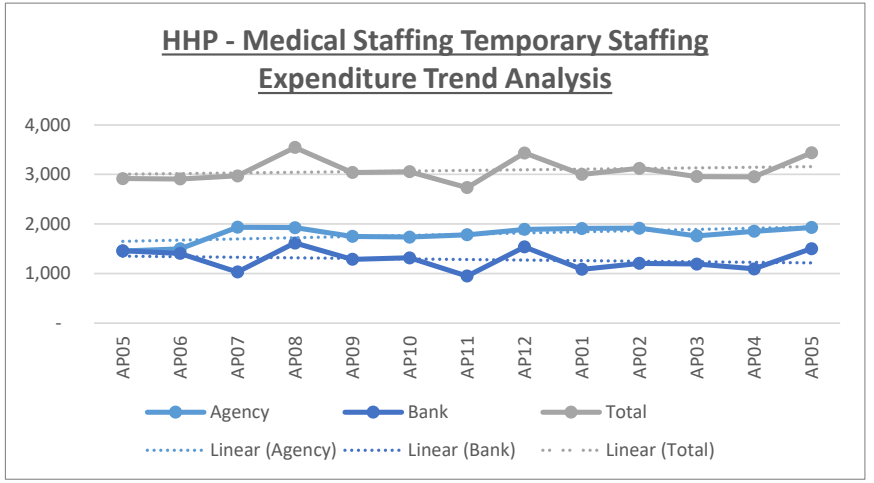


Type	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05
Agency	2,000	1,934	2,317	2,378	2,255	1,980	2,147	2,403	2,433	2,465	2,405	2,478	2,558
Bank	3,423	3,383	3,459	3,628	3,150	3,322	2,579	4,391	3,035	3,627	3,249	3,195	3,598
Total	**5,423**	**5,317**	**5,776**	**6,006**	**5,405**	**5,302**	**4,726**	**6,794**	**5,468**	**6,092**	**5,654**	**5,673**	**6,156**

Temporary Staffing Summary – Medical Staffing

The Group has spent £15.5m on Medical Staffing agency and bank pay YTD. This is (£0.2m) 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	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	37	209	(173)	21	19	2	57	228	(171)
	Digestive Diseases	166	120	46	455	394	61	621	514	108
	Head & Neck	486	560	(74)	929	706	223	1,415	1,267	148
	Major Trauma Network	0	20	(20)	0	0	0	0	20	(20)
	Patient Services	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	507	547	(40)	355	393	(38)	862	940	(78)
	Theatres, Anaesthetics and Critical Care	1,103	1,025	78	952	1,123	(171)	2,055	2,148	(93)
	Sub Total Operations North	**2,299**	**2,481**	**(182)**	**2,712**	**2,635**	**77**	**5,011**	**5,116**	**(105)**
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine	1,451	1,561	(109)	3,528	3,717	(188)	4,980	5,277	(298)
	Community, Frailty & Therapy	283	652	(369)	591	616	(25)	874	1,268	(394)
	Family Services	680	382	299	898	500	398	1,578	881	697
	Neuroscience	388	176	212	253	266	(13)	641	442	199
	Pathology Network Group	0	0	0	220	144	77	220	144	77
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Medicine	193	147	46	598	976	(377)	791	1,122	(331)
	Specialist Surgery	264	388	(124)	945	773	173	1,209	1,161	49
	Sub Total Operations South	**3,259**	**3,305**	**(45)**	**7,035**	**6,991**	**44**	**10,294**	**10,296**	**(2)**
Total Operations		**5,558**	**5,786**	**(228)**	**9,746**	**9,625**	**121**	**15,304**	**15,411**	**(107)**
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	1	0	1	0	0	0	1	0	1
	Chief Nurse Office	0	6	(6)	0	0	0	0	6	(6)
	Director of Assurance	0	0	0	0	0	0	0	0	0
	Director of People	0	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		**1**	**6**	**(4)**	**0**	**0**	**0**	**1**	**6**	**(4)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical Reserves	0	62	(62)	(15)	(10)	(5)	(15)	52	(67)
		(32)	(0)	(32)	0	0	0	(32)	(0)	(32)
Total Central Income, Reserves & Technical		**(32)**	**62**	**(94)**	**(15)**	**(10)**	**(5)**	**(47)**	**52**	**(99)**
Surplus / (Deficit)		**5,528**	**5,854**	**(326)**	**9,731**	**9,615**	**116**	**15,258**	**15,469**	**(210)**

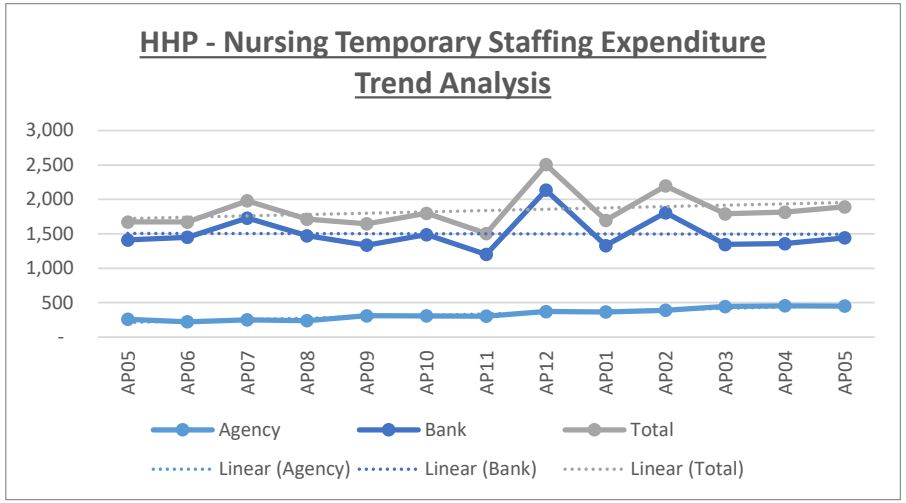


Type	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05
Agency	1,457	1,502	1,936	1,927	1,750	1,737	1,783	1,892	1,911	1,917	1,763	1,854	1,930
Bank	1,461	1,408	1,034	1,618	1,289	1,319	952	1,540	1,089	1,208	1,194	1,097	1,505
Total	2,918	2,909	2,971	3,545	3,040	3,056	2,735	3,432	3,000	3,125	2,957	2,951	3,435

Temporary Staffing Summary - Nursing

The Group has spent £9.4m on Nursing agency and bank pay YTD. This is (£0.6m) 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	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Cancer Network	0	0	0	8	0	8	8	0	8
	Cardiovascular	75	87	(13)	120	141	(21)	195	228	(34)
	Digestive Diseases	244	216	28	526	540	(14)	770	755	15
	Head & Neck	36	18	17	32	6	26	67	24	43
	Major Trauma Network	36	52	(16)	75	92	(17)	111	144	(33)
	Patient Services	4	4	(1)	83	65	18	87	69	17
	Specialist Cancer and Support Services	345	222	123	85	79	6	429	300	129
	Theatres, Anaesthetics and Critical Care	36	46	(9)	480	298	182	517	344	173
	Sub Total Operations North	**775**	**645**	**130**	**1,409**	**1,221**	**188**	**2,184**	**1,866**	**319**
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine	397	505	(108)	1,948	2,120	(173)	2,345	2,625	(280)
	Community, Frailty & Therapy	306	562	(257)	722	733	(12)	1,027	1,296	(268)
	Family Services	199	206	(7)	1,316	1,380	(65)	1,515	1,586	(72)
	Neuroscience	136	77	59	224	227	(3)	360	304	56
	Pathology Network Group	1	0	1	0	0	0	1	0	1
	Site Management & Discharge teams	22	197	(176)	123	117	7	145	314	(169)
	Specialist Medicine	234	158	76	527	550	(23)	761	708	53
	Specialist Surgery	208	113	95	183	240	(58)	390	353	37
	Sub Total Operations South	**1,502**	**1,818**	**(316)**	**5,042**	**5,368**	**(326)**	**6,544**	**7,186**	**(642)**
Total Operations		**2,278**	**2,463**	**(185)**	**6,451**	**6,589**	**(138)**	**8,728**	**9,052**	**(323)**
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	1	(1)	12	23	(11)	12	24	(12)
	Director of Assurance	0	0	0	0	0	0	0	0	0
	Director of People	3	12	(9)	8	6	2	11	18	(7)
	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		**3**	**13**	**(10)**	**20**	**28**	**(8)**	**23**	**42**	**(18)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(91)	16	(108)	0	277	(277)	(91)	293	(385)
	Reserves	0	0	0	100	0	100	100	0	100
Total Central Income, Reserves & Technical		**(91)**	**16**	**(108)**	**100**	**277**	**(176)**	**9**	**293**	**(284)**
Surplus / (Deficit)		**2,189**	**2,493**	**(304)**	**6,572**	**6,894**	**(322)**	**8,761**	**9,387**	**(626)**



Type	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05
Agency	260	222	251	239	310	309	304	372	366	391	444	456	450
Bank	1,411	1,450	1,729	1,473	1,335	1,489	1,201	2,134	1,330	1,806	1,345	1,358	1,442
Total	**1,671**	**1,672**	**1,980**	**1,712**	**1,645**	**1,797**	**1,505**	**2,505**	**1,696**	**2,196**	**1,789**	**1,814**	**1,892**

Appendices

Appendix A – Trust I&E & Divisional Budgetary Performance

Income & Expenditure

£million	HUTH £m						NLAG £m						Group £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	74.7	76.1	1.4	376.7	379.0	2.3	46.6	46.8	0.2	232.8	232.8	0.0	121.3	122.9	1.6	609.4	611.8	2.3
Other Income	6.9	18.3	11.3	44.9	45.0	0.0	6.7	6.0	(0.6)	31.1	26.5	(4.6)	13.6	24.3	10.7	76.1	71.5	(4.6)
Total Operating Income	**81.7**	**94.4**	**12.7**	**421.6**	**423.9**	**2.3**	**53.2**	**52.8**	**(0.4)**	**263.9**	**259.3**	**(4.5)**	**134.9**	**147.2**	**12.3**	**685.5**	**683.3**	**(2.2)**
Pay Costs																		
Medical Staff	(17.4)	(18.3)	(1.0)	(87.9)	(89.9)	(2.0)	(10.0)	(10.8)	(0.8)	(50.9)	(52.0)	(1.1)	(27.4)	(29.2)	(1.8)	(138.8)	(141.9)	(3.1)
Nursing Staff	(14.8)	(15.1)	(0.3)	(73.6)	(77.1)	(3.5)	(12.8)	(12.7)	0.1	(64.2)	(64.1)	0.1	(27.6)	(27.8)	(0.3)	(137.9)	(141.2)	(3.4)
Scientific Therapeutic & Technical Staff	(7.0)	(7.1)	(0.1)	(34.4)	(35.5)	(1.0)	(5.0)	(5.2)	(0.2)	(25.0)	(26.0)	(0.9)	(12.0)	(12.3)	(0.3)	(59.5)	(61.5)	(2.0)
Total Clincial Pay	**(39.2)**	**(40.5)**	**(1.4)**	**(196.0)**	**(202.5)**	**(6.6)**	**(27.8)**	**(28.8)**	**(1.0)**	**(140.2)**	**(142.1)**	**(1.9)**	**(67.0)**	**(69.3)**	**(2.3)**	**(336.2)**	**(344.6)**	**(8.5)**
Admin & Clerical Staff	(6.2)	(6.3)	(0.1)	(30.7)	(31.4)	(0.8)	(5.4)	(5.2)	0.2	(26.6)	(26.0)	0.6	(11.6)	(11.5)	0.1	(57.2)	(57.4)	(0.2)
Maintenance Staff	(0.3)	(0.3)	0.0	(1.6)	(1.5)	0.1	(0.2)	(0.2)	0.0	(0.9)	(0.8)	0.1	(0.5)	(0.5)	0.0	(2.5)	(2.4)	0.2
Support Staff	(1.7)	(1.6)	0.1	(8.2)	(8.1)	0.1	(1.6)	(1.6)	0.0	(8.2)	(8.1)	0.1	(3.3)	(3.2)	0.1	(16.4)	(16.1)	0.2
Other Staff	(0.0)	0.0	0.0	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Apprentice Levy	0.0	0.0	0.0	0.0	(0.0)	(0.0)	(0.1)	(0.2)	(0.0)	(0.7)	(0.7)	0.0	(0.1)	(0.2)	(0.0)	(0.7)	(0.7)	0.0
Total Other Pay	**(8.4)**	**(8.4)**	**(0.0)**	**(41.4)**	**(42.0)**	**(0.6)**	**(7.3)**	**(7.1)**	**0.2**	**(36.4)**	**(35.6)**	**0.8**	**(15.7)**	**(15.5)**	**0.2**	**(77.8)**	**(77.7)**	**0.2**
Total Pay Costs	**(47.5)**	**(49.0)**	**(1.4)**	**(237.4)**	**(244.6)**	**(7.2)**	**(35.1)**	**(35.9)**	**(0.7)**	**(176.6)**	**(177.7)**	**(1.1)**	**(82.7)**	**(84.8)**	**(2.2)**	**(414.0)**	**(422.3)**	**(8.3)**
Drugs	(10.9)	(12.6)	(1.7)	(54.7)	(58.4)	(3.7)	(3.4)	(3.2)	0.2	(17.5)	(16.6)	0.9	(14.4)	(15.8)	(1.5)	(72.2)	(75.0)	(2.8)
Clinical Supplies & Services	(7.4)	(6.6)	0.7	(36.5)	(38.6)	(2.1)	(3.9)	(3.8)	0.1	(19.8)	(21.4)	(1.7)	(11.3)	(10.4)	0.9	(56.3)	(60.1)	(3.8)
Total Clinical Non Pay	**(18.3)**	**(19.2)**	**(0.9)**	**(91.2)**	**(97.0)**	**(5.8)**	**(7.3)**	**(7.0)**	**0.3**	**(37.3)**	**(38.1)**	**(0.8)**	**(25.6)**	**(26.3)**	**(0.6)**	**(128.5)**	**(135.1)**	**(6.6)**
General Supplies & Services	(1.9)	(1.6)	0.3	(9.5)	(9.7)	(0.2)	(0.5)	(0.7)	(0.2)	(2.6)	(3.6)	(1.1)	(2.5)	(2.3)	0.1	(12.1)	(13.3)	(1.2)
Establishment Expenses	(0.5)	(0.6)	(0.0)	(2.6)	(2.9)	(0.3)	(0.8)	(0.6)	0.2	(3.4)	(3.0)	0.3	(1.3)	(1.1)	0.2	(6.0)	(6.0)	0.0
Other Establishment Costs	(2.4)	(2.4)	0.0	(12.1)	(12.0)	0.0	(1.5)	(1.5)	0.0	(7.5)	(7.4)	0.0	(3.9)	(3.9)	0.0	(19.6)	(19.5)	0.1
Premises and Fixed Plant	(2.8)	(3.5)	(0.6)	(16.7)	(12.5)	4.2	(2.1)	(2.1)	(0.0)	(10.8)	(10.0)	0.8	(4.9)	(5.6)	(0.7)	(27.5)	(22.5)	5.0
Purchase of Healthcare Services	(3.6)	(2.8)	0.8	(19.5)	(17.2)	2.2	(1.7)	(1.6)	0.0	(8.6)	(8.1)	0.6	(5.3)	(4.4)	0.9	(28.1)	(25.3)	2.8
Miscellaneous Expenditure	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	0.1	(0.5)	(0.7)	(0.2)	(0.2)	(0.2)	0.1	(0.6)	(0.8)	(0.2)
Education Expenditure	(0.6)	(0.4)	0.2	(3.3)	(2.9)	0.4	(0.6)	(0.3)	0.3	(1.4)	(1.3)	0.2	(1.2)	(0.6)	0.5	(4.7)	(4.2)	0.5
Consultancy Expenditure	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.2)	(0.3)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.3)	(0.1)
Total Other Non Pay	**(12.0)**	**(11.3)**	**0.7**	**(63.8)**	**(57.6)**	**6.2**	**(7.4)**	**(7.0)**	**0.4**	**(34.9)**	**(34.4)**	**0.5**	**(19.3)**	**(18.3)**	**1.1**	**(98.7)**	**(91.9)**	**6.8**
Total Non Pay Costs	**(30.3)**	**(30.5)**	**(0.3)**	**(155.0)**	**(154.6)**	**0.4**	**(14.7)**	**(14.0)**	**0.7**	**(72.2)**	**(72.4)**	**(0.2)**	**(45.0)**	**(44.5)**	**0.4**	**(227.2)**	**(227.0)**	**0.2**
Total Operating Expenditure	**(77.8)**	**(79.5)**	**(1.7)**	**(392.4)**	**(399.1)**	**(6.8)**	**(49.9)**	**(49.9)**	**(0.1)**	**(248.8)**	**(250.1)**	**(1.3)**	**(127.7)**	**(129.4)**	**(1.7)**	**(641.2)**	**(649.3)**	**(8.1)**
EBITDA	**3.9**	**14.9**	**11.0**	**29.2**	**24.8**	**(4.4)**	**3.4**	**2.9**	**(0.4)**	**15.1**	**9.2**	**(5.9)**	**7.2**	**17.8**	**10.6**	**44.3**	**34.0**	**(10.3)**
Depreciation	(2.5)	(2.5)	0.0	(12.3)	(12.2)	0.1	(2.1)	(1.9)	0.2	(10.4)	(9.5)	0.8	(4.6)	(4.4)	0.2	(22.7)	(21.7)	1.0
Non Operating Items	(1.4)	(1.4)	0.0	(7.0)	(6.8)	0.2	(0.7)	(0.6)	0.1	(3.4)	(3.0)	0.3	(2.1)	(1.9)	0.1	(10.3)	(9.8)	0.6
Surplus/(Deficit)	**(0.0)**	**11.1**	**11.1**	**9.9**	**5.8**	**(4.1)**	**0.6**	**0.5**	**(0.1)**	**1.4**	**(3.3)**	**(4.7)**	**0.6**	**11.5**	**11.0**	**11.3**	**2.5**	**(8.8)**
NHSE Allowable Adjustments	(0.9)	(12.0)	(11.0)	(14.8)	(13.5)	1.3	(1.5)	(1.4)	0.1	(7.5)	(3.1)	4.5	(2.4)	(13.4)	(11.0)	(22.3)	(16.6)	5.7
Adjusted Surplus / (Deficit)	**(1.0)**	**(0.9)**	**0.0**	**(4.9)**	**(7.7)**	**(2.8)**	**(0.9)**	**(1.0)**	**(0.1)**	**(6.2)**	**(6.4)**	**(0.2)**	**(1.9)**	**(1.9)**	**(0.0)**	**(11.0)**	**(14.1)**	**(3.0)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						GROUP (£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	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	(0.0)
	Cancer Network	(0.5)	(0.4)	0.1	(2.1)	(2.1)	(0.1)	(0.3)	(0.3)	0.0	(1.4)	(1.3)	0.1	(0.8)	(0.7)	0.1	(3.5)	(3.4)	0.1
	Cardiovascular	(3.8)	(2.8)	1.0	(17.3)	(17.4)	(0.1)	(1.0)	(1.0)	0.1	(4.7)	(4.7)	0.0	(4.8)	(3.7)	1.1	(22.0)	(22.1)	(0.1)
	Digestive Diseases	(3.3)	(3.5)	(0.2)	(14.6)	(15.9)	(1.3)	(2.9)	(2.9)	0.0	(12.7)	(12.4)	0.3	(6.1)	(6.4)	(0.2)	(27.3)	(28.3)	(1.1)
	Head & Neck	(3.9)	(4.0)	(0.1)	(17.5)	(18.0)	(0.5)	(1.4)	(1.6)	(0.2)	(6.5)	(6.8)	(0.3)	(5.3)	(5.6)	(0.3)	(24.0)	(24.8)	(0.9)
	Major Trauma Network	(0.6)	(0.5)	0.0	(2.4)	(2.4)	(0.0)	(0.2)	(0.2)	0.0	(1.0)	(1.0)	0.0	(0.8)	(0.7)	0.1	(3.4)	(3.4)	0.0
	Patient Services	(2.5)	(2.4)	0.1	(11.0)	(11.3)	(0.2)	(2.0)	(1.8)	0.2	(8.4)	(8.4)	0.1	(4.4)	(4.2)	0.3	(19.5)	(19.6)	(0.2)
	Specialist Cancer and Support Services	(19.1)	(19.3)	(0.2)	(90.6)	(90.0)	0.6	(6.6)	(6.4)	0.2	(30.4)	(30.1)	0.3	(25.7)	(25.7)	(0.0)	(121.0)	(120.1)	0.9
	Theatres, Anaesthetics and Critical Care	(8.3)	(8.0)	0.3	(36.8)	(37.8)	(0.9)	(4.6)	(4.3)	0.3	(21.1)	(21.0)	0.1	(12.9)	(12.3)	0.5	(57.9)	(58.8)	(0.9)
	Sub Total Operations North	**(41.9)**	**(41.0)**	**0.9**	**(192.6)**	**(195.3)**	**(2.7)**	**(19.0)**	**(18.5)**	**0.5**	**(86.1)**	**(85.6)**	**0.6**	**(60.9)**	**(59.5)**	**1.4**	**(278.8)**	**(280.9)**	**(2.1)**
	Chief Delivery Officer	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.1	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.1
	Acute and Emergency Medicine	(3.8)	(4.1)	(0.3)	(16.7)	(18.2)	(1.5)	(6.4)	(6.1)	0.3	(27.8)	(27.9)	(0.1)	(10.2)	(10.2)	0.0	(44.6)	(46.2)	(1.6)
	Community, Frailty & Therapy	(4.1)	(4.1)	(0.0)	(17.8)	(18.6)	(0.8)	(4.6)	(4.5)	0.1	(20.7)	(21.1)	(0.4)	(8.7)	(8.6)	0.1	(38.5)	(39.7)	(1.2)
	Family Services	(5.4)	(5.6)	(0.3)	(23.7)	(25.3)	(1.6)	(5.1)	(4.9)	0.2	(22.2)	(22.6)	(0.4)	(10.4)	(10.5)	(0.1)	(45.9)	(47.8)	(1.9)
	Neuroscience	(2.5)	(2.3)	0.2	(11.2)	(11.0)	0.1	(0.7)	(0.8)	(0.1)	(3.2)	(3.5)	(0.2)	(3.2)	(3.1)	0.1	(14.4)	(14.5)	(0.1)
	Pathology Network Group	(2.1)	(2.0)	0.1	(9.7)	(9.9)	(0.2)	(2.4)	(2.3)	0.1	(10.6)	(10.6)	(0.1)	(4.5)	(4.3)	0.2	(20.2)	(20.5)	(0.2)
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(1.4)	(1.6)	(0.2)	(0.4)	(0.4)	0.0	(1.7)	(1.8)	(0.0)	(0.7)	(0.7)	(0.0)	(3.1)	(3.4)	(0.3)
	Specialist Medicine	(4.2)	(4.0)	0.2	(19.2)	(19.3)	(0.1)	(2.3)	(2.2)	0.1	(9.8)	(10.2)	(0.4)	(6.5)	(6.3)	0.2	(29.0)	(29.5)	(0.5)
	Specialist Surgery	(4.0)	(4.3)	(0.3)	(17.7)	(18.6)	(0.9)	(2.1)	(2.0)	0.1	(9.1)	(9.1)	0.0	(6.0)	(6.3)	(0.3)	(26.8)	(27.7)	(0.9)
	Sub Total Operations South	**(26.2)**	**(26.8)**	**(0.6)**	**(117.3)**	**(122.5)**	**(5.2)**	**(24.1)**	**(23.3)**	**0.8**	**(105.6)**	**(107.0)**	**(1.4)**	**(50.3)**	**(50.1)**	**0.2**	**(222.9)**	**(229.5)**	**(6.6)**
Total Operations		**(68.2)**	**(67.8)**	**0.3**	**(310.0)**	**(317.8)**	**(7.8)**	**(43.1)**	**(41.8)**	**1.3**	**(191.7)**	**(192.6)**	**(0.9)**	**(111.3)**	**(109.6)**	**1.6**	**(501.7)**	**(510.4)**	**(8.7)**
Corporate	Chief Executive	(0.1)	(0.1)	(0.0)	(0.6)	(0.7)	(0.1)	(0.1)	(0.1)	(0.0)	(0.5)	(0.6)	(0.1)	(0.2)	(0.3)	(0.1)	(1.1)	(1.3)	(0.2)
	Chief Medical Officer	(1.5)	(1.7)	(0.2)	(6.7)	(6.8)	(0.1)	(1.5)	(1.5)	(0.0)	(6.8)	(6.5)	0.3	(3.0)	(3.3)	(0.2)	(13.5)	(13.2)	0.3
	Chief Nurse Office	(3.0)	(3.2)	(0.2)	(14.9)	(15.3)	(0.4)	(2.3)	(2.3)	0.0	(11.2)	(11.0)	0.2	(5.3)	(5.5)	(0.2)	(26.1)	(26.3)	(0.2)
	Director of Assurance	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	0.0	(0.4)	(0.4)	(0.0)	(0.1)	(0.1)	0.0	(0.4)	(0.5)	(0.0)
	Director of People	(0.9)	(0.9)	(0.0)	(4.4)	(4.1)	0.3	(0.8)	(0.8)	0.0	(4.1)	(3.9)	0.2	(1.8)	(1.8)	0.0	(8.5)	(8.0)	0.5
	Director of Finance, Estates & Facilities	(6.2)	(5.6)	0.6	(29.2)	(27.9)	1.2	(4.3)	(4.2)	0.2	(19.8)	(19.9)	(0.1)	(10.5)	(9.7)	0.8	(49.0)	(47.9)	1.1
	Strategy and Partnerships	(0.5)	(0.5)	(0.0)	(2.6)	(2.4)	0.2	(0.4)	(0.3)	0.0	(1.7)	(1.5)	0.2	(0.9)	(0.9)	0.0	(4.4)	(4.0)	0.4
Total Corporate		**(12.4)**	**(12.2)**	**0.2**	**(58.5)**	**(57.4)**	**1.2**	**(9.5)**	**(9.4)**	**0.2**	**(44.5)**	**(43.8)**	**0.7**	**(21.9)**	**(21.5)**	**0.3**	**(103.1)**	**(101.2)**	**1.9**
Central Income, Reserves & Technical	Central Income	76.9	87.7	10.8	397.2	394.5	(2.7)	48.3	48.2	(0.0)	241.1	240.3	(0.7)	125.2	135.9	10.8	638.2	634.8	(3.4)
	Central Technical	(3.5)	(3.2)	0.3	(20.2)	(13.3)	6.8	(1.1)	(0.8)	0.3	(5.3)	(7.2)	(1.9)	(4.6)	(4.0)	0.6	(25.5)	(20.5)	4.9
	Reserves	7.1	6.6	(0.5)	1.4	(0.2)	(1.5)	6.0	4.2	(1.8)	1.9	(0.1)	(1.9)	13.1	10.8	(2.4)	3.2	(0.2)	(3.5)
Total Central Income, Reserves & Technical		**80.5**	**91.1**	**10.6**	**378.4**	**381.0**	**2.6**	**53.2**	**51.6**	**(1.6)**	**237.6**	**233.1**	**(4.6)**	**133.7**	**142.7**	**9.0**	**616.0**	**614.1**	**(1.9)**
Surplus / (Deficit)		**(0.0)**	**11.1**	**11.1**	**9.9**	**5.8**	**(4.1)**	**0.6**	**0.5**	**(0.1)**	**1.4**	**(3.3)**	**(4.7)**	**0.6**	**11.5**	**11.0**	**11.3**	**2.5**	**(8.8)**
Adjustments to adjusted financial performance		(0.9)	(12.0)	(11.0)	(14.8)	(13.5)	1.3	(1.5)	(1.4)	0.1	(7.5)	(3.1)	4.5	(2.4)	(13.4)	(11.0)	(22.3)	(16.6)	5.7
Adjusted financial performance Surplus / (Deficit)		**(1.0)**	**(0.9)**	**0.0**	**(4.9)**	**(7.7)**	**(2.8)**	**(0.9)**	**(1.0)**	**(0.1)**	**(6.2)**	**(6.4)**	**(0.2)**	**(1.9)**	**(1.9)**	**(0.0)**	**(11.0)**	**(14.1)**	**(3.0)**

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)192

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9th October 2025
Director Lead	**Emma Sayner – Group Chief Financial Officer**
Contact Officer / Author	**Tom Myers - Group Director of Estates, Facilities and Development**
Title of Report	**The annual fire reports for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS FT**
Executive Summary	HUTH and NLaG produce their own annual fire report in order to satisfy the statutory obligations. However, to assist those working across the Group this report contains one executive summary which considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management. The annual fire reports are circulated to PEF for information and then Trust Board approval and annual statement completion.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Performance, Estates and Finance CiC Estates, Facilities and Development Governance Groups HUTH Security, Fire, Health and Safety Group NLAG Health, Fire and Safety Group
Financial Implication(s) (if applicable)	Within current Estates, Facilities and Development Resources.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Group Directorate of Estates, Facilities and Development

Annual Fire Reports

1st April 2024 to 31st March 2025

Combined Executive Summary

Executive Summary

This executive summary is formulated from the two statutory reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Each partner organisation produces its own annual fire report in order to satisfy its statutory obligations.

However, to assist those working across the Group this executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management across the Group.

Key Points

The use of an Authorised Engineer (AE) Fire has been implemented at both organisations. After a review, the same AE has now been appointed for both organisations and audits undertaken in 2025/26 will be able to be combined into a single action plan and enhance the consistency in fire safety management across the Group.

Recommendations are identified for one of the organisations or both and labelled as such in this combined executive summary.

For HHP

1. Fire training requirements across the Group need to be reviewed and revised in light of changes to the requirements for fire safety training and the frequencies that training should be delivered. The need for face-to-face training is also re-iterated in the revised HTM and needs to be incorporated within any training regime. A small working group is to be formed, and current training reviewed and revised, and changes implemented within 25/26.

2. Trained fire warden numbers are down at both organisations and more so at NLaG which suffered a significant drop as a result of Covid (from which it has never recovered). Fire training requirements in relation to fire safety management have been revised and re-issued across the NHS and so this new guidance outlining the roles and training required needs to be fully reviewed. A consistent training package for each of these roles needs to be completed and a new campaign launched across the Group.

3. Resources for fire safety management at both organisations to ensure the passive surveys, support for capital projects, maintaining assessments etc. is limiting the ability to maintain the programme of work and so should be reviewed across the group. There have been a number of retirements particularly at HUTH which has affected the work programme currently so a review utilising more collaborative working across the group and make more effective use of current resources and identify any additional that may be required. Recruitment to vacant posts is on-going and in addition the EFD

Group restructure in 25/26 will give an opportunity to review resources needed across the Group.

4. Consider further capital funding to undertake a complete fire stopping survey to ensure the integrity of the 60 min fire compartments is maintained and check 30 min sub-compartments fire stopping to reduce any smoke or flame migration in the event of a fire within the compartment. Surveys are required to be undertaken periodically to ensure that compartment and sub-compartment penetrations are appropriately fire-stopped and so falls within the capital funding streams.

5. Ensure that the programme of reviewing fire risk assessments is completed, and the frequency of assessments is aligned across the Group. The systems used should also be reviewed to consider if alignment into one system is appropriate to give more consistency and allow better performance metrics to be developed.

6. The fire teams within each organisation develop closer working relationships so developing a more consistent approach to fire safety management across the Group and allow aspects such as cross-organisational auditing etc. to be implemented as well as consistent standards to be applied.

For HUTH

7. Although there has been significant investment on the Southbank there has also been work undertaken on the Northbank. However, fire alarm management software used (known as Hercules) at Hull Royal Infirmary (HRI) is causing restrictions in performance and also the ability to edit and display appropriate alarm activation addresses. Whilst this does not delay the detection of any fire it does in some instances lead to a delay in locating the exact location and increasing the amount of Unwanted Fire Signals (UwFS). The system needs to be upgraded to a cloud-based version or replaced to maintain compliance with the HTM and FSO.

8. Some problems have been identified within the alarm cause & effect (C&E) affecting the first four floors of the Tower Block at HRI meaning that on some alarm activations the alarm has sounded in more than one zone. This gives rise to an increased risk of harm to patients being moved when not required and the C&E needs to be reviewed for this area by an appropriate third party (as there is no in-house resource currently). This issue needs to be addressed to maintain assurance that the Cause & Effect (C&E) is appropriate for these areas.

The above recommendations are made to ensure that adequate assurance can continue to be given, and more detail is contained the respective reports for each partner organisation.

FOOTNOTE

The issues relating to the senior nominated persons has been resolved but it in the individual organisations report as this was not resolved until after the 31st March 2025.

It should also be noted that significant fire issues in relation to the tower block at Hull Royal Infirmary (HRI) since the compilation of this report. Separate briefings will be undertaken during 25/26 to the Trust Board and Cabinet to give updates and will be included within the 25/26 annual report.

Hull University Teaching Hospitals NHS Trust

Directorate of Estates, Facilities & Development

Annual Fire Report

1st April 2024 to 31st March 2025

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1.0 EXECUTIVE SUMMARY

Risk based Fire risk assessments (FRA) are carried out on Trust premises under the FSO. A web-based software system (BORIS) is used for the majority of FRAs. All Trust main wards and departments are now on BORIS. Trust main building generic and mobile scanner unit FRAs currently remain on non-database documents. Trust FRAs are subject to periodic external audits by Humberside Fire and Rescue Services (HFRS) as part of their statutory compliance Risk Based Intervention Programme (RBIP).

Increases in the number of candidates for fire warden courses continue to improve the overall Fire warden coverage.

The Trust's fire policies and procedures are due to be audited by an external Authorising Engineer (Fire) from Fire Safety Partnership. A request for Information has been sent by the AE, which is currently being populated by the fire team. A date for the audit has been confirmed as 11th August 2025.

The Trust's fire alarm call filtering system commenced on 20th July 2020 in agreement with HFRS. A six-minute investigation period is implemented between 0800-1800 hours Monday to Friday on HRI and CHH sites, with suitable safeguards implemented, as necessary. The data for the unwanted fire calls and call filtering can be reviewed in Graph 2 & 3.

At 86.5% the mandatory Fire Safety Training Statistics for 2024/25 met the Trust target of 85%. Additional fire warden courses and a wider awareness have increased the figures. A breakdown of the most recent figures can be found in Section 4.7 below.

Trust global records show a total of 197 fire incidents and fire alarm activations. There were 165 in the previous year 2023-24.

Fire Expenditure 2024/25

The table below indicates the statutory compliance budget for fire and how it is apportioned.

Fire Budget Expenditure 2025 - 2026	
Fire Extinguishers	£5k
Fire Dampers	£38.5k
BORIS System	£6k
Fire Audit works	£20k
Remedial works	£40k
Total	**£109.5**

Table 1

2.0 INTRODUCTION

The purpose of this document is to provide the Performance, Estates & Finance (PEF) Committee an update for assurance regarding the fire management at HUTH.

Trust fire safety compliance is driven by the Regulatory Reform (Fire Safety) Order 2005 (FSO). The responsibility for ensuring necessary precautions to protect people and property in the event of fire rests with the Trust Board. The Department of Health Firecode (HTM 05) suite of documents provides guidance on statutory compliance and other fire safety measures that apply to healthcare premises.

HUTH's Risk Based Inspection Programme (RBIP) focuses resources to best effect across the Trust. This places the largest weighting on higher risk patient care areas (12 monthly inspections), plant and laboratory type areas are medium risks (18 months) with mainly lower risk administration areas at 24 monthly inspections. The programme is flexible, and changes can be made for areas or buildings, dependent on relevant risk factors.

The full extent of the impact on fire safety arising from Grenfell Tower fire in June 2017 in London is now more apparent and includes changes to high-rise accommodation legislation (The Building Safety Act 2022). No buildings apart from the residence block on HRI is registered under the legislation (no other buildings need to be registered currently.

Humberside Fire and Rescue Service (HFRS) last issued a Notification of Deficiencies (R-02B) on the 24th July 2024 with regards to failings and deficiencies in some fire doors identified on an organised audit of the Women's

and Children's Building at HRI. These deficiencies were subsequently rectified; this was confirmed on the 28th October 2024 by the inspecting officer for Humberside Fire and Rescue.

The Estates, Facilities and Capital Development management teams continue to maintain existing fire safety standards and work towards improvements (including the cladding, structural integrity, and fire-stopping of Trust building stock) wherever this is possible and/or practicable.
Corporate risk register entries and action plans are made for any such matters which remain outstanding.

3.0 COMPLIANCE WITH REGULATIONS AND GUIDANCE

The table below shows compliance against regulations and guidance. In some cases, the Trust's systems and processes will be compliant but the RAG rating may be increased where there are frequent or major failings operationally.

Table 2

Requirement/ Recommendation	Progress	RAG
Regulatory Reform (Fire Safety) Order 2005		
Fire risk assessment of premises *Statutory Requirement*	Only partially compliant due to fluctuating resource issues with regards to staffing levels.	
HTM 05 – 01 managing healthcare fire safety (second edition)		
Clearly defined fire safety policy. *Mandatory*	Compliant. Policy CP034 on Trust Intranet.	
Director nominated re: Fire Safety *Mandatory*	Non-compliant – no nominated Director of Estates & Facilities or deputy is currently appointed. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	
Nomination of Fire Safety Manager *Mandatory*	Non-compliant – currently there is no nominated senior manager of Estates & Facilities or deputy is currently appointed. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	
Central reporting of all fire related incidents *Mandatory*	Compliant- As mandatory there is a central internal reporting system, which is monitored and logged.	
Emergency evacuation procedures *Mandatory*	Compliant – Fire Safety Information Manuals are broadly in place. A strategic building evacuation group is working up evacuation plans for major buildings	
Adequate fire alarm and detection systems *Mandatory*	Compliant, with additional systems installed or upgraded as necessary	

Staff training programme appropriate to level of risk and duties. *Mandatory*	Basic compliance- programme in place to continually improve attendance levels (Table 4).	
Annual audit of fire safety provisions and report to Board *Recommendation*	No audit was undertaken in year 24/25 due to issues regarding the contracted AE(Fire) and the move to Group appointed AE(Fire).	
Access to a Fire Safety Adviser *Recommendation*	Currently partially compliant, this is due to retirement of part of the team Currently recruiting to the positions.	
Formation of Fire Safety Committee *Recommendation*	Compliant. Fire, Health & Safety & Security Committee reporting to the Non-Clinical Quality Committee.	
Provision of Fire Wardens *Recommendation*	Improving steadily but not always in place during 'off peak' periods. Surveys completed to identify areas for targeted recruitment,	
Liaison with External Bodies *Mandatory*	Compliant – six monthly HFRS Service level meetings	
Authorising Engineer (Fire) [External Specialist) *Recommendation*	Compliant – a suitable competent and qualified person has been appointed.	
HTM 05-03 Operational Provisions *All are Recommendations.*		
Monitoring and mitigation of Unwanted Fire Signals	Compliant via shared file databases	
Arson Policy	Compliant – see main fire policy CP034	
Textures and furniture purchasing policy.	Compliant – see main fire policy CP034	
Planned preventative maintenance programme	Compliant- Improved fire door completion rates and trained staff in place.	
Regulatory Reform (Fire Safety) Order 2005		
Fire risk assessment of premises *Statutory Requirement*	Currently partially compliant, this is due to retirement of part of the team Currently recruiting to the positions.	
HTM 05 – 01 managing healthcare fire safety (second edition)		
Clearly defined fire safety policy. *Mandatory*	Compliant. Policy CP034 on Trust Intranet.	
Director nominated re: Fire Safety *Mandatory*	Non-compliant – no nominated Director of Estates & Facilities. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	

Nomination of Fire Safety Manager *Mandatory*	Non-compliant – currently there is no nominated senior manager of Estates & Facilities or deputy is currently appointed. Needs to be confirmed in writing and tabled at the Fire Safety Committee.	
Central reporting of all fire related incidents *Mandatory*	Compliant- As mandatory there is a central internal reporting system, which is monitored and logged.	
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Adequate fire alarm and detection systems *Mandatory*	Compliant, with additional systems installed or upgraded as necessary	
Staff training programme appropriate to level of risk and duties. *Mandatory*	Basic compliance- programme in place to continually improve attendance levels (Table 3).	
Annual audit of fire safety provisions and report to Board *Recommendation*	Compliant	
Access to a Fire Safety Adviser *Recommendation*	Currently partially compliant, this is due to retirement of team members. Currently recruiting to the positions.	
Formation of Fire Safety Committee *Recommendation*	Compliant. Fire, Health & Safety & Security Committee reporting to the Non-Clinical Quality Committee.	
Provision of Fire Wardens *Recommendation*	Improving steadily but not always in place during 'off peak' periods. Figures are monitored by fire safety committee.	
Liaison with External Bodies *Mandatory*	Compliant – six monthly HFRS Service level meetings	
Authorising Engineer (Fire) [External Specialist) *Recommendation*	Compliant – a suitable competent and qualified person has been appointed.	
HTM 05-03 Operational Provisions *All are Recommendations.*		
Monitoring and mitigation of Unwanted Fire Signals	Compliant via shared file databases	
Arson Policy	Compliant – see main fire policy CP034	
Textures and furniture purchasing policy.	Compliant – see main fire policy CP034	

Planned preventative maintenance programme	Compliant- Improved fire door completion rates and trained staff in place.	

Changes identified in HTM 03-03 Operational Provisions – Part B will be reviewed in 25/26 are part of an ongoing review of job descriptions which are part of the restructure.

4.0 RISK MANAGEMENT

4.1 Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 3.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
4398		There is a risk that safe fire evacuation may be at risk due to the unresolved cause and effect fire alarm strategy.	Inspection and testing programme in place for the active modified L1 fire alarm system. Building occupied 24/7 Fire dampers inspected and tested annually. Fire extinguisher PPM system in place. Fire Door PPM in place. Fire Training is mandatory. Department Nominated Fire Officer (DNFO) training provided	12

4158		There is a risk that the fire structure integrity could be breached resulting in a spread of smoke or fire.	Fire damper inspection and testing programme in place, for those dampers that can be located and accessed. Annual fire risk assessments carried out in all wards and high-risk departments. Estates staff told to report any fault seen in such locations during their maintenance works. Fire stopping to most 60-minute compartments carried out in 2019. Use of 3rd party accredited fire stopping companies. Modified L1 fire alarm system installed to provide early warning of fire events. The Trust offers and encourages staff to attend Fire Warden training so that there can be Fire Wardens at their place of work. There is also the Emergency Response Fire Team to react to all fire calls. Additional operative has been booked onto a Fire Safety Adviser's course to take place in December 2023. Works have been contracted out for the surveying of the fire stopping to the 12th and 13th floors the HRI Tower Block. Additional floors also surveyed.	8
4399		There is a risk that there may be a delay in the initial fire response due to the fact that devices are now incorrectly labelled	Inspection and testing programme in place for the active modified L1 fire alarm system	12

4.2 Fire Risk Assessments

The Regulatory Reform (Fire Safety) Order 2005 requires a suitable and sufficient fire risk assessment of all relevant Trust premises covered by the Order. Trust premises have been assessed in accordance with the regulations using the Fire code and national risk assessment standards. All assessments are reviewed periodically by the Fire Safety Team.

The Trust Fire Team web-based system (BORIS) is used for the vast majority of FRA's. A small number are currently on the shared drive in Word format. New buildings are inputted onto BORIS as a matter of course.

At peak times in certain areas, it remains an accepted practice by some staff to leave storage cages, beds etc. causing obstruction and fire loading to primary escape routes. Such breaches could lead to further enforcement action against the Trust by HFRS. The Fire Safety Team periodically carry out spot checks and advise staff and may issue internal fire action notices, as necessary.

4.3 HFRS Fire Safety Audits

During the year 2024 to 2025 HFRS carried four routine compliance fire safety audits, covering nine targeted wards and departments at CHH and HRI.

A level of minor deficiencies was noted by HFRS at both HRI and CHH. These deficiencies were forwarded to the Estates Department, PFI for action with no enforcement measures issued.

Consultation with HFRS shows that for 2025/26 they have four fire safety compliance visits planned for CHH and the same for HRI.

4.4 Local Plans and Fire Safety Manuals

Fire Safety Information Manuals have been previously produced for all wards and departments. Ongoing department changes etc. routinely result in some new or amended Manuals. The Fire Safety Team continues to action this matter as resources permit. The Capital Development team are responsible for the provision of the initial fire safety plan within any capital project which is required to develop any operational fire risk assessment to be developed before occupancy can take place.

Current Trust fire safety plans do not always reflect changes in wards or departments as they occur. This is due to a current resource issue and a lack of information being made available in a timely manner. There is a recruitment process currently in progress to address.

A gap in compliance remains with the nominated departmental Fire Warden arrangements. Deputies are not always nominated or trained for the warden role, particularly when staff are on annual leave or sick or they change post. Problems occasionally arise as ward/department management changes. Fire Risk Assessments identify such shortfalls, but all relevant managers should be proactive to reduce such shortfalls.

4.5 Fire compartments

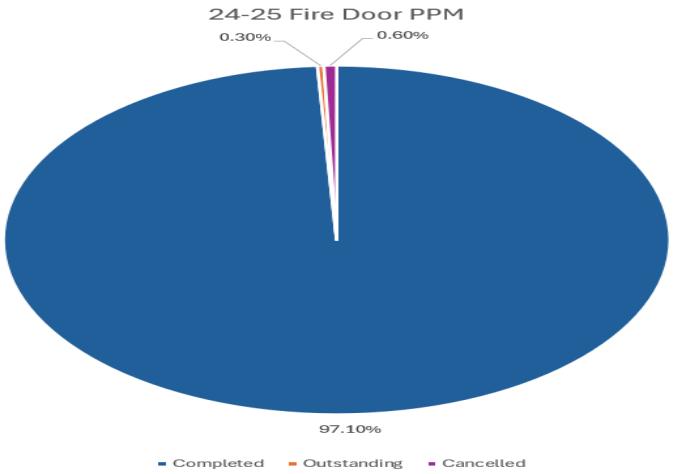
Department of Health Estates & Facilities Alert ref. DH/2014/003 identified the need to survey and audit fire compartment integrity in Trust premises. Fire stopping survey works and monitoring system updates have now recommenced. Further resources and working arrangements have been confirmed for this important aspect of building fire safety to continue. Identified in Operational Risk Register item 4158 (see 4/4.1 above). The routine programmed testing of ventilation system fire dampers continues.

During this financial year a passive fire survey was undertaken by a third party accredited passive fire inspector, which identified there were breaches across six ward areas of the Tower Block HRI, namely (wards 9, 90, 8, 80, 7, 70, 6, 60), the findings were penetrations to wall, ceilings and floors. These deficiencies have been logged on to the Bolster system. Fire stopping work has commenced on wards 6 & 60.

4.6 Fire Door Maintenance

HUTH undertake the fire door inspection and maintenance of the fire doors throughout the Trust properties via the direct labour in-house estates team. The staff have been trained by an external accredited company and are qualified to the appropriate standard to check and repair the fire doors. Below is a pie chart, which identifies the current compliance figures for fire door inspection.

Graph 1-The current compliance figure of 97.10% for fire door inspection



4.7 Fire Dampers

During the last fiscal year 24/25 the fire dampers where tested but no remedial repairs were undertaken due to funding and restricted access.

4.8 Fire Safety Committee

The Fire Safety Committee has met regularly during 24/25 to review the detailed technical aspects in relation to fire safety management for HUTH. It also considers and reviews compliance against the statutory provisions within the FSO and also the HTM fire safety documents. The Fire Safety Committee will also consider requested derogations from HTM based on risk assessments.

The group report and escalate to the Security, Fire, Health & Safety Group. The SFHSG oversee and manage fire safety issues which may need a group decision, or further escalation to the Performance Estates & Finance Group CiC.

The SFHSG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the higher groups when the Group meeting structures are finalised to enable issues to be escalated when appropriate.

4.9 Training *(Trust figures from Education & Development)*

Table 4 Mandatory Training Figures 2024/2025

The table below identifies the Trust's mandatory training figures for the clinical and support services, showing the level of compliance.

Area	completed	Not completed	Grand Total	% compliant	% not compliant
Cancer Network	112	7	119	94.10%	5.90%
Cardiovascular	354	87	441	80.30%	19.70%
Chief Delivery Officer	19	1	20	95.00%	5.00%
Corporate Directorates	1802	381	2183	82.50%	17.50%
Digestive Diseases	412	72	484	85.10%	14.90%
Head and Neck	406	56	462	87.90%	12.10%
Major Trauma Network	85	12	97	87.60%	12.40%

Patient Services	982	60	1042	94.20%	5.80%
Specialist Cancer and Support Services	1294	180	1474	87.80%	12.20%
Theatres, Anaesthetics and Critical Care	1091	120	1211	90.10%	9.90%
Acute and Emergency Medicine	454	64	518	87.60%	12.40%
Community, Frailty and Therapy	727	131	858	84.70%	15.30%
Family Services	726	143	869	83.50%	16.50%
Neuroscience	220	61	281	78.30%	21.70%
Pathology Network Group	54	7	61	88.50%	11.50%
Site Management and Discharge teams	51	4	55	92.70%	7.30%
Specialist Medicine	348	44	392	88.80%	11.20%
Specialist Surgery	396	60	456	86.80%	13.20%
Grand Total	**9533**	**1490**	**11023**	**86.50%**	**13.50%**

The fire training comprises mandatory training delivered by the training department as well as more specific fire training targeted at specific staff. The fire team cover the initial induction first responder, tabletop evacuations and theatre fire training.

Table 5 - Fire Training Compliance

Period	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Staff trained	970	321	357	233	545*	292**	162	104

* - no face-to-face training

** face to face training reintroduced

Last year there was 1894 trained Fire Wardens, this has increased to 2106 training fire wardens within the Trust, which is a positive increase of 212.

The training fire team offered one hundred face-to-face sessions, each session comprising of two places per session. Of the two hundred potential places, seventy-four members of staff attended and are now fully trained. The figures are low due to a lack of availability of training facilities to book, as a result of the Training department being demolished owing to the discovery of RAAC in the building. This lack of training has now been resolved with the opening of a new training facility at Castle Hill.

5.0 UNWANTED FIRE SIGNALS (UwFS) AND FIRE INCIDENTS

The Trust report database has recently been comprehensively reviewed and updated by the EF&D administration team and the Business Information Manager.

The database shows that there were five reportable fires during the year. These were all at HRI. All the fires were bin fires around the site due to cigarettes not being extinguished correctly.

The incidents were dealt with by staff and no call was made to HFRS. There were no Incidents at CHH nor at Harrow Street and Sykes Street, satellite sites in Hull.

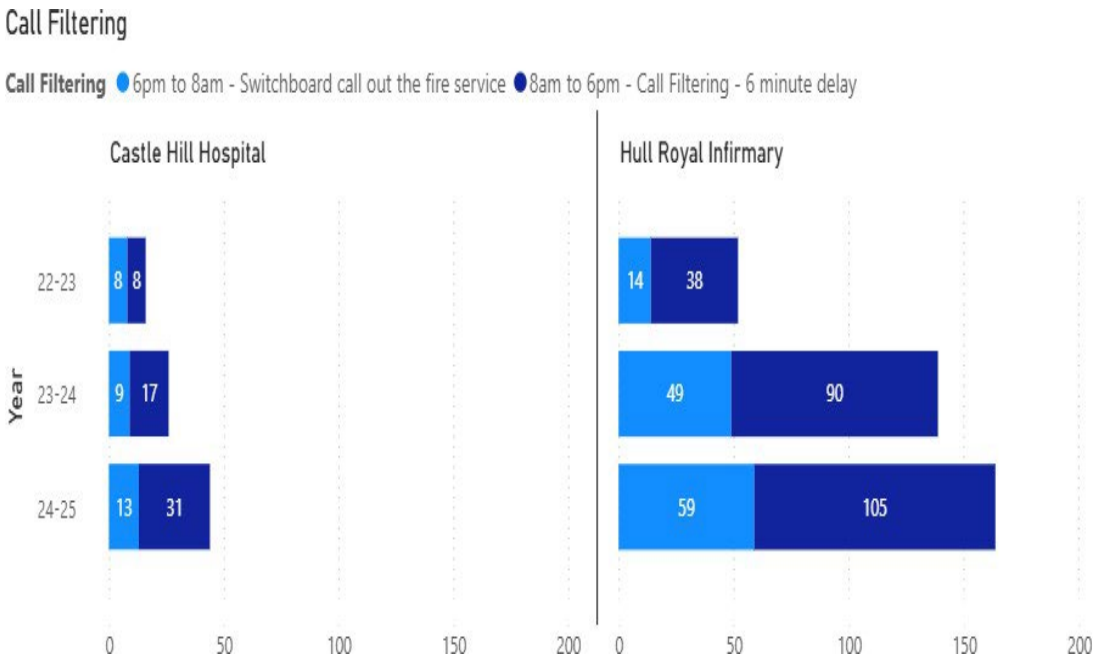
Trust fire records show a total of (208) fire incidents and fire alarm activations, this is an increase in comparison to the previous year by 38 (170).

The largest category in 2024-25 at CHH was “System Failures” (contractors accidentally activating the alarms) ‘environmental effect and other, which includes dust, aerosols, steam etc. as potential causes and accidental activation by a patient.

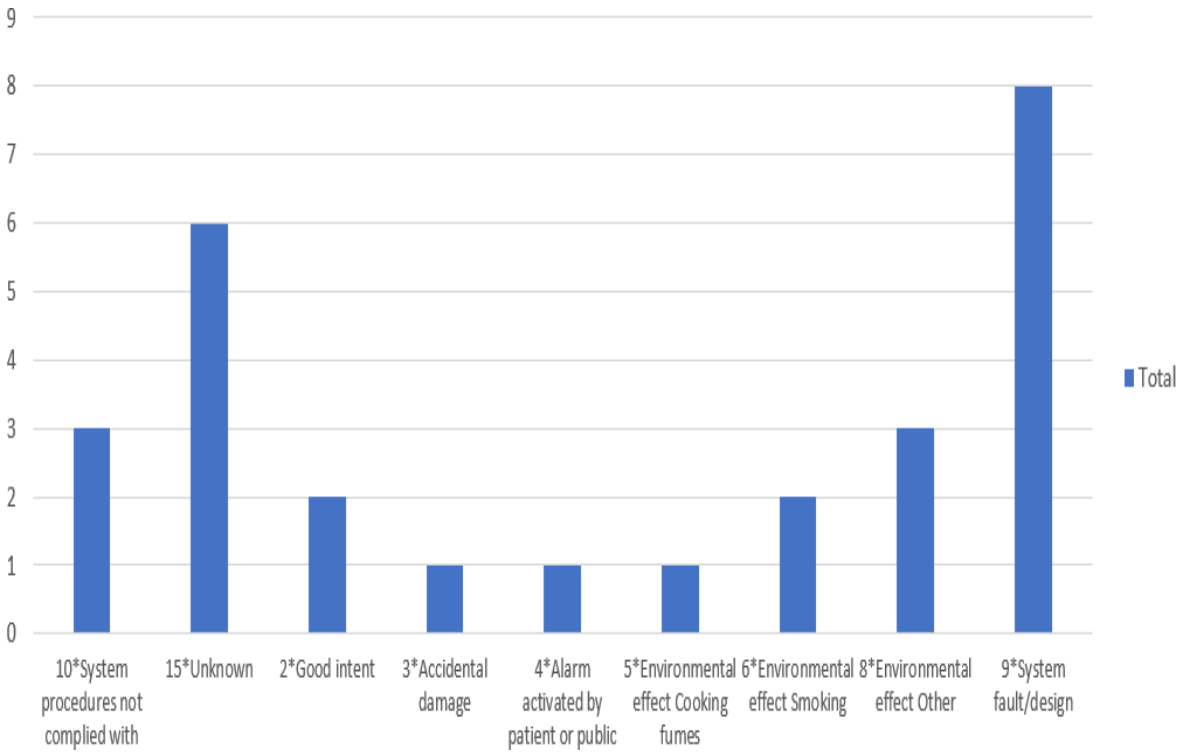
The figures for HRI show that the highest category for fire activations and an ongoing issue is Environmental (Smoking) in the main reception toilets, followed by Environmental (cooking) due to toasters predominantly as well as accidental activation by patients.

Ongoing cooperation and coordination between all stakeholders (Estates, PFI providers, contractors) is therefore essential to reduce and eliminate such largely avoidable causes.

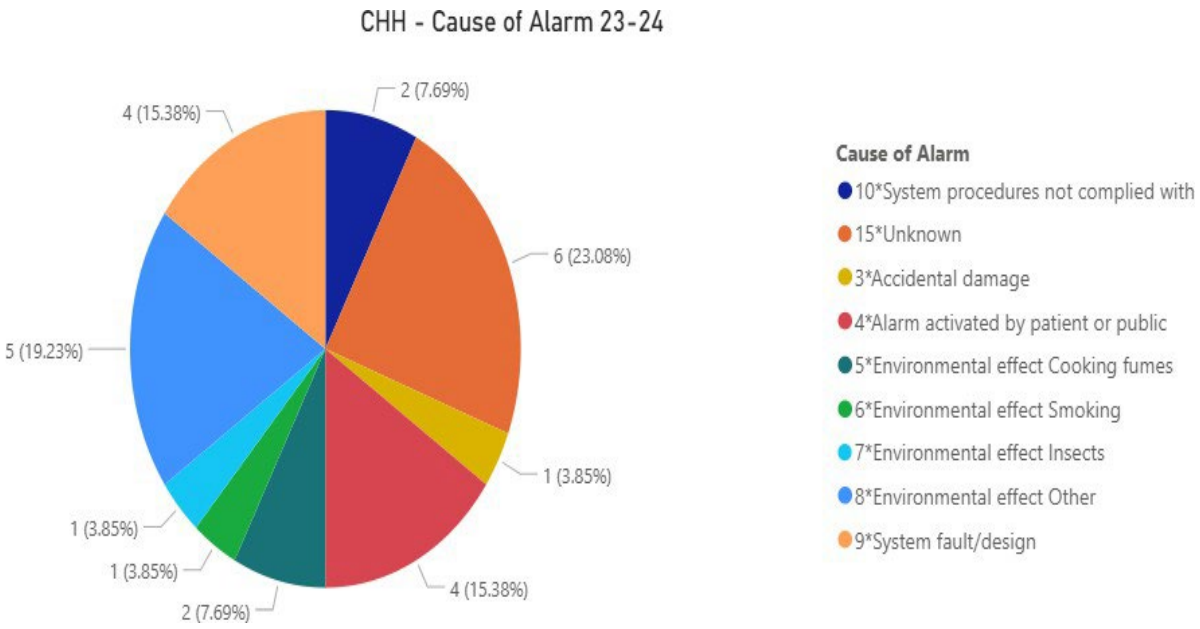
Graph 2- The data below shows the figures from the initial introduction of the call filtering, numbers, and the effectiveness of the call filtering process.



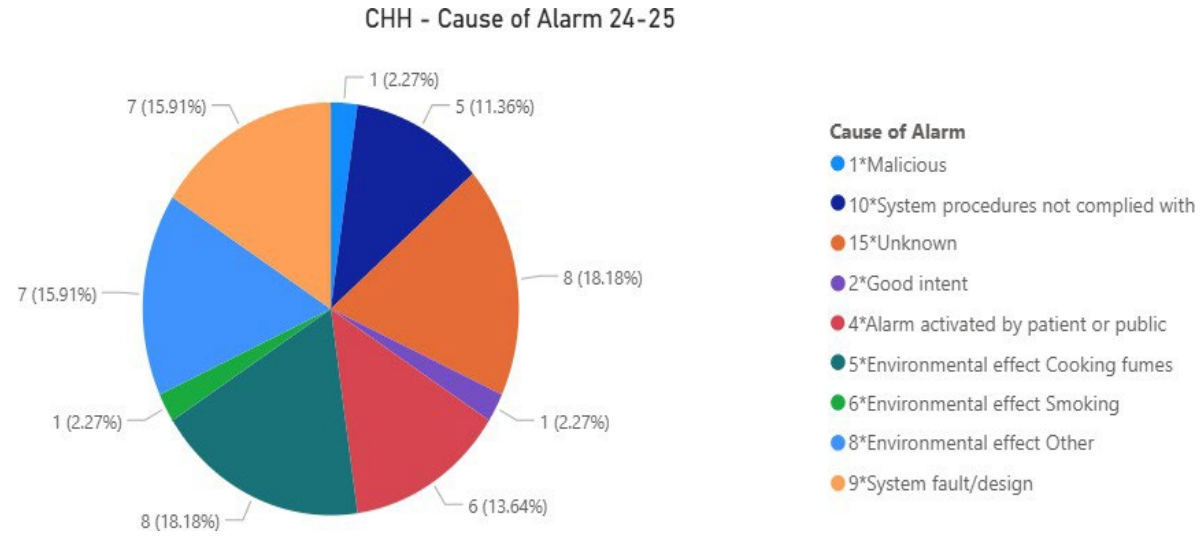
Graph 3 - Brigade attendance to the unwanted fire calls



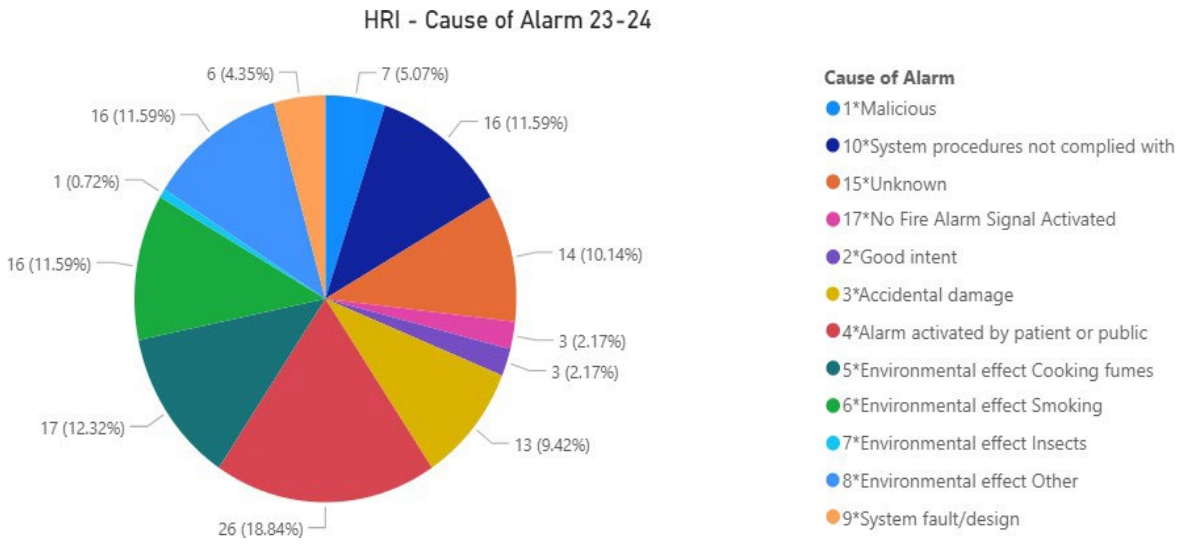
Graph 4 CHH cause of alarm activation 23 - 24



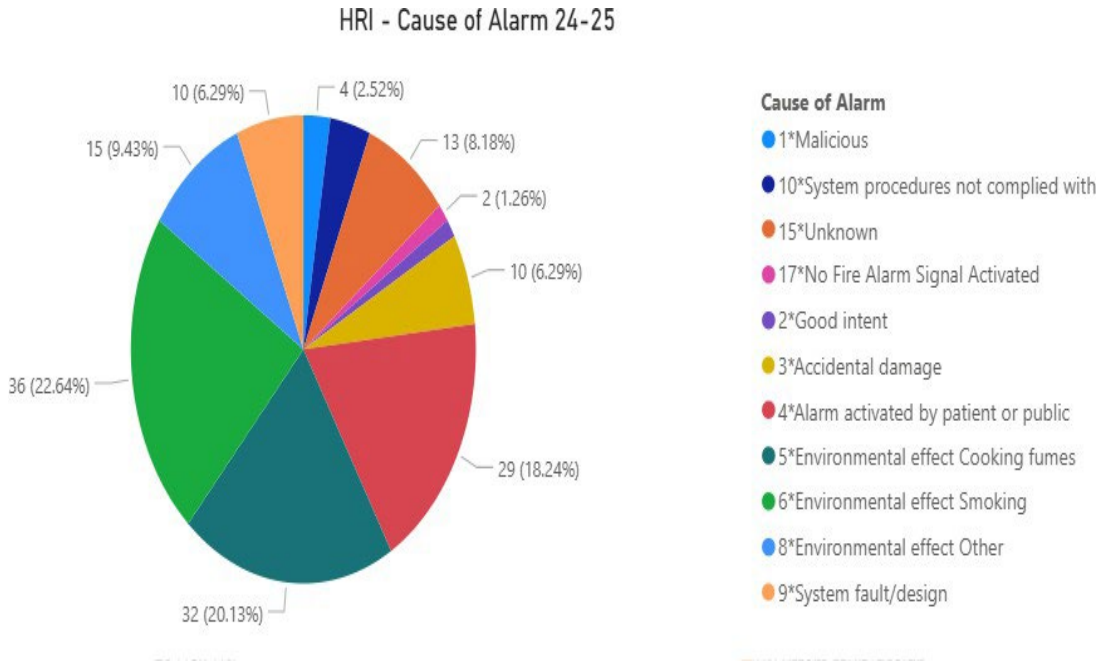
Graph 5 CHH cause of alarm activation 24 – 25



Graph 6 HRI Cause of alarm activation 23 - 24



Graph 7 HRI Cause of alarm activation 24 - 25



Ongoing discussions with HFRS business safety managers have indicated that HFRS is extending its current policy of call challenging and charging for some attendances which are confirmed as false alarm calls.

Although there may be some dispensation for sleeping risks, especially at night, this cannot be guaranteed for all Trust sites and buildings indefinitely.

Previous charges were approximately £430.75 per appliance per call out, plus an administration figure of £90.25.

This policy is currently evolving for the wider business community. Positive six-monthly Service level liaison meetings with HFRS have continued to mitigate any significant effect of this policy on the Trust to date.

Call filtering principles are adopted to:

- Reduce calls and impact on service delivery and Key Performance Indicators (Fire) for both organisations.
- Avoid placing members of the public at risk during incidents and attendances.
- Prevent damage to the environment.

6.0 PREMISES ASSURANCE MODEL (PAM) DATA FOR FIRE SAFETY

The PAM assurance model for fire comprises of ten questions, based on how the Trust can evidence the fire information it holds. The following are a summary of the questions, the rating given and any subsequent actions required to strengthen the current position.

6.1 Policies and Procedures

The current rating judgement is Amber (Requires Moderate Improvement)

Actions -

The Fire Safety Manuals, protocols and documentation are to be reviewed by the fire team to strengthen assurance.

The fire safety procedures are to be developed by the fire team and to be presented for approval at the relevant committee.

6.2 Roles and Responsibilities

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions-

There needs to be a confirmed identification of the roles, with the recent reorganisation of the E, F&D re-structure, with confirmation given in writing.

There needs to be a more robust fire warden/Senior Management coverage to wards and multi-occupancy office areas.

6.3 Governance

The current rating judgement is Yellow (Requires minimal Improvement)

Actions -

A final Fire Authorising Engineers (AE) report will be distributed to the HUTH Governance & Assurance Committee, upon completion of the audit in August.

6.4 Enforcement

The current rating judgement is Green (Good)

Actions -

No actions identified.

6.5 Fire Risk Assessment

The current rating judgement Orange (Requires Moderate Improvement)

Actions -

The Fire AE needs to be commissioned to approve the proposed fire compartmentations at HRI from the ground to the third floor of the Tower Block and North Blocks as an addition to their fee bid for fire AE duties.

The building fire risk assessment and Ward Risk Assessment programme is to be reviewed and developed to enable monitoring and compliance to provide the appropriate level of assurance to the E,F&D Management Committee/Trust Security, Fire, Health & Security Committee.

6.6 Maintenance

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

A costed action plan for passive fire surveys and remedial works is to be developed by the fire team.

6.7 Training and Development

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

The fire team are to carry out passive fire inspection qualifications to allow the fire compartmentation surveys to be undertaken “In-House.” Dates for the training are to be organised and are funded form the training budget.

Two members of the team have now attended the HTM course in May 2025.

The Trust fire team are implementing tabletop fire evacuation to High Dependency areas where the full evacuation training is impractical. The team have also formulated a power point theory and practical evacuation, as well as training for the risk of surgical fires and how to deal with them.

There remains a backlog of fire evacuation training needs throughout the Trust. This is down to a resource issue and also the practicalities of evacuating the wards. The team are going to undertake desk-top evacuation exercises to the wards to ensure partial compliance, in line with the latest HTM guidance.

The Trust training department are currently reviewing the Trust training standards, specifically the induction process. This will involve more specific and detailed fire training, which is in line with the changes to the HTM standards.

6.8 Resilience, Emergency Planning and Business Continuity

The current rating judgement is Yellow (Requires Minimal Improvement)

Action -

Evacuation drills are required to be undertaken and recorded in both clinical and administration areas where possible, with the option of a “Table-Top” exercise in critical care and Theatre areas.

6.9 Review Process

The current final rating judgement is Amber (Requires Moderate Improvement)

Actions -

To review the current electronic recording system for both passive fire and fire audit purposes.

6.10 Costed Action Plans

The current position is yes.

Action -

There is a costed plan for the passive fire surveys and associated remedial work. Orders have been placed for the remedial work identified to date via the passive fire surveys.

7.0 FIRE SAFETY IMPROVEMENT AND DEVELOPMENT

The HUTH fire team are scheduled to be audited on the 11th August 2025. The outcome of the audit will be an action plan with recommendations.

Estates/PFI agreed cyclical fire alarm system improvements remain in place for all Trust sites to help reduce false alarms/ UWFS and to improve system reliability and property protection. It is important to continue this impetus to maintain the effectiveness of the Trust fire alarm systems and to maintain suitable statutory compliance levels.

New developments and major refurbishment or extensions are prioritised as far as practicable for a new or updated Fire Risk Assessment (FRA) after appropriate consultations between the Trust Capital Development and Fire Teams, relevant Building Control Bodies and HFRS, as necessary.`

The Capital Development and Fire Safety teams need to reconvene to confirm a previous scheme to consolidate the fire compartment lines for the HRI Tower Block
ground to third floor inclusive, as well as the issues with the cause and effect in the ED department.

The scheme was previously agreed in principle; however, it was not ratified by the Trust's previous Authorised Engineer (Fire) [Trenton Fire Engineers].

This matter remains outstanding and is expected to be reviewed during the year with the current AE (Fire).

8.0 ONGOING FIRE SAFETY PRIORITIES FOR 2025-26

An annual audit has been confirmed for the week commencing 11th August 2025 (three-day audit) with the fire Authorising Engineer (Fire safety Partnership).

Continue liaison with HFRS regarding false alarm fire calls, attendances, and potential charges etc.

Promote joint working with Learning and Development, Health Groups, and other stakeholders to further improve global fire training figures.

Further improve and refine the Trust Fire Safety Risk Based Inspection Programme
and the BORIS database.

Maintain and further develop HFRS statutory fire safety and operational risk information site visits and Service level liaison meetings.

Increase and monitor the numbers and frequencies of local ward and department fire drills and fire plan exercises etc.

Continue with the passive fire surveys and remedial work associated with the surveys to the high-risk areas.

The fire team did manage to recruit to the full establishment for a short period of time, however a full-time member of the team left, leaving a resource void. A new member of the team is due to start in July 2025.

9.0 CONCLUSION

In conclusion, it is shown that the service had a good operational presence, however the recent reduction of the fire team, coupled with the recruitment processes has left the fire team with a large workload and small workforce. There has been continued support from a member of the fire team on the Bank staff and a member of the fire team from NLaG, to ensure the high and medium risk areas are being audited.

Additionally, good progress has been made this year with regard to the actions detailed in the fire compartmentation / fire stopping Alert, it is hoped that the funding for these fire stopping works will continue to be available to mitigate the risks identified in the Alert.

10.0 RECOMMENDATIONS

The committee is asked to note the content of this report and support the actions identified within the report.

The following recommendations are made to address issues identified within the body of the report.

1. The Hercules Fire Alarm Management System is showing a deterioration in performance and restricted ability to give more detailed address details indicating location of fire alarm activation. This is leading in some instances, to a delay in locating the exact location and increasing the amount of Unwanted

Fire Calls (UwFS). The system requires to be upgraded to a cloud-based version or replaced to maintain compliance with the HTM and FSO.

2. Some problems have been identified within the alarm cause & effect (C&E) affecting the first four floors of the Tower Block at HRI meaning that on some alarm activations the alarm has sounded in more than one zone. This gives rise to an increased risk of harm to patients being moved when not required and the C&E needs to be reviewed for this area by an appropriate third party (as there is no in-house resource currently). Whilst this issue does not increase the risk of fires not being detected, it nevertheless needs to be addressed to maintain assurance that C&E is appropriate for these areas.

3. The Fire Team has suffered a reduction in resources due to staff being recruited and subsequently leaving the Trust. This has impacted on the ability to undertake the high and medium fire risk assessments in line with the annual programme. Steps are being made to address in the short term; long term there will be another fire advisor commencing with the Trust in July 2025.

4. Review the newly issued HTM regarding fire training and revised training content appropriately with the Training Department and Fire Team. There are new training standards being discussed with the Training and Development team.

5. Continue to Increase the number of fire wardens and trained senior management across the Trust to ensure that there is adequate cover.

6. Review and update fire risk assessments for the 25/26 period.

7. Work collaboratively with the NLaG fire teams to adopt a more consistent approach to fire safety management across the group where practicable.

Authors:

Hedley Wilson
Deputy Head of Operational Estates

Nick Harrison
Head of Operational Estates

June 2024

Appendix 1 – HUTH Annual Fire Statement

<table>
<tr><td colspan="3">HUTH ANNUAL FIRE STATEMENT

FOR PERIOD – April 2024 – March 2025</td><td>NHS
Hull University Teaching Hospitals
NHS Trust</td></tr>
<tr><td colspan="4">I confirm that for the period 1st April 2024 to 31st March 2025, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (appropriate boxes below ticked)</td></tr>
<tr><td>1</td><td colspan="2">There are no significant risk arising from the risk assessments</td><td>N/A</td></tr>
<tr><td>OR
2</td><td colspan="2">The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessments</td><td>N/A</td></tr>
<tr><td>OR
3</td><td colspan="2">The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks* (see appendix 2 within NLaG report)</td><td>✓</td></tr>
<tr><td colspan="4">* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk Date: Quarter 3 (24/25)</td></tr>
<tr><td>4</td><td colspan="2">During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below</td><td>No</td></tr>
<tr><td>5</td><td colspan="2">Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below</td><td>No</td></tr>
<tr><td>AND
6</td><td colspan="2">The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.</td><td>✓</td></tr>
<tr><td rowspan="2">Fire Safety Manager</td><td colspan="3">Name: Bill Parkinson Signature:</td></tr>
<tr><td colspan="2">Contact e-mail : bill.parkinson@nhs.net</td><td>Date:</td></tr>
<tr><td rowspan="2">Chief Executive</td><td colspan="3">Name:
Signature:</td></tr>
<tr><td colspan="2">Contact e-mail</td><td>Date:</td></tr>
<tr><td colspan="4">Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.</td></tr>
</table>

None
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any
proposed further actions need to comply, costs incurred, and additional costs required to comply.
Humberside Fire and Rescue Service (HFRS) last issued a statutory FSO Enforcement Order to the Trust in late 2017 pertaining to the storage of beds on the link bridge from the Women's and Children's Hospital to the main Tower Block HRI. The Notice was lifted in March 2018; however, this still remains an ongoing issue within the Trust as a specific bed storage issue has not been rectified. It is noted that in an audit in 2024 this issue was again raised as a concern by HFRS that needed to be addressed.
NB Statement to be retained for external fire authority audits.

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates, Facilities & Develop

Annual Fire Report

1st April 2024 to 31st March 2025

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1.0 INTRODUCTION

The responsibility for compliance with the Fire Regulatory Reform (Safety Order) referred to as the FSO rests with the "responsible person" (RP) which in the case of Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) is the Group Chief Executive Officer or in the event of remote buildings off site buildings this may be the person in control of those premises.

In-light of the Group structure some aspects of the RP duties will also fall within the role of the South Bank Chief Executive as NLaG remains a legal entity and is regulated as such.

Generally, the RP is responsible for ensuring that, through appropriate delegation, current fire statutory requirements are met. In addition, for areas within the definition of clinical activities, that the requirements of Health Technical Memorandum (HTM) 05-01 (Fire Safety Management within Healthcare) are also complied with (as well as the accompanying HTM's linked to 05-01.

Under Firecode (i.e. HTM 05 suite), the primary responsibility for ensuring that there is an effective policy rests with the board-level director assisted by the Fire Safety Manager.

This report has been developed to provide information to the Trust Board of Directors concerning the management of fire safety for the period **1st April 2024 to 31st March 2025** and to also identify potential issues for the next 12 months. Included within this report is a workplan for 25/26 which is across the Group. Issues for a specific Trust will be stated as some differences may occur due to layout, buildings composition and activities which are being undertaken (also may take into account those areas under PFI control).

This report will also assist with the formulation of annual statement within this report and may also assist with demonstrating performance against Regulation 15 of the Care Quality Commission (CQC) Essential Standards of Quality & Safety. This report should therefore be retained along with the workplan as the assurance to external authorities in terms of fire safety management within the Trust.

It should also be noted that the HTM 05 suite of documents have been revised and will be updated documents will be issued during the 24/25 period. These documents when issued will need to be reviewed and appropriate amendments made to the relevant policies and procedures. In addition, it is not presently known what (if any) changes may be required to the annual report as the relevant HTM part has not been published at the time of producing this report. Any changes will therefore be made in future reports.

Likewise, the Group structure across NLaG and HUTH is not yet complete and the impact on responsibilities to comply with the HTM will be reviewed when this is finalised.

2.0 EXECUTIVE SUMMARY

Fires within acute Trusts are not common but should they occur then there could be significant risk to life and so the fire safety management strategy should be to:

- Prevent fires occurring.
- Detect them at the earliest stage possible
- Ensure appropriate responses are made when a fire is detected.
- Contain a fire to the immediate area and reduce the risk of spreading to other areas.
- Should a fire spread then ensure that there is the ability to move to a safe place as soon as possible.
- Ensure areas of high dependency such as Intensive Care Units (ICU) are constructed with additional measures, so the evacuation of these patients is regarded as the last resort.

As a result of the capital investment made and completed in 2023/24 DPoW now has a full digital system which will give detection and protection for the next two decades. This investment has continued in the period this report covers, as the detection and alarm system has been replaced at SGH during 2023/24 with the strip-out of the old alarm being completed in 2024/25.

The impact of the replacement is not fully seen yet as the SGH system replacement is not completed until March 24 so the effect on system faults for SGH will be reported in future reports.

The breakdown of system faults per site is shown in Figure 1

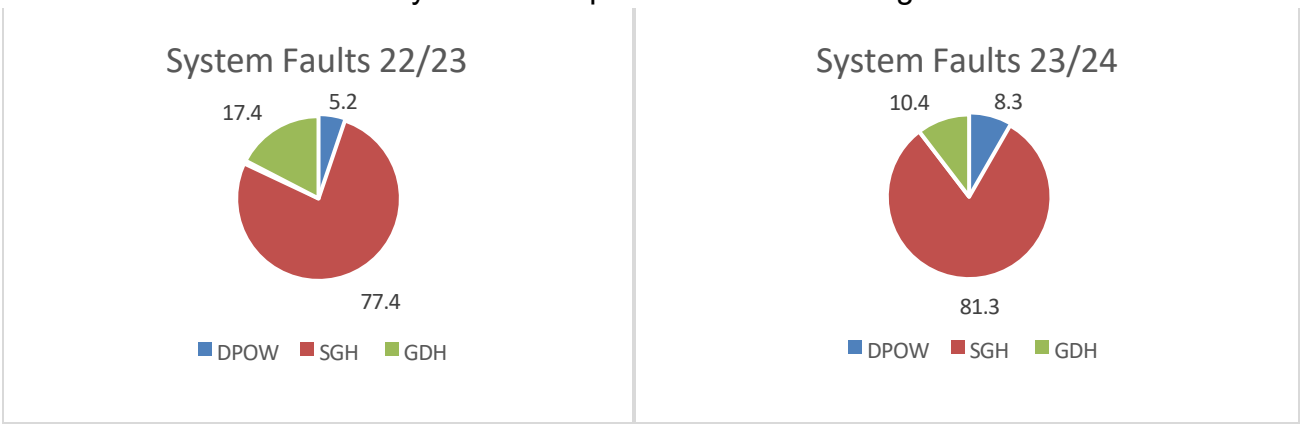

Figure 1 - Comparison of System Faults

The number of system faults for DPOW has increased slightly as third-party interface issues are being identified and resolved. In all the new AFD system at DPOW is performing well. Also figure 1 shows the continuing deterioration in the performance of the fire alarm system at SGH which has increased on the same period previously. This

should reduce in 24/25 as the new AFD system is commissioned and the old system is switched off and stripped out.

Other causes of fire alarm activations are covered below within this report. In addition, fire safety related risks which are on the risk register are also covered below.

The Group reports to the Health, Fire & Safety Group (HFSG) the escalation from the HFSG to groups above is part of the Group meeting structure which is to be finalised in Q1 in 24/25 but during the 23/24 period any issues have been escalated to the Trust Board (TB) in accordance with HTM 05-01.

Within the detailed report below the following recommendations are made:

1. The revised part of the HTM relating to training needs to be fully reviewed across the Group to determine changes required to the training needs for staff and those with additional responsibilities.
2. The number of fire wardens has reduced significantly since pre-covid levels and an initial campaign to increase the overall numbers has had some limited success. A more concerted campaign needs to be launched (once the training elements from the revised standard has been reviewed)
3. The fire risk assessments (which incorporate passive fire elements) should be reviewed in accordance with the programme and reminders generated from the electronic system.
4. Whist collaborative work across the Group is already in place there is scope for greater working together to address the common fire safety management issues in both partner organisations. This will also result in a more consistent approach to reducing the risks and protecting staff, patients, visitors alike.

Finally, acknowledgement must be made for the capital investment made to replace the aged alarm fire alarm systems at DPOW and SGH to increase the protection and early detection of a fire occurring before it can significantly affect patient care.

3.0 REPORT

3.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 1.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating

2038	SGH	Risk of failure of SGH fire alarm leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff (*NB this risk will be removed when installation of new alarm system is completed).* ***This risk has now been closed and a new moderate (score of 12) risk created for Goole Fire alarm system***	• SGH funding allocation now secured and enabling surveys and work underway. • Some old panels replaced until full replacement.	20
2464	Trust-wide	Trust estates alarms not being effectively covered especially within the boiler-house which requires monitoring 24/7. Gaps in switchboard cover and estates staff cover difficulties are raising concerns that cover can be maintained. ***This risk is linked to the digital strategy and upgrades to the E&F Building Management System (BMS). The latter is estimated to be completed by March 2025 subject to any funding priorities which may change the current timescales***	• Currently gaps are covered but are resources are increasingly strained due to illness and vacancies. • Upgrades to BMS ongoing including notifications of alarms to on call staff	12

Table 1 - Fire risks on Trust Risk Register

Previous risks have now been removed due to completion of work.

A previous risk related to the fire hydrants having Domestic Water Systems (DWS) connected to it has now been removed after agreement reached with the water authorities agreeing to those connections remaining. However, this does mean that when the hydrants are flushed the cost of the water used cannot be reclaimed from the water companies. This cost is currently estimated to be circa £20,000 per annum.

Operational risks that sit within the functional responsibilities of the Estates Department are identified through the E&F Operational Risk Register. These risks are separate from the Trust Risk Register and cover specific issues (rather than generalised) and enable appropriate prioritisation to be undertaken so the funding allocation is used to tackle the higher risks as a priority. This operational risk register also includes costed options which will allow any additional allocations received to be quickly utilised avoiding undue delay.

Further work within the Coronation Block has been undertaken but compliance with statutory requirements. The agreement with HFRS to allow the fracture clinic to maintain its current position at present remains but in the longer term this will need to be considered for relocation.

There are also, still, compliance issues within the Ward 2 block and Planned Investigation Unit (PIU) at SGH. These areas are some of the oldest buildings within the SGH footprint and were never designed for current fire requirements. The Trust was granted permission to utilise Ward 2 for a temporary SDEC area under the express restriction of no patients being housed overnight. This permission has now expired after the relocation of the SDEC area and so this area will no longer be able to be used for clinical use without further agreement from the Fire Authority.

3.2 Fire Safety Technical Group

The Fire Safety Technical Group (FSTG) has met regularly during 24/25 to review the detailed technical aspects in relation to fire safety management. It also considers and reviews compliance against the statutory provisions within the FSO and also the HTM fire safety documents. The FTSG will also consider requested derogations from HTM based on risk assessments. The group reports to the Health, Fire & Safety Group and allows the HFSG to oversee fire safety rather than get too detailed which could detract from other agenda items.

During the period of this report there have been topics such as the derogation process and the impact of the revised Regulation 38 requirements that have been escalated to the Health, Safety and Fire Group and to the EF& D Group Governance Group improve compliance and ensure that fire safety management is embedded within the processes operated within the Trust.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the higher groups when the Group meeting structures are finalised to enable issues to be escalated when appropriate.

3.3 Fire Safety Management Polices

The Trust has now appointed an Authorising Engineer (AE) for fire safety management and the first audit was undertaken by the AE in 23/24 which raised two significant issues. These issues were addressed and signed off in 24/25 and the second audit has not raised any further significant issues.

The audit report findings and action plan are reviewed as a standing agenda item by the FTSG with the EF& D Governance Group having overview with any issues escalated.

The overall fire safety management policy was reviewed during the period and minor amendments made. It should be noted that this was prior to the full Grenfell Inquiry report was published and the changes made (and being proposed) will mean that a further review may be required in the 25/26 period.

3.4 Management of Fire Risks

There are currently 163 active fire risk assessments covering the Trust and units which are currently being used by NLaG staff. This is an increase on the previous period due to the reactivation (or new assessment) for areas that were under capital development and also rezoning as part of the fire alarm system refurbishment at SGH. In addition, pre-occupancy assessments for the Community Diagnostic Centres (CDC) were added.

In addition, new requirements under the Building Safety Act and regulations now require fire risk assessments to be undertaken for whole buildings to be able to include communal areas such as corridors, general reception, and entrances etc.
There are 4 assessments which are overdue for review, and this will be completed within Q1. There are a further 37 assessments due for review in 25/26.
The current review periods for assessments are:

- In-patient areas - 12 months
- Out-patient areas - 24 months
- Admin areas - 36 months

The assessments are maintained on an electronic system which is cloud-based system containing a number of assessment types (service provided by Evotix) and updated by the Fire Safety Officers (FSO) and Fire Safety Manager (FSM). New areas such the new ED and SDEC projects have either had their initial assessments completed or will be undertaken in Q1 of 24/25. The previous assessments covering the areas prior to completion of these projects will have their assessments archived on the system.

3.5 Structural Fire Protection

Changes made to the FSO and the introduction of the Building Safety Act, implementation of the Fire Safety (England) Regulations (2022) have strengthened fire safety requirement particular in relation to residential premises (especially those over 18m in height).

Currently these changes are predominately aimed at residential blocks and there are more stringent requirements in relation to “high” residential buildings regarding fire door installation, inspection etc. However, the Government is consulting over the Grenfell Inquiry recommendations of which there are circa 50 which require a response

from the government. These are to be formally responded to in Q1 with strong hints that nearly all are expected to be accepted in full.

A significant change which occurred during 24/25 period was the amendments to the Regulation 38 requirements. These now specify that certain documents relating to fire safety must be in place and verified before any occupancy occurs within a refurbished area or new build. In addition, these documents must be in electronic format so that they are available to the fire brigade on request from the point of occupancy. A certificate of compliance must also be completed by the Principal Architect/Designer, the Principal Contractor and also the Client that the statutory requirements have been met. Declaring falsely that they have is also now classed as a criminal offence and individuals as well as organisations can be held accountable for wrongful completion.

As part of working across the Group the CAFM system specification is to go out to tender to determine if a system can be used across the two organisations for more consistency, compatibility of data and also to allow direct performance comparison for all sites within the Group. This project is expected to be completed within the 25/26 period and may extend to fire risk assessments etc if there are suitable modules within the system chosen.

3.6 Fire Doors Inspection & Maintenance

The maintenance of fire doors is important as they are potentially the weakest element within the strategy of fire compartmentation. Damage to the door or the architrave itself can mean the fire retaining properties of the door set are severely compromised. Fire doors when damaged beyond repair will be required to be replaced as a door set and this can cost the Trust between £3,000 to £6,000 per door set.

During the 24/25 period a business case was proposed for the establishment of an in-house team (3 wte) to undertake fire door inspections and repairs to an accredited standard (recognised by the fire brigade) to reduce the need to replace damaged doors if they could be repaired. The benefits of such a team would be that over a five-year programme there would be significant reductions in both capital and revenue costs and that after this period fire door compliance would be 100%.

This team would be trained to accredited and recognised standards to undertake inspections within NLaG and implement approved repairs to circa 85% of the current doors that failed their last inspection. Whilst identifying savings in relation to fire doors it would also enable the Trust to demonstrate compliance against statutory obligations and after 5 years would mean that the cost of maintaining the fire doors would be significantly lower than the current costs. The business case will be submitted as part of the 25/26 business planning process.

3.7 Fire Response Management

The FSO and HTM give requirements in relation to a response to an alarm activation require organisations to deal with the initial stages of fires and alarm activations without relying on the attendance of the fire services. There is a group wide review which will cover the 25/26 period looking to update training of fire wardens, identify gaps in provision of fire wardens and response in relation to staff roles. The method of recording the training and refresher intervals is also part of this work as well as any issues identified within the respective AE Audit Reports.

Regular drills are required to check the effectiveness of arrangements and review where further improvements can be made. However, HFRS recognise that it is extremely difficult to undertake live drills in clinical areas where patients are located (especially in those areas with overnight patients, immobile patients or those who are seriously ill). It is therefore agreed (with HFRS) that live top exercises will be undertaken areas including those areas which are subject to a different fire strategy than others (e.g. ITU areas). There will be feedback from these exercises to the Fire Safety Technical Group and any actions monitored via this group.

More details are also included in the sections below and timescales shown within the workplan attached in Appendix 2.

3.8 Fire Training

Face-to-face fire training is a requirement under the HTM and also the FSO requirements and the recently revised HTM 05-03 Part A has further emphasised that “periodic” fire safety training is required to be undertaken. The frequency and type of training is based on a Training Needs Analysis [TNA] but guidance is given within the HTM.

The HTM also identifies that face-to-face training for fire evacuation using evacuation equipment is the only appropriate method, also local induction within a staff members work area should also be face-to-face. In respect of e-learning the HTM acknowledges the usefulness of this type of training but stipulates that face-to face training by a competent person must be delivered every two years.

Discussions across the group has resulted in agreement that this frequency is to be adopted across the Group going into 25/26 and onwards. Also, the content of fire training for all levels (i.e. fire warden, response teams, incident manager etc.) is being reviewed with induction having already been reviewed and implemented.

General fire training will also include practical fire extinguisher training (as part of the requirement to ensure that there are sufficient persons at any one time who are able to use a fire extinguisher correctly.

During the 24/25 period there has been a significant increase in the percentage of those trained as the number of sessions being delivered continues to be increased in places offered. In addition, a more flexible approach for ad-hoc sessions can be offered due to the purchase of more training equipment so now equipment is available at all three sites allowing for training to be delivered on different sites at the same time.

The number of training sessions for face-to-face training is calculated using the records of those who will come out of compliance in the next 12 months. A safety factor to allow for non-attenders has been implemented so that over 1300 additional places are available for staff to access.

The fire training compliance for the 24-25 period is included in Table 2 below.

Period	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
% staff trained	80	79	78	84	84	91*	77**	75	83

Table 2 - Fire Training Compliance

* - no face-to-face training

** face to face training reintroduced

As shown in Table 2 there has been an improvement on the training completed by staff. However,

The training requirements themselves will need to be reviewed as the HTM documents covering fire safety are being updated and re-issued. There is also an additional HTM which is dedicated to training requirements that had been issued at the time if compiling this report. The whole training programme will therefore be reviewed and adjustments made as part of the 25/26 work programme.

3.9 Fire Alarm Activations and Unwanted Fire Signals

The definition of an Unwanted Fire Signal (UwFS) from the Chief Fire Officers Association (CFOA) is:

where an alarm activation causes a requirement for the local fire & rescue services to attend the organisation's premises un-necessarily and which impacts on the fire cover for the local population potentially putting lives at risk.

These are not fire alarm activations which is the AFD system is triggered via a sensor or manual call point. Whilst there may a large number of false alarms the number of UwFS should be reduced to the lowest level possible. If the Fire Authority identify that efforts are not being made to reduce this then they can take action in the form of an enforcement notice and also submit a charge for the attendance of each tender and admin costs. For NLaG this would amount to circa £1500 per attendance. However,

the Trust has 24 hour “call filtering” in place where there is a six-minute delay to determine if there is a significant fire or whether it is a false alarm. This means that the actual number of attendances by the brigade is reduced and therefore fire cover for the rest of the town/area is not compromised.

The Trust has (to date) never received an invoice for attendance of the fire brigade, but this has occurred at other NHS Trusts within England.

The UwFS incident at Goole was classed as “good intent” in that a roof void sensor activated but there was no fire and communication were made with HFRS with a stop call. However, the brigade decided to attend the site to check that were issues.

The Trust uses a “call filtering” system whereby HFRS are not called for the first 5-6 mins of an alarm activation so a check can be made to determine if the activation was a false alarm. In the 24/25 there was a total of 257 alarm activations which only resulted in 11 UwFS and despite an increase on the previous report this shows the effectiveness of the call filtering system (and response by staff and the security team). If there was no such system in place, then the cost of charges would be in excess of £260,000.

UwFS Calls on a rolling fiscal year.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
SGH	3	7	4	3	10	10	7	7	1	2	3
DPOW	4	9	8	9	8	17	3	9	1	5	7
GDH	0	0	2	2	0	1	0	0	2*	2	1*
Total	7	16	14	14	18	28	10	16	4	9	11

Table 3 - UwFS for NLaG

* Classed as “good intent” but HFRS attended despite “stop” call

There were a further 5 activations that would have been classed as UwFS but stop calls by switchboard were made in time to prevent attendance. In relation as a percentage of total activations the UwFS is 4.2% of activations and is considerably lower than the fire authority guidelines for enforcement intervention (i.e. Fire Protection Association (FPA) guidance is no more than one UwFS per 20 detectors)

In relation to the number of alarm activations there were 257 (compared to 329 for the same period last year). The breakdown of the alarm activations is seen in Figure 2 below for this reporting period and in Figure 3 for the previous year.

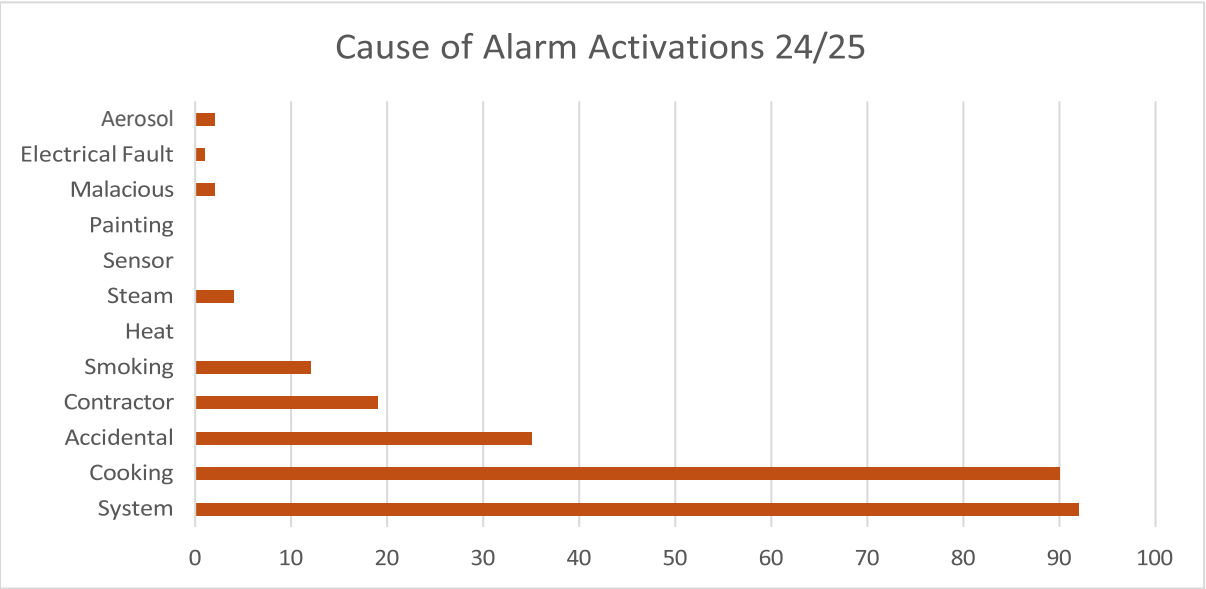

Figure 2 - Breakdown of activations 24/25

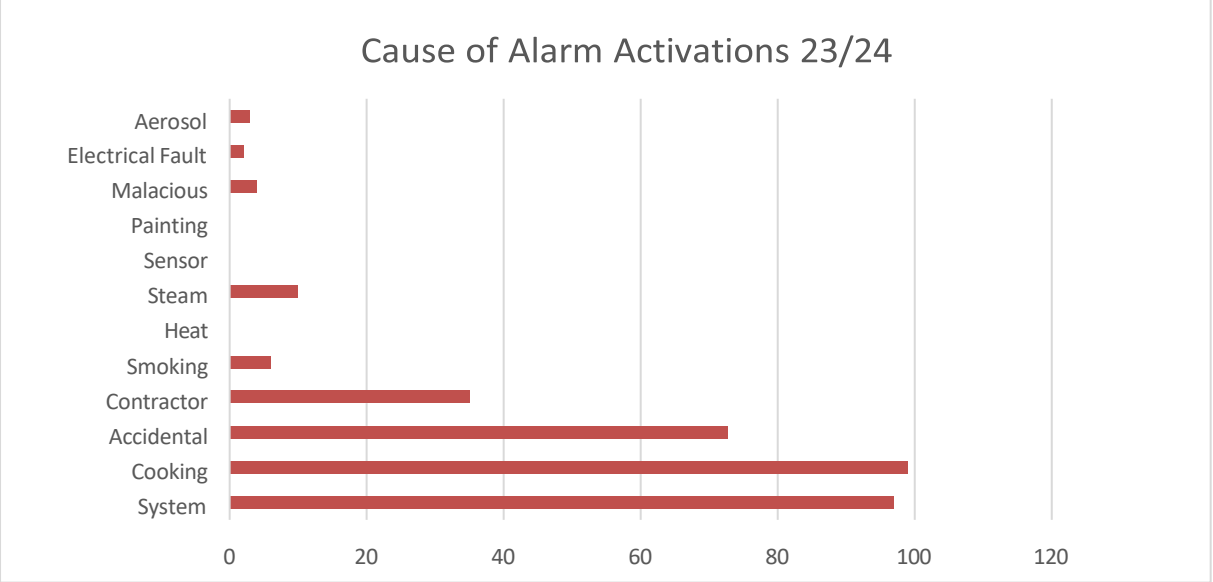

Figure 3 - Breakdown of activations 23/24

Comparing the activations with 22/23 (see Figure 3 above) it can be seen that cooking is now the highest cause of alarm activation across NLaG. Given the replacement of systems at DPOW and SGH the reduction in activations due to system faults it is not surprising to see such a fall and it is anticipated that this trend will continue in 24/25 as the full effect of the new AFD system at SGH is seen.

The comparison of “cooking” alarm activations compared to 23/24 is shown in Fig 4.

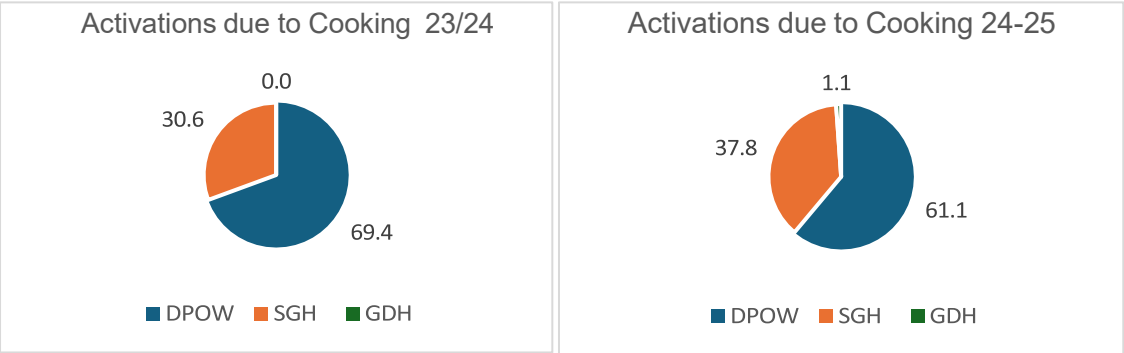

Figure 4 - Activations due to cooking

The other highest category is accidental activations and work undertaken in 24/25 has resulted in a positive downwards trend with a circa. 50% less activation than in the previous year. Work to reduce these activations will continue in 25/26.

From Figure 4 three causes of alarm activations account for 80% of all activations of which two have already been discussed above. The number of system faults is linked to the replacement programme for SGH and 24/25 should see a reduction in this category.

3.10 Enforcement Activities by Local Fire Authorities

There has been no enforcement action undertaken by HFRS in respect of fire safety within NLaG premises. There have been a number of physical audits by the Fire Authority at all three sites with no items of concern raised. Minor issues were raised in relation to improving signage and ensuring that risk assessments are reviewed at appropriate periods. All of the issues have either been completed or included within the work programme outlined in Appendix 2.

In respect of neighbouring Trusts an enforcement notice was served Louth Hospital in November 2024. The issues identified in the notice as needing development were in relation to:-

- Fire risk assessments.
- Resources for planning and organising for fire safety management.
- Keeping emergency exit routes clear
- Procedures for dealing with fire safety management.
- Maintenance of fire-fighting equipment
- Provision of information to employees

3.11 Capital Investment

As GDH's system is similar in age to that of the old SGH system more monitoring is now in place to consider any increase in system faults which signifies a deterioration in performance. Whilst a small increase in the average number of system faults was

identified this would NOT indicate any potential immediate risk of the system failing. However, funding is likely to be required in the next two – three years given the age and that the system is obsolete with respect to replacement parts.

To reduce the consequences of a panel failure a number of alarm panels from the SGH system were kept when replacing the SGH alarm system but this is a small number and once exhausted further panel failures could result in areas of the hospital not being covered by the system. The significance of the this is that is a legal requirement for a L1 fire alarm system within a hospital otherwise fire watchers would be required 24 hours per day within all areas to keep the hospital open.

Issues such as fire stopping have received limited funding, but it is noted that fire authorities in other areas have identified this as an issue and given the issues identified in Grenfell regarding fire migration this is an area that needs to be addressed going forward.

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As GDH's system is similar in age to that of the old SGH system more monitoring is now in place to consider any increase in system faults which signifies a deterioration in performance. Whilst a small increase in the average number of system faults was identified this would NOT indicate any potential immediate risk of the system failing. However, funding is likely to be required in the next two – three years given the age and that the system is obsolete with respect to replacement parts. A number of alarm panels from the SGH system are kept as spares but once these are used up there will be no ability to source parts should a panel fail. The significance of the this is that is a legal requirement for a L1 fire alarm system within a hospital otherwise fire watchers would be required 24 hours per day within all areas to keep the hospital open.

Issues such as fire stopping have received limited funding, but it is noted that fire authorities in other areas have identified this as an issue and given the issues identified in Grenfell regarding fire migration this is an area that needs to be addressed going forward.

3.12 Actual Fires Recorded

There were no actual fires recorded for NLaG for the period of this report. However, work continues on a national level in relation to the storage of Lithium-ion batteries due to the potential consequences of a Li-ion fire within any hospital main building.

4.0 Work Plan for 25/26

The workplan for the next period (25/26) is attached in Appendix 2. It should be noted that this workplan may be further developed and added to after the next AE(Fire) audit depending on the findings and action plan developed. In addition, as the

various parts of the revised HTM documents for fire are issued the action plan will be reviewed and addition items added where appropriate.

5.0 Conclusions & Recommendations

Management of fire safety within NLaG and in the wider Group context is an ongoing development and the workplan shown in Appendix 2 gives more detail on the various elements that need to be further developed. The level of capital investment in fire safety is at a precedent high and it should be recognised for this level of investment and demonstrates how important fire safety is considered within NLaG and the Group as a whole.

The appointment of an AE(Fire) further demonstrates the Trust's approach to fire safety and was in place before the HTM requirements to appoint an independent expert to assist on fire safety management. The move to appoint the same AE (Fire) across the Group is a further positive step in aligning fire safety management, a consistent approach, and improvements to protect patients, staff, and visitors alike.

The recommendations of this report are:-

- Review the revised HTM regarding fire training and revised training content appropriately to implement within HHP.
- Increase the number of fire wardens across the Trust to ensure that there is adequate cover.
- Review and update those fire risk assessments which are due to be reviewed within the 25/26 period.
- Work collaboratively with the HUTH fire teams to adopt a more consistent approach to fire safety management across the group where practicable.
- Consider further capital funding to undertake a complete fire stopping and rectify issues especially to restore 60 min fire compartment lines.

Author:

Bill Parkinson

Associate Director of Safety and Statutory Compliance

Appendix 1 – Annual Fire Safety Statement

ANNUAL FIRE STATEMENT FOR PERIOD – April 2024 – March 2025		
I confirm that for the period 1st April 2024 to 31st March 2025, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)		
1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment (see appendix 2)	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A
* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action predating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail : bill.parkinson@nhs.net	Date:
Chief Executive	Name: Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
None
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred, and additional costs required to comply.
None
NB Statement to be retained for external fire authority audits.

As a Foundation Trust annual fire safety statements are not required to be submitted to the Department of Health & Social Care. However, the completion of an annual statement signed off by the Trust Board is seen as good practice and allows the Board to gain assurance in relation to fire safety that adequate systems and controls are in place to reduce the risk of fire within the Trust premises.

Appendix 2

2025/26 Work Plan for Fire Safety Management

Item	Area	Task / Objective	HUTH/ NLAG Or HHP	Target Dates	Completed/Progress
Review of Policies					
1.1	Review fire safety management policies and guidance with revised HTM 05 suite of documents and 24/25 AE. Potential scope for Group documents to be considered	• Review new training HTM requirements. • AE Action plan arising from 25 audit. • Update AE Audit action plan for policy requirements. • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	HHP HHP HHP HHP HHP	December 2025 July 2025 July 2025 May 2025 July 2025	**In progress** **In progress** **In progress** **In progress** **In progress**
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• Arrange operational plan review visit (annual) • Fire audits with HFRS. • Complete any actions arising from HFRS audits	HHP HHP HHP	August 2025 March 2026 March 2026	**In progress** **In progress** **In progress**
1.3	Review Technical Fire Safety Terms of Reference after 12 months of operational meetings	• Ensure FSTG continues to develop and review technical fire safety issues. • Schedule meetings for 25/26 period	NLaG NLaG	March 2026 April 2025	**In Progress** **Completed**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within HTM • Complete draft annual report for consultation • Finalise annual report and send to CIC PEF for information • Approval by Trust Board	HHP HHP HHP HHP	April 2025 May 2025 June 2025 July 2025	**Completed** **Completed** **In progress** **In progress**

Fire Training					
2.1	Review annually face-to-face training content for delivery of fire lecture	• Revise training presentation and content in light of new HTM. • Highlight reports on fire training attendance	HHP HHP	May 2025 Ongoing from July 2025	**In progress** **In progress**
2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Increase number of fire wardens per area • Maintain register of fire wardens • Review and revise fire warden training content. • Implement recruitment campaign for fire wardens.	HHP HHP HHP HHP	March 2026 July 2025 July 2025 June 2025	**In progress** **In progress** **In progress** **In progress**
Fire Drills and Exercises					
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify priority areas where desktop exercises are required. • Engage with fire wardens training scenarios for clinical areas requiring desktop exercises. • Implement series of desktop exercises	HHP HHP HHP	July 2025 March 2026 June 2025	**In progress** **In progress**
Fire Alarm Tests					
4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Review with AE (Fire) alarm testing strategy and notification processes. • Review MCP testing programme to ensure that all MCP undergo testing	HHP HHP	July 2025 March 2026	**In progress**
Fire Action Plans					
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Audit areas to ensure fire action plans are in place and updated. • Red fire boxes to be installed in each area	HHP NLaG	March 2026 March 2026	**Ongoing** **In progress**
5.2	Fire safety response kits should be developed and rolled out to each area	• Identify fire response kit contents and supply sources. • Roll out response kits to all areas where identified.	NLaG NLaG	March 2026 March 2026	**In progress**

Fire Strategy Development					
6.1	Work with HUTH to align fire safety management principles	• Review training content across both organisations to align so more transferable workforce resources. • Review general safety management policies across both organisations and standardise where appropriate. • Review fire inspection processes across the organisations to determine if single process can be applied. • Review reporting process and format of reports to determine if standard report can be utilised for Group performance on fire safety management	HHP HHP HHP HHP	July 2025 September 2025 December 2025 July 2025	**In progress** **In progress** **In progress** **In progress**
6.2	Development of fire strategy to improve fire safety across the Group	• Work with AE(fire) to ensure that fire safety strategy is appropriate for all areas with regards to HTM revisions • Fire strategy drawings to be drawn up on MiCad. • Undertake fire stopping surveys and ensure appropriate fire stopping in place. • Use MiCad or new CAFM system to develop appropriate “layers” of information to enable fire strategy drawings to be available to all areas. • Update and maintain fire risk assessments in-line with fire safety policy. • Continue and further develop working relationship with HFRS to avoid enforcement action.	HHP NLaG HHP HHP HHP HHP	March 2026 March 2026 March 2026 March 2026 March 2026 March 2026	**In progress** **In progress** **Capital funding allocation.** **Tender stage reached.** **In progress** **In progress**

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)193

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9th October 2025
Director Lead	Tom Myers – Group Director of Estates Facilities and Development
Contact Officer / Author	Bill Parkinson – Associate Director of Safety & Statutory Compliance (NLAG), Head of integrated Safety Services (HUTH)
Title of Report	Group Annual Security Report
Executive Summary	Each partner organisation produces its own annual security report to satisfy their statutory obligations. There are differences in terms of the information given and the structure of security management within the two organisations. Some recommendations are made after considering the two reports to assist in the development of a Group Strategy across both organisations.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Performance, Estates and Finance CiC Health, Fire and Safety Group NLAG Health, Fire and Safety Group HUTH
Financial Implication(s) (if applicable)	Patient watches at HUTH
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:

NHS
Humber Health
Partnership

Directorate of Estates, Facilities & Development

Annual Security Reports

1st April 2024 to 31st March 2025

Combined Executive Summary

This executive summary is formulated from the two reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Each partner organisation produces its own annual security report to satisfy their statutory obligations.

However, to assist those working across the Group this executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to security management across the Group.

There are differences in terms of the information given and the structure of security management within the two organisations. Some recommendations are made after considering the two reports to assist in the development of a Group Strategy across both organisations.

Both partner organisations have in the recent past undertaken work to upgrade their surveillance systems and build in the capacity to switch control of the CCTV system to an alternative site should the need arise. These upgrades will increase the reliability and image quality of the systems and give better opportunities to pursue perpetrators and provide evidential quality for the police and crown prosecution services for their investigations and court cases.

Key Points

1. The responsibilities and structure differ in that in HUTH all security management elements are within the same section whilst at NLaG operational security management sits within Facilities (as in HUTH) but the security management strategy sits within the Statutory Compliance functions through the appointment of a Local Security Management Specialist (LSMS) allowing a degree of independence and development of a security strategy, as well as an auditing function without conflicts of interest. Recruitment of a Security Manager/LSMS has commenced with the post expected to be implemented during 25/26 although the current structures will remain until the Directorate restructure is completed.

2. There is a significant difference across the organisations regarding relating to patients who may be at risk of self-harm. At NLaG there are only a few occasions where a patient watcher is considered as required and this is requested through the operational teams. At HUTH the enhanced care team undertake a risk assessment and request a level 5 patient watch through the security provider and is recharged to the area the patient is located. Training for De-escalation Management & Intervention (DMI) training has previously

been provided to staff to reduce the need for level 5 patient watches but this funding has not been renewed and therefore the financial cost relating to patient watches at HUTH is a significant issue as well as security contractors providing a clinical patient watch service. The funding of DMI training for staff to enable appropriate clinical staff to undertake this service would be more beneficial for patients as well as reduce costs being incurred presently.

3. The level of incidents in each organisation is comparable given the crime profile across the areas involved. There has been an increase in the number of incidents across the group although the majority of incidents on the north side are reported by the security staff whilst on the south side are via the staff. Incidents on the north side are recorded as one of three categories; malicious; non-malicious or unknown. A larger number of categories are used to be able to identify incidents such as sexual assaults etc. The categories used should be reviewed to ensure that they are consistent and allow direct comparisons across the sites.

4. Lone working devices are used across the group however due to the level of community services provided on the south side the number used is significantly higher. The take up of these devices is concerning as both organisations are trying to increase the usage. During the period of this report the average usage has increase by circa 15% but this still leaves 70% of the devices are not being used but with the Care Group are paying for and have been identified as a control measure within the lone worker risk assessment. This system will, should the need arise, result in a quicker response then dialling 999 and therefore device usage should be reviewed to determine if there are still required and active take up encouraged. If this approach fails then more steps may need to be considered to ensure that the organisation discharges it's statutory obligations as well as individual employees.

5. The enactment of Martyn's Law occurred at in March 2025 and there is a two year implementation period. However, detailed guidance for the NHS on implementing the requirements is still awaited and the impact on both HUTH & NLaG will be significant and widespread in terms of training/awareness for staff at all levels, physical reviews of sites and installation of systems and measures to reduce risks for large public venues including hospitals.

6. During the 25/26 period work will be undertaken in relation to the reviewing of security and car parking services provided across both organisations and the development of a Group wide specification for the provision of these services which will then allow the Group to move towards a single provider.

The above points and recommendations are made to ensure that adequate assurance can continue to be given, and more consistent detail is contained within future reports for each partner organisation and the group.

Bill Parkinson

Associate Director of Safety & Statutory Compliance

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)194

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 9th October 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 23rd July and Wednesday 27th August 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 27th August and Wednesday 24th September 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 23rd July 2025 at 09:00 to 12:30 in The Nightingale Room, Scunthorpe General Hospital

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) – (Virtual)
David Sulch	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Simon Nearney	Group Chief People Officer
Laura Treadgold	Non-Executive Director (HUTH) – (Virtual)
Sue Liburd	Non-Executive Director (NLaG)
Murray MacDonald	Non-Executive Director and Vice Chair
Heather McNair	Interim Group Chief Nurse

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement
Lucy Vere	Group Director of Learning and Organisational Development
Elizabeth Houchin	Freedom to Speak Up Guardian (NLaG) – (items 4.3.1 and 4.3.2)
Michela Littlewood	Deputy Director of Nursing Quality – (item 3.1)

Observers:

Robert Pickersgill	Public Governor (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 Committees in Common Chair welcomed those present to the meeting. Apologies were noted for Fran Moverley, Freedom to Speak Up Guardian (HUTH), Leah Coneyworth, Head of Quality Compliance.

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 25th June 2025**

The minutes of the meeting held on 25th June 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

No matters were arising.

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 shared positive progress regarding the Band 2/3 support workers. Unison negotiators had accepted the offer and would recommend that NLaG accept the offer. It was expected that the HUTH negotiators would propose the offer to the Unison branch in two weeks and if agreed it would be recommended to the members to accept it.

Simon Nearney and Dr Kate Wood had emailed both LNC's regarding the rates of pay for additional hours that resident doctors and consultants would be paid during industrial action. HUTH had responded in writing and although were not fully contented with the rate of pay, they had agreed to undertake the additional hours. Simon had a telephone conversation with NLaG LNC chair and they were in the same position as HUTH LNC.

Dr Kate Wood updated that all identified required shifts were currently covered during the industrial action period with the exception of ED and general surgery on the North Bank, but it was anticipated that they would be filled prior to the industrial action starting. Unfortunately some elective activity would have to be cancelled, which could have an impact on cancer services.

David Sulch queried whether the resident doctors had given indication that they would participate in the industrial action. Paul Bunyan shared that a tool was launched this week which enabled resident doctors to share whether they planned to work over the industrial action period and 201 resident doctors (13% of resident doctors) had already confirmed they would be working.

Heather McNair updated that the Group were reviewing band 5 job descriptions against the national profiles which have recently been published. There was a steering group to ensure consistency across Yorkshire and Humber which agreed to three operational workstreams and would be divided into community, mental health and acute. The steering group would meet again in September 2025 to review the band 5 profile. The Royal College of Nursing (RCN) were supportive of band 5 nurses to be uplifted to a band 6 within a year of competency which would

potentially pose a significant financial challenge for the Group should this be the agreed interpretation of the profiles.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Tony Curry asked for an update around holiday planning which was contributing to a demand on agency workers. Simon Nearney clarified that discussions were taking place around medical cover and the number of doctors on duty during holiday periods which was impacting on agency spend. Dr Caroline Hibbert and Dr Nick Cross were leading on this work. Both had raised the matter with Chiefs of Service and would continue to hold senior medics to account for adhering to the medical annual leave policy. Simon Nearney confirmed that the challenge was not around the policy or process, but rather around compliance and managers and medical staff not adhering to minimum cover.

Dr Kate Wood shared that impact on service delivery would be expected during staff shortages and emphasised the importance of forward planning. Simon Nearney mentioned that regular communication was essential to manage this.

3. RISK & ASSURANCE

3.1 CQC Actions Group Progress Report

Michela Littlewood provided an update. Task and Finish Groups have been established and chaired by the North and South Medical Directors to support the ongoing actions for the End of Life (EOL) training for medical staff, challenges in surgery due to medical records and training compliance. Restraint training in ED had progressed and the South Director of Nursing was leading on that work. An updated CQC Actions Group report would be presented at Quality & Safety CiC on 24 July 2025. Lucy Vere shared that she would pick up the compliance issues to find out what was happening from a system point of view.

Michela Littlewood noted challenges around working in different organisations and aligning compliance systematically. Dr Kate Wood clarified that this was now resolved at a national level from 01 May 2025 and training records would move across.

The CiC requested knowledge around timescales of the plans from the Task and Finish Groups and how quickly those plans would impact mandatory training compliance. Michela Littlewood clarified that the Task and Finish Groups were developed to provide rapid improvement work within the next 3 months. She advised that further work was required to review unrecorded compliance and recognised that the Group were in a challenged position as training did not align. Lucy Vere recognised the challenges in encouraging staff to attend their training and there was only so much that the Group could do.

Murray MacDonald noted that NLaG had not improved any red actions since December 2024. Dr Kate Wood explained that the Group had trialled several unsuccessful strategies and were taking a different approach. Murray MacDonald noted that there was confusion around training being mandated but not classed as mandatory. Simon Nearney shared that the statutory mandatory training was in an overall positive position, but he also shared his frustration at this matter not being progressed by service managers.

Sue Liburd wondered whether the Task and Finish Groups would review work around what was deemed to be mandatory and non-mandatory training.
Michela Littlewood explained that the Task and Finish Groups expected to generate actions to support this. She mentioned that the Group had been under-resourced for 5 months and had recently recruited band 8a to start in September 2025 which would support with progressing the CQC actions.

Action: A report to come back to a future WEC CiC that clearly articulates progress to date, clear plans and actions under scrutiny following the Task and Finish Groups.

Lucy Vere shared that a mandatory learning steering group was in place with a focus on decision-making and the Group were expected to be more stringent. A culture shift was critical to support improving compliance which would take time to be carried out. Heather McNair updated that the Group had recently recruited a Director of Patient Safety and Quality which was expected to support with this.

Heather McNair, Dr Kate Wood and Simon Nearney left the meeting at 09:58 hours.

Michela Littlewood left the meeting at 09:58 hours.

Action: Lucy Vere to provide a further report regarding the locally mandated training as opposed to mandatory training.

The Committees-in-Common gave no assurance for this item due to the degree of challenge and the requirement for detailed plans to come back to this CiC for scrutiny.

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

4.2 **Workforce Integrated Performance Report**

The Agenda was taken out of order at this point.

Paul Bunyan updated that the Workforce Transformation Programme aimed to achieve a reduction in agency spend by 30% in 2025/26. The Group were currently in Month 3 of the programme delivery and were £2.2 million below plan. Eleven key areas were identified within the Group that did not provide adequate traction. Workforce transformation teams would work with Care Groups to identify drivers for using agency spend and actions to try and address. A procurement exercise was undertaken around agency provider provision and Retinue were appointed as the Group agency provider and Locums Nest as the provider of bank.

This would be implemented on 04 August 2025 and was expected to provide an opportunity for the Group to negotiate a reduction in rates. The internal governance process around agency spend, and mechanisms including roster efficiencies and staffing levels would be reviewed. There was a focus on living within our means and the Group would explore an internal agency cap to utilise finances and reduce agency spend. Discussions were ongoing around strengthening data in relation to BAME staff and the Group hiring, leaver and promotional processes against the established workforce were being reviewed.

Dr Kate Wood rejoined the meeting at 10:10 hours.

Lucy Vere shared that an inclusive recruitment project group was in progress to review career progression and recruitment. Succession planning and talent development would commence in Q3 as part of the Putting People First programme. A paper would be presented at Remuneration Committee around short-term succession planning at an executive level and a more detailed, longer term succession planning paper would come to a future WEC CiC following this.

Julie Beilby shared concerns around metrics within the report and noted that appointing metrics were missing targets. Paul Bunyan explained that there had been resource constraints due to sickness but the team were now back on track. He noted the challenges between June to August as this was the recruitment period for doctors and also challenges with resident doctors rotation. Metrics regarding general staffing and time taken to interview would be monitored and a further update would be included in the next report.

Action: Paul Bunyan to include an update on metrics around general staffing and the time taken to interview in the next IPR report.

Tony Curry noted the long-term challenge at NLaG in recruiting consultants and wondered whether the workforce succession model provided an opportunity. Paul Bunyan explained that the established workforce was dependent on each specialty and conversations were ongoing with Chiefs of Service and Care Groups. Dr Kate Wood shared that the Group monitored all locum consultants that did not have Certificate of Completion of Training (CCT) on a quarterly basis through Financial Planning Improvement Board, and support was provided to these colleagues to either be moved to work towards their CCT equivalence, consider appointment to a Specialist or Specialty and Associate Specialist (SAS) role – but not to be employed on long term contracts without a clear plan.

Tony Curry queried the reasons why BAME candidates were less successful through the recruitment process. Lucy Vere highlighted that this was due to structured processes not being followed. There was an opportunity to implement talent pools however the Group would need to define the behaviours and expectations from staff. She reported that a mindset shift of staff would be required to break down the barriers currently being displayed.

Heather McNair re-joined the meeting at 10:27 hours.

Julie Beilby noted that sickness absence relating to mental health and psychiatric illness was disproportionately high.

4.1 **Group Registered Nursing & Midwifery Staffing**

The Agenda returned to order at this point.

Heather McNair highlighted that there was a gap in ward to board assurance due to absence of quality metrics and a dashboard. There was no change in care hours per patient day (CHPPD), NLaG remained in the upper quartile and HUTH in the lower quartile. Unregistered staff, sickness and turnover remained significantly high across the Group. A recruitment and retention lead nurse was now in place with a main focus on registered staffing, however work was required to review unregistered staffing.

Paul Bunyan shared that other organisations utilised agency for unregistered staffing and the Group did not.

Julie Beilby asked for further clarity around who the ask for additional resources was aimed at and noted that it was not clear where it was picked up within the financial planning. Heather McNair explained that key areas of focus for investment were for ED and the 13th Floor. She noted that £800k was spent which was in the run rate but not budgeted. There was a disconnect between staffing-related items reported through Financial Planning Improvement Board and planned investment. This would be presented to Boards-in-Common in August 2025 to understand the financial implications.

Simon Nearney re-joined the meeting at 10:37 hours.

David Sulch wondered what the impact on Nursing Staffing would be if the No Criteria to Reside (NCTR) patients were utilised across other wards. Heather McNair explained that NCTR patients were currently utilised across other wards however there was a challenge regarding the 13th Floor model as there was no therapy input.

Julie Beilby queried whether Goole could provide step-down accommodation for No Criteria to Reside (NCTR) patients. Heather McNair explained that this was being explored however there was a difference in the risk appetite within community. There was a high volume of step-down beds within the community which could not be utilised due to staffing levels not being optimised.

There was an opportunity for the Group to utilise the capacity of newly qualified registrants for both Nursing and Midwifery.

Heather McNair mentioned that there were 4 further investment papers that the CiC did not have oversight on. She shared that there was a maternity business case which was essential to ensure compliance in Clinical Negligence Scheme for Trusts (CNST) and Maternity Incentive Scheme (MIS) year 7 and this would be presented to Boards-in-Common in August 2025. Dr Kate Wood shared that there were business cases relating to neo-natal nursing and medical staffing which would be presented to Quality and Safety CiC in July 2025 regarding continuing to provide services in obstetrics, gynaecology and paediatrics. There were further medical staffing business cases regarding rota compliance in obstetrics and gynaecology at NLaG and HUTH. Heather McNair updated that discussions had taken place around potential options for neonatal unit delivery. There was also a risk highlighted regarding no obstetric cover overnight in the tertiary unit at HUTH due to staffing constraints.

The biggest risk within midwifery and nursing was the turnover of unregistered nursing however this was being managed. 200 newly qualified nurses would be recruited across the Group in the Summer 2025 and the Group expected over-

establishment.

Murray MacDonald wondered whether the Group required broader visibility on the medical staffing workforce which indicated whether the workforce model was right sized for the Group. Julie Beilby highlighted the risk of this getting fragmented between discussions and emphasised the importance of the Group ensuring mutli-disciplinary consideration at Boards-in-Common through the budget setting process, and in doing so commented that there was a fixed financial envelope within which priorities had to be evaluated. Julie Beilby asked if the Executive team had a considered view on the asks in this and other papers. Dr Kate Wood advised not at this stage.

The CiC identified that the Group were unaware of the current and required workforce levels. Simon Nearney proposed a base set of data could be provided for assurance alongside additional professional lead input.

Action: Dr Kate Wood and Paul Bunyan to review with Andy Gratrix how to articulate the medical staffing workforce areas that require focus and improvement and provide an update to the CiC.

Action: Simon Nearney to provide the CiC with a base set of medical workforce data and Dr Kate Wood to a provide professional narrative on the medical perspective.

The Committees-in-Common noted that this paper was shared for discussion and did not require an assurance rating.

4.6 **Medical Revalidation / Responsible Officer Annual Report – HUTH and NLaG**

4.6.1 **Medical Revalidation / Responsible Officer Annual Report – HUTH**

The Agenda was taken out of order at this point.

Dr Kate Wood shared that a long-term shortage of medical appraisers within HUTH was identified. 100 of 868 doctors did not have a medical appraiser which was in breach of statutory regulations however an approved business case was currently in the process of being implemented to resolve this. 90 doctors had unapproved missed appraisals due to an insufficient number of appraisers. Dr Kate Wood mentioned that the GMC were asked whether the Group could amend those appraisals as ‘approved missed appraisals’ due it being an organisational fault rather than individual fault, however they declined.

The other key area of focus for 2026 would look at enabling case investigators and case managers to fulfil responsibilities through the MHPS which was currently a key gap.

David Sulch wondered whether there was an opportunity for NLaG appraisers to assess HUTH staff. Dr Kate Wood confirmed that this option was explored however it was not possible due the risk of destabilising current processes in place in NLaG. She raised concerns that a revalidation had to be deferred for some doctors at HUTH due to the insufficient number of appraisers. All appraisals took place between March and December at NLaG and there were plans to consider this implementation at HUTH also.

David Sulch queried the ability for the Group to hire private appraisers on an ad-

hoc basis. Dr Kate Wood explained that the Group had recruited recently-retired people to undertake 20-30 appraisals per year.

Julie Beilby noted the statement around the Group remaining in risk of non-compliance with Responsible Officers regulations until actions were implemented and queried whether the Group were compliant. Dr Kate Wood explained that the Group would be compliant if the actions were implemented. There was a focus on compliance with a robust plan and a funded business case in place. This paper would be presented to the next Boards-in-Common for sign off by the Chair.

Sue Liburd queried whether there was a reputational or safety risk in terms of individuals not being revalidated or compliant in their mandatory training. Dr Kate Wood explained that discussions had taken place with the Responsible Officer and General Medical Council (GMC) and work was ongoing to review the contracts as the terms and conditions were not clearly articulated. She noted that the GMC did not deem statutory training as a requirement for revalidation and the Group would consider local mandatory training.

The Committees-in-Common agreed limited assurance for this item.

4.6.2 **Medical Revalidation / Responsible Officer Annual Report – NLaG**

Dr Kate Wood updated that historically there had been a shortage of medical appraisers and this had been resolved. There were 5 of 499 doctors who had unapproved missed appraisals. She highlighted that although medical staff at NLaG were paid to complete their statutory and mandatory training there did not appear to be a significant increase in compliance.

The Committees-in-Common agreed reasonable assurance for this item.

5.3 **Monthly Job Planning Update Report**

Dr Kate Wood shared that job planning licenses had to be moved across from one organisation to the other to enable Care Groups oversight of both individual Trusts, however the Group faced challenges with contract licensing due to restrictions in increasing the number of licenses and job plans required to be processed manually to allow the job plan to be moved between HUTH and NLaG. She noted that the process was still ongoing and new contract negotiations would be reviewed in the future with the company providing the job planning software. A BI report was established which would enable the Group to access a live dashboard. Work was ongoing to align a unified job planning policy across the Group. Discussions were ongoing with Chiefs of Service and all Care Groups to achieve 90% job planning compliance by October 2025. Dr Caroline Hibbert and Dr Nick Cross would meet with Care Groups on a fortnightly basis to obtain information and hold them accountable. The Group had been unable to provide challenge or oversight on the processes due to ongoing challenges which had delayed the journey by 12-14 months.

David Sulch wondered whether a job planning policy would be in place for 2026. Dr Kate Wood explained that the Group hoped to implement the job planning policy by October 2025 and discussions were taking place to review further support that was available to progress this.

Julie Beilby noted the variance and queried whether there were blockages in compliance. Dr Kate Wood explained that the reporting was still in its early phases

with some areas showing 0% compliance – this was not necessarily due to not having their job plans signed off, but in some circumstances may be due to the job plan having been transposed from HUTH to NLaG (or vice versa) and therefore has had to be manually transcribed and not yet 're-signed' by the individual doctor. She advised the CiC to give Care Groups the opportunity to have sight of the dashboard and work through these challenges. Julie Beilby highlighted that the Group would be required to work differently if the significant step change was not made by October 2025 and asked that the future monthly reports were clearly marked for discussion, not information.

Liz Houchin joined the meeting at 11:46 hours

Action: Karena Groom to amend the Workplan for Monthly Job Planning reports to come to the WEC CiC for discussion.

Dr Kate Wood left the meeting at 11:53 hours.

4.3 **Freedom to Speak Up Quarterly Report – HUTH and NLaG**

4.3.1 **Freedom to Speak Up Quarter 1 Report 2025/26 - HUTH**

The Agenda returned to order at this point.

Elizabeth Houchin provided an update on the Quarter 1 position for HUTH. She shared that 68 cases were raised during Quarter 1 which was a 10% increase in comparison to Quarter 1 in 2024/25 and had decreased by 11% since Quarter 4. There were no anonymous concerns raised. Top reasons for speaking up included Information Governance issues, pay and contractual concerns, time off work, secondment concerns, flexible working, and inappropriate behaviours. There was a mixture of behaviours from peers and senior staff. The top 3 groups were admin and clerical, nursing and midwifery, and additional clinical services and AHPs. Corporate continued to be the highest Care Group reported.

Sue Liburd queried whether there was a trend of particular behaviours. Elizabeth Houchin shared that rude behaviour, incivility and toxic cultures were highlighted as issues but Simon Nearney assured the CiC that there were no trend patterns of behaviours seen. Regular meetings were taking place between the FTSUGs and HR to ensure that should any trends appear, then they would not be tolerated.

The Committees-in-Common agreed significant assurance for this item.

4.3.2 **Freedom to Speak Up Quarter 1 Report 2025/26 – NLaG**

Elizabeth Houchin shared that 122 concerns were raised in Quarter 1 at NLaG which was an increase in comparison to 96 concerns raised in 2024/25. This included one group of 9 staff members and 10 separate staff members from the same department who had raised the same concerns individually. Only one concern was raised anonymously and NLaG had seen a downward trend in the amount of anonymous concerns raised. 14% of cases were closed on the same day following advice and signposting. The main themes were around worker safety, HR processes and inappropriate behaviours. There were also environmental concerns raised regarding hot offices and wards. A concern raised around HR processes was in relation to whether the recruitment process had been followed in line with policy and it was revealed that the processes had been followed appropriately. Work was ongoing within the Care Group to resolve this

internal issue. Inappropriate behaviours raised were mainly colleague on colleague with some inappropriate behaviours from managers. The top 3 groups were nursing and midwifery, additional clinical sciences, and admin and clerical. Over 50% of concerns raised included an element of worker safety which appeared to be a main theme over the last 9 months.

Sue Liburd noted that the National Guardian Office had completed a review of the speaking up experiences of overseas-trained workers and wondered whether the gap analysis undertaken by the FTSUGs would feed into the work the Organisational Development team had commenced. Elizabeth Houchin confirmed this and shared that the Group were awaiting feedback from EDI Leads and the findings would return to a future WEC CiC.

The Committees-in-Common agreed significant assurance for this item.

Liz Houchin left the meeting at 12:03 hours.

4.4 **Modern Slavery Statement: Final Version**

The Committees-in-Common noted that the final version of the Modern Slavery Statement answered all the questions that the CiC had asked in the previous meeting and reflected the changes to be made.

The Committees-in-Common endorsed the report for Boards-in-Common approval.

4.5 **Staff-on-Staff Assaults**

Paul Bunyan shared that the Group had reviewed staff survey, Datix and HR casework metrics and there were no concerns identified.

The Committees-in-Common noted that this paper was shared for information and did not require an assurance rating.

Paul Bunyan left the meeting at 12:06 hours.

5. ITEMS FOR INFORMATION

5.1 **Workplan**

David Sharif shared that there were several items that required adjustment for frequency on the Workplan and noted a previous discussion around a reduction in the frequency of the WEC CiC meetings. David Sulch proposed a reduced frequency for WEC CiC meetings going forward and noted that the CiC should consider preparing for longer meetings if the frequency changed.

David Sharif mentioned that WEC CiC receive several reports for information and suggested adapting the agenda to accommodate those.
Tony Curry wondered whether certain agenda items could be discussed annually or by exception.

Julie Beilby expressed concerns around reducing the frequency of WEC CiC meetings at this point in time due to the current level of scrutiny the Group were under. She further noted that the challenge provided by the NEDs may need to be undertaken in a different way moving forward.

It was agreed that the meeting Chairs would review the agendas in greater detail at the agenda set meetings going forward and the workplan would be updated in time for the next agenda set meeting.

5.2 **Workforce Transformation Group Minutes**

This was shared for information.

5.4 **Organisational Development Quarterly Report - Q4 2024/25**

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:

- Resident Doctors strike, the Group were standing elective activity down which could impact on cancer patients
- CQC outstanding actions – Task and Finish Groups were being established. The CIC were not assured and requested further detailed plans. Nursing/Midwifery/Obstetrics workforce discrepancies were discussed. Investment papers would be presented to the next Board meeting.
- Annual leave performance issues were being reviewed by Dr Caroline Hibbert and the Care Groups.
- IPR - Agency and medical staffing reduction required.
- BAME recruitment discussions were ongoing.
- Non-compliance in the Medical revalidation position for HUTH but a funded plan was in place.
- Job Planning – concerns over compliance. A plan was in place to achieve 90% compliance by October 2025 to be closely monitored.
- Significant assurance was provided for FTSU.
- Modern Slavery statement endorsed for Board Approval.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 27th August 2025 at 9am till 12:30pm, in The Boardroom, Castle Hill Hospital

The Committee Chair closed the meeting at 12:24 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					
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y					
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y					
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D								
Heather McNair	Interim Group Chief Nurse					Y	D	Y					
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y					
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y					
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y					
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y					
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	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, 27th August 2025 at 09:00 to 12:30 in The Boardroom, Castle Hill Hospital

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) – (Virtual)
Dr Kate Wood	Group Chief Medical Officer
Simon Nearney	Group Chief People Officer
Sue Liburd	Non-Executive Director (NLaG)
Jo Ledger	Deputy Chief Nurse (Attending for Group Chief Nurse) (Virtual)

In Attendance:

Rebecca Thompson	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
Dr Elizabeth Evans	Guardian of Safe Working Hours (NLaG) (item 4.2.1)
Myles Howell	Director of Communications and Engagement (item 4.1) (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 Committees in Common Chair welcomed those present to the meeting. Apologies were noted for Amanda Stanford, Group Chief Nurse, and Laura Treadgold, Non-Executive Director (HUTH), Murray MacDonald, Non-Executive Director and Vice Chair.

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.

1.4 **To approve the minutes of the meeting held on 23rd July 2025**

The minutes of the meeting held on 23rd July 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

Julie Beilby queried what the roadmap looked like on resourcing within Nursing and Midwifery. Simon Nearney stated that safer staffing was reviewed twice a year and a paper would be presented to WEC CiC with the findings, and if required it would be presented to the Board-in-Common in terms of issues, risks or investment. He continued that due to changes that had taken place within the Executive team, there was a delay in the paper being presented to the Boards-in-Common as Amanda Stanford was briefing Lyn Simpson regarding the significant investment proposed.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

Dr Kate Wood mentioned the timescale on the action around CQC reporting and wondered whether it could wait until October 2025 to be presented at WEC CiC. Julie Beilby shared that CQC was discussed in multiple forums and rather than bring this back to WEC CiC prematurely, the CiC expected to see improvement by October 2025.

Lucy Vere noted that the Group were focusing on compliance and the national drive was to move to assessment of competency. Further work would be undertaken to review compliance and a further update would come to a future WEC CiC.

1.7 **Urgent and Emerging Issues**

Simon Nearney updated that Unison had agreed the offer for the Band 2/3 healthcare support workers. A further meeting with Unison would take place to confirm a collective agreement with Trade Unions and no challenges were expected. This would enable the Group to implement the new pay with effect from October 2025 and backpay was expected to commence following this.

Tony Curry wondered the impact this would have on staff. Simon Nearney clarified that the majority of staff welcomed the approach, hence staff voting in favour of in Unisons ballot and it was included in the financial plan.

Dr Kate Wood shared that positive discussions continued with the NLaG Consultants regarding WLI and emergency pay rates. On-call shifts were covered appropriately however the Group were awaiting the Executive team to confirm they were happy with the wording around a revised offer for the out of hours on-call payment which needed to be tied in with rapidity behind rota change. If agreed, it would be offered to NLaG Consultants with an aim for resolution.

Sue Liburd queried whether there was any impact on staff following the various demonstrations that had taken place over the weekend regarding race and asylum.

Simon Nearney explained that he was unaware of any negative impact and the feedback provided by staff was positive.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework: including Risk Register Report

David Sharif provided an update on the Board Assurance Framework (BAF). The current risk score under the category of 'People' remained the same at 20. Together with an upwards trajectory and assumption that the actions would complete, a lower score of 12 was expected towards the end of 2030. The People risk focused on the potential challenge for the Group not to embed compassionate and inspirational leadership in the Organisation. He noted that actions were ongoing to address the gaps, controls and assurance in place, particularly recruitment drives and wellbeing platform for staff which were rated as significant.

Julie Beilby mentioned that although the risk was high and work was ongoing, the perceived instability within the senior leadership team was unhelpful.

The Committees-in-Common approved the Board Assurance Framework.

David Sharif shared an update on the Risk Register Report. Further work was required to raise the profile, particularly at Care Group directorate level. The Group were yet to establish manageable risk reporting from Executives on a Group-wide basis. The risks highlighted challenges around low levels of staffing and mandatory training, particularly for Acute and Medicine. He mentioned that work was ongoing to raise the quality of the high-level reporting with an aim to compliment the BAF.

Tony Curry queried whether the risk level was too low around specialist cancer support services under-resourcing at NLaG, noting the current Group position for cancer.

Action: David Sharif to circulate a briefing around the risk score for Specialist Cancer and Support Services and the CiC would review this at the next meeting.

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

<u>Joint Business Items</u>

4.1 **National Quarterly Pulse Survey Q1 & Q2 Report**

Myles Howell joined the meeting at 09:43 hours.

Simon Nearney shared that the pulse quarterly survey received notoriously lower completion rates than the national survey, which revealed 2k staff at HUTH and 1.2k staff at NLaG had completed the survey. Results from HUTH revealed that staff engagement, motivation, and advocacy scores had increased. Results from NLaG revealed that staff engagement and advocacy scores had increased, however motivation scores had decreased. The national average results for overall staff engagement had reduced. Although further work was required, the Group had halted the decline and had made some very small improvements, against the context of decline seen at national level.

Results showed the Trust scores, but also an insight to which corporate services and Care Groups were performing well and not. Simon Nearney shared that this fed into the work ongoing with Care Groups. There was a focus on culture transformation and these results would be shared in the next round of performance meetings taking place with the Care Groups. Actions were being progressed with a focus on improving engagement and communication, staff wellbeing, reward and key foundations. Myles Howell updated that Care Group engagement was positive and score cards that were developed by the Care Groups would be presented to WEC CiC alongside the cultural update.

Sue Liburd queried whether there was intelligence captured from staff regarding how to improve confidence in working within the Group. She wondered whether there was a unique factor to the Groups workplace culture or if national fragility was at play. Myles Howell confirmed that the Group had a knowledge of intelligence. He highlighted that feedback from the staff survey revealed three main themes around communication, engagement and psychological safety. The results revealed that staff felt disengaged from the Group leadership and felt unsafe to raise concerns. There was a focus to improve the concerns and ensure staff felt safe to raise concerns and Care Groups were working to enhance the data. Myles Howell noted that the NHS was challenged nationally and the national average had never been so low. National financial challenges had attributed to decreased staff working morale, however the Group remained at a slight upwards trajectory which was encouraging despite the ongoing challenges.

Simon Nearney shared that feedback from many staff via the staff survey revealed that staff felt they were not able to make improvements in their roles. The Group had a QI methodology, but further conversations would take place with the Executives and Care Groups to review how to enhance and further support transformation.

David Sulch queried whether the Group had further support in place for the site team and whether there was evidence that they were under pressure. Simon Nearney mentioned that although sickness absence had increased across the board, the Group were in a healthy position at 4.6% in comparison to other organisations.

The HRI emergency department was highlighted as a particular area of concern, prompting the deployment of the major trauma management team to provide additional support and management oversight which would allow targeted focus with an aim to improve the position and service in ED.

The CiC discussed the significant pressure to reduce costs and the challenge of engaging staff in transformation efforts. Simon Nearney shared that whilst staff were engaged, there was concern that Care Groups lacked the time and resources to think creatively about the future of the Group and implement meaningful transformation. This posed a risk to the future work around the survey. He emphasised the importance of a greater focus on transformation to support Care Groups to have conversations around the future of the Group.
Lucy Vere shared that further discussions were ongoing to determine the impact on transformation and how that translated against the pulse survey.

Sue Liburd queried whether the Group were making progress and on track. Simon Nearney shared that the data from the survey suggested that the Group had halted the decline. In the face of such significant challenges, the Group had plans in place and were implementing them, so were heading in the right direction however it was crucial that the Care Group leaders felt supported and united as one senior leadership team with the Executives in order to fulfil their obligations.

Julie Beilby shared that the financial restraints taking place across the NHS was an organisational shock. She observed the pockets of culture with staff who were previously comfortable with their roles now being pushed to improve performance which would cause discomfort and resistance and potentially a decline in working morale.

David Sulch highlighted that the Groups standstill given the scale of change and financial challenge was impressive.

Dr Elizabeth Evans joined the meeting at 10:21 hours.

The Committees-in-Common agreed reasonable assurance, noting that the Group had haltered the decline, bucking the national downwards trend, and were three months into the five-year programme.

4.2 **Guardian of Safe Working Hours Quarter 1 Report – HUTH & NLaG**

4.2.1 **Guardian of Safe Working Hours Quarter 1 Report – NLAG**

Dr Elizabeth Evans updated that the rate of exception reporting was higher than expected however the pattern was similar in comparison to previous years. Most exception reports related to excess hours. The ratio of immediate safety concerns against the number of exception reports remained the same which suggested that people used the system effectively. The highest rates of exception reports were submitted by Grade F1 level and were in diabetes, endocrinology, gastroenterology and general medicine. There was a lack of engagement from the educational supervisors however the system was expected to change in a few weeks and their involvement to review reports would no longer be required.

Targeted interventions were implemented in Medicine following the GMC survey however it was too soon to ascertain whether improvements were made. The changes to the contract expected to provide differences in the levels of reporting. Doctors had raised concerns that they were discouraged from the exception reporting however communication was made with the doctors to address this.

Sue Liburd noted that it felt the Group were better resourced in NLaG than at HUTH. Dr Elizabeth Evans acknowledged that NLaG were better resourced due to

having fewer doctors and two PAs in comparison to having one PA at HUTH, however she expected that this would change from September 2025 when the admin team would support with closing the exception reports and NLaG would reduce to one PA.

Sue Liburd queried cardiology training at Scunthorpe General Hospital (SGH) being discontinued and wondered whether the Group should be concerned about patient safety given the increase in Never Events. Dr Kate Wood confirmed that this linkage with Never Events was not a specific factor. She explained that there was an ongoing challenge with cardiology trainee doctors and the Group needed to ensure there was a cardiology presence on the SGH site however it had been a difficult balance to strive.

Simon Nearney left the meeting at 10:32 hours.

The Committees-in-Common agreed reasonable assurance.

Dr Elizabeth Evans left the meeting at 10:34 hours.

4.2.2 **Guardian of Safe Working Hours Quarter 1 Report – HUTH**

Dr Kate Wood took the report as read, and invited any questions. None were forthcoming.

The Committees-in-Common agreed reasonable assurance.

Simon Nearney re-joined the meeting at 10:41 hours.

4.3 **Job Planning Monthly Update**

Dr Kate Wood updated that job planning compliance had increased by 11% since the update provided at the previous meeting in July 2025. The Group had a current target to achieve 90% job planning compliance by end of October 2025. She demonstrated the live job planning dashboard which extracts data from the Allocate system where job plans were held. The dashboard would enable the Care Groups understand what was taking place within their specialties. It provided an overview of percentages of expired job plans (greater than 12 months of the previous job plan), job plans due to expire, and the percentage of medical staff that have never had a job plan.

Dr Kate Wood explained that when reviewing the dashboard, combining the percentages of current performance and ‘never had a job plan’ would provide the Group with an indication of whether meeting the compliance target was achievable. The Group expected to meet the compliance target and further improvement within job planning was expected.

Tony Curry queried whether the software licensing was site-specific. It was confirmed that the software licensing was sovereign-based. Work was ongoing with the Care Groups to ensure the software licensing issues resolved.

Julie Beilby queried the significant effort it would take to transition from an expired job plan to a new job plan. Dr Kate Wood explained that it was dependent on what was taking place within that individuals Care Group. She noted that the work ongoing to meet the 90% compliance target and planning for 2026/27 would provide the Group with a better understanding of available capacity.

Simon Nearney left the meeting at 10:59 hours.

Tony Curry queried how long it would take to translate a 'never had a job plan' into a job plan. Dr Kate Wood explained that the process of signing off the job plan would now take 15 minutes. She highlighted that the process had taken significant time to due to individuals needing to undertake a manual data input.

Tony Curry queried the higher number of PAs used at NLaG in comparison to the number used at HUTH and wondered whether a level of negotiation was required. Dr Kate Wood clarified that job plans in NLaG reflected the work that was undertaken and if there was a higher volume of PAs used it was due to a service-need.

Julie Beilby mentioned that a conversation took place at the Governors meeting around mandatory training at NLaG not being covered under job plans. Dr Kate Wood explained that the Group were in active negotiation with Union colleagues around a unified job planning policy, however there was a challenge around statutory and mandatory training. A paper was presented to Group Executives on 26 August 2025 and support was provided to bring negotiations around statutory and mandatory training to a close.

David Sharif shared that an email would be circulated to the Governors to clarify the use of SPA, once wording was confirmed.

Simon Nearney re-joined the meeting at 11:18 hours.

Julie Beilby queried whether progress was made since 15 August 2025. Dr Kate Wood shared that there was a 1% increase seen since last week and attributed the slow progress due to the peak holiday-season.

Julie Beilby wondered how many Care Groups fell into the category of not expecting to achieve 90% sign off by October 2025. Dr Kate Wood shared that it was solely Family Services that had said this at this stage as they provided the least confident assurance that they had a grip and understanding on their position. She assured that the granular level of data that was being monitored on a weekly basis would provide a better insight.

The Committees-in-Common agreed that the report would be accepted for information however it would come back to future meetings for assurance.

Action: Karena Groom to amend the workplan for the job planning monthly update to come to WEC CiC for assurance.

4.4 **Learning & Organisational Development Update: August 2025**

Lucy Vere took the report as read and highlighted that her teams in year one of the people strategy were focusing on learning, leadership and talent framework, reviewing Group values and how to reduce instability.

Leadership Essentials was consistently fully booked and the Group were reviewing options to increase capacity. The Group piloted a leadership programme with 18 participants which reviewed what was working well across the Group however a further review would take place to see whether it met current business needs. The Group planned to relaunch Putting People First with a new design by December

2025 following conversations with Operations and Finance Leads. Discussions were ongoing with Sarah Tedford and Adam Creeggan to establish further support for the Operations teams during this process.

200 people were scheduled to partake in the 'Braver than Before' programme which would focus on psychological safety and supporting nursing teams, and if successful, the Group would review the outcome of the programme to understand the impact on areas of engagement scores. A new Group Agenda for Change (AFC) appraisal was launched which was still in the pilot phase and feedback would be reviewed every month.

Organisational Development (OD) interventions were concentrated in Family Services, Cardiovascular, and Theatres and Critical Care, with a mix of restorative and transformational work. The OD team use approaches such as restorative practice to address interpersonal and cultural issues, tracking outcomes through staff surveys scores.

The CiC noted that they were not sighted through the report on the impact of the work that was taking place. Lucy Vere explained that translating the work taking place into fundamental standards improvements was a challenge.

Julie Beilby wondered whether there would be benefit in monitoring metrics on performance from teams particularly in key areas that were under scrutiny. Lucy Vere confirmed that the Group undertook this process for leadership programmes, however it was time-intensive.

Lucy Vere shared that the Group were facing significant reductions in OD and learning. The Group had lost two full-time senior OD practitioners and would either need to restrict the reactive work or the number of taught sessions taking place. Work around organisational change was expected to increase practitioner capacity. Conversations would take place with HR Business Partners and Care Groups to review prioritisation. Continued Professional Development (CPD) funding would be utilised to support Nurses and AHPs in the meantime however the impact of the true capacity would become more apparent from 01 April 2026 when that funding ends.

Simon Nearney noted that there were current pressures due to high levels of employee tribunals and sickness absence.

Dr Kate Wood wondered whether the income associated with the simulation team could be utilised or expanded. Lucy Vere clarified that the Group were exploring further options around income support. She noted that a skills gap in the simulation team was identified and work was ongoing to review putting support in place to develop those skills.

Julie Beilby wondered whether the quarterly update report was required on a six-monthly basis which would enable a greater chance for direction of travel on outcomes and provide assurance on the strategic objectives that were set.

Action: Lucy Vere and Simon Nearney will bring a revised report to a future WEC CiC which will focus on core priorities of OD and the benefits gained.

The Committees-in-Common agreed that assurance was not required at this stage.

4.5 **EDI Steering Group Time Out Update**

Lucy Vere shared that Amanda Stanford and Ivan McConnell were co-Chairs of the EDI Steering Group meeting, however changes within their job roles had caused an impact on progress made with the EDI Steering Group re-design. A dedicated session would take place next week to review the Terms of Reference and determine what was required from the EDI Steering Group. She mentioned that further work was required around health inequalities. A recommendation paper would be presented to a further WEC CiC following the dedicated session.

Dr Kate Wood acknowledged that health inequalities differed significantly in comparison to EDI and emphasised the importance of differentiating between them to avoid overlapping.

It was confirmed that health inequalities would be separated and monitored separately through Strategic Programmes and Partnership CiC.

Julie Beilby emphasised the importance of ensuring the CiC did not overstep Governance boundaries around the direction of the EDI Steering Group.

4.6 **People Data Triangulation Discussion Paper**

Lucy Vere shared that developing a cultural dashboard on a wider-level provided a challenge due to the inability of obtaining access to multiple data sources. She mentioned that the NLaG Anaesthetics team had the lowest engagement scores, however she was unable to review this effectively without having access to other data streams. Lucy Vere wondered how the Group would explore a cultural dashboard and what the NEDs required in terms of data triangulation.

Simon Nearney noted that not having adequate access to data was labour-intensive and at a time when the Group were reducing corporate resources, this could not be done.

Julie Beilby wondered whether the Group were making the best opportunity to understand staffing metrics sitting under key metrics on performance that the Group were being judged on.

Tony Curry wondered whether there were key metrics that the Group could obtain or any specific questions they could ask around data that would provide useful insight.

David Sharif shared that Adam Creeggan was developing score cards which would enable the Group to see metrics alongside each other from a performance and quality perspective. He suggested seeing what that looked like in practice. A paper that was presented to Audit, Risk and Governance CiC regarding this would be circulated to the WEC CiC for information following this meeting.

Sue Liburd emphasised the importance of seeing a correlation analysis which would address the contributing factors of what was taking place. David Sharif surmised that the data available tended to be the externally required data rather than the internal operational management data that reveals the true situation.

David Sharif left the meeting at 12:27 hours.

Dr Kate Wood left the meeting at 12:28 hours.

David Sulch noted that the Executive and Operational teams were the people who needed to define the data that they wanted to see, and the CiC needed to ensure that people were reacting appropriately to that data.

Julie Beilby asked for assurance that the Executive teams were addressing cultural and people challenges that played a part in quality and performance. Simon Nearney confirmed that the Executive team were asking the appropriate questions and conversations were taking place on a regular basis in the Care Group accountability meetings, however it was a challenge as improving sickness or engagement does not necessarily lead to performance improvements. Those improvements would clearly help but the challenges, may be process or system issues or with external partners if you were looking at patient flow. It was agreed that the CiC would continue with the information it currently receives, Executives would continue to triangulate and progress matters and the position would be reviewed as BI improved across the Group.

Tony Curry left the meeting at 12:32 hours.

5. ITEMS FOR INFORMATION

5.1 Workplan

Action: Julie and Tony to have a discussion around the Workplan outside of this meeting.

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:

- Job planning compliance had improved by 11% and plans were in place.
- Learning Organisational work was ongoing to support the Care Groups despite the reduction of staff in the OD team.
- Band 2/3 support workers agreed the pay offer.
- Positive discussions continued with the NLaG Consultants.
- WEC CiC will receive monthly assurance updates around job planning.
- The EDI Steering Group ToR would be presented to a future WEC CiC once agreed.
- The triangulation of data.
- Medical staff mandatory training compliance.

- The Group had halted the decline in the quarterly pulse survey results. Reasonable assurance was given in comparison with the national picture.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 24th September 2025 at 9am till 12:30pm, in The Boardroom, Diana, Princess of Wales Hospital, Grimsby.

The Committee Chair closed the meeting at 12:38 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				
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y	Y				
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y				
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D				D				
Heather McNair	Interim Group Chief Nurse					Y	D	Y					
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y	Y				
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y	Y				
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y	Y				
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y	N				
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y	Y	Y	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)195

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	09 October 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 One Report (Doctors and Dentists in Training) Hull University Teaching Hospitals NHS Trust (HUTH) – 01 April 2025 to 30 June 2025**
Executive Summary	This is the quarterly report for HUTH which details the number of exception reports, along with the reasons behind them and details the fines imposed for contract breeches. <u>Exception reports:</u> 45 exception reports submitted over the quarter, with the highest number (16) submitted by F1 trainees. Exception reports were submitted for a variety of reasons with the main reason being excess hours worked. Of the 45 exception reports, 31 were submitted due to excess hours worked, 12 due to rota working pattern, and 2 due to support received by the service. There was no educational exception reports submitted. <u>Fines:</u> 28 fines were issued over the quarter, a higher-than-average number due to a backlog from the previous quarter. The fines totaled £32,244.26. Of the 28 fines issued, 25 were issued to Paediatric Surgery (£29,005.52), 1 issued to Plastic Surgery (£1638.26), 1 issued to Oncology (£1562.69), and 1 issued to Obstetrics and Gynaecology (£37.79). 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.

	e-Roster Rollout: Since the last Quarterly Report, work is ongoing with ENT and OMFS to implement them onto e-Roster. They are expected to be live on the system by the Q2 report. Trainee Doctor Fill Rate: Over the quarter, 94.0% of NHSE appointed doctor in training posts were filled, an increase from 92.9% last quarter. Immunology has a fill rate of 0% due to their establishment consisting of 1 doctor which NHSE were unable to recruit to. OMFS has a fill rate of 23.1% due to having an establishment of 10 Dental Core Trainees which is currently unfilled. However, from September all 10 posts are filled. Emergency Medicine is the department with the highest bank and agency usage over the quarter. Emergency Medicine has a fill rate of 88.8% due to NHSE vacancies and several 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 27 August 2025.
Financial implication(s) (if applicable)	The Guardian of Safe Working Hours Funds stands at £73,722.35 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 ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
(Doctors and Dentists in Training)
Quarter One - 01 April - 30 June 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 01 April 2025 to 30 June 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):	658.6 WTE
(establishment)	701 WTE
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.

There was one exception report flagged as an immediate safety concern this quarter. This report related to DME, and the resident doctor escalated their exception report due to the department being short staffed which they felt affected the prompt review of patients.

4. Exception Reports

There was a total of 45 exception reports (45 episodes) reported by doctors in training and locally employed doctors for this quarter. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

At a national level, several reforms to the Exception Reporting process for Resident Doctors are to be introduced in September 2025. Exception reporting is a process where a doctor covered by the 2016 Terms and Conditions can submit a report in circumstances where their actual work has varied from their published work schedule from either a training or an hours worked perspective.

- Previously doctors had up to 14 days to submit an exception report, this will now increase to up to 28 days from the date of the occurrence.

- Previously all exception reports were signed off by the doctor's supervisor whereas under the new provisions an exception report for overtime (2 hours or less) will be automatically granted as TOIL or payment depending on the doctor's preference. Exception reports for overtime (2 hours or more) are to be determined by a local process.
- Going forward all exception reports linked to training/education will be sent to Medical Education for approval rather than the supervisor.

In addition to above several "fines" have also been introduced

- £250 per resident doctor/per week in circumstances where the resident doctor is not given access to a e-Rota to report an exception
- £250 fine in circumstances where the response to the exception report is not completed within a 10-day time frame of receipt (rises to £500 per resident doctor/per week from 01 February 2026)
- £500 per proven information breach. The GOSW is now not able to discuss or share information relating to the exception report with the Resident Doctors supervisor without the consent of the Resident Doctor

Although NHSE have not yet released guidance to employers and system providers or updated the national terms and conditions of service, the Medical Staffing and Medical Education Teams are working closely with the Guardians of Safe Working (HUTH and NLaG) to review current processes with the aim of avoiding unnecessary fines in the future. This will be supported by communications and guidance being provided to current supervisors about the importance of ensuring Resident Doctors are able to leave on time to, where possible, avoid overtime claims going forward.

Paediatric Surgery and Oncology and Haematology had the highest number of exception reports submitted over the quarter.

Paediatric Surgery consistently have high numbers of exception reports submitted due to excess hours relating to non-resident on call shifts, where resident doctors are required to be resident to maintain patient safety. Oncology and Haematology has seen a rise in exception reports due to service support and excess hours, with sickness putting extra strain on the rota.

Table A: Exception reports (episodes) by department 01 April - 30 June 2025

Specialty (Where exception occurred)	**No. exceptions carried over**	**No. exceptions raised (episodes)**	**No. exceptions closed**	**No exceptions outstanding**
Accident and emergency	0	3	1	2
Cardio-thoracic surgery	1	1	1	1
General medicine	3	17	7	13
Medical oncology	1	8	2	7
Paediatric surgery	0	12	12	0
Trauma & Orthopaedic Surgery	0	1	0	1
Vascular Surgery	5	3	2	6
Total	**10**	**45**	**25**	**30**

Table B: Exception reports (episodes) by grade 01 April - 30 June 2025

Grade	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No. exceptions outstanding
FY1	5	16	3	18
FY2	1	7	5	3
CT/ST1&2	4	13	10	7
ST3+	0	9	7	2
Total	**10**	**45**	**25**	**30**

Table C: Exception reports (episodes) by rota 01 April - 30 June 2025

Rota	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
2021 Rota 15 - Gastro/Endo/Renal/ID	1	1	0
2024 Rota 121 - CT Surgery and Cardiology	1	1	0
2024 Rota 14 - DME	1	1	0
2024 Rota 23 - Surgery F1	3	2	1
2024 Rota 5 - Neuro/DME/Derm	1	1	0
2024 Rota 8 - Oncology and Haematology	8	2	6
2025 Rota 18 - Medicine F1	1	1	0
2025 Rota 18 - Medicine F1 - Chest	1	0	1
2025 Rota 18 - Medicine F1 - Oncology	4	0	4
2025 Rota 18B - Medicine F1 - Crit Care	1	0	1
2025 Rota 18B - Medicine F1 - Psychiatry	1	0	1
2025 Rota 4B- Medicine F1 Gastro	2	0	2
2024 Rota 134 - Orthopaedic/Orthogeri F2	1	0	1
2024 Rota 130 - NCTR / Gen Medicine	1	1	0
2024 Rota 2C - A&E SHO	3	1	2
2024 Rota 130 - NCTR & Gen Medicine	2	2	0
Rota 131 - NCTR & Gen Medicine	1	1	0
Rota 66 - Paediatric Surgery	12	12	0
Total	**45**	**26**	**19**

Table D: Exception reports (episodes) - response time 01 April - 30th June 2025

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	No. outstanding
FY1	1	0	2	13
FY2	2	2	1	2
CT/ST1-2	2	4	4	3
ST3+	5	0	2	2
Total	**10**	**6**	**9**	**20**

Work Schedule Reviews

Throughout the period 01 April to 30 June, the following rotas were under review, and the outcome of the organisational change process is listed below.

Care Group	Rota number	Stage of Consultation
N- Head and Neck	34	Implementation date: August 2025
S- Family Services	66	Pre-Consultation Planning
S- Specialist Medicine	9, 15	Implementation date: August 2025
S- Community, Frailty and Therapy	14	Implementation date: August 2025
S- Neuroscience Specialist Care	5	Implementation date: August 2025
N- Digestive Diseases	15	Implementation date: August 2025
S- Specialist Surgery	15	Implementation date: August 2025
S- Specialist Surgery	134, 135, 124b, 124a	Implementation date: August 2025
N- Digestive Diseases	124a	Implementation date: August 2025
N- Cardiovascular	124a	Implementation date: August 2025
S- Neuroscience Specialist Care	133	Implementation date: August 2025
N- Head and Neck	124b	Implementation date: August 2025
S- Family Services	124a	Implementation date: August 2025
N- Head and Neck	37	Implementation date: September 2025
N- Cardiovascular	121	Beginning stages of work schedule review
S- Specialist Medicine	121	Beginning stages of work schedule review
N- Specialists Cancer and Support Services	8	Beginning stages of work schedule review

5. Locum bookings 01 April - 30 June 2025

Table E – G: Bank 01 April - 30 June 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 'Remarkable 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 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.

Table H – J: Agency 01 April - 30 June 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 Site Medical Director.

The bank and agency locum data has been included at the end of this report.

Table K: Locum work carried out by doctors in training 01 April - 30 June 2025

The table represents the top 10 doctors in training that have worked the most additional hours/overtime and their base specialty.

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week
General Practice	F2	174	47:15
Emergency Medicine	F2	154.5	47:00
General Practice	F2	151	20:00
General Practice	ST3	137.5	40:00
General Practice	ST3	124	32:00
General Practice	F2	119.5	40:45
Vascular Surgery	ST1	111	47:00
Emergency Medicine	ST4	109	33:45
Emergency Medicine	F2	108	40:45
General Practice	ST2	100	46:15

6. 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 June 2025	% Filled March 2025
Academic, GP, Psych & Community	8	26	0	112	2	148	8	26.6	0	100.5	2.8	137.9	93.2%	91.5%
Acute Medicine	4	6	9	0	6	25	4	7	9	0	4.8	24.8	99.2%	76.2%
Anaesthetics	5	3	23	0	33	64	5	3	20.5	0	33.3	61.8	96.6%	99.7%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	100.0%	80.0%
Cardiology	3	2	1	1	8	15	3	2	1	0.8	12.2	19	126.7%	118.8%
Cardiothroacic Surgery	0	2	0	0	4	6	0	2	0	0	3	5	83.3%	82.9%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	100.0%	100.0%
Colorectal Surgery	10	0	1	0	2	13	10	0	1	0	1.6	12.6	96.9%	90.7%
Dermatology	1	0	0	1	0	2	1	0	0	0.8	0	1.8	90.0%	90.0%
Elderly Medicine	8	2	5	7	7	29	8	2	5	7	6	28	96.6%	97.1%
Emergency Medicine	0	12	13	6	17	48	0	12	12.3	4	14.3	42.6	88.8%	87.5%
Endocrinology	3	0	2	0	4	9	3	0	1	0	4	8	88.9%	97.8%
ENT	1	2	5	3	3	14	1	2	5	2.2	3	13.2	94.3%	94.3%
Gastroenterology	3	1	0	0	6	10	3	1	0	0	5.8	9.8	98.0%	98.5%
General Surgery	0	1	2	0	0	3	0	1	1	0	0	2	66.7%	100.0%
Haematology	4	0	1	0	5	10	4	0	0	0	4	8	80.0%	89.1%
Histopathology	0	0	5	0	2	7	0	0	2.6	0	2	4.6	65.7%	65.7%
Immunology	0	0	0	0	1	1	0	0	0	0	0	0	0.0%	0.0%
Infectious Diseases	2	0	1	2	8	13	2	0	1	2	7.3	12.3	94.6%	96.7%
Neuro-Rehab	0	0	0	2	0	2	0	0	0	2	0	2	100.0%	100.0%
Neurology	5	1	0	0	6	12	5	1	0	0	5.8	11.8	98.3%	86.7%
Neurosurgery	1	1	2	0	4	8	1	1	1.6	0	4	7.6	95.0%	93.8%
Obstetrics & Gynaecology	0	4	0	4	13	21	0	4.6	0	3.8	12.6	21	100.0%	94.1%
Oncology	1	3	1	4	11	20	1	3	1	4	9	18	90.0%	93.6%
Ophthalmology	1	1	2	0	4	8	1	1	2	0	4	8	100.0%	110.0%
Oral & Maxillofacial Surgery	0	0	10	0	3	13	0	0	0	0	3	3	23.1%	50.0%
Paediatric Neonatal Medicine	0	0	8	0	9	17	0	0	7.8	0	9	16.8	98.8%	81.4%
Paediatric Surgery	3	1	2	0	0	6	3	1	1.8	0	0	5.8	96.7%	93.3%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	100.0%	100.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	6	9	100.0%	100.0%
Paediatrics	3	5	14	0	17	39	3	5	9.6	0	17.1	34.7	89.0%	115.6%
Radiology	0	1	0	0	24	25	0	1	0	0	28.4	29.4	117.6%	99.0%
Renal Medicine	1	1	1	0	5	8	1	1	1	0	5.6	8.6	107.5%	96.4%
Respiratory Medicine	5	2	1	2	8	18	5	2.6	1	1.8	8	18.4	102.2%	89.0%
Rheumatology	3	1	0	2	2	8	2.6	1	0	2	1.8	7.4	92.5%	92.0%
Stroke Medicine	4	2	1	0	1	8	4	2	1	0	0	7	87.5%	0.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	5	3	1	8	17	94.4%	94.4%
Upper GI	10	0	2	0	3	15	10	0	1	0	2.6	13.6	90.7%	84.0%
Urology	1	3	3	0	3	10	1	3	2.3	0	3	9.3	93.0%	103.3%
Vascular Surgery	4	0	2	0	5	11	4	0	1.8	0	5	10.8	98.2%	98.3%
TOTAL	**96**	**88**	**124**	**149**	**244**	**701**	**95.6**	**90.8**	**98.3**	**133.9**	**240**	**658.6**	**94.0%**	**92.9%**

7. Fines

The 2016 Medical and Dental T&C's 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.

Table L: Summary of fines issued 01 April - 30 June 2025

28 fines were issued over the quarter, a higher-than-average number due to a backlog from the previous quarter. The fines totaled £32,244.26.

Of the 28 fines issued, 25 were issued to Paediatric Surgery (£29,005.52), 1 issued to Plastic Surgery (£1638.26), 1 to Oncology (£1562.69), and 1 to Obstetrics and Gynaecology (£37.79).

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 internal locum cover is being booked to support the roster and associated compliance.

<u>Steps taken to resolve issues:</u>

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 Rota 8 in Oncology and Haematology (F2 and CT) 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.

The Site Medical Director (North) and the Guardian of Safe Working, supported by the Medical Staffing Team, worked closely with Chiefs of Service to redesign existing rotas, consolidating these rotas into 5 new identical rotas. The new rotas incorporate a designated handover shift, staggered start and finish times, and multiple consecutive weeks of normal working days to enable resident doctors to take leave more easily. These changes have been implemented in August 2025.

Concerns around out of hours staffing within Cardiology were raised at the RDF in relation to out of hours staffing. The rotas are under review, pending further feedback, but hope to be live within the near future.

8. GOSW Funds Expenditure

Over the quarter, the GOSW funds have been used to purchase refreshments for resident doctors attending teachings within Medical Education, totalling £4,530.

All expenditure from the GOSW Funds is agreed at the Resident Doctors' Forum.

The RDF representatives have voted in favour of purchasing new furniture for two breakout rooms, funding an F1 attending a Society of Radiology Conference to present a poster, and funding between 30 – 50 places at a Hull based British Society of Emergency Radiology Conference taking place in November 2025. The total cost of these purchases will be provided once complete.

Table E – G: Bank 01 April - 30 June 2025

Locum Bookings (bank) by grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	113	33	886.9	299.5
F2	1887	630	19083.25	6488.24
CT/GPSTR/ST1-2	674	220	5621.57	2063.66
ST3+	1180	321	10112.75	2798.67
Total	3854	1204	35704.47	11650.07

Locum Bookings (bank) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Additional Resource	806	272	7540.5	2319.83
Annual Leave	30	15	180.25	128.17
Compassionate Leave	20	3	149	26
Maternity/Paternity Leave	54	16	617.5	198.58
Occupational Health	44	31	500.25	343
Sickness	398	123	3447.47	1274.17
Study Leave	11	3	78.25	32
Vacancy	2491	741	23191.25	7328.32
Total	3854	1204	35704.47	11650.07

Locum Bookings (bank) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Internal Medicine	100	23	829.67	220.17
Anaesthetics	24	0	123.25	0
Breast Surgery	1	0	3.5	0
Cardiology	31	5	418.25	53.25
Cardiothoracic Surgery	22	0	25	0
Colorectal	21	0	160.15	0
CT Surgery	15	0	122	0
Dental	9	0	112.5	0
Dermatology	1	0	12.25	0
Elderly Care	328	105	2903.9	1030.74
Emergency Medicine	1474	447	14330.5	4363.91
Endocrinology and Diabetes	18	4	118.25	41.5
ENT	99	38	1141.25	442.75
Gastroenterology	22	2	171.5	15.67
General Internal Medicine	151	42	1662.5	417.25
General Surgery	230	85	2162.75	767.08
Haematology	13	0	104	0
Infectious Diseases	44	15	446.5	152.5
Medical Oncology	30	0	218	0
Neonatal Medicine	22	13	249	169
Neurology	25	5	234.25	61.25
Neurosurgery	160	51	1590.5	566.5
Obstetrics & Gynaecology	151	36	1395	397.75
Oncology	25	18	258.5	177.5
Ophthalmology	10	0	96	0
Oral and Maxillofacial Surgery	175	123	1349.25	915
Paediatric Surgery	53	26	343.5	169
Paediatrics	70	20	589.5	197
Plastic Surgery	28	2	202.5	28.08
Radiology	3	0	14	0
Rehabilitation	7	7	56	56
Renal Medicine	19	3	158	36.75
Respiratory Medicine	17	9	208.5	110.5
Rheumatology	39	17	355.75	172
Stroke Medicine	66	5	555	45.92
Trauma & Orthopaedics	193	57	1721	579.25
Upper GI	34	0	204	0
Urology	67	36	627.25	361.25
Vascular Surgery	57	10	431.25	102.5
Total	3854	1204	35704.47	11650.07

Table H – J: Agency 01 April - 30 June 2025

Locum Bookings (agency) by grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	113	0	886.9	0
F2	1887	320	19083.25	3198.04
CT/GPSTR/ST1-2	674	0	5621.57	0
ST3+	1180	69	10112.75	723.76
Total	3854	389	35704.47	3921.8

Locum Bookings (agency) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Additional Resource	806	169	7540.5	1545.38
Annual Leave	30	0	180.25	0
Compassionate Leave	20	0	149	0
Maternity/Paternity Leave	54	17	617.5	202.26
Occupational Health	44	0	500.25	0
Sickness	398	8	3447.47	94.25
Study Leave	11	0	78.25	0
Vacancy	2491	195	23191.25	2079.91
Total	3854	389	35704.47	3921.8

Locum Bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Internal Medicine	100	0	829.67	0
Anaesthetics	24	0	123.25	0
Breast Surgery	1	0	3.5	0
Cardiology	31	0	418.25	0
Cardiothoracic Surgery	22	2	25	25
Colorectal	21	0	160.15	0
CT Surgery	15	0	122	0
Dental	9	0	112.5	0
Dermatology	1	0	12.25	0
Elderly Care	328	53	2903.9	607.5
Emergency Medicine	1474	210	14330.5	1931.29
Endocrinology and Diabetes	18	0	118.25	0
ENT	99	9	1141.25	83.25
Gastroenterology	22	0	171.5	0
General Internal Medicine	151	45	1662.5	517.5
General Surgery	230	42	2162.75	414.5
Haematology	13	0	104	0
Infectious Diseases	44	0	446.5	0
Medical Oncology	30	0	218	0
Neonatal Medicine	22	3	249	36.75
Neurology	25	0	234.25	0
Neurosurgery	160	13	1590.5	165.26
Obstetrics & Gynaecology	151	0	1395	0
Oncology	25	4	258.5	46.5
Ophthalmology	10	1	96	22
Oral and Maxillofacial Surgery	175	0	1349.25	0
Orthopaedics	2	0	9	0
Paediatric Surgery	53	0	343.5	0
Paediatrics	70	0	589.5	0
Plastic Surgery	28	0	202.5	0
Radiology	3	0	14	0
Rehabilitation	7	0	56	0
Renal Medicine	19	0	158	0
Respiratory Medicine	17	1	208.5	11.25
Rheumatology	39	0	355.75	0
Stroke Medicine	66	3	555	26
Trauma & Orthopaedics	191	3	1712	35
Upper GI	34	0	204	0
Urology	67	0	627.25	0
Vascular Surgery	57	0	431.25	0
Total	3854	389	35704.47	3921.8

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)195

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	09 October 2025
Director Lead	Dr Kate Wood, Group Chief Medical Director
Contact Officer/Author	Dr Liz Evans, Guardian of Safe Working Hours Helen Fitzpatrick, Admin for Guardian of Safe Working Hours
Title of the Report	**Guardian of Safe Working Hours Quarter One Report (Doctors and Dentists in Training) Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) – 01 April 2025 to 30 June 2025**
Executive Summary	This is the quarterly report for NLaG which details the number of exception reports, along with the reasons behind them and details the fines imposed for contract breeches. <u>Exception Reports:</u> 130 exception reports submitted over the quarter, with the highest number (81) submitted by F1 trainees. Exception reports were submitted for a variety of reasons with the main reason being excess hours worked. <u>Fines:</u> No fines issued over the quarter. There were six immediate safety concerns raised which have been escalated to the relevant departments, and no fines were imposed. The money accrued from previous fines has been spent appropriately following discussion with the Resident Doctors Forum. <u>Trainee Doctor Fill Rate:</u> There is information contained concerning locum spends and fill rates per department. The number of reports in this quarter is consistent with the preceding quarter. This is a higher rate of reporting than we would usually see at this time of year. It is unclear why this is the case. These reports have been actioned and closed as appropriate. Issues highlighted in the previous report regarding the working environment in medicine have been escalated to the Medical Director and a plan is in place in conjunction with PGME to try to resolve these issues.
Background Information and/or Supporting Document(s)	Doctors and Dentists in Training Terms and Conditions (England) 2016 – Available on NHS Employers website:

(if applicable)	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 27 August 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 ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Quarterly Report on Safe Working Hours
(Doctors and Dentists in Training)
Quarter One - 01 April 2025 to 30 June 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 01 April 2025 to 30 June 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):	198
(establishment)	242
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):	15 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 6 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 within Trauma and Orthopaedics and Medicine. The concerns have been raised across all sites within NLAG. The themes of these concerns include lack of service support and insufficient rota cover for resident doctors impacting safe service delivery. All issues have been escalated to the areas concerned and have been addressed appropriately.

4. Exception Reports

There have been a total of 130 exception reports received in this quarter. A similar number of reports were submitted within the preceding quarter. This is a higher number of reports than would usually be received. The reasons for this are unclear as the reports have been received from all areas of the hospital and for a variety of concerns. By far the most common reason for reporting is excess hours worked- this is usually the case as these seem to be the most common type of incident which is easily quantifiable.

Table A: Exception reports (episodes) by department

Specialty (Where exception occurred)	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
Accident and emergency	0	7	5	2
Acute Medicine	0	16	15	1
Anaesthetics	0	1	1	0
Cardiology	0	2	2	0
Diabetes & endocrinology	0	14	14	0
Gastroenterology	0	32	32	0
General medicine	4	21	19	6
General surgery	2	9	9	0
Geriatric medicine	0	2	2	0
Paediatrics	2	11	7	6
Respiratory Medicine	0	12	12	0
Trauma & Orthopaedic Surgery	2	3	5	0
Total	**10**	**130**	**123**	**15**

Table B: Exception reports (episodes) by grade

Grade	No. exceptions carried over	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
F1	5	81	81	5
F2	3	9	5	5
F2 (TG)	0	1	1	0
CT1	1	25	24	2
CT1 (TG)	0	1	1	0
CT2	0	1	1	0
ST1	0	1	1	0
ST3	0	2	1	1
ST4	0	1	1	0
ST5	1	8	7	2
Total	**10**	**130**	**123**	**15**

Table C: Exception reports (episodes) by rota

Rota	No. exceptions raised (episodes)	No. exceptions closed	No exceptions outstanding
AAU SGH Sept 2024	1	1	0
Acute SpD Rota DPoW	7	7	0
Acute SpD Rota SGH Jan 24	5	5	0
DPoW A&E FY2 ST1/2 1 in Feb 25	2	0	2
DPOW Gen Surg Junior April 25	10	10	0
DPOW Gen Surg Junior Dec 24	1	1	0
DPOW Medicine Acute FY2 CT1-2 Aug 23	11	11	0
DPOW Medicine FY1 FY2 April 25	62	57	3
DPOW Medicine FY1 FY2 December 24	1	1	0
DPOW Medicine IMT on 14 April 25	4	3	1
DPOW T&O ENT Junior Dec 24	3	3	0
SAS Rota A&E March 25	2	0	2
SGH A&E FY1 April 25	1	1	0
SGH Gen Med FY1 F2 April 25	10	10	0
SGH Gen Med FY1 F2 Dec 24	1	1	0
SGH Gen Med FY1 F2 Dec 23	3	3	0
SGH Med Rota IMT April 25	1	1	0
SGH Med Rota IMT Aug 24	1	1	0
SGH Paediatrics Junior March 25	8	1	7
SGH Paediatrics St4+ SAS Dr Loo LTFT 80%	4	4	0
SGH Paediatrics St5 LTFT 80% Dr Ahmed March 23	2	2	0
Total	**140**	**123**	**15**

(Note: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself. The figures shown above include the figures of safety concerns, in addition, number of reports raised includes reports carried over from the previous quarter).

The 2016 TCS 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 almost all of the reports received in this quarter were closed by the Guardian of Safe Working. It is likely that the updated TCS which are due to be released in September (see below) will remove the requirement for the educational supervisor to review the reports which will make the system more consistent across the group.

Table D: Exception reports (episodes) - response time

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in 7+ days	Outstanding
F1	38	43	12	2
F2	3	2	8	7
CT1	11	12	2	1
CT2	1	0	0	0
ST1	0	1	0	0
ST3	0	0	2	0
ST4	0	0	1	0
ST5	0	0	7	0
Total	**53**	**58**	**32**	**10**

A particular area of concern is the medicine departments in both Scunthorpe and Grimsby. Concerns in this 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 been held in this quarter between the resident doctors, medical staffing and post graduate medical education to ensure matters are resolved smoothly and effectively.

Following this, a structured, time-bound recovery plan is being implemented that is being led by PGME Department as follows:

1. Listening Forums Across All Departments
Resident-led listening forums are now active across every specialty. These provide protected spaces to identify priorities, share experience, and co-design improvements.

2. Reinstating Supervision Standards
Supervision policies are being reviewed Trust-wide. An enhanced Foundation Supervision Framework is now in place, backed by a Standard Operating Procedure. This clearly outlines that FY1 doctors must not be expected to discharge patients, prescribe medication, or make unsupervised clinical decisions. Full compliance with GMC standards is expected by 01 October 2025.

3. Rota and Workload Reform
Chiefs of Service, along with medical staffing are leading comprehensive rota reviews to address staffing gaps, protect teaching time, and ensure access to study leave. Rotas are being stress-tested against real clinical conditions, with 100% stabilisation targeted by 31 October 2025.

4. Cardiology Department Changes
Following ongoing trainee feedback, cardiology training at Scunthorpe General Hospital will be decommissioned from August 2025. All Foundation, IMT, and specialty training placements in this department will cease. A hybrid model is now in place, relocating supervised daytime cardiology activity to Diana, Princess of Wales Hospital, with shuttle transport and flexible working arrangements.

5. Changes to Resident Doctors Contract

NHS Employers, in partnership with the BMA, have announced an Exception Report Reform with an implementation date of 12 September 2025. The reform is proposing significant changes to the process for both resident doctors, supervisors and the Guardian of Safe Working team.

The changes include:

- No clinical or educational supervisor involvement in the exception reporting system
- The Guardian of Safe Working team must review exception reports within 10 calendar days
- Exception reports can be submitted up to 28 days after the day they occurred rather than the current 7-day limit
- Exception reports for overtime (2 hours or under) will automatically be allocated TOIL or payment depending on the doctor's preference
- Doctors granted TOIL have 10-days to arrange for it to be taken with their rota-coordinator
- All educational exception reports are sent to Post Graduate Medical Education for approval (this is also subject to the 10-calendar day timeframe)

Fines can also be levied for the following breaches:

- Access and completion: £250 per resident doctor/per week for doctors who do not have access to their Allocate account to exception report. (Please note, the fine is set at £250 until 01 February 2026, when both access and information breach fines will be set at £500).
- Information breach: £500 per proven information breach. The Guardian of Safe Working is not able to discuss or share identifiable information relating to exception reports without the consent of the resident doctor concerned.

The reform is expected to make the exception reporting process easier for resident doctors; however, confidentiality constraints will impact the Guardian of Safe Working's ability to resolve issues within departments and will impact the way exception reports are reported in board reports moving forward. The Trust has not received guidance on this from NHS Employers yet, once guidance has been received, we will have more clarity on how we will achieve this. We are expecting to be able to provide information about exception reports received at care group level but any more detail than this would risk the confidentiality of the individual involved.

6. Work Schedule Reviews

No work schedule reviews have been requested or carried out during this quarter.

7. 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.

8. GOSW Funds Expenditure

During this quarter, it has been agreed to spend pre-existing fines on items to replenish the wellbeing boxes previously purchased to make on the working environment more pleasant for the residents. The wellbeing boxes include items such as toothbrushes and toothpaste, shower gel, deodorant, sanitary products, snacks and drinks, and are located in various locations in the hospitals.

9. 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, at present these issues remain unresolved, however, work is being carried out to ensure resolution.

10. Annual Survey

The Guardian of Safe Working conducts a survey each year to ensure that the resident doctors know how to exception report and feel supported by the Guardian of Safe Working. This also helps us to identify areas where more support might be needed. The results are detailed below:

- 81% of trainees felt they have been supported by the GoSW team this academic year (a slight increase from 79% in 2024)
- 76% feel able to raise concerns in comparison to 77% in 2024
- 40% have attended the RDF in comparison to 37% in 2024
- 82% of resident doctors (including LED's) have an awareness of the GoSW having seen advertising engagement session, poster, leaflets suggesting that these methods have been effective

These results suggest that the GoSW is embedded well in the trust. It is worth noting that 25% of the respondents felt unable to raise concerns; this is something that has been escalated to the Group Chief Medical Officer following a concern being raised recently. There is a piece of work in hand to address this issue to promote the culture of exception reporting in the trust.

Officer to Contact
Dr Liz Evans, Guardian of Safe Working Hours NLaG
Helen Fitzpatrick, E-Medical Workforce Administrator and Admin for Guardian of Safe Working

Appendices

Locum bookings 01 April 2025 to 30 June 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 also presented via department, grade and reason for booking.

Appendix 1: Locum bookings (bank) by grade

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	16	16	125.58	125.58
F2	1	1	11.5	11.5
Core Trainee/ST1&2 (formerly SHO)	202	202	1638.1	1638.1
Specialist Registrar	337	337	2297	2297
Trust Grade (Junior)	68	68	524.86	524.86
ST4-8	4	4	34	34
StR (ST3-8)	126	126	1020.5	1020.5
StR Lower Paediatrics (ST1-3)	31	31	261.5	261.5
StR Paediatrics (ST4-8)	22	22	241.03	241.03
Total	**807**	**807**	**6154.07**	**6154.07**

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.

Appendix 2: Locum bookings by specialty

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	25	25	289.5	289.5
Care of the Elderly	6	6	51.5	51.5
Emergency Medicine	231	231	1707.72	1707.72
ENT	23	23	178	178
Gastroenterology	12	12	107.08	107.08
General Medicine	118	118	626.01	626.01
Obstetrics & Fetal Medicine	4	4	24	24
Obstetrics & Gynaecology	194	194	1597.76	1597.76
Orthopaedic and Trauma Surgery	45	45	349.75	349.75
Paediatrics and Neonates	86	86	768.75	768.75
Stroke Medicine	63	63	454	454
Total	**807**	**807**	**6154.07**	**6154.07**

Appendix 3: Locum bookings (bank) by reason

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Compassionate/Special leave	8	8	78	78
Deanery gap - Vacancy	99	99	775.58	775.58
Extra Cover	15	15	126	126
Induction/Rotation	10	10	80	80
Less Than FT Trainee Gap	17	17	157.53	157.53
Maternity/Paternity leave	55	55	542	542
Restricted Duties	2	2	14.5	14.5
Sickness	84	84	753.13	753.13
Study Leave	14	14	105.5	105.5
Vacancy	503	503	3512.83	3512.83
Total	**807**	**807**	**6145.07**	**6145.07**

Agency Quarter 1: 01 April 2025 to 30 June 2025

The Trust also uses limited amount of agency staff. All agency bookings are managed by the Care group Rota coordinators, however, are only used when internal and bank routes are exhausted.

Appendix 4: Locum bookings (agency) by grade

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F2	36	36	450	450
Core Trainee/ST1&2 (formerly SHO)	48	48	600	600
Specialist Registrar	44	44	550	550
Trust Grade (Junior)	48	48	600	600
Total	**176**	**176**	**2200**	**2200**

Appendix 5: Locum bookings (agency) by specialty

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	48	48	600	600
Emergency Medicine	80	80	1000	1000
ENT	48	48	600	600
Total	**176**	**176**	**2200**	**2200**

Appendix 6: Locum bookings (agency) by reason:

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Annual Leave	25	25	312.5	312.5
Maternity Leave	5	5	62.5	62.5
Paternity leave	3	3	37.5	37.5
Sickness	35	35	407.5	407.5
vacancy	108	108	1400	1400
Total	176	176	2220	2220

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).

Northern Lincolnshire & Goole NHS Foundation Trust – Junior Doctor Trainee Establishment – April 2025

		Trainee Establishment						Trainee In Post						
Care Group	Department	F1	F2	CT/ ST1-2	GP STR	ST	**Total**	F1	F2	CT/ ST1-2	GPS TR	ST	**Total**	**% Fill Rate April 2025**
Patient Admin & Corporate	Academic, GP, Psych & Commu	8	17	0	37	0	62	9	17	0	33	0	59	**95.2%**
Acute & Emergency Medicine	Acute Medicine	1	0	3	6	4	14	1	0	0	1	3	5	**35.7%**
Theatres, Anaesthetics & Critical Care	Anaesthetics	1	3	10	0	3	17	1	2	8	0	3	14	**82.4%**
Specialist Surgery	Breast Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Cardiovascular Care Group	Cardiology	1	0	0	0	2	3	1	0	0	0	1	2	**66.7%**
Digestive Diseases	Colorectal Surgery	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Community, Frailty and Therapy	Elderly Medicine	2	1	0	1	0	4	2	1	0	0	0	3	**75.0%**
Acute & Emergency Medicine	Emergency Medicine	3	4	2	0	6	15	3	2	1	0	7	13	**86.7%**
Specialist Medicine	Endocrinology	5	2	0	0	1	8	6	2	0	0	1	9	**112.5%**
Head and Neck	ENT	0	2	0	0	0	2	0	1	0	0	0	1	**50.0%**
Digestive Diseases	Gastroenterology	2	1	1	1	1	6	2	1	1	1	0	5	**83.3%**
Digestive Diseases	General Surgery	4	4	6	0	0	14	4	5	4	0	0	13	**92.9%**
Specialist Cancer and Support Service	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 Service	Immunology	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	0	0	0	0	0	**0.0%**
Neuroscience Specialist Care Group	Neurology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Family Services	Obstetrics & Gynaecology	3	3	0	3	25	34	3	3	0	2	14	22	**64.7%**
Specialist Cancer and Support Service	Oncology	0	0	0	0	0	0	0	0	0	0	0	0	**0.0%**
Head and Neck	Ophthalmology	1	1	1	0	0	3	1	1	2	0	0	4	**133.3%**
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	2		2	0	0	0	0	0	0	**0.0%**
Family Services	Paediatrics	1	7		4	12	24	1	9		0	10	20	**83.3%**
Specialist Cancer and Support Service	Radiology	0	0	3	0	2	5	0	0	4	0	2	6	**120.0%**
Specialist Medicine	Respiratory Medicine	7	4	0	0	0	11	6	4	0	0	0	10	**90.9%**
Specialist Medicine	Rheumatology	1	0	0	0	0	1	1	0	0	0	0	1	**100.0%**
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	4	0	2	10	2	2	1	0	2	7	**70.0%**
Digestive Diseases	Upper GI	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%**
	TOTAL	**45**	**53**	**30**	**54**	**58**	240	**46**	**51**	**21**	**37**	**43**	198	**82.5%**

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)196

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	09 October 2025
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Wajiha Arshad, Guardian of Safe Working Joey Robson, Group Medical Staffing Manager Rose Bundy, Guardian of Safe Working Analyst
Title of the Report	**Guardian of Safe Working Hours Annual Report - HUTH**
Executive Summary	A total of 592 exception reports reported by resident doctors for the period 01 April 2024 to 31 March 2025. 473 of the 592 exception reports were submitted due to excess hours worked. The other 119 will be a combination of support received by the service, rota working pattern or not being able to access educational opportunities. 43 fines were issued during the period, totalling £55,403.91. In the reporting period this funding has supported, for example, refreshments at teaching events and two sofa beds in the doctor's mess. Of the 43 fines issued, 29 were issued to Paediatric Surgery, and 3 were issued to Plastic Surgery. Whilst compared to last year there is a significant decrease in the number of occurrences for Plastic Surgery the total value of fines amounted to £6,790.53. The fines issued to Paediatric Surgery are 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.
Background Information and/or Supporting Document(s) (if applicable)	This report includes an overview of exception reports and fines over the year which can be found within the report.
Prior Approval Process	Workforce Education and Culture Committees-in-Common meeting held on 24 September 2025.
Financial implication(s) (if applicable)	This report contains information on Guardian of Safe Working fines. £55,403.91 fines have been issued over the annum. In the reporting period this funding has supported, for example, refreshments at teaching events and two sofa beds. Plans are in place to purchase more furniture for doctor's breakout areas and fund educational and leadership opportunities.

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 ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Annual Report on Safe Working Hours
Doctors and Dentists in Training
01 April 2024 – 31 March 2025

1. Executive Summary

This paper provides an annual summary of gaps, exception reports, and fines department for each quarter from April 2024 – March 2025.

From April 2024 – March 2025 exception reports have been submitted for a wide range of themes, such as increased hours worked covering colleagues taking industrial action, missed educational opportunities, lack of service support, and isolated instances across several specialties requiring resident doctors to work additional hours to maintain patient safety.

Most fines issued were to Paediatric Surgery and were in relation to non-resident on call shifts where doctors breached 13-hour maximum shift length, and did not receive adequate rest.

2. Introduction

This report provides an overview of rota gaps, vacancies, exception reports and fines for the period 01 April 2024 – 31 March 2025.

3. High Level Data

The table below summarises average rota gaps and vacancies for the period 01 April 2024 to 31 March 2025.

Average number of doctors / dentists in training (total):	658.95
Annual fill rate among this staff group (%):	87.93%

Information on exception reporting is detailed within Schedule 05 of the Doctors and dentists in training terms and conditions (England) 2016 found on NHS Employers website.

4. Exception Report Summary

There was a total of 592 exception reports (592 episodes) reported by doctors in training and locally employed doctors for the period 01 April 2024 – 31 March 2025. Out of 592 exception reports submitted, 21 were flagged as immediate safety concerns.

In comparison to the previous year, April 2023 – March 2024, there has been 18 more exception reports submitted. However, despite the increase in exception reports, there have been fewer immediate safety concerns.

The previous annum saw 574 exception reports submitted, with 39 of those being categorised as immediate safety concerns.

Table 1: 01 April 2024 to 31 March 2025 (Reasons for Exception Reports)

Reason:	**Number of exception reports submitted:**
Hours	473
Pattern	46
Educational	41
Service Support	32
Total	**592**

The rotas with the most exception reports submitted throughout the annum are detailed below:

Table 2: 01 April 2024 to 31 March 2025 (Five Top Rotas with Exception Reports)

Rota & Department:	**Number of exception reports submitted:**
Rota 18B F1 Endocrinology	67
Rota 18 F1 Oncology	58
Rota 4B F1 Gastroenterology	40
Rota 8 F1/ST1 Oncology and Haematology	35
Rota 66 ST3 Paediatric Surgery	32

Of the 592 exception reports submitted over the year, 171 were closed within the 7-day contractual period.

Table 3: 01 April 2024 to 31 March 2025 (Number of Exception Reports submitted by Grade)

Grade:	**Number of exception reports submitted:**
F1	335
F2	106
CT1/ST1	83
CT2/ST2	9
ST3/CT3+	59

5. Summary of Fines issued 01 April 2024 – 31 March 2025

43 fines were issued during the period, totalling £55,403.91 Of the 43 fines issued, 29 were issued to Paediatric Surgery, and 3 were issued to Plastic Surgery. Whilst compared to last year there is a significant decrease in the number of occurrences for Plastic Surgery the total value of fines amounted to £6,790.53.

The table below summarises the fines issued across different departments throughout the year:

Department	Number of fines issued
Paediatric Surgery	29
Plastic Surgery	3
Oncology and Haematology	3
Acute & Elective Surgery	2
General Surgery	3
ENT	2
Endocrinology	1

All of the fines issued to Paediatric Surgery are in relation to non-resident on call shifts where doctors have not received adequate rest and have breached 13-hour maximum shift length.

The clinical lead in Paediatric Surgery has also produced several business cases to combat rota issues which have resulted in breaches, and the most recent case is still pending financial approval. The department are now covering Friday night shifts with locums, who are also frequently breaching 13-hour maximum shift length.

Oncology and Haematology have seen a rise in the number of exception reports, and subsequent fines throughout the year. The department has seen a rise in exception reports due to service support and overtime, with sickness putting extra strain on the department.

6. Annual Data Summary

The following table shows the NHSE establishment rate for 01 April 2024 – 31 March 2025.

This does not include any locally employed doctors recruited to backfill any NHSE vacancies.

	Quarter 1 April - June 2024		Quarter 2 July - September 2024		Quarter 3 October - December 2024		Quarter 4 January - March 2025		Average fill rate percentage
Department	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	
Academic, GP, Psych & Community	143	133.4	150	136.7	151	136.6	148	135.4	91.57%
Acute Medicine	29	25.3	27	23.5	26	23.5	26	19.8	85.28%
Anaesthetics	64	62.5	63	66.2	63	63.2	63	62.8	100.67%
Breast Surgery	5	4	5	4	5	4	5	4	80.00%
Cardiology	18	18	17	19.2	17	18.6	17	20.2	110.14%
Cardiothroacic Surgery	7	5	7	6	7	5.8	7	5.8	80.71%
Chemical Pathology	1	1	1	1	1	1	1	1	100.00%
Colorectal Surgery	14	12	14	12	15	13.6	15	13.6	88.28%
Dermatology	2	2	2	1	2	1	2	1.8	72.50%
Elderly Medicine	27	25	28	27.6	28	26.8	28	27.2	96.04%
Emergency Medicine	48	35.7	55	50.1	55	50	51	44.6	86.32%
Endocrinology	9	8	9	9	9	8.8	9	8.8	96.11%
ENT	13	11.6	14	12.6	14	14	14	13.2	93.45%
Gastroenterology	10	8.5	13	12.8	13	12.8	13	12.8	95.71%
General Surgery	1	1	1	1	1	1	1	1	100.00%
Haematology	10	9	11	12.4	11	11.6	11	9.8	99.53%
Histopathology	7	6.6	7	5.8	7	5.8	7	4.6	81.43%
Immunology	1	1	1	0	1	0	1	0	25.00%
Infectious Diseases	14	14.3	12	11.6	12	10.6	12	11.6	96.20%
Neuro-Rehab	2	2	2	0.8	2	0.8	2	2	70.00%
Neurology	15	13.3	16	12.8	15	13	15	13	85.41%
Neurosurgery	8	8	8	8	8	8	8	7.5	98.44%
Obstetrics & Gynaecology	28	26	27	26.6	27	26.6	27	25.4	95.96%
Oncology	21	20.8	21	18.6	22	19.6	22	20.6	92.56%
Ophthalmology	8	6.8	8	8.4	8	8.8	8	8.8	102.50%
Oral & Maxillofacial Surgery	11	3	12	6	12	6	12	6	44.68%
Paediatric Neonatal Medicine	16	14.2	14	14.4	14	14.4	14	11.4	93.79%
Paediatric Surgery	2	2	3	2	3	2	3	2.8	80.00%
Palliative Care	2	2	2	2	2	2	2	2	100.00%
Plastic Surgery	9	9	9	9	9	9	9	9	100.00%
Paediatrics	24	22.6	22	24.7	23	23.7	25	28.9	106.28%
Radiology	38	32.4	40	39.4	40	39.4	40	39.6	95.44%
Renal Medicine	11	10	11	10.6	11	10.6	11	10.6	95.00%
Respiratory Medicine	20	20.3	20	18.6	20	18.6	20	17.8	94.13%
Rheumatology	6	5.8	10	10.6	10	9.4	10	9.2	97.22%
Stroke Medicine	1	1	1	0	1	0	1	0	25.00%
Trauma & Orthopaedics	18	14	18	17	18	17	18	17	90.28%
Upper GI	15	13	15	14.8	15	12.6	15	12.6	88.33%
Urology	9	9	9	8	9	8	9	9.3	95.28%
Vascular Surgery	12	8.6	12	9.8	12	12	12	11.8	87.93%
Total	**699**	**627.7**	**717**	**674.6**	**719**	**670.2**	**714**	**663.3**	**87.93%**

7. Issues Arising and Actions taken to resolve issues

Resident doctors working in the Tower Block at HRI voiced concerns at the RDF over not having enough normal working days in their rotas to support annual and study leave requests, self-development time and sufficient time for handover.

The Site Medical Director (North) and the Guardian of Safe Working, supported by the Medical Staffing Team, worked closely with Chiefs of Service to redesign existing rotas, consolidating these rotas into 5 new identical rotas. The new rotas incorporate a designated handover shift, staggered start and finish times, and multiple consecutive weeks of normal working days to enable resident doctors to take leave more easily. These changes have been implemented in August 2025.

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 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 Rota 8 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 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.

8. Changes to Exception Reporting

At a national level, several reforms to the Exception Reporting process for Resident Doctors are to be introduced in September 2025. Exception reporting is a process where a doctor covered by the 2016 Terms and Conditions can submit a report in circumstances where their actual work has varied from their published work schedule from either a training or an hours worked perspective.

- Previously doctors had up to 14 days to submit an exception report, this will now increase to up to 28 days from the date of the occurrence.
- Previously all exception reports were signed off by the doctor's supervisor whereas under the new provisions an exception report for overtime (2 hours or less) will be automatically granted as TOIL or payment depending on the doctor's preference. Exception reports for overtime (2 hours or more) are to be determined by a local process.
- Going forward all exception reports linked to training/education will be sent to Medical Education for approval rather than the supervisor.

In addition to above several "fines" have also been introduced

- £250 per resident doctor/per week in circumstances where the resident doctor is not given access to an eRota to report an exception.
- £250 fine in circumstances where the response to the exception report is not completed within a 10-day time frame of receipt (rises to £500 per resident doctor/per week from 01 February 2026).

- £500 per proven information breach. The GOSW is now not able to discuss or share information relating to the exception report with the Resident Doctors supervisor without the consent of the Resident Doctor

Although NHSE have not yet released guidance to employers and system providers or updated the national terms and conditions of service, the Medical Staffing and Medical Education Teams are working closely with the Guardians of Safe Working (HUTH and NLaG) to review current processes with the aim of avoiding unnecessary fines in the future. This will be supported by communications and guidance being provided to current supervisors about the importance of ensuring Resident Doctors are able to leave on time to, where possible, avoid overtime claims going forward.

9. Conclusion/Next Steps

The Workforce, Education and Culture Committees-in-Common are requested to note the content of this report and future changes in the exception reporting process.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)196

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	09 October 2025
Director Lead	Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Dr Elizabeth Evans, Guardian of Safe Working, NLaG
Title of the Report	**Guardian of Safe Working Hours Annual Report - NLaG**
Executive Summary	This is the annual report for the Guardian of Safe working for NLaG, which details the number of exception reports, along with the reasons behind them. This is compared with the pattern of reports received in previous years. **Exception report analysis** The reasons for reports throughout the year were overwhelmingly for excess hours worked- this is something that has been seen in all previous years. The pattern of reports received remains the same as has been seen in previous years, although the number of reports is higher than has been seen previously. The reasons for this are unclear. **Fines** There have been two fines for excess hours- there were some issues with allocation of funds, but this has now been resolved and the funds have been spent. **Summary** There has been an improvement in engagement with the resident doctors during the course of the year and this has helped to begin to address some of the issues they face. The resident doctors forum is running successfully and is regularly attended by several different execs, PGME and the freedom to speak up guardian. Over the last year it has managed a variety of different issues. This year has started to reveal some of the challenges faced by the resident doctors, and this is reflected in the increased number of reports received towards the end of the year. The issues raised in the medical departments have started to be addressed which is an encouraging start to managing these issues.
Background Information and/or Supporting Document(s) (if applicable)	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 24 September 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 ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Annual Report

Dr Liz Evans
Guardian of Safe Working
April 2025

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Executive summary

The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of April 2024 to March 2025. Quarterly reports continue to be generated and shared at WEC, JLNC, the Resident Doctor's Forum (RDF) and with colleagues at NHS England (previously Health Education England).

There are no trainees within the Dentistry service at NLaG and so the Annual Report applies only to doctors in training.

We are now in the ninth year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. Exception reporting (ER) of extra hours, missed breaks and missed educational opportunities is well established in Northern Lincolnshire and Goole NHS Foundation Trust and we continue to positively promote exception reporting through induction, training, drop ins and the monthly Resident Doctors' Forum.

The 2016 contract was subject to review in 2019 and although largely unchanged there were some notable differences which the Trust has implemented. There has been further negotiation following the pay deal agreement which will change the exception reporting system further, but at the time of writing these changes have not come into force.

Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

Fill rates for doctors in training at the Trust continue to be high, over 95%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

Rota design and co-ordination currently sits within medical staffing. This provides oversight of rota design and ensures that the terms and conditions of service as per the Resident Doctors Contract are met within that design.

High level data – as of March 2025

Number of training posts (total): 324.14

Number of doctors in training posts: 315.02 (includes 243.24 doctors in training programmes and 82.7 doctors in trust grade positions)

Number of training post vacancies: 9.12

Number of LTFT trainees: 69

Source: Recruitment via establishment spreadsheets and vacancy spreadsheets.

Exception report analysis

Usually, an analysis of the number of exception reports per resident doctor for each directorate would be provided to highlight any areas of concern. In this report however this will not be possible- following the move to the group structure during then last financial year the way this information would be collated has changed, and there is no fair and clear way to demonstrate this. An example is medicine, which used to be the medical directorate, but which is now split between three care groups. Resident doctors may do their on calls in a different care group than their routine work, but when they exception report this will be reported under their base rota, making the numbers inaccurate and not reflective of the actual situation. This means that untangling where the issues are on a large scale is difficult without the nuance of the actual reports. In the future we will look at ways to make this clearer and hope to provide this information in the coming financial year.

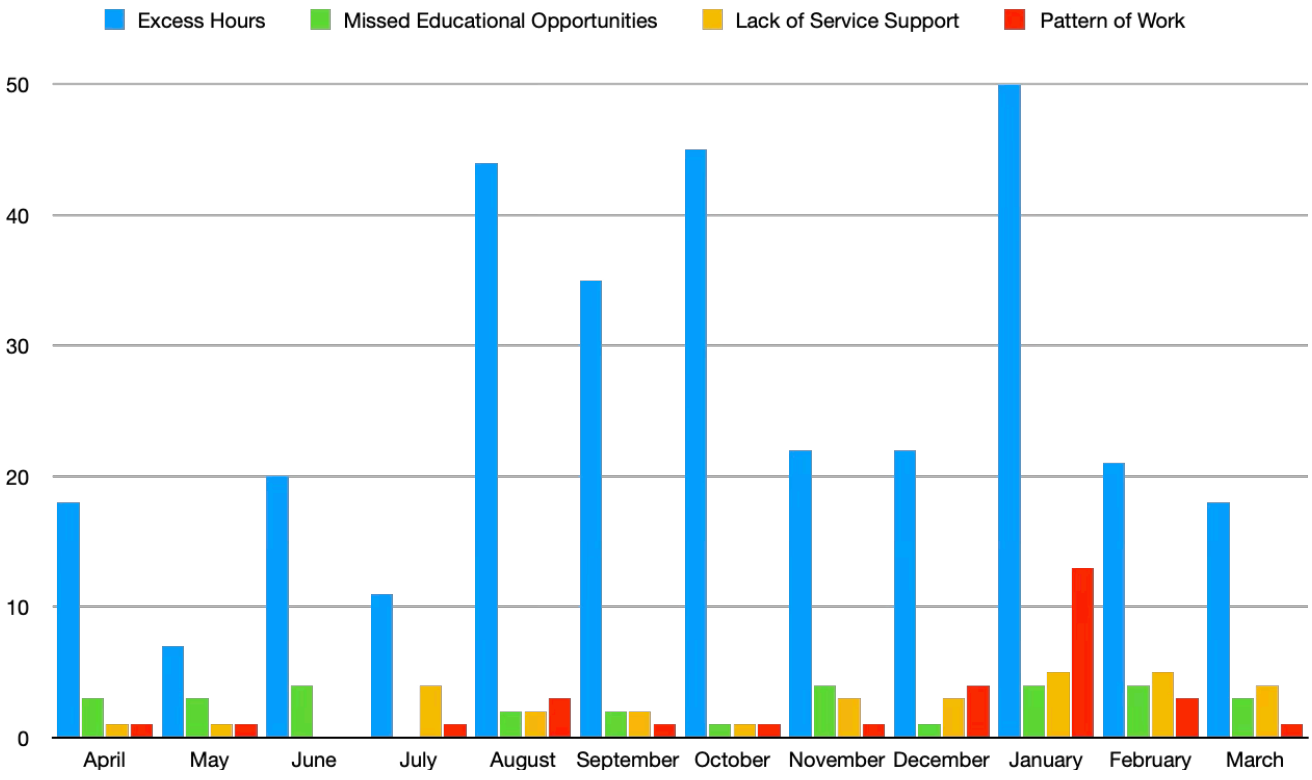

Figure 1: Reasons for exception reporting by month.

The above table (figure 1) shows the number of exception reports submitted from all departments by month, broken down to show the reasons reports were submitted. As is usual the vast majority of the reports received concern excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported.

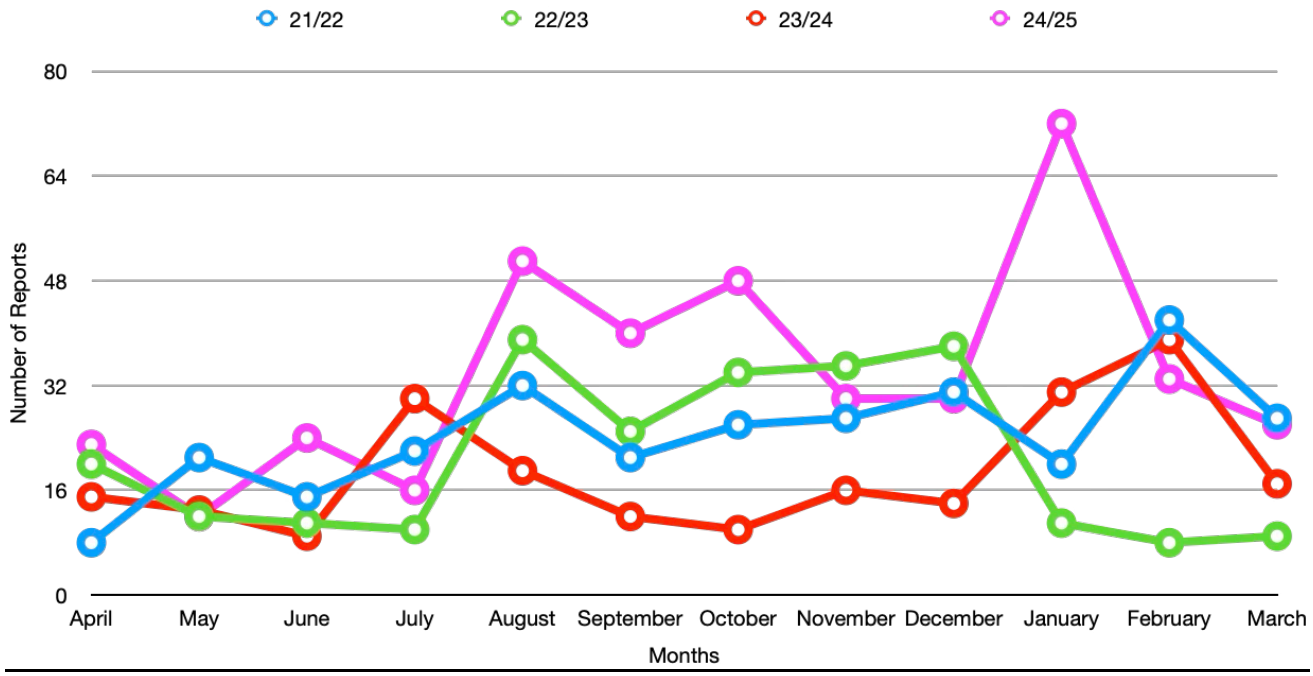

Figure 2: Exception reports by month

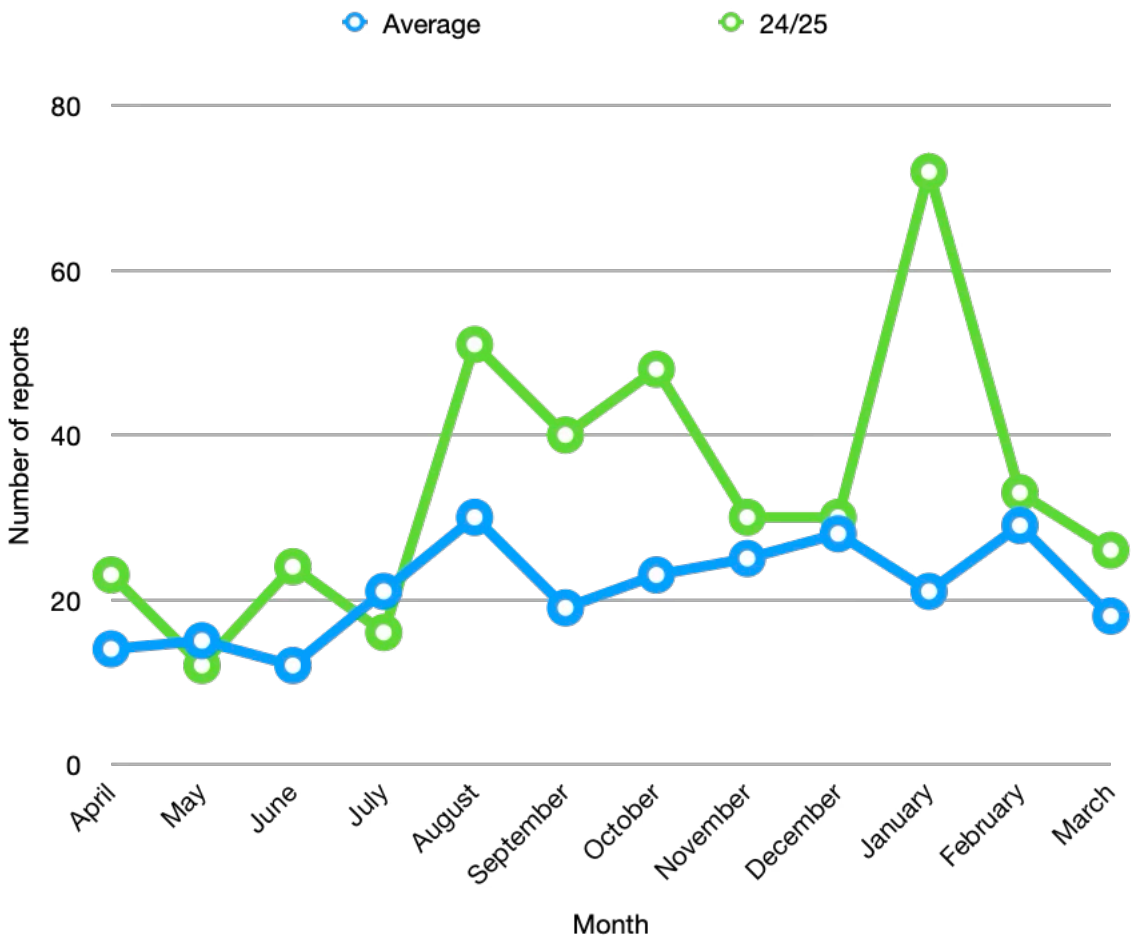

Figure 3- comparison of 2024/25 reporting numbers in comparison with average of last 3 years

As figures 2 and 3 show there is an increase in the number of reports submitted in August, September and October, which is to be anticipated owing to the Resident Doctors rotating jobs. This usually settles down as the doctors, in particular the foundation year one doctors, become more familiar with their roles and therefore more efficient and less likely to need to stay after hours. The number of reports received is higher than has been seen previously but the pattern is explainable, and not entirely unexpected. There has been a high rate of reporting for excess hours during January, this is likely to be due to a combination of winter pressures and staff sickness. There have been far more reports submitted than have been seen in previous years, it is difficult to establish the reasons for this; partly it is due to the clinical workload, but it is also possibly a consequence of the culture of exception reporting in the trust and therefore isn't entirely a negative finding. Concerns regarding the working environment in medicine were raised at the Resident Doctors Forum (RDF), these have been escalated to the medical director who is facilitating a piece of work to investigate and improve the working environment in acute and general medicine. The GoSW is supporting the ongoing dialogue between the Medical Director, management and the Resident Doctors.

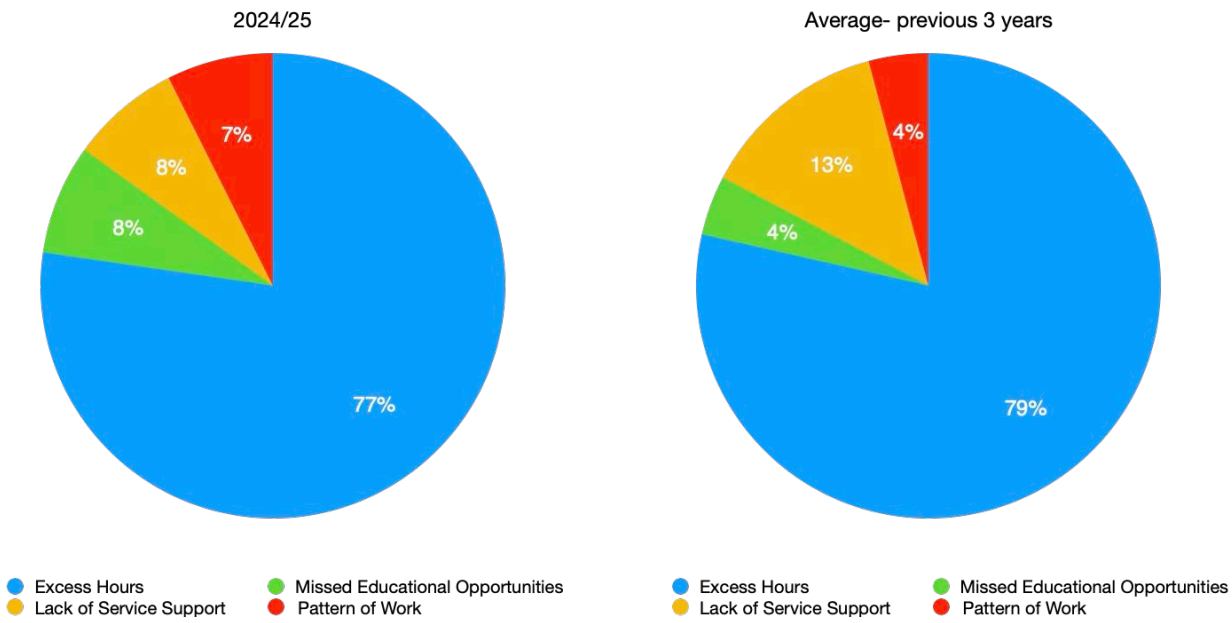

Figure 4: Reasons for Exception Reporting by Year

As shown in figure 4, the reasons for exception reporting shows consistency comparing this year with the average of the previous 3. By far the most common reason for exception reporting remains excess hours, and this is a pattern we would expect to see continue moving forward. This is because excess hours is the most easily quantifiable type of breech, which makes the doctors much more likely to report it. A higher proportion of the reports this year concerned issues with service support. It is encouraging that the doctors in training felt that they were able to escalate their concerns in this way, and that positive change could be made in response.

Fines

There have been two fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors working excessive hours. At the time of writing the Guardian of Safe working has been unable to access these funds so they are yet to be spent, however following action by the head of medical staffing this situation is likely to have been resolved. The funds will be spent following agreement by the Resident Doctors Forum, in line with the contract.

Case study

During the third quarter of the year an issue was raised via exception reporting and via the BMA about the work intensity for doctors covering the Trauma and Orthopaedics bleep at the weekends in DPOW. This was escalated to the medical directors for the relevant specialities and a meeting set up between the affected doctors and members of the management team. An interim solution to reduce their work intensity was found, and the

need for more staff identified and escalated. At the time of writing this seems to have improved the situation substantially.

Summary

1. This past year continued to see an improvement in engagement with our doctors in training. We will continue to build on this during the next academic year.

2. The GoSW holds Resident Doctor Forums every month and these are a valuable opportunity for our Doctors representatives to meet with the Guardian, MD office, Director of Medical Education (DME) office, BMA and LNC in one place. We have regular attendance from the freedom to speak up guardian, and the trusts Chief Medical Information Officer, Dr Alastair Pickering. This enables the Doctors in Training to engage in the improvements to the digital infrastructure and gives them the opportunity to shape their working environment.

3. Issues addressed at the JDF over the past year have included:
   - Trust Grade Contracts
   - Locum Rates
   - On Call rooms and the availability of these
   - Bleep cover
   - Ward cover

4. There is a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the resident doctors.

5. The GoSW has regular meet ups with the Freedom to Speak Up Guardian and the representatives of PGME to identify common themes. These have been very successful at identifying areas of difficulty, enabling us to provide more holistic support to the Resident Doctors

6. Work to improve the knowledge and engagement of the educational supervisors is ongoing.

7. The accepted nomenclature for the Doctors who are in postgraduate training has changed nationally, what were previously referred to as ‘Doctors in Training’ are now referred to as ‘Resident Doctors’

Recommendations

1. To continue to support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system.

2. To ensure a positive regard for the education of resident doctors, recognising the importance of the medical workforce and safeguarding the balance of service provision and education.

3. To support initiatives to improve the experience of resident doctors at NLaG, and to celebrate examples of good practice. This will strengthen the Trust's reputation and attractiveness as a training provider/employer.

4. To promote the engagement of the Resident Doctors in the exception reporting process, and to promote the system as an agent for positive change and patient safety within the trust.

Dr Liz Evans - Guardian of Safe Working

Date: April 2025

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)197

Name of the Meeting	Trust Boards-in-Common Front Sheet
Date of the Meeting	09 October 2025
Director Lead	Sarah Tedford, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer/Author	Chris Fry, Associate Director 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 Q2 for UEC, Cancer, Diagnostics and in addition for NLAG for RTT Summary Compliance:

Domain	GROUP	HUTH Performance	NLAG Performance
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	August 2025 0 2 116 4,086	August 2025 0 0 62 3,261	August 2025 0 2 54 1,025
• % 52 weeks (target <1.3% March 2026)	3.6%	4.0%	2.6%
Diagnostics: 6ww Performance (target <5% March 2026)	August 2025 36.2%	August 2025 32.4%	August 2025 38.7%
Cancer: 28 Day FDS (target > 80% March 2026) 62-day Performance (all sources) (target > 63% March 2026)	July 2025 55.3% 55.1%	July 2025 50.8% 55.3%	July 2025 64.1% 54.5%
UEC: ED: 4-hour standard (Type 1&3) (target > 78% March 2026) ED: 12-hour standard	August 2025 67.7% 12.1%	August 2025 61.9% 10.1%	August 2025 72.9% 14.2%

Update on BAF and mitigating actions:

- Extensive actions are in progress, alongside the review and augmentation of elective improvement plans.

Background Information and/or Supporting Document(s) (if applicable)	
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 ✓ Information ☐ Review ☐ Other – please detail below:

Key messages

Referral to Treatment (RTT)

Waiting list (PTL) growth has been arrested at both Trusts, ending four years of c8% annual waiting list growth. This is a direct result of:

- Over delivery of RTT pathway completions versus plan.
- Lower than planned/historic referral levels in the latter part of 2024/25
- The inception of the national 'Validation Sprint' programme in 2025/26.

At HUTH these actions have resulted in a stable waiting list of 80,655 which is 1.2% below plan.

At NLAG the reduction is more pronounced, with the latest months volume of 39,698 being 3,848 pathways (9.7%) below trajectory.

Despite this stabilisation of the PTL, both Trusts have seen the percentage of RTT patients waiting less than 18 weeks return to start of financial year performance. At HUTH 56.7% shows a reduction and is 2.3% below the 25/26 trajectory. The change in compliance reflects a reduction in 0-18 week waiter and an increased tip in of >52-week waiters (+300).

In contrast to the significant improvement in waiting list volumes, the percentage of NLAG patients waiting less than 18 weeks has remained static with performance of 59.1% a 1% reduction on the previous month, and 6% below the planned improvement trajectory. This variance to plan has triggered NLAG being placed into Tier 1 oversight for RTT. The variation to plan is reflective of validation pathway completion outcomes 'negatively' influencing the compliance percentage (i.e. validation removals in the 0–18-week cohort). This mathematical relationship belies the positive benefits to patients of removal of inaccurate pathways of care remaining live of the RTT PTL.

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) has historically delivered at the Trust aggregated level by high volume / high compliance in tumour sites such as Breast. In recent months these key tumour sites have been challenged in FDS delivery due to outpatient demand / supply imbalances, in turn compromising aggregate compliance for both Trusts.

HUTH performance has decreased in year to 50.8% with significant delays due to radiology capacity, loss of CNS Alliance funding and Consultant shortfalls.

NLAG July performance 64.1% is an increase of 5.3% on the previous month, however, significantly below plan with additional capacity sought for Breast and Colorectal.

Cancer referral demand continues to grow on both sites. At HUTH both June and July saw 400 more referrals versus the same points last year and similar is observed at NLAG with a net 27% increase to date. 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.

Compliance against key stage of treatment targets in July	HUTH - from June to July	NLAG - from June to July
FDS	Decline - from 52.9% to 50.8%	Improvement - from 60.2% to 64.1%
31-day compliance	Decline - from 77.8% to 76.8%	Decline - from 96.5% to 93.7%
62-day compliance	Improvement - from 48.1% to 55.3%.	Static - from 54.2% to 54.5%

August (provisional) shows similar improvement.

Diagnostic Access

The Group is a national outlier for Diagnostic 6-week waits, with August data showing HUTH at 32.4% HUTH and NLAG at 38.7% versus the national expectation of <5%.

Total activity plan across all diagnostic modalities is being achieved, however notable reduction in August for HUTH of -11% versus July resulting in a negative 6.2% swing in perfromance. Underperformance is evident in key endoscopy modalities on both sides of the Group whilst increases in emergency, planned care and surveillance pathways are activity constricting waiting list (DM01) activity leading to associated waiting list growth of 17% at HUTH and 25% at NLAG since start of calendar year.

Notable in-month themes:

- An ongoing national issue with the **Auditbase** product has been corrected, resulting a Paediatric Audiology reporting correction of c500 breaches, taking compliance from 2.2% to 45.1%.
- Neurophysiology capacity contract awarded with mobilisation expected from October
- Utilisation of NLAG CDC Echo capacity for HUTH waiters has begun and should see impact during October

Unplanned & Emergency Care (UEC)

HUTH A&E 4 Hour standard (all types) was 61.9% in August 2025 (plan 72.8%). Type 1 performance of 46.3% was below the 25/26 operating plan target of 62.1%. Type 3 performance (HRI UTC) was 95.8% against the 95% target. Type 1 attends were below plan whilst Type 3 attendances were also below planned levels.

NLaG combined type 1 and 3 performance was 72.9% against a target of 75%. Type 1 performance = 54.6% (Target 58.9%) and Type 3 performance = 99.2% (Target 99%). Type 1 and Type 3 attendances were lower than planned levels in August 2025.

Update on key actions

- Interim Group Chief Delivery Officer has absorbed operational leadership for Elective Care
- Recruitment of 2 x Directors of Operational Transformation to Interim Chief Delivery Officers senior team to lead operational improvement of UEC and Elective Care respectively.
- Delivery of Flow model as part of UEC improvement plans
- Fundamental review of existing risks and action plans relating to Elective Care.
- Revised recovery trajectories being developed for elective care, with Cancer 28 Day and 62 Day improvement plans agreed by Board in September
- Development of enhanced reporting commenced comprising Foundation Scorecards, National Oversight Framework dashboards, pathway staging reports, etc.
- Refresh of HUTH bed model to incorporate NLAG forecast bed need requirements.

Key changes to regulatory oversight

Changes made to national Tiering oversight arrangements relating to the Group:

- **UEC** - Current Tiering status relates to ICB system. The Group has been notified this will end with immediate effect and be replaced with Acute Provider specific tiering meetings. As part of this revision HUTH and NLAG will be subject to separate Tiering meetings.
- **NLAG** has triggered Tier 1 oversight for RTT
- **Cancer and Diagnostics** remain in Tier 1 oversight.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)198

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 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 2025 and December 2025. The report also includes the schedule for January - 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 - 2025 - V19

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		13.02.25 **Boardroom, HRI**		10.04.25 **Boardroom, DPOW**		12.06.25 **Boardroom, HRI**		14.08.25 **Boardroom, DPOW**		09.10.25 **Boardroom, HRI**		11.12.25 **Boardroom, DPOW**
Board Development (Thursdays - 9.00 am - 5.00 pm)			13.03.25 **Boardroom, DPOW**		08.05.25 **Boardroom, HRI**		10.07.25 **Boardroom, DPOW**		11.09.2025 **Boardroom, HRI**		13.11.25 **Boardroom, DPOW**	
HUTH Annual General Meeting & NLaG Council Of Governors Annual Members Meeting (Virtual Meeting)										22.10.25 (2.30 pm - 5.00 pm)		
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	Meeting falls in December 2024 due to previous reporting cycle	04.02.25 **Boardroom, DPOW**	04.03.25 **Boardroom, HRI**	01.04.25 **Nightingale, SGH**	06.05.25 **Boardroom, HRI**	03.06.25 **Boardroom, CHH**	01.07.25 **Boardroom, DPOW**	05.08.25 **Boardroom, HRI**	02.09.25 **Boardroom, DPOW**	30.09.25 **(please note falls in September)** **Boardroom, CHH**	04.11.25 **Boardroom, DPOW**	02.12.2025 **Nightingale, SGH**
Capital & Major Projects (9.00 am - 12.00 pm)	30.01.25 **Conference Room, GDH**			22.04.25 **TBC, CHH**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI** (Tuesday)	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**		25.09.25 **Boardroom, DPOWH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Conference Room, GDH** **(Time Out Session)**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25 (Meeting cancelled)				17.06.25		06.08.25			20.11.25	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	29.01.25 **Boardroom, DPOW**	26.02.25 **Boardroom, HRI**	26.03.25 **Boardroom, DPOW**	30.04.25 **To be held Virtually**	28.05.25 **Boardroom, DPOW**	25.06.25 **Boardroom, HRI**	23.07.25 **Nightingale, SGH**	27.08.25 **Boardroom, CHH**	24.09.25 **Boardroom, DPOW**	29.10.25 **Boardroom, HRI**	26.11.25 **Nightingale, SGH**	17.12.25 **Boardroom, CHH**
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	23.01.25 **Boardroom, HRI**			24.04.25 **Boardroom, HRI**		20.06.25 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	31.07.25 **Boardroom, DPOW**				12.11.25 **Boardroom, DPOW**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	22.01.25			02.04.25			09.07.25 **Boardroom, DPOW**			14.10.25		
HUTH (9.00 am - 12.00 pm)		06.02.25			07.05.25			07.08.25			06.11.25	
Executive Team Meetings												
Group Cabinet Meeting (Tuesdays - 2.00 pm - 5.00 pm)	07.01.25 14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25	01.04.25 08.04.25 15.04.25 22.04.25 29.04.25	13.05.25 20.05.25 27.05.25	03.06.25 10.06.25 17.06.25 24.06.25	08.07.25 15.07.25 22.07.25 29.07.25	05.08.25 12.08.25 19.08.25 26.08.25	09.09.25 16.09.25 23.09.25 30.09.25	07.10.25 14.10.25 21.10.25 28.10.25	11.11.25 18.11.25 25.11.25	02.12.25 09.12.25 16.12.25 23.12.25
Financial Planning & Information Board (FPIB) (Mondays - 2.00 pm - 4.00 pm - bi-weekly)									22.09.25	06.10.25 20.10.25	03.11.25 17.11.25	01.12.25 15.12.25 29.12.25
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (10.00 am - 11.00 am) **NED & Governor only Meeting**		16.04.25			17.07.25	21.08.25 (4.00 pm - 5.30 pm) **Highlight Reports**			05.11.25	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			11.03.25			03.06.25				07.10.25		02.12.25
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		20.02.25			29.05.25				25.09.25			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays - 10.00 am - 12.00 pm)	21.01.25 (9.00 am - 11.00 am)	18.02.25	18.03.25	15.04.25	22.05.25 (Thursday - 1.00 pm - 3.00 pm)	17.06.25 (meeting cancelled)	15.07.25	19.08.25	16.09.25	21.10.25	18.11.25	09.12.25
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	20.01.25	17.02.25	17.03.25	21.04.25	19.05.25	16.06.25	21.07.25	18.08.25	15.09.25	20.10.25	17.11.25	15.12.25
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	02.01.25		06.03.25		01.05.25		03.07.25		04.09.25		06.11.25	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	21.01.25	18.02.25	18.03.25	15.04.25	20.05.25	17.06.25	15.07.25	19.08.25	16.09.25	21.10.25	18.11.25	16.12.25
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	15.01.25		19.03.25		21.05.25		16.07.25		17.09.25		19.11.25	
Care Group Performance & Assurance Meetings												
Cardiovascular Care Group	17.01.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	25.02.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**		07.04.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	20.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	30.06.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		12.08.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	24.09.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		03.11.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Family Services Care Group	14.01.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	27.02.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		08.04.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	22.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**		03.07.25 **10.00 am – 11.30 am** **Boardroom, HRI**	12 August 2025 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	25.09.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		06.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Neuroscience Care Group	22.01.25 **2.30 pm – 4.00 pm** **Boardroom, HRI**		03.03.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**	14.04.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**	28.05.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		07.07.25 **1.30 pm – 3.00 pm** **Boardroom, DPOW**	20.08.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		01.10.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	10.11.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Specialist Cancer and Support Services	23.01.25 **3.30 pm – 5.00 pm** **Boardroom, HRI**		06.03.25 **11.00 am – 12.30 pm** **Boardroom, HRI**	16.04.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	29.05.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		07.07.25 **3.30 pm – 5.00 pm** **Boardroom, DPOW**	21.08.25 **9.00 am – 10.30 am** **Boardroom, HRI**		02.10.25 **9.00 am – 10.30 am** **Boardroom, HRI**	11.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Care Group for Theatres, Anaesthetic and Critical Care	27.01.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**		10.03.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**	23.04.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		02.06.25 **9.00 am – 10.30 am** **Boardroom, DPOW**	14.07.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	27.08.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		06.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	19.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Community, Frailty and Therapy Care Group	27.01.25 **11.00 – 12.30 pm** **Boardroom, Main Admin Block, CHH**		10.03.25 **3.00 pm – 4.30 pm** **Boardroom, DPOW**	23.04.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		02.06.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	14.07.25 **3.30 pm – 5.00 pm** **Boardroom, DPOW**	28.08.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		07.10.25 **10.00 – 11.30 am** **Boardroom, Main Admin Block, CHH**	19.11.25 **1.00 pm – 2.30 pm** **Boardroom, Main Admin Block, CHH**	
Head and Neck Care Group		05.02.25 **1.00 pm – 2.30 pm** **Boardroom, HRI**	19.03.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	30.04.25 **2.00 pm – 3.30 pm** **Boardroom, Main Admin Block, CHH**		09.06.25 **10.00 am – 11.30 am** **Boardroom, DPOWH**	23.07.25 **2.00 pm – 3.30 pm** **Exec Meeting Room, SGH**		01.09.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	13.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	24.11.2025 **10.00 am – 11.30 am** **Boardroom, DPOW**	
Digestive Diseases		06.02.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	20.03.25 **10.00 am – 11.30 am** **Boardroom, HRI**		01.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**	10.06.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	24.07.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**		04.09.25 **9.00 am – 10.30 am** **Boardroom, DPOWH**	15.10.25 **10.00 am – 11.30 am** **Boardroom, HRI**	25.11.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	
Acute and Emergency Medicine Care Group		11.02.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	25.03.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		09.05.25 **10.00 am – 11.30 am** **Boardroom, HRI**	18.06.25 **3.00 pm – 4.30 pm** **Boardroom, DPOW**	30.07.25 **10.00 am – 11.30 am** **Boardroom, HRI**		09.09.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	20.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		01.12.25 **10.00 – 11.30 am** **Boardroom, DPOW**
Pathology Care Group		11.02.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	26.03.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**		09.05.25 **1.00 pm – 2.30 pm** **Boardroom, HRI**	19.06.25 **10.00 am – 11.30 am** **Exec Meeting Room, SGH**	30.07.25 **2.00 pm – 3.30 pm** **Boardroom, HRI**		08.09.25 **10.30 am – 12.00 pm** **Boardroom, Main Admin Block, CHH**	23.10.25 **10.00 am – 11.30 am** **Boardroom, HRI**		04.12.25 **10.00 am – 11.30 am** **Boardroom, HRI**
Specialist Medicine		19.02.25 **10.00 am – 11.30 am** **Boardroom, HRI**		02.04.25 **2.00 pm - 3.30 pm** **Exec Meeting Room, SGH**	12.05.25 **10.30 am – 12.00 pm** **Boardroom, DPOW**	24.06.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		04.08.25 **10.00 am – 11.30 am** **Boardroom, DPOW**	15.09.25 **11.00 am – 12.30 pm** **Boardroom, HRI**	27.10.25 **10.00 am – 11.30 am** **Boardroom, DPOW**		08.12.2025 **10.30 am – 12.00 pm** **Boardroom, DPOW**
Specialist Surgery		20.02.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**		03.04.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**	15.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block, CHH**	26.06.25 **3.00 pm – 4.30 pm** **Boardroom, Main Admin Block, CHH**		07.08.25 **10.00 am – 11.30 am** **Boardroom, Main Admin Block, CHH**	15.09.25 **3.00 pm – 4.30 pm** **Boardroom, HRI**	28.10.25 **10.30 am – 12.00 pm** **Boardroom, Main Admin Block, CHH**		12.12.25 **11.00 am – 12.30 am** **Boardroom, HRI**
Major Trauma Network		03.02.25 **9.00 am – 10.30 am** **Boardroom, DPOW**			13.05.25 **9.00 am – 10.30 am** **Boardroom, Main Admin Block, CHH**			07.08.25 **1.00 pm – 2.30 pm** **Boardroom, Main Admin Block, CHH**			06.11.25 **8.30 am – 10.00 am** **Boardroom, Main Admin Block, CHH**	
Cancer Network		03.02.25 **11.00 am – 12.30 pm** **Boardroom, DPOW**			13.05.25 **11.00 am – 12.30 pm** **Boardroom, Main Admin Block CHH**			11.08.25 **2.00 pm – 3.30 pm** **Boardroom, DPOW**			06.11.25 **1.00 pm - 2.30 pm** **Boardroom, Main Admin Block, CHH**	

MEETING SCHEDULE - 2026 - V7

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
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, HRI**		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 **Boardroom, CHH**	03.02.26 **Boardroom, DPOW**	03.03.26 **Boardroom, HRI**	07.04.26 **Nightingale, SGH**	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**			18.06.26 **Nightingale, SGH**			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)	29.01.26 **Boardroom, DPOW**	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**	27.08.26 **Boardroom, DPOW**	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 (2.00 pm - 4.30 pm)			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26 **Nightingale, SGH**	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 **Boardroom, DPOW**			23.04.26 (subject to NHSE Submission Deadline) **Boardroom, DPOW**		22.06.26 HUTH & NLaG **Annual Accounts** Monday - 9.00 am - 12.00 pm (subject to NHSE Submission Deadline) **Boardroom, HRI**	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			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 - 10.00 am - 1.00 pm - exceptions as stated)	06.01.26 (pm-tbc) 13.01.26 20.01.26 27.01.26	03.02.26 (pm-tbc) 10.02.26 17.02.26 24.02.26	03.03.26 (pm-tbc) 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 (pm-tbc) 14.04.26 21.04.26 28.04.26	05.05.26 (pm-tbc) 12.05.26 19.05.26 26.05.26	02.06.26 (pm-tbc) 09.06.26 16.06.26 23.06.26 30.06.26	07.07.26 (pm-tbc) 14.07.26 21.07.26 28.07.26	04.08.26 (pm-tbc) 11.08.26 18.08.26 25.08.26	01.09.26 (pm-tbc) 08.09.26 15.09.26 22.09.26 29.09.26 (pm-tbc)	06.10.26 13.10.26 20.10.26 27.10.26	03.11.26 (pm-tbc) 10.11.26 17.11.26 24.11.26	01.12.26 (pm-tbc) 08.12.26 15.12.26 22.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	24.02.26 (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)			10.03.26			02.06.26				06.10.26		01.12.26
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 - 10.00 am - 12.00 pm)	14.01.26 (2.00 pm - 4.00 pm)	18.02.26	18.03.26	22.04.26	20.05.26	17.06.26	15.07.26	19.08.26	16.09.26	14.10.26	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	

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)200

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in August 2025. The report includes documents sealed by Hull University Teaching Hospital (HUTH) NHS Trust during this period. Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust had no documents sealed during this period.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
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:

Use of Trust Seal – October 2025

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at HUTH has been used on the following occasions, NLaG did not have any documents sealed during this period:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
NLaG Documents Sealed			
	No documents sealed during this period		
HUTH Documents Sealed			
2025/03	HUTH and Andrew Johnson Ltd – Form of Agreement for the Daisy Building 2nd Floor remodelling	Lyn Simpson & Emma Sayner	08.08.2025
2025/04	HUTH and Hull City Council – Lease relating to Community Diagnostics Hub	Lyn Simpson & Emma Sayner	21.08.2025
2025/05	HUTH and Ridge and Partners Ltd – Lease relating to Community Diagnostics Hub for multi disciplinary team consultancy	Lyn Simpson & Emma Sayner	01.09.2025
2025/06	HUTH and HEB Group UK Ltd and Vinci Construction UK Ltd - Lease relating to Community Diagnostics Hub for completion works	Lyn Simpson & Emma Sayner	01.09.2025
2025/07	HUTH and The Monk Bridge Construction Co Ltd and Vinci Construction UK Ltd – Lease relating to Community Diagnostics Hub for completion works	Lyn Simpson & Emma Sayner	01.09.2025
2025/08	HUTH and Chemplas Ltd and Vinci Construction UK Ltd – Lease relating to Community Diagnostics Hub for completion works	Lyn Simpson & Emma Sayner	01.09.2025
2025/09	HUTH and Hadrian Architectural Glazing Systems Ltd and Vinci Construction UK Ltd – Lease relating to Community Diagnostics Hub for completion works	Lyn Simpson & Emma Sayner	01.09.2025

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
2025/10	HUTH and Imedco Ltd and Vinci Construction UK Ltd – Lease relating to Community Diagnostics Hub for completion works	Lyn Simpson & Emma Sayner	01.09.2025
2025/11	HUTH and P+HS Architects Ltd and Vinci Construction UK Ltd – Lease relating to Community Diagnostic Hub for the provision of Fire Safety plans and fire stopping design services	Lyn Simpson & Emma Sayner	01.09.2025
2025/12	HUTH and Omega Fire Engineering Ltd and Vinci Construction UK Ltd – Duty of care deed for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/13	HUTH and Phoenix Drywall (UK) Ltd and Vinci Construction UK Ltd – Duty of care deed for the completion works for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/14	HUTH and Faulkner Browns LLP and Vinci Construction UK Ltd – Duty of Care Deed relating to Architect Services for the Community Diagnostic Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/15	HUTH and ASG Fabrications Ltd and Vinci Construction UK Ltd – Duty of Care Deed for the provision of completion works for the Community Diagnostic Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/16	HUTH and Briggs Amasco Ltd and Vinci Construction UK Ltd – Duty of Care, deed for the provision of completion works for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/17	HUTH and Mott Macdonald Ltd and Vinci Construction UK Ltd – Duty of care deed rebating to structural engineering and civil engineering services for the Community Diagnostic Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/18	HUTH and Gillespies LLP and Vinci Construction Uk Ltd – Duty of Care Deed relating to Landscape/site Architect for the Community Diagnostic Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/19	HUTH and Roger Bullivant Ltd and Vinci Construction UK Ltd – Duty of care deed relating to the provision of everything relating to the three ships mural works for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
2025/20	HUTH and Classic Lifts Ltd and Vinci Construction UK Ltd – Duty of Care , deed for the provision of the delivery and installation of lifts for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/21	HUTH and Vinci Construction UK Ltd - Duty of Care deed relating to the construction work for the Community Diagnostics Hub	Lyn Simpson & Emma Sayner	01.09.2025
2025/22	HUTH and Humber Teaching NHS Foundation Trust – Lease relating to the land south of Beverley Community Hospital	Lyn Simpson & Emma Sayner	01.09.2025
2025/23	HUTH and Humber Teaching NHS Foundation Trust – Licence for alterations relating to land to the South of Beverley Community Hospital	Lyn Simpson & Emma Sayner	01.09.2025

Action Required

The Trust Boards-in-Common are asked to note the report.

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)208

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**09 October 2025**
Director Lead	**Kate Wood, Group Chief Medical Officer**
Contact Officer / Author	Linsay Cunningham, Group Deputy Director of Strategy and Partnerships
Title of Report	**Clinical Strategy**

Executive Summary	The Group Clinical Strategy has been designed to provide a clear, positive vision for the future of our clinical services.
	
	The strategy has been developed in response to the changing health needs of our population, advances in treatments and healthcare technology and changes in local and national policy – most significantly, the recent publication of the government's 10 Year Health Plan.
	
	The strategy provides an overarching vision for our clinical services in five years' time, and a set of core design principles that give the framework for our clinical teams to design models of care for the future that are more sustainable and meet the needs of our population in years to come.
	
	The document describes:
	
	• Our Ambition
	  - to consistently deliver **safe, sustainable** and **inclusive** healthcare services that meet our population's diverse needs.
	• Our Clinical Operating Model for
	  - Tertiary and specialist services
	  - Core district general hospital (DGH) services
	  - Community and virtual hospital
	• What will be different for
	  - our patients, people and population
	• How we will transform our services by
	  - Building solid foundations
	  - Transforming our services
	
	The clinical strategy will enable leaders and decision-makers within the organisation to make decisions about how best to prioritise investment in our digital infrastructure, physical estate, and equipment. It will help us to identify our future workforce requirements and ensure we are training and developing the type of people and roles we will need to deliver care differently in the future.
	
	Utilising the principles set out within the Clinical Strategy, all Care Groups will be required to refresh their Strategies on a Page and develop five-year plans for the services they manage. This work will be undertaken as part of the 2026/27 planning round, which requires organisations to produce five-year strategic plans in addition to one-year operational plans. This work will be undertaken through Q3.

	This work will enable us to prioritise services for inclusion in a rolling programme of service transformation that will take place over the timeframe of the strategy. The pace of change and transformation will be regularly reviewed and challenged through the group's internal performance and accountability processes and structures and, where necessary, escalated to the most relevant board committee (Performance, Estates and Finance CiC and/or Quality and Safety CiC, as appropriate). **Recommendation** The Board is asked to: • Discuss and approve the clinical strategy to enable Care Groups and Clinical teams across the Group to begin working towards implementation.
Background Information and/or Supporting Document(s) (if applicable)	Clinical Strategy
Prior Approval Process	• Review of draft strategy by Chiefs of Service and Directors of Nursing (August 2025) • Extended Executive Strategy session (19/08/25) • Quality and Safety Committee in Common (25/09/25)
Financial Implication(s) (if applicable)	No direct implications – the Clinical Strategy sets the framework for delivery of services within available resources
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No direct implications – the Clinical Strategy sets the framework for action to address health inequalities
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

CLINICAL SERVICES STRATEGY

2025 - 2030

NHS
Humber Health
Partnership

Other Formats

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information you can contact:

Call (01482) 674828

Email nlg-tr.comms@nhs.net

Write to Communications, Alderson House Hull Royal Infirmary, Hull, HU3 2JZ

Strategy on a Page (2025 - 2030)

United by Compassion – Driving for Excellence

NHS Humber Health Partnership

In five years... we will be one of the leading hospital groups in the UK, delivering safe, sustainable and inclusive healthcare services

Guided by our values...

Compassion | Honesty
Respect | Teamwork

We will achieve this by focusing on our...

Patients

We will make sure our patients get the safe, quality care they need and have a good experience

People

We will put our people first, supporting our teams to be the best they can be and grow our future workforce

Population

We will focus our efforts on those with the greatest needs and help people in our communities to live well

To deliver our strategic goals...

Our Patients get the best care

CQC Outstanding

Top 25% performance

Our People feel proud to work here

75% recommend as a place to work and be treated

Our Population live more years in good health

Gap in access for people from deprived areas halved

We will strive to be...

Pioneers

We will embrace digital and tech, prioritise research and innovation and build skills for transformation

We push the boundaries

Partners

We will work well with others, build trust and develop ambitious partnerships for the future

We work in partnership

Guardians of the Public Purse

We will live within our means, deliver value-based care and reduce our impact on the planet

We use our resources well

NHS Humber Health Partnership

Clinical Services Strategy 2025/30

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Foreword

The NHS is constantly changing and adapting as new technologies, treatments and approaches make it possible for us to do more to enhance the lives and life chances of our patients and service users. It is important we continue to embrace the opportunities that change can bring and equip our people to adapt so they are able to provide the best possible care to our patients.

We are facing unprecedented challenges within the health and care sector. Demand for healthcare services is growing and set to grow even faster in years to come yet the resources we have available to us are not growing at the same rate. Our population is getting older, more frail and, at every stage of life, the patients we see in our organisation have increasingly complex needs. The gap in life expectancy between those living in our most deprived communities and those in our most affluent is more than a decade and our population is living for an average of 20-25 years in poor health. We cannot simply do more of the same – if we are to give our patients the best possible care, we must radically re-think how we deliver services in the future.

We have come together as a group of two hospital trusts because we recognise that together we have greater strength and stand a better chance of meeting these challenges. By working together, we can harness the unique talents of all 19,000 of our people. We can put in place more sustainable and resilient services that will deliver safe and effective care for our patients, no matter which part of the region they live in. We can use our size to leverage new digital and technology opportunities, broaden the reach of our research and academic partnerships and build a name for our organisation as a leader in innovative care delivery in rural, coastal and deprived communities.

We know we have a long way to go. We have clinical quality and safety challenges within both trusts. We are failing to meet the expected standards across a range of services and too many of our patients are waiting too long to get the care that they need.

By working together, we can meet these challenges head-on and deliver long-lasting, sustainable change. We will continue to strive for excellence, united by our compassion and shared desire to make a difference in the lives of our people and communities.

Amanada Stanford

Group Chief Nurse

Dr Kate Wood

Group Chief Medical Officer

Who we are

About Us

Across the NHS Humber Health Partnership (HHP) we provide healthcare services to a population spanning around 1,500 square miles, home to a diverse mix of rural, coastal and urban communities.

Our district general hospital services provide care for a population of just over 1 million people across both banks of the Humber estuary, from our five hospital sites supported by a network of community locations. Our tertiary and specialist services serve a population of around 1.5 million people across Humber and parts of North Yorkshire and Greater Lincolnshire. Additionally, we provide a range of community health services for people living in North and North East Lincolnshire.

Our Vision

Our vision is: United by Compassion, Driving for Excellence.

We have come together as a group so that we can work together to solve our collective challenges, bringing the strengths and assets of both organisations delivering more than the sum of its parts. Whilst bringing together clinical teams across two organisations is challenging, there is much we can gain from sharing and learning from the different experiences and different ways of working each service, team and individual brings.

Our organisation in numbers... every year we see

8,100
Births

356,700
A&E attendances

155,000
Admissions to hospital

141,500
Day case operations

1,309,000
Outpatient appointments

Purpose of the Clinical Strategy

We have developed this clinical strategy to provide a clear, positive vision for the future of our clinical services. As we face unprecedented challenges and changing health needs of our population, this clinical strategy provides the framework to enable our clinical services and teams to adapt to changes in local and national policy, changes in the needs of our population and advances in treatments and healthcare technology. This strategy provides the framework for our clinical teams to design models of care for the future that are more sustainable and meet the needs of our population in years to come.

The strategy provides an overarching vision for our clinical services in five years' time, which will support us to make decisions about how best to prioritise investment in our digital infrastructure, physical estate, and equipment. It will help us to identify our future workforce requirements and ensure we are training and developing the type of people and roles we will need to deliver care differently in the future.

Our clinical strategy provides a roadmap for the further detailed work we will undertake over the coming years to enable us to transform our clinical services and radically reimagine how and where we deliver care. This will be vital if we are to deliver our organisational ambition: to be one of the leading hospital groups in the UK, delivering **safe**, **sustainable** and **inclusive** healthcare services.

Where we are now and why things need to change

Opportunities and assets

Coming together as a group presents new opportunities for us as an organisation and means we are better placed to deliver our ambitions for our population.

With over 19,000 people working in our organisation, some of the most highly trained and highly skilled individuals in the region, 380,000 square meters of real estate and an annual turnover of c.£1.6 billion, we have a range of assets at our disposal. With more than 5,000 patient contacts every day, we have an incredible opportunity to influence the lives of people living in our region both directly through the provision of high-quality care and indirectly through our influence in communities and our impact in the local economy.

Our population is diverse, and we serve a distinctive mix of rural, urban and coastal communities, many with high levels of deprivation which impact upon health and life chances. Whilst this presents significant challenges for us in meeting our population's healthcare needs, it also presents opportunities to be at the forefront leading change in how the NHS delivers care and tackles inequity in health and health outcomes. We have opportunities, working with research, policy and industry partners, to be at the forefront of designing the solutions that will enable the whole of the NHS to meet the growing and changing demands of the future.

The changing national policy landscape also presents us with opportunities to think differently about how and where we deliver care and enables us to work in a more integrated way with partners to improve outcomes for patients.

Key challenges

Our population

The population we serve has significantly poorer health outcomes than people living in other parts of the country.

Like in other parts of the country, our population is getting older. The number of people in our region aged over 75 is set to treble in the next 20 years, which will continue to drive increases in demand for healthcare and put increased pressure on our hospital services.

Deprivation drives inequity in health outcomes and increased barriers to accessing care. A significant proportion of our population (more than 50% in Hull and around a third across Northern Lincolnshire) live in communities that are classed as the most deprived in England.

People in our region are not always living well in their older age. Due to deprivation and a range of other factors our population are living with one or more health condition for an average of 20-26 years. Levels of acuity, complexity and comorbidities are rising and our patients and service-users require more joined-up approaches to meet their increasingly complex needs.

Our rural and coastal geography, combined with high levels of deprivation, can make it difficult for people to get around to access healthcare, visit loved ones in hospital and access employment opportunities. Digital and health literacy levels are low across many communities and people do not always have access to the tools they need to improve their health and wellbeing.

Responding to these challenges requires a whole-system approach to deliver prevention, early intervention, self-help and increased support at or close to home to improve the overall health and wellbeing of our population.

Where we are now - and why things need to change

Our clinical services

Our clinical services operate within an extremely challenged health and care system and are not always meeting the needs of everyone in the region and are not set up to do so in the future.

- We are not providing the standards we should be in all our services – too many people are waiting too long to be seen and treated.
- We don't have enough staff to continue to do everything everywhere – due to workforce shortages and the way in which services are configured, we are struggling to meet a number of key clinical standards, and we are not always making the best use of the skilled expertise we have.
- Some of our buildings and equipment are not fit for the future – ageing estate, equipment and digital infrastructure impacts upon our ability to deliver effective care to meet the demands we face.
- We face structural deficits and long-running finance challenges – a structural deficit exists where we are providing the same service across multiple sites, which creates pressure on staff, results in double running costs and low productivity.

As a collective of hospitals working better together, we can provide improved services and care for all. But to do so, **things need to change. We need to significantly change how we provide care for the population of the Humber.**

National policy drivers

In July 2025, the Government published their Ten Year Health Plan for England. This plan sets out a vision for health and healthcare in the future that will fundamentally re-wire the NHS transforming through three major shifts:

- Hospital to community
- Analogue to digital
- Treatment to prevention

The NHS of the future will be based on a neighbourhood model of care delivery, rooted in places and communities wrapping services around the patient and their needs rather than organising them around current provider boundaries and ways of working. This turns our current models of care on their head and reduces the prominence of the hospital as the main focus of healthcare services in England.

Our clinical strategy has been designed to support us to deliver this national vision in our area and sets the framework for our clinical services to transform and integrate into new neighbourhood-based ways of working. This will require significant change and transformation as resources are shifted out of hospital and bed-based models of care and into new ways of working in and with local people and communities.

This transition will rely on significantly improved digital infrastructure and connectivity between organisations and individuals, a more digitally literate workforce and targeted support for people to get online so they can access advice and support when and where they need it.

The Ten Year Plan also requires us to get more serious about prevention and supporting people to live well and stay healthy – a "health" service, rather than a "sickness" service. Within our clinical services, we must identify and exploit opportunities for secondary prevention to help our patients to live well with their health conditions and avoid exacerbations. Our clinical services must also adapt to enable them to provide more proactive interventions to get 'upstream' of problems before they emerge.

These three shifts were fundamental to shaping our clinical strategy and future direction.

Where we want to be

Our Group Ambition

Our five-year ambition for our group is to be one of the leading hospital groups in the UK, delivering safe, sustainable and inclusive healthcare services that meet our population's diverse needs.

In five years:

Patients

We will be one of the leading hospital groups in the UK, delivering **safe**, **sustainable** and **inclusive** healthcare services.

People

We will be an organisation that attracts ambitious and forward-thinking people to work here – providing challenge, reward and opportunities to really **make a difference**.

Population

We will be at the forefront of designing new and innovative ways to meet the healthcare needs of rural, coastal and deprived communities – taking hospital expertise into communities in sustainable ways, delivering **value** and **excellence** for our population.

This strategy, for clinical services describes how we will achieve that vision by working together across our group and with wider partners.

What good looks like

Our ambition is to consistently deliver **safe**, **sustainable** and **inclusive** healthcare services that meet our population's diverse needs.

Safe

- Patients can access the care they need in a timely manner and our services perform well against national standards (e.g., GiRFT and other national benchmarking tools).
- A just and learning culture is embedded across the organisation.
- Our safety culture is supported through robust governance processes.
- We have the right systems, processes and skills in place to ensure vulnerable patients and service-users are kept safe at all times.
- We have safe and effective staffing in place across our services, ensuring the right skill-mix and levels of supervision are in place within services.
- Our staff have the skills and knowledge they need to work safely.
- Our teams work in environments that promote and enhance the delivery of safe care.
- Our teams work proactively to eliminate avoidable harm (including infection, falls, medication errors).
- Information is joined up and clinical teams have access to the information they need when they need it.

What good looks like

Sustainable

- Care is delivered in the most appropriate setting and by the most appropriate professional.
- Our services make the best use of the available resources and there is optimal configuration of workforce (no duplication).
- Our services are right-sized to meet current and future need, within the resources available to the system (right-sized services).available to the system (right-sized services).
- We promote and sustain the appropriate mix of tertiary services to meet our population needs within the resources available.
- There is appropriate depth and resilience within clinical teams to enable a consistent offer to patients (no fragility).
- Succession planning and growing a sustainable future workforce is prioritised within service design (futureproofing).
- Research and innovation focused on finding ways to meet the needs of our population drive change within services.
- Our services are designed to support prevention and self-management to reduce demand and increase the value of our interventions.
- Our services actively work to reduce their impact on the environment.

What good looks like

Inclusive

- Our services are built around patient needs not around service, geographical or disciplinary boundaries (patient-centred).
- Our services work to reduce not widen health inequalities.
- Our services are provided in a way that is welcoming, open, and supportive for all.
- Our teams are supported and enabled to deliver compassionate care without judgement and discrimination within our services is actively sought out and tackled.
- Care is joined up across organisational and sectoral boundaries to ensure the needs of vulnerable people are met effectively.
- Our services enable innovative use of the clinical workforce, supporting different professions to work together as equals, delivering for the benefit of patients.

Our Clinical Operating Model

Our overarching clinical operating model is designed to address the challenges set out above and ensure that our patients receive excellent care, the first time, every time. This means compassionate care that is built around the individual and their needs, wants and aspirations, and not built around organisational processes or geographical boundaries.

It seeks to deliver clinical services that are:

- **Safe** – in our clinical services everyone we care for is well looked after and kept safe. We actively prioritise safety in our culture, systems and behaviours, recognising that healthcare carries inherent risks.
- **Sustainable** – our clinical services are reliable and deliver value. Recognising that we can't do everything everywhere, we make the best use of all our resources (people, buildings, equipment, money) and focus on the things that matter most to our patients and their loved ones.
- **Inclusive** – our clinical services meet the diverse needs of our population. We take positive action to remove barriers and work in a way that is equitable and recognises the underlying inequalities and challenges some of our communities face.

Our clinical model has been designed to ensure that our services will be able to meet the changing needs of our population, now and into the future.

Overview

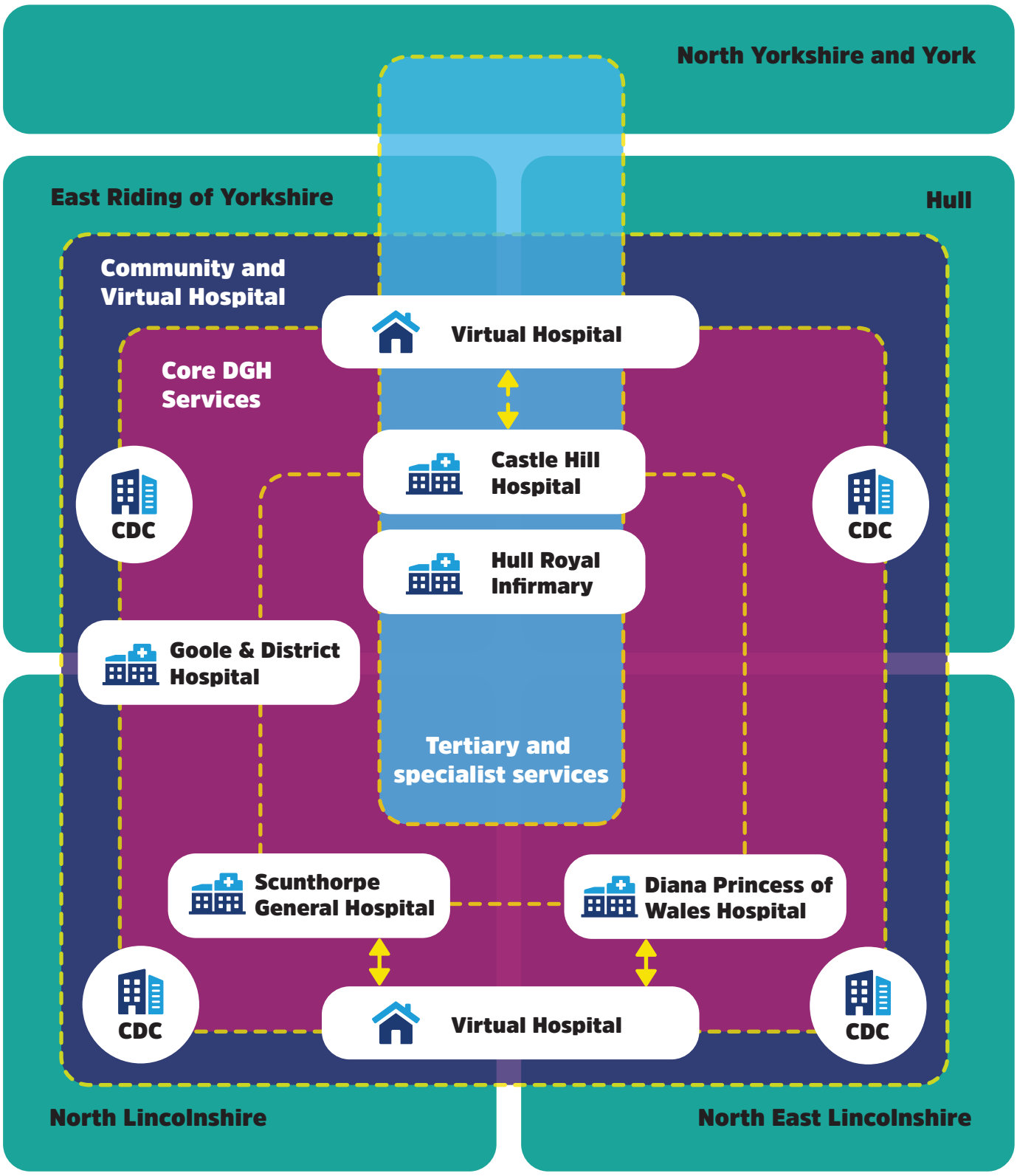
Our clinical model begins with the assumption that care will only take place in a hospital setting if it absolutely needs to, recognising that many patients could have their health needs met better in an alternative setting or via a different type of intervention if services were designed differently. It seeks to deliver equitable access to hospital-level expertise, ensuring scarce specialist resources are targeted to those who need them most. It leverages the benefits of working as a group by putting in place networked services with centralised functions where these add value and distributed modes of delivery to support local access.

To deliver care in this way, our workforce must be freed up to work differently, to provide care remotely, to collaborate with colleagues across care groups, sites, specialisms and organisations and to be more adaptable and agile in their approach. This will require a radical shift in our approach to digital and technology, putting in place effective digital infrastructure and building the skills, confidence and enthusiasm needed in both our staff and our patients. It will also require our patients, people and population to take a more active role in their care and in improving their health and wellbeing.

Clinical Services Approach

The diagram below sets out the core elements of clinical service provision within our clinical operating model and how these work together to provide effective care for the population we serve in and beyond the Humber region. Three broad areas of services are described in the model:

- Tertiary and specialist services
- Core district general hospital (DGH) services
- Community and virtual hospital



Specialist and tertiary services

Definition: specialist expertise serving a wider population

Guiding principle: do once, do well – support people to access

Unless there is a compelling population need or clinical requirement, specialist, tertiary and quaternary services will be provided from one site with clinical expertise, equipment and other resources consolidated together to drive improved service quality and long-term sustainability.

In most cases this will be either Castle Hill Hospital (CHH) or Hull Royal Infirmary (HRI), however, some specialist services may be better suited to be delivered from one of our other hospital sites or in a community location. As plans are developed for each of our clinical services, opportunities to consolidate specialist care at other HHP sites will be explored to ensure we are driving best value across the whole group and making the most of our skills and expertise across both banks of the Humber estuary.

Core district general hospital (DGH) services

Definition: core offer supported by networked specialist provision

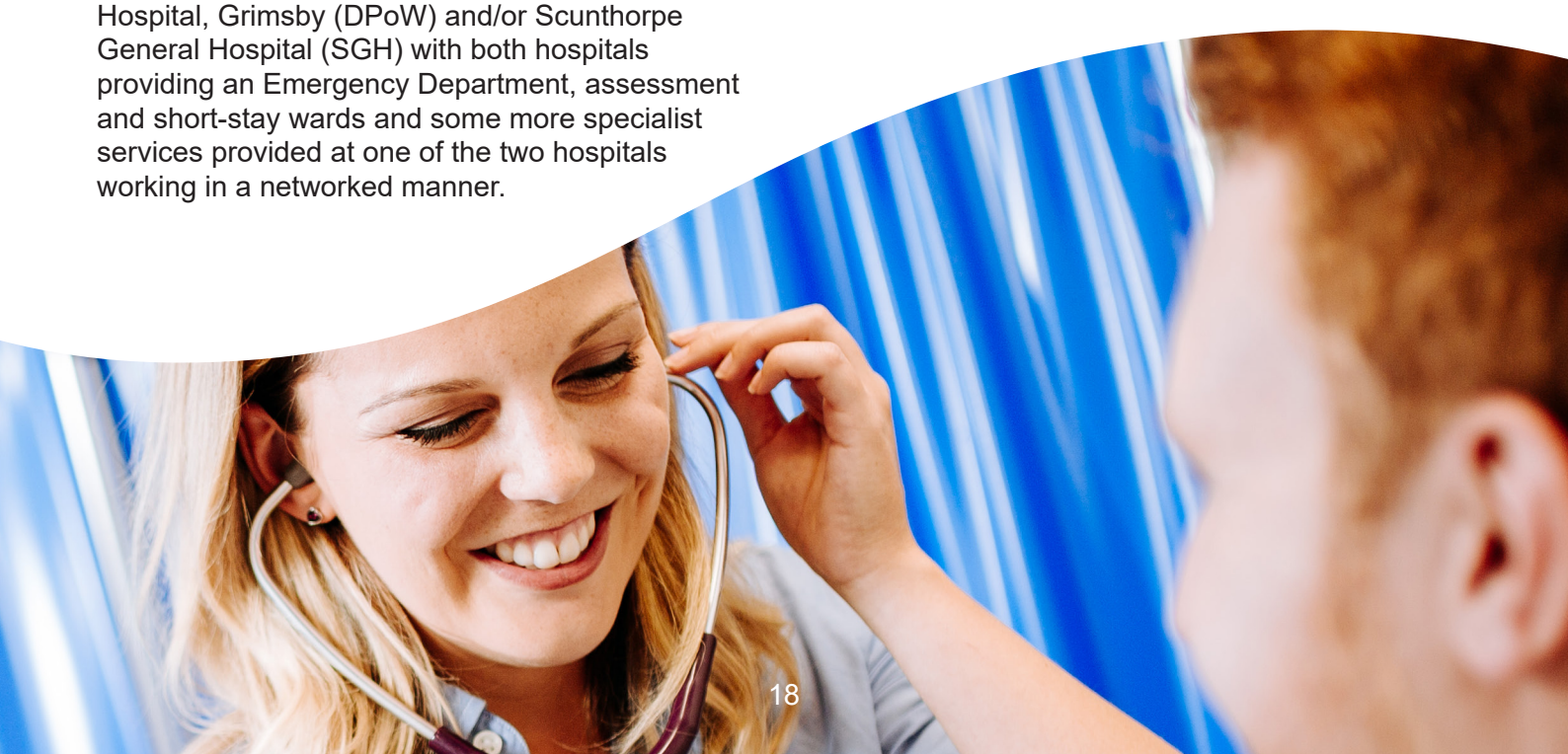
Guiding principle: do efficiently, do equitably – make best use of resources to provide excellent care as close to where people live as possible

Our core DGH offer will provide for the majority of the hospital needs of the local population by providing high quality, sustainable services across some or all of our main sites. We will work to maximise the benefits of the group model by consolidating elements of services into fewer locations to improve outcomes for patients and create sustainable centres to build skills and expertise. Services will be effectively networked with consistent pathways across the group to ensure equitable access for all patients irrespective of where they first interact with us.

On the whole, residents of Hull and East Riding will access District General Hospital (DGH) services at either Hull Royal Infirmary (HRI) or Castle Hill Hospital (CHH) with most emergency and maternity care provided at HRI and the majority of elective services provided at CHH. Residents across Northern Lincolnshire, will access the majority of their DGH service at Diana Princess of Wales Hospital, Grimsby (DPoW) and/or Scunthorpe General Hospital (SGH) with both hospitals providing an Emergency Department, assessment and short-stay wards and some more specialist services provided at one of the two hospitals working in a networked manner.

A range of DGH services that meet the local population health needs will also be provided at Goole and District Hospital (GDH) for communities living in and around Goole.

Diagnostic services, outpatient consultations, pre- and post-operative care and simple procedures will, wherever possible, be provided in each of the five communities and as close to home as possible, integrated into Neighbourhood Health services and new community-based ways of working. As plans are developed for each of our clinical services, opportunities to shift elements of core service provision out of our hospital buildings and into communities and peoples' own homes will be explored as a top priority.



Community and virtual hospital

Definition: hospital expertise provided in peoples' own homes and other community locations

Guiding principle: do differently, do more – embrace technology and new ways of working to bring hospital expertise closer to where patients are

Our clinical services in five years' time will look fundamentally different from how they look today with far more care delivered remotely, in peoples' own homes and in community locations away from our main hospital sites. We will reduce the overall size of our physical estate and take advantage of new and emerging technologies to deliver care in or close to where people live, integrating fully into new models of Neighbourhood Health delivery.

Across specialist and core district hospital services, we will develop more ways for patients to interact with clinical professionals at a time and in a manner that works for them. We will enable patients to take greater ownership of their own conditions through remote monitoring and support and responsive services that ensure they get the input from specialists they need when and where they need it.

As we develop new models of care delivery, we will take an equity-driven approach that recognises the barriers faced by many in our communities – such as of digital poverty, low levels of literacy and social isolation. We will adapt our delivery methods to ensure no one is left behind.

Building the Virtual Hospital

One of the most critical elements to ensuring the success of our clinical strategy will be our work to build the virtual hospital within our group. Expanding capacity through our virtual hospital is critical to ensure we can meet the anticipated growth in demand within the resources we have available to us.

Virtual wards, virtual care and remote monitoring at scale will drive improved efficiency of services, reduce footfall on our hospital sites and support people to have a better experience of care. When it works well, virtual hospital provision enables people to sleep in their own bed, stay close to family and friends and continue with the things that matter most to them. It can also enable patients and healthcare providers to work together to prevent a health condition from deteriorating.

Our vision

In building our virtual hospital we are **seeking to re-create all the elements of a hospital in a virtual space**, with tech-enabled care wrapping around patients where they are.

Our virtual hospital will work alongside our physical sites and be fully integrated into our existing service offer. In five years, virtual care will be a core element of every service within our organisation. The front door of the virtual hospital will be as easy (if not easier) to access than the front door of our physical sites.

How we will deliver it

We will build on the pockets of good practice we have already – such as our respiratory virtual ward or paediatric Hospital at Home – and expand our offer into homes, including care homes, across the region. We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded.

We will develop appropriate virtual care pathways and approaches for each of the core building blocks of a hospital, which may include some or all of the following examples:

- Urgent and Emergency Care (supporting remote triage and preventing unnecessary ambulance conveyance to hospital)
- Inpatient care (virtual wards at scale, enabling more people to go home sooner or avoid an inpatient stay altogether)
- Outpatients (turning condition management pathways on their head, using medical devices and AI-enabled surveillance to detect changes in a patient's condition and provide the support they need remotely without the need for regular check-ups)
- Diagnostics (taking diagnostics to the patient, such as mobile X-ray services)
- Maternity and Paediatrics (virtual wards, remote monitoring)

Virtual hospital solutions will look different for different cohorts of patients, different specialties and different levels of need. Some may require very little in the way of technology, others may require significant investment in digital infrastructure, wearables and other equipment.

Our virtual hospital offer will be fully integrated into Neighbourhood Working. It will help to ease the pressure on our physical sites and hospital-based teams and support the broader shift of care from hospitals to communities as described in the Ten Year Health Plan.

Design Principles

The clinical operating model described above is underpinned by a set of design principles. These design principles describe how clinical services will be designed and operated across the Humber Health Partnership (HHP) group, enabling the shifts described in our clinical model and national health policy. Each design principle has a number of associated actions that our clinical service leads will work through together to enable the three shifts from hospital to community; analogue to digital; and treatment to prevention.

The design principles will be used by care groups to shape the future of their services over the coming months and years. Each care group will critically evaluate their service areas and reshape what they do and how they do it in line with these principles in order to implement this clinical strategy across our hospital group over the next five years.

Design Principle	Strategic Actions
Care will only take place in a hospital setting if it absolutely needs to	• Work with partners to shift the locus of care away from hospital beds and towards community-based alternatives wherever it makes sense to do so. • Re-imagine our model for outpatient services and stop providing outpatient appointments without procedures on main hospital sites by the end of this strategy period. • Build our virtual hospital to deliver an increasing proportion of hospital-level care through virtual and remote models.
Services will operate in a networked model across the group	• Standardise/align clinical pathways to remove unwarranted variation across the group. • Re-design models of care delivery to maximise the benefits of working at scale across the group, whilst maintaining local access wherever possible. • Develop single points of access to services to direct patients to the most appropriate clinical professional for their needs – freeing up our most specialist resource to treat those with the most complex needs.

Design Principle	Strategic Actions
Clinical expertise will be deployed flexibly and move to where (and when) they are needed	• Put in place the supporting infrastructure and culture (HR, training, support services, e.g. pathology) to enable flexible deployment of clinical expertise across the group and enable teams to access opportunities and environments to develop specialist skills. • Build the digital infrastructure (including a new EPR) that enables teams to work flexibly and remotely. • Develop our data and insight capabilities to enable real-time decision-making and flexibly deploy resources to meet demand. • Review job plans, rotas and workforce plans to ensure the workforce is deployed effectively across the group.
Consolidation of services, where required, can take place at any site	• Review potential configuration options for fragile and vulnerable services to drive improved sustainability, exploiting opportunities to develop centres of excellence both north and south and enabling teams to work flexibly across the group.
Clinical pathways will be designed to work across the whole system	• Work with partners across primary, secondary and community care to streamline diagnostic and treatment pathways, so organisational boundaries do not get in the way of providing the best patient care. • Develop a core offer to support effective delivery of Neighbourhood Health provision across the Humber. • Work with neighbouring providers to develop sustainable models of care for specialist and tertiary services that meet wider population health needs.

Design Principle	Strategic Actions
Clinical services will focus on delivering effective care that adds most value for patients	• Identify and cease providing procedures and practices that are of limited clinical value, with support from commissioners where required. • Empower clinicians, patients and their loved ones to make informed decisions about their care based on what matters most to them, recognising that what defines a good outcome will be as individual as each person we treat. • Seek to embed the principles of Realistic Medicine within our clinical services with support for teams to adopt new ways of working that drive better value.
Patients, carers and loved ones will be active partners in their health and care	• Embed shared decision-making across clinical services. • Develop pathways that encourage and support better self-management and secondary prevention – giving patients more control and responsibility for directing their own care. • Work with partners to deliver improved health and digital literacy for the population.
Services will seek to deliver equity in access, experience and outcomes	• Develop a robust approach to identifying and measuring health inequity. • Involve service-users and experts by experience in clinical re-design and implementation of change to help design out structural barriers and inequity. • Improve awareness and understanding of health inequity through training and experiential learning for teams.

Our ways of working

Turning the clinical model described above into a reality will require our teams to adopt new ways of thinking and doing. Our Group Strategy describes how we will work as an organisation to deliver change and improvement, working as:

- Pioneers – we push the boundaries
- Partners – we work in partnership
- Guardians of the Public Purse – we use our resources well

Pioneers

As we look to the future, our clinical services must continue to prioritise research and innovation, this will be vital to enabling continuous improvement and long-term viability of clinical specialisms. Increasingly, we will focus our research on the issues that are most pressing to our population and use our unique assets (e.g., the longitudinal health records we hold for specific disease areas, the diversity of our population and its unique health challenges and disease burden) to promote the Humber as a testbed for innovation in healthcare research globally. Humber as a testbed for innovation in healthcare research globally.

Partners

The new clinical operating model described will only work if delivered in true partnership with others across the health and care system. In order to meet the increasingly complex needs of our population and deliver care that is centred around the individual, we need to ensure our services are fully integrated both digitally and operationally. Our clinicians across acute, primary, community and mental health must embrace shared ownership and risk for patient safety and outcomes to design pathways that really do put the patient at the centre.

Public purse and planet

As we redesign our clinical services, we will robustly question everything we do and why we do it. Looking at every penny of public money we spend within a service and asking if we are getting the best value for it. Carefully considering our processes and ways of working to identify where we could reduce our impact on the planet and improve the experience for our patients. Stripping out wasteful duplication will reduce frustration for staff, improve outcomes for patients and help to guard the public purse.

What will be different?

In delivering the clinical vision described above over the coming five years, the services we provide will look and feel very different to our patients our people and our population.

For our patients

- “I rarely go to the hospital anymore. If my heartbeat or other measurements look a bit off, the hospital will message me to let me know and send me to the health centre for a scan or a blood test and I’ll get the results in the app. If I need to speak to someone, I have a number I can call, and they always get back to me.”
- “When I had to wait for my surgery, they gave me a choice about where I could go and told me how long the waits were in each place. I could track my position in the queue on the app and I had exercises I could do to get myself as fit as possible ahead of my operation.”
- “When I was really poorly and they didn’t know what was wrong with me, the different doctors and nurses from different areas all came to see me where I was and came up with a plan. I was able to go home after a few days, when I was at home they hooked me up to all these monitors and the nurse came by each day to check on me.”

For our people

- “I have learnt so much over the last few years because I have had the opportunity to move around and work with different experts around the group.”
- “I spend my time doing the job I trained for, not filling out loads of forms or chasing down information or doing tasks that other people could do. I get to spend time with patients, and I love it!”
- “I have access to the right equipment, the right support staff and decent buildings which help me to do the best for my patient.”
- “We have bigger, more resilient teams now so we can take time off and cover for each other. When I go away, I don’t have to worry anymore about who will look after my patients when I’m gone.”
- “My department is involved in some really exciting research projects, and I am excited about the potential to make new advances and save more lives.”

What will be different?

For our population

- “My grandchildren were very impressed when I showed them how I track my blood sugars on my phone. I don’t think they realised I knew what an app was!”
- “My stay in hospital gave me the kick I needed to finally quit smoking. It’s been a long time coming but the extra support I got from the team helped me to get where I wanted to be.”
- “When I couldn’t afford the data on my phone, my midwife helped me to get a voucher so I could stay connected and access my maternity notes when I needed them. It helped me to feel safe during my pregnancy and really meant a lot that they thought to ask and didn’t make assumptions.”

How we will get there – our roadmap for delivery

Delivering the vision set out in this strategy will require significant and sustained change across our clinical services. Across every clinical service area, we will apply the design principles set out above to reshape the model of care delivery to ensure the service can meet growing demand within the resources available to the system. We will seek to exploit all the benefits of working as a group across a broad geography to build more resilient services and teams. Working with commercial and academic partners on innovative research projects, pioneering new roles and trialling new digital technologies will support in making our clinical services attractive places to work and to train, building and sustaining the workforce we need for the future.

Building solid foundations

1

Alignment

As a relatively new group, there is still inequity and unwarranted variation within our clinical services, between and sometimes within our constituent organisations. Many of our clinical services are operating with difference and variation within the group, such as, for example, different referral routes for patients, different approaches to triage, prioritisation and waiting list management, different operating procedures and ways of working and different standards of training and support for development.

In addition, many of the support services and enabling systems which our clinical services rely upon – such as pathology, radiology, digital systems, booking and scheduling – have been designed, procured and/or operated differently within our different organisations and sometimes even between different teams and individuals.

Operating as a group offers significant opportunity to improve the efficiency and effectiveness of our clinical services, but this will only be delivered through a sustained effort to drive convergence in systems and ways of working and eliminate unwarranted variation across the group.

In year one each of our Care Groups will:

- Confirm leadership arrangements and align clinical teams and ways of working within each service area they are responsible for.
- Identify, within every care group and clinical service, all instances of duplication and unwarranted variation and develop a plan to address these.
- Design and implement fully aligned clinical pathways and operating procedures across north and south bank services, undertaking this work through the Electronic Patient Record (EPR) replacement programme.
- Ensure all internal processes and ways of working are aligned within each Care Group and (wherever possible) between them.
- Where service changes and developments have been agreed – e.g., through the Humber Acute Services programme – ensure changes are implemented as swiftly and effectively as possible.

2 Preparing for transformation

Through the alignment work within Care Groups, we will identify and prioritise areas where transformation and change is more pressing and/or requires additional support. During this time, we will also undertake preparatory work in a number of areas.

As an organisation, we will:

- Complete a business case and programme plan for the Virtual Hospital, clearly identifying the scope of change, the priority areas for transformation and the resource required to undertake this work.
- Identify and prioritise services where reconfiguration and/or substantive change may be required, developing an appropriated phased programme of work to support this transformation.
- Undertake a review to confirm our tertiary portfolio, based on population need, available resources and wider partnership and system considerations.
- Complete a business case for expansion of robotic surgery, taking into account population needs, estates considerations and workforce requirements to identify the best approach.

3 Building blocks for change

In order to undertake the level and scale of transformation that is required, we must put in place solid foundations and key building blocks for change.

We will:

- Produce a strategic bed model to enable us to align capacity to demand across the Group, ensuring we have the right beds in the right places with the right staffing models to support.
- Ensure every clinician has an up-to-date job plan and review our approach to operational planning to ensure job planning aligns to anticipated demand within services.
- Ensure we have the infrastructure – data warehouse and reporting framework – knowledge and skills within teams to use data to drive decision-making and future planning for clinical services.
- Build the skills and capability of our clinical leaders to drive transformational change, encouraging and supporting our leaders to go and learn from others and broaden the reach of their networks.

Transforming our services

4 Prioritisation

Building on the foundations laid, we will seek transform our clinical services across the group over the coming years.

Applying the design principles set out above, we will review and redesign clinical services in each of our Care Groups over the coming two to three years. This will be done through a robust and structured programme of review and transformation, prioritised according to a risk-based assessment across the three domains of safety, sustainability and inclusivity.

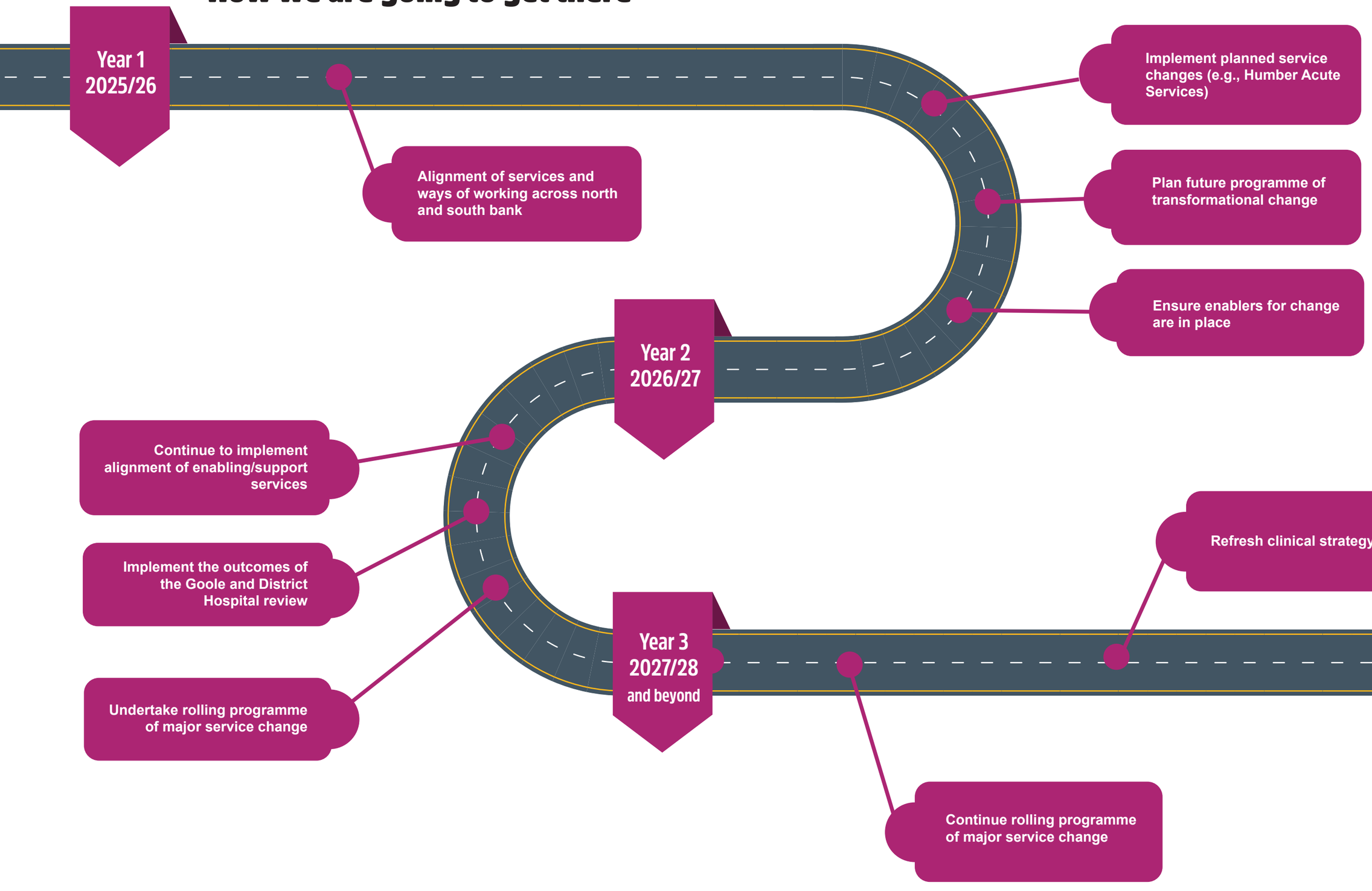
Where services are at risk of becoming unsafe and/or there are significant and pressing challenges to the continued safe operating of a service, these areas will be prioritised for more rapid review and change. The prioritisation approach will also seek to identify and prioritise service areas where the current configuration drives significant structural deficits and/or reliance on temporary staffing with the aim of developing more sustainable models of care for the future that will better meet the changing needs of our population.

5 Service redesign

Utilising the design principles within this strategy, each Care Group will:

- Identify which services are required to sit on one or more of our hospital sites and what can be delivered through Neighbourhood Health Centres and/or the virtual hospital to support our new estates strategy.
- Redesign models of care within each service to maximise the available assets (skills, knowledge, equipment, infrastructure) across the group and deliver the best possible service that will meet the population health need.
- Develop and implement a rolling programme of service review and redesign across clinical pathways and services, with a focus on delivering safety, sustainability and inclusivity. Priority areas for clinical review include pathology, neonatal and maternity care, gynaecology and stroke services. Services will be prioritised based upon safety, sustainability and current performance.
- Clinical service reviews will be undertaken in all services on a rolling basis to ensure they are adapting to meet changing needs within our population and taking advantage of the latest developments in technology and advancements in clinical care.

How we are going to get there



How we will measure success

We will use the descriptions (on pp.12-14) of what good looks like to measure our progress against delivery of this strategy. Each service will seek to deliver against the ambitions set out in this strategy.

We will assess how well our services are performing against the standards we, and our external regulators, have set on a regular basis to ensure we are making progress towards our overall group ambition to be one of the best hospital groups in the country, delivering **safe, sustainable and inclusive healthcare services** that meet the needs of our local population.

The delivery framework used to assess performance will include a mix of quantitative and qualitative measures, encompassing key national performance indicators alongside subjective analysis of progress in each of the area defined in this strategy.

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Clinical Services Strategy 2025- 2030

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