NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public)
to be held on Thursday, 11 June 2026 at 10.00 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** Alan Downey, Group Chair	Verbal	Information	**10:00**
1.2	**Staff Charter and Values** Alan Downey, Group Chair	Attached	Information	
1.3	**Patient Story** Jo Ledger, Deputy Chief Nurse	Verbal	Assurance	**10:05**
1.4	**Questions from the Public and Governors** Alan Downey, Group Chair	Verbal	Discussion	**10:25**
1.5	**Declarations of Interest** Alan Downey, Group Chair	Attached	Assurance	**10:30**
1.6	**Minutes of the Meeting held on Thursday, 14 May 2026** Alan Downey, Group Chair	BIC(26)129 Attached	Approval	
1.7	**Matters Arising** Alan Downey, Group Chair	Verbal	Assurance	
1.8	**Action Tracker** - **Public** Alan Downey, Group Chair	BIC(26)130 Attached	Assurance	
2.	**CHAIR REPORT**			
2.1	**Group Chair's Briefing** Alan Downey, Group Chair	BIC(26)131 Attached	Assurance	**10:35**
2.2	**Group Chief Executive's Briefing** Lyn Simpson, Group Chief Executive	BIC(26)132 Attached	Assurance	**10:45**
2.3	**National Reports and Guidance** Lyn Simpson, Group Chief Executive	BIC(26)133 Attached	Information	**10:55**
3.	**PATIENT SAFETY UPDATE**			
3.1	**Monthly Patient Safety Update (including Assurance Committee Update)** Mr Peter Sedman, Deputy Medical Officer & Hilda Gwilliams, Group Chief Patient Safety Officer	BIC(26)134 Attached	Assurance	**11:00**
3.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch, NED Maternity & Neonatal Safety Champion	BIC(26)135 Attached	Assurance	**11:15**

3.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** • Maternity Incentive Scheme (MIS) Year 8 Compliance Jo Ledger, Deputy Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(26)136 Attached	Assurance	**11:20**
4.	**STRATEGIC PROGRESS**			
4.1	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Sam Peate, Group Chief Delivery Officer	BIC(26)137 Attached	Assurance	**11:30**
4.2	**People (including Assurance Committee update)** Paul Bunyan, Deputy Chief People Officer Julie Beilby, NED Committee Chair	BIC(26)138 Attached	Assurance	**11:45**
4.2.1	**Freedom to Speak Up (FTSU) Guardian Report – Quarter Four & Annual Report** • Maternity-related FTSU concerns Fran Moverley & Liz Houchin, FTSUGs	BIC(26)139 Attached	Assurance	**11:55**
5.	**OTHER ITEMS FOR ASSURANCE**			
5.1	**Provider Licence and Code of Governance Compliance** David Sharif, Group Director of Assurance	BIC(26)140 Attached	Approval	**12:05**
6.	**OTHER ITEMS FOR APPROVAL**			
6.1	**Health & Safety Policy Statement** Emma Sayner, Group Chief Financial Officer	BIC(26)141 Attached	Approval	**12:15**
6.2	**NHS Equality Delivery System (EDS) Submission** Paul Bunyan, Deputy Chief People Officer	BIC(26)142 Attached	Approval	**12:20**
7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
7.1	**Items for Information / Supporting Papers (as per Appendix A)** Alan Downey, Group Chair	Verbal	Information / Assurance	
8.	**ANY OTHER URGENT BUSINESS**			
8.1	**Any Other Urgent Business** Alan Downey, Group Chair / All	Verbal		**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** Alan Downey, 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, 9 July 2026**			

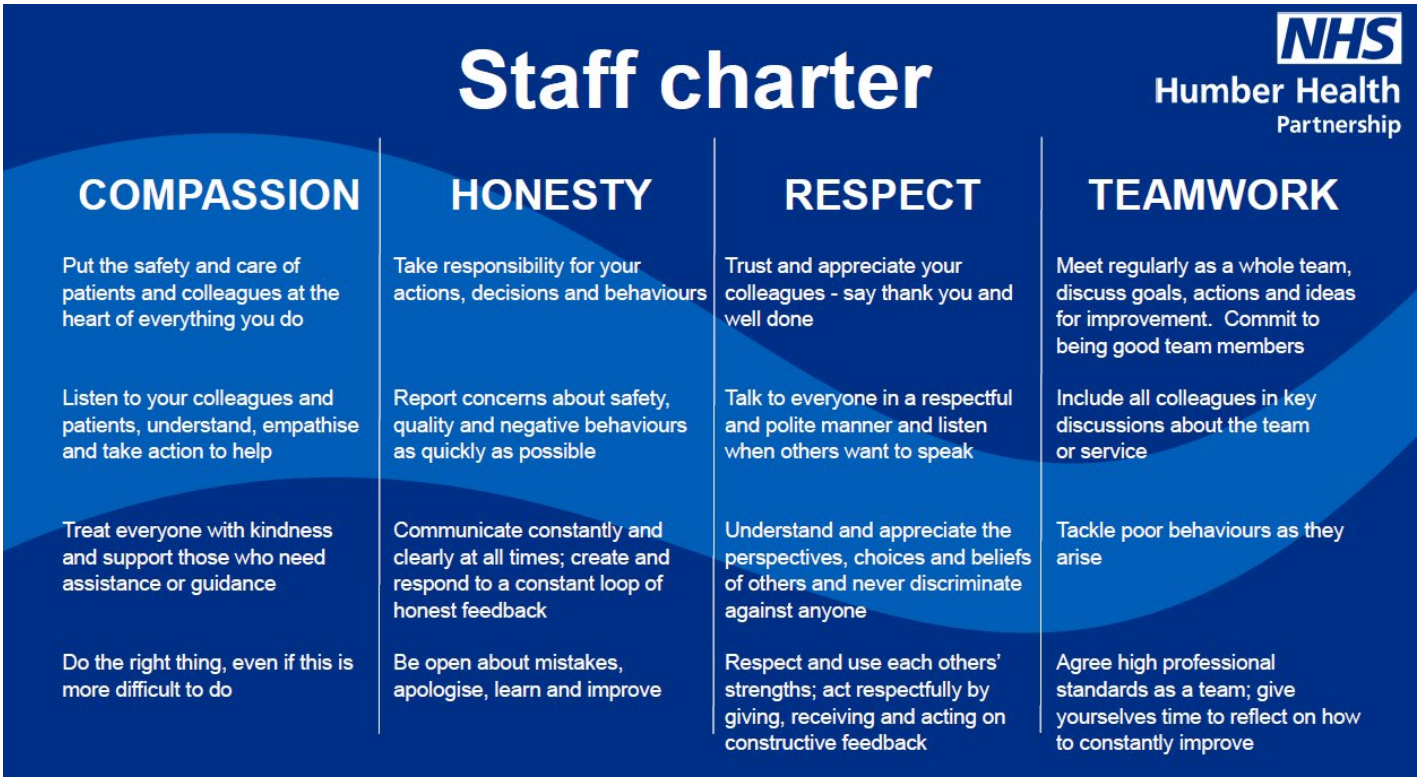
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – April 2026** Hilda Gwilliams, Group Chief Patient Safety Officer	BIC(26)143 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Finance Report – Month 1** Emma Sayner, Group Chief Financial Officer	BIC(26)144 Attached
7.3	**Workforce, Education & Culture Committees-in-Common**	
7.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – March 2026** Julie Beilby, Non-Executive Director Committee Chair	BIC(26)145 Attached
7.4	**Audit, Risk & Governance Committees-in-Common**	
7.4.1	**None**	
7.5	**Health Tree Foundation Trustees' Committee**	
7.5.1	**None**	
7.6	**Other**	
7.6.1	**Trust Boards & Committees Meeting Cycle – 2026** David Sharif, Group Director of Assurance	BIC(26)148 Attached
7.6.2	**Board Assurance Framework (BAF)** David Sharif, Group Director of Assurance	BIC(26)149 Attached
7.6.3	**Documents Signed Under Seal** David Sharif, Group Director of Assurance	BIC(26)150 Attached
7.6.4	**Group Performance Report** Chris Fry, Associate Director of Performance	BIC(26)151 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 May 2026 at 10.00 am

in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Alan Downey	Group Chair
Lyn Simpson	Group Chief Executive
Jo Ledger	Covering Group Chief Nurse
Sam Peate	Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Mr Peter Sedman	Deputy Chief Medical Officer
Julie Beilby	Non-Executive Director (NLaG) (attended virtually)
Jane Hawkard	Non-Executive Director (HUTH)
Murray Macdonald	Vice Chair (HUTH) & Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)

In Attendance:

Henry Anderson	Health Service Journal (attended virtually)
Paul Bunyan	Covering Group Chief People Officer
Hilda Gwilliams	Group Chief Patient Safety Officer
Sharon Humberstone	Safeguarding (for item 1.3)
Helena Lelew	Care Quality Commission (CQC)
Dr Alastair Pickering	Interim Group Chief Digital Officer
Dr Wishva Rathnayaka	Member of Staff
Ian Reekie	Lead Governor (attended virtually)
Lesley Saunders	Member of the Public
David Sharif	Group Director of Assurance
Dr Kapila Singhaprathapa	Member of Staff
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

Alan Downey welcomed Board members and observers to the meeting and declared it open at 10.00 am. It was noted that two attendees were present from Sri Lanka, participating in a year-long placement to gain insight into NHS operations through a programme sponsored by the Sri Lankan Government.

Alan Downey also congratulated Lyn Simpson on her appointment as substantive Group Chief Executive of the Humber Health Partnership (HHP).

Apologies for absence were received from:

Dr Kate Wood	Group Chief Medical Officer

1.2 **Staff Charter and Values**

Alan Downey reminded everyone of the Staff Charter shared at the meeting and highlighted that everyone should always adhere to this.

1.3 **Patient Story**

Jo Ledger introduced Sharon Humberstone from the Safeguarding Team to Board members. She advised that the story that was to be shared illustrated effective multi-agency working in addressing and resolving complex safeguarding issues.

Sharon Humberstone introduced the story in respect of a recent modern day slavery case for a patient that had attended the organisations Emergency Department (ED) at Diana, Princess of Wales Hospital (DPoWH). She explained that staff had raised concerns after identifying that the patient had been registered living at multiple homes within a short period of time.

Concerns had been raised by a member of staff in line with required policies and had been appropriately escalated to relevant external providers to seek support for the lady. Sharon Humberstone advised of how the concerns progressed and what support was provided to the lady. This case included contact with the Safeguarding Team, Salvation Army and the Police.

Completion of a National Referral Mechanism form via the Home Office was required; however, as the NHS is not designated as a first responder organisation for modern slavery, staff were unable to submit the referral directly. This created challenges, as referrals could only be made by a limited number of authorised organisations. As a result, delays were encountered, and the patient remained an inpatient until a suitable safe house placement could be secured.

Sharon Humberstone highlighted that modern slavery was a national issue, with cases also identified within the local region. She noted that the Police encouraged the reporting of any suspected cases.

Following this case, the organisation attended the Humber Modern Slavery meeting and raised concerns regarding the NHS's inability to submit referrals as a first responder. This issue has since been escalated to the Home Office. It was acknowledged that the majority of cases occur in domestic settings, and therefore the safeguarding team emphasised the importance of maintaining visibility to support staff in such circumstances. Sharon Humberstone reported that two further cases had been identified subsequent to this incident.

Alan Downey acknowledged the distressing nature of the case, whilst highlighting the positive and coordinated response from the team in supporting

the patient. He noted it was particularly reassuring that the patient remained in hospital until a safe and appropriate placement had been secured.

Lyn Simpson thanked Sharon Humberstone for sharing the case study and noted that increased awareness had led to a rise in safeguarding concerns being identified. She welcomed the positive multi-agency response, which had contributed to a successful resolution. Lyn Simpson sought assurance that the team was appropriately supported, recognising the demanding nature of the work, and queried whether the training provided adequately equiped staff to feel confident in asking the necessary questions.

Sharon Humberstone advised that safeguarding training is delivered across three levels, tailored to staff roles, with Level 3 now provided on a face-to-face basis. She noted that case studies formed a key component of the training to support staff in understanding how to identify concerns and ask appropriate questions. In terms of staff support, she reported that the team worked collaboratively and provided mutual support, including through structured debriefs following cases. However, she highlighted that complex cases were becoming increasingly frequent and that the team was relatively small in relation to the associated workload. She acknowledged that further consideration may be required to ensure the team was sufficiently supported.

Hilda Gwilliams noted that this case represented a positive example of effective multi-agency collaboration in resolving complex issues for the patient. Julie Beilby commented on the complexity of the National Referral Mechanism and acknowledged that the threshold for referral was high, which should be recognised. She also reflected on a recent meeting with the safeguarding team, expressing appreciation for their commitment. Mr Peter Sedman commended the team for their persistence and vigilance in addressing the issues and supporting the patient in this case.

Alan Downey noted that he would wish to follow up on the adequacy of support available to the safeguarding team, with a view to this being considered further by the Boards. Jo Ledger advised that a review of the safeguarding team was currently underway and could be shared with the Boards in due course.

Action: Report on safeguarding capacity to be shared with the Trust Boards-in-Common by Jo Ledger once the review had been undertaken

1.4 **Questions from the Public and Governors**

David Sharif advised that there were no questions received by the public for this meeting.

1.5 **Declarations of Interest**

Alan Downey sought declarations of interest from Board members, none were received.

1.6 **To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 9 April 2026 – BIC(26)103**

The minutes of the meeting held on the 9 April 2026 were accepted as a true and accurate record and would be duly signed by the Group Chair.

1.7 **Matters Arising**

Alan Downey invited board members to raise any matters requiring discussion not captured on the agenda; none were received.

1.8 **Action Tracker – Public – BIC(26)104**

Alan Downey referred to the action tracker for the meeting and requested an update on current actions for the meeting. It was agreed updates on actions for future meetings would be shared at the required date.

- Item 1.4, 9 April 2026 meeting, Questions from the Public & Governors - Response to be provided to questions asked. Sam Peate advised that he had met with John Palmer on the 15 April 2026 where information had been provided. It was agreed that a further meeting would be scheduled should any outstanding queries be raised.
- Item 1.4, 9 April 2026 meeting, Questions from the Public & Governors - review of administrative function to be undertaken. It was advised that this item would be raised through the Performance, Estates & Finance Committees-in-Common meeting with an update to then be shared with the Trust Boards-in-Common. Sam Peate advised this would be included within the outpatients update at the June 2026 meeting of the Performance, Estates & Finance Committees-in-Common.
- Item 2.2, 9 April 2026 meeting, Group Chief Executive's Briefing - Board Development Session on 24/7 staffing. David Sharif advised that this session had been included on the Board Development session schedule for a date to be agreed.
- Item 3.1, 9 April 2026 meeting, Monthly Patient Safety Update – Integrated Performance Report (IPR) update shared. It was advised this would be shared once available.
- Item 5.3, 9 April 2026 meeting, The Value Circle Report. It was advised that an updated on this item would be shared at the private meeting.
- Item 6.2, 9 April 2026 meeting, Capital Plan - planning cycle to include plan. Emma Sayner advised that this had been discussed and explained that this would be more embedded to be shared at Committees and the Boards. A wider piece of work was to be undertaken to ensure there was more visibility in respect of planning.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Chair's Report – BIC(26)105**

Alan Downey referred to the report, noting that it included his personal reflections from his first month in the role of Group Chair. He advised that he had undertaken

visits to all five sites and expressed his appreciation for the enthusiasm and professionalism demonstrated by staff.

He further reflected on the staff survey results, particularly in relation to staff morale, and considered how these may be influenced by current challenges, including organisational performance and media portrayal. He expressed confidence that the organisation would continue to make progress, noting that improvements were already being delivered.

He further advised that he had met a number of patients in recent weeks, who had commented positively on the quality of care received.

Alan Downey advised that he had met with a number of partner organisations in recent weeks. He emphasised the importance of continuing to strengthen these relationships going forward, noting that both he and Lyn Simpson recognised partnership working as a key priority for the organisation.

Alan Downey thanked Board members for their welcome to the organisation. He acknowledged that a number of senior leadership roles remain to be appointed and expressed confidence that these positions would attract high-quality candidates. He also highlighted his ambition to move towards a unitary Board model to support effective governance.

Hilda Gwilliams referred to the level of scrutiny currently faced by the Group and its potential impact on staff. She advised that a communications strategy was being developed to support staff morale and ensure the continued delivery of high-quality patient care. She also emphasised the importance of maintaining positive working relationships to support service delivery and noted the value of effective partnership working.

Julie Beilby reflected on the discussion regarding partnership working and suggested that further focus is required on relationships with Lincolnshire County Councils within the organisation's footprint. She noted that this had implications for 'no criteria to reside' (NCTR) patients and may influence patterns of ED attendance, including the use of Grimsby rather than alternative sites such as Louth.

2.2 **Group Chief Executive's Briefing – BIC(26)106**

Lyn Simpson referred to the report and advised that the organisation had been included in the Intensive Recovery Programme (IRP). She noted the importance of engaging positively with the programme and associated support to enable organisational improvement. It was highlighted that a number of organisations nationally were within this programme. While acknowledging the categorisation, she recognised the continued efforts of staff and the progress being made.

Lyn Simpson further advised that a 'Time Out' session had been held that week with the Senior Leadership Team (SLT), which provided a positive opportunity to focus on key priorities. The session included presentations and tabletop exercises, enabling reflection on progress to date. A further session was scheduled for September 2026.

Lyn Simpson referred to the report and accompanying dashboard, highlighting key areas of improvement in organisational performance.

Murray Macdonald referred to the quality and safety priorities outlined within the dashboard. He noted that, while areas such as end-of-life care and mental capacity were referenced, these were not reflected in sufficient detail within the patient safety report. He sought clarification on whether performance in these areas was improving and where Board members could access more detailed information.

Hilda Gwilliams advised that these are established quality priorities, supported by dedicated workstreams reporting to the Quality & Safety Committees-in-Common and the Trust Boards-in-Common. She noted that this information was also included within the Integrated Performance Report (IPR). She added that, while further detail could be provided if required, there was a preference to present this information in a single report to avoid duplication across multiple reporting routes.

Murray Macdonald acknowledged the points made and suggested that it would be helpful for Board members to be clearly directed to any key highlights or areas of concern. In response, Hilda Gwilliams advised that these topics are discussed in detail at Committee level, where appropriate challenge is applied to provide assurance.

Julie Beilby referred to complaint response times, noting that some cases can take a considerable period to resolve. She welcomed the significant improvement seen in the timeliness of responses.

Lyn Simpson supported the points raised in relation to complaints, highlighting the importance of timely engagement with patients and families to support earlier resolution of concerns. She advised that the Clinical Policy Group (CPG) had received a presentation emphasising the importance of addressing concerns proactively before escalation to formal complaints. She noted that a review of the current process may support further improvements.

2.3 **National Reports and Guidance - BIC(26)107**

Lyn Simpson referred to the report and highlighted key points. She added that discussion had taken place at the SLT meeting and Executive team meeting to ensure information was acted upon as appropriate.

3. PATIENT SAFETY UPDATE

3.1 **Monthly Patient Safety Update (including Assurance Committee Update) – BIC(26)108**

Hilda Gwilliams referred to the report and advised that it continues to be developed to ensure a strong focus on quality and safety. She noted that data was triangulated from multiple sources, including complaints and Patient Advice and Liaison Service (PALS) enquiries, to support organisational learning and identify actions to improve practice. This approach aligns with the quality priorities and improvement plan workstreams, ensuring that actions are implemented and improvements are embedded.

At this point Lyn Simpson left the meeting.

Jo Ledger advised that the year-end position for infection prevention and control (IPC) was included within the report. She noted that work in this area continued at a

national level, and that deep-dive reviews were being undertaken in relation to Clostridioides difficile (C. diff) and other IPC-related issues. She further advised that support from national and regional teams was being provided and was welcomed.

Hilda Gwilliams reported that, in relation to Duty of Candour compliance, a focused improvement programme has been implemented, resulting in significant progress.

Mr Peter Sedman reported that the organisation had reached five consecutive months without any reported never events, which was a positive development. He advised that work was ongoing to sustain this position, including strengthening the dissemination of learning from incidents.

Alan Downey sought assurance regarding the sustainability of this position, querying whether the absence of reported never events reflected sustained improvement rather than a temporary focus. In response, Mr Peter Sedman advised that reported never events had increased over the previous two years, partly reflecting improved awareness, and that staff now recognise and respond to such incidents more readily.

Hilda Gwilliams added that significant assurance work had been undertaken in relation to national compliance requirements to support continued improvement. Alan Downey further queried at what point the organisation could be considered to be in a consistently improved position. Hilda Gwilliams advised that, in line with national benchmarks, between one and two reportable never events would typically be expected. She noted that the organisation had moved 12 places in national ranking within the last quarter.

Mr Peter Sedman clarified that, as the organisation operated as two sovereign Trusts, never events are reported separately. Dr David Sulch advised that an organisation of this scale would typically expect to report up to six never events per year.

Julie Beilby advised that a comprehensive report had been presented to the Quality & Safety Committees-in-Common, which included key information such as mandatory IPC training compliance. She added that, further to previous comments, she would welcome greater clarity within Board reports regarding prior consideration, specifically indicating which reports had been reviewed and approved at Committee level to enable members to track their progression through the governance structure. It was agreed that this request would be communicated to relevant report authors.

Action: David Sharif to communicate to report authors details to be included on front sheets including prior approval

Hilda Gwilliams advised that there was currently a backlog of complaint cases under review. She noted that a three-month plan had been established to identify learning from these cases and inform changes in practice. As part of this work, consideration was also being given to whether complaints had been received that had been created by artificial intelligence (AI), with some responses appearing to have been generated in this way. She added that, as part of the review process, families were being contacted to ensure that accurate information had been received in relation to their complaints.

Julie Beilby acknowledged that complaints can be complex to manage and queried whether the use of AI in responding to complainants should be subject to further consideration, particularly in relation to patient confidentiality. Hilda Gwilliams confirmed that this matter had been discussed at Executive level and requires further consideration due to confidentiality implications.

Jo Ledger advised that complaints and PALS cases were due to be reviewed; however, it had been identified that additional support was required within the teams. She further noted that, in relation to PALS, an amnesty process was being introduced by the senior nursing team to address elements of the backlog. An update on the effectiveness of this approach will be provided at the next meeting.

Action: Jo Ledger to provide an update on the success of the amnesty process for PALS concerns

Sam Peate referred to the safer surgery sessions in relation to never events. He advised that these sessions had been well attended by clinicians, reflecting a positive engagement with learning and a shared commitment to improvement and the ongoing reduction of risk.

Dr David Sulch reported that the escalation report from the Quality & Safety Committees-in-Common had not been included within the report, it was noted this would be included in the future.

The Committees noted that there had been significant progress across key areas, with evidence of learning being embedded to support sustained improvement. As a result, the Committees reported increased assurance that improvements were being delivered across the organisation.

It was further noted that the number of patients with complex care needs had increased, requiring changes to care delivery, including a greater emphasis on one-to-one support. Improvements in the provision of holistic care were highlighted, with rapid and positive progress observed. Dr David Sulch recognised the contributions of Jackie Fenwick, Rachel Hoggarth and Karen Harrison in leading this work.

Alan Downey queried whether a presentation on complex care cases would be beneficial for Board members. Dr David Sulch confirmed that such a presentation would be informative.

Action: Complex cases presentation to be shared with Board members

Murray Macdonald referred to the improvements in the use of temporary escalation space (TES), noting this as a positive development, and queried whether this position could be sustained. In response, Sam Peate advised that he was confident this would be the case. He further highlighted that a Board development session scheduled for later that day would provide additional detail regarding future plans for managing corridor care. He added that this remains a priority area to ensure continued improvement.

4. STRATEGIC PROGRESS

4.1 Staff Survey Results – BIC(26)109

Paul Bunyan referred to the report and highlighted key areas of improvement compared to the previous year. He noted that there remain opportunities to reduce bank costs across the organisation to support the financial position.

It was acknowledged that, while there had been improvements in equality and diversity, performance in this area remains below the desired standard. Feedback indicated that staff from minority groups continue to report fewer opportunities compared to others, and higher levels of bullying and harassment when compared to White staff.

Paul Bunyan confirmed that staff survey results would continue to be monitored through the Pulse Survey over the coming year, alongside the Learning, Improvement and Safety Academy (LISA) programme to support ongoing development.

Dr David Sulch noted the perception within the survey that there was a greater organisational focus on finance than on patient care and staff welfare. He reflected that, at Board level, there was a clear focus on these priorities and suggested that communications to staff should better reflect this. He also queried how the organisation's results compared with those of other organisations within the same tier. It was agreed that this information would be reviewed.

Action: Paul Bunyan to review staff survey results from comparator organisations within the same tier and report findings to the Boards

Julie Beilby advised that the staff survey results had been discussed at the Workforce, Education & Culture Committees-in-Common, where it was confirmed that an action plan is being developed to monitor progress. She noted that the Pulse Survey will also support ongoing monitoring.

Jane Hawkard referred to feedback relating to equality and highlighted a perceived disconnect between staff networks and their leadership. She noted that there was a desire for greater engagement at Chief Executive level and expressed concern that some staff felt their voices were not being heard.

Alan Downey sought clarification on whether the concerns raised related primarily to interactions with colleagues or patients. Jane Hawkard indicated that issues were more frequently associated with patient behaviour, although she noted that improved support from colleagues could positively influence staff experience.

Paul Bunyan advised that Lyn Simpson has committed to meeting with network chairs within the next two weeks. Alan Downey noted that, while the local population is predominantly White, this was not reflected within the workforce, and emphasised the importance of vigilance in addressing abuse from patients and ensuring staff are appropriately supported and trained.

Alan Downey further observed that senior leadership roles are predominantly held by individuals from White backgrounds and highlighted the need to consider this in future workforce and career progression planning.

Hilda Gwilliams advised that the accreditation programme was launched in April 2026 and has been piloted across 25% of areas. She noted that the programme was intended to support the delivery of quality and safety standards, incorporating staff perspectives, and includes all relevant national requirements to ensure sustained improvement.

4.2 Public Purse (including Assurance Committee Update) – BIC(26)110

Emma Sayner referred to the report and highlighted key points. She advised that work continues with the CPG and Care Group teams in relation to workforce growth. She noted that regional colleagues had also provided information on pay growth, which had increased by approximately £140 million over the past five years.

She further advised that additional work was required in relation to workforce deployment, as it had been identified that some staff were not currently aligned to the required service areas.

Emma Sayner reported that the organisation had completed the formal year-end close-down for 2025/26. She noted that the Performance, Estates & Finance Committees-in-Common had piloted the Triple A report during the current month. It was also reported that the Integrated Quality Improvement Group (IQIG) meeting took place in the previous week, and that Emma Sayner and Lyn Simpson met with Nicci Briggs from NHS England (NHSE) to support a wider system discussion.

Emma Sayner highlighted that the attendance of the Group Chair at the IQIG meeting had been positive, demonstrating Board ownership of the current position. She emphasised the importance of robust governance arrangements, including grip and control, to support organisational improvement. She noted that expenditure should be carefully controlled and prioritised appropriately. It was reported that the overall financial plan for 2025 / 26 reflected a deficit of £63 million, indicating that the organisation remains non-compliant.

At this point Lyn Simpson rejoined the meeting.

It was reported that key lines of enquiry from the recent system meeting focused on the level and nature of organisational activity, with consideration given to whether current approaches were delivering the intended outcomes. In particular, this related to elective activity and associated clinical practices. Examples from other organisations were shared, alongside opportunities for networking to support learning and improvement. The overarching message was that the organisation should continue to progress delivery of its agreed plan. It was noted that a further session was scheduled in London on 9 June 2026, to be attended by Emma Sayner and Lyn Simpson.

Emma Sayner advised that early indications for 2026 / 27 showed some improvement at the start of the year; however, greater consistency would be required to achieve the overall plan. It was noted that industrial action in April 2026 had impacted performance, resulting in Month 01 being off plan.

She further advised that discussions have taken place with Care Groups to strengthen grip and control arrangements.

Sam Peate reported that reviews had been undertaken to assess capacity and demand gaps and to identify further opportunities for improvement. Services had been asked to outline proposed changes to service delivery over the next 12 months.

Emma Sayner concluded that the year ahead would be challenging and that delivery of the plan would be demanding; however, a clear and sustained focus would be maintained to achieve the required objectives.

Hilda Gwilliams highlighted that engagement with teams had improved, with evidence of more collaborative ways of working. She noted that the introduction of new forums had supported strengthened partnership working, and that staff feedback regarding engagement has been positive.

Jane Hawkard referred to the discussion at the Performance, Estates & Finance Committees-in-Common, noting that the organisation has submitted a request for additional cash support. She advised that the four-hour performance target had been reviewed, with some changes identified. The next Committee meeting would focus further on cancer performance to ensure robust grip and control was maintained.

Jane Hawkard also advised that the Tower Block enforcement notice was due to expire on 16 July 2026. It was acknowledged that, although a 12-month period had been available to complete the required works, this would not be achieved within the timeframe. An extension would therefore be requested 28 days prior to expiry. She noted that work continued in collaboration with the Fire Service.

In relation to the Board Assurance Framework (BAF), Jane Hawkard referred to the introduction of the Finance Strategy and requested that its milestones be reported regularly to the Committee throughout the year.

Action: Emma Sayner to share milestones relating to the Finance Strategy with the Performance, Estates & Finance Committees-in-Common

Emma Sayner acknowledged the points raised and confirmed that assurance would be provided at Committee level.

Julie Beilby welcomed the reported cultural shift and improved staff engagement, noting that this was critical to sustaining improvement. She highlighted that the organisation had previously been overly reliant on non-recurrent savings and emphasised the need for increased focus on Care Groups facing greater challenges in achieving financial targets.

Julie Beilby also referred to the introduction of the Triple A report, expressing support for its implementation while acknowledging that further development would be required to ensure it was fully embedded. She requested that future iterations include both an Equality Impact Assessment (EqIA) and a clear statement of financial implications.

Reflecting on the escalation reporting process, she queried whether the current approach sufficiently highlighted issues requiring Board attention. She noted that, while multiple status reports were presented at Committee level, these had at times provided limited assurance. She therefore sought clarity on the threshold at which matters should be escalated to the Boards for further discussion and noted that the revised reporting format would benefit from further review.

Action: Further discussion to take place regarding how the Triple A report highlights concerns requiring escalation to the Boards

Emma Sayner noted that the Triple A report referred to Advise, Alert and Assure to highlight to the Boards.

5. OTHER ITEMS FOR ASSURANCE

5.1 Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report – BIC(26)111

Jane Hawkard referred to the report and advised that the meeting had focused on the draft Annual Accounts, which had been completed within a 27-day timeframe. She noted that the final accounts would be presented to the Audit, Risk & Governance Committees-in-Common in June 2026, and that both the Chief Executive and Group Chair had been invited to attend.

In respect of the Going Concern report considered by the Committees, she advised that this had been approved, confirming the organisation's ability to continue operating for a further year. It was recommended to the Boards that the position be supported, with no concerns raised, and this had also been endorsed by the external auditors.

The Trust Boards-in-Common agreed to continue for a further year.

Jane Hawkard advised that a number of issues had been identified in relation to the Annual Governance Statement (AGS), which would be presented in full to the Boards in due course.

She further reported that the Committees had received a Draft Head of Internal Audit Opinion, which differed from the previously reported position. The revised conclusion identified four areas relating to governance, risk management, financial reporting, and data capture, with differing levels of assurance across each domain.

Jane Hawkard advised that the 'amber-red' ratings for governance and risk management were anticipated, reflecting ongoing work required in these areas. It was also noted that a number of audit reports remain outstanding and were expected to be received by June 2026.

In respect of matters for escalation, Jane Hawkard reported that the Committees had reviewed a Digital Resilience Report, which identified a number of findings. Further assurance has been requested to ensure that appropriate actions were being completed and reviewed.

The Committees also received a report on overdue policies and procedures, with a number remaining outstanding. Concerns were raised regarding the potential

impact on patient safety. The report included a risk stratification, with 42 items identified as high risk, although not all were directly related to patient safety. It was noted that these items will be reviewed by Hilda Gwilliams and David Sharif.

Jane Hawkard further advised that the Committees had requested an organogram to illustrate how assurance on the Integrated Improvement Plan is provided to the Boards. It was noted that this remains in draft.

In respect of the Board Assurance Framework (BAF), the Committees expressed concern that limited progress had been made and requested that improvements be accelerated.

Dr David Sulch referred to the number of out-of-date policies and procedures. He acknowledged that these were not routinely reviewed at Committee level and queried whether greater oversight should be considered, particularly for those relating to patient safety.

Hilda Gwilliams advised that policies requiring Committee approval are included within Committee workplans. Jane Hawkard clarified that those currently outstanding do not require Committee approval and are therefore approved at service level.

Murray Macdonald suggested that Committee Chairs should have oversight of policies relevant to their remit, particularly those with implications for patient safety. David Sharif advised that a review of document control arrangements is underway, with actions in place to address this. He further reported that there were 11 outstanding audit recommendations at the end of April 2026.

Lyn Simpson referred to the broader oversight of policies and procedures and suggested that this could be strengthened through Executive-level oversight, with core policies subject to annual review and updates provided to NEDs. She noted that policies relating to specific services should remain under the oversight of Chiefs of Service, with escalation to Committees where appropriate to provide assurance. Dr David Sulch supported the need for clear linkage between Executive oversight and Committee assurance in relation to core policies.

5.2 Trust Constitution – BIC(26)126

David Sharif referred to the Northern Lincolnshire and Goole (NLaG) Trust Constitution and outlined recent amendments. He advised that, under normal process, changes would be approved by the NLaG Trust Board prior to consideration by the Council of Governors (CoG); however, this process had been expedited due to the CoG meeting the previous week. He reported that one further amendment had been made following CoG consideration, relating to the correct naming of the Performance, Estates & Finance Committees-in-Common.

Alan Downey advised that amendments to the Constitution were also required to reflect proposals relating to Group NEDs, which were due to be considered at the Private Board meeting, including arrangements for remuneration. It was agreed that the Constitution would be formally approved as part of the Private meeting, following discussion of the NED proposals.

Post Meeting Note:

The changes to the Trust Constitution were approved by the NLaG Trust Board at the private meeting held on Thursday, 14 May 2026.

6. OTHER ITEMS FOR APPROVAL

6.1 Draft Strategic Objectives 2026 / 27 – BIC(26)128

Lyn Simpson referred to the report and advised of key points.

The Trust Boards-in-Common noted the Draft Strategic Objectives 2026 / 27.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 Items for Information / Supporting Papers

The following items for information were shared.

- Quality & Safety CiC Minutes – March 2026
- Finance Report – Month 12
- Audit, Risk & Governance CiC Minutes – January 2026
- Group Performance Report – NLaG & HUTH
- Trust Boards & Committees Meeting Cycle - 2026
- Board Assurance Framework (BAF)

Murray Macdonald referred to the meeting schedule circulated for information and queried whether meetings would continue to be held virtually, noting that the schedule indicated a return to in-person meetings. Alan Downey advised that it was important for Trust Boards-in-Common meetings to continue to be held in person, while noting that Committees-in-Common had operated effectively in a virtual format. He therefore confirmed that he was content for Committees-in-Common to continue to be held virtually.

Action: Committees-in-Common Meetings to be held virtually, amended diary invites to be circulated

Julie Beilby referred to the scheduling of the Workforce, Education & Culture Committees-in-Common, noting that these had recently been held on a bi-monthly basis. She queried whether this arrangement would continue or whether a return to monthly meetings should be considered, and it was agreed that this required further discussion. She also requested that consideration be given to the scheduling of meetings in 2027, particularly where multiple meetings fall within the same week, due to the demands this placed on paper review.

Action: Further discussion required as to whether the Workforce, Education & Cultures Committees-in-Common continues to be held on a bi-monthly basis

8. ANY OTHER URGENT BUSINESS

Alan Downey sought any other urgent business items; none were raised.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 There were no matters for referral to any Committees-in-Common.

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 11 June 2026 at 10.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 12.11 pm.

Cumulative Record of Board Director's Attendance 2026/27

Name	Possible	Actual	Name	Possible	Actual
Alan Downey	2	2	Sam Peate	2	2
Lyn Simpson	2	2	Alastair Pickering	2	2
Julie Beilby	2	2	Emma Sayner	2	2
Paul Bunyan	2	2	Peter Sedman	2	2
Hilda Gwilliams	2	2	David Sharif	2	2
Jane Hawkard	2	2	David Sulch	2	1
Jo Ledger	2	2	Kate Wood	2	0
Murray Macdonald	2	2			

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(26)130

BOARDS-IN-COMMON - PUBLIC ACTION TRACKER

2026 / 27

ACTION TRACKER - CURRENT ACTIONS - 11 JUNE 2026

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
5.1	12.02.26	Nursing Establishment Paper - how investment would be managed on staffing		Executive report to be shared at the Workforce, Education & Culture Committees-in-Common on how the staffing investment would be managed in respect of reducing bank and agency staffing in areas where investment had been made	Executives (Jo Ledger)	June 2026	Paper presented to Workforce, Education & Culture Committees-in-Common in May 2026.		
5.1	12.02.26	Nursing Establishment Paper - risk register score to be reviewed		Heather McNair to review risk register score for staffing due to investment being approved	Jo Ledger	October 2026	To be reviewed in October once new recrutis have commenced employment with organisation		
4.1	12.03.26	Public Purse - model hospital data shared at PEF CiC		Model Hospital data to be included within reports to the Performance, Estates & Finance Committees-in-Common for oversight	Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
1.4	09.04.26	Questions from the Public & Governors - review of administrative function to be undertaken		Performance, Estates & Finance Committees-in-Common to review administrative functions to provide assurance to the Trust Boards-in-Common	NED Chair, TBC / Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
3.1	09.04.26	Monthly Patient Safety Update - IPR update shared		IPR to be shared with Boards once it had been redesigned	David Sharif	July 2026	Update to be provided at July 2026 meeting		
5.1	09.04.26	Briefing on Ward Accreditation Programme - Schedule of Dates		Hilda Gwilliams to share accreditation programme of dates with NED and governor colleagues	Hilda Gwilliams	June 2026	Update to be provided at June 2026 meeting. On track to be provided.		
5.2	09.04.26	Establishment Review of Safe Staffing		Safer Staffing paper to be shared with Boards in August 2026, to be shared six monthly thereafter	Hilda Gwilliams / Jo Ledger	September 2026	Update to be provided at September 2026 meeting		
5.3	09.04.26	The Value Circle Report		Value Circle Priorities to be clarified	David Sharif	June 2026	Item discussed at the May 2026 meeting, Value Circle to undertake a further session with the Boards in June 2026		
6.1	09.04.26	Quality Priorities - insulin safe practice		Jo Ledger to review current position for insulin safe practice and incorporate into the Quality Priorities	Jo Ledger	June 2026	Update to be provided at June 2026 meeting including information		
6.2	09.04.26	Capital Plan - planning cycle to include plan		Sam Peate and David Sharif to include Capital planning within the Boards timetable	David Sharif / Emma Sayner	September 2026	Update to be provided at September 2026 meeting		
1.3	14.05.26	Patient Story - safeguarding capacity update		Report on safeguarding capacity to be shared with the Trust Boards-in-Common by Jo Ledger once the review had been undertaken	Jo Ledger	June 2026	Full service review being undertaken by Tracy Campell, Site Nursing Director and will be shared with Trust Board in September		
3.1	14.05.26	Monthly Patient Safety Update - More detailed information to be added to front sheets		David Sharif to communicate to report authors details to be included on front sheets including prior approval	David Sharif	July 2026	Update to be provided at July 2026 meeting		
3.1	14.05.26	Monthly Patient Safety Update - PALS Concerns Update		Jo Ledger to provide an update on the success of the amnesty process for PALS concerns	Jo Ledger	June 2026	Verbal update to be provided at June 2026 meeting.		
3.1	14.05.26	Monthly Patient Safety Update - Complex Cases Presentation		Complex cases presentation to be shared with Board members	Hilda Gwilliams / Wendy Page	July 2026	It was agreed an update would be provided at the July 2026 meeting.		
4.1	14.05.26	Monthly Patient Survey Results - Review other organisations in same tiering		Paul Bunyan to review staff survey results from comparator organisations within the same tier and report findings to the Boards	Paul Bunyan	June 2026	Data for the NOF 5 trusts has been isolated and benchmarked against the national average as well as the trusts in the NEY region. Information shared with Board members.		
4.2	14.05.26	Public Purse - Finance Strategy - milestones		Emma Sayner to share milestones relating to the Finance Strategy with the Performance, Estates & Finance Committees-in-Common	Emma Sayner	September 2026	Update to be provided at September 2026 meeting		
4.2	14.05.26	Public Purse - Triple A Report		Further discussion to take place regarding how the Triple A report highlights concerns requiring escalation to the Boards	David Sharif	July 2026	Update to be provided at July 2026 meeting		
7.1	14.05.26	Items for Information - CiC to move to virtual meetings		Committees-in-Common Meetings to be held virtually, amended diary invites to be circulated	David Sharif	June 2026	Administrators for the CiC updated meeting invites to virtual meetings		
7.1	14.05.26	Items for Information - WEC CiC frequency		Further discussion required as to whether the Workforce, Education & Cultures Committees-in-Common continues to be held on a bi-monthly basis	David Sharif	July 2026	Update to be provided at July 2026 meeting.		

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									
1.4	12.02.26	Questions from the Public		Matt Powls to discuss with John Palmer to gain more understanding of experience by patient	Matt Powls	March 2026	Meeting held with John Palmer on the 6 March 2026 to discuss issues		
1.4	12.02.26	Questions from the Public		David Sharif to provide response to questions raised by John Palmer	David Sharif	March 2026	Meeting held with John Palmer on the 6 March 2026 to discuss issues		
3.1.2	12.02.26	Maternity Reporting		Yvonne McGrath to include the mitigations and the date for completion on the red rated maternity and neonatal risks	Yvonne McGrath	April 2026	This will be included in the March assurance report for MNAG to be shared at Boards in April 2026		
5.1	12.02.26	Nursing Establishment Paper - detail on benchmarking		Heather McNair to include further detail within future safer staffing papers around benchmarking against other peers and detail including metrics on improvements made due to investments approved	Jo Ledger	April 2026	Included in April 2026 paper to Trust Boards-in-Common		
5.1	12.02.26	Nursing Establishment Paper - safer staffing paper - updated		Heather McNair to present a safer staffing paper at the April 2026 meeting, following this the paper would be shared on a six-monthly basis	Jo Ledger	April 2026	Paper shared at April 2026 Boards meeting		
1.6	12.03.26	To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 12 February 2026 - change to wording		Emma Sayner to provide clarification around wording of sentence within minutes	Emma Sayner & Sarah Meggitt	April 2026	Updated wording provided, minutes updated		
2.3	12.03.26	Letters of Enforcement Undertakings - Value Circle Report		Value Circle Report to be shared at April 2026 Trust Boards-in-Common meeting and April 2026 Audit, Risk & Governance Committees-in-Common meeting	David Sharif	April 2026	Closed. Item on agenda for April 2026 meeting		Finanlsied ValueCircle report
3.1	12.03.26	Monthly Patient Safety Update - Ward Accreditation Programme Update		Hilda Gwilliams to provide an update on the ward accreditation programme at the meeting due to be held in April 2026	Hilda Gwilliams	April 2026	Closed. Item on agenda for April 2026 meeting		
3.1	12.03.26	Monthly Patient Safety Update -IPC Update		IPC update to be shared at the Quality & Safety Committees-in-Common, any highlights to be shared back to the Trust Boards-in-Common	Jo Ledger	April 2026	Update shared at the March Quality & Safety Committees-in-Common meeting		
4.1	12.03.26	Public Purse -session to be held		Session to be held with Care Groups and Boards on workforce and savings	Emma Sayner	April 2026	Sessions are in diaries w/c 17 April 2026		
4.1	12.03.26	Public Purse - wte equivalent included in finance reports		Emma Sayner to include the whole-time equivalent within the finance report in the future	Emma Sayner	April 2026	Report format has been updated for April Board		
4.1	12.02.26	Audit, Risk & Governance Committees-in-Common Highlight Report - CQC Actions		Heather McNair to share with the Audit, Risk & Governance Committees-in-Common the work being undertaken in reviewing CQC actions	Jo Ledger	May 2026	Paper to be shared at the next Audit, Risk & Governance Committees-in-Common in April 2026		Paper was shared at Audit, Risk & Governance CiC on 23.04.26
2.2	12.03.26	Group Chief Executive's Briefing - review of risk register		Issues around resident doctors review to be added to risk register by Mr Peter Sedman	Peter Sedman	May 2026	Risk added to the Risk Register.		
4.1	12.03.26	Public Purse - further review on grip and control at PEF CiC		Further consideration at the Performance, Estates & Finance Committees-in-Common in respect of improving the financial position due to the grip and control. Session to then be held with the Trust Boards-in-Common to highlight any issues.	Emma Sayner	May 2026	Next PEF meeting to be held in May 2026		This has been incorporated in the regular finance update on the agenda in May 2026
1.4	09.04.26	Questions from the Public & Governors - Response to be provided to questions asked		Updated response to question following meeting between Sam Peate and John Palmer to be provided at May 2026 meeting	David Sharif / Sam Peate	May 2026	Sam Peate met with John Palmer on the 15 April 2026		
1.4	09.04.26	Questions from the Public & Governors - Sam Peate to meet with John Palmer to discuss points raised		Sam Peate to arrange to meet with John Palmer	Sam Peate	April 2026	Sam Peate met with John Palmer on the 15 April 2026		
2.2	09.04.26	Group Chief Executive's Briefing - Board Development Session		Board Development Session on 247 staffing provision to include holiday periods and weekend cover	Paul Bunyan	May 2026	Item added to Board Development Sessions - date to be agreed		
2.3	09.04.26	National Reports & Guidance - Lead added to report for initiatives		Lead to be added to report to highlight who was overseeing initiatives	Lyn Simpson	May 2026	Update to be provided at May 2026 meeting		Sharepoint system introduced for all correspondence to be added to including lead executive, reports to continue being shared with the Boards
3.1	09.04.26	Monthly Patient Safety Update -Further detail included within report		Infection control and corridor care to be included within future patient safety reporting	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Report now included in Patient Safety Report, to then be included in IPR future report.
5.1	09.04.26	Briefing on Ward Accreditation Programme - Indicators to be added		Appendix of indicators to be included within future reports	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Information included in future reports
5.1	09.04.26	Briefing on Ward Accreditation Programme - Session with colleaques at organisation to be scheduled on system		Sam Peate to schedule session on ward accreditation programme with colleagues using the system from previous organisation	Sam Peate	May 2026	Session scheduled with colleagues at South Tees Hospital.		
6.1	09.04.26	Quality Priorities - further detail within front sheets of reports on approval process		Report authors to include required detail within reports in respect of prior approval process, using the front sheet as a minimum	Executives (David Sharif)	May 2026	Reminders issued. Will also form part of the guidance to accompany the AAA reporting across the Group.		

Key:

Green	Completed

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(26)131

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 June 2026**
Director Lead	Alan Downey, Group Chair
Contact Officer / Author	Alan Downey, 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 ✓ Assurance ☐ Other – please detail below:

Group Chair's Update

Performance

For so long as we remain in what used to be called special measures our performance will rightly continue to be under intense scrutiny, not just by our regulators and the media, but also by members of staff, our partner organisations, our patients and our communities. It is therefore gratifying that we are seeing improvements in the key areas of patient safety (e.g. never events and corridor care) and access to services (waiting times in our Emergency Departments, and referral-to-treatment times for cancer and other procedures and therapies). I want to take time to acknowledge and applaud the progress that has been made, thanks to the efforts of colleagues right across the group. I can see how tirelessly Lyn Simpson and her executive team are working, and I can tell from my site visits that this is replicated in departments, wards and theatres in all our sites and in our community services.

Partnerships

Our second strategic objective, after stabilising services and delivering care, is to improve flow and restore operational performance. We will never be fully successful in that endeavour, if we fail to work closely and co-operatively with our partner organisations, both within and outside the NHS. I am therefore continuing to meet frequently with partners and stakeholders: since the May 2026 Board meeting I have had useful discussions with Councillor Mike Ross (Leader) and Matt Jukes (Chief Executive) at Hull City Council, with the Humber senior leadership group (which covers four local authorities, plus police and fire), with Jason Stamp (Chair of our Integrated Care Board (ICB)), Paul Bellotti (Chief Executive of East Riding of Yorkshire Council), and Professor Kevin Kerrigan (Interim Vice-Chancellor of Hull University).

Governance

One of my priorities as Chair is to make sure that we have a stable and effective Group Board. Lyn Simpson has been making good progress in filling gaps in the executive positions. I have been focusing on the non-executive directors (NEDs), and in the last couple of weeks have reached agreement to the appointment of what will effectively be Group NEDs. This will be achieved by appointing all NEDs, with the exception of the NED nominated by Hull University, to the Boards of both our trusts. Our existing NEDs (Jane Hawkard, Dr David Sulch and Julie Beilby) will be confirmed as Group NEDs, and we will shortly commence recruitment of an additional Group NED and three associate Group NEDs. We will then have a full complement. I meet regularly with the NEDs and have recently started discussions with Murray Macdonald, our Group Vice-Chair, and with each of the NEDs, to finalise NED appraisals for the year just ended, and to set objectives for the year ahead.

One of our key governance forums, while we remain in special measures, is the Humber Health Partnership (HHP) Integrated Quality Improvement Group (IQIG) which meets monthly, chaired by Fiona Edwards, our NHS England Regional Director. By the time of the June 2026 board meeting, I will have attended three IQIG meetings. The questioning is challenging, but fair, and I believe we have demonstrated to the satisfaction of Fiona Edwards and her NHS England and Care Quality Commission (CQC) colleagues, that we are able to achieve significant improvements in performance when we make targeted interventions and focus on getting "back to basics". The challenge we now face is to

demonstrate continual improvement and that the progress we have made will be sustained and embedded in policies, systems, standard working practices and organisational culture.

The NLaG Council of Governors (CoG) is another key governance forum. The Governors represent the views of patients, local people, staff and partner organisations and they offer a unique perspective on the services we provide, particularly in terms of patient experience. In addition to the regular CoG meetings, which I chair, the Governors meet in various forums and sub-committees, chaired by the Lead Governor, Ian Reekie. Within the last month I have attended meetings of the Appointments and Remuneration Committee (ARC) and the Membership and Public Engagement & Assurance Group (MPEAG). I also joined Governors for a presentation by Jason Stamp on the new role of the ICB as a strategic commissioner.

I should also mention that I have had an introductory meeting with our internal auditors. We had a useful discussion about the risks and challenges we face, one of which I have mentioned above – the need for stability at board level and to strengthen the lines of communication, accountability and trust that should run consistently throughout our entire organisation.

Colleagues

One of my personal objectives as Chair is to get out and about as much as possible. In the last month I have had walk-abouts in the company of our Freedom to Speak Up Guardians – at Hull Royal Infirmary (HRI) with Fran Moverley and at Diana, Princess of Wales Hospital (DPoWH) with Liz Houchin. I was impressed by the energy and enthusiasm they both bring to the Guardian role. Creating an environment in which our people feel comfortable raising issues and concerns is an important step in creating the organisational culture we aspire to – one in which members of staff feel supported, empowered, clear about their roles and responsibilities and happy to recommend our trusts as places to work and to receive care.

I have also been on a site visit with Jo Ledger, our Interim Group Chief Nurse, and by the time of the June 2026 Board meeting I will have completed a walk-around at DPoWH with Natalie Griffiths, Site Nursing Director for the South Bank.

On 2 June 2026 I welcomed Bill McCarthy (Chair of NHS England for the North East and Yorkshire) for a tour of HRI and Castle Hill Hospital (CHH). We visited the Emergency Department, Same Day Emergency Care (SDEC) and the Maternity and Neurology Departments at HRI, and then travelled across to Castle Hill for a tour of the Queen's Centre. I am grateful to the many colleagues who made the visit a success.

Patients

Since joining the group I have had a number of interesting and often moving conversations with patients and families. But it is only a small number, and a personal resolution for the next few months is to find ways of connecting more frequently with the people who depend on our services.

Alan Downey
Group Chair

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)132

Name of Meeting	Trust Boards-in-Common – Public
Date of the Meeting	11 June 2026
Director Lead	Lyn Simpson, Group Chief Executive
Contact Officer / Author	Lyn Simpson, Group Chief Executive
Title of Report	**Chief Executive Briefing**
Executive Summary	This report provides an update on the Humber Health Partnership's (the 'Partnership') improvement journey, including the commencement of the next phase of organisational review work, national recognition for elective surgical services, innovation in specialist cardiac care, and award-winning use of artificial intelligence to support earlier intervention and better outcomes for patients.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Assurance ✓ Information ☐ Other – please detail below:

Public Board of Directors
11 June 2026

GROUP CHIEF EXECUTIVE UPDATE

1. Introduction

The last month has seen the Partnership move into the next important stage of its development.

Alongside the continued delivery of our clinically led improvement plan, work has now started to review whether our current organisational arrangements are best placed to support safe, high-quality and sustainable services for patients and communities across Humber.

At the same time, colleagues across the Partnership continue to demonstrate the quality, innovation and ambition that exist across our services.

This month's update highlights national accreditation for our elective surgical hubs in Goole and Grimsby, the introduction of same-day discharge for selected transcatheter aortic valve implantation (TAVI) patients at Castle Hill Hospital (CHH), and national award recognition for the use of artificial intelligence (AI) to help identify and support patients at higher risk of serious vascular complications.

These examples are important because they show two sides of our current journey: a clear and honest focus on the organisational challenges we need to resolve, alongside strong evidence of the excellence and innovation already being delivered by our teams.

2. Organisational review and future model

The Partnership has commenced the next phase of improvement and organisational review work, supported by NHS England (NHSE) through the Intensive Recovery Programme (IRP) and an independent review by Carnall Farrar (CF). This work is expected to conclude over the summer of 2026.

The review follows the work undertaken since August 2025 by clinicians and colleagues across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to develop a clinically led Improvement Plan and a shared understanding of the long-standing challenges facing the Partnership.

The current Group model was established to bring the two organisations closer together and support more joined-up working. While this has delivered benefits in some areas, a number of structural challenges remain. The next phase will therefore look at whether the current model provides the right basis for long-term improvement, stronger accountability and sustainable services.

This work will consider a range of possible future arrangements. The review is not about structure for its own sake. Its purpose is to identify the model that will best support better care for patients, clearer accountability for delivery, and a more sustainable future for services. Engagement with colleagues, stakeholders and partners will continue as the work develops.

3. National recognition for elective surgical services

There has been welcome national recognition for our planned care services, with the elective surgical hubs at Goole Hospital and Diana, Princess of Wales Hospital (DPoW) in Grimsby awarded “Hub Accreditation” by NHSE’s Getting It Right First Time (GIRFT) programme, in collaboration with the Royal College of Surgeons of England.

The accreditation recognises the quality of care, facilities, staff and training within the hubs. It places Goole and DPoW among nationally recognised surgical hubs and follows the work undertaken by colleagues across theatres, day surgery wards, booking teams and operational teams to prepare for and deliver the required standards.

This is a significant achievement for the teams involved and for patients using our planned surgical services. It also reinforces the important role of elective surgical hubs in reducing waiting times and improving access to common procedures such as cataract surgery, general surgery, trauma and orthopaedics, including hip and knee replacements, and ear, nose and throat.

The recognition is particularly important in the context of our wider elective recovery programme. It demonstrates that, alongside the operational pressures facing the Partnership, we have services delivering at a standard that is being recognised nationally.

4. Improving patient pathways through innovation

At CHH, the structural heart team has introduced same-day discharge for selected patients undergoing TAVI.

TAVI is a minimally invasive procedure used to replace an aortic valve that does not open properly. It can significantly improve quality of life for patients by reducing symptoms such as chest pain, breathlessness and fatigue. The first same-day discharge patient attended CHH at 7.30am and was discharged home at 4pm the same day.

This development reflects careful pathway redesign and close multidisciplinary working. Same-day discharge will only be appropriate for carefully selected patients, but it has the potential to improve patient experience, support recovery at home, increase capacity within the TAVI programme, reduce waiting times and free up inpatient beds for those who need them most.

The team will continue to monitor and evaluate the pathway as it develops, ensuring that patient safety and experience remain central to its implementation.

5. Digital innovation and national award recognition

The Partnership has also received national recognition for the use of AI to support better outcomes for patients with intermittent claudication.

Mr Bharadhwaj Ravindhran, a Trainee Academic Vascular Surgeon, won a national Health Service Journal Digital Award for TRAFIC, a digital tool designed to help identify patients at higher risk of serious complications, including amputations, strokes and heart attacks. The project won the ‘Driving Prevention and Early Intervention through Digital’ category.

TRAFIC uses advanced algorithms to support earlier identification of risk, more personalised intervention and better clinical decision-making. It is an important example of how digital innovation can support prevention, improve outcomes and help clinicians target care where it is most needed.

This award is a significant achievement and reflects the strength of research, innovation and clinical leadership across the Partnership. It also aligns closely with the national direction of travel towards earlier intervention, more personalised care and better use of digital tools across the NHS.

6. Conclusion

The long-standing issues facing the Partnership remain significant and will continue to require sustained focus, openness and support over the coming months. The organisational review now underway is an important part of ensuring that we have the right arrangements in place for the future.

At the same time, the examples highlighted in this report demonstrate the commitment and capability of colleagues across the Partnership. National accreditation, pathway innovation and award-winning digital work all point to the potential that exists within our services.

Our task is to build on that strength while continuing to address the underlying challenges that affect consistency, sustainability and delivery across the organisation.

NHS
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)133

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	11 June 2026
Director Lead	Lyn Simpson, Group Chief Executive
Contact Officer / Author	Richard Dickinson, Associate Director of Quality Governance
Title of Report	National Reports and Guidance

Executive Summary	The attached report provides a summary of guidance and national reports. and relevant operational lead identified. published from:
	• NHS England (NHSE)
	  ○ Best practice guide for NHS Frailty Pathways
	• Department of Health and Social Care (DHSC)
	  ○ No items
	• Health Services Safety Investigations Body (HSSIB)
	  ○ Medication Related Harm
	The Boards-in-Common are asked to note the content of the report.

Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No negative impact
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Name	Organisation	Subject	Summary	Published on	Lead officer
Best practice guide for NHS Frailty Pathways.url	NHS England (NHSE)	Frailty pathways	A new best practice guide outlines key priorities to ensure frail individuals receive high-quality, personalised, compassionate, and well-coordinated care, with strong emphasis on communication, continuity, and shared decision-making.	14/05/2026	ROSEVEAR, Anthony, Ops Director CFT Care Group
Medication Related Harm.url	Health Services Safety Investigations Body	Medication Safety	Recommendations arising from HSSIB undertaking a series of medication related investigations. NHS trusts can improve patient safety by using the information contained in the information pack for the Royal College of Emergency Medicine's Quality Improvement Programme on time critical medications to assess their preparedness and make local improvements in identifying, prescribing, and administering time critical medications in emergency departments.	28/05/2026	GOODE, Joanne, Chief Pharmacist

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)134

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 June 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer Peter Sedman, Deputy Group Chief Medical Officer
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance
Title of the Report	**Monthly Patient Safety Update**
Executive Summary	The report provides the Board with an overview of patient safety activity in April 2026, triangulating learning themes across various sources to inform quality improvement decision making. The boards are asked to note the following: • Incident reporting remains within expected rates and proportional levels of harm reporting are seen, with action being taken to ensure appropriate steps to review the care provided. • Infection control rates remain a priority area of focus for improvement, although C.difficile rates have increased regionally. • Never Event frequency has reduced, with no cases occurring during 2026. ○ A series of safety summits commenced on 8 May 2026 working though all theatre team specialties, supporting improvements in patient safety and culture, running until October 2026, including professional standard setting. • Corridor care trajectories for improvement have been met. • Group Chief Patient Safety Governance Officer is supporting colleagues and teams to continually put patient safety first, learn from experience, and keep improving.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	This report has been provided to the Quality and Safety Committees-in-Common
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Monthly Patient Safety Report, April 2026

Section 1: Clinical Incidents

Definition

NHS England define a patient safety incident as any unintended or unexpected incident that could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare. The incidents range from “no harm” events (near misses) to severe harm or death.

Incident Reporting

Figure 1 below represents trends of reporting patient safety for NLAG and HUTH, showing:

- Reporting rates

There is common cause reporting in NLAG and an increased rate of reporting at HUTH compared to previous months.

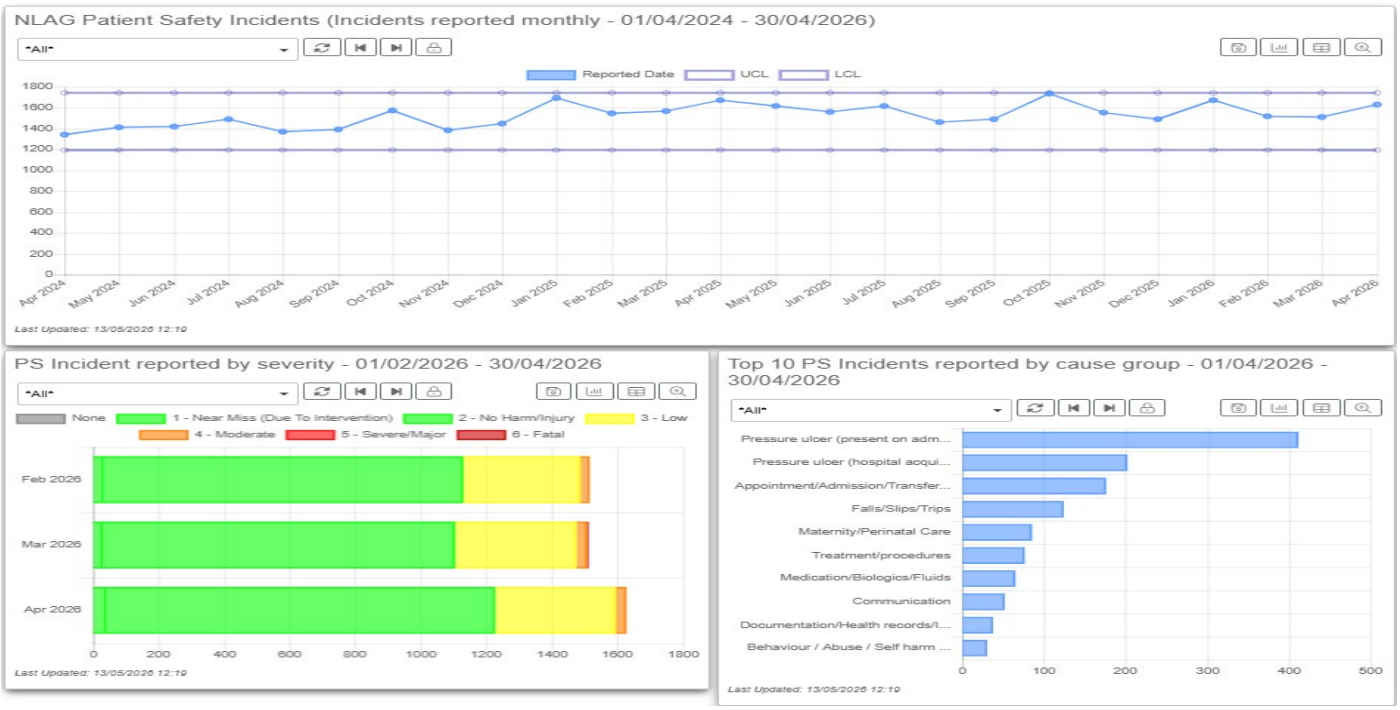
- Distribution of harm levels

While there is an increase in incident reporting at HUTH, this rise is in no harm reporting, which is positive and movement is reducing to have lower and no harm reporting at NLAG.

- Top 10 cause groups of incidents (most frequent themes)

Pressure ulcers identified on admission remains the highest category across the group. It is acknowledged that the patient has suffered harm, however as the skin damage occurs outside of the acute setting, these incidents are recorded as no harm from a reporting perspective.

Figure 1 – Patient Safety Incident Overview Dashboards



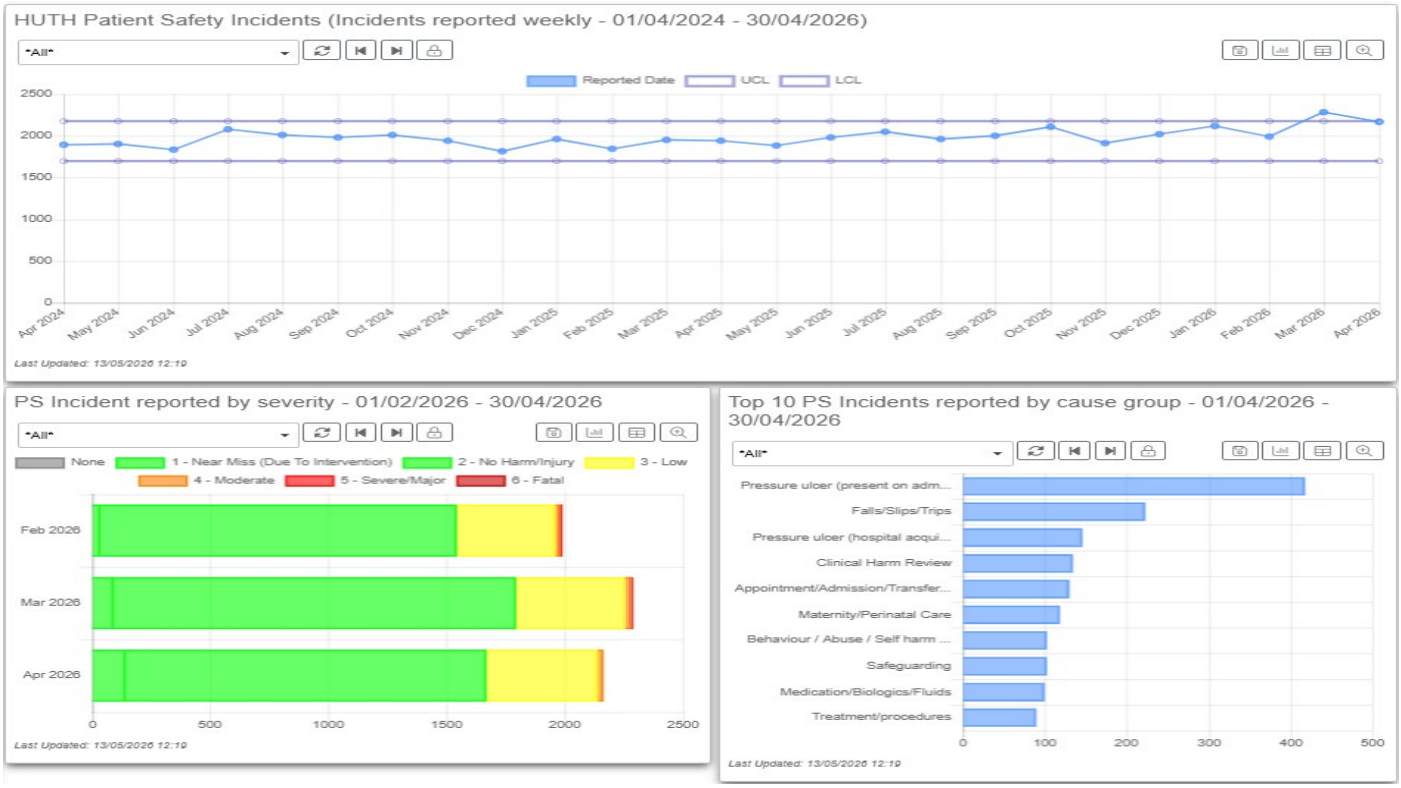


Figure 2: Patient Safety incidents with moderate or greater severity grading by Group and Trust.

Reported in April 2026	NLAG	HUTH	HHP
Fatal	0	1	1
Severe/Major	0	2	2
Moderate	34	24	57
Total	**34**	**27**	**61**

All 61 cases are under review by care group Nurse Directors and through relevant reporting routes of the Falls Group, Pressure Ulcer review groups and the Weekly Learning Response Panel.

Section 2: Infection Prevention Control (IPC)

Context

The Health and Social Care Act (2008) (Code of Practice on the prevention and control of infections) mandates that all NHS providers implement robust infection prevention and control procedures. The Care Quality Commission (CQC), require NHS providers to maintain clean, safe, and hygienic environments to prevent the spread of infections, primarily enforced under Regulation 12 (safe care and treatment) and Regulation 15 (Premises and equipment).

Quality and Safety Performance

The Partnership currently reports separately both HUTH and NLAG position, relating to the reporting of mandatory organisms (Health care associated infections (HCAIs)). The tables below report the current position for both HUTH and NLAG, using the targets for 2025/2026 until they are reset by the UKHSA. The National Outcomes Framework (NOF) is updated periodically. The scores and banding are based on their published model, with Publicview data used, as updated for February 2026.

Key	In year Trajectory performance	NOF quartile ranking of Trusts
	Over the annual target	Quartile 4 (worst)
	Over the trajectory	Quartile 3
	-	Quartile 2
	Below the trajectory	Quartile 1 (best)

Figure 3: HUTH current HCAI figures:

HUTH	2025/26 Target	M1	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	61	16	16	115	1.89	1.75	3.85
E. Coli	203	23	23	213	1.04	1.05	2.13
P. Aeruginosa	30	3	3	26	0.87	NA	NA
Klebsiella spp.	72	6	6	80	1.11	NA	NA
MRSA bacteraemia	0	0	0	2	NA	5	3.12
MSSA bacteraemia	No target	11	11	98	NA	NA	NA

Figure 4: NLAG Current HCAI figures:

NLAG	2025/26 Target	M1	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	18	4	4	35	1.94	1.67	3.77
E. Coli	57	2	2	86	1.51	1.06	2.16
P. Aeruginosa	5	0	0	12	2.40	NA	NA
Klebsiella spp.	34	3	3	41	1.21	NA	NA
MRSA bacteraemia	0	0	0	6	NA	4	2.88
MSSA bacteraemia	No target	3	3	36	NA	NA	NA

The position at month one, shows April data as being over trajectory for four of the five targets at HUTH and two at NLAG. There is potential for the E.Coli NOF score and banding to deteriorate when the NOF data is next refreshed, despite an improved position in April 2026. There is potential for improvement of the NOF score and banding for HUTH on MRSA bacteraemia.

The way in which the data is calculated within the NOF (rolling 12 month) doesn't demonstrate the Thresholds data clearly.

The tables below show the end of financial year figures and performance against 2024/25. There are numerous workstreams in progress to support the improvement delivery of the plan.

HUTH	2025/26 Target	M12	YTD rate	Year End 2024/2025 Comparative	Trust performance against previous Year
C. Difficile	61	11	108	92	Deteriorated
E. Coli	203	14	214	220	Improved
P. Aeruginosa	30	2	29	26	Improved
Klebsiella spp.	72	11	77	74	Deteriorated
MRSA bacteraemia	0	1	5	9	Improved
MSSA bacteraemia	No target	8	93	74	Deteriorated
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory					

NLAG	2025/26 Target	M12	YTD rate	Year End 2024/2025 Comparative	Trust performance against previous Year
C. Difficile	18	4	33	36	Improved
E. Coli	57	8	88	69	Deteriorated
P. Aeruginosa	5	1	16	13	Deteriorated
Klebsiella spp.	34	3	43	32	Deteriorated
MRSA bacteraemia	0	2	4	6	Improved
MSSA bacteraemia	No target	2	27	36	Improved
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory					

Education and Training

The IPC team have undertaken a review of training and education needs required within the new IPC team members to ensure progress against National IPC educational framework and support achievement of competencies and develop the team with expert knowledge base. The IPC practice development matrons (PDM) will continue to lead the IPC educational agenda against the National IPC educational Frameworks and support the delivery of the IPC annual work-plan. A training needs (TNA) analysis is in place; the IPC competency package has been completed and has now been approved, with a roll out planned. In addition, the IPC teams have conducted events and activities for the World Hand Hygiene Day this month and delivered some clinical skills workshops. The IPC teams continue to support the Care groups, including attending the Care group governance meetings to update on key issues/escalations.

Training compliance

The Group is delivering the 85% compliance target, HUTH compliance is at 91.3% and NLAG compliance 85.1%. Source: HHP Learning HUB 31st March 2026.

These figures are reported through Operational Infection Reduction Committee and also relayed to the care groups. Additional bespoke sessions are available if required.

Section 3: Corridor Care Reduction Programme

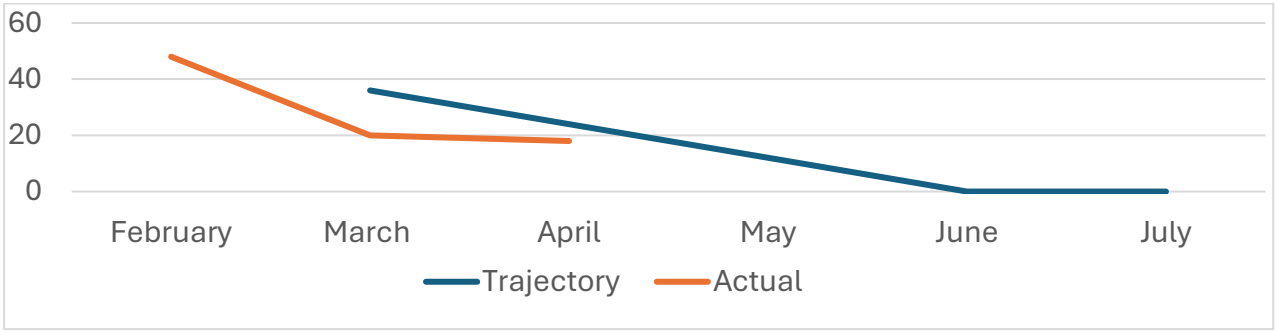
Definition & National Request

Corridor care has been identified nationally as a major patient safety concern. The GIRFT guidance states that corridor care exposes individuals to avoidable harm and compromises their privacy, dignity and clinical safety.

National expectations require NHS organisations to eliminate corridor care wherever possible and ensure strong operational flow across the urgent and emergency care pathway.

NHS England has mandated that all providers adopt the GIRFT Clinical Operational Standards by July 2026, with responsibility for delivery resting with the Chief Executive and the executive triumvirate (COO, CNO, CMO).

Figure 5: Corridor Care Reduction – Trajectory vs Actual (March–June 2026:



February 2026 HUTH had 48 chairs on corridors onwards. Trajectory set in March to reduce in line with NHSE GIRFT requirements with the aim to eradicate corridor care by the end of July 2026. The April update shows that the Corridor Care Reduction Programme performance continues to exceed the planned trajectory for HUTH. April utilisation is 18 corridor chairs remaining on the wards, outperforming the April trajectory target of 24, demonstrating accelerated progress against the agreed programme. This reflects sustained improvement aligned to the Corridor Care Reduction Programme and GIRFT standards, following earlier delivery ahead of the March milestone.

Work has progressed to meet NHSE digital reporting standards for corridor care. ED is now fully compliant, reporting only patients waiting over 45 minutes in corridors. Ward-level compliance plans for digital data capture are in place for implementation by the first week of May.

The focus now is on maintaining this positive trajectory while continuing the safe reduction of non-compliant spaces. NLaG has less reliance on corridor care, trajectories are being set to launch in May to ensure compliance by the end of July Work is also progressing to formally embed Temporary Escalation Spaces (TES) within the OPEL framework, with all areas on track to meet the required standard by the end of July 2026.

Figure 6: Current position across Humber Health Partnership:

TRUST	March	April	May	June	July
HUTH Trajectory	48	36	24	12	0
HUTH Actual	20	18			
NLaG Trajectory	14	12	9	6	0
NLaG Actual	12	9			

HUTH Progress

- Ahead of trajectory
- Corridor chairs removed from all wards

NLAG Progress

- Ahead of trajectory
- 3 chairs removed from surgery wards

Group Progress

- Agreed roll out programme with GIRFT support forward and board round and criteria led discharge implementation
- In built assessment and audit built into the ward. Benchmarking being completed to provide baseline. accreditation programme for MDT approach and support through LISA
- Updated TES policy and patient information leaflet

Remaining Focus:

- Finalise digital footprint and BI reporting
- Continue phased reduction aligned to operational pressures and patient flow
- Formal TES use aligned to OPEL framework and FCP

Figure 7: Outlining the Different TES Pressures:

Operational flow pressure	Workforce pressure	Assurance gaps
High occupancy	TES Outside Normal staffing Levels	Documentation inconsistency
TES outside normal staffing level	Maintain safe staffing oversight	Tracking/Duration in TES
Delayed discharge	Staff Welfare & Support	SOP adherence
ED demand		

Management, Risks & Improvement Actions

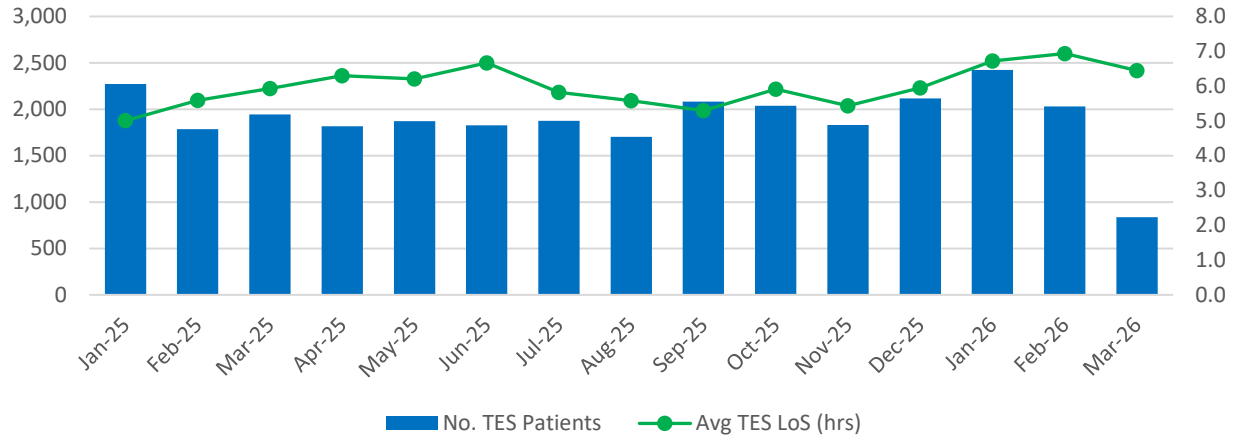
Governance & Management

- Programme governance
- Executive oversight
- Weekly operational review
- Daily safety huddles
- Corridor Care Task & Finish Group
- Integration into OPEL framework
- Performance & Assurance
- Quality Assurance Group

Quality and Safety Performance

The current performance against plan for Corridor Care reduction is ahead of planned trajectory, with current utilisation at 18 compared to the April trajectory target of 24 across HUTH, demonstrating accelerated progress against the agreed programme. All areas on track to meet required standards by the end of July 2026.

Figure 8: Corridor Care Activity and Performance Data:



Section 4: Patient Safety Incident Response Framework (PSIRF)

Definition

The NHS PSIRF framework mandates a proportionate, learning-focused approach to patient safety incidents, moving away from a "blame culture" and excessive, formulaic investigations. It focuses resources on actions that improve safety through compassionate engagement, system-based reviews, and tailored responses.

Patient Safety Incident Investigation (PSII) & Proportionate Learning Response caseload by Trust

In response to strengthening our leadership culture an oversight group has been implemented to focus on reduction of the time taken to complete investigations led by the Group Chief Patient Safety Governance Officer. The governance model has been strengthened to ensure there is a clinical, operational and investigation leads identified. In addition, timelines for completion have been agreed with each Care Group with a specific focus on all cases that are greater than 6-months old.

The cumulative HHP position is there are 141 patient safety learning responses in progress, 57 PSII and 84 proportional responses (After Action Review and MDT Reviews), with targeted improvement in the PSII cohort cases to complete 23 of the 57 cases target date agreed as the end of July 2026. A breakdown by Trust is captured below.

PSII Position NLAG

The table below, reflects for the NLAG Trust there are nineteen open PSII cases with two of these being externally investigated by the Maternity and Newborn Safety Investigations (MNSI) Team hosted by the Care Quality Commission (CQC). One case is on hold due to a police force investigation, allergic reaction to penicillin from 2023. Three PSII reports are the final report stage with quality checks. With four cases completed over the last month, there are 10 cases expected to be completed over the coming 3 months.

Figure 9: PSII open casework

NLAG PSII	2023	2024	2025									2026	Total
	Oct	Oct	Nov	May	Jul	Aug	Sep	Oct	Nov	Dec	Mar	Apr	
Grand Total	1*	1	1	2	2	1	1	2	2	1	1	1	16

*Footnote: * Police investigation*

Proportional Learning Response Position NLAG

Key aspects of the PSIRF framework enables different methods of review to be used ensuring resources are matched to the potential for learning, meaning not every incident requires a full in-depth investigation.

The below table summarises the position at the end of April 2026, in relation to the total number of open Proportional Learning Responses is 32, with 11 cases in the quality checking process for completion. Nine reports are being written and 11 cases in progress.

Figure 10: Proportional Learning Responses

NLAG Proportional Learning Responses	2025									2026				Total
	Feb	Mar	Apr	Jun	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Assurance	1		2	1		2	3		1		1			11
Report					1	1		2	2	1		1	1	9
Review		1		1				1		3	1	3	2	12
Grand Total	**1**	**1**	**2**	**2**	**1**	**3**	**3**	**3**	**3**	**4**	**2**	**4**	**3**	**32**

PSII Position HUTH

- For HUTH there are 35 open PSII cases with 5 of these being externally investigated by MNSI.
- 6 cases are going through draft report engagement with patients and their families.
- 6 PSII reports are at various stages of sign off through the Report QA process.
- 7 PSIIs have been completed over the past month, with 4 cases declared in April.

Figure 11: HUTH PSII open casework

	2024			2025							2026				Grand Total
HuTH PSII	Oct	Nov	Dec	Mar	Apr	May	Jun	Jul	Sep	Nov	Dec	Jan	Feb	Apr	
Grand Total	**2**	**1**	**1**	**3**	**4**	**2**	**3**	**1**	**4**	**3**	**2**	**2**	**3**	**4**	**35**

Footnote: There are 5 MNSI cases

Proportional Learning Response Position

The learning themes align to our strategic action plans with falls and pressure ulcer prevention, as well as Sepsis recognition and treatment, in turn informing the selection of the quality priorities for 2026/27.

The below table summarises the current position as of April 2026, in relation to the total number of open Proportional Learning Responses is 38, with 10 cases completed in the previous month, 7 cases in the quality checking and sign off process.

Figure 12 - HUTH Proportional Learning Responses

HUTH Proportional Learning Responses	2024	2025								2026			Grand Total
	Dec	Feb	May	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
In progress	1	1	3	4	1	3	1	2	1	3	5	5	31
Sign off processes				1			2	1		1		2	7
Grand Total	**1**	**1**	**3**	**5**	**1**	**3**	**3**	**3**	**2**	**4**	**5**	**7**	**38**

Section 5: Never Events

Definition

A “never event” is a serious, preventable medical error that should never occur if proper safety procedures are followed. These incidents, which can result in severe harm or death, are used for public accountability and to prompt improvements in healthcare safety systems.

Never Event Position

There have been zero never events reported that occurred in 2026 which is an improved position since the group formation.

A thematic review of Never Events that have completed investigations is being used to further develop the action plan for reducing Never Events, illustrating the timeline for all elements, including what has been completed. The investigation findings from Never Event Investigations are being added to the learning themes, which are shared through the relevant Care Group Governance meetings and more widely through the PSIRF Oversight Group, as well as feedback through workshops in quarter 3. The action plan developed from the themes identified and work of the Safer Surgery Interventions Group was provided to the Quality & Safety Committees-in-Common in March 2026. The latest published data for 2025/26 shows that HUTH/ NLAG has the joint 12th highest number of Never Events from all NHS providers in England.

Improvement actions include:

- A series of safety summits commenced on 8 May 2026 supporting improvements in patient safety and culture for TACC care group.
- A Surgical Safety series of engagement sessions are planned throughout 2026, including professional standards setting.
- Implementation of the NatSSIPS2 theatre checklists for south bank is being supported with training and group wide audit of processes, checking documentation and direct observation.

Section 6: Coroner's Inquests

Definition

An inquest is a public, judicial investigation conducted by a Coroner to determine the facts surrounding a death that appears sudden, violent, unnatural, or unknown. It establishes who died, and when, where, and how they died, rather than blaming individuals.

Coroner Case Position

The Group works in partnership with the Coroner's Offices to support case management, and the timeframe for hearings is largely determined by the coroner. Internally, a new process for an Inquest Panel has been introduced to provide robust oversight and assurance of the inquest processes.

The key themes from inquests include:

- Patient safety to prevent falls
- Communication between teams
- Documentation standards
- Safe staffing levels

These themes align to the quality priorities deconditioning workstream and nurse staffing improvement plans.

- Regulation 28 Letters

A regulation 28 report, or Prevention of Future Death (PFD) report, is a statutory notice issued by coroners in England when an investigation reveals action is needed to prevent future deaths. Recipients, such as NHS acute provider organisations, must respond with 56-days, detailing action taken or proposed to address the risks.

There has been one Regulation 28 Letters issued in respect of the initial triage of a patient in the emergency department at HRI, who presented with an infection and developed sepsis. The concern

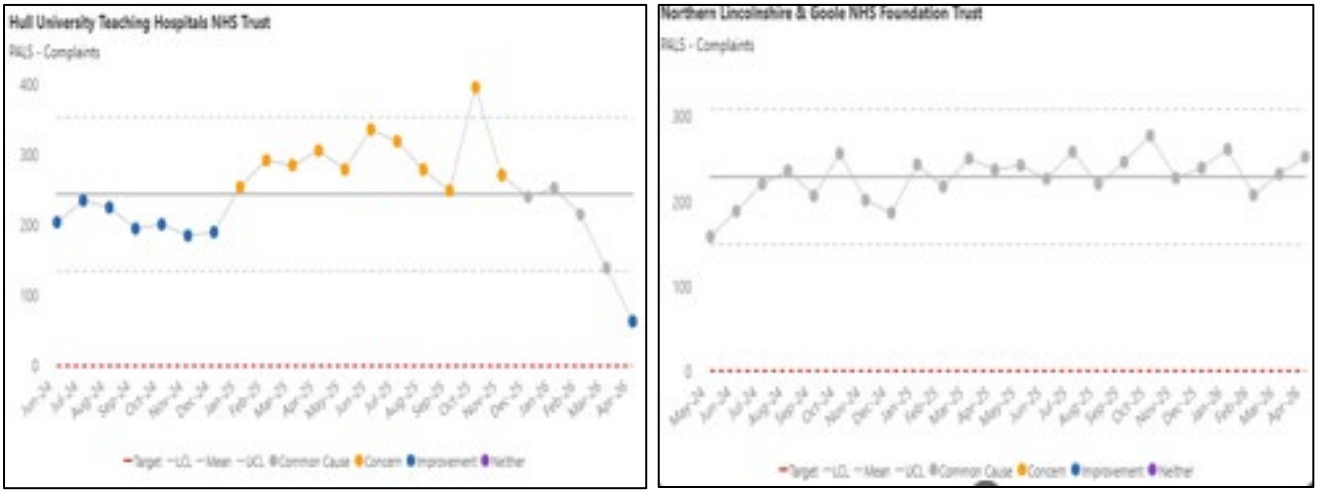
relates to the need for a single validated triage assessment tool to be universally used and the need for staff to be appropriately trained to use it.

Section 7 - Patient Experience, Patient Advice Liaison Service (PALs) and Complaints

The learning from harm Patient Experience, PALs and Complaint Section provides an update across the Group for the following Date range 1/4/2026 to 30/4/2026. Work is being undertaken to note the changes over time with themes and trends and any harms that are found and reviewed via the PALs and complaints route. In addition the Patient Experience team collect feedback via compliments, Friends and Family Tests and other annual report, this information is provided in Quarterly Patient Experience reports.

There have been at total of 385 PALs cases for the Group during April 2026. With 527 PALs resolved during April 2026 (March only 448 PALs were resolved). A number of PALs cases will become formal complaints.

Figure 13. PALs cases logged

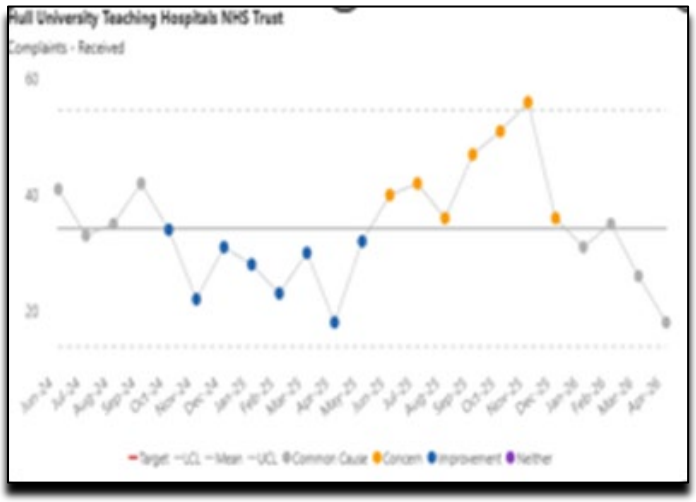


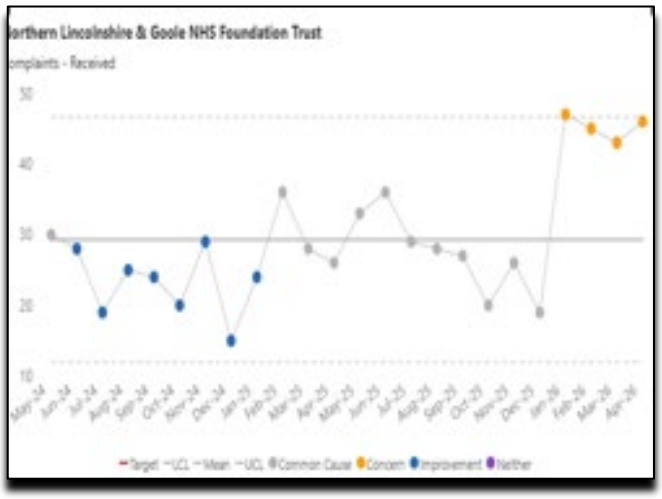
HUTH have challenges in the logging and completion of PALS concerns within 5 days (KPI is 60%) HUTH achieve around 50% resolution in the target timeframe and are currently not showing a sustained improvement. NLAG are consistently achieving above 60% resolution and are reviewing how they can support HUTH to achieve this target.

HHP PALS Themes and Learning

- Communication
- Delays (including OPA, wait times & cancellations)
- Clinical Care
- Discharge planning, process
- Lost property & Car parking

Figure 14. Complaints Received





HUTH complaints have reduced, following an increase. Compliance with 60 day response timescales remains below the 85% target for HUTH/ NLAG.

There have been 70 new complaints opened in April with no second complaints. However, the number of historic complaints mean that there are 345 open complaints. Complaints closed in April 63m this is an improvement in March when only 11 complaints closed, with a further 35 in the final Quality checking stages.

Complaints linked to Incidents

Of the complaints received in April one case is linked to patient safety incident process:

HUTH/NLAG cross organisation patient, a delay in a cancer diagnosis, an MDT review has been undertaken with the Patient safety team. There was delayed radiology referral and follow up. The outcome was graded as moderate harm.

HHP Complaints Themes and Learning

- Communication
- Staff Attitude
- Delays (including OPA, wait times & cancellations)
- Nursing Care & Treatment
- Discharge planning, process

PALS and Complaints Improvement Work

- Recruitment into PALs Patient Experience officer and Complaint Facilitator posts underway. PALs Patient Experience (Manage)r HUTH post now recruited.
- HUTH/NLAG staff PALs workshop took place in 24 April 2026, a number of actions alignment processes agreed, further actions for improvement in PALs underway.
- The NLAG complaint investigation and response planning has taken place, plan to introduce group model during May.
- Working with Patient services to address PALs, waiting list, delays in treatment work.
- Delays in IT / Telephony work expected date was August 2025, meeting took place reviewing additional options on 2 April, further work required.
- Ulysses dashboard for care groups now under development with panned launch in early June.

- Care Group Performance Meetings with Site Nurse Director continue weekly/ Biweekly
- QI programme established, - Medicine care group meeting rescheduled. This is a Learning from Complaints and PALS Improvement Programme. The aim is to target Care Group areas of concern. 12 Care Groups are developing their own tailored QI initiatives, with Care Group accountability for their improvement

MP complaints

The majority of MP concerns arrive via the Chief Executive office or into the PALs email inbox. The total number of MP complaints received in April was 8, a reduction from a total in March of 18. (HUTH 3 complaints received in April a reduction from 11 in March. NLAG 5 in April a reduction from 7 in March)

The themes for these align with the wider PALs and complaints themes. Waiting times for appointments staff attitude, discharge processes, eligibility for care treatment and ED waiting times. The work to address these themes are part of the wider Quality Improvement work and the ongoing work to reduce patient waiting lists.

Parliamentary Health Service Ombudsman (PHSO)

If after a response complainants remain dissatisfied, they can request that PHSO review their complainant.

The number of Complaints Open with PHSO for March is 29 (decrease of 1 since previous reporting of 30).

- HUTH has 23 (increase of 1 since previous report) with 13 for ongoing investigation (increase of 2 since previous report) with the remainder being requests for information.
- NLAG 6 (decrease of 2 since previous report, 2 are being investigated (decrease of 1 since previous report) of with the remainder being requests for information.

Section 8: Learning from experience safety actions

Summarised examples of finalised learning responses are provided below:

PSII 2024 9465

Incident summary (October 2024):

A young woman presented to urgent care and ED on 31 October 2024 with symptoms of infection and was later diagnosed with sepsis and pancolitis. There were delays in recognition and escalation of deterioration, including delayed observations, delayed senior review, delayed antibiotics until after CT imaging, and late initiation of the Sepsis Six pathway. Contributing factors included ED overcrowding, staffing pressures, IT documentation failures, and use of the abdominal pain pathway instead of the sepsis pathway. The patient deteriorated to septic shock and multi-organ failure and died in November 2024.

Safety actions:

- Develop and implement SOP for recognition and management of deteriorating patients in ED
- Introduce enhanced escalation pathways linked to NEWS2 triggers and suspected infection
- Develop and implement a new sepsis screening tool to improve early recognition
- Reinforce prioritisation and consistent use of the sepsis pathway (Sepsis Six)

- Undertake staff wellbeing survey and implement action plan addressing workload, overcrowding, and morale

PSII 2025 4696

Incident summary (June 2025):

During cataract surgery in June 2025, an incorrect intraocular lens was implanted in the patient's left eye (Never Event), using a lens intended for the right eye. The error arose from selection of the wrong biometry documentation page, compounded by multiple pages of similar information, lack of clear document separation, and failures in checking processes. The incorrect lens resulted in unintended visual outcome but no immediate procedural harm.

Safety actions:

- Ensure prescribing and administration documentation (MAR) for eye drops is completed and signed correctly
- Reinforce that medication must not be administered without prescription and must be documented
- Separate and clearly identify relevant biometry documentation for theatre use
- Print key biometry documentation on coloured (yellow) paper to improve visibility
- Display IOL Implant Verification Process (DCR 191) and flowcharts in theatres
- Provide staff access to and visibility of checking processes (laminated guidance)
- Retain and archive marked theatre lists to evidence lens selection decisions
- Introduce audit and governance monitoring (e.g. spot checks, audits) to ensure compliance

PSII 2025 540

Incident summary (October 2024):

An 83-year-old woman presented to the Emergency Department on 28 October 2024 with suspected sepsis following GP referral. Although sepsis was suspected, there were delays in sepsis screening, senior review, antibiotics, fluids, and investigations. The Sepsis Six pathway was not completed within the recommended timeframe, and escalation of ongoing deterioration was inconsistent amid significant ED overcrowding and operational pressure. The patient developed urosepsis and multi-organ failure and died on 2 November 2024.

Safety actions:

- Develop and implement an ED SOP for recognition and escalation of deteriorating patients
- Introduce clear escalation pathways for NEWS2 triggers and suspected infection
- Develop and test a new sepsis screening tool to improve early recognition
- Reinforce consistent use of the sepsis pathway (Sepsis Six)
- Undertake staff wellbeing survey and implement actions addressing workload and overcrowding

PSII 2025 4920

Incident summary (August 2025):

A patient with insulin-dependent diabetes received an incorrect dose of insulin in August 2025 due to use of an inappropriate syringe, resulting in 60 units being administered instead of 6 units on two occasions (Never Event). The error was linked to confusion between syringe types, ineffective second-checking processes, limited staff familiarity with insulin preparation, and inconsistent policies. The patient was monitored closely and did not experience harm.

Safety actions:

- Increase staff awareness and education on safe insulin administration
- Introduce and mandate annual insulin safety training (CDEP e-learning package)
- Introduce hypoglycaemia knowledge audit for staff
- Standardise injectable medication and second-checking policies across the organisation
- Develop a single joint injectable medicines policy
- Review and rationalise availability of 1ml syringes on wards
- Ensure appropriate storage and clear separation of insulin and non-insulin syringes
- Disseminate safety messaging (posters, digital resources) across clinical areas

Section 9: Summary

The triangulation of the learning themes across various sources have informed the quality priorities and the further development of our strategic action plans.

The committee is asked to consider the content of the report as assurance of the systems and processes supporting the patient safety improvement agenda.

ADVISE, ALERT and ASSURE REPORT	
Meeting	Quality and Safety Committees-in-Common
Meeting date	28 May 2026
Chair	David Sulch, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality The CIC were assured on a number of occasions due to the robust processes in place and the improvements being seen. However, limited assurance was given due to outcomes and current performance figures.				
Complaints and PALS improvement recovery plan	2162 PALs across the Group 248 new complaints in month Work on the backlog was ongoing	**The CIC agreed to give an assurance rating in 3 months time to allow the recovery actions time to progress**	Closed 150 complaints/PALs within the week due to wider team working A PALS team would be located in the foyer at HRI to allow public access PALS manager appointed HUTH/PALS recovery week in place	Deep Dive into Complaints and PALs at the next Q&S meeting
ATHENs training compliance and staff capacity	Delivery compliance constrained	**Limited Assurance**	Action plan in place	Monitored through WECC in June

Maternity and Neonatal Report	Ultrasound capacity is creating a level of risk MIS Year 7 funding received MIS Year 8 training checkpoint is 31 July 2026 – plans in place to achieve compliance Induction of labour is still a risk VTE compliance in maternity is a challenge and being reviewed	**Reasonable Assurance**	Developing an Ultrasound plan Additional midwife on Labour Ward, allocation of discharge midwife to support flow	July 2026
Patient Led Assessment of the Care Environment	HUTH has deteriorated in all domains except for food and hydration scores NLAG has deteriorated in all domains except for food hydration scores The CIC expressed concern regarding the cleanliness and deteriorating estate scores	**Minimal assurance was given and a broader discussion with Board was required**	PLACE agenda now harmonised across the Group Action plans are in place and have a multidisciplinary approach Communications page established Investment required due to the aging estate – to be escalated to the Board Cleaning harmonisation process is being carried out across the Group	

Clinical Effectiveness – national outliers and significant variations in performance	**NLAG** Surgical Site Infection - negative National Neonatal Audit - negative **HUTH** National Paediatric Diabetes Audit - Positive National Joint Registry Knee Revision Rate - Negative National Audit of Care at the End of Life - Negative	**Limited assurance was given**	Alert to the Board	May 2026

ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Board Assurance Framework	Pioneering Risk – CiC expressed concern regarding the low score of 12 and the lack of digital outcomes	**N/A**	Review risk with the Acting Chief Digital Officer Deep Dives of both risks being carried out	June 2026
Quality Priorities	Review of each workstream taking place, Sepsis was raised as a concern	**Limited assurance was given, but the CIC noted the improvement work**	Validation of Sepsis deaths being undertaken Sepsis coding review taking place	June 2026 – monitored through IPR
CQC – 5 reports received	Improvements seen in each report	**Reasonable – The CIC were assured that the CQC were highlighting**	Work is ongoing regarding the CQC Well-Led review	

		areas already noted by the Group		
Learning and Improvement Report	This report is evolving and governance processes are in place. The CIC asked for further assurance around how learning was embedded	**Progress has been made with the report. Clear line of sight to communication and deteriorating patient.** **Limited assurance was given but the CIC noted that the processes are more robust and improvements were anticipated as a result.**	Monitoring, audits and governance in place. No Never Events had been reported in 2026. A review of staffing provisions is taking place and a redesign of the team will be required due to the Group's financial position.	
Pressure Ulcers	Figures are static and not reducing Issues with data quality and catagorisations Focus on wards with the most number of PUs	**Limited assurance as given due to the amount of work yet to do.**	Photography of wounds needs harmonising across the Group Business Case HUTH new mattresses Simulation training being carried out Daily PU assessments by Sisters	

ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Heading				
Elective surgery harm review update	Action plans in place Concerns raised about Cancer 62 day performance	**Reasonable assurance was given due to the processes in place to review harm** **CIC monitoring the outcomes in the action plans will give further assurance**	Review of complaints/claims being undertaken	
Maternity and Neonatal Annual Report	The CIC received the report	**N/A**	For the Board to note	
Learning from Deaths Report	HSMR and SHMI showing sustained improvements	**Reasonable assurance was given**		
Never Events	Varying issues and showing some improvements	**The CIC agreed to assure this item on a quarterly basis to give the improvements time to mature**	Action plans are in place	

2. Board Assurance Framework (BAF):

The committees considered the areas of the BAF for which it has oversight and has proposed the following change(s) to the risk rating or entry:

The committees considered the areas of the BAF for which it has oversight and no changes are proposed.

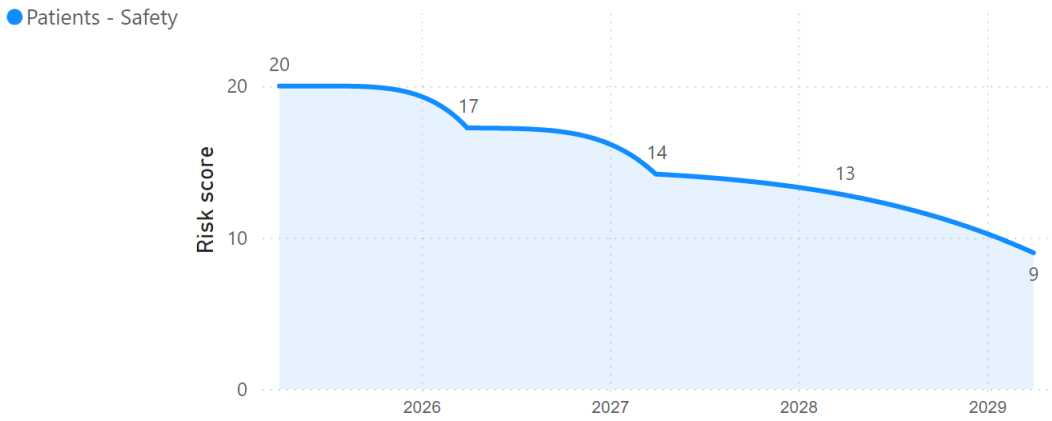
3. Patients - Safety

The strategic risk affecting our objective, 'Patients - Safety' is led by Kate Wood, Group Chief Medical Officer; Sam Peate, Group Chief Delivery Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Patients - Safety, the risk's current score is 20 and its score last changed on 26/01/2026. The actions were last reviewed on 19 February 2026. In full, the risk is:

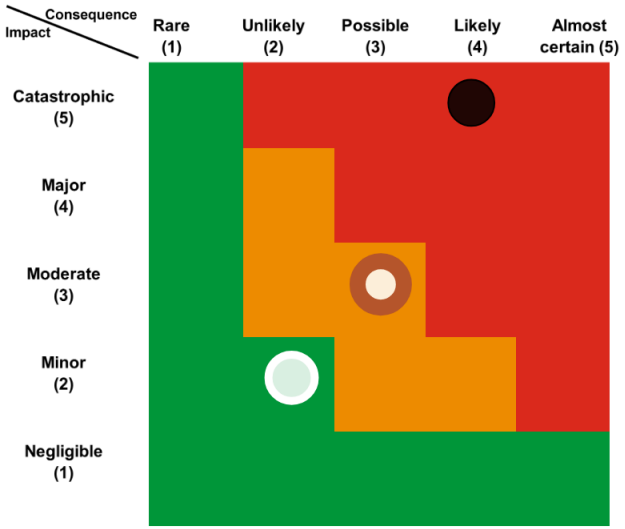
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

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

Control	Rating
Accreditation Frameworks	Limited
Care Group Performance and Accountability	Limited
Clinical Policy Group (CPG)	Limited
Continuous Professional Development for all health professionals	
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 Group	
Patient Safety and Learning Group	
Patient Safety Partners involvement	
Peer Review Process	
Professional standards	Reasonable
Quality and Safety Strategy	Reasonable
Risk and Compliance Group	Limited
Safe Staffing Models	Reasonable
Senior Leadership Team (SLT)	Limited

Gaps in control (and Action ID)	12	13	15	52	54	Total
Fully safe staffing levels (North)		✓				1
Inconsistent evidence of embedded improved processes	✓					1
Instances of data quality issues in supporting metrics		✓				1
Insufficiently strong speak up and reporting culture			✓			1
Lack of comprehensive safety culture		✓	✓	✓	✓	4
Lack of consistent basic hygiene compliance			✓			1
Lack of involvement in national quality audits				✓		1
Lack of positive medical engagment in delivery					✓	1
Poor Martha's Rule compliance					✓	1
Total	1	2	2	3	1	3	12

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Clinical audit outcomes	Reasonable
Internal	CQC Action Plan	Significant
Internal	Daily OPEL status	Limited
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	Reasonable
Internal	Incident reporting	Limited
Internal	Infection Preventation and Control BAF report	Minimal
Internal	Integrated Performance Report	Reasonable
Internal	Mandatory training levels	Limited
Internal	Maternity Neonatal Dashboard	
External	National Patient Survey	Limited
Internal	Never events	Limited
Internal	Ouputs from QI Programme	Limited
Internal	Patient complaints via Patient Experience Quarterly report	Minimal
Internal	Risk Register compliance and coverage	Limited
Internal	Statutory and mandatory compliance levels	Limited
Internal	Ward accreditation metrics	

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

A green flag or arrow indicates a recent addition / change to the report.

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
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	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25	31/03/29	1st Draft to NMB end of Jan	04/02/25	Group Chief Medical Officer, Group Chief Delivery Officer	
15	Develop and embed the Patients First 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.	19/02/26	Group Chief Medical Officer, Group Chief Delivery Officer	Significant
52	Developing and implementing a robust clinical audit programme	31/03/26	31/03/27	Programme developed, now in process of implementation	12/09/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
54	Implementing programme of Martha's Rule actions (for pilot phase)	31/03/26	01/04/27	Piloting six wards, using feedback to inform rollout for organisation. Phase 2 in operation (to Mar 26). Patient Well Being questionnaire already implemented across the group - reporting to Q&S - except for staff gaps to enable paediatric second opinion	12/09/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
55	***** QS ***** Patient decision-making					Group Chief Medical Officer, Group Chief Delivery Officer	
67	Implementation of Staffing business cases for maternity services	31/12/27	31/12/27		02/12/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
73	***** QS ***** Risk Summit and Safety Summit actions					Group Chief Medical Officer, Group Chief Delivery Officer	
77	Implementation of Nurse Safer Staffing level	31/12/26	31/03/27	Business case approved by Board in Feb-26. Implementation phase underway.	19/02/26	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)135

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 11 June 2026**
Director Lead	**David Sulch, Non-Executive Director & Maternity & Neonatal Safety Champion**
Contact Officer / Author	**As above**
Title of Report	**Maternity & Neonatal Safety Champion's Report**
Executive Summary	**Executive Summary for Trust Boards in Common**
Background Information and/or Supporting Document(s) (if applicable)	This report provides assurance from the Non-Executive Director (NED) Maternity & Neonatal Safety Champions for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust for the period April and May 2026. **Overall assurance positive:** Continued progress across maternity and neonatal services, with strong governance, improving workforce recruitment, and good staff engagement. **Key improvements:** Removal of Section 31 conditions at HUTH, opening of a new bereavement suite, and ongoing recruitment strengthening services. **User experience issues:** Persistent concerns around induction of labour delays, clinic waiting times, and usability of BadgerNotes. **Workforce & culture:** Staff report feeling heard at HRI, with ongoing work to improve engagement and address concerns at DPOW. **Escalated risks:** Induction of labour capacity and acuity pressures, ultrasound capacity across the Group, and IT connectivity issues at Scunthorpe.
Prior Approval Process	
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**Safe and equitable maternity and neonatal services crucial for addressing health inequalities**
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

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Maternity & Neonatal Safety Champion's Report
For the Month of June 2026

Executive summary:

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

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

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

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between April and May 2026 have included a standard programme of walk rounds, meetings with service executive leads, plus attendance at maternity and neonatal assurance and service meetings as follows:

Hull University Teaching Hospitals (HUTH)
16 April Maternity & Neonatal Assurance Group
14 May Safety Champion Walkaround- Hull Royal Infirmary
21 May Maternity & Neonatal Assurance Group

Northern Lincolnshire and Goole (NLaG)
16 April Maternity & Neonatal Assurance Group
29 April Safety Champion Walkaround- Scunthorpe General Hospital
21 May Maternity & Neonatal Assurance Group

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
The Safety Champion was pleased to review the Annual Report for maternity services and to note the positive progress made and the clear understanding of areas that continued focus and improvement. .	Services Users continue to raise concerns about Badger notes and induction of labour. Women report long waits in clinic- the Safety Champion that is ongoing to work to address clinic capacity and improve experience.	The Safety Champion is delighted to note the staff at Hull Royal Infirmary reporting feeling heard when raising concerns, The Safety Champion is assured that progress is ongoing to address issues raised at DPOW.

Good practice, improvements & innovation to share:

- **Section 31:** The Safety Champion is pleased to note that the Section 31 Conditions for HUTH have now been removed.
- **Bereavement Suite:** The Safety Champion acknowledged the opening of the new Bereavement Suite and the positive impact it will have for families.
- **New Posts:** The Safety Champion notes the positive progress with recruitment across maternity services.

Risks & concerns to escalate:

- Concerns around acuity and delays in the induction of labour clinic were raised on the HRI walkaround. The Safety Champion notes that there is a Task and Finish Group in place to tackle these issues.
- At Scunthorpe the staff raised concerns about computer connectivity in clinical areas.
- The Safety Champion considers that the issues with ultrasound capacity across the Group need focus and consideration to address.

Activities planned next month:

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

- 18 June 2026 Maternity & Neonatal Assurance Group

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

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)136

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 11 June 2026**
Director Lead	**Jo Ledger, Interim Group Chief Nurse**
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternity and Neonatal Assurance Report**
Executive Summary	1. Confirmation of funds received in respect of Maternity Incentive Scheme Year 7- HUTH £813,846 including £46,041 share of surplus from trusts that did not achieve 10/10 NLAG MIS Discretionary Funding to support our improvement plan £235,245 which must be ring-fenced for maternity services. 2. Maternity Incentive Scheme Year 8- training checkpoint 1 for Safety Action A will be the 31st of July 2026 (compliance must be >90% in all staff groups at this point) 3. Interviews for several Specialist Midwife and Manager/Lead roles will take place across late May and June. 4. The Perinatal Health Inequalities Steering Group will launch on the 9th of June 2026 **Advise** 5. Cultural issues raised at DPOW Maternity continue to be worked through with support from OD and HR. Paper has been shared with Executive Team 6. Concerns raised from Student Midwives about their experiences, primarily at Scunthorpe (Listening Event due to take place on the 20th of May 2026 7. Ultrasound capacity continues to be a concern across the Group with actions underway to address in the short-term but a long-term plan will need to be developed. 8. Induction of labour delays continue particularly at HUTH, this is multi-factorial and a number of actions are in place to address including an additional midwife on the long day on Maple Ward, an extra midwife on Labour Ward, allocation of a discharge midwife on Rowan all to support flow. The guidelines are also currently under review. 9. Antenatal clinic capacity continues to be a concern at NLAG, review of capacity and demand required. 10. Fetal medicine service fragility and capacity issues identified. **Assure** 11. Lots of 'Shining Lights' received for staff across both trusts 12. Fingerprint access is now available to enable parents to have 24 hour access to the Neonatal Unit at HUTH 13. The Birth in Focus Project with the Midwifery Unit Network continues with positive feedback from staff.

	14. Homebirth PFD- Two workshop with Community Midwives have been undertaken and Scunthorpe, Goole and Hull midwives and a follow-up survey has been issued to all staff. Workshop and survey will shortly be undertaken with DPOW Midwives. New Matron for Community and Antenatal Clinic appointed at NLAG and has commenced in post this week. Personalised Care Task and Finish Group continues and job matching awaiting for Consultant Midwife post.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Quality & Safety Committees in Common
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

May 2026

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Executive Summary

Performance, challenges, risks and interventions	
Information	1. Confirmation of funds received in respect of Maternity Incentive Scheme Year 7- HUTH £813,846 including £46,041 share of surplus from trusts that did not achieve 10/10 NLAG MIS Discretionary Funding to support our improvement plan £235,245 which must be ring-fenced for maternity services. 2. Maternity Incentive Scheme Year 8- training checkpoint 1 for Safety Action A will be the 31st of July 2026 (compliance must be >90% in all staff groups at this point) 3. Interviews for several Specialist Midwife and Manager/Lead roles will take place across late May and June. 4. The Perinatal Health Inequalities Steering Group will launch on the 9th of June 2026.
Alert	
Advise	1. Issues raised at DPOW Maternity continue to be worked through with support from OD and HR. Paper has been shared with Executive Team 2. Concerns raised from Student Midwives about their experiences, primarily at Scunthorpe (Listening Event due to take place on the 20th of May 2026 3. Ultrasound capacity continues to be a concern across the Group with actions underway to address in the short-term but a long-term plan will need to be developed. 4. Induction of labour delays continue particularly at HUTH, this is multi-factorial and a number of actions are in place to address including an additional midwife on the long day on Maple Ward, an extra midwife on Labour Ward, allocation of a discharge midwife on Rowan all to support flow. The guidelines are also currently under review.
Assure	1. Lots of 'Shining Lights' continue to be received for staff across both trusts. 2. Fingerprint access is now available to enable parents to have 24 hour access to the Neonatal Unit at HUTH. 3. The Birth in Focus Project with the Midwifery Unit Network continues with positive feedback from staff.

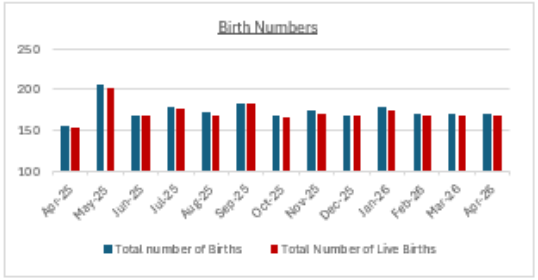
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1. MATERNITY DASHBOARD OVERVIEW

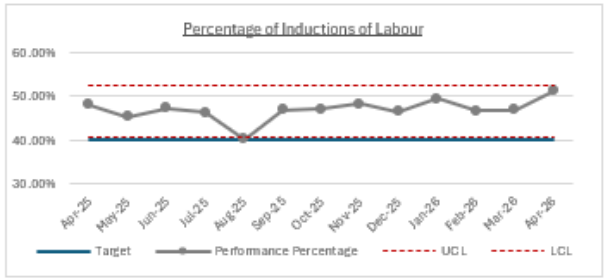
Maternity Overview - Diana Princess of Wales (DPOW)

Latest Month: April 2026

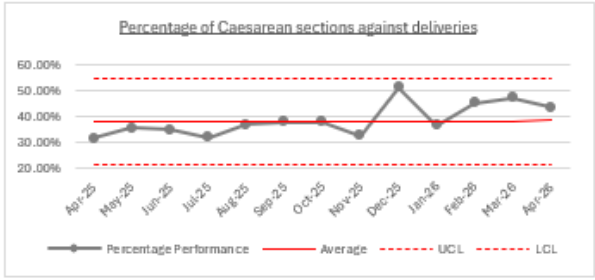
Number of Births / Live Births



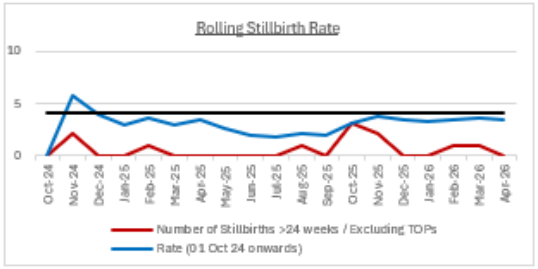
Induction of Labour Rate



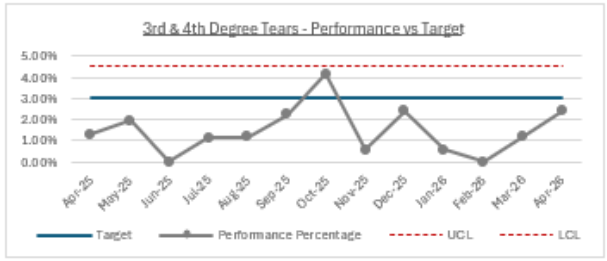
Caesarean Section Rate



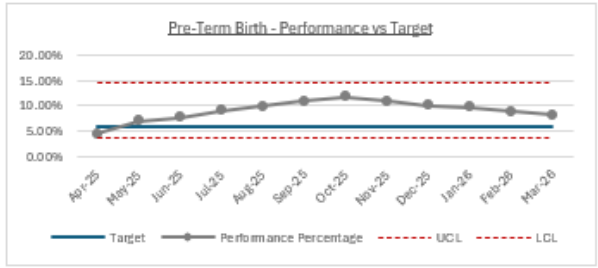
Rolling Stillbirth Rate (per 1000 births)



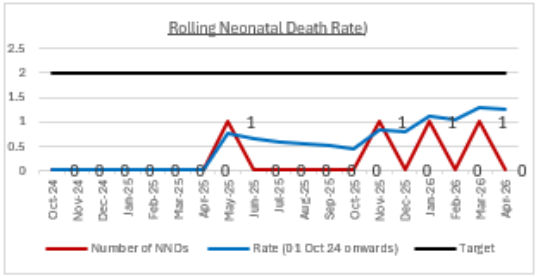
Third and Fourth Degree Tear Rate



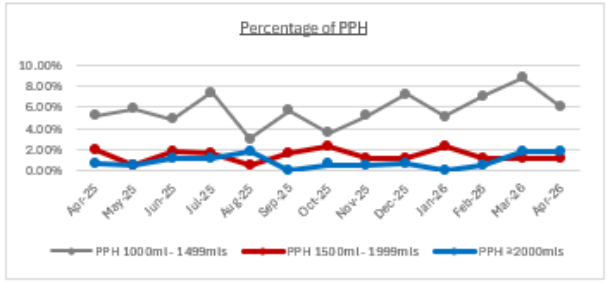
Preterm Birth Rate



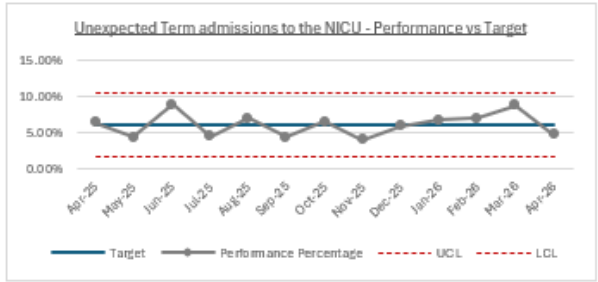
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



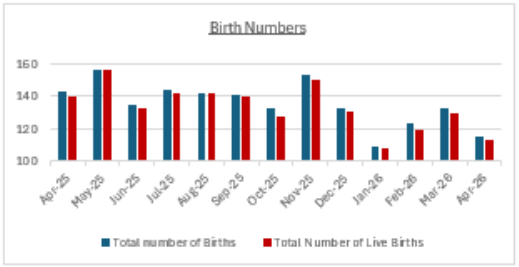
Unexpected Admission to NICU



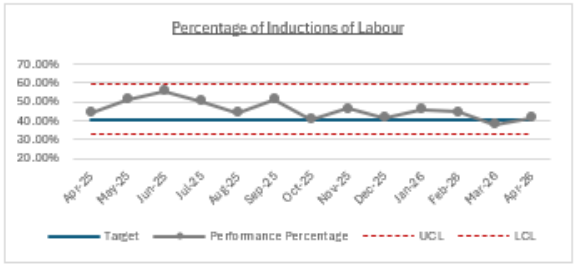
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: April 2026

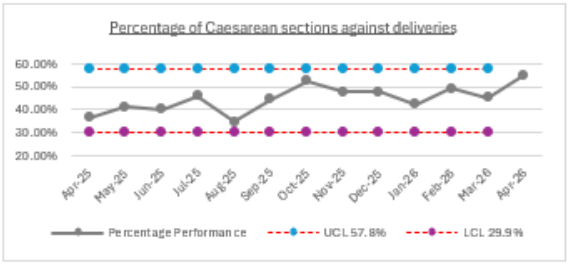
Number of Births / Live Births



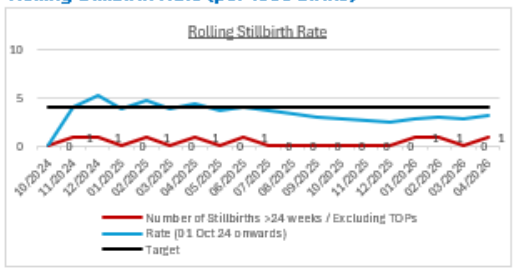
Induction of Labour Rate



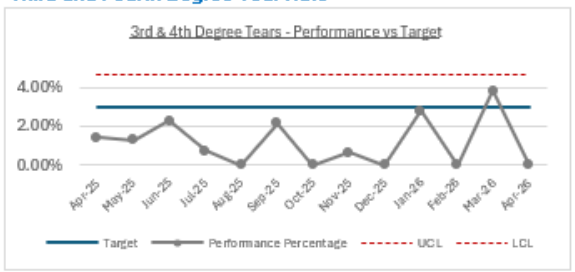
Caesarean Section Rate



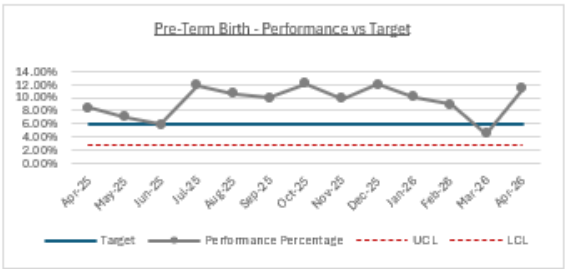
Rolling Stillbirth Rate (per 1000 births)



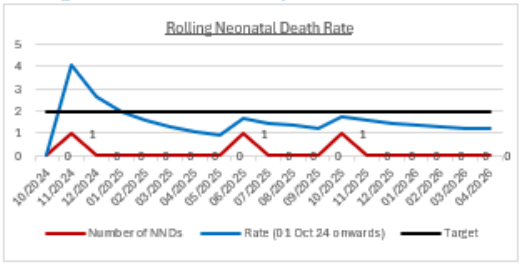
Third and Fourth Degree Tear Rate



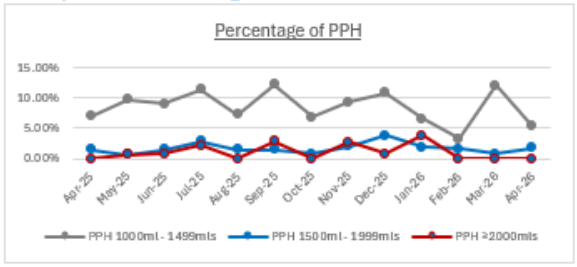
Preterm Birth Rate



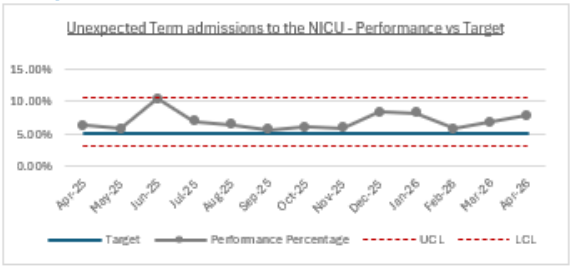
Rolling Neonatal Death Rate (per 1000 births)



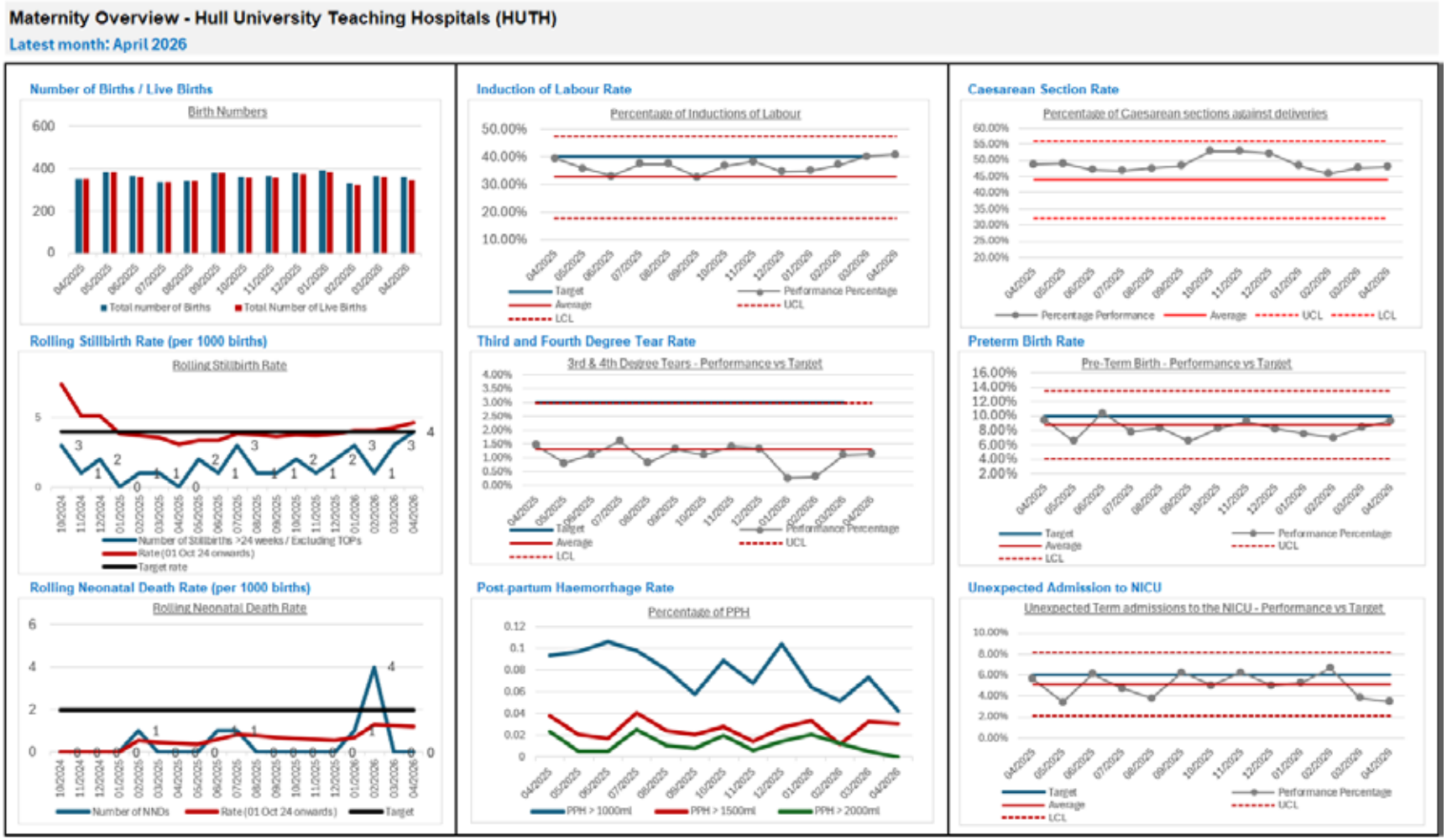
Post-partum Haemorrhage Rate



Unexpected Admission to NICU



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



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

2. PERFORMANCE METRICS

2.1 NHS Resolution Maternity Incentive Scheme Update

MIS year eight was launched on the 23rd April 2026. New guidance shows a significant shift in how MIS functions with the introduction of mid-year peer checkpoints. It responds directly to the findings of national inquiries, system feedback, and Trust-level learning from previous years.

The biggest risk at present relates to the mid-year checkpoint for training compliance (safety action B). The date can be agreed locally and is required to be declared beforehand. Both HUTH and NLAG have agreed for this to be the 31st July 2026.

The remaining standards are currently being worked through to identify any gaps for immediate action.

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

MIS YEAR 8 Safety action	HUTH				NLAG			
	Red	Amber	Green	Blue	Red	Amber	Green	Blue
A Workforce and capacity								
B Training								
C Learning from review and investigations								
D Service user voice and equity								
E Care bundles								
F Board oversight, governance, culture and leadership								
Total	**0**	**6**	**0**	**0**	**0**	**6**	**0**	**0**

2.2 CQC Progress Update

Northern Lincolnshire and Goole NHS Foundation Trust

The Maternity Service CQC action reports for 2022 & 2024 contained 18 actions. 2 remain open but are now green, 16 actions have been closed.

Hull University Teaching Hospitals NHS Trusts

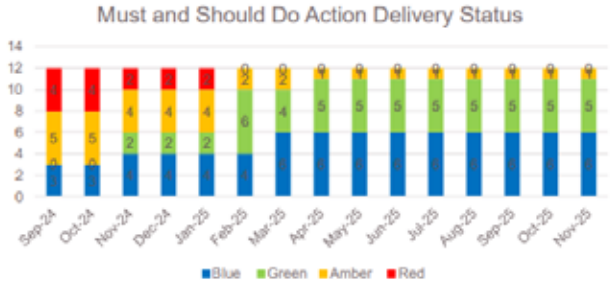
The overarching Maternity Service CQC action plan contains 37 sub actions from the '9 Must' and '3 Should' (12) do actions detailed in the inspection report published in August 2023. Confirmation that the Section 31 conditions have now been removed as been received from the CQC.

- 6 actions remain open (no red actions):
  - 4 actions are in the process of being closed
  - 1 action – continue to monitor training
  - 1 amber remains - medical workforce within the Maternity Service, especially ADU impacted by investment

Blue	Delivered & sustained
Green	Actions are complete but will require a quality assurance process to indicate level of embedding of the change and the transformation achieved
Amber	Managed actions underway, on track to deliver
Red	No progress/not progressing to plan

	Blue	Green	Amber	Red	Total
November 2024	4	2	4	2	12
December 2024	4	2	4	2	12
February 2025	4	6	2	0	12
March 2025	6	4	2	0	12
April 2025	6	5	1	0	12
May 2025	6	5	1	0	12
June 2025	6	5	1	0	12
July 2025	6	5	1	0	12
August 2025	6	5	1	0	12
September 2025	6	5	1	0	12
October 2025	6	5*	1	0	12
November 2025	6	5*	1	0	12

*4 of these are in the process of being closed and will turn blue once approved and submitted to the CQC, leaving 1 green rated action



2.3 Ockenden: Progress of Essential Actions

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. A total of 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. The remaining 84 have been assessed, the status of each sub action is detailed in the table below for both HUTH and NLAG.

Actions that are not on track predominantly relate to workforce capacity, the introduction of key leadership roles and standalone clinics. A detailed review and narrative of Ockenden actions will be complete for May MNAG.

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

Status	NLAG	HUTH
Blue	70	34
Green	2	29
Amber	3	17
Red	9	3
Grey (National/Regional)	8	8

2.4 Saving Babies' Lives Care Bundle (v.3)

Improvement work continues at both HUTH and NLAG with the overall aim of being fully compliant with the Saving Babies Lives Care Bundle Version 3.2. Current compliance is detailed in the table below for quarter 4 25/26. The key risks across the group relate to smoking in pregnancy and pre-term birth / optimisation. The Pre-term Birth Lead Midwife will be advertised as soon as table topping of job description aligned to new job profiles is complete.

Quarter 3 25/26 – Performance	HUTH	NLAG
Element	**Current Compliance**	**Current Compliance**
Element 1: Smoking in pregnancy	70%	90%
Element 2: Fetal growth restriction	95%	95%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	88%	85%
Element 6: Diabetes	100%	83%
Total	**88%**	**88%**

2.5 Maternity & Neonatal Safety Improvement Plan – Progress

The Maternity and Neonatal Improvement plan continues to be monitored by the Maternity and Neonatal Improvement Group. A total 398 actions are now complete. The table below provides a breakdown of progress for the remaining open actions within each workstream. A meeting is took place in February to review the open/off track actions.

Workstream	Number of Actions HUTH	Number of Actions NLAG
Culture		
Signed off and evidenced	11	21
Complete	9	-
In progress	8	7
Delays/issues	1	1
Safety		
Signed off and evidenced	16	14
Complete	21	4
In progress	12	4
Delays/issues	5	2
Experience		
Signed off and evidenced	17	11
Complete	6	-
In progress	7	3
Delays/issues	6	2
Assurance		
Signed off and evidenced	61	113
Complete	60	34
In progress	24	16
Delays/issues	23	34

Assurance includes the Maternity Incentive Scheme, Saving Babies Lives', NICE compliance, actions from PMRT, audits, Ockenden, outliers, external visits and the Three-Year Delivery Plan.

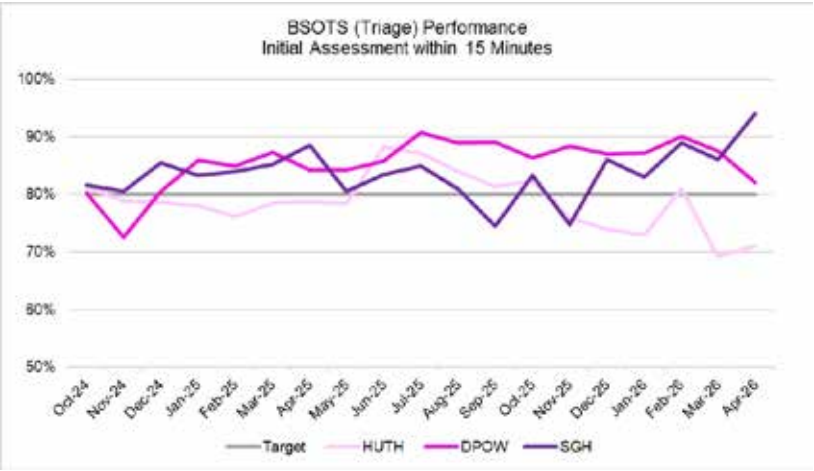
2.6 VTE Risk Assessment Performance

The table below details the performance for each hospital site for **April 2026**. Compliance is sourced from BadgerNet reporting, further ward breakdown can be accessed from Power BI reporting, however, caution should be applied as the lag in data import from the data warehouse means that data is not updated in 'real time' which results in lower compliance reported for the current month.

	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
HUTH	81%	92%	94%	99.4%
DPOW	83%	89%	93%	94.6%
SGH & GOOLE	72%	85%	91%	97.4%

2.7 BSOTS Performance

The chart and table below demonstrate ongoing performance with regards to women/birthing people being seen for initial assessment in Triage within 15 minutes of arrival for each hospital site and whether those categorised as red are seen within 15 minutes. At HUTH, March was reported to have high acuity throughout the month, with a noted decline in compliance. Regular communications continued with staff, alongside daily and weekly monitoring of compliance. Following recent recruitment and an increased budget allocation, the department will soon be staffed exclusively with core Band 6 Midwives, aiming to improve compliance. The Lead (Manager) for this area now has her office on the clinical area to offer visible leadership and has real-time digital monitoring in her office to see overall activity and to enable her to offer support when required. Work is also ongoing to increase the opening hours in the Antenatal Day Unit to ensure that planned appointments do not impact on triage.



Seen within 15 minutes - Level of urgency: RED				
Month	**Target**	**HUTH**	**DPOW**	**SGH**
Oct 25	100%	96% (16/17)	75% (3/4)	100% (2/2)
Nov 25	100%	89% (16/18)	100% (6/6)	66% (2/3)
Dec 25	100%	100% (12/12)	100% (3/3)	100% (2/2)
Jan 26	100%	100% (6/6)	100% (3/3)	N/A
Feb 26	100%	100% (12/12)	100% (2/2)	100% (3/3)
Mar 26	100%	88% (7/8)	100% (4/4)	100% (2/2)
Apr 26	100%	100% (10/10)	100% (4/4)	100% (2/2)

3. PERINATAL MORTALITY

3.1 Perinatal Mortality Summary for the period

Perinatal deaths within month (April 2026)					
	Antepartum Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	3 (35+5, 35+1, 34+1)	-	1 (42+5 – unbooked)	3 (20+3, 17+4, 28+6)	1 (41+4)
NLAG	1 (32+5)	-	-	2 (21+3, 22+0)	-

3.2 Details of PMRT Review Outcomes (March 2026)

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 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.

The tables below provide an overview of the cases discussed at PMRT meetings during March 2026 including the overall grading assigned to each case and the outcome / learning identified.

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
101427	B – neonatal care only	N/A	N/A	Report written
101730	A – neonatal care only	N/A	N/A	Report written
101631	B/B/A	N/A	N/A	Report written

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
100922	B / B	N/A	N/A	Report written and published. Actions relate to change to discussion with Pathology staff re Kleihauer testing, updating bereavement care mandatory training for further education to staff and PMRT information packs to be made up for staff to access.
100630	B / A	N/A	N/A	Report written and published. Actions relate to raising staff awareness of the DNA policy.
101427	B / B / B	N/A	N/A	Report written and published. Actions relate to education regarding the use of skin temperature probes for resuscitation events.

4. MATERNITY TRAINING COMPLIANCE

Hull University Teaching Hospitals NHS Trust

Month: Mar 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	93%	N/A	83%	93%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	94%	89%	72%	88%	78%	54% (new starters)	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	92%	N/A	N/A	N/A	N/A	N/A	92%	82%	84.4%	100%
Personalised Care	93%	92%	79%	71%	N/A	N/A	N/A		N/A	N/A

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Apr 26	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetists (Consultants)	Anaesthetists (other doctors)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	96%	N/A	100%	Before Jul 25 100% After Jul 25 86%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	96%	93%	93%	Before Jul 25 100% After Jul 25 76%	88%	Before Jul 25 88% After Jul 25 75%	N/A	N/A	N/A	N/A
Personalised Care (SBLCB)	95%	94%	80%	Before Jul 25 92% After Jul 25 59%	N/A	N/A	N/A	N/A	N/A	N/A
Care during Labour & PN	95%	N/A	80%	Before Jul 25 58% After Jul 25 89%	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year) (MIS)	95%	N/A	N/A	N/A	N/A	N/A	75%	Before Jul 25 89% After Jul 25 96%	90%	100%
NLS (4 year) (MIS)	N/A	N/A	N/A	N/A	N/A	N/A	88%	Before Jul 25 94% After Jul 25 93%	N/A	N/A

5. SAFER STAFFING

5.1 Maternity & Neonatal Fill rates – planned versus actual (inpatient areas)

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Mar 26	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	3234.8	97.7%	3300.6	3230.8	97.9%	1674.0	1681.4	100.4%	1426.0	1409.5	98.8%
SGH	2567.1	2248.8	87.6%	2557.1	2068.3	80.6%	713.0	604.0	84.7%	945.5	726.8	76.9%

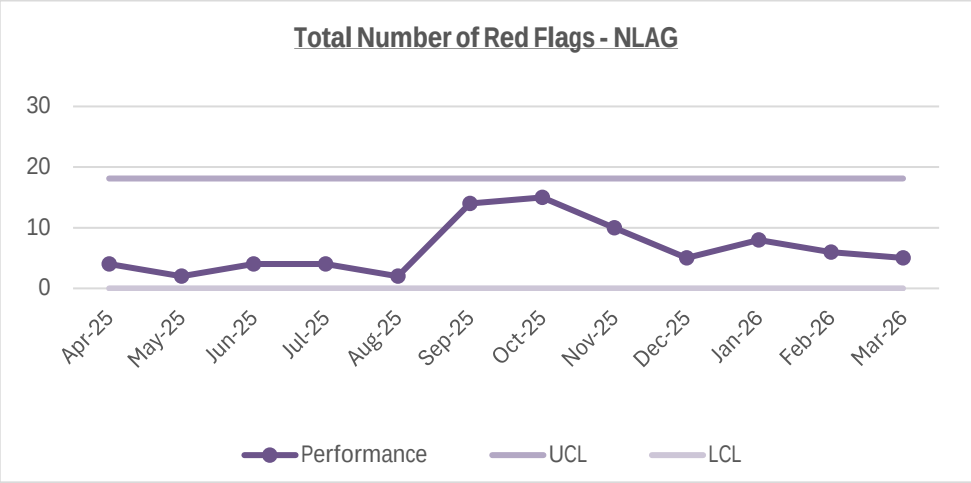
Month: Mar 26	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	1782.5	1244.5	69.8%	1426.0	1182.9	83%	713.0	443.3	62.2%	713.0	486.0	68.2%
SGH	1426.0	1140.0	79.9%	1069.5	1060.3	99.1%	713.0	533.8	74.9%	713.0	575.2	80.7%

Hull University Teaching Hospitals (HUTH)

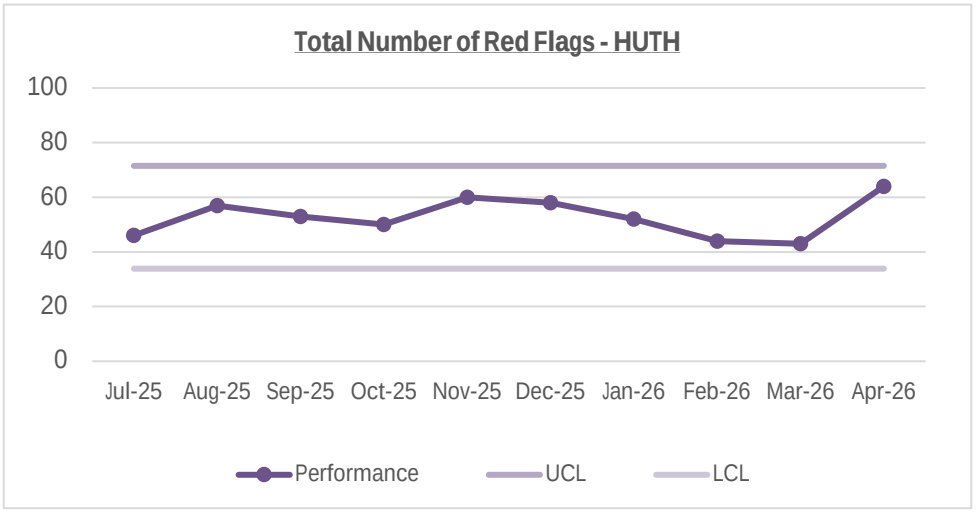
Month: Apr 26	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	8282.75	7716.58	93.16%	5249.00	4734.00	90.19%	3072.50	2837.85	92.36%	2609.00	2312.75	88.65%

Month: Apr 26	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	7184.50	4934.58	68.68%	6661.50	4346.33	65.25%	428.00	433.50	98,97%	330.00	165.00	50.00%

5.2 Red flags



NLAG (Apr 25 - Mar 26)	
Measure	
Delayed or cancelled time critical activity	16
Missed or delayed care	14
Missed medication during an admission to hospital	5
Delay in providing pain relief	1
Delay between presentation and triage	0
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	19
Delayed recognition of and action on abnormal vital signs	4
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Community staff called to work in the unit	19
Total	**79**



HUTH (Jul 25 - Apr 26)	
Measure	
Delayed or cancelled time critical activity	173
Missed or delayed care	3
Missed medication during an admission to hospital or MLU	0
Delay in providing pain relief	2
Delay between presentation and triage	0
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	343
Delayed recognition of and action on abnormal vital signs	1
Any occasion when 1 midwife is not able to provide continuous 1:1 care	1
Labour Ward Coordinator not supernumerary – Providing 1:1 Care	0
Coordinator unable to maintain supernumerary status- NOT 1:1 care	4
Total	**527**

5.3 Midwifery and Nursing Staffing Vacancy Rates (April 2026)

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH	Vacancy rate NLAG	Vacancy rate adjusted NLAG
Midwifery	2.5%	0.6%	6.6%	1.2%
Neonatal Nurses	5%	4.4%	13%	6.1%

**The above is taken from PowerBi and differs somewhat from local intelligence related to staff moves/leavers/joiners and reductions/increases in hours.*

- Interview for newly qualified midwives will take place on the 27th of May, currently there are a small number of vacancies (3.0 WTE) at DPOW and 13.0 WTE at HUTH.
- Interviews for various Senior Midwifery (Band 7) are due to take place in May and June.

6. LEARNING LESSONS

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

Hull University Teaching Hospitals (HUTH)

MNSI number	IMD/Ethnicity	Qualify for EN?	Have the family received notification of role of 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-048159	White British – IMDD 1	No	Yes	Yes	Yes	Yes	37+6 MOH 5500ml and hysterectomy. MDT including anaesthetic and theatre MDT planned 07/11/2025. Uplift to LRP. Final report received. Action plan being drafted – to follow governance pathway and PSIRF panel May.
MI-050092	BA – IMDD 1	No	Yes	Yes	Yes	Yes	39+2 Intrapartum SB. BA booked ELLSCS for previous. Attended ? labour and baby believed to be alive. Delivered via CS. Nuchal cord and thick meconium seen. USS rejection pathway discussed. Regional exploration of USS pathways for triple anti-retroviral therapy in progress. Local non-adherence to GAP pathway. Review completed. Action plan being drafted – to follow governance pathway and PSIRF panel May
MI-048987	WB – IMDD 8	Yes	Yes	Yes	Yes	Yes	37+6 actively cooled. Pre-terminal CTG. MLC (Seizure in pregnancy). Not risk assessed in ANC. Equipment shortage of sonicaid (did not affect outcome). MRI – HIE 3 (first since December 2023). Draft report received, Re-wording of recommendation requested. Due back 08/05/2026.
MI-051713	BA – IMDD 1	No	Yes	Yes	Yes	Yes	38+4 actively cooled/NND. Severe HIE. Cord prolapse at home. Report completed. Action plan being drafted – to follow governance pathway and PSIRF panel May

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

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-049981	9 / White British	No	Yes	Yes	Yes	Yes	Awaiting draft report for factual accuracy.
MI-056976	9 / White British	Yes (CLM1972012)	Yes	Yes	Yes	Yes	G2 P0, augmentation at 39+2 weeks for PROM. Progressed to fully dilated with CTG concerns, trial of instrumental delivery in theatre, progressed to Cat 1 LSCS. Live male infant born, full resuscitation and intubation in theatre, taken to NICU and subsequently transferred to Leeds for therapeutic cooling. Mild HIE diagnosed however due to parents concerns raised accepted by MNSI. Currently at fact finding stage.
MI-058207	8 / White Irish	No	Yes (provided directly by MNSI)	Yes (provided directly by MNSI)	N/A	N/A	Did not meet MNSI reporting criteria. Self-referral for investigation, case accepted by MNSI May 2026. Currently at fact finding stage.

6.2 Detail of incidents graded moderate or above and rapid reviews (April 2026)

Hull University Teaching Hospitals

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
425029 - x2 PN readmission with PPH.	4/WB	Obstetric	Moderate (not for LRP)	Management in line with recommendations but required 2nd readmission and return to theatre. DoC complete (verbal and written).
425012 – Unbooked approx. 42+5 IPSB (MNSI criteria met)	1/WB	Obstetric	Moderate – LRP review x2.	MNSI identified organisational learning (A&E supporting this review) and discussed twice at LRP. Due to this uplifted to moderate. DoC verbal and written performed.
429214 – 33+ abruption (30/04/2026)	TBC	Obstetric	Moderate (awaiting review of care – planned w/c 04/05/2026)	TBD

Northern Lincolnshire and Goole NHS Foundation Trust

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
426330 - Trial of instrumental in theatre for pathological ctg abandoned after fetal bradycardia and proceeded to cat 1 section. Baby born in poor condition requiring extensive resuscitation. Unexpected admission to NICU. Baby transferred out for cooling.	9 / White British	Obstetric	Moderate (MNSI/EN criteria met)	Duty of candour completed. Rapid review undertaken and identified concerns about hyperstimulation and the effects on the fetus as well as appropriate escalation.
426446 - return to theatre for MOH following category 2 LSCS.	1 / White British	Obstetric	Moderate	Duty of candour completed. No learning identified.
428782 - Category 2 LSCS for abnormal CTG and significant PET. Difficult delivery of a transfer lie baby at 35+5, possible hypoxia for mum.	4 / White British	Obstetric	Moderate (downgraded to low)	Rapid review completed with minimal learning identified. Discussed at Perinatal Morbidity and Mortality Meeting and grading reduced. Learning identified of a lack of staff awareness of changes to the Hypoglycaemia guideline.

6.3 Maternity Risk Register

The tables below include the top three risks for maternity and neonatal services.

Hull University Teaching Hospitals NHS Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Maternal Diabetic and Maternal medicine ANC capacity and staffing	Moderate
Maternity	Obstetrics and Gynaecology Consultant staffing	Moderate
Maternity	Outpatient prescriptions	Moderate
Neonatal	High risk of the spread of pseudomonas within the neonatal unit due to it being detected in the sinks *Mitigation: plan to replace sinks*	High
Neonatal	There is a risk that the nursing establishment does not meet the BAPM framework	Moderate
Neonatal	Risk to patient safety due to guidelines not being updated on Bridget	Moderate

Northern Lincolnshire and Goole NHS Foundation Trust

Top three risks on risk register – Maternity / obstetrics & Neonates		
Specialty	**Risk**	**Level**
Maternity	Inappropriate accommodation (community midwives)	Moderate
Maternity	Lack of compliance with BSOTS standards	Moderate
Maternity	Antenatal clinic review capacity	Moderate
Neonatal	Electricity supply failure in NICU	Moderate
Neonatal	CPAP drivers	Moderate
Neonatal	NICU incubators	Moderate

7. SERVICE USER FEEDBACK

7.1 MNVP/Service User Feedback

Hull University Teaching Hospitals NHS Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production (May 26 update)	
Going well **Maternity** • Caring staff, going the extra mile. Especially in emergency situations - feeling safe and cared for. • C-Sections (planned and emergency), all staff involved . • Community midwifery appointments. • MLU. • Ask a Midwife service. • Midwife led ante natal education sessions and Carousel. • Golden hour & overall experiences on Rowan improving. • Breastfeeding support in hospital. • Perinatal mental health support from mental health teams and specialist midwife. **Neonatal** · High praise for staff. · Postnatal care for mum now down corridor, very well received · Whole family made to feel welcome · Fingerprint entry now in place!	**Not going so well** **Maternity** · Badger notes app – still slow, hard to use. Scan info not on which concerns women as they think other things are missing (and can miss scan appts as not on). · Feeling dismissed/not listened to (reducing vs previous months but still some feedback around this). · IOL - Women not understanding the reasons for IOL, feeling pressured into it. · Clinic appointments - women unsure why they are attending. · Parking – finding a space/walking a long way in late pregnancy, especially between IOL appts. Cost to park has increased. · Early loss, feeling 'passed around', unsure where to go for help before 16 wks. Long waits for gynae appointments and procedures. · Lack of positive comms. **Neonatal** · Lack of info on NICU in antenatal education. · Lack of birth debrief from senior doctor after a complex birth (especially GA).

Northern Lincolnshire and Goole NHS Foundation Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production (May 26 update)	
Going well – Maternity · Feeling included in conversations / making choices during pregnancy and time to ask questions. · Nest & Nurture fair helping with information and knowing options. · Staff are caring and supportive. · Positive 15 steps visit at SGH - report now available. **Going well – Neonatal** · MH midwifery support for those with history of pre-term birth. Partners able to access support if needed. · Staff are supportive and taking time to build confidence. · PTBC - Feel supported by the midwives/consultants and understand the reasons for being under their care.	**Not going so well – Maternity** · Not feeling listened to during labour, partners also not feeling heard when trying to advocate. · Induction not feeling like a choice - feeling pressured into it. · Long wait for Birth Reflections continues to be a theme. · Badger notes continue to receive negative feedback. · Long wait times in clinics continue to be a theme. · Communication around discharge - long process and 'just left not knowing what's happening'. · Student midwives reporting not feeling valued or included in the team (scared to speak up too). · Service users are commenting on how they can see that staff are 'so stretched' and 'stressed' (DPoW). **Not going so well – Neonatal** · Self-discharge from postnatal ward (SGH). · Lack of information on signs of PTL, NICU information, ward tours.

7.2 Complaints Received

The number of complaints received in maternity during April **2026** are detailed in the tables below along with any themes identified.

NLAG		HUTH	
No received:	1	No received:	3
The 1 complaint was related to concerns regarding: · 1 clinical treatment		The 3 complaints were related to concerns regarding: · 1 clinical treatment · 1 regarding misdiagnosis and clinical treatment · 1 in relation to visiting	

7.3 Friends and Family Test Feedback

Hull University Teaching Hospitals NHS Trust

In March 2026, 21 responses were received. Positive comments are provided alongside feedback regarding areas of improvement.

Score	Responses
1 (Very good)	18 (85.7%)
2 (Good)	-
3 (Okay)	-
4 (Poor)	1 (4.8%)
5 (Very poor)	2 (9.5%)

AMLU: “Midwives were amazing, keeping me calm and ensuring mine and my baby’s safety was paramount. They listened to myself and my partner and I could not thank Willow, Danielle and Louise enough.”

Rowan: “I was monitored and cared for the whole five days of my stay. They looked after my physical health and mental health when my baby was poorly in NICU. I felt heard and like I mattered. This hospital went above and beyond and I cannot thank them enough.”

Triage: “Maternity triage was really good. Cleanliness and friendly staff.”

Northern Lincolnshire and Goole NHS Foundation Trust

In March 2026, 35 responses were received for Maternity and 11 for Neonatal. Positive comments are provided alongside feedback regarding areas of improvement.

Maternity	
Score	**Responses**
1 (Very good)	31 (88.5%)
2 (Good)	2 (5.7%)
3 (Neither good nor poor)	0 (0%)
4 (Poor)	2 (5.7%)
5 (Very poor)	0 (0%)
6 (Don’t know)	0 (0%)

Neonatal	
Score	**Responses**
1 (Very good)	10 (90.9%)
2 (Good)	1 (9%)
3 (Neither good nor poor)	0 (0%)
4 (Poor)	0 (0%)
5 (Very poor)	0 (0%)
6 (Don’t know)	0 (0%)

8. LISTENING TO OUR STAFF

8.1 General Staff Feedback

- Issues raised at DPOW Maternity continue to be worked through with support from OD and HR. Paper has been shared with the Executive team and a plan is place.
- Student midwives reporting not feeling valued or included in the team at Scunthorpe- Listening Event Planned for 20th of May 2026.

8.2 Safety Champion Feedback

Walkaround took place on 29th April 2026 at Scunthorpe General Hospital. Issues identified:

- Current practice is for band 5's not to perform fresh eyes reviews, however staff requesting the possibility band 5's being included.
- Computer connector activity intermitted on ward 26.

Walkaround took place on 14th May 2026 at Hull University Teaching Hospitals. The walkaround was on the antenatal and postnatal ward.

- Issues regarding acuity and the IOL clinic being busy were raised.
- Staff reported feeling heard.

9. PERINATAL QUALITY OVERSIGHT 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	March 2026
Findings of reviews of all perinatal deaths using the real time data monitoring tool	PMRT reviews: 3. Occurred 18th March 2026. External reviewers present. 101427 37+1 NND (shared with DPoW/MNSI) – Neonatal care B (No antenatal/delivery care provided by HUTH). 101730 25+0 NND (Shared with ULTH) - Neonatal care A (No antenatal/delivery care provided by HUTH). 101631 35+4 NND – Graded B/B/A. Discussion regarding best practice for high risk MDT discussions for cervical suturing.
Number of cases referred to MNSI/ENS	0
Findings of review of all cases eligible for referral to MNSI	0
Number of incidents graded as moderate or above and what action is being taken	0
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	Issues regarding acuity and the IOL clinic being busy, however staff reported feeling heard.
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	Compliance declared for MIS Year 7. MIS Year 8 launched 31/03/2026.
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

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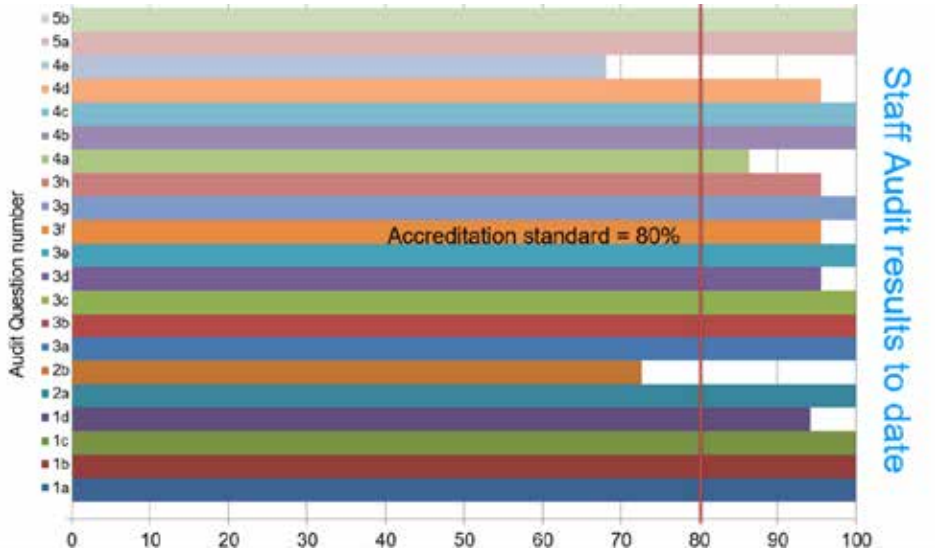
CQC Maternity Ratings	Safe	Effective	Caring	Responsive	Well Led	Overall
DPOW	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Goole	Requires Improvement	Good	Good	Good	Good	Good
SGH	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity Support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

Data measure	March 2026
Findings of review of all perinatal deaths using the real time data monitoring tool	3 cases were discussed at PMRT meetings during March 2026. CNST requirements met. Outcome detailed within section 3.2 of the report. The gradings of care are provided below: 100922: B / B 100630: B / A 101427: B / B / B
Number of cases referred to MNSI/ENS	0 referrals
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	144 maternity/obstetrics incidents (0 moderate) / 31 neonatal (1 moderate - duty of candour complete, Infant Feeding Lead to review feeding advice given and care provide by midwives. Rapid review undertaken, also discussed at Learning Response Panel 02/04/26 – AAR declared.)
Training compliance for all staff groups in maternity related to the core competency framework	Please refer to body of report
Service User Voice – themes	Please refer to body of report
Staff feedback from frontline champions and walk-abouts - themes	Concerns regarding computer connectivity on Ward 26 at SGH. Request for Band 5s to be able to undertake fresh eyes reviews on Central Delivery Suite, SGH.
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

10. BFI update

Hull University Teaching Hospitals NHS Trust

Following a meeting with the BFI team, HUTH planned to submit audit results and from those, plan a stage 2 or 3 assessment accordingly for late spring, however this has been delayed due to time to complete enough staff audits. They are time consuming, and availability of both the infant feeding team and maternity staff is a challenge. However, 22 have now been completed, with a requirement of 20-30. Whilst staff were randomly selected, Labour ward staff will be audited to ensure a true reflection of all areas as this area has been difficult to access. Compliance for the staff audits are 80% answered correctly, and to date 19 of 21 questions are meeting this standard. The question around the 'Code' is at 68%, and having noted this information has been shared around this question with staff via email and the HUTH staff Facebook group.



Further requirements:

- The minimum requirements for the mother audits are 20-30 minimum 6 monthly. The last set were completed July 2025, so will be prioritised following staff audits.
- Supplementation audits are challenging as BadgerNet data has many inaccuracies/missing data in relation to feeding. This has been explored with the data team and a review is required to see if this has improved.
- The completed audits will be submitted as soon as possible, with a further discussion with BFI regarding booking an assessment.

- To date, HUTH do not have a functioning BFI board group. This is an urgent action now management posts are filled, and the infant feeding lead and support hours have increased. The first meeting will be used as a fresh BFI launch and coincide it with the BFI Managers training for the new clinical leads.
  As per BFI, a BFI board and strategy group require regular structured, recorded meetings. This includes a **quarterly** board meeting; guardian, HOM, maternity managers, infant feeding lead and team, outside agencies (IF leads from 0-19 services and children's centres for Hull & ER and Goodwin development). Strategy/task and finish group meetings will also be required **monthly**, including IF lead and team, champions and anyone relevant to the current task/agenda. It may include anyone involved in the board meetings, other specialties or outside agencies.

Northern Lincolnshire and Goole NHS Foundation Trust

Following the achievement of the Gold Award work has been progressing in anticipation of the follow up reassessment. However, work has been slow to progress in some of the areas due to staffing with unforeseen circumstances with long term staff sickness and the x 2 Infant Feeding Leads (IFL) at DPOW covering some of the workload particularly the provision of the Frenulotomy Service for the Scunthorpe women and their babies and this has had a additional impact on the amount of work that could be undertaken for the Gold Award overall.

Due to the amount of workload that the DPOW IFL's provide to the Frenulotomy services the BFI audits of both staff and women have been slightly behind schedule in comparison to the normal audit plan. However, audits do demonstrate a good knowledge and skills by the staff with some areas of improvement to be made in relation to responsive feeding particularly with bottle feeding women and use of first milk and the WHO code

The plan is to submit Audits from NLAG as a collective rather than separate due to the issues with Staffing and once the IFL is in post at SGH and confident then we will re commerce the schedule.

Training has still been provided by the IFL's despite the additional workload with the 1- and 2-day BFI training as well as updates on the Professional Skills days and the Doctors Induction days. And providing the Infant Feeding workshop once a month at a weekend (DPOW only) as well as attendance at the Nest and Nurture sessions Bimonthly at SGH and DPOW.

Guidelines have been updated into the new format and additional guidelines developed in relation to Syringe feeding to support the addition of new staff on the Peer Support teams.

There has been a recent appointment to a temporary IFL post to cover the long-term sickness at SGH so hopefully more progression can be made with the audits and the temporary IFL has completed her Frenulotomy training and therefore will hopefully be able to start to undertake a Frenulotomy Clinic at SGH once she is confident with the support of the IFL's at DPOW

Frenulotomy clinics continue to be provided x twice a week at DPOW, with all the slots available been filled on a weekly basis as the number of Tongue tie babies are identified. Also, an additional room has been secured in Child Development Centre DPOW so there is a dedicated space to provide the clinics in from July 2026 which will make a big difference to have a dedicated space for the service to run from.

There is a now an additional Midwife who has completed her Frenulotomy course and will possibly be able to provide some additional clinics cover at SGH and a further 3 more midwives are to complete their training imminently too. (x 2 DPOW, X1 SGH). With a full team once the midwives have completed their Frenulotomy training and the temporary IFL is confident in her role our goal is to progress to maintaining sustainability, to ensure our service supports families so that all babies get the best start in life.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)136

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 11 June 2026**
Director Lead	**Jo Ledger, Interim Group Chief Nurse**
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	**Maternity Incentive Scheme Papers** · **Bi- Annual Maternity and Neonatal Staffing Report** · **HUTH Maternity Services Quarter 4 Thematic Review & HUTH Quarter 4 Claims Scorecard** · **HUTH PMRT Report** · **NLAG Maternity Services Quarter 4 Thematic Review & NLAG Quarter 4 Claims Scorecard** · **NLAG PMRT Report** · **Saving Babies Lives Quarterly Report**
Executive Summary	**Bi- Annual Maternity and Neonatal Staffing Report** This report provides an overview of maternity and neonatal workforce capacity across Humber Health Partnership (HUTH and NLaG), in line with NHS England, NQB, and CNST MIS Year 8 requirements. Services continue to face workforce pressures due to high demand and acuity. While progress has been made, staffing gaps remain across specialities. Key risks are being managed through recruitment, retention, skill mix review, and strengthened escalation processes to maintain safety. The report outlines current performance, risks, and actions, with separate sections for HUTH and NLaG, followed by joint recommendations to support safe and sustainable staffing. **HUTH Maternity Services Quarter 4 Thematic Review & HUTH Quarter 4 Claims Scorecard** The thematic review detailed within the report is based on 18 safety incidents that occurred during quarter 4, consisting of 1 new MNSI, 12 new PMRT, 3 ongoing MNSI and 3 ongoing AAR. There were no eligible cases for a MOSS review. NHSR claims scorecards are published annually, for the purposes of this report any themes, learning and recommendations from the most recent publication (October 2025) have been included for triangulation. Themes identified include a surge of neonatal deaths and non-compliance with hypertensive management and use of PLGF. Learning: 1 term HIE 3/NND (Cord prolapse at home) well managed over the phone Make every contact count ICP guidance requiring update to be line with RCOG Anti-D pathway (including IV ANTI-D) · Q4 ATAIN 5.17% (2025/2026 rate 5.02%) · Neonatal death surge (escalated by neonates) · Neonatal unit cot availability downgraded to moderate on the risk register

- MBRRACE 2024 figures released
    - 3.29 per 1000 (Stillbirth)
    - 1.18 per 1000 (Neonatal Death)

HUTH PMRT Report
There have been 10 incidents reviewed through the PMRT process in quarter 4; 5 of these were conducted with partner organisations where care was provided prior to an in utero/ ex-utero transfer of care. 2 of these were conducted with the attendance of MNSI.

There have been reports published for 8 of these. 1 is due to the external partner organisation wanting to await the completed MNSI report prior to their grading of care.

Fully compliant with MIS Year 7 standards.

- Learning and key themes: Improved PLGF use, QIP registered on AMaT.
- 1 term HIE 3/NND (Cord prolapse at home) well managed over the phone.
- Perinatal optimisation – IV antibiotics not given in 1 case.

Scorecard Q4 Themes

- Q4 ATAIN 5.17% (2025/2026 rate 5.02%)
- Neonatal death cluster (escalated by neonates)
- Neonatal unit cot availability downgraded to moderate on the risk register
- MBRRACE 2024 figures released
    - 3.29 per 1000 (Stillbirth)
    - 1.18 per 1000 (Neonatal Death)

NLAG Maternity Services Quarter 4 Thematic Review & HUTH Quarter 4 Claims Scorecard
It has been identified through the thematic review of the four eligible cases from Q4 that the main themes are:

- Policies not being followed.
- Training issues – in particular neonatal resuscitation and the failure to follow the Resuscitation Council algorithm and a lack of compliance with Advanced Neonatal Resuscitation (NLS) training competence.

Areas for improvement:

- Changes to be made to actions about not following local guidance. To review how these learning lessons are produced and disseminated.
- Attendance of all Labour Coordinators to the NLS Resuscitation Council Training to gain competence of Advanced Neonatal Resuscitation training and all shifts to have an NLS competent midwife.
- Close monitoring of the NLS compliance for all Labour Coordinators and ensure that there is always a NLS competent midwife on shift.
- Local yearly neonatal resuscitation update training reviewed to ensure the neonatal resuscitation algorithm is included within it.

Scorecard Q4 Themes

- Increase in postnatal readmissions following delivery
- MNVP feedback and complaints indicate women feel they are not being listened to.
- Bereavement documentation checklists not completed appropriately.

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Delayed cord clamping not always undertaken.
NLAG PMRT Report
There have been 3 incidents reviewed through the PMRT process, 2 where the death occurred at NLAG (2 antepartum stillbirths) and 1 where the death occurred in another Trust but the care/PMRT review was joint with NLAG (x1 NND). This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby.

Key themes and or learning identified from Q4 cases PMRT or continued from previous quarterly reviews are as follows:

Documentation of bereavement care requires improvement as it is not always possible to tell from the notes whether the bereavement pathway was followed or the required information was offered/provided.
Escalation required to pathology to ensure Kleihauer bloods are tested as per policy.
Incorrect risk allocation at booking resulted in inappropriate care and serial scans not being undertaken.
Refresher email for staff to follow DNA policy to ensure women are re-appointed
During resuscitation baby’s temperature was not maintained within normal range.

Saving Babies Lives Quarterly Report

<table>
<tr><th>% of interventions fully Implemented</th><th>Self-assessment</th><th>Self-assessment</th></tr>
<tr><td>Site</td><td>HUTH</td><td>NLAG</td></tr>
<tr><td>Element 1: Smoking in pregnancy</td><td>70%</td><td>90%</td></tr>
<tr><td>Element 2: Fetal growth restriction</td><td>95%</td><td>95%</td></tr>
<tr><td>Element 3: Reduced fetal movements</td><td>50%</td><td>50%</td></tr>
<tr><td>Element 4: Fetal monitoring in labour</td><td>100%</td><td>100%</td></tr>
<tr><td>Element 5: Preterm birth</td><td>88%</td><td>85%</td></tr>
<tr><td>Element 6: Diabetes</td><td>100%</td><td>83%</td></tr>
<tr><td>TOTAL</td><td>88%</td><td>88%</td></tr>
</table>
</td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td>N/A</td></tr>
<tr><td>Prior Approval Process</td><td></td></tr>
<tr><td>Financial Implication(s) (if applicable)</td><td></td></tr>
<tr><td>Implications for equality, diversity and inclusion, including health inequalities (if applicable)</td><td></td></tr>
<tr><td>Recommended action(s) required</td><td>☐ Approval
ü Assurance
☐ Information
☐ Other – please detail below:</td></tr>
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HUTH & NLaG Bi-Annual Maternity and Neonatal Staffing Report

1. Background

This bi-annual report provides an overview of maternity and neonatal workforce capacity, risks, and improvement actions across Humber Health Partnership (HHP), covering Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole (NLaG). The report fulfils the NHS England Three-Year Delivery Plan requirements, the National Quality Board (NQB) standards for safe staffing, and contributes to assurance for CNST Maternity Incentive Scheme (MIS) Year 8 Safety Actions.

The paper summarises:

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

2. Strategic Context

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

Key strategic influences include:

- Ockenden recommendations
- BAPM Neonatal Nurse Standards (2023)
- CNST MIS Year 8 requirements
- Regional and national workforce shortages
- The National Maternity Review

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

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

1. Introduction

It is a requirement of the Maternity (and Perinatal) Incentive Scheme (MIS) that a midwifery staffing oversight report, covering staffing and safety issues, is submitted to the Trust Board every six months during Year 8.

Following the Care Quality Commission (CQC) inspection in March 2023, maternity services at HUTH were rated *Inadequate* and Section 31 conditions were imposed. The inspection identified significant concerns regarding leadership, staff morale, staffing levels, and governance—issues that present a direct risk to the safety and wellbeing of mothers and babies and require immediate, sustained improvement. Since the last staffing report HUTH has exited the Maternity Safety Support Programme and the conditions of the Section 31 have been removed. A full CQC inspection is anticipated soon.

In November 2025, business cases to support midwifery staffing reflecting the update Birthrate Plus evaluation, meet BAPM standards in nursing and neonatal medical workforce and to significantly increase obstetric workforce and facilitate separate obstetrics and gynaecology on-call rota were agreed.

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

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

Neonatal

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

Neonatal workforce planning is informed by NHS England priorities, BAPM standards, and CNST MIS Year 8 requirements, and is subject to review at local, regional, and operational delivery network (ODN) levels. The NHS Long Term Plan highlights workforce as fundamental to improving neonatal outcomes. However, staffing growth has not kept pace with increasing acuity and complexity, creating the need for both establishment expansion and enhanced specialist training.

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

- nurse-to-baby ratios of 1:1 (Intensive Care), 1:2 (High Dependency), and 1:4 (Special Care/Transitional Care)
- 85% of the nursing workforce trained in Qualification in Speciality (QIS)
- a supernumerary coordinator on every shift
- a 25% uplift to account for leave, training, and non-clinical requirements

The Neonatal Medical Staffing standards are described in the BAPM frameworks for NICU (2021) and LNU (2025).

The following standards apply to HUTH:

- The minimum staffing of any should include a tier one clinician - ANNP or junior doctor ST1-3 and at tier 2 generally an experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP
- As units increase in size more staff would be required at all levels:
- Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone
- NICUs with more than 2500* intensive care days$ per annum should double tier 2 cover at night by adding a second experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative (HUTH could theoretically achieve this with the 7 ITU cots)
- Compliance- Currently HUTH Neonatal Consultants provide clinics for new and follow up clinics for under 1 year olds in the community therefore not fully compliant. However, this is likely to change by the end of this financial year with plans to re-allocate this activity to General Paediatrics
- There is concern over acuity and workload- the intensive care delivery has increased significantly over the last 2 years and if the trend is sustained a review of the medical workforce will be required. The workforce planning with expansion in 2022-23 was based on estimated 2000 HRG1/ Intensive care days; HUTH is currently achieving 2300.
- Neonatal Implementation Board and BAPM Quality Standards (especially for mortality review) have recommended specialist roles with prescribed session allocation which will be challenging to achieve within the current WTE and will need to be reviewed with the acuity to estimate the medical workforce gap.

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

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

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

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

Current leadership and specialist roles	WTE	Band	Notes
Director of Midwifery	0.5		Pan-Group
Head of Midwifery	1	8C	
Consultant Midwife	3	8B	
Maternity Matron x 4	4	8A	
Quality & Safety Matron	1	8A	
Governance Midwife	1.8	7	
Bereavement Midwife	0.8	7	
Bereavement support midwife	0.8	6	
Digital Lead Midwife	1	7	
Fetal Monitoring lead Midwife	1	7	
Infant Feeding Midwife	1.9	7	
Public Health & Saving Babies Lives Lead Midwife	1	7	
Lead Midwife for Diabetes	0.85	7	
Diabetes Specialist Midwife	1.03	6	
Screening Midwife	1	7	
Screening Midwife	1	6	
Perinatal Mental Health Midwife	1.5	7	
Practice Educator Midwives	2	7	
Recruitment, Retention and PMA Lead	1	7	
Safeguarding Lead Midwife	1	7	
Maternity Audit & Compliance Manager	1	7	
Midwifery Practice Leads for Ward Areas	8	7	
Pre-term Birth and Multiple Birth Lead Midwife	1	7	
Maternal Medicine Lead Midwife	0.8	7	
Patient Engagement Lead Midwife	0.8	7	Pan-Group
Birth Reflections	0.4	7	

As per MIS Year 8 requirements funding is in place to achieve Birthrate Plus recommendations and recruitment is ongoing to new posts- this process will be complete by March 2027.

3. Neonatal Workforce and BAPM Standards

Qualified in Speciality

In view of the very specialist requirements of neonatal nursing, BAPM standards recommend that 70% of Neonatal Nurses have completed additional specialist training. As Hull Royal Infirmary is a Level 3 Neonatal Unit with high levels of activity and acuity, it is recommended that 85% of Neonatal Nurses are qualified in speciality. Completing this training is now an expectation at the point of recruitment whereas previously this was opt-out. Staff also now have to complete 150 hours supernumerary across the QIS programme in order to achieve speciality status. When the new Band 5 intake commence their posts, this will dilute this compliance. However, all three intakes throughout the year are maximal intakes.

Trajectories	
Current	54%
December 2026	70%
December 2027	85%

Leadership and Specialist Nurse Roles

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

Current leadership and specialist roles	WTE	Band	Notes
Nurse Director	0.5		
Deputy Nurse Director	0.5	8B	Pan-Group
Matron	1	8A	
Neonatal Governance Nurse	0.91	7	
Neonatal Unit Ward Manager	1	7	
Lead Neonatal Nurse Educator	1	7	
Clinical Neonatal Nurse Educator	1.9	6	
Lead Neonatal Bereavement Nurse	0.8	7	
Infant Feeding Lead	0.64	6	Role banding needs to be reviewed
Safeguarding and Discharge Lead Nurse	0.96	6	
Transitional Care and Outreach Lead	0.8	7	
Special Care Junior Sister	0.5	6	

An identified gap is for a Family Care Lead Nurse at a Band 7 1.0 WTE and a Surgical Specialist Nurse at Band 7 0.6 WTE.

The Neonatal Nursing Business Case to achieve compliance with BAPM nursing standards and meet the requirements of the Maternity Incentive Scheme (MIS) Safety Action A was approved by the Trust Board in November 2025. The business case sets out a phased programme of investment to close the identified

gaps in establishment, skill mix, and QIS-trained workforce. Quarterly meetings with the Neonatal Workforce Lead for the ODN are held to review staffing levels, numbers, and compliance with BAPM. See Appendix 2 for action plan.

4. Safe Staffing Oversight, Monitoring and Escalation

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

4.1 Establishment Reviews and Six-Monthly Reporting

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

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

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

4.2 Daily Operational Oversight

Daily real-time staffing oversight includes:

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

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

4.3 Escalation Framework and On-Call Arrangements

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

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

There is a Neonatal Cot Crisis huddles Monday-Friday between Level 3 Units, Embrace and ODN representative. This allows the Trust to discuss any escalation required.

4.4 Birthrate Plus® Live Acuity Tool

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

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

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

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

Use of the Acuity Tool to Support Safe Staffing

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

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

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

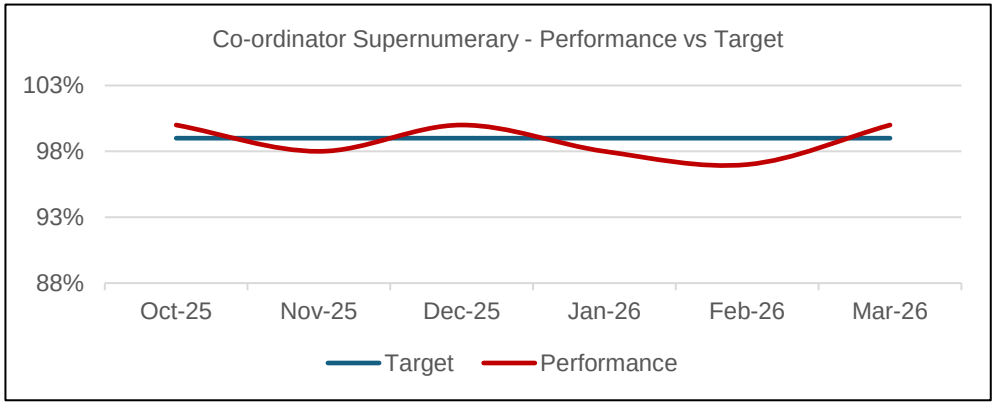
- Redeployment of midwives in specialist roles to work clinically
- Prioritisation of elective workload to maximise available staffing
- Band 7 and above managers providing clinical support
- Redistribution of staff to maintain 1:1 care in labour and protect the supernumerary Labour Ward Coordinator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

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

4.4.1 Supernumerary Labour Ward Co-ordinator

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

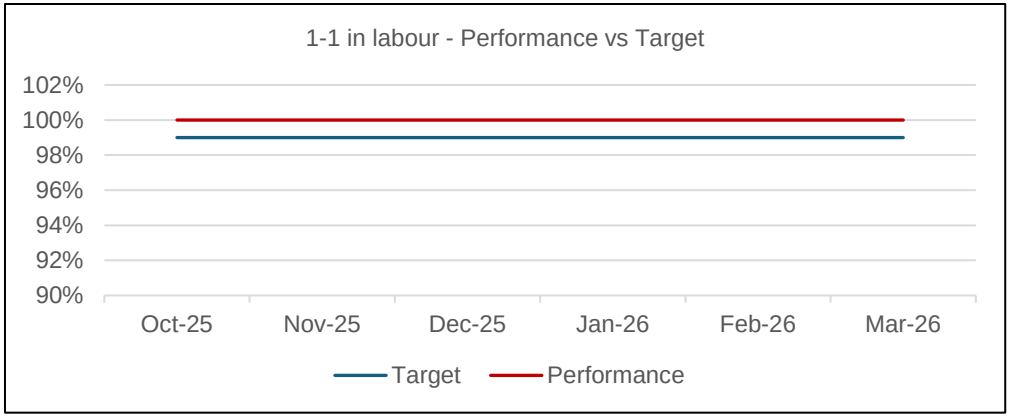
The following chart outlines the compliance by month:



All red flags reported regarding supernumerary status stated that the coordinator was not providing 1:1 care. There was one occurrence in November January and two in February. These were not at handover and were for short times when acuity was high. The escalation policy was followed and there is documentation through the Birthrate Plus acuity tool and Ulysses regarding actions taken, redeploying staff where and when required.

4.4.2 One to One in Established Labour

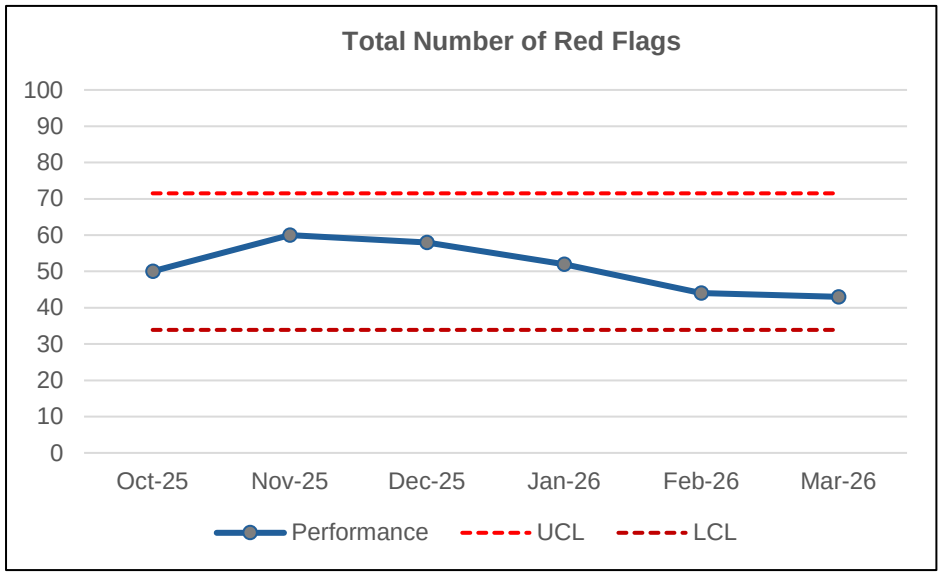
Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative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



4.4.3 Maternity Red Flag Incidents

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

The following tables demonstrate red flag events:



HUTH (Oct 25 - Mar 26)	
Measure	**Total**
Delayed or cancelled time critical activity	88
Missed or delayed care	2
Missed medication during an admission to hospital or MLU	0
Delay in providing pain relief	2
Delay between presentation and triage	0
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	210
Delayed recognition of and action on abnormal vital signs	0
Occasions when 1 midwife is not able to provide continuous 1:1 care	1
Labour Ward Coordinator not supernumerary – Providing 1:1 Care	0
Coordinator unable to maintain supernumerary status- NOT 1:1 care	4
Total	**307**

4.4.4 Neonatal Red flag Incidents

Neonatal red flags remain under development and will include supernumerary status of the NICU co-ordinator and compliance with BAPM nursing ratios. The ability to run full capacity has been compromised due to Nurse staffing constraints frequently in the last 6 months.

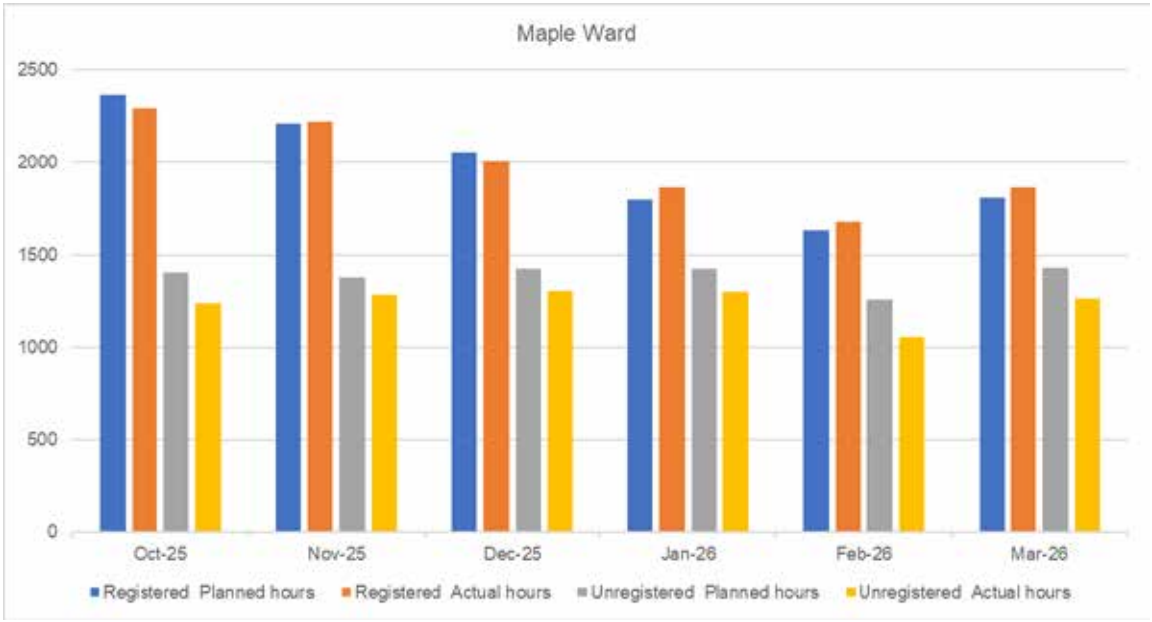
There have been more than one instance where additional neonatal medical cover has been requested to cope with acuity on the unit prompting a reflection on current medical staffing models. A diary exercise from consultants on 2 different time periods has demonstrated a significant increase in overnight call in.

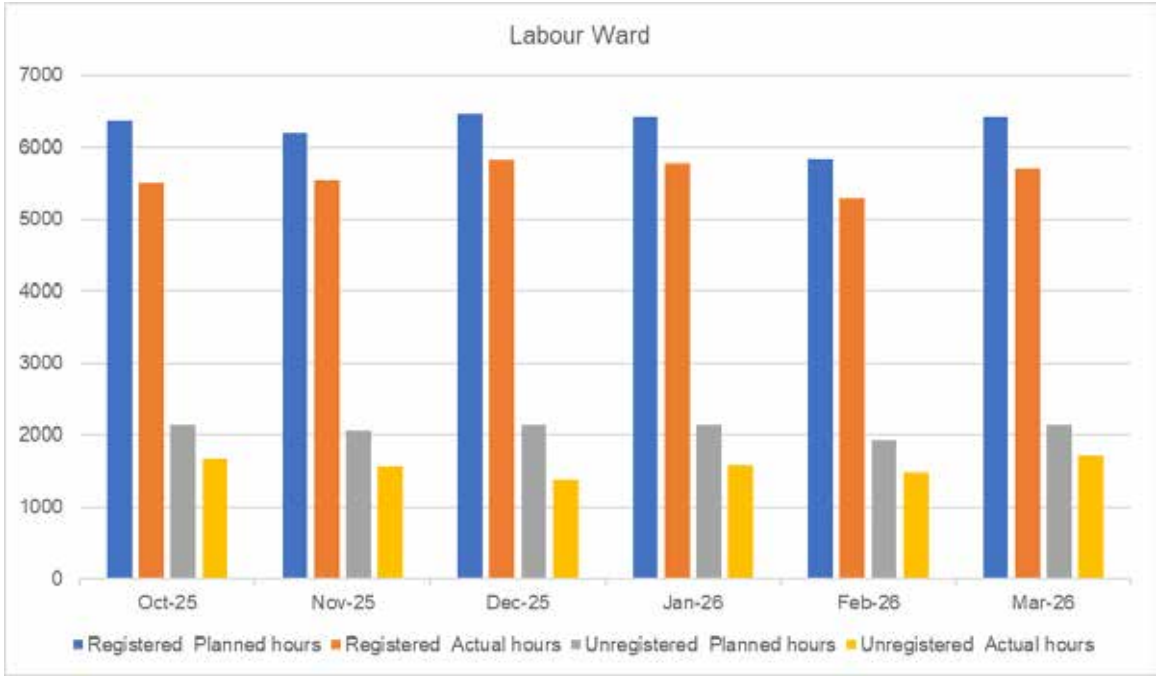
4.4.5 Monitoring of Actual vs Planned Staffing

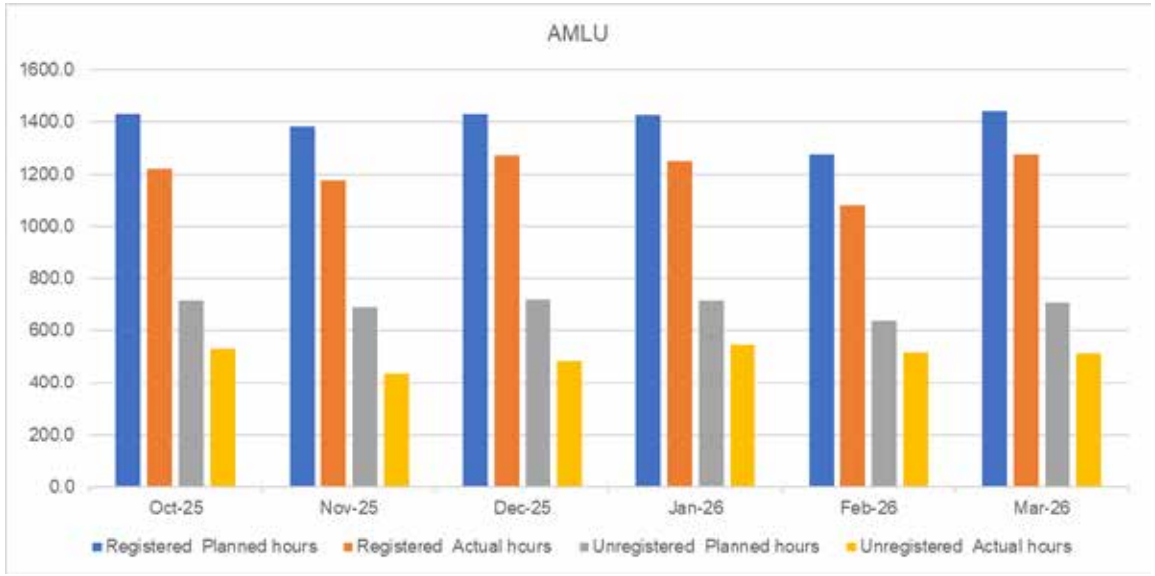
Matrons monitor actual versus planned staffing across all maternity areas each shift. Actions taken may include:

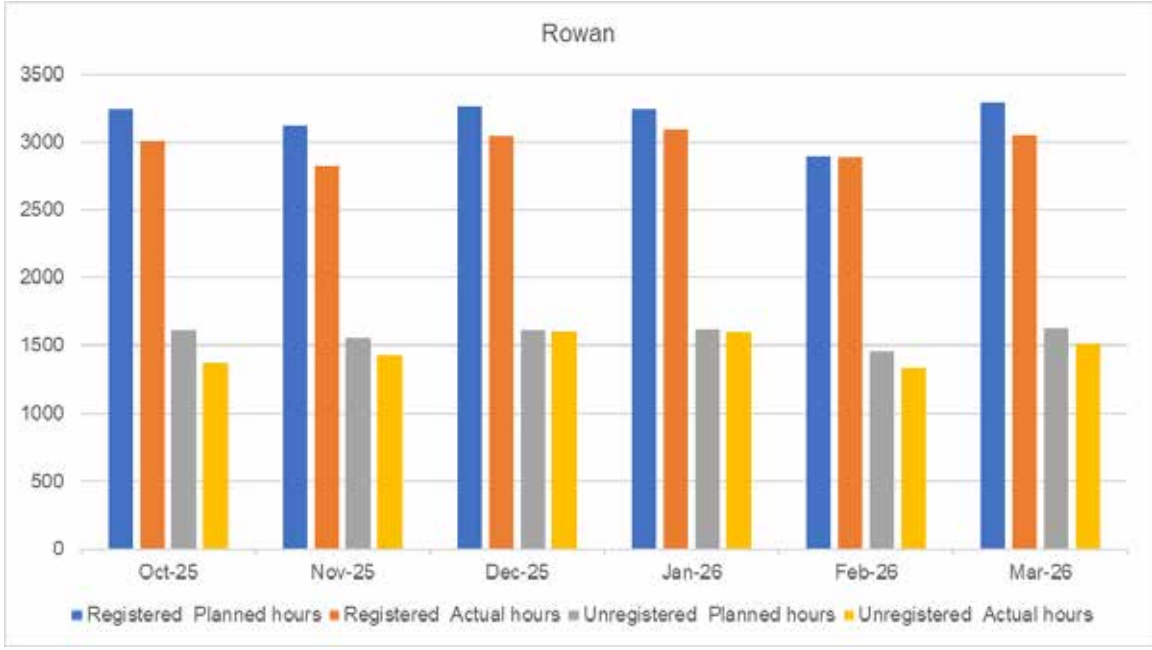
- Redeployment of staff between areas to maintain safe skill mix in both maternity and neonates
- Prioritisation of 1:1 intrapartum care
- Pausing of non-essential activity where required
- Senior management escalation
- Use of bank, offering overtime and double pay incentive where appropriate

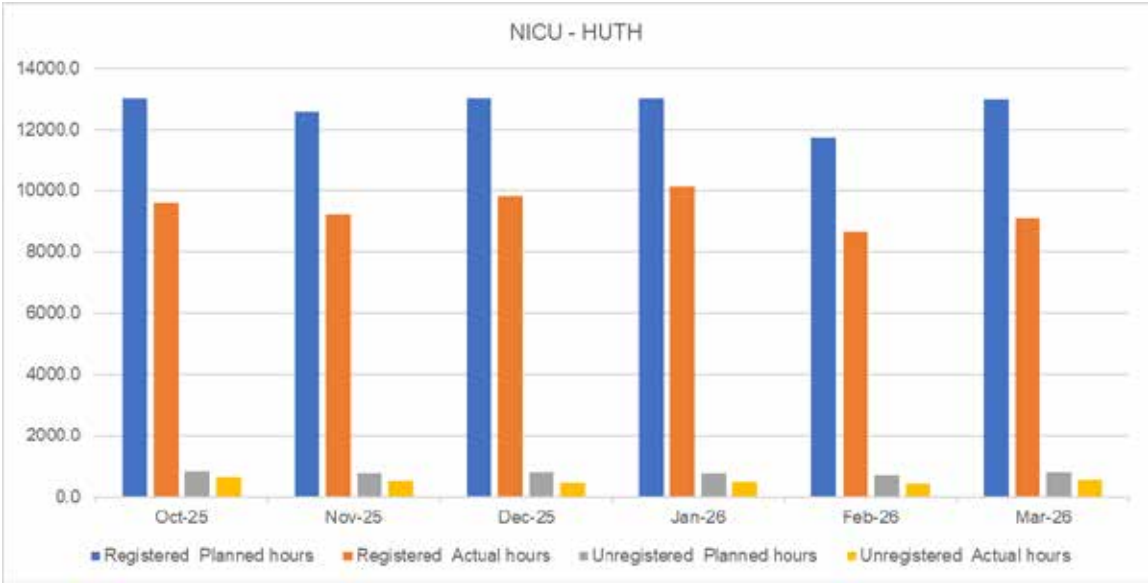
This continuous monitoring supports delivery of safe care and ensures a rapid response to fluctuations in activity or acuity.




Labour Ward
7000
6000
5000
4000
3000
2000
1000
0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


AMLU
1600.0
1400.0
1200.0
1000.0
800.0
600.0
400.0
200.0
0.0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Rowan
3500
3000
2500
2000
1500
1000
500
0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


NICU - HUTH
14000.0
12000.0
10000.0
8000.0
6000.0
4000.0
2000.0
0.0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours

4.4.6 Community Midwifery Caseloads

Community midwifery caseloads remain above the nationally recommended level. The current average caseload is 1:106, compared with the recommended 1:96 per whole-time equivalent (WTE) midwife. Reductions are expected as part of the midwifery workforce implementation plan. Increased rotation of midwives into community teams began in late 2025 and will continue throughout 2026. There is currently 4 WTE on maternity leave and 1.45 WTE on long-term sick. The table below shows the goal set out in the previous staffing paper and the progress made.

By end of December 25	1:130 Met
By end of February 26	1:110 Met
By end of April 26	1:96 Not Met
Current Caseload	**1:106**

5. Current Midwifery & Neonatal staffing Issues and Risks

5.1 Midwifery

Recruitment and retention progress

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH
Midwifery	2.7%	1.3%
Midwifery Support Workers	6.5%	5.7%

Attrition

Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed. HUTH has retained all Internationally Recruited Midwives who have joined the Trust since first in late 2023. Turnover is 3.0% against a target of 10%

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	3.0%	6.1	17.8	0.0	0.0%
Total	**3.0%**	**6.1**	**17.8**	**0.0**	**0.0%**

Maternity leave position

In May 2026, the maternity leave rate is 17.7wte (10.57%) midwifery staffing.

Sickness absence rates from October 2025 – March 2026:

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

Month	October	November	December	January	February	March
% of all midwives	4.2%	4.2%	4.4%	4.4%	4.8%	5.2%

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

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

Birth to Midwife Ratio from October 2025 – March 2026:

Month	October	November	December	January	February	March
Midwife to Birth	01:27	01:30	01:30	01:31	01:29	01:29

Actions taken to address attrition

- Core posts recruited into for labour ward, triage and community midwives to offer an increased sense of belonging to one area
- Recruitment, Retention and Pastoral Lead Midwife now has designated space to work and provide pastoral support in a safe, confidential environment. Staff made aware of “wobble room” seeing an increase in restorative support, guidance around difficult conversations, personal growth and career development
- Tea trolley rounds continue reliably and consistently
- Daily updates to closed Maternity Staff Communication Facebook page, relating to praise and reward, education opportunities and recruitment updates
- Listening forums held by Head of Midwifery with “You said, we did” feedback in a timely manner
- Maternity Incivility Reporting Tool remains in place however minimal use in the last eight weeks as staff are more likely to speak to managers, matrons, 9 F2SU champions and 20 Professional Midwifery Advocates

5.2 Neonatal

Attrition

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	8.2%	7.1	9.0	0.8	11.3%
Total	**8.2%**	**7.1**	**9.0**	**0.8**	**11.3%**

Retention has been impacted by factors outside of the control of the care group, however, measures such as Clinical Psychologist to support staff are in place**.** Previously the Neonatal Unit was allocated early career nurses centrally, going forward the Neonatal will be involved in the recruitment processing and focusing recruitment on Registered Sick Children's Nursing rather than Adult Nurses that may not have had any exposure to a Neonatal Unit. We have recently seen an increase in staff leaving due to securing places on the HV course and jobs outside the NHS.

Maternity Leave position

By Autum 2026 there will be 10.7 WTE on Maternity leave, this is a sharp increase from 6.4%. The trust continues to support the Neonatal workforce in allowing our recruitment process to continue on both a substantive & fixed term basis while the maternity leave paper is being written.

Sickness absence rates April 2025 to October 2025

Staff Group Summary

Staff Group	% Sickness	% ST	% LT	% Maternity	% Total Absence	% Turnover
Nursing and Midwifery Registered	7.1%	3.6%	3.5%	5.5%	12.6%	8.2%
Total	**7.1%**	**3.6%**	**3.5%**	**5.5%**	**12.6%**	**8.2%**

Sickness levels remain persistently above the intended target of 4.0%. The most common reasons for mental health and stress. Neonatal services have been significant operational pressure for the 12 months which as increased burnout, stress levels and sickness for staff. We are confident we will begin to see a decrease in the sickness levels over the coming months due to LTS staff being well enough to return to work with appropriate support in place.

Vacancy rate

Rota tools have recently been reviewed and deficit in budget identified this has now been rectified and recruitment is progress to close that gap. Current vacancy rate is 4.7 WTE and we will be going out to advert.

6. Maternity and Neonatal Activity, Acuity and Complexity

6.1 Maternity Activity and Complexity

Although birth rates have declined both nationally and locally, the **complexity of women using HUTH maternity services continues to rise**. This reflects broader public health trends and local population characteristics. Key factors influencing acuity include:

- Increasing numbers of women requiring safeguarding support
- Rising prevalence of high BMI
- Higher rates of diabetes in pregnancy
- Continued smoking in pregnancy
- Growing proportion of women with multiple long-term conditions
- Increasing numbers of complex obstetric and fetal medicine cases

The service at Hull Royal Infirmary provides care for more than **5,000 families per year**, supporting women with both straightforward and highly complex pregnancies. The presence of a midwife-led birth centre, alongside specialist obstetric, fetal and neonatal services, ensures a full spectrum of intrapartum and perinatal care.

This increasing complexity places higher demands on midwifery staffing, skill mix, and leadership oversight, reinforcing the need for adequately funded establishments and robust escalation systems.

6.2 Neonatal Acuity and Dependency

Neonatal activity and acuity have also grown significantly, driven by:

- Increasing maternal complexity
- Higher survival rates of extremely preterm infants (from 22 weeks gestation)
- Expanded cot capacity
- Consolidation of all Level 3 activity within Hull
- Socioeconomic factors associated with poorer neonatal outcomes

Hull Neonatal Unit is a Level 3 tertiary neonatal unit comprising 33 cots**:** 7 Intensive Care (IC), 10 High Dependency (HD), 12 Special Care (SC), and 4 Transitional Care (TC). It is the only Level 3 unit in the local area and serves a population characterised by significant deprivation and clinical complexity.

As part of the Humber Health Partnership, all Level 3 neonatal activity is now consolidated at Hull**;** previously, NLAG's Level 3 activity was aligned to Sheffield. To maintain Level 3 tertiary designation, neonatal networks require services to deliver a minimum of 2,000 Intensive Care days per year**.**

Since realignment, combined with expansion of cot capacity, Hull Neonatal Unit achieved over 2,000 Intensive Care days **in** the last financial year and is on track to reach approximately 2,300 Intensive Care days **in** the current financial year.

7.0 Obstetric Staffing

Consultant attendance

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts’ positions with the requirement should be shared with the Trust board and the board-level safety champions.

HUTH complete an annual audit regarding consultant attendance. Compliance was declared in MIS Year 7 following completion of the audit, with compliance at 98% (target >80%). A further audit will take place by the end of quarter 2 in the MIS Year 8 period.

Locum staffing

Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. HUTH have an SOP for engaging short term and long-term locums as per RCOG guidance which has been ratified and embedded in practice, with on boarding checklists, safety netting measures and induction checklists.

An audit is yet to be completed to allow timeframe to be within the MIS year 8 reporting period. Audit findings will be shared with Trust Board and included in the next bi-annual staffing report.

8.0 Anaesthetic Staffing

For safety action A of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1). In previous MIS years, compliance has been declared and representative month rota saved as evidence. HUTH continue to be compliant in this measure. If short notice sickness, rota coordinators always move other resident doctors or look for extra cover.

9.0 Neonatal Medical Staffing

To meet safety action A of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If any gaps are identified, Trust Board should evidence progress against an agreed action plan which demonstrates how the Trust intends to move towards full compliance.

As part of MIS year 7 gaps were identified and an action plan was approved by Trust Board. In addition, a business case was put forward to and agreed by Trust Board in November 2025 with significant financial investment to allow the service to be BAPM compliant. Appendix 1 is attached for further detail.

Northern Lincolnshire and Goole Bi-Annual Maternity & Neonatal Staffing Oversight Report

1. Introduction

It is a requirement of the Maternity (and Perinatal) Incentive Scheme (MIS) that each provider submits a midwifery staffing oversight report to the Trust Board every six months during Year 8. This section provides an overview of maternity and neonatal workforce and safety issues across Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), operating across Diana, Princess of Wales Hospital (DPOW) in Grimsby and Scunthorpe General Hospital (SGH).

Following national concerns surrounding maternity safety and workforce sustainability, NLaG has undertaken significant work to strengthen leadership, improve governance, and stabilise midwifery and neonatal staffing. While NLaG has not been subject to the same regulatory escalation as HUTH, both sites continue to experience considerable operational pressure, driven by staffing gaps, rising acuity, and persistent workforce challenges.

As NHS providers, NLaG must ensure that maternity and neonatal services are staffed with the right people, with the right skills, in the right place at the right time, in line with the National Quality Board (NQB) safe staffing principles and NICE (2017) guidance. Establishment reviews are undertaken six-monthly, underpinned by Birthrate Plus® modelling for maternity services and BAPM workforce standards for neonatal care.

Maternity services across NLaG provide care to a diverse and often high-need population. Despite stable birth numbers, the complexity of women accessing care continues to rise, linked to high levels of deprivation, increased safeguarding concerns, higher rates of smoking in pregnancy, rising BMI, and medical comorbidities. Community midwifery teams cover large rural and coastal geographies, adding further demands on caseload management and travel time.

Both DPOW and SGH operate alongside specialist fetal medicine pathways, obstetric services, and neonatal care provision. Each site is supported by daily monitoring of actual versus planned staffing, senior matron oversight, and morning LMNS-wide huddles to assess system pressures and enable cross-site mutual aid. A pan-group safety huddle occurs Monday to Friday to review staffing, acuity, and opportunities for mutual aid. Additional huddles occur as required throughout the day.

The development of a specialty-specific on-call rota remains a priority to ensure appropriate clinical leadership out of hours, as current arrangements rely on the site team. The OPEL escalation framework is consistently applied, and work to implement a pan-group escalation tool is progressing. Further work is underway to enhance escalation processes, strengthen clinical leadership out of hours, and improve resilience across both sites.

Neonatal

The Neonatal Units at Scunthorpe & Grimsby are designated as Local Neonatal Units (LNU, formerly called Level 2) and expected to look after babies over 27 weeks gestation. SGH were admitting to a modified criteria of >30 weeks and no invasive ventilation following a ODN & commissioning recommendation since April 2025. Following the delivery of a successful action plan and a recent review (May 2026) this is expected to revert to normal LNU criteria from September 2026. Both units operate within the Yorkshire and Humber Operational Delivery Network.

Neonatal workforce planning at NLaG is shaped by NHS England priorities, BAPM (2017) standards, and CNST MIS Year 8 requirements. As with other providers, staffing growth has not kept pace with rising acuity, dependency, and the increased survival of preterm and medically complex infants.

The BAPM standards set the minimum requirements for safe neonatal staffing, including:

- nurse-to-baby ratios of 1:1 (Intensive Care, where applicable), 1:2 (High Dependency), and 1:4 (Special Care)
- at least 70% of nurses trained in Qualification in Specialty (QIS)
- a supernumerary shift coordinator on every shift
- a 25% uplift to support annual leave, sickness, training, and non-clinical duties

NLaG, in line with many LNU providers nationally, does not currently meet full BAPM framework, particularly regarding QIS proportions and protection of shift leadership time (nursing), however, strong progress is being made through targeted recruitment, improved education capacity, and investment in neonatal nursing through the HHP-wide neonatal business case.

At present neither unit is compliant for the medical workforce standards. The Neonatal Medical workforce business case was approved last year with a planned direction of one fully compliant LNU in next 3 years with successful phased recruitment of 8 additional consultants (3 each in Years 1 & 2 and 2 in Year 3).

A BAPM Framework for Practice

LNU MEDICAL WORKFORCE RECOMMENDATIONS – TIERS 1, 2, & 3
MINIMUM STANDARDS

ACTIVITY CATEGORY	TIER*	DAY SHIFT^	EVENING SHIFT^	NIGHT SHIFT^
STANDARD	**1** Minimum 8 WTE on rota	At least **ONE DEDICATED** practitioner with **BASIC** airway capability		
	2 Minimum 8 WTE on rota	At least **ONE DEDICATED** practitioner with **STANDARD** airway capability	At least **ONE DEDICATED** practitioner with **INTERMEDIATE** airway capability unless **Tier 3** practitioner with **ADVANCED** capability is **IMMEDIATELY AVAILABLE**. In such situations, **Tier 2** practitioner could be of **STANDARD** airway capability	At least **ONE IMMEDIATELY AVAILABLE** practitioner with **INTERMEDIATE** airway capability
	3 Minimum 7 WTE on rota, 1: 7 on call including weekends	**Mon-Fri: 0830 – 1700** **Sat/Sun: 0830 – 1800** (onsite hours) At least **ONE DEDICATED** practitioner with **ADVANCED** airway capability operating on a **Consultant of the Week** model	Practitioner with **ADVANCED** airway capability on call from home available within 30 minutes	

***Tier 1:** ST1-3, GPST, FY1-2, Clinical Fellow, Trust Grade, ANNP, **Tier 2:** ST3-8, Clinical Fellow, Trust Grade, ANNP, Resident Consultant, **Tier 3:** Consultant or Equivalent
^Typical shift timings [local variations may apply]: **Day shift:**0830 – 1630 **Evening shift:** 1630 - 2100, **Night shift:** 2030 - 0900
Ensure 30-minute overlap for handover between shifts]

There have been no incidents of patient harm or PSIIs directly attributed to neonatal workforce gaps at NLaG, though the risk remains significant given the dependence on temporary staffing, the limited supply of QIS-trained nurses, and the increasing complexity of infants requiring care.

NLaG continues to work collaboratively with the Operational Delivery Network, HUTH colleagues, and the wider LMNS to strengthen neonatal workforce resilience, improve compliance with national standards, and ensure safe, high-quality care for babies and families across Northern Lincolnshire.

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

Birthrate Plus® (BR+) is the only nationally recognised and validated workforce planning tool for maternity services. It provides a robust framework for determining the midwifery establishment required to deliver safe, high-quality care and is based on an assessment of the total midwifery time needed to care for women, including the minimum requirement of 1:1 care in established labour. The BR+ methodology aligns with the NICE (2017) Safe Midwifery Staffing Guideline and is endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG).

NLaG maternity services completed a full BR+ assessment in 2024, with the final report received in July 2025. The assessment identified a required establishment of:

- 185.38 WTE clinical midwives, plus
- An uplift for specialist and management roles from 13.7 WTE to 22.92 WTE
- Resulting in a total BR+ requirement of 213.95 WTE

A business case to agree funding to Birthrate Plus requirements was agreed in November 2025 and recruitment is ongoing and scheduled to complete by March 2027 as required to comply with MIS Year 8 requirements.

This trajectory is essential to support preparations for the next BR+ data collection in Quarter 2 of 2027 and to ensure the updated BR+ report is received by June 2028, in line with NICE recommendations that BR+ reviews be undertaken every three years.

Role	WTE	Band	Notes
Director of Midwifery	0.5		Pan-Group
Head of Midwifery	1	8C	
Consultant Midwife	2	8B	
Maternity Matron x 3	3.0	8a	
Quality & Safety Matron	1	8a	Also cover Gynae, Neonates and Paediatrics
Consultant Midwife (Public Health)	1	8a	
Workforce, Education and QI Matron	1	8a	Pan-Group
Patient Safety Midwife	2	7	
Bereavement Midwife	1.5	7	
Digital Lead Midwife	1	7	
Fetal monitoring & Saving Babies Lives Lead Midwife	1	7	
Infant feeding Midwife	1.6	7	
Lead Midwife for Diabetes	1	7	
Diabetes Specialist Midwife	1	6	
Screening Midwife	1	7	
Deputy screening Midwife	1.0	6	

Perinatal Mental Health Midwife	1.5	7	
Practice educator Midwives	2	7	
Recruitment, Retention and Pastoral Lead	1	7	
PMA Lead Midwife	0.5	7	
Perinatal Pelvic Health Lead Midwife	1.0	7	
Ward Managers	7	7	
Pre-term & Multiple Birth Lead Midwife	1	7	Pan-Group not yet recruited
Maternal Medicine Lead Midwife	0.8	7	Pan-Group not yet recruited
Birth Reflections	0.4	7	

The Midwifery Business Case to achieve BR+ compliance and meet the Maternity Incentive Scheme (MIS) Safety Action 5 (year 7) was approved by the Trust Board in November 2025. The business case outlines a phased approach to closing the identified gap with the intention of achieving full BR+ compliance within an 18-month period. This timeline is essential to enable the Trust to undertake the next BR+ data collection in Quarter 2 of 2027 and receive the updated report by May 2028.

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

See Appendix 2 for action plan

3. Neonatal Workforce and BAPM Standards

Qualified in Speciality

In view of the very specialist requirements of neonatal nursing, BAPM standards recommend that 70% of Neonatal Nurses have completed additional specialist training. Completing this training is now an expectation at the point of recruitment whereas previously this was opt-out.

Trajectories DPOW	
Current	69%
March 2026	70.5%

Trajectories SGH	
Current	58%
June 2027	70%

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

Leadership and Specialist Nurse Roles

Current leadership and specialist roles	WTE	Band	Notes
Nurse Director	0.5		
Deputy Nurse Director	0.5	8B	Pan-Group role
Matron	2	8A	Joint neonates/paediatrics- site based
Neonatal Governance Nurse	0.58	7	Commences in post 15th December
Neonatal Unit Ward Manager	2	7	X1 per site
Lead Neonatal Nurse Educator	1.62	7	
Clinical Neonatal Nurse Educator	2.2	6	
Deputy Ward Manager	0.7	6	

Following approval of the Workforce Business Cases specialist roles will be reviewed. The recommendation is for one Nurse Educator per 50 staff which equate to 1.0 WTE per site, currently there is a gap of 0.42 WTE per site.

The Neonatal Nursing Business Case to achieve compliance with BAPM nursing standards and meet the requirements of the Maternity Incentive Scheme (MIS) Safety Action A was approved by the Trust Board in November 2025. The business case sets out a phased programme of investment to close the identified gaps in establishment, skill mix, and QIS-trained workforce. See Appendix 4 for action plan.

4. Safe Staffing Oversight, Monitoring and Escalation

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

4.1 Establishment Reviews and Six-Monthly Reporting

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

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

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

4.2 Daily Operational Oversight

Daily real-time staffing oversight includes:

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

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

4.3 Escalation Framework and On-Call Arrangements

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

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

4.4 Birthrate Plus® Live Acuity Tool

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

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

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

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

Use of the Acuity Tool to Support Safe Staffing

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

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

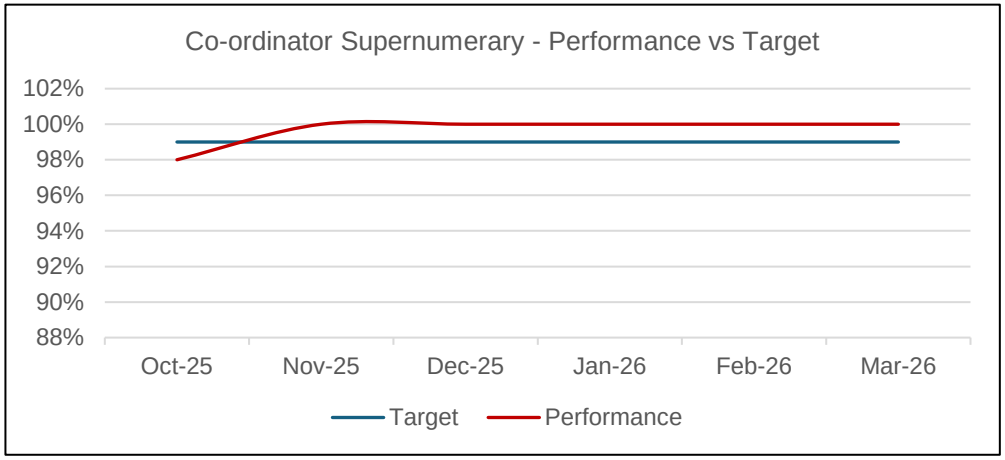
When staffing is below the required level or acuity increases, the following actions are taken in line with the escalation policy:

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

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

Supernumerary Labour Ward Co-ordinator

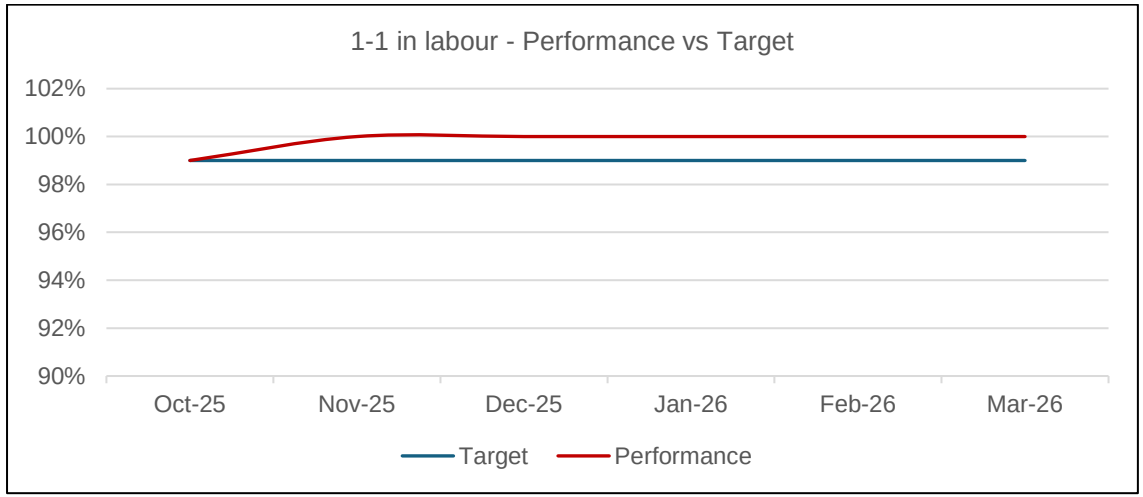
Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. The following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



There has been 1 recorded incident between October 2025 and March 2026 where the co-ordinator needed to take a midwifery led care labourer for just over two hours. The unit was in escalation, all options of staffing had been utilised and it was felt by the coordinator that this option was the most appropriate and least invasive for her to still keep oversight of the maternity areas. This was appropriately incident reported and has been investigated. This does not affect the supernumerary status according to MIS.

One to One in Established Labour

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



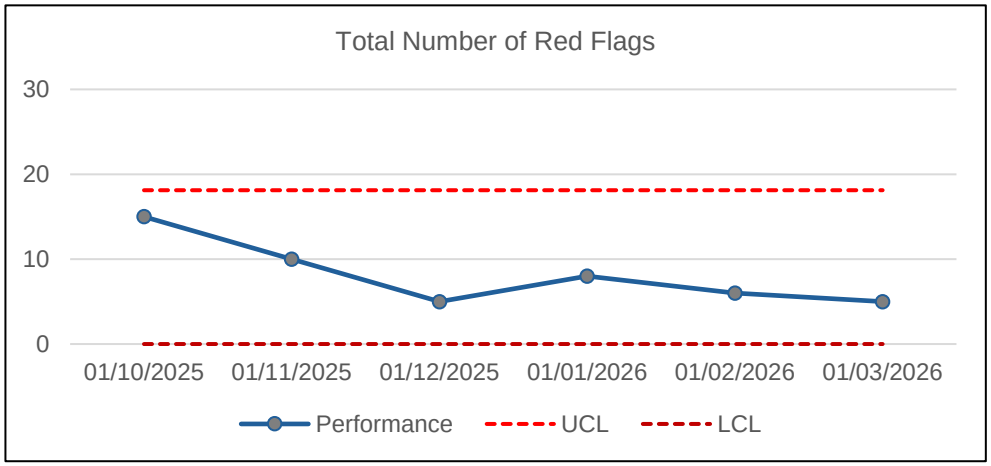
There has been 1 recorded incident where the lack of 1:1 care in labour was escalated by a midwife during a Safety Champion Walkabout. This related to an incident where there were two women post termination of pregnancy and the midwife was waiting to hand those over to the bereavement midwife.

There was an elective LSCS also that day (patient arrived early) and the matron asked the midwife to show her to the room and do the basics (i.e observations). The two TOPs required observations and breakfast prior to the bereavement midwife arriving. Having these 3 patients just for a short period of time is satisfactory as none were in labour. There is sufficient evidence that on this occasion, 1:1 care in labour was achieved.

Maternity Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following table provides a breakdown of the red flag events from 1st October 2025 to 31st March 2026:



NLAG (Oct 25 - Mar 26)	
Measure	**Total**
Delayed or cancelled time critical activity	5
Missed or delayed care	12
Missed medication during an admission to hospital	4
Delay in providing pain relief	1
Delay between presentation and triage	0
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	14
Delayed recognition of and action on abnormal vital signs	3
Any occasion when 1 midwife is not able to provide 1:1 care	0
Community staff called to work in the unit	10
Total	**49**

Neonatal Red flag Incidents

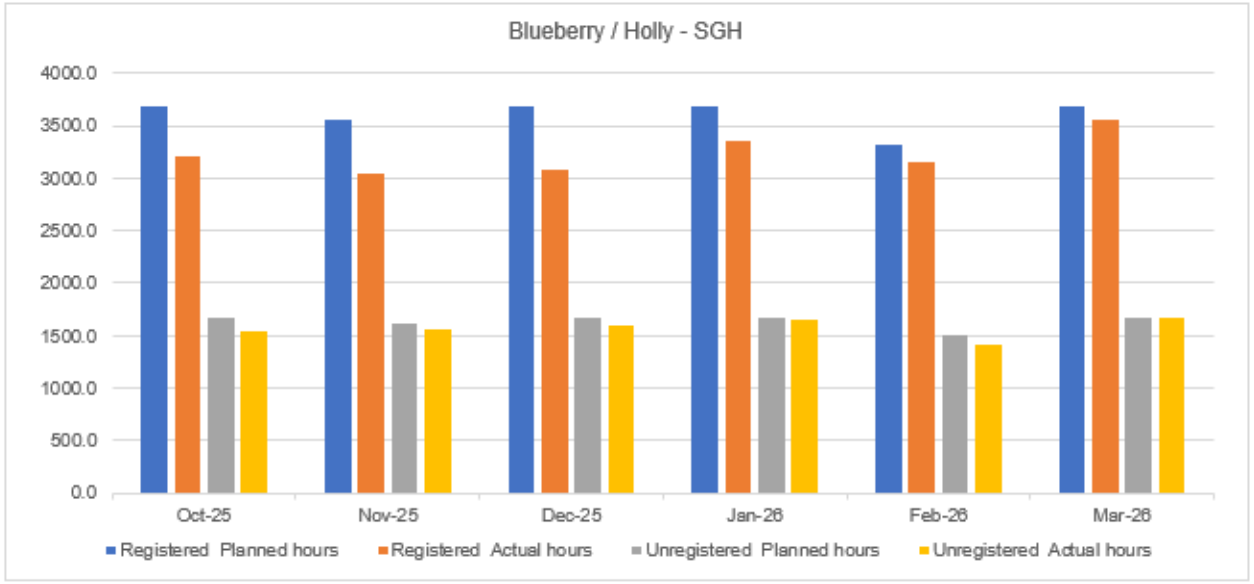
Neonatal red flags are currently being developed and will include supernumerary status of the NICU co-ordinator and compliance with BAPM nursing ratios.

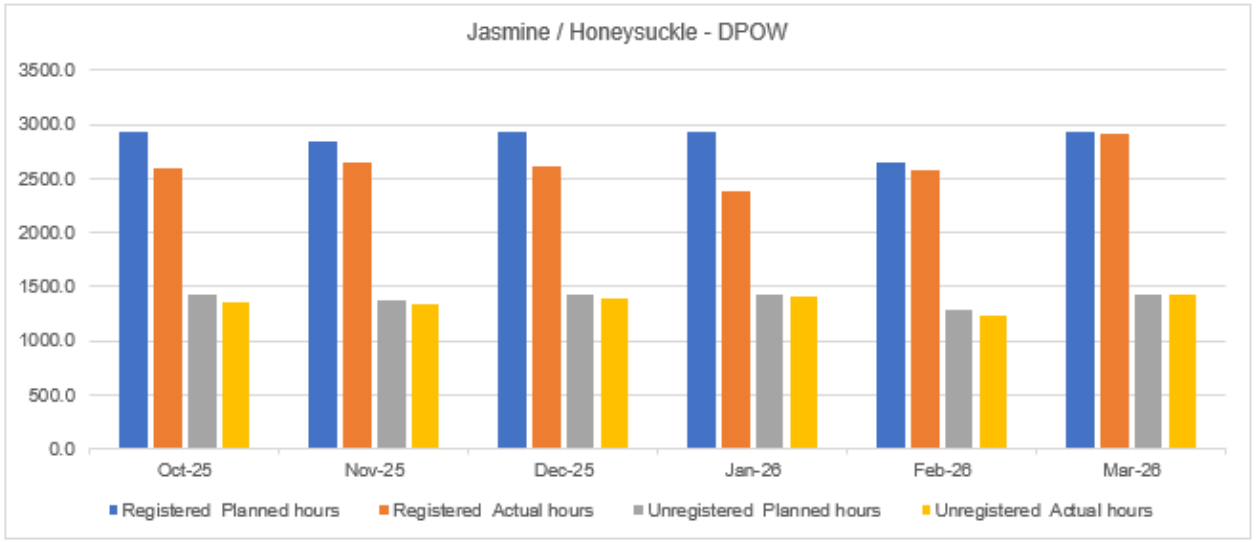
4.5 Monitoring of Actual vs Planned Staffing

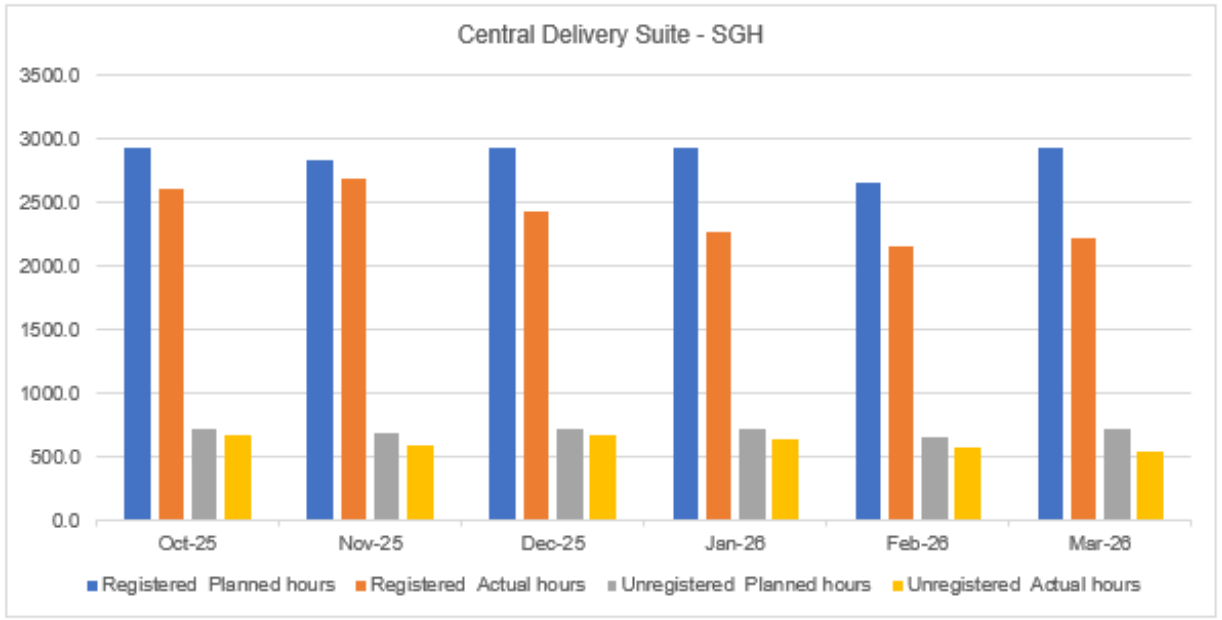
Matrons monitor actual versus planned staffing across all maternity areas each shift. Actions taken may include:

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

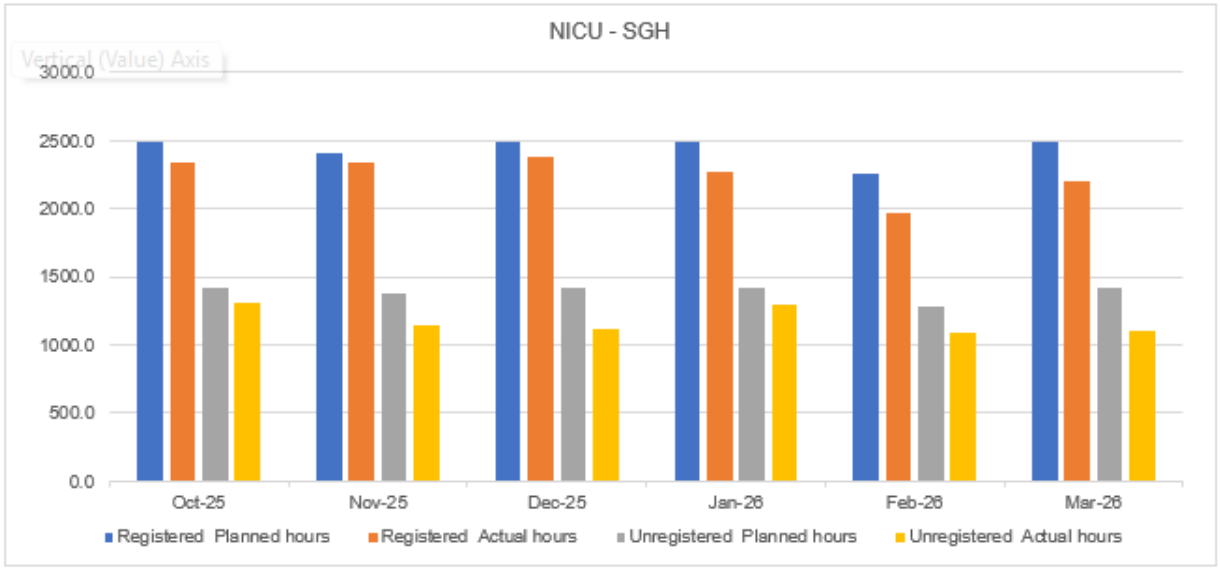
This continuous monitoring supports delivery of safe care and ensures a rapid response to fluctuations in activity or acuity.

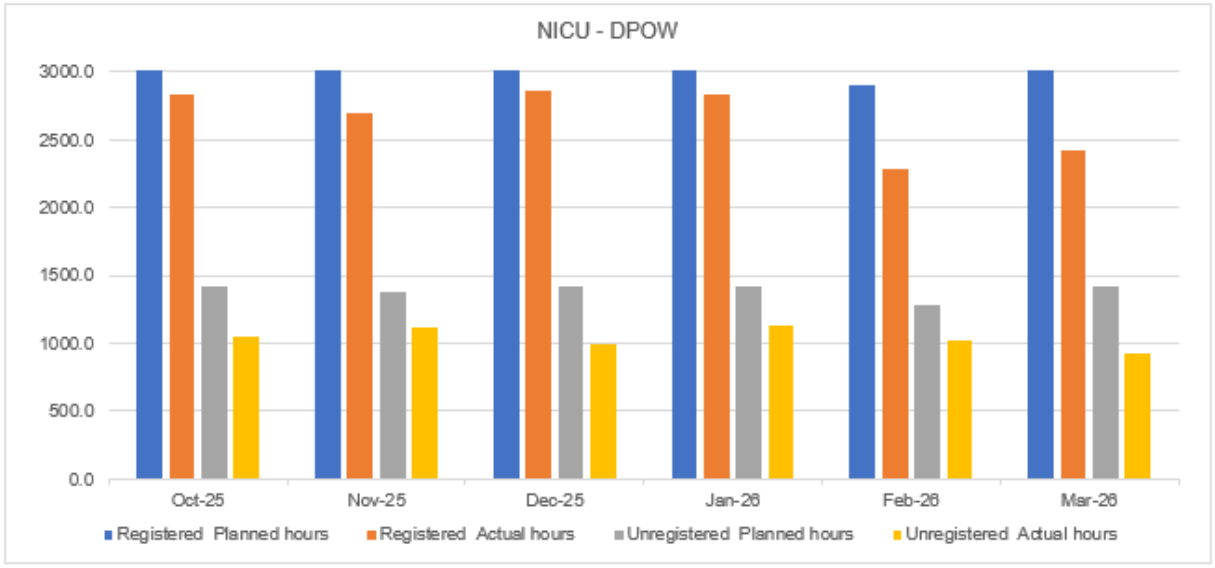





Central Delivery Suite - SGH
3500.0
3000.0
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours


Ward 26 - SGH
2500.0
2000.0
1500.0
1000.0
500.0
0.0
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Registered Planned hours
Registered Actual hours
Unregistered Planned hours
Unregistered Actual hours





Fill rates are monitored daily, and staff redeployed based on the acuity. All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

4.6 Community Midwifery Caseloads

Community caseload sizes have reduced over the last 18 months but remain above recommended caseload numbers. This is anticipated to reduce to the recommended 1:96 by the end of April 2026, due to increased rotation of midwives to community. Diana, Princess of Wales currently has a continuity of carer team which has been in place for the last 5 years based on a community and ward-based model.

	Annual recommended caseload	Average current caseload May 2026
Scunthorpe & Goole	1:96	1:83
Grimsby & Louth	1:96	1:95
Poppy	1:42	1:20

5.Current Midwifery & Neonatal staffing Issues and Risks

5.1 Midwifery

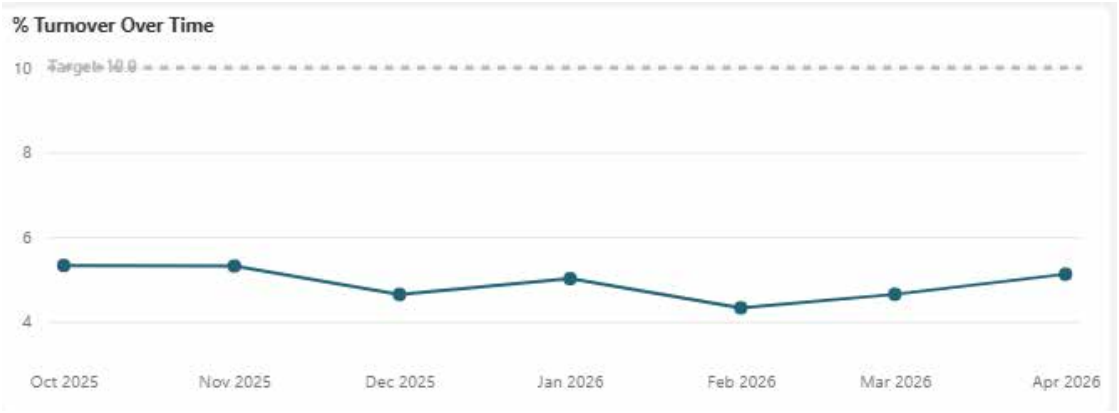
Recruitment and retention progress

Only a small proportion of our workforce work full time. As at the 30th of April the Trust had only a small number of vacancies, however anticipated movement due to specialist and managerial recruitment may increase the band 6 vacancy.

Attrition

Between October 2025 and March 2026 six midwives left. Currently ward managers are facilitating exit interviews and signposting to the Recruitment and Retention Lead for further support if needed.

Role	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Midwife	5.1%	7.4	4.8	0.8	10.8%
Midwife - Advanced Practition...	21.1%	0.5	0.0	0.0	0.0%
Midwife - Consultant	0.0%	0.0	0.0	0.0	
Midwife - Manager	6.2%	1.1	0.0	0.0	0.0%
Midwife - Specialist Practitioner	0.0%	0.0	1.6	0.0	
Total	**5.1%**	**9.0**	**6.4**	**0.8**	**8.9%**



Pastoral support and Retention midwife role of supporting midwives (specifically early career and International Midwives) impacting positively on the service.

- Emotional support, following work related and personal situations impacting their mental wellbeing.
- Sign posting to other agencies for specialist support, such as counselling and mental health support through our internal services.
- Wellbeing support to staff off on long-term sick to enable them to return to work and remain at work.
- Listening to colleagues without the need of offering resolution (as this may not always be possible).

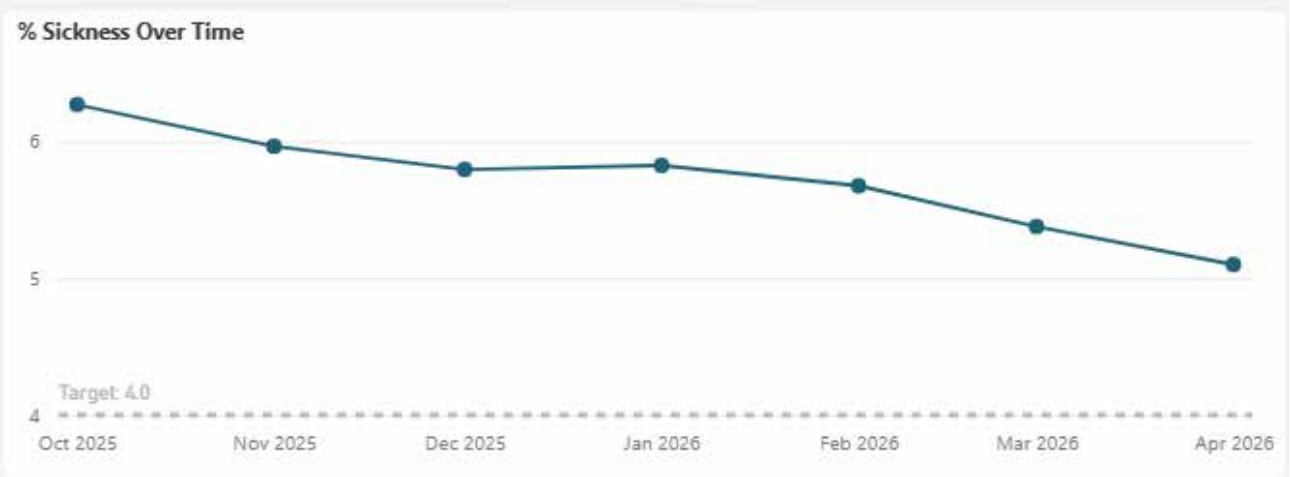
Maternity Leave position

In March 2026 3.9% of the Midwifery workforce (band 5, 6, 7 including specialist midwives) were on maternity leave. Midwifery Support Workers are at 2.7% and in total across the whole maternity workforce this was 5.04%.

Sickness absence rates October 2025 to March 2026:

Sickness levels for Nursing and Midwifery Registered staff (short-term and long-term) have remained around 6% during this period:

Month	October	November	December	January	February	March
% of all midwives	6.27	5.96	5.79	5.82	5.67	5.38



Birth to Midwife Ratio from October 2025 – March 2026:

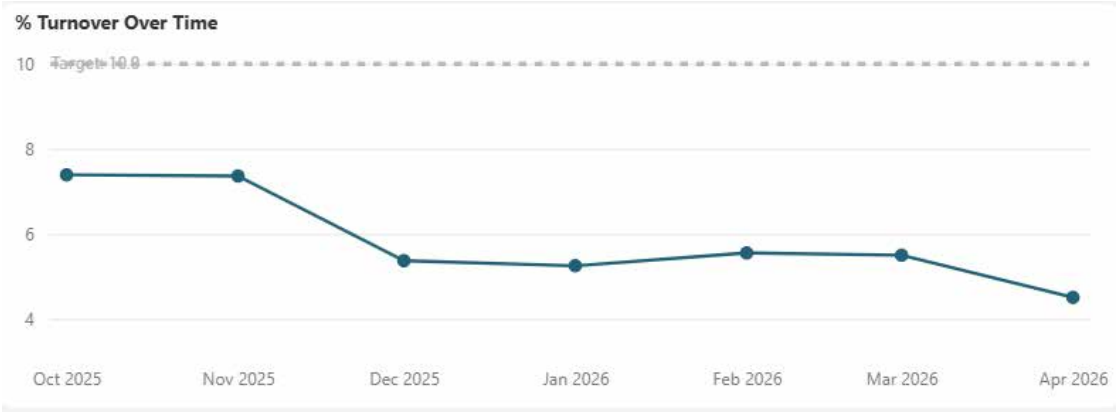
Month	October	November	December	January	February	March
Midwife to Birth	24.4	26.5	25.3	23.2	24.5	24.4

5.2 Neonatal

Recruitment and retention

Turnover for nurses is currently 4.5%, performing well against the KPI of 10%. Previously, early-career nurses were allocated to the Neonatal Unit through a central placement process. For the most recent intake, applicants applied directly to neonatal posts, resulting in a more self-selecting and motivated cohort. Some turnover reflects normal progression into specialist neonatal roles or movement into secondments, which is expected within a developing workforce.

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Nursing and Midwifery Registered	4.5%	2.0	3.1	0.7	32.8%
Total	**4.5%**	**2.0**	**3.1**	**0.7**	**32.8%**

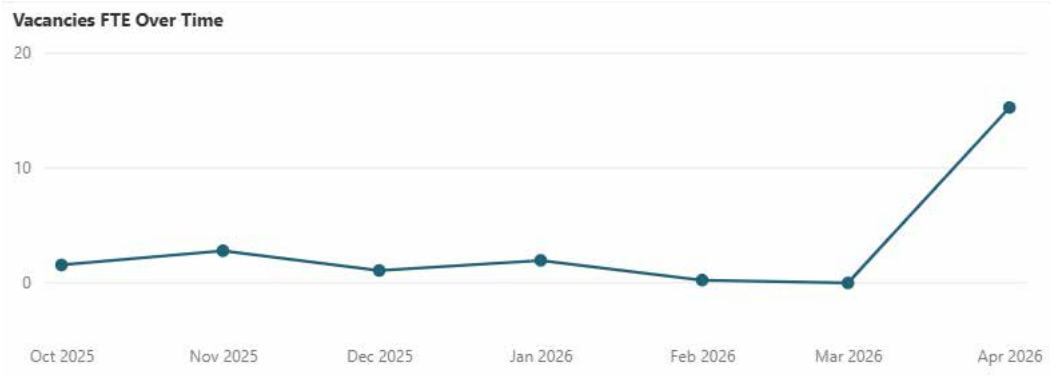


Maternity Leave

As of March 2026, maternity leave across the Neonatal Unit (including ward and outreach teams) is 7.8%**,** an increase from 4.8% in November 2024.

Vacancy Position

Across the Trust 10.2 WTE vacancies for Band 7 Clinical Sister roles went live and out to advert in April 2026. 8.3 WTE were recruited to in May 2026 and there are currently 1.9 WTE Clinical Sister role, 2.4 WTE band 5 and 1.0 WTE band 7 Clinical Educator roles out to advert.



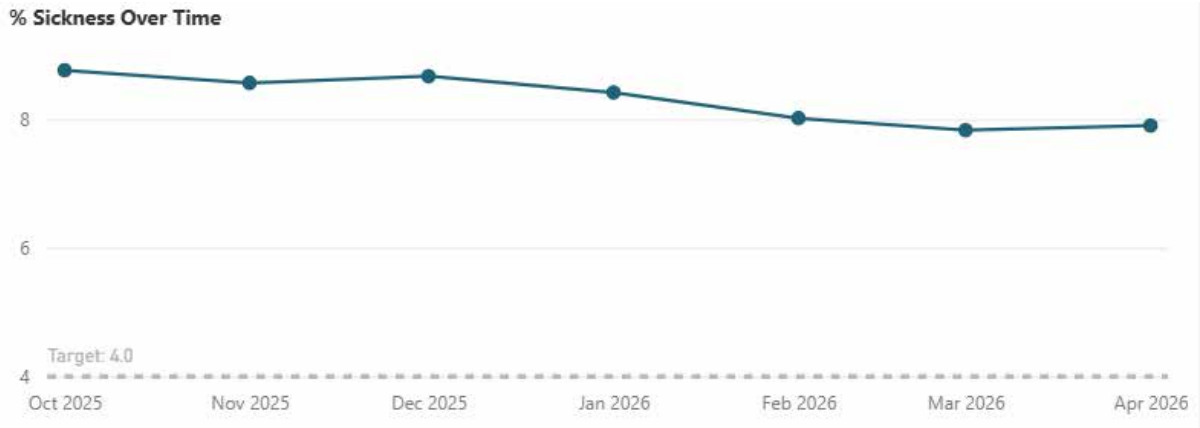
Vacancy levels remain low overall, but ongoing recruitment and retention remain essential to maintain safe staffing and meet BAPM standards.

Sickness Absence (October 2025 – March 2026)

Sickness absence for neonatal nursing staff has improved, reducing from 10.4% (May 2025) to 7.8% in March 2026.
The primary reason for absence continues to be stress and mental health-related conditions. Maternity and neonatal teams are implementing a series of supportive measures, including:

- Access to CiC (Care in Confidence) support
- Increased visibility of Professional Nurse Advocates (PNAs)
- Early referral to Occupational Health
- Promotion of wellbeing initiatives

These interventions aim to reduce absence further and support staff wellbeing.



6. Maternity and Neonatal Activity, Acuity and Complexity – NLaG

6.1 Maternity Activity and Complexity
Although birth numbers across Northern Lincolnshire have remained broadly stable, the complexity of women accessing maternity services at NLaG continues to increase, reflecting both local population demographics and widening health inequalities across the region. Key contributors to rising acuity include:

- Higher proportions of women requiring safeguarding support
- Increasing rates of high BMI and obesity
- Elevated diabetes prevalence, including gestational and pre-existing diabetes
- One of the highest smoking-in-pregnancy rates regionally
- A growing number of women with multiple long-term conditions
- Rising numbers of complex obstetric, fetal medicine and high-risk pregnancies

Maternity care is delivered across two sites—Diana, Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH)—both of which support women with a wide spectrum of clinical need, from straightforward pregnancies to those requiring specialist obstetric input. Services are delivered within a geographical area that includes a mix of urban, rural and coastal communities, with significant pockets of deprivation, which adds to both demand and complexity. The increasing acuity of the maternity population places heightened pressure on midwifery staffing, skill mix, community capacity and clinical leadership oversight. This reinforces the importance of achieving Birthrate Plus® compliance, strengthening specialist roles, and maintaining robust escalation processes across both NLaG sites.

6.2 Neonatal Acuity and Dependency

Neonatal activity and acuity have also risen across NLaG's two Local Neonatal Units (LNUs), located at DPOW and SGH. Both units support babies requiring special care and high dependency care and are caring for an increasingly complex patient group. Key drivers of this increased dependency include:

- Rising maternal and pregnancy complexity
- Higher survival of preterm and medically fragile infants
- Sustained demand for high dependency care
- Socioeconomic deprivation, linked to poorer neonatal outcomes
- Increased numbers of infants requiring transitional care and enhanced postnatal support

Both LNUs operate within the Yorkshire and Humber Operational Delivery Network (ODN) and work closely with Hull as the regional Level 3 centre. Babies requiring intensive care continue to be transferred to Hull Neonatal Unit, while NLaG LNUs provide a high volume of special care and high dependency activity.

NLaG's neonatal services remain under sustained workforce and activity pressure, particularly due to challenges in achieving BAPM-compliant nurse-to-baby ratios and the required proportion of QIS-trained nurses. Increasing acuity and dependency also impact flow, increasing demand for Transitional Care across maternity wards and community outreach follow-up.

Despite these pressures, both DPOW and SGH continue to deliver safe neonatal care through daily senior oversight, cross-site escalation, LMNS huddles, and mutual aid with Hull where required. Workforce investment through the neonatal nursing business case is essential to strengthen resilience and meet BAPM standards across both units.

7.0 Obstetric Staffing

<u>Consultant Attendance</u>
The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions and LMNS.

The data is collected concurrently by the labour ward co-ordinators on all intrapartum women on the maternity wards across the Trust. Compliance levels per site/per month are provided in the tables below, the occasions where the consultant was not in attendance will be investigated as part of MIS year 8 evidence and detailed in a separate audit report.

DPOW Results						
	Oct-25	**Nov-25**	**Dec-25**	**Jan 26**	**Feb 26**	**Mar 26**
Total No.	12	15	11	8	14	13
Consultant present at birth	11	13	10	8	14	13
% compliance	**92%**	**87%**	**91%**	**100%**	**100%**	**100%**

SGH Results						
	Oct-25	**Nov-25**	**Dec-25**	**Jan 26**	**Feb 26**	**Mar 26**
Total No.	10	10	14	5	9	TBC
Consultant present at birth	10	10	14	5	9	TBC
% compliance	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Engagement of Locum Medical Staff

Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

A Standard Operating Procedure for the engagement of locum medical staff in Obstetrics is in place (DCR282). The previous audit (undertaken in 2025) reported 100% compliance against the standards. Re-audit is yet to be completed as part of MIS year 8 reporting period. Findings will be shared with Trust Board and included in the next bi-annual staffing report.

8.0 Anaesthetic Staffing

For safety action A of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. 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 to obstetric patients. (ACSA standard 1.7.2.1).

The following demonstrates compliance with this standard by month.

Month	January	February	March
% compliance	100%	100%	100%

9.0 Neonatal Medical Staffing

To meet safety action A of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If any gaps are identified, Trust Board should evidence progress against an agreed action plan which demonstrates how the Trust intends to move towards full compliance.

As part of MIS year 7 gaps were identified and an action plan was approved by Trust Board (Appendix 1). In addition a business case was presented to and agreed by Trust Board in November 2025 with significant financial investment to allow the service to be BAPM compliant. It was acknowledged this this would potentially take three to five years to achieve but work is ongoing to progress this.

Recommendations across NHS Humber Health Partnership

1. Implement the Board-approved Midwifery Workforce Business Case
Continue with planned recruitment.
2. Deliver the Neonatal Nursing Business Case to Achieve Full BAPM Compliance
Implement the phased programme to achieve required nurse-to-baby ratios, 70% QIS workforce, supernumerary coordinators and the 25% uplift, ensuring full compliance within 18 months.
3. Strengthen Leadership Capacity Across Maternity and Neonatal Services
Recruit to vacant leadership posts, protect supernumerary leadership time and invest in development programmes/
4. Improve Recruitment Pipelines and Retention
Enhance recruitment campaigns, strengthen preceptorship, provide flexible working options, expand pastoral support and protect professional midwifery and neonatal advocacy roles.
5. Continue to Reduce Community Midwifery Caseloads
Deliver the planned rotation model to achieve the recommended 1:96 community caseload ratio by April 2026 and monitor caseload acuity monthly.
6. Protect One-to-One Intrapartum Care and Supernumerary Coordinator Roles
Ensure 1:1 care in labour is prioritised during all periods of activity and maintain the supernumerary Labour Ward Coordinator and Neonatal Shift Coordinator roles in line with national standards.
7. Strengthen Real-Time Safe Staffing Oversight
Maintain and further embed the BR+ Live Acuity Tool, four-hourly coordinator reviews, LMNS and pan-group safety huddles, and improved documentation of escalation actions.
8. Develop and Implement a Specialty-Specific Maternity On-Call Rota
Replace reliance on generic site team escalation with a dedicated maternity on-call rota to ensure 24/7 clinical leadership and improved decision-making.

9. Increase Transitional Care and Neonatal Community Outreach Team (NCOT) Capacity
Expand TC and NCOT workforce models to support patient flow, reduce unnecessary admissions and improve family-centred care.
10. Continue to Strengthen Staff Wellbeing, Culture and Restorative Practices
Support Culture Champions, restorative sessions, time-out days, enhanced OD support and improved internal communication to address moral injury and support a positive working environment.
11. Maintain Six-Monthly Safe Staffing Establishment Reviews
Ensure ongoing safe staffing reviews in line with NICE (2017), NQB requirements and MIS Year 8 standards, including Board-level visibility of risks, mitigations and progress against improvement plans.
13. Ensure Full CNST MIS Year 8 Compliance Monitoring
Monitor progress against all elements of Safety Action A as required by MIS>
14. Align Workforce Planning with Future BR+ and BAPM Cycles
Prepare for the next BR+ data collection in Q2 2027 and the next BAPM workforce review cycle, ensuring ongoing investment, modelling accuracy and sustainability.
15. Develop a 3–5 Year Integrated Maternity and Neonatal Workforce Strategy
Produce a long-term, system-wide workforce plan encompassing recruitment, retention, skill mix, education, digital tools, culture, and leadership, aligned with NHSE and local priorities.

Appendix 1: Neonatal nursing workforce BAPM recommendations and standards (HUTH)

Requirements for Safety Action 4: 1. The neonatal unit must meet the service specification for neonatal standards. 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, Nurse Director	N/A	Compliant	N/A
A minimum of 70% (special care) of the workforce should be registered A minimum of 80% (high dependency and intensive care) of the workforce should be registered.	**Current Position:** 95% Registered Nurses. 5% Unregistered Nurses (not included in baseline cot side nursing numbers). **Workforce Paper Opportunities:** Approval in principle to recruit to an establishment that is 100% capacity based and maintains the RN workforce requirements against standards.	Recruit to required WTE and uplift in banding required to enable the RN establishment to meet the requirement of the approved workforce paper phasing plan.	Deborah Bray, Nurse Director	N/A	Compliant – but further action required to meet revised workforce requirements	N/A

A minimum of 70% of the registered nursing and midwifery workforce establishment hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty (QIS).	Current Position: **55%** (as of September 25). The next cohort of QIS training (5 RN's) will commence the programme in January 2026. HUTH are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and QIS Speciality, including meeting the 150 hours of supernumerary time. Additional funding received from the ODN to support QIS supernumerary training. As the QISF is now mostly online learning the ability to increase the number of staff released to 4 nurses twice yearly. Current trajectory to meet the 70% compliance rate is December 2026.	Continue to execute current training plan, ensuring allocated staff attend the QIS programme (no more than 8 staff at any one time in the year).	Jenny Hemingway Neonatal Lead Educator	Dec 2026	Ongoing	Training compliance & Trajectories
Units have a minimum of two registered nurses/midwives on duty at all times, of which at least one is QIS.	Fully Compliant.	No further action required.	Deborah Bray, Nurse Director		Compliant	E-roster
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC: 1 RN 2 HD: 1 RN 4 SC: 1 RN 4 TC: 1 RN	**Current Position:** Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce. **Workforce Paper Opportunities:**	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses.	Deborah Bray, Nurse Director Francesca Matthews, Matron	April 2026 Recruitment Element	Compliant	Workforce Tool

	Approval in principle to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics	Recruit to required WTE and progress uplift of Banding in line with agreed neonatal workforce phasing plan.				
There is a nursing co-ordinator on every shift in addition to those providing direct clinical care.	**Current Position:** Band 7 Nurse Co-ordinator established 24/7. Final WTE post being recruited to currently. Mitigation in place to support shift leadership during escalation.	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses.	Deborah Bray, Nurse Director Francesca Matthews, Matron		Compliant	Roster Incident & Red Flag Reports
Neonatal units providing surgical services have a nurse/midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery.	**Current Position:** No substantive Nurse/Midwife with surgical clinical leadership responsibility. **Current Mitigation**: Surgical Link Team in place with 1 x Band 7 Clinical Sister who has completed the specialist surgical course. **Workforce Paper Opportunities:** Surgical CNS post approved in principle within the Workforce Paper.	Recruit to post in line with agreed neonatal workforce phasing plans	Deborah Bray , Nurse Director Francesca Matthews, Matron	September 2026	Partially Compliant	Workforce Paper – Phasing Plan
Neonatal units providing surgical services have at least one nurse/midwife with neonatal surgical experience who has responsibility for co-ordinating transfer and discharge of babies	**Current Position/Mitigation:** Neonatal Band 7 Shift Co-ordinator is responsible for liaising with the necessary transport team required for transfer. Discharge Lead Nurse also supports the staff with liaising with community services for discharge. More complex babies are often transferred to Paediatrics Surgical Ward for on-going care once they reach 44 completed weeks.	Recruit to CNS post in line with neonatal workforce paper phasing plans	Deborah Bray, Nurse Director Francesca Matthews, Matron	September 2026	Compliant	Workforce Paper – Phasing Plan

pre- and post-surgery, liaising with primary and community services, and supporting parents and referring teams.	Close collaborative working with the Specialist Lead Nurse in Leeds in place and can reach out for support/advice if needed. **Workforce Paper Opportunities**: Surgical CNS post approved in principle within the Workforce Paper.					

Appendix 4: Neonatal nursing workforce BAPM recommendations and standards (NLAG)

Requirements for Safety Action 4:

1. The neonatal unit must meet the service specification for neonatal standards.
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, Nurse Director	N/A	Compliant	Rosters
There should be a 1WTE Band 7 Lead nurse for Transitional Care Services who are Supernumerary 100% of the roster period	**Current Position:** Due to Band 7 Lead Nurse for the LNU's being supernumerary the oversight of the Transitional Care Service is incorporated into their role and responsibilities. **Workforce Paper Opportunities:** Approval in principle for 1wte Band 7 Lead Nurse for Transitional Care across NLAG. This will allow dedicated enhanced leadership of the Transitional Care Service.	Recruitment to post in line with agreed Neonatal Workforce Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley, Matrons	August 2026	Partially Compliant	Roster Job Description

A designated lead nurse/midwife is responsible for the clinical and professional leadership and management of the service, working with the lead consultant.	Neonatal Matrons in post and works closely with the lead consultant neonatologists.	No further action required.	Deborah Bray, Nurse Director	-	Complete	Job descriptions
There must be a supernumerary Band 6 Shift lead 24/7	**Current Position:** Neither SGH or DPoW achieve 24/7 band 6 supernumerary status, however, consistently strive to achieve this when acuity and activity allows. **Workforce Paper Opportunities**: Approval in principle gained to recruit the required WTE to allow a Band 6 supernumerary shift lead to be in core baseline establishment	Recruitment to required posts in line with agreed Neonatal Workforce Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley, Matrons	April 2026		Workforce Phasing Plan Rosters
1 WTE Band 7 Nurse Educator required to work cross site	**Current position:** 2 x 0.63 WTE Band 6 Neonatal Nurse Educators in place (1 at each site). The ODN expectation is that the Neonatal Educators are Band 7 and have created a network job description for hospitals to work to. Additional funds have been received from the ODN to increase the Nurse Educator role with the expectation that there will be 2 x 0.6 WTE on each site at Band 7 – uplift in progress	Recruitment to additional WTE in line with agreed Neonatal Workforce Phasing Plan.	Emma Spicer Matron	April 2026	Partially Compliant	Job Description Roster Workforce Phasing Plan

	Workforce Paper Opportunities: Approval in principle gained to uplift the WTE to allow 1:50 ratio (1WTE Band 7 per site).					
Nursing cot ratio should be met 100% of the time cot ratio should be: 1 IC:1 RN 2 HD:1 RN 4 SC:1 RN 4 TC:1 RN	**Current Position:** Staffing levels and cot capacity/acuity data is entered into BadgerNet on a daily basis and risk mitigated accordingly, in line with available escalation plans, and utilisation of wider neonatal workforce. **Workforce Paper Opportunities:** Approval in principle to increase the Direct Cotside Care WTE in line with BAPM requirements, and activity/acuity metrics.	Development of a Red Flag reporting system for monitoring non-compliance against metrics being developed. Once agreed and ratified through Governance to be added to both Safecare and Ulysses. Recruit to required WTE and progress uplift of Banding in line with agreed neonatal workforce phasing plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley Matrons	April 2026 Recruitment Element	Compliant	Workforce Toolkit Roster
						Escalation Plan
70% of the workforce should be Registered Nurses	Current Position: **DPOW: 74%** **SGH: 63%**	**Workforce Paper Opportunities:** Approval in principle to move to a workforce split of 95/5% - with realignment of unregistered workforce to neonatal community-based roles in line with BAPM (2025) & BAPM (2021) guidance. HR Consultation and Implementation of a Rotational Unregistered Workforce Model between the Neonatal Unit and the NCOT Service required. Recruit to required WTE to enable the RN establishment to meet the requirement of the approved workforce paper phasing plan.	Deborah Bray, Nurse Director Emma Spicer & Jennifer Copley Matrons	September 2026	Partially Compliant SGH	Rosters
30% of the workforce should be non-registered.	**DPOW: 26%** **SGH: 37%**				Compliant DPoW	

80% of registered nurse workforce should be QIS 70% compliance with QIS standard to be maintained 100% of the time.	**Current Position:** NLaG are not currently meeting all the national guidance for QIS standards but have a rolling training programme for both QIS foundation and QIS Speciality, including meeting the 150 hours of supernumerary time. DPOW: **69%** SGH: **56%** Trajectory to meet 70%: DPoW– March 2026 SGH – September 2027	Continue with training plan in place to support appropriate staff to access the relevant training and education modules to achieve the QIS. Trajectories to meet compliance metric, in place across the Trust. New starters without QIS to commence Foundation Programme after supernumerary preceptorship period completed.	Laura Parker & Rebecca Pearson, Neonatal Educators	SGH – Sept 2027 DPoW – March 2026	SGH DPoW	Training compliance rates
Neonatal Care Outreach Team (NCOT) must be available 7 days a week.	**Current Position:** SGH established to deliver a 5-day service DPoW established to deliver a 6-day service Ability to flex service provision to facilitate discharge across the 7 day period as required **Workforce Paper Opportunities:** Approval in principle to establish the NCOT service 7 days per week with a revised workforce model in line with BAPM standards for NCOT Services (2025).	Recruit to required WTE to enable the RN NCOT establishment to meet the requirement of the approved workforce paper phasing plan. Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan.	Deborah Bray, Nurse Director Emma Spicer & Jenny Copley, Matrons	September 2026	Partially Compliant	Roster
Non-registered workforce should complete a minimum of NVQ level 3 training.	**Workforce Paper Opportunities:** Workforce model for the cot side care (BAPM 2021) and the neonatal outreach service has	Realign the unregistered workforce model in line with the agreed Neonatal Workforce Paper Phasing Plan	Deborah Bray, Nurse Director	September 2026	Partially Compliant	Roster Job Description

	been mapped against the BAPM NCOT Guidance (2025) and agreed in principle. The revised workforce model for the Unit based cot side care will see a reduction in the unregistered workforce. Approval in principle to develop and enhance the NCOT workforce to meet BPAM (2025). Workforce realignment from the current cot side workforce WTE will be required with support through an appropriate programme of training and competency based education.	Develop an appropriate education and training programme to support role development across the community setting. No action required for current workforce configuration as all unregistered workforce have completed appropriate programme of study/competency.	Laura Parker & Rebecca Pearson Nurse Educator Emma Spicer & Jenny Copley, Matrons			Education & Training Programme

Hull University Teaching Hospitals NHS Trust

Family Services Division: Maternity Services

Thematic Analysis and Safety Recommendations

Quarter 4 2025/26

Date: May 2026

Author: Matthew Proctor

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Executive Summary

In March 2026 NHR Resolution published refreshed guidance for the Maternity (Perinatal) Incentive Scheme (Year 8) which has an increased focus on effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.

One of the safety actions (Safety Action C: Learning from reviews and investigations) aims to embed a culture in which findings are not only reported but critically analysed for their meaning and impact, focusing on the essential 'so what'. The requirement is for the Trust to produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

The report must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly and should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

The thematic review detailed within the report is based on 18 safety incidents that occurred during quarter 4, consisting of 1 new MNSI, 12 new PMRT, 3 ongoing MNSI and 3 ongoing AAR. There were no eligible cases for a MOSS review. NHSR claims scorecards are published annually, for the purposes of this report any themes, learning and recommendations from the most recent publication (October 2025) have been included for triangulation.

Themes identified include an increase in neonatal deaths and non-compliance with hypertensive management and use of PLGF.

Scope / Definition

A thematic review is undertaken when the Trust/Organisation identifies common features to a number of patient safety incidents. Common features may include similar location, similar means of harm, similar teams or services. The goal of a thematic review is to enable wider systemic learning from incidents, and to ensure that commonalities between individual incidents and investigations are identified and addressed.

The aim of the formal thematic review is to identify common themes, make recommendations as to future actions to address risks identified and to ensure learning can take place.
A thematic review may be undertaken when:

- Multiple similar incidents occur in one Directorate
- A cluster of similar incidents are identified in one team
- Multiple rare occurrences of an incident happen across several Directorates

Thematic reviews may raise more questions than answers resulting in actions best approached through a quality improvement lens, utilising a PDSA cycle to refine the process. The findings of the thematic review will be tabled at the Maternity and Neonatal Assurance Group meeting and shared with Trust Board on a quarterly basis. Where necessary it will be shared with other agencies / Commissioners to enable wider systemic learning in line with the Patient Safety Incident Response Framework (PSIRF) principles.

Background

Patient safety incidents result from multiple interactions between work system factors. The systems engineering initiative for patient safety (SEIPS) framework prompts us to look for interactions rather than simple linear cause and effect relationships.
When a learning response thoroughly examines the different work system components and their interactions, safety actions can focus on wider system issues, not individuals.

Over the past 2 years theming has taken place and has been reported as part of the quarterly claims scorecard triangulation, it is hoped that this report strengthens reporting by using the attached theming template that was shared nationally following the MIS webinars in April 2026. The template identifies themes by using a score system which takes into account organisational, task and environment and individual factors.

Investigation Process and Methodology

To systematically identify, review, and learn from themes emerging in patient care through incident reporting, ensuring continuous quality improvement and patient-centred care we utilise:

- **Patient-centred approach:** Patient experience and outcomes are central to all reviews
- **Open safety culture:** Psychological safety enabling staff to speak openly about concerns
- **Twice-weekly MDT review meetings:** Inclusive participation from all relevant professions
- **Learning over blame:** Focus on system improvement rather than individual fault
- **Evidence-informed practice:** Guided by national and local policies and best practice**:** used to identify cases for MDT thematic review. Examples include:

  - Patient safety incidents (moderate to severe harm)
  - Near misses with learning potential
  - Recurrent themes (e.g., postnatal readmissions, medication errors, birth injuries)
  - Delayed care, missed diagnoses, or deterioration events
  - Safeguarding concerns
  - Complaints or significant patient feedback
  - Staff concerns raised through open-door channels
- **Supporting staff collate relevant information including:**
  - Clinical records
  - Incident reports
  - Staff interviews
  - Patient and family feedback
  - Input/views from Maternity and Neonatal Voice Partnership Lead (MNVP).
  - Policies and standards applicable to the case
  - Alignment to current national and local guidance is identified
  - Cases are anonymised where appropriate

Analysis

Safety incidents during quarter 4 were reviewed and scored by the Clinical Governance Led Midwife for Maternity Services using the attached data collection tool in Microsoft Excel to identify recurrent themes across all incidents.

Patient Safety Events Included in this Review

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
05/11/2025 (ongoing)	MI-048987	Severe Harm	Term baby admitted to NICU. HIE grade 3 diagnosed.	MDT (local) MSNI	· Awaiting finalised report (expected Q1 2026-2027) · Local review escalated to LRP – no further review required · Final report to be shared with all midwives and obstetricians. · To be presented at PSIRF panel with action plan.
08/01/2026	MI-051713/102116	No-Harm	Cord Prolapse at home. Severe HIE diagnosed. NND day 12.	MDT (local) MSNI PMRT	· Local review escalated to LRP – no further review required · Staff posters utilised and communication strategy to prompt 9 prior to 999 (outside line required). · PROMPT algorithms by phones to aid advice (building on good practice demonstrated) · Final report to be shared with all midwives and obstetricians. · To be presented at PSIRF panel with action plan.
21/10/2025 (ongoing)	MI-048159	Severe Harm	Term intrapartum still birth, major obstetric haemorrhage and hysterectomy.	MDT (local) MSNI PMRT	· Local review escalated to LRP – no further review required

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
					· Being taught on PROMPT MDT for 2026 re: holistic risk assessment, personalised care and escalation of emergencies. · Sonic aid not available – labour ward matron ordered additional stock · Final report to be shared with all midwives and obstetricians. · To be presented at PSIRF panel with action plan. · BadgerNet documentation of lowest recordable fetal heart rate can be 0 communicated.
26/11/2025 (ongoing)	MI-050092	Severe Harm	Term intrapartum still birth. Attended maternity triage in early labour. No fetal heart identified.	MDT (local) MSNI PMRT	· Strategy being considered about how we ensure closed loop communication from non-obstetric specialities · Monthly BSOTs oversight at MNIG and monthly governance updates · Local review escalated to LRP – no further review required
16.01.2026	102078	Moderate	Antenatal still birth 35+2	MDT – ongoing PMRT	· Incident upgraded to moderate harm · AMAT QI PLGF created · Review not yet complete
29.01.2026	102257	No-Harm	Antenatal still birth 33+1	MDT – ongoing PMRT	· Review not yet complete

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
04.02.2026	102356	No-Harm	Neonatal death – delivered 22+3	MDT – ongoing PMRT	· Review not yet complete
06.02.2026	102412	No-Harm	BBA 23+6 – neonatal death.	MDT – ongoing PMRT	· Review not yet complete
09.02.2026	102422	Severe Harm	Neonatal death in theatre 24+3	MDT – ongoing PMRT	· HHP position statement not supporting CTG <26/40 approved via governance · Difficult airway pathway path made clearer in theatre and escalation pathways · Local review escalated to LRP – no further review required · Review not yet complete
10.02.2026	102423	Low Harm	Neonatal death – delivered 26+2	MDT – ongoing PMRT	· Perinatal optimisation (IVABXs) shared via newsletter · Review not yet complete
15.02.2026	102477	Low Harm	Neonatal death – delivered 24+0	MDT – ongoing PMRT	· Review not yet complete
17.02.2026	102539	Moderate	Antenatal stillbirth 35+3	MDT – ongoing PMRT	· Review not yet complete · Shared learning of updated RCOG guidance of IHP and shared literature review regarding use of Ursodeoxycholic acid/Rifampicin. · Risk assessment of diabetes – make each contact count via the safety brief.
07.03.2026	102771	No-Harm	Antenatal still birth 25+6	MDT – ongoing PMRT	· Review not yet complete · Shared learning regarding if an investigation is abnormal, to

Date	Incident Reference	Level of Harm Reported	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
					escalate. Confirmation bias shared via safety brief.
14.03.2026	102836	No-Harm	Late miscarriage 22+6	MDT – ongoing PMRT	· Review not yet complete · Safety brief communication regarding RFM communication – to promote attendance
16.03.2026	102879	No-Harm	Antenatal still birth 31+6	MDT – ongoing PMRT	· Review not yet complete · Safety brief communication regarding RFM communication – to promote attendance
21.03.2023	103099	No-Harm	Neonatal death – delivered 23+4	MDT – ongoing PMRT	· Review not yet complete
10.12.2025 (ongoing)	362303	Moderate	Intrauterine transfer to another hospital	MDT AAR	· Transfer process with YAS inconsistent. New SOP developed to aid this (collaborative with Yas) · Delay in performing PLGF included in QI project. · Findings and action plan shared and discussed at PSIRF
21/09/2025 (ongoing)	W347845	Moderate	Skull fracture following kiwi delivery	MDT AAR	· Poor documentation due to acuity – continuation of documentation audit (existing on AMAT). · Findings and action plan shared and discussed at PSIRF

Findings

Patient safety incidents result from multiple interactions between work system factors. The systems engineering initiative for patient safety (SEIPS) framework prompts us to look for interactions rather than simple linear cause and effect relationships. When a learning response thoroughly examines the different work system components and their interactions, safety actions can focus on wider system issues, not individuals.

During this analysis, in response to a thematic rise in non-compliance with hypertensive management and use of PLGF, a QI project was registered. We were able to identify themes of:

- Confirmation bias
- Lack of education
- Non-standardised education

There was an increase in neonatal deaths reported during this period. We were able to identify themes of:

- Level 3 NICU accepting regional intrauterine/ex-utero transfers
- Extreme prematurity <26 weeks

There was a high level of deprivation (IMDD 1-3) of those affected, reflecting national and local challenges with health and societal inequalities.

Learning from 2024/2025 NHS resolution scorecard

- Failure or delay in treatment remains the most frequent cause of maternity claims (14.3%), followed by failure or delay in diagnosis (9.5%) and failures to monitor progress in the first stage of labour (8.3%).
- Inadequate nursing care and failure to act on abnormal test results each account for 7.1% of claims, highlighting recurring issues in escalation and multidisciplinary communication.
- The majority of claims relate to delays in recognising and responding to maternal or fetal deterioration, or gaps in intrapartum monitoring and escalation during labour.
- The most serious injuries, including stillbirth (14.1%), fatality (9.4%), brain damage (8.2%), and cerebral palsy (4.7%), are directly associated with missed or delayed recognition of fetal distress.
- Additional or unnecessary operations (15.3%) are a notable cause of harm, reinforcing the importance of surgical safety checks, operator competence, and senior supervision.
- High-value maternity claims (£90.06m) are consistently linked to delayed intervention resulting from CTG interpretation errors, extended decision-to-delivery intervals, and inconsistent escalation when risk factors emerge.
- Other contributory factors include incomplete antenatal surveillance, missed growth scan follow-ups, and communication breakdowns between midwives, obstetricians, and neonatology teams.
- Themes across incidents indicate that the critical window for timely intervention in high-risk or deteriorating labours is frequently exceeded, leading to preventable hypoxic injuries.

Safety Recommendations

Annual Maternity Claims Scorecard

- **Strengthen fetal monitoring and escalation protocols** Ensure compliance with national CTG and intrapartum senior review when abnormalities are identified. Reinforce prompt decision-making for urgent or category 1 deliveries.
- **Improve reliability of antenatal growth surveillance and follow-up** Introduce robust failsafe systems for antenatal referrals, growth scans and Doppler follow-ups to ensure timely review of small-for-gestational-age or high-risk pregnancies, and consistent documentation of care plans.
- **Enhance governance and oversight of operative and complex births** Ensure senior obstetric presence and direct supervision during complex caesarean sections or high-risk deliveries, particularly where staff are in training or under practice restrictions.
- **Embed targeted learning from high-severity incidents** Continue multidisciplinary reviews under PSIRF for all cases involving HIE, cerebral palsy, stillbirth or severe maternal harm, focusing on escalation, decision-making, and handover reliability. Share outcomes through maternity safety forums and simulation training.
- **Strengthen escalation culture and situational awareness** Promote an open safety culture where midwives and obstetric staff feel empowered to escalate concerns immediately, supported by ongoing human factors and CTG interpretation training.
- **Improve communication and handover processes** Standardise handover procedures and ensure continuity of monitoring during transfers, shift changes or high-activity periods to avoid missed deterioration or duplicated information.

MNSI

- All learning and action plans are first agreed at local governance processes prior to PSIRF closure.
- Reports and safety recommendations are shared with all obstetric and midwifery staff via the monthly patient safety newsletter
- Action plans are monitored monthly within the maternity patient safety team
- **Holistic risk assessments** – Teaching via the PROMPT MDT 2026 agenda will allow the journey of the family to be real. This is thought to be more powerful in supporting holistic risk assessments via educational discussions.
- **BSOTs compliance** – monthly monitoring and oversight at local governance and MNIG to be commenced. This will aid the identification and discussion of SEIPS factors affecting care delivery.

PSIRF responses

- All learning and action plans are first agreed at local governance processes prior to PSIRF closure.
- Reports and safety recommendations are shared with all obstetric and midwifery staff via the monthly patient safety newsletter
- Action plans are monitored monthly within the maternity patient safety team
- **Transfer of pregnant women via ambulance** – the development and integration of a collaborative SOP (developed with YAS) and education of this will standardise the handover between the MDT and improve holistic risk assessment pathway.

PMRT

- All graded C/D are escalated to the learning response panel for transparency and discussion if further learning responses may be indicated.
- Action plans are monitored monthly within the maternity patient safety team.
- **PLGF registered QI** – This is aimed to promote specific organisational learning and address the human factors of non-compliance. Local review pathways have noted an improvement in adherence to national and local pathways.
- **Intrahepatic Cholestasis of pregnancy policy update** – linked to complaint resolution and PMRT response. Local pathways updated to reflect national expectations of care. Education performed.

Supporting Documents

- NHS England (2022). SEIPS Quick Reference and Work System Explorer
- NHS England (2022), Top Tips for Completing a Thematic Review
- NHS England (2020). Patient Safety Incident Response Framework Contributory and mitigating factors classification
- Samantha Machen (2023) *Thematic reviews of patient safety incidents as a tool for systems thinking: a quality improvement report.* BMJ Open Quality, doi: https://bmjopenquality.bmj.com/content/12/2/e002020
- Six Phases of Reflexive Thematic Analysis
- Quality Improvement: A Facilitators Guide to Quality Improvement
- Maternity (Perinatal) Incentive Scheme Year 8 v1.0 (2026)
- NHS Resolution Maternity Scorecard (2025)

Appendix 1 - SEIPS Worksheet: Safety Investigations & Learning Reviews

Work System Design Facilitators & Barriers

External Influences
- Health inequalities – deprivation index
- Accessibility of healthcare
- Cot availability

Environment
- Not a theme

Organisation
- Level 3 NICU
- Not a regional MMC

People
- Identification of emergencies
- Training and policy protocols

Tasks
- High acuity of service
- Birthrate plus not completed

Equipment
- Sonic aid availability
- Digital EPR and IPad access

Process

Work Processes

- Level 3 NICU acceptance of very early gestation or unwell babies
- PROMPT education of learning
- Planned MDT reviews twice a week with neonatal and anaesthetic attendance)
- Lack of sonic aids

Outcomes

Wanted/ Unwanted Outcomes *(consider both system performance and human wellbeing factors)*

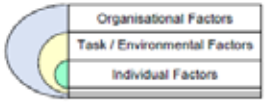
- Leading to unwanted outcomes due to frequent unavailability of neonatal cots (on the risk register)
- Higher neonatal death rate in extreme gestations
- Improved MDT learning and transparency
- Improved attendance and MDT discussions of learning (MatNeo)
- Ordering of sonic aids improves care delivery

Appendix 2 – PSIRF Contributory & Mitigating Factors Classification

NHS

Patient Safety Incident Response Framework

Contributory and mitigating factors classification – Print only in A3



External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Operational management factors	Components
Safety focus	• Rule compliance • Dealing with risks from past incidents • Awareness of current practice • Adherence to current practice • Empowerment of staff to act
Work planning and delivery	• Risk management plans • Scheduling • Incentive schemes • Contingency planning
Staffing levels and skill mix	• Skill mix • Staff to patient ratio • Workload/weighting/dependency • Temporary staff • Staff turnover
Workload, shift patterns, hours of work	• Working hours • Work breaks • Workload (under/over/balanced) • Extraneous tasks • Social relaxation, rest and recuperation
Training design	• Training needs analysis • Training design • Training/education content • Targeted training • Style of delivery • Time of day provided
Training availability/accessibility	• Training availability/accessibility • Core skills training • On the job training • Emergency scenario training (skills drills) • Team training • Refresher training
Staff supervision	• Orientation • Personal supervision • Monitoring of supervision (assessment) • Mentorship
Staff competence	• Knowledge • Skill • Experience • Familiarity with task • Competence testing and assessment

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information Interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

Team and social factors	Components
Culture	• Approach to newcomers • Approach to adverse events • Approach to conflict • Approach to rules/regulations • Approach to seeking support • Approach to interprofessional challenge • Interpersonal relationships • Power relationships
Team structure and consistency	• Shared understanding • Familiarity • Mutual respect • Clarity of roles and responsibilities • Congruence of roles and responsibilities • Informal support networks
Leadership	• Clinical leadership • Managerial leadership • Leadership impact • Leadership decision-making • Timeliness of leadership action • Respect for leadership • Formal support networks for staff
Communication management	• Communication strategy and policy documents • Involvement of patient/family/carers in treatment and decisions • Communication of risks to patient/family/carers • Communication of risks to staff • Communication of risks to the board • Information from patient/family/carers • Communication flow to staff up, down and across • Communication with other agencies (partnership working) • Measuring effectiveness of communication
Verbal communication	• Tone of voice • Style of verbal communication delivery • Use of language • Specificity • Direction • Channel/route • Verbal communication aids/equipment
Written communication	• Readability • Accessibility/availability • Collated • Completeness • Contemporaneous • Accuracy • Currency • Circulation of written information • Patient identification • Information to patients
Non-verbal communication	• Body language/gestures/facial expression

Task factors	Components
Clinical condition	• Pre-existing co-morbidities • Complexity of condition • Seriousness of condition • Options available to treat condition
Plans, guidelines, policies, procedures and protocols	• Informative • Instructional • Representative • Routine use • Usability • Currency • Accuracy • Availability • Accessibility (ambiguous, complex, irrelevant, incorrect) • Monitoring • Review • Targeting/focus (ie audience)
Decision-making aids (information/results/ tools/machines, etc)	• Available • Accessible • Working • Accurate • For prioritisation of tasks • Access to specialist advice • Access to technical information, flow charts and diagrams
Procedural or task design and clarity	• Task complexity • Task memorability • Understandable • Agreed with staff (feasibility) • Time allocation • Task sequencing/stage sequencing • Workload (under/over/balanced) • Compatibility of tasks/task stages • Competing task demands • Feedback from the task • Transferability to/from other situations • Influence on task/outcome • Automation • Audit, quality control, quality assurance

Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

Hull University Teaching Hospital - Maternity Incentive Scheme (SA C) Quarter 4 2025/26

Quarterly review of Trust's claims scorecard alongside incident and complaint data should be discussed with the Trust Perinatal and Board level safety champions and submitted to Trust Executive Board at least quarterly.

NHS Humber Health Partnership

Claims Scorecard 01 April 2015 – 31 March 2025 (84 claims)

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

Claims Breakdown Q4 25/26

New:

1 – Alleged clinical negligence regarding an incomplete termination of pregnancy

Closed:

1 – Summary below (Ref: 2023.7889)

Description of treatment and claim

The claim related to maternity care during induction of labour and emergency Caesarean section in May 2023. The allegations included delay in artificial rupture of membranes, failure to act on proteinuria/possible pre-eclampsia, delay in repeat vaginal examination, delay in category 2 Caesarean section and extravasation injury.

Liability position and learning

Breach was admitted in part, including failures in induction management, maternal observations, escalation of possible pre-eclampsia, delay in category 2 Caesarean transfer and IV access monitoring. Causation was admitted in relation to increased severity of haemorrhage and avoidable extravasation injury. The learning relates to induction pathway reliability, labour ward capacity escalation, maternal observations, theatre transfer times, IV access monitoring and clear documentation of labour plans.

Incidents Q4 25/26

Top 5 incident by volume:

- Term NNU admissions **(56)**
- Postnatal readmission **(19)**
- Communication failure between teams **(18)**
- Post partum haemorrhage (PPH) >1500mls **(14)**
- Delay in treatment **(10)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **397**

Complaints Q4 25/26

There have been 7 new complaints received relating to the following

- Delayed treatment
- Unhappy with treatment
- Concerns with care provision

Clinical Audits Registered Q4 25/26

- (HHP) National Comparative Audit on the use of prophylactic anti-D in pregnancy
- (HHP) Use of Interpreter in Maternity Services
- (HHP) Home Birth Audit

Deep Dive Reviews Q4 25/26

- Thematic reviews highlight not an outlier in PPH >1500ml, shoulder dystocia or perineal trauma
- Neonatal death increase reviewed by neonatal clinical lead – no concern
- Pre-term optimisation thematic review commenced (aiming completion Q1)

Learning Q4 25/26
o 1 term HIE 3/NND (Cord prolapse at home) well managed over the phone o Make every contact count o ICP guidance requiring update to be line with RCOG o Anti-D pathway (including IV ANTI-D) o No MOSS alerts

Themes Q4 25/26

o Q4 ATAIN 5.17% (2025/2026 rate 5.02%)
o Neonatal death increase (escalated by neonates)
o Neonatal unit cot availability downgraded to moderate on the risk register
o MBRRACE 2024 figures released
  o 3.29 per 1000 (Stillbirth)
  o 1.18 per 1000 (Neonatal Death)

Action Plan Q4 25/26	Not started / In progress / Complete	
Induction of Labour Deep Dive	Aug 2025	
Thematic review of postnatal readmissions	Sept 2025	
Quality Improvement project to be registered regarding Hypertension and PLGF	April 2026	

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 4 2025/26)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

April 2026

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

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

1.1 MBRRACE-UK reporting requirements and PMRT support:

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

2. STANDARDS

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

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

3. SUMMARY

3.1 Eligible Incidents in MIS Year Seven and Eight (Appendix A)

There has been a total of **42** incidents reported to MBRRACE-UK via the PMRT that fall within the MIS year seven period (01 December 2024 – 30 November 2025). **16** incidents have been reported to date in MIS Year 8 (Commenced 01 December 2025):

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive	Not eligible
Q2 (01 Jul – 30 Sept 25)	10	2	1	4 (post-neonatal)
Q3 (01 Oct – 31 Dec 25)	7 (4 in MIS Y7)	1	1	1 (post-neonatal)
Q4 (01 Jan – 31 Mar 26)	16 (MIS Y8)	1	1	0
Total	**33**	**4**	**3**	**5**

Within Q2-Q4, 37 cases are eligible for notification only or review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days.

During Q4 a Neonatal board report detailing the increase in neonatal deaths was presented. This was jointly prepared and demonstrated no trends or themes.

From 1st December 2024, please note there are **8** cases registered with MBRRACE where the deaths occurred at other Trusts and HUTH contributed to the care. It is the responsibility of the other Trusts to collaboratively complete the PMRT review. These cases do not appear on HUTH MIS case list but are included in the yearly case list.

3.2 Summary of all incidents reviewed through PMRT in Quarter 4 2025/26 (Appendix B)

There have been **10** incidents reviewed through the PMRT process in quarter 4; **5** of these were conducted with partner organisations where care was provided prior to an in utero/ ex-utero transfer of care. 2 of these were conducted with the attendance of MNSI.

There have been reports published for **8** of these. **1** is due to the external partner organisation wanting to await the completed MNSI report prior to their grading of care.

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

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

- 2 cases had no issues identified that would have had an impact on the outcome.
- 8 case had issues identified that would have had no impact on the outcome.
- 0 case had issues identified that may have impacted the outcome
- 0 case had issues that would have impacted the outcome

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

- 2 cases had no issues identified with care from birth up to the point that the baby died
- 5 cases had issues identified which would not have impacted the outcome for the baby
- 1 case had issues that would have impacted the outcome – this was not at HUTH

Grading of care provided to the mother after the death of the baby (HUTH Care)

- 5 cases had no issues identified that would have had an impact on the outcome.
- 3 case had issues identified that would have had no impact on the outcome.
- 0 case had issues identified that may have impacted the outcome

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

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

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

3. Saving Babies' Lives (Appendix E)

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

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

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

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

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

	100027	Early NND	22+6	27.08.25	28.08.25	520g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100090	Late NND	103 days	15.05.25	26.08.25	1000g	HUTH	HUTH	Martin House	Yes	No	Yes	Yes	Yes	Yes
Q2 25/26	100143	Early NND	3 days	01.09.25	04.09.25	3302g	Rotherham	Rotherham	HUTH	Yes	Yes	Yes	Yes	No *	Yes
	100134	Late NND	54 days	12.07.25	04.09.25	480g	DPOW	DPOW	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100192	Antenatal stillbirth	34+3 days	08.09.25	08.09.25	2300g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100249	Late NND	34 days	24.08.25	11.09.25	550g	Doncaster	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100360	Late NND	5 months	21.04.25	18.09.25	660g	Pinders	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100449	NND	21+2	26.09.25	26.09.25	410g	HUTH	HUTH	HUTH	N/A	No	Yes	‘Not suitable for R/V’	‘Not suitable for R/V’	‘Not suitable for R/V’
	100467	Late NND	66 days	28.07.25	27.09.25	2710g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100766	Antenatal stillbirth	26+3	16.10.25	16.10.25	780g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes

Q3 25/26	100869	Intrapartum stillbirth	37+6	21.10.25	21.10.25	2825g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	Yes	Yes
	101373	Intrapartum stillbirth	39+2	26.11.25	26.11.25	3420g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	Yes	Yes
	101427	Early NND	37+1	30.11.25	30.11.25	2815g	DPOW	DPOW	HUTH	Yes	Yes	No	Yes	Yes	Yes
	101629	Antenatal stillbirth	22+6	13.12.25	13.12.25	495g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	April Planned
	101730	Early NND	25+0	20.12.25	22.12.25	755g	UHLT	UHLT	HUTH	Yes	No	Yes	Yes	On track	Planned April
	101816	Antenatal stillbirth	35+0	23.12.25	23.12.25	2435g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	April Planned
	101817	Antenatal stillbirth	25+0	23.12.25	23.12.25	597g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	April Planned
	102014	Antenatal stillbirth	38+2	13.01.26	13.01.26	3125g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	May Planned
	102078	Antenatal stillbirth	35+3	16.01.26	16.01.26	2490g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	May Planned

Q4 25-26	102116	Neonatal Death	Early NND	08.01.26	20.01.26	2800g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	On track	May Planned
	102257	Antenatal stillbirth	33+1	29.01.26	29.01.26	2065g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	May Planned
	102252	Early Neonatal Death	25+4	10.01.26	29.01.26	540g	Pinders	Pinders	Pinders	Yes	No	Yes	Yes	On track	June Planned
	102356	Neonatal Death	22+6	29.01.26	04.02.26	445	York	HUTH	HUTH	Yes	No	Yes	Yes	On track	June Planned
	102365	Neonatal Death	Early NND	02.02.26	06.02.26	2040	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	June Planned
	102412	Neonatal Death	23+6	09.02.26	09.02.26	585g	DPoW	HUTH	HUTH	Yes	No	Yes	Yes	On track	June Planned
	102422	Neonatal Death	24+5	10.02.26	10.02.26	705g	Pinders	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102423	Neonatal Death	26+6	24.01.26	10.02.26	946g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102477	Neonatal Death	24+	22.01.26	15.02.26	650g	ULTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned

	102539	Antenatal stillbirth	35+3	17.02.26	17.02.26	1690g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	July Planned
	102771	Antenatal stillbirth	25+6	07.03.26	07.03.26	365g	SGH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	102836	Late Misc	23+5	14.03.26	14.03.26	575g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	102879	Antenatal stillbirth	32+1	16.03.26	16.03.26	1190g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	103099	Neonatal Death	23+4	20.03.26	21.03.26	650g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	102836	Antenatal stillbirth	23+5	08.03.26	08.03.26	575g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	August Planned
	102829	MTOP	26+6	10.03.26	10.03.26	765g	HUTH	HUTH	HUTH	Notification only	No	Yes	Notification only	Notification only	Notification only

Appendix B – Summary of all incidents reviewed through PMRT and reviews completed/moved to report writing in Q4 2025-2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
100249	PPROM, Cervical incompetence	A/B/A	No maternity issues Neonatal issues x2 (BP monitoring and management)	No maternity issues Neonatal action x1 (Educational support regarding BP monitoring)	Yes
100090	MUSK Variant Congenital Myasthenia syndrome	A/B/A	Nil	Nil	Yes
100766	Undetermined	B/A	No pre-conception care when on SSRI PLGF not performed	Preview pre-conception care as part of NHSE maternal care bundle PLGF QI project via AMAT	Yes
100143	1a) HIE 1c) PPROM, maternal PIH	-/A/A	Neonatal action Not possible to tell if religious support was offered	Nil	Yes
100467	1a) Mitochondrial DNA Depletion Syndrome 12A (MTDPS12A) 1b) Cardiomyopathy	A/A/A	Nil	Nil	Yes
100360	Extreme prematurity at 24 weeks and 6 days	B/B/B	Missed IVABXs Partogram not used	Communicating with staff regarding partogram use and IVABXs	Yes
101373	Undetermined	B/B	Did not follow GAP protocol (local policy) Placenta not sent for histology	Safety brief and MIRM learning shared with all staff regarding GAP pathway with suspected LGA	Yes
101427	1a - Grade 4 HIE 1b - DIC 2 - Placental abruption	B/B/B	No HUTH Issues	No HUTH Actions	Yes
101730	Grad 4 IVH and persistent pulmonary Hypertension, pneumothorax, prematurity	B/D/A *Did not deliver at HUTH	No HUTH Issues	No HUTH Actions	Yes
101631	Septic shock from enterobacteria Hormaedchei, Prematurity	B/B/A	Partogram not used due to abruption on AN ward MDT discussion of cervical suturing approach	MDT discussion regarding cervical suture approach	Yes

Grading of care

Stillbirth:

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

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

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

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

Neonatal death:

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

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

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

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

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

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

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

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Q4 Jan – Mar 26
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	4/4 (100%)	8/8 (100%)	5/5 (100%)	12/12 (100%)	7/7 (100%)	16/16 (100%)
Cases applicable for PMRT review are applicable to the following standards (n=46)							
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%)	10/10 (100%)	7/7 (100%)	16/16 (100%)
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	3/3 (100%)	8/8 (100%)	3/4 (75%)	8/8 (100% - 2 allocated to different trust)	7/7 (100% - 2 allocated to different trust)	15/16 (94% - 1 joint case and ongoing)
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3/3 (100%)	8/8 (100%)	4/4 (100%)	8/8 (100%)	5/7 (71%, 2 cases ongoing, in timeframe, 1 external)	All ongoing, in timeframe.
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT. (from 02/04/2025)	**50%**	N/A	N/A	4/4 (100%)	8/8 (100%)	5/7 (71%, 2 cases ongoing, in timeframe, 1 external)	All ongoing, in timeframe.
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted January 2025	Submitted April 2025	Submitted July 2025	Submitted October 2025	Submitted January 2025	To be submitted June 26

Appendix D: Learning Points and Key Themes:

Key themes and/or learning identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows:

- Improved PLGF use, QIP registered on AMaT.
- 1 term HIE 3/NND (Cord prolapse at home) well managed over the phone.
- Perinatal optimisation – IV antibiotics not given in 1 case.

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

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)					
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Q4 Jan – Mar 2	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/10 (0%)	0/6 (0%)	0/10 (0%)	0/8 (0%)	0/10 (0%)	**0%**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/10 (0%)	0/6 (0%)	1/10 (10%)	0/8 (0%)	0/10 (0%)	**2.3%**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/10 (0%)	0/6 (0%)	0/10 (0%)	0/8 (0%)	0/10 (0%)	**0%**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/10 (0%)	1/6 (16.6%)	0/10 (0%)	1/8 (12.5%)	0/10 (0%)	**4.5%**

Family Services Division: Maternity Services

Thematic Analysis and Safety Recommendations

Quarter 4 2025/26

Date: May 2026

Author: Natalie Jenkin

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Executive Summary

In March 2026 NHS Resolution published refreshed guidance for the Maternity (Perinatal) Incentive Scheme (Year 8) which has an increased focus on effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents. One of the safety actions (Safety Action C: Learning from reviews and investigations) aims to embed a culture where findings are not only reported but critically analysed for their meaning and impact, focusing on the essential 'so what'. The requirement is for the Trust to produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

The report must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly and should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

The thematic review detailed within the report is based on 4 safety incidents where reports were concluded during quarter 4 (3 PMRT cases and 1 MNSI case). There were no eligible cases completed for a PSIRF review, MOSS or Early Notification Reporting. NHSR claims scorecards are published annually, for the purposes of this report any themes, learning and recommendations from the most recent publication (October 2025) have been included for triangulation.

Themes identified were the lack of following local guidelines/policies and issues of neonatal resuscitation not following the Resuscitation Council algorithm. The learning from the cases has been identified and is being monitored closely.

Scope / Definition

A thematic review is undertaken when the Trust/Organisation identifies common features to a number of patient safety incidents. Common features may include similar location, similar means of harm, similar teams or services. The goal of a thematic review is to enable wider systemic learning from incidents, and to ensure that commonalities between individual incidents and investigations are identified and addressed.

The aim of the formal thematic review is to identify common themes, make recommendations as to future actions to address risks identified and to ensure learning can take place.
A thematic review may be undertaken when:

- Multiple similar incidents occur in one Directorate
- A cluster of similar incidents are identified in one team
- Multiple rare occurrences of an incident happen across several Directorates

Thematic reviews may raise more questions than answers resulting in actions best approached through a quality improvement lens, utilising a PDSA cycle to refine the process.

The findings of the thematic review will be tabled at the Maternity and Neonatal Assurance Group meeting and shared with Trust Board on a quarterly basis. Where necessary it will be

shared with other agencies / Commissioners to enable wider systemic learning in line with the Patient Safety Incident Response Framework (PSIRF) principles.

Background

Patient safety incidents result from multiple interactions between work system factors. The systems engineering initiative for patient safety (SEIPS) framework prompts us to look for interactions rather than simple linear cause and effect relationships. When a learning response thoroughly examines the different work system components and their interactions, safety actions can focus on wider system issues, not individuals.

Over the past 2 years theming has taken place and has been reported as part of the quarterly claims scorecard triangulation, it is hoped that this report strengthens reporting by using the attached theming template that was shared nationally following the MIS webinars in April 2026. The template identifies themes by using a score system which takes into account organisational, task, environment and individual factors.

Investigation Process and Methodology

The process was based on the following methodology:

- Gathered all relevant evidence
- Established the factual circumstances surrounding each event
- Analysed the evidence
- Identified the most significant safety factors and safety issues that contributed to the event being investigated
- Formulated findings and safety recommendations

This process was supported by the following:

- Review of medical records (electronic and paper records)
- Staff interviews
- Patient experience conversations/reflections of their care experience
- Consultation with a subject specialist (e.g., external consultant, MNSI)
- Input/views from Maternity and Neonatal Voice Partnership Lead (MNVP).

Analysis

Safety incidents that were concluded during quarter 4 were reviewed and scored by the Clinical Governance Lead Midwife for Maternity Services using the attached data collection tool in Microsoft Excel to identify recurrent themes across all incidents.

Please refer to the table on page 5 for incident reference numbers included.

Patient Safety Events Included in this Review



NLAG Worksheet inLearning from revie

Date	Incident Reference	Level of Harm Reported	Ethnicity IMD Decile	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
04/08/25	MI-045011	Moderate	White British Decile 1	Baby born by NVD, transferred for therapeutic cooling	Rapid review and MNSI investigation	Learning about holistic review, the use of FSE whilst on CTG and hyperstimulation sent out on Fetal Monitoring Newsletter and included in the mandatory Fetal Monitoring Study Day. All Coordinators booked on to Advanced Neonatal Life Support training. Clarification received to ensure cardiac compressions are taught on the Neonatal Resuscitation annual update and the importance of following the resuscitation algorithm. Implementation of oxygen cylinders being available for midwives to change on the resuscitaires during active resuscitation.

Date	Incident Reference	Level of Harm Reported	Ethnicity IMD Decile	Description	Level of Investigation Prior to Thematic Review	Actions Taken as a Result of any Previous Review
27/10/25	100922	No harm	Black African Decile 9	Antepartum stillbirth at 27+1 weeks	Rapid review and PMRT review	Cherished Pathway documentation not completed which has been disseminated within the PMRT Newsletter. Investigation with Transfusion Services as to why the Kleihauer bloods were not processed despite sending to the lab. Learning disseminated within the Pathology Team.
07/10/25	100630	No harm	White British Decile 1	Antepartum stillbirth of a triplet, born at 28+0 weeks	Rapid review and PMRT review	Email to all Antenatal staff to remind them of the content of the DNA policy. Concerns of neonatal resuscitation being performed and the algorithm not being followed appropriately.
30/11/25	101427	No harm	White British Decile 9	Neonatal death at 2 days following antepartum haemorrhage	Rapid review, PMRT review and awaiting MNSI report	Email sent to all staff about risk assessments being completed to identify Consultant Led care (previous SGA). Newsletter sent to all neonatal staff to ensure the use of the skin temperature probes during resuscitation.

Findings

It has been identified through the thematic review of the four eligible cases from Q4 that the main themes are:

- Policies not being followed.
- Training issues – in particular neonatal resuscitation and the failure to follow the Resuscitation Council algorithm and a lack of compliance with Advanced Neonatal Resuscitation (NLS) training competence.

Areas for improvement:

- Changes to be made to actions about not following local guidance. To review how these learning lessons are produced and disseminated.
- Attendance of all Labour Coordinators to the NLS Resuscitation Council Training to gain competence of Advanced Neonatal Resuscitation training and all shifts to have an NLS competent midwife.
- Close monitoring of the NLS compliance for all Labour Coordinators and ensure that there is always a NLS competent midwife on shift.
- Local yearly neonatal resuscitation update training reviewed to ensure the neonatal resuscitation algorithm is included within it.

Review of 2024/2025 Annual Maternity Claims Scorecard

The following suggested learning points have been drawn solely from a review of the claims data provided within the annual Scorecard.

- Failures or delays in treatment remain the most common cause of claims (31%), followed by failures or delays in diagnosis (13.8%), together accounting for almost 45% of all maternity claims.
- The most severe injuries seen in the dataset, including fatalities, stillbirths, cerebral palsy, and other neurological harm, are closely linked to delays in recognising and responding to fetal distress during labour.
- Bladder and urinary tract injuries associated with caesarean section represent a recurring theme of harm, often resulting in multiple corrective procedures and long-term symptoms.
- High-value claims are predominantly driven by failures in CTG interpretation, continuous fetal monitoring, and timely escalation, particularly where labour risk factors emerge or evolve.
- Issues linked to workload pressures and transfers, including intermittent or interrupted monitoring during handover or changes in setting, appear in several of the costliest claims.
- At least one case demonstrates risks associated with operator competence and inadequate senior supervision during complex obstetric procedures.

Safety Recommendations

Annual Maternity Claims Scorecard - Recommendations

1. Strengthen fetal monitoring and escalation pathways Reinforce adherence to national CTG guidance, including clear escalation points and senior review when abnormalities persist or risk factors emerge.

2. Improve reliability of intrapartum risk assessment Ensure dynamic risk assessments are maintained throughout labour, particularly during transfers or workload pressures, and appropriately trigger obstetric led care.

3. Governance and oversight of operative births Enhance supervision structures for staff with training needs or restrictions and ensure senior presence or oversight during high-risk caesarean sections.

4. Targeted learning from severe harm cases Continue multi-disciplinary reviews of all cerebral palsy, HIE, stillbirth and severe maternal injury cases under PSIRF, with a focus on avoidable delays and decision making gaps.

5. Escalation culture and situational awareness Support decision-making and psychological safety to ensure midwives and staff escalate concerns promptly, even when workload pressures or competing priorities exist.

6. Improve monitoring continuity during transfers and service congestion Review handover and monitoring processes between sites/teams to prevent interruption to fetal surveillance during busy periods.

Q4 Claims Scorecard has not been received as yet within the Care Group and will form part of the next Quarterly Theming Report

Supporting Documents

- NHS England (2022). SEIPS Quick Reference and Work System Explorer
- NHS England (2022), Top Tips for Completing a Thematic Review
- NHS England (2020). Patient Safety Incident Response Framework Contributory and mitigating factors classification
- Samantha Machen (2023) *Thematic reviews of patient safety incidents as a tool for systems thinking: a quality improvement report.* BMJ Open Quality, doi: https://bmjopenquality.bmj.com/content/12/2/e002020
- Six Phases of Reflexive Thematic Analysis
- Quality Improvement: A Facilitators Guide to Quality Improvement
- Maternity (Perinatal) Incentive Scheme Year 8 v1.0 (2026)
- NHS Resolution Maternity Scorecard (2025)

Appendix 1 – Sample Data Collection Template

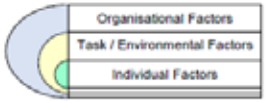
Patient Safety Incident Reference									Recurrence of theme across all incidents	Were any of these factors identified as an area of good practice? (Y/N - if Y, make a note of good practice as evidence for the report)
Contributory and Mitigating Factors - score 1 if they apply										
Domain	Components								Total	
External context factors	National guidelines and policies								0	
	Economic and regulatory context								0	
	Societal factors								0	
	Themes within domain total	0	0	0	0	0	0	0		
Organisational Strategic Factors	Structure								0	
	Priorities/resource								0	
	Safety culture								0	
	Policies, standards, and goals								0	
	Themes within domain total	0	0	0	0	0	0	0		
Operational Management Factors	Safety focus								0	
	Work planning and delivering								0	
	Staffing levels and skill mix								0	
	Workload, shift pattern, hours of work								0	
	Training								0	
	Staff supervision								0	
	Staff competence								0	
	Themes within domain total	0	0	0	0	0	0	0		
Workplace Factors	Environment factors								0	
	Design of physical environment								0	
	Administrative factors								0	
	Themes within domain total	0	0	0	0	0	0	0		
Equipment & Technology Factors	Display								0	
	Integrity and maintenance								0	
	Positioning and availability								0	
	Usability/design								0	
	Themes within domain total	0	0	0	0	0	0	0		
Team & Social Factors	Culture								0	
	Team structure and consistency								0	
	Leadership								0	
	Communication management								0	
	Verbal communication								0	
	Written communication								0	
	Non-verbal communication								0	
	Themes within domain total	0	0	0	0	0	0	0		
Task Factors	Clinical condition								0	
	Plans/policies/procedures in place for task								0	
	Decision making aids								0	
	Procedural or task design and clarity								0	
	Themes within domain total	0	0	0	0	0	0	0		
Individual Patient Factors	Physical factors								0	
	Social factors								0	
	Psychological factors								0	
	Themes within domain total	0	0	0	0	0	0	0		
Individual Staff Factors	Physical health								0	
	Psychological factors								0	
	Social/domestic factors								0	
	Personality factors								0	
	Social factors								0	
	Cognitive factors								0	
	Themes within domain total	0	0	0	0	0	0	0		

Appendix 2 – PSIRF Contributory & Mitigating Factors Classification

NHS

Patient Safety Incident Response Framework

Contributory and mitigating factors classification – Print only in A3



External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Operational management factors	Components
Safety focus	• Rule compliance • Dealing with risks from past incidents • Awareness of current practice • Adherence to current practice • Empowerment of staff to act
Work planning and delivery	• Risk management plans • Scheduling • Incentive schemes • Contingency planning
Staffing levels and skill mix	• Skill mix • Staff to patient ratio • Workload/weighting/dependency • Temporary staff • Staff turnover
Workload, shift patterns, hours of work	• Working hours • Work breaks • Workload (under/over/balanced) • Extraneous tasks • Social relaxation, rest and recuperation
Training design	• Training needs analysis • Training design • Training/education content • Targeted training • Style of delivery • Time of day provided
Training availability/accessibility	• Training availability/accessibility • Core skills training • On the job training • Emergency scenario training (skills drills) • Team training • Refresher training
Staff supervision	• Orientation • Personal supervision • Monitoring of supervision (assessment) • Mentorship
Staff competence	• Knowledge • Skill • Experience • Familiarity with task • Competence testing and assessment

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information Interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

Team and social factors	Components
Culture	• Approach to newcomers • Approach to adverse events • Approach to conflict • Approach to rules/regulations • Approach to seeking support • Approach to interprofessional challenge • Interpersonal relationships • Power relationships
Team structure and consistency	• Shared understanding • Familiarity • Mutual respect • Clarity of roles and responsibilities • Congruence of roles and responsibilities • Informal support networks
Leadership	• Clinical leadership • Managerial leadership • Leadership impact • Leadership decision-making • Timeliness of leadership action • Respect for leadership • Formal support networks for staff
Communication management	• Communication strategy and policy documents • Involvement of patient/family/carers in treatment and decisions • Communication of risks to patient/family/carers • Communication of risks to staff • Communication of risks to the board • Information from patient/family/carers • Communication flow to staff up, down and across • Communication with other agencies (partnership working) • Measuring effectiveness of communication
Verbal communication	• Tone of voice • Style of verbal communication delivery • Use of language • Specificity • Direction • Channel/route • Verbal communication aids/equipment
Written communication	• Readability • Accessibility/availability • Collated • Completeness • Contemporaneous • Accuracy • Currency • Circulation of written information • Patient identification • Information to patients
Non-verbal communication	• Body language/gestures/facial expression

Task factors	Components
Clinical condition	• Pre-existing co-morbidities • Complexity of condition • Seriousness of condition • Options available to treat condition
Plans, guidelines, policies, procedures and protocols	• Informative • Instructional • Representative • Routine use • Usability • Currency • Accuracy • Availability • Accessibility (ambiguous, complex, irrelevant, incorrect) • Monitoring • Review • Targeting/focus (ie audience)
Decision-making aids (information/results/ tools/machines, etc)	• Available • Accessible • Working • Accurate • For prioritisation of tasks • Access to specialist advice • Access to technical information, flow charts and diagrams
Procedural or task design and clarity	• Task complexity • Task memorability • Understandable • Agreed with staff (feasibility) • Time allocation • Task sequencing/stage sequencing • Workload (under/over/balanced) • Compatibility of tasks/task stages • Competing task demands • Feedback from the task • Transferability to/from other situations • Influence on task/outcome • Automation • Audit, quality control, quality assurance

Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 4 2025/26)

Yvonne McGrath
Group Director of Midwifery – Family Services Care Group

April 2026

1. INTRODUCTION

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

1.1 MBRRACE-UK reporting requirements and PMRT support:

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

2. STANDARDS

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

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

3. SUMMARY

3.1 Eligible Incidents

There has been a total of 24 incidents reported to MBRRACE-UK via the PMRT between the 01 December 2024 and the 31st March 2026:

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2024	1	0	0
Q4 (01 Jan – 31 Mar 25)	2	0	0
Q1 (01 Apr – 30 Jun 25)	4	0	0
Q2 (01 Jul – 30 Sept 25)	1	1	0
Q3 (01 Oct – 31 Dec 25)	7	2	2
Q4 (01 Jan – 31 Mar 26)	4	0	0
Total	**19**	**3**	**2**

Of the 24 incidents, 19 were eligible for review and full assessment against CNST standards, 2 babies were still alive (triplets of a reportable case) and 3 cases were reported to MBRRACE but were for notification only (2 termination of pregnancy, 1 neonatal death at 21 weeks) and therefore not eligible for full assessment against CNST standards or review.

Of the 22 perinatal deaths, 3 met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) and have been reported accordingly. 2 babies passed away at NLAG, 1 case was accepted and an investigation is complete, 1 case was rejected due to no consent obtained from the family and has therefore been reviewed internally by the Learning Response Panel and via a rapid review to identify any learning. 1 baby passed away at HUTH following transfer for neonatal care from NLAG, referral to MNSI was completed by NLAG, the death was reported to MBRRACE by HUTH and is being investigated by MNSI as well as being jointly reviewed via the PMRT process.

In addition, please note there are 12 further cases registered with MBRRACE where the deaths occurred at other Trusts but NLAG contributed to the care provided. It is the responsibility of the other Trusts to complete the PMRT process with joint input and have local NLAG action plans where required.

3.2 Summary of all incidents reviewed through PMRT in Quarter 4 2025/26 (Appendix B)

There have been 3 incidents reviewed through the PMRT process, 2 where the death occurred at NLAG (2 antepartum stillbirths) and 1 where the death occurred in another Trust but the care/PMRT review was joint with NLAG (x1 NND). This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby.

3.3. Grading of Care

At the conclusion of the multidisciplinary review the team agree the grading of care, the categories and outcome following review of the 3 cases are as follows:

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

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

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

- 1 case had no issues identified that would have had an impact on the outcome
- 2 cases had issues identified that would have had no impact on the outcome
- 0 cases had issues identified that were likely to have made a difference to the outcome for the baby.

Grading of care provided to the mother following confirmation of the death of the baby

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

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

The Trust achieved full compliance for cases reported in MIS year 7. Please refer to Appendix C for further breakdown.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

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

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

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

Appendix A – Summary of eligible incidents for full PMRT

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

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

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q1 25/26	**98971**	Antepartum stillbirth	36+4	11/06/25	11/06/25	1990g	SGH	SGH	SGH	Yes	No	Yes	Yes	Yes	Yes
	98745	Late fetal loss	22+6	25/05/25	25/05/25	532g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Yes	Yes
	98741	Early neonatal death	37+4	23/05/25	23/05/25	1606g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Yes	Yes
	98007	Antepartum stillbirth	38+2	01/04/25	01/04/25	2870g	SGH	SGH	SGH	Yes	No	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q2 25/26	**99969**	Antepartum stillbirth	30+5	26/08/25	26/08/25	1718g	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q3 25/26	**101451**	Antepartum stillbirth	25+0	28/11/25	28/11/25	450g	DPOW	DPOW	DPOW	Met	No	Yes	Yes	Not yet met	Not yet met
	101307	Antepartum stillbirth	35+6	24/11/25	24/11/25	2186g	DPOW	DPOW	DPOW	Met	No	Yes	Yes	Yes	Yes
	100922	Antepartum stillbirth	27+1	27/10/25	27/10/25	828g	DPOW	DPOW	DPOW	Met	No	Yes	Yes	Yes	Yes
	100801	Antepartum stillbirth	29+5	18/10/25	18/10/25	2046g	DPOW	DPOW	DPOW	Met	No	Yes	Yes	Yes	Yes
	100797	Neonatal Death	35+0	17/10/25	18/10/25	2540g	SGH	SGH	SGH	Met	No	Yes	Yes	Yes	Yes
	100659	Late fetal loss	22+1	08/10/25	08/10/25	174g	SGH	SGH	SGH	Met	No	Yes	Yes	Yes	Yes
	100630	Antepartum stillbirth	28+0	07/10/25	07/10/25	1436g	DPOW	DPOW	DPOW	Met	No	Yes	Yes	Yes	Yes

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Q4 25/26	**102786**	Antepartum stillbirth	24+1	10/03/26	10/03/26	650g	DPOW	DPOW	DPOW	Not yet met	No	Yes	Yes	Not yet met	Not yet met
	102460	Antepartum stillbirth	25+3	12/04/26	12/04/26	200g	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet met	Not yet met
	102342	Antepartum stillbirth	35+6	02/02/26	02/02/26	2710g	Out of country transfer to DPOW	DPOW	DPOW	Not yet met	No	Yes	Yes	Not yet met	Not yet met
	102001	Antepartum stillbirth	38+5	09/01/26	09/01/26	3260g	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet met	Not yet met

Appendix B – Summary of all incidents reviewed through PMRT in Q4 of 2025/2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?	Discussed at Learning Response Panel?
100922	Antepartum stillbirth	B / B	Cherished Care Pathway not fully completed so difficult to ascertain whether all care received. Not possible to tell form notes if parents were informed of PMRT process. Kleihauer not tested by pathology.	Discussion with bereavement midwives for inclusion on mandatory training days and PMRT packs to be made for ward staff to discuss with parents. Escalation email sent to pathology.	Yes	N/A
100630	Antepartum stillbirth	B / A	DNA policy not followed for missed appointments.	ANC Managers to remind all staff to refamiliarize themselves with the DNA policy and ensure further appointment made.	Yes	N/A
101427	Neonatal Death	B / B / B	Risk allocation at booking was incorrect based on her history. Type of care received was inappropriate for her risk allocation. Serial scans were not planned. Baby's temperature not maintained within normal range during resuscitation.	Email reminder to all staff to highlight risk categories and discussion with ANC Managers. Education from Governance via newsletter to inform the neonatal team to always use skin temperature probes for resuscitation events. Neonatal Newsletter with learning to be disseminated to all staff.	Yes	N/A

Grading of care

Stillbirth:

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

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

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

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

Neonatal death:

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

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

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

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

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

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

Appendix C – Summary of CNST

Compliance as per MIS Year 7 standards (01/12/24 – 31/03/26)

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	Q4 Jan – Mar 26
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%)	7/7 (100%)	4/4 (100%)
Cases applicable for PMRT review are applicable to the following standards (n=19)							
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	95%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)	2/2 (100%) **2 not yet met**
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	95%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)	4/4 (100%)
Multi-disciplinary reviews should be published within six months of the death.	75%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)	4 not yet met
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	50%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	6/6 (100%) **1 not yet met**	4 not yet met
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	Submitted Oct 2025	Submitted Feb 26	To be submitted June 26

Appendix D: Learning Points and Key Themes:

Key themes and or learning identified from **Q4** cases PMRT or continued from previous quarterly reviews are as follows:

- Documentation of bereavement care requires improvement as it is not always possible to tell from the notes whether the bereavement pathway was followed or the required information was offered/provided.
- Escalation required to pathology to ensure Kleihauer bloods are tested as per policy.
- Incorrect risk allocation at booking resulted in inappropriate care and serial scans not being undertaken.
- Refresher email for staff to follow DNA policy to ensure women are re-appointed
- During resuscitation baby's temperature was not maintained within normal range.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Q4 Jan – Mar 26
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/5 (20%)	1/5 (20%)	1/4 (25%)	2/4 (50%)	1/3 (33%)
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	3/5 (60%)	0/5 (0%)	2/4 (50%)	0/4 (0%)	0/3 (0%)
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/5 (20%)	0/5 (0%)	0/4 (0%)	0/4 (0%)	0/3 (0%)
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	1/5 (20%)	0/5 (0%)	0/4 (0%)	0/4 (0%)	0/3 (0%)

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 4

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

NHS Humber Health Partnership

Claims Scorecard 01 April 2015 – 31 March 2025 (55 claims)

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

Claims Breakdown Q4 25/26

Claims closed: 0

New claims opened: 0

Incidents Q4 25/26

Top 5 incidents by volume:

- Re-admission of mother after delivery (24)
- Unexpected admission to NICU (21)
- Delay in induction of labour (18)
- Staffing levels affecting patient care (16)
- Delay in treatment or procedure (15)

Number of incidents reported on Ulysses for Obstetrics / Maternity: **454**

Complaints Q4 25/26

There have been 12 new complaints received relating to the following categories:

- 3 Clinical care and communication
- 4 Clinical care
- 2 Clinical treatment
- 1 Clinical care and treatment
- 1 Misdiagnosis
- 1 nursing care

Clinical Audits Registered Q4 25/26

- Saving Babies' Lives Q4 (Elements 1 – 6)
- (HHP) National Comparative Audit on the use of prophylactic anti-D in pregnancy
- (HHP) Use of Interpreter in Maternity Services
- (HHP) Home Birth Audit
- Fresh Eyes Audit

Deep Dive Reviews Q4 25/26

In progress:

- Postpartum Haemorrhage (>1000mls) following an increase in September 2025 (SGH).
- ATAIN (TWD)
- Induction of Labour

To be commenced:

- Preterm birth

Learning Q4 25/26
Locums and new starters were not being formally trained or have competency assessment in scrubbing to receive the baby in theatre.

Themes Q4 25/26
· Increase in postnatal readmissions following delivery · MNVP feedback and complaints indicate women feel they are not being listened to. · Bereavement documentation checklists not completed appropriately. · Delayed cord clamping not always undertaken.

Action Plan Q4 25/26	Not started / In progress / Complete	
Bereavement Midwife to commence in post (Trustwide).	April 2026	
Training to be provided for all staff who scrub to receive the baby in theatre to promote delayed core clamping.	April 2026	
Resuscitation platform to be trialled in SGH theatre (brought from Grimsby).	01 June 2026	
Deep dive review into postnatal readmissions	June 2026	
Anonymised complaints are to be presented at ward meetings.	From April 26 onwards	

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FAMILY SERVICES DIVISION

Saving Babies Lives V3.2 Quarterly Report
HUTH and NLAG

Reporting period: Quarter 4 2025/26

Yvonne McGrath – Group Director of Midwifery

May 2026

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

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Background
The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Version three by March 2024. A new implementation tool was made available to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three.

The update of SBLCBv3.2, maintained an approach of continuous improvement. Within each element the focus is on a small number of outcomes with fewer process measures. Implementation of the elements require a more comprehensive evaluation of each organisation's processes and pathways and an understanding of where improvements can be made.

Introduction
The aim of this report is to provide a quarterly update on the implementation of all six elements of the Saving Babies Lives care bundle v3.2.

MIS Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle with Trust Board oversight of progress with implementation on a quarterly basis. It is expected that Trusts maintain high level of compliance whilst making meaningful improvements and moving towards embedding this as business as usual. In previous years the LMNS have carried out peer assurance reviews, however this is no longer required as part of MIS year 8, any additional assurance arrangements (in addition to Trust Board oversight) are yet to be confirmed.

Saving babies lives audits for quarter 4 2025/26 have been completed to provide continued assurance that that both Trusts are maintaining a consistent high level of compliance against the agreed interventions whilst striving to improve in areas that have not been achieved.

Executive Summary
The table below provides an overview of compliance for quarter 4 2025/26 based on the latest self-assessment using the national implementation tool.

% of interventions fully Implemented	**Self-assessment**	**Self-assessment**
Site	**HUTH**	**NLAG**
Element 1: Smoking in pregnancy	70%	90%
Element 2: Fetal growth restriction	95%	95%
Element 3: Reduced fetal movements	50%	50%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	88%	85%
Element 6: Diabetes	100%	83%
TOTAL	**88%**	**88%**

Please refer to page 9 for a detailed breakdown for each site.

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle elements:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Fetal Growth: Risk assessment, surveillance, and management
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth and optimising perinatal care
- Element 6: Management of Pre-existing Diabetes in Pregnancy

Overview of Compliance / Actions Taken

Element 1 Reducing Smoking in pregnancy

Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser is offered to all pregnant women who smoke, using an opt-out referral process.

Quarterly audit %	Actions taken and progress made
HUTH **70%**	Compliant interventions: 7/10 Non-compliant intervention: 1.6, 1.9, 1.10 Ongoing difficulty achieving this element regarding smokers who are referred for tobacco dependence treatment who set a quit date, are verified as non-smokers at 4 weeks and 36 weeks, a theme identified regionally. The TDTT to continue to trial different communications methods and have recently implemented 'significant others' as part of the scheme. The TDTT currently ensure a system whereby women receive the same number of calls, with the same minimum gap between calls and messages, to ensure optimum engagement. Potential data discrepancies identified which could be impacting outcome indicators. Many women stop smoking upon referring their pregnancy. A referral is received via direct access however if the booking is more than 2 weeks since the quit date, the TDTT will not be seen by the team. The data will be explored further. There has been a drop in compliance this quarter with CO and VBA training, with some new starters noted. SBL lead liaising with new practice development midwife to review bookings and optimise training dates for new starters.
NLAG **90%**	Compliant interventions: 9/10 Non-compliant requirement: 1.6 Ongoing difficulty achieving this element of the Care Bundle regarding smokers who are referred for tobacco dependence treatment who set a quit date, are verified as non-smokers at 4 week and 36 weeks. The TDTT team continue to engage with pregnant women who are identified as smokers at any point throughout their pregnancy. Engagement following referral remains an issue despite the incentive scheme introduction.

Element 2 Risk assessment and surveillance for fetal growth restriction

Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Quarterly audit %	Actions taken and progress made
HUTH **95%**	Compliant interventions: 19/20 Non-compliant intervention: 2.2 HUTH have been previously compliant for vitamin D recommendation at booking, however deep dives have been conducted due to documentation variations. Emails and texts sent to community midwives previously, along with attending community meetings. Deep dive completed this quarter and similar findings. Target 95%, compliance 92%. To meet with community managers and staff to improve this. Digital lead has already been contacted regarding making this a mandatory field. Digital Lead reports mandating this field is not possible.
NLAG **95%**	Compliant interventions: 19/20 Non-compliant requirement: 2.7 There are currently ongoing process changes to ensure women at DPOW are offered a uterine artery doppler without having to travel to SGH following the roll out of training to sonographers. A further audit will be undertaken to assess compliance once the process is embedded.

Element 3: raising awareness for reduced fetal movements

Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Quarterly audit %	Actions taken and progress made
HUTH **50%**	Compliant interventions: 1/2 Non-compliant intervention: 3.2 There are 3 aspects to intervention 3.2. Q2 full compliance was declared for this element of SBL. Following the implementation of SBLCB v3.2, there was an increase in requirements regarding fundal heigh measurements, commencing from 24+0 weeks. This has increased demand for the Ultrasound department. Meetings are in progress at senior level to discuss scanning capacity requirements as the previous business case was based on v2 and the department is breaching targets for scan referrals.
NLAG **50%**	Compliant interventions: 1/2 Non-compliant requirement: 3.2 The intervention specifies that women presenting with recurrent reduced fetal movement should have an ultrasound scan by the end of the next working day. Compliance with this intervention is inconsistent as capacity and demand remains an issue. In previous quarters, the intervention was predominantly met as women/birthing people had a fetal growth scan within the 14 days prior to attendance due to a high risk pregnancy and/or being on the serial scan pathway.

Element 4: Effective fetal monitoring during labour

Quarterly audit %	Actions taken and progress made
HUTH **100%**	Full compliance declared with 5/5 interventions. Although there is not the requirement for this to be reported to the LMNS, the Fetal Monitoring team continue spot check audits. All guidelines are in place as required and documented on the implementation tool. Training >90%.
NLAG **100%**	Full compliance declared with 5/5 interventions. Although there is not the requirement for this to be reported to the LMNS, the Fetal Monitoring team continue spot check audits. All guidelines are in place as required and documented on the implementation tool.

Element 5: Reducing preterm birth and optimising perinatal care

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.

Quarterly audit %	Actions taken and progress made
HUTH **88%**	Compliant interventions: 22/26 Non-compliant interventions: 5.1, 5.2, 5.20. 5.1 – HHP preterm birth lead midwife post currently out for advert, with interviews planned. Interview completed and job offer made. 5.2 – The preterm birth rate across the trust is higher than the national average, a deep dive is underway to highlight potential opportunities to prevent pre-term and ensure the appropriate optimisation. 5.20 – 5c Magnesium sulphate compliance initially 87% (NNAP data), target 90%. The non-compliant cases were reviewed. One case was a BBA, and if this was excluded from this, compliance would be 93%.
NLAG **85%**	Compliant interventions: 22/26 Non-compliant requirements: 5.1, 5.2, 5.18, 5.19 5.1 – HHP Preterm birth lead midwife is required to complete the pre-term birth team. The post is currently out for advert. 5.2 - The preterm birth rate across the trust remains higher than the national average. A deep dive is being planned to gain a further understanding of any issues and identify potential areas for improvement. 5.18 – 2 babies was born off pathway. All off pathway babies are reviewed as part of clinical governance processes. 5.19 – Compliance for giving a full dose of antenatal steroids was below the 55% target at DPOW (46%). Low compliance is attributed to clinical presentation / with no time to administer the full course prior to delivery.

Element 6: Management of Pre-existing Diabetes in Pregnancy

This covers the management of pre-existing diabetes for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. This element recommends MDT pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes using HbA1c to risk stratify and provide additional support / surveillance, and consistently offering access to evidence-based continuous glucose monitoring and pregnancy-specific hybrid closed loop technology to improve glucose control.

Quarterly audit %	Actions taken and progress made
HUTH **100%**	Compliant with 6/6 interventions.
NLAG **83%**	Compliant interventions: 5/6 Non-compliant requirement: 6.1 6.1 to separation of pre-existing and gestational diabetes clinics is required to meet this intervention. There have been ongoing logistical challenges in arranging extra clinics for the diabetes pathway. Proposal progressing with clinical leads, anticipated that this will be in place by 04/06/26.

Action Planning

As part of the quarterly reviews, separate reports and action plans are devised for each of the elements. All agreed actions are detailed within the reports and monitored until completion.

Fetal growth chart update

Both HUTH and NLAG currently use the Perinatal Institute GROW 2.0 fetal growth charts and are compliant with the surveillance pathways as required in SBLVB v3.2 guidance.

Safety intelligence, themes and learning

A pan group preterm birth deep dive is being undertaken to review pathways of care. Element 5 continues to be the area where improvement is required, however this remains a challenge due to the nature of presentation and opportunity to optimise birth. It is hoped that once the preterm birth midwife is in post greater focus can be placed on improvement. Mutual aid to neighbouring Trusts continues to be offered to women in pre-term labour due to the lack of NICU cots across the network. The aim of the deep dive is to identify any themes arising from transfers in separate to areas for improvement across the group.

Ultrasound capacity continues to be a concern across the Group with actions underway to address in the short-term, but a long-term plan will need to be developed. This is impacting compliance for different elements of SBL for both Trusts. This has been previously escalated and is on the risk register.

Although both Trusts are non-compliant for recommendation 1.6 regarding quit rates, the MNVP has provided feedback that service users have praised the support provided by the TDTT throughout pregnancy and in the long-term postnatal period.

Appendix A: Breakdown of Compliance

Q4 data (January – March 2026)

Element 1: Reducing Smoking in pregnancy							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
1.1	1a i)	Percentage of women where CO measurement is recorded at booking.	90%	98%	90%	92%	94%
	1a ii)	Percentage of women where CO measurement is recorded at 36 weeks	80%	95%	80%	93%	94%
1.2		CO testing offered at all other antenatal appointments - V3.2 update.	Guideline in place				
1.3	1a iii)	Percentage of women where their smoking status at booking is recorded	80%	100%	80%	99%	99%
	1a iv)	Percentage of women where their smoking status at 36 weeks is recorded	80%	98%	80%	94%	98%
	N/A	Percentage of women where their smoking status is recorded at all antenatal appointments – V3.2 update.	Guideline in place		Guideline in place		
1.4	1b)	Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	90%	93%	90%	95%	91%
1.5	N/A	NRT should be offered to all smokers as soon as possible	Guideline in place				
1.6	1c)	Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	40%	24%	40%	15%	20%
	1e)	Percentage of smokers that set a quite date are identified as CO verified non-smokers at 4 weeks	40%	33%	40%	53%	47%
	1d)	Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks.	40%	2%	40%	29%	41%
1.7	N/A	Percentage of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointment with their in-house tobacco dependence treatment service	50%	100%	80%	93%	87%
1.8	N/A	Percentage of staff within date training compliance on the use of a CO testing and discussion of results	80%	85%	90%	91%	
1.9	N/A	Percentage of staff providing maternity care with annual in date training compliance on the delivery of VBA making an opt-out referral and maternity pathway processes	90%	87%	90%	91%	
1.10	N/A	Percentage of individuals delivering tobacco dependence treatment interventions who are fully trained to NCST standards	90%	100%	90%	100%	

Element 2: Fetal Growth: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
2.1	N/A	Percentage of women booked who had a completed risk assessment undertaken for Aspirin	95%	99%	95%	96%	98%
2.2	N/A	Percentage of women booked who are recommended vitamin D supplementation	95%	92%	95%	97%	96%
2.3	N/A	Assess smoking status and manage findings as per element 1	Guideline in place				
2.4	2a)	Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.	80%	100%	80%	100%	100%
2.5	N/A	During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff	SBLv3 GROW Tick list (system supplier evidence)				
2.6	N/A	Blood pressure should be recorded by using a digital monitor that has been validated for use in pregnancy	Implementation Plan			Implementation Plan	
2.7	N/A	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	80%	100%	80%	20%	
2.8	2c)	Percentage of perinatal mortality cases where the identification and management of FGR was a relevant issue	N/A	0%	N/A	50%	
2.9	N/A	When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care	Guideline in place				
2.10	N/A	Women who are at low risk of FGR following risk assessment should have serial measurement of symphysis fundal height (SFH) at each antenatal appointment after 24+0. The first measurement should be carried out by 28+6. Measurements should be plotted or recorded on charts by clinicians trained in their use - V3.2 update.	Guideline in place		Guideline in place		
2.11	N/A	Staff who perform SFH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated.	Training plan in place		Training plan in place		
2.12	N/A	Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. SFH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk	Guideline in place				
2.13	N/A	Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth (3-4 weekly)	Guideline in place				
2.14	N/A	When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements and if required computerised CTG	Guideline in place				
2.15	N/A	Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks	Guideline in place				
2.16	N/A	When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed with local ICSs following advice from the provider's Clinical Network and/or regional team	Guideline in place				
2.17	N/A	Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that must be agreed by both the local ICSs and the regional maternity team	Guideline in place				
2.18	2d)	Percentage of babies <3rd birthweight centile born >37+6	<48%	44%	<48%	37%	
2.19	2b)	Percentage of pregnancies where an SGA fetus is antenatally detected (between 3rd & <10th centile)	-	56%	-	24.4%	

Intervention	Process/ outcome indicator	SBL Interventions	Target HuTH	Q4 HUTH	Target NLAG	Q4 SGH	Q4 DPOW
2.20	N/A	Opinion on timing of timing of birth for fetuses with declining growth velocity and EFW <10th, where risk factors are present, should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability	Guideline in place				

Element 3: Raising awareness of reduced fetal movement							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
3.1	N/A	Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact	Guideline in place				
3.2	3a)	Percentage of women who attend with RFM who have a computerised CTG	95%	100%	95%	99%	96%
	3b)	Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth	80%	72%	80%	88%	64%
	3c)	Percentage of stillbirths which had issues associated with RFM management identified using PMRT	-	0%	-	0%	
	3d)	Induction of labour when RFM is the only indication before 39+0 weeks' gestation V3.2 update.	Guideline in place		Guideline in place		

Element 4: Effective fetal monitoring during labour							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
4.1	4a)	Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness	90%	91%	90%	95%	
	4b)	Percentage of staff who have successfully completed mandatory annual competency assessment	90%	91%	90%	95%	
4.2	N/A	There is a structured risk assessment at onset of labour to determine the most appropriate fetal monitoring method - V3.2 update.	Guideline in place		Guideline in place		
4.3	4d)	The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	-	0%	-	0%	
		Regular (at least hourly) systematic review of maternal and fetal wellbeing, with a clear guideline for escalation.	Guideline in place		Guideline in place		
4.4	N/A	A separate clinical review should be undertaken to help provide an objective holistic review, for example 'Fresh Eyes'. All intrapartum CTGs at least hourly or 4 hourly fresh eye review when IA is utilised.	Guideline in place		Guideline in place		
4.5	4c)	Identify a dedicated lead midwife and lead obstetrician with expertise to focus on and champion best practice	In place				

Element 5: Reducing pre-term birth and optimising perinatal care							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
5.1	N/A	Each provider trust should have: an Obstetric Consultant lead for preterm birth, an identified local preterm birth/perinatal optimisation Midwife Lead, a Neonatal Consultant lead and an identified Neonatal Nursing lead	-	Midwife required	N/A	Midwife required	
5.2	5l)	Incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (16+0 to 23+6)	<0.5%	0.3%	<0.5%	0%	0%
		b) preterm (24+0 to 36+6)	<6%	6.5%	<6%	7.4%	7.9%
	5k)	Percentage of PMRT cases annually where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	-	0%	N/A	0%	
	5i)	Mortality to discharge in very preterm babies. Percentage of babies born below 32 weeks gestation who die before discharge home, or 44-week post-menstrual age (whichever occurs sooner)	<6/5%	6%	6.5%	0%	0%
5.3	N/A	Assessment of all women at booking for their risk for preterm birth and stratification to pathways - Guideline in place.	Guideline in place		Guideline in place		
5.4	N/A	In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUiPP) to improve predictive accuracy of triage and enable collaborative decision making	Guideline in place				
5.5	N/A	Networked Trusts should agree on the use of these tools within their ICS/LMNS	Guideline in place				
5.6	N/A	Risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local ICS following advice from the provider's regional maternity team	Guideline in place				
5.7	N/A	Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks	Guideline in place				
5.8	N/A	Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network	Guideline in place				
5.9	N/A	Symptomatic women require assessment and use of decision-assist tools for preterm birth – V3.2 update due to discontinuation of Ffn.	Guideline in place				
5.10	N/A	Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her	Guideline in place				
5.11	N/A	Test for asymptomatic bacteriuria in women who are assessed as being intermediate or high risk of preterm birth by sending off a MSU for culture and sensitivity at booking. Following any positive, repeat MSU to confirm clearance – V3.2 update.	Guideline in place				
5.12	N/A	Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation	Guideline in place				
5.13	N/A	Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories	Guideline in place				

Intervention	Process/ outcome indicator	SBL Interventions	Target HuTH	Q4 HUTH	Target NLAG	Q4 SGH	Q4 DPOW
5.14	N/A	Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur	Guideline in place		Guideline in place		
5.15	N/A	Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth – V3.2 update.	Guideline in place		Guideline in place		
5.16	N/A	Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered.	Leaflet approved		Leaflet approved		
5.17	N/A	Acute tocolysis may be used when short term delay is desirable	Guideline in place				
5.18	5a)	Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)	80%	100%	80%	0%	0%
5.19	5b)	Percentage of babies born between 22+0 to 33+6 who receive a full course of antenatal corticosteroids within 1 week of birth – *see report for potential exceptions.*	55%	74%	55%	67%	46%
5.20	5c)	Percentage of babies being born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth	90%	87%	90%	100%	100%
	5h)	Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with brain injury: IVH grade 3 or 4 – V3.2 update.	<15%	23%	N/A	0%	0%
	5h)	Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with brain injury: cPVL – V3.2 update.	<15%	23%	N/A	0%	0%
5.21	N/A	All women in preterm labour <37 weeks gestation should be offered intravenous intrapartum antibiotic prophylaxis irrespective of whether they have ruptured amniotic membranes – V3.2 update.	Guideline in place		Guideline in place		
5.22	5d)	Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth	72%	78%	72%	100%	83%
5.23	5e)	Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5– 37.5°C and measured within one hour of birth	70%	70%	70%	100%	75%
5.24	5f)	Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within the first 2 days of life	52%	64%	52%	67%	64%
5.25	N/A	For babies born <34 who need invasive ventilation, VTV should be used in combination with synchronised ventilation as the primary mode of respiratory support – V3.2 update.	Guideline in place		Guideline in place		
5.26	N/A	For <30 weeks, caffeine reduced the chance of death or disability. Caffeine citrate should be started within the first 3 days of life.	Guideline in place		Guideline in place		

Element 6: Management of Pre-existing Diabetes in Pregnancy							
Intervention	**Process/ outcome indicator**	**SBL Interventions**	**Target HuTH**	**Q4 HUTH**	**Target NLAG**	**Q4 SGH**	**Q4 DPOW**
6.1	6a)	Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one-stop clinic, providing care to pre-existing diabetes only, which routine offers MDT review and has the resource and skill set to address all antenatal care requirements.	In place		Anticipated implementation by 04/06/26		
6.2	6f)	The percentage of women with type 1 who were offered a pregnancy-specific HCL system during pregnancy – V3.2 update.	45%	100%	80%	100%	100%
	6d)	Demonstrate appropriate expertise to onboard and manage pregnant women using pregnancy-specific HCL – V.3 update.	In place		In place		
6.3	6c)	Women with Type 2 diabetes should have an objective record of their blood glucose levels in hospital record and be offered alternatives (IE CGM_ if not monitoring or glycaemic targets aren't achieved.	Guideline in place				
6.4	6g)	The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women) Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups	80%	87%	80%	100%	100%
6.5	N/A	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e. PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic.	Guideline in place				
6.6	N/A	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	Guideline in place				

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)137

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 June 2026**
Director Lead	**Murray Macdonald, Chair of Performance, Estates and Finance Committees-in-Common**
Contact Officer / Author	**Rebecca Crashley, Deputy Director of Assurance**
Title of Report	**Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report to the Trust Boards**
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on including those matters which the committees specifically wish to escalate to either or both Trust Boards. **Recommendation/s** The Trust Boards-in-Common are asked to note the contents of the report.
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	**All financial implications are included in the report**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**N/A**
Recommended action(s) required	☐ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	✓
Our Patients - Safety	☐
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	✓

V3

ADVISE, ALERT and ASSURE REPORT	
Meeting	Performance, Estates and Finance Committees-in-Common
Meeting date	02 June 2026
Chair	Murray Macdonald, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Finance				
Month 1 Financial performance off plan	• Month 1 adverse out turn of £2.2m (Industrial Action impact is £1.3m across the Group). • YE projection £40.2m adverse • Variable pay £0.6m worse than last year (would be a c£700k improvement without the impact of IA at £1.3m in April 26). • CIP month 1 £4.6m adverse • CIP Year end forecast	Not assured.	Weekly Variable pay tracker in place since 1 April - onboarding an automated system WEF 1 July (Locums Nest) Board session with care groups on CIP and run-rate reduction plans – 16 June Maidstone and Tunbridge Wells and East Kent CEO & CFO scheduled to talk to CoS and Site re-learning and	Updates to the next CiC July 2026

	£46.4m adverse		experience of reducing reliance on variable pay and reduction in WTE. Nicci Briggs and May Li to hold a session on the national reflections on improvement opportunities.	
Performance				
Constitutional Standards off plan	All constitutional standards are below national requirements with no assurance if trajectory will achieve target. Improvements in 4 Hour compliance with both HUTH and NLAG above performance trajectory for Type 1 performance year to date RTT recovery for both NLAG and HUTH in line with operating plan submission for end of May. 62 day cancer performance in NLAG at highest level in over two years and highest in last 12 months at HUTH.	Not assured.	Continued system working with partners across to progress unplanned care work streams being monitored via the Unplanned Care board. Surgical Hub accreditation gained for both Golle and DPoW surgical Hubs in the last month with action plans to be signed off in next 6 weeks for further improvement. Learning from Hub Optimisation weeks to be embedded. Outpatient improvement plan being refreshed with involvement from primary care.	Updates to the next CiC July 2026

	FDS performance at HUTH stabilising. 6 week diagnostic standard off plan in month			
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates and Facilities				
PET CT Tender	Committee recommended option 3 but Board should be aware of the operational, financial and clinical opportunities and risks.	N/A	The CIC approved option 3	
Committee Business				
Work programme currently with Strategic Programmes and Partnership CiC	PEF discussing the Digital, Capital business cases and Partnership working. .	N/A	Deputy Director of Assurance to present a paper to the NED meeting suggesting how the work will be allocated before Board approval. In the interim PEF agree to host Digital and Capital.	June 2026
IPR reporting	The Committee was presented with a revision to the IPR	NA	The IPR has been developed without consulting the NEDs. Meeting to be arranged before final draft being presented to	June 2026

			Board.	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates, Facilities and Development				
Update including Tower Block remediation, Estates Return Information Collection, Premises Assurance Model	Thorough assurance report and debate identified no areas of concern.	Assurance received through comprehensive report and data	None	
Health and Safety Statement	Updated statement was reviewed and approved	Report.	Forward to Board	June 2026

2. Board Assurance Framework (BAF):

The committees considered the areas of the BAF for which it has oversight and has proposed the following change(s) to the risk rating or entry:

The committees considered the areas of the BAF for which it has oversight and no changes are proposed.

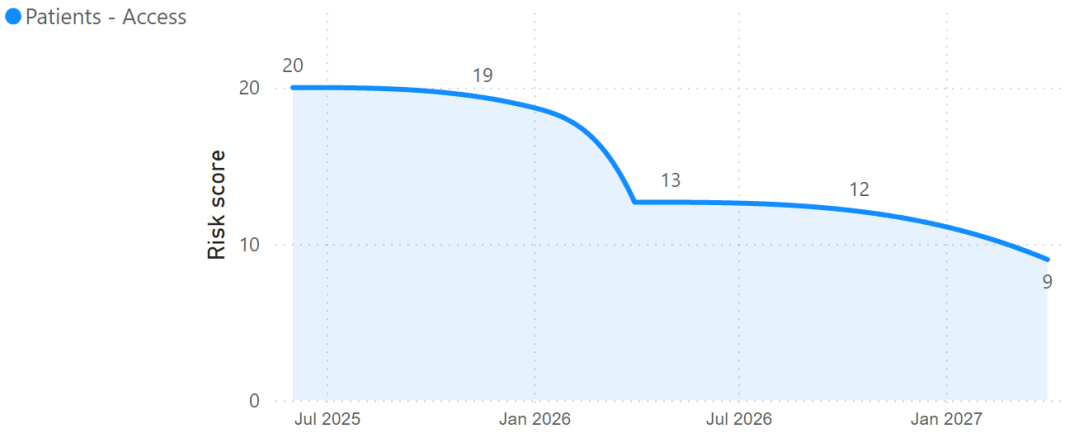
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Sam Peate, 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 03 February 2026. In full, the risk is:

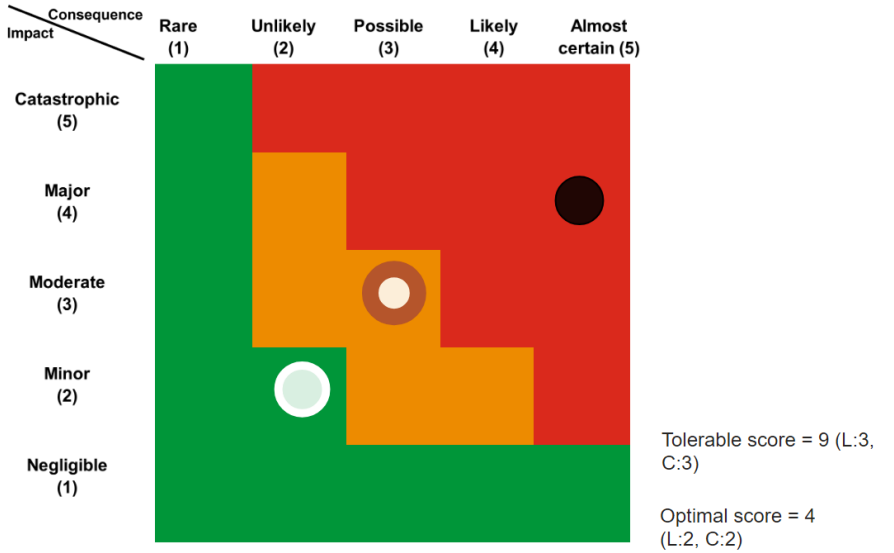
We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.

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 (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)

Meeting our consitutional standard targets are a key objective for the Group. Our willingness to accept operational risk that puts achievement of this objective is therefore cautious. We will accept some degree of risk to improving performance, providing the actions are more likely to improve agreed aspects of constitutional standards.

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
Bed modelling project	Limited
Care Group Performance and Accountability	Limited
Daily / weekly PTL meetings (cancer and elective)	Reasonable
Executive Team	Limited
Flow programme	Limited
Fortnightly check-in with NHSE / ICB	Reasonable
National oversight framework (for support and scrutiny)	Reasonable
Operating plan 2026-27 (draft)	Limited
Operations Director meetings (weekly)	Reasonable
Planned Care Board	Limited
Quality Improvement Group (NHSE led)	Reasonable
Senior Leadership Team (SLT)	Limited
Site Tri meetings	Reasonable
Tier 1 review processes - UEC, Cancer, Elective and Diagnostics	Reasonable
Unplanned Care Board	Limited

Gaps in control (and Action ID)	37	68	75	76	78	79	Total
Challenge in resolving numerous national expectations / targets with available finance, space and resources, degrading or overriding control	✓		✓				2
Embryonic culture of improvement/change management and siloed working	✓	✓					2
Full adherence to planned actions agreed at QIG					⚑	⚑	2
Inert behaviour towards addressing system solutions by ICB	✓						1
Lack of clarity arising from the Care Group structure within the partnership	✓						1
Lack of positive medical engagment in delivery	✓						1
Lack of sufficient capacity to identify and implement service improvement gains from exemplar sites or best practice	✓						1
Weak pockets of team working within the Group partnership				⚑			1
Total	4	2	1	1	1	1	1	11

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	2026-28 Operational Plan with Assurance Statements	Limited
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Reasonable
Internal	Global daily emails on UEC performance	Limited
Internal	Integrated Performance Report	Reasonable
External	National Operating Framework segment	Limited
External	NHS tiering arrangements and support or freedoms	Reasonable
External	NHSE Provider Board Capability assessment	Minimal
Internal	Planned Care Board reporting to Performance, Estates & Finance CiC	Limited
External	Provider licence compliance	Minimal
Internal	Unplanned Care Board reporting to Performance, Estates & Finance CiC	Limited

Assurance gaps (and Action ID)	53	74	78	79	Total
Absence of a sophisticated demand and capacity (bed) model that supports scenario analysis and planning	✓	✓			2
Capability Rating of Red			⚑	⚑	2
Non compliance with provider licence condition NHS2.2, NHS2.5 (a to g), NHS2.6 (a to f)			⚑	⚑	2
Total	1	1	2	2	6

A green flag or arrow indicates a recent addition / change to the report.

2. Patients - Access

NHS Humber Health Partnership

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

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
37	Developing skills and capability of Care Group leadership to support D&C planning and associated operational tasks	31/03/26	01/04/27	B7 to 8b ops courses made available but yet to identify recurrent resources to support	18/12/25	Group Chief Delivery Officer	Limited
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 domains of finance, activity and workforce	18/12/25	Group Chief Delivery Officer	Reasonable
68	Separation and clarification of north and south operations where structural change is not required e.g. bed meetings	31/12/25	31/03/26	Weekly PTL meetings in place and reinvigorated	18/12/25	Group Chief Delivery Officer	Reasonable
74	Produce an internal bed modelling tool to achieve appropriate bed balance (site, elective / non-elective). To also interface with wider system bed modelling.	30/09/26	31/03/27	Initial bed modelling work presented to SLT (24/2/26). Noted some limitations in the model (north more advanced than south). Further 'what-if' work to follow with clinical and inclusion of positive factors; frailty SDEC, admission avoidance, Teletracking.	24/02/26	Group Chief Delivery Officer	Reasonable
75	Execution of RTT recovery actions (65 and 52-week waiters to zero, for elective, diagnostics and cancer pathways)	31/03/27	31/03/27		03/02/26	Group Chief Delivery Officer	Limited
76	Execution of UEC recovery plan	31/12/26	31/03/27	Latest actions: Red lines and Professional standards being agreed	24/02/26	Group Chief Delivery Officer	Limited
78	Improvement Plan and Operating Plan submission and delivery	31/03/26	31/03/27	Work underway to produce an Integrated Improvement Plan	25/02/26	Group Chief Delivery Officer	Reasonable
79	Enforcement actions	31/03/27	31/03/28	In response to Feb-26 letter an action plan is being produced that will also incorporate the recommendations of the ValueCircle review	25/02/26	Group Chief Delivery Officer	Limited

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(26)138

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11th June 2026
Director Lead	Paul Bunyan, Deputy Group Chief People Officer
Contact Officer / Author	Myles Howell, Group Director of Communications Lucy Vere, Group Director of Learning and Organisational Development Lauren Wilkinson, Group Head of Workforce Intelligence and Systems
Title of Report	**Our People**
Executive Summary	This report provides Trust Boards-in-Common with assurance regarding workforce performance across Humber Health Partnership through review of key people metrics, workforce risks and delivery of workforce priorities. Month 1 workforce performance demonstrates a broadly stable position, with turnover, vacancy rates, time to hire, Core Mandatory Training and Job Planning compliance performing at or above target. Delivery of the 2026/27 Operational Workforce Plan continues, supported by workforce controls, Executive oversight and alignment with financial and operational plans. Key areas requiring continued focus include sickness absence, appraisal compliance, Role Specific Training compliance and staff experience measures, with National Staff Survey and Q1 Pulse Survey results indicating ongoing challenges in engagement and advocacy. Workforce affordability requirements, vacancy controls, workforce reduction targets and the ongoing impact of industrial action continue to present operational and workforce risks. The report provides assurance that governance, monitoring and mitigation arrangements remain in place to support workforce sustainability, delivery of workforce priorities and implementation of improvement actions across the Group.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	There are no direct financial implications arising from this report. Workforce affordability, vacancy controls and temporary staffing expenditure continue to be monitored through established workforce and financial governance arrangements.
Implications for equality, diversity and inclusion, including health inequalities	The report supports ongoing monitoring of workforce equality, diversity and inclusion through staff survey results, staff engagement initiatives and workforce performance metrics. No

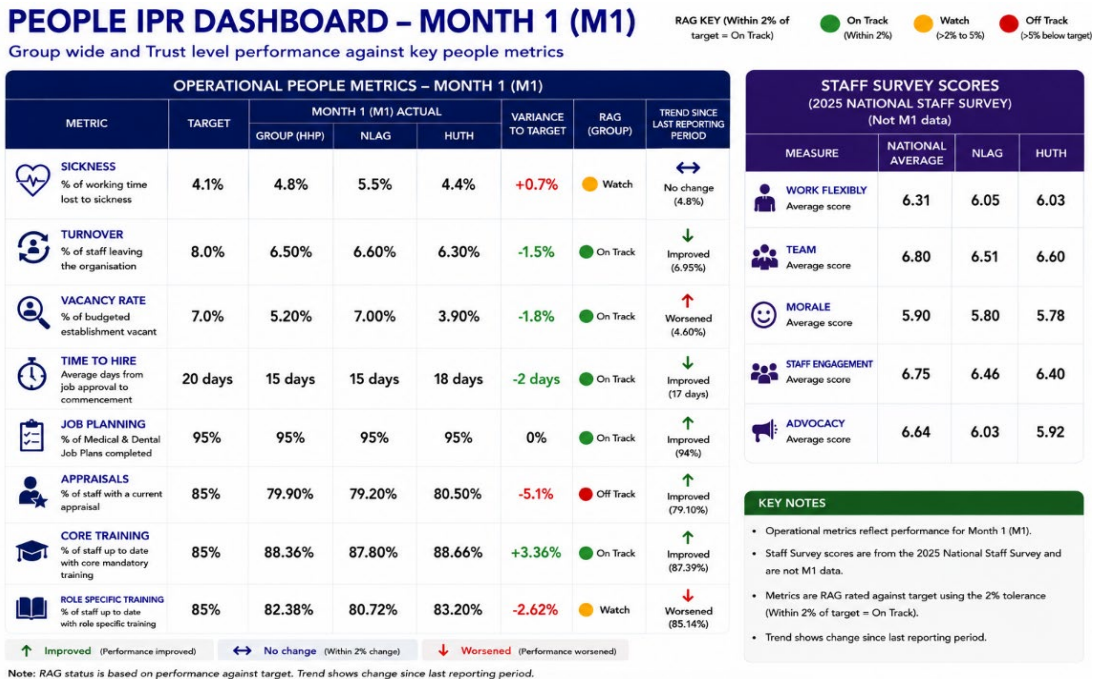
(if applicable)	specific adverse equality impacts have been identified through this report.	
Recommended action(s) required	☐ Approval ✓ Assurance	☐ Information ☐ Other – please detail below:

PURPOSE OF REPORT

To provide the Trust Boards-in-Common with assurance on workforce performance through the review of key people metrics, workforce risks and mitigating actions, enabling effective oversight of workforce sustainability and organisational performance.

KEY POINTS

People IPR Dashboard M1



PEOPLE IPR DASHBOARD – MONTH 1 (M1)

Group wide and Trust level performance against key people metrics

RAG KEY (Within 2% of target = On Track) — On Track (Within 2%) — Watch (>2% to 5%) — Off Track (>5% below target)

OPERATIONAL PEOPLE METRICS – MONTH 1 (M1)

METRIC	TARGET	MONTH 1 (M1) ACTUAL			VARIANCE TO TARGET	RAG (GROUP)	TREND SINCE LAST REPORTING PERIOD
		GROUP (HHP)	NLAG	HUTH			
SICKNESS – % of working time lost to sickness	4.1%	4.8%	5.5%	4.4%	+0.7%	Watch	↔ No change (4.8%)
TURNOVER – % of staff leaving the organisation	8.0%	6.50%	6.60%	6.30%	-1.5%	On Track	↓ Improved (6.95%)
VACANCY RATE – % of budgeted establishment vacant	7.0%	5.20%	7.00%	3.90%	-1.8%	On Track	↑ Worsened (4.60%)
TIME TO HIRE – Average days from job approval to commencement	20 days	15 days	15 days	18 days	-2 days	On Track	↓ Improved (17 days)
JOB PLANNING – % of Medical & Dental Job Plans completed	95%	95%	95%	95%	0%	On Track	↑ Improved (94%)
APPRAISALS – % of staff with a current appraisal	85%	79.90%	79.20%	80.50%	-5.1%	Off Track	↑ Improved (79.10%)
CORE TRAINING – % of staff up to date with core mandatory training	85%	88.36%	87.80%	88.66%	+3.36%	On Track	↑ Improved (87.39%)
ROLE SPECIFIC TRAINING – % of staff up to date with role specific training	85%	82.38%	80.72%	83.20%	-2.62%	Watch	↓ Worsened (85.14%)

↑ Improved (Performance improved) ↔ No change (Within 2% change) ↓ Worsened (Performance worsened)

Note: *RAG status is based on performance against target. Trend shows change since last reporting period.*

STAFF SURVEY SCORES (2025 NATIONAL STAFF SURVEY) (Not M1 data)

MEASURE	NATIONAL AVERAGE	NLAG	HUTH
WORK FLEXIBLY – Average score	6.31	6.05	6.03
TEAM – Average score	6.80	6.51	6.60
MORALE – Average score	5.90	5.80	5.78
STAFF ENGAGEMENT – Average score	6.75	6.46	6.40
ADVOCACY – Average score	6.64	6.03	5.92

KEY NOTES

- Operational metrics reflect performance for Month 1 (M1).
- Staff Survey scores are from the 2025 National Staff Survey and are not M1 data.
- Metrics are RAG rated against target using the 2% tolerance (Within 2% of target = On Track).
- Trend shows change since last reporting period.

To **alert** WECC to the following issues:

- Sickness absence remains above target, driven primarily by long-term psychological health-related absence across the Group.
- Appraisal compliance and Role Specific Training compliance remain below target, requiring continued improvement to achieve organisational standards.
- Staff Survey and Q1 Pulse Survey results indicate ongoing challenges in staff engagement, advocacy and staff experience, with further deterioration in engagement scores across both HUTH and NLAG.
- Workforce affordability pressures, vacancy controls and delivery of workforce reduction targets linked to financial recovery requirements continue to present operational and workforce risks.
- Ongoing operational and financial impacts arising from Resident Doctor industrial action.
- Operational workforce planning risks relating to recruitment, retention, temporary staffing reduction targets and delivery of CIP programmes.

To **advise** WECC on the following issues:

- Progress against the Group's 2026/27 Operational Workforce Plan, with workforce assumptions aligned to finance, activity and operational plans.
- Vacancy rates, turnover and time to hire continue to perform within target tolerance, supporting workforce stability across the Group.
- Core Mandatory Training compliance has improved and remains above target, whilst Job Planning compliance has achieved the required national standard.
- Ongoing delivery of staff engagement and cultural improvement initiatives in

response to National Staff Survey and Pulse Survey findings. • Development of the Learning, Improvement and Safety Academy (LISA), Operational Managers development programmes and the HHP Learning Hub. • Continued workforce transformation, workforce systems modernisation and workforce planning activity across Humber Health Partnership.
To **assure** WECC about the following issues • Workforce performance remains broadly stable, with key indicators demonstrating continued progress against workforce priorities despite operational and financial pressures. • Workforce plans have been triangulated with finance, activity and operational plans and are subject to ongoing Executive oversight. • Progress continues across workforce transformation, leadership and development, health and wellbeing, workforce systems modernisation and cultural improvement initiatives. • Governance, monitoring and mitigation arrangements remain in place to support delivery of workforce, operational and people priorities throughout 2026/27, ensuring alignment with the Group's operational and clinically led improvement objectives.

IMPLICATIONS

BAF reference to which the paper relates:	Tick all those appropriate
Our Patients - Access	
Our Patients - Safety	
Our People	✓
Our Partnerships	
Our Pioneers	
Our Public Purse	✓

RECOMMENDATIONS

Trust Boards-in-Common is asked to:

- Note the contents of the report
- Receive assurance regarding workforce performance against key people metrics, operational workforce plan delivery and workforce risk management arrangements.
- Note the key workforce, operational and cultural risks, mitigations and delivery actions in place throughout 2026/27

DOCUMENT HISTORY

This report has previously been considered through the Workforce, Education and Culture Committees-in-Common governance arrangements as part of routine workforce performance and People assurance reporting.

People Delivery

1. ALERT – Urgent Issues Requiring Board Attention

1.1 Workforce Performance M1

- Sickness absence remains above target at 4.8% against a target of 4.1%, with NLAG reporting 5.5% and HUTH 4.4%. The primary contributor continues to be long-term sickness absence, particularly absences relating to psychological health and wellbeing. Targeted support and case management arrangements remain in place to support attendance improvement.
- Appraisal compliance remains below target at 79.9% against a target of 85%. Performance has improved marginally from the previous reporting period (79.1%) but remains below the required standard, with improvement actions continuing across both organisations.
- Role Specific Training compliance remains below target at 82.38% against a target of 85% and has deteriorated from 85.14% in the previous reporting period. Targeted actions are in place to improve compliance and support a return to the required standard.
- Staff Survey and Pulse Survey results indicate ongoing challenges in staff engagement and advocacy. National Staff Survey scores remain below the national average across key workforce indicators, including Staff Engagement, Advocacy, Team Working, Morale and Flexible Working. In addition, Q1 Pulse Survey results show a deterioration in engagement scores at both HUTH (6.0, down from 6.4) and NLAG (5.9, down from 6.4), with advocacy scores also declining, indicating a continued need to strengthen staff experience, engagement and organisational culture across the Group.

1.2 Financial Pressures & Vacancy Controls

- A strengthened vacancy management process was introduced in December 2025 for non-clinical roles and has now been extended for a further year, with Tier 3 and Tier 4 vacancies continuing to require additional Executive Panel approval before recruitment can proceed.
- The two most significant areas of financial recovery in 2026/27 are linked to workforce and include a requirement for 30% reduction in variable pay and a whole-time equivalent reduction of 633 posts. This latter issue has come about due to a significant rise in the number of staff at HUTH and NLaG over the past five years.

1.3 Industrial Action Impact

- There has been one period of resident doctor industrial action already in Q1, costing approximately £1.3m and placing pressure on activity and financial delivery.
- Further action is expected in 2026, which will continue to impact on the People Strategy progress.

1.5 Operational Workforce Planning Update

- The Group's 2026/27 Operational Workforce Plan was developed and submitted in line with NHS England planning requirements, with workforce assumptions triangulated against finance, activity and operational plans.
- The Month 1 workforce position demonstrates that planning assumptions were broadly accurate, with only a small variance against the planned baseline position.

- Delivery of the workforce plan continues to be monitored through Care Group accountability, monthly workforce and finance reviews, and Executive oversight.
- Key risks include workforce affordability pressures, delivery of CIP schemes, recruitment and retention challenges, temporary staffing reduction targets and maintaining safe staffing levels during periods of operational pressure.
- Mitigations include workforce controls, recruitment and retention initiatives, workforce redesign, productivity schemes, Job Planning, and ongoing review of workforce performance and operational delivery.

2. ADVISE – Important new developments

2.1 Workforce Performance M1

These are things the Board should be sighted on but which are not necessarily risks:

- Vacancy rates remain within target tolerance at 5.2% against a target of 7%, although performance has deteriorated from 4.6% in the previous reporting period.
- Time to Hire remains better than target at 15 days (NLAG) and 18 days (HUTH) against a target of 20 days.
- Core Mandatory Training compliance has improved from 87.39% to 88.36%.
- Job Planning compliance has improved from 94% to 95%, achieving the required target.

2.2 Oversight of cultural improvement

- WECC support is requested for the National Staff Survey action plan which has been discussed at Board.
- A wide-reaching programme of staff engagement is underway. This will see 64 senior leaders (including executive directors) visiting teams across the group each quarter to help understand the barriers they are experiencing and what support they require in order to deliver change.

2.3 LISA (Learning, Improvement & Safety Academy)

- A paper will go to SLT by the end of June to agree the final LISA approach and programme of work. This is being led by Sue Page (Improvement Team) supported by Scott Fitzgerald – Director of Operational Transformation and Lucy Vere, Group Director of Learning and OD. Year one will focus on practical delivery to support the clinically led improvement plan, with years two and three looking at how we bring learning, improvement and innovation into one integrated service.
- An easy to access portal will be created by mid-June on Bridget to soft launch LISA with new branding, courses and services currently available. This will link to the new HHP Learning Hub, which has been live for the whole Group from 1st April, so there is a seamless experience for those looking to access and record their learning.
- The Putting Patients First Clinical Accreditation Programme is underway and the 30 wards in the first pilot phase have fed back on the self-assessment spreadsheet and are now beginning the 3-month self-assessment period. improvement work
- The first Surgical Safety Day took place with the Digestive Diseases and TACC teams coming together to explore the improvements needed to address the safety concerns and never events we have experience as a group over the last 18 months. This was well attended by surgeons and theatre teams and planning is now taking place to create a sustainable quality improvement programme alongside further safety days across all sites.
- A pilot Operational Managers Essentials programme has started, with a focus on Demand and Capacity to support operational manager with their speciality 18-week

pathways. They will learn the practical skills and apply it to reducing wait to 1st outpatient appointment. The next module starting in June will focus on Making Data Count, followed by Making Decisions count and Managing Change and

3. ASSURE – Progress, delivery and mitigations

3.1 Workforce Performance M1

These are the areas where performance is meeting target or improving:

- Turnover remains below target at 6.5% against a target of 8% and has improved since the previous reporting period.
- Core Mandatory Training compliance exceeds the target at 88.36% against an 85% target.
- Governance and performance monitoring arrangements remain in place to oversee workforce performance and support improvement actions where required.

3.2 Overall Delivery Performance Y1

- Year 1 People Strategy delivery continued to progress across all themes during Q4 despite significant operational and financial pressures during 2025/26.
- Q4 activity focused on consolidating Year 1 delivery, embedding governance arrangements, and establishing the foundations for Year 2 priorities including workforce planning, leadership development, workforce controls and cultural improvement.
- A small number of workforce systems projects originally scheduled for delivery in Q3/Q4 were reprofiled into Year 2 following delays associated with SQL server implementation and digital dependencies. Mitigations are now in place and revised delivery plans have been agreed.
- The People Strategy is being fully reviewed and year 2 plans adapted where needs be to ensure we are able to support our Clinically led Integrated Improvement Plan e.g. The development of the Learning, Improvement and Safety Academy Model of delivery for our Leadership, Learning and Talent programme.

3.3 Policy Harmonisation

- Significant progress has been made in aligning workforce policies across Humber Health Partnership, supporting a consistent Group-wide approach to people management and employee relations.
- Q4 saw continued progression of Organisational Change and Capability Management policy alignment, with further harmonisation work planned during Year 2

3.4 Workforce Systems Modernisation

- Q4 focused on strengthening the digital infrastructure required to support workforce transformation and improved establishment control. Following implementation of the Group SQL server infrastructure, development work commenced on establishment control functionality and workforce reporting improvements.
- The Group-wide flexible working system has now been implemented, improving oversight, consistency and reporting capability across both organisations. Year 2 priorities will focus on automation, workforce intelligence and further reduction in manual transactional processes.
- Focused work by the e-rostering team to improve rostering efficiency using action cards identifying key metrics for improvement e.g. unfilled roster and roster publication

lead times, published on a weekly basis. This approach is now being rolled out across theatres and is in development for therapies.
- Job Planning is now supported by three Power BI Dashboards focusing on compliance, conciliation and consistency. The compliance dashboard was instrumental in the Group achieving the national requirement for 95% of job plans to be signed off by 31st March 2026.

3.5 Health & Wellbeing Improvements

- During 2025/26, the Group continued to strengthen its Health & Well-being offer across HUTH and NLaG, focusing on prevention, early intervention, improved working environments and increased access to staff support services.
- Progress has been seen across most Health & Well-being domains, including improvements in psychological sickness absence, flexible working and manager wellbeing training compliance, with performance broadly aligned to national averages. Burnout scores remain an area of focus across both organisations, reflecting continued operational pressures being experienced nationally across the NHS.

Key achievements during the year included:

- Recruitment of two Health & Well-being Practitioners
- Expansion of Health & Well-being Champion networks
- Delivery of leadership and Mental Health First Aid training
- Completion of Phase 1 staff rest room refurbishments (13 staff rooms)
- Development of a single referral route into Occupational Health and Staff Physiotherapy services
- Expansion of wellbeing support networks and digital wellbeing resources
- The 2026/27 Health & Well-being programme will continue to focus on preventative wellbeing initiatives, workforce sustainability, environmental improvements, long-term sickness prevention and strengthening access to support services across the Group.

3.6 Culture & Engagement

- The National Staff Survey action plan has been approved at Board and work is underway across all the main areas – Safety Culture, Civility and Respect, Staff Voice, Equality and Inclusion, Advocacy.
- Clinical Policy Group and SLT arrangements have significantly strengthened clinical engagement
- Freedom to Speak Up Guardians are running a series of focus groups to understand what barriers to speaking up currently exist in the partnership
- The Group LGBTQIA+ conference is being held on 29 June at Diana Princess of Wales Hospital, Grimsby focusing on the topic of 'Breaking Barriers to Healthcare for Transgender Patients'.
- There are now active BAME, LGBTQIA+ and Disability networks in place north and south, with Chairs and meetings in place. The next step is to explore the need for Women's Networks north and south and this work will begin in Q2.

3.7 Leadership, Learning & Talent

- The new HHP Learning Hub has been launched for the Group from 1st April 2026, ensuring that there is now one system to book and record learning. All staff have access and we have a helpdesk in place for those new to the system needing support. We have had positive feedback from NLAG staff, who like the format and accessibility of the new HHP Learning Hub. We continue to adapt the system based on regular feedback.

- The Mandatory Learning Oversight Group is working effectively to reduce the amount of locally mandated, and role specific training staff have to complete. This is a clinically led group to ensure we can make effective decisions on what can be removed from our locally mandated list. The first big change has to been to move resus training for consultants from annually to biannually. The group is now focused on a systematic cleanse by topic and removing things that have no relevance and benefit.

3.8 Workforce PMO

- The Workforce PMO continues to support delivery of the Group's Operational Workforce Plan through strengthened workforce governance, programme oversight and Care Group workforce planning arrangements.
- Progress has been made in the development of specialty-level workforce plans, with approximately 60% now in place across the Group. This work supports improved alignment between workforce capacity, operational demand, productivity and financial planning.
- A continued area of focus for 2026/27 is reducing time to hire and improving recruitment timelines. Current average time to hire is 17 days, with further work underway to streamline recruitment processes, reduce delays and improve workforce supply into priority operational areas.

3.9 Performance of People Strategy Year 1 Update

Strategic Pillar	KPI Measure	Source	2026 Target	2026 Actual Performance	2028 Target
People & Partnership	Consultant Vacancy Position %	ESR/Finance	10%	16.6%	8%
	Overall Vacancy Position%	ESR/Finance	3.5%	4.6%	2.5%
	Agency as % of gross staff costs	Finance	4%	2.4%	3.5%
	First Year Turnover %	ESR	18%	18%	15%
	Turnover %	ESR	8%	6.9%	8%
	Group Time to Hire Combined conditional to unconditional	TRAC	22 days	17 days	<20 days
	Speciality Workforce Plans in Place	Workforce Planning	80%	60%	100%
	Satisfaction with Onboarding Experience	Recruitment KPI's	80%	80%	90%
Workforce Systems Transformation	Removal of paper-based processes via introduction of ESR MSS across the Group	ESR	90%	71%	100%
	% of in scope departments utilising the Health Roster	Health Roster	90%	92%	100%

	All group pay impacting changes to be administered through Establishment control processes	Establishment Control System	75%	70%	100%
	Workforce Reporting - Real Time	Power BI	Daily	Daily	Daily
Health and Wellbeing	NSS - We are Safe and Healthy	NSS	6	HUTH 5.29 NLAG 5.49	6.5
	Psychological related sickness % of overall sickness	ESR	18%	18.9%	15%
	% of Leaders completed REACT training	HEY 247/ESR	30%	32%	50%
	NSS - Burnout (higher scores demonstrates improvement)	NSS	5	Group 3.30	5.3
	NSS - Flexible Working	NSS	6	NLAG 6.66 HUTH 6.31	6.85
Culture & Engagement	Our Staff Engagement Score is above the average for NHS England Trusts	NSS	6.7	HUTH 5.95 NLAG 5.86	7.0
	Percentage of staff experiencing harassment, bullying and abuse (from a colleague or manager)	NSS	16%	NLAG Manager 9.7% Colleague 20.7% HUTH Manager 8.8% Colleague 18%	12%
	Recommend my organisation as place to work	NSS	55%	NLAG 48% HUTH 47.2%	65%
	Experienced discrimination from a colleague or a manager	NSS	4.5%	HUTH 8.1% NLAG 7.8%	3.79%
Leadership, Learning & Talent Development	Appraisal %	Hey 247/ESR	85%	86.24%	85%
	Quality of Appraisal – left me feeling valued	NSS	35%	HUTH 30.2% NLAG 29.9%	42%
	Learning Needs Analysis completed	Internal	50%	21%	90%
	We are always learning	NSS	5.8	NLAG 4.25 HUTH 4.76	6.07
Group	CQC Well Led	CQC	Good	TBC (June	Good

	Review			2026)	

Summary and Recommendations

In summary, the report provides assurance that delivery of the People Strategy continues to progress across key priorities, with governance, monitoring and mitigation arrangements in place to support implementation throughout 2026/27. Whilst significant operational, workforce and financial pressures remain, these risks are understood, are subject to ongoing Executive oversight, and are being actively managed through established workforce planning, performance review and improvement arrangements. WECC is therefore asked to take assurance from the progress made to date, whilst recognising the continued focus required to deliver the Group's workforce, culture and organisational development ambitions.

ADVISE, ALERT and ASSURE	
Meeting:	Workforce, Education and Culture Committees in Common
Meeting Date:	27 May 2026
Chair:	David Sulch, Non-Executive Director
Quorate:	Yes

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received:**	**Action**	**Timescale**
Workforce				
Staff Survey/Pulse Survey Q1	There has been a slight deterioration in the engagement scores. Scores relating to recommending the Trust as a place to work/receive treatment have also deteriorated.	**Limited**	Senior leaders to identify areas to visit and support. Ward teams to have a staff engagement score as part of the ward accreditation programme.	Immediate
Resident doctor industrial action and financial impact	Awaiting further information nationally at this current time	**Limited**	Workforce plans are in place should industrial action take place	N/A

Workforce consolidated report	The NEDs requested a regular report be produced that triangulates workforce KPIs, CIP, operational workforce planning actions and trajectories.	**Limited**	An overarching report to be produced with trends identified. Financial gains to be monitored. Oversight of all workforce KPIs to be included.	Immediate
AI usage and governance arrangements	For discussion at Board regarding the organisation's strategic approach to AI .	**N/A**	N/A	N/A
Operational Workforce Planning	A report was presented outlining workforce planning.	**Limited** **The NEDs were advised that in order to reduce headcount there would need to be clinical transformational change. However, the NEDs expressed concern regarding the pace of any changes. In particular that as the organisation will be in Q2 shortly the ability for any changes to impact in this financial year would be reducing**	Clinical Strategy and business planning to be aligned. Group Chief Delivery Officer working with the Care Groups to determine any investment required. KPIs to be set in relation to Job Planning, particularly in relation to them being linked to demand and capacity work. Further work to be undertaken to ensure that information being presented to the Workforce Committee provides clarity of information on the delivery of the asks within the MFP and that there is clear thread between the	Work to be presented at July meeting

			information that is presented in various forums, so there is one version of the truth. .	
Job Planning	Job Planning Met target – for 2025/26		More clarity required about the trajectory for 2026/27	July 2026
ADVISE (Provide here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
ATHENs training	Rollout capacity issues	**Limited**	Review of Simulation Team recruitment taking place	
Apprenticeship Levy – national funding changes continue to constrain levy spend	Different nursing apprenticeship models are being developed.	**For Information**	Support from finance regarding levy planning. 100 places secured with Corndel apprenticeship programmes.	
Transforming People Services	Presentation shared with the Committee.	**For Information**	Board Development item. KPMG is supporting the programme nationally. The organisation is involved in discussions with Humber and North Yorkshire Collaborative of Acute Providers (CAP) to take this agenda forward.	

ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
Nursing and Governance Workforce	There appears to be a downward trend in agency spend within nursing. However, this will continue to monitored to understand if this is sustained.	**Limited – but the amount of work being carried out was acknowledged**	Nursing and Governance workforce controls in place in the form of Monthly meetings with Nurse Directors and Financial leads. To establish weekly meetings between senior nursing leads and ward managers to prospectively review rosters on a confirm and challenge basis. To ensure that there is a clear triangulation with harms and patient safety measures.	
LISA	Currently work is being undertaken to map out the delivery of the programme across the year	**Item for information**	Clear branding in place, access portal will be added to Bridget.	
Freedom to speak up annual reports HUTH/NLAG	Group national policy is now in place	**Significant Assurance The NEDs recognised the challenges the organisation is facing and continued to support**	Detriment guidance has been developed. Learning from the themes of the	

		the work of the FTSU Guardians.	concerns raised to be highlighted in future reports to ensure continuous improvement.	
Undergraduate Medical Education Report	NLaG have been awarded 4 of the 8 HYMS Teaching Excellence Awards. Student feedback remains positive.	**Reasonable assurance**	Funding transparency had been requested to ensure the funds were allocated appropriately.	
Occupational Health Annual Report	Digital investment to upgrade the OH record platform – harmonized across the group	**Item for Information**	Received by the CIC	

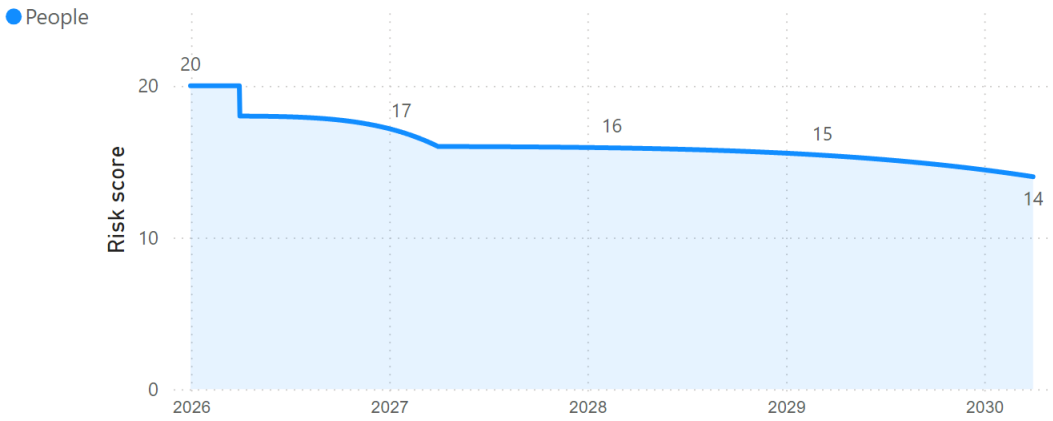
1. People

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 21 January 2026. In full, the risk is:

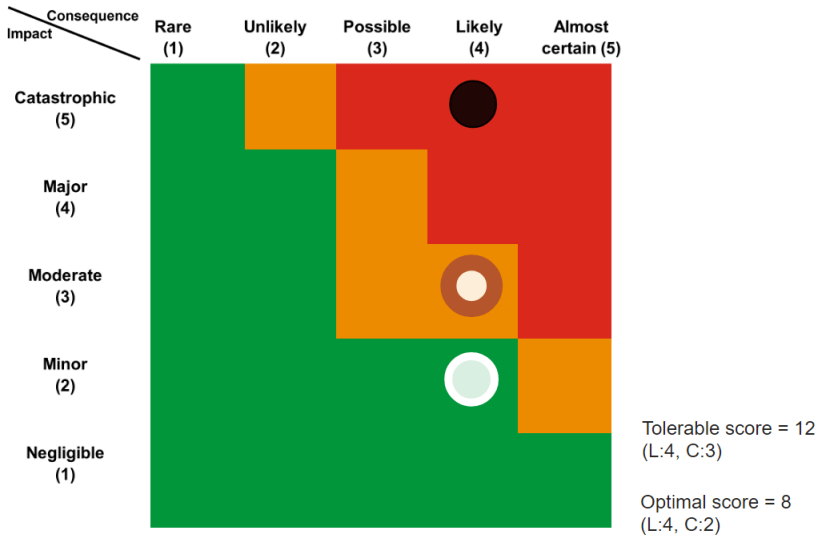
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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
Clinical Policy Group (CPG)	Limited
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Executive Team	Limited
Freedom to Speak Up Guardian	Reasonable
FTSU Group Strategy 2025-28	Reasonable
Group Leadership Strategy	Limited
Group People Strategy 2025-28	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Reasonable
Resident Doctor 10 Point Plan Oversight Delivery Group	Reasonable
Senior Leadership Team (SLT)	Limited
Talent management team for international recruitment	Limited
Vacancy Control Panel	Reasonable
Workforce Transformation Group	Reasonable

Gaps in control (and Action ID)	6	7	8	69	Total
Gaps in hard to recruit roles in medical specialities		✓	✓		2
Instability among Board-level leadership				✓	1
Insufficient attraction, to recruit and retain staff to work in the area		✓	✓	✓	3
Low clinical engagement across specialities and Group	✓				1
Management and Leadership inconsistency in delivering the People Promise to staff			✓		1
Total	1	2	2	1	8

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
External	External Safer Staffing report on application of model	Reasonable
External	GMC and NHSE (deanery) visits	Limited
External	GMC National Training Survey	Limited
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Never events	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequency of culture and staff experience measures	✓	1
Lack of assurance re short term additional hours / overtime from Care Groups	✓	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	✓	1
Plans to address ageing workforce profile	✓	1
Poor levels of mandatory training compliance	✓	1
Total	4	5

A green flag or arrow indicates a recent addition / change to the report.

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.	21/01/26	Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	People First programme to evolve and support Safety agenda	21/01/26	Group Chief People Officer	Reasonable
8	Group Leadership network and training programme	30/12/25	01/04/27	New leadership programme for the Group ongoing (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	21/01/26	Group Chief People Officer	Reasonable
69	Development of Executive Team programme of development	31/03/27	31/03/27	Draft plan agreed	21/01/26	Group Chief People Officer	Limited

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(26)139

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11th June 2026
Director Lead	Paul Bunyan, Deputy Group Chief People Officer
Contact Officer / Author	NLaG - Elizabeth Houchin, Freedom to Speak Up Guardian HUTH - Frances Moverley, Freedom to Speak Up Guardian
Title of Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 4) and Annual Report – NLaG and HUTH**
Executive Summary	The reports present an overview of number of FTSU concerns raised, national and regional updates and the proactive work undertaken by the NLAG and HUTH FTSU Guardians. **For NLAG:** • Worker safety, HR process and inappropriate behaviours were the top themes. • The results from the NHS Staff Survey 2025, relating to four speak up questions show the scores increased for questions 20b, 25e and 25f and decreased for question 20a. **For HUTH:** • Themes including an increase in concerns related to service delivery, and concerns raised by Administrative and Clerical staff, have been noted. • The results from the NHS Staff Survey 2025, relating to four speak up questions show the scores increased for question Q20a and showed a slight decrease for questions Q20b, Q25e and Q25f. • A recent NHSE Senior Leaders Engagement report highlighted the work from the FTSUG and Guardian of Safe Working Hours as an area of good practice. **For both Trusts:** • The FTSU process continues to work effectively and in line with national guidance. • Themes and numbers of concerns continue to be monitored, and oversight shared with senior leaders. • The FTSUGs continue to promote awareness of speaking up through a communications plan and proactive work e.g. promotion to students. • The feedback gained from individuals speaking up indicates that 100% would speak up again to the FTSUGs.
Background Information and/or Supporting Document(s) (if applicable)	No supporting documents are applicable.
Prior Approval Process	This document has not previously been considered at other committees. However, due to Workforce Education and Culture Committees-in-Common (WEC CiC) requesting the FTSU reports

	are presented bi-annually, the Q3, Q4 and annual data contained in this report was previously considered at WEC CiC on 27th May 2026.
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 4 Report January to March 2026 & Annual Report 2025-2026

Liz Houchin
16th April 2026

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 4 2025/2026
& Annual Report 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 4 (Q4) of the 2025/2026 reporting year. The report also gives an annual update for 2025/2026. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Group Priorities

2.1 This paper satisfies the Group Strategic Objectives of ‘Our People – we will look after the health and wellbeing of our people’ and ‘Quality & Safety – we will keep our patients safe and reduce avoidable harm’.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at NLAG in place that allow staff to raise concerns, including, but not limited to:

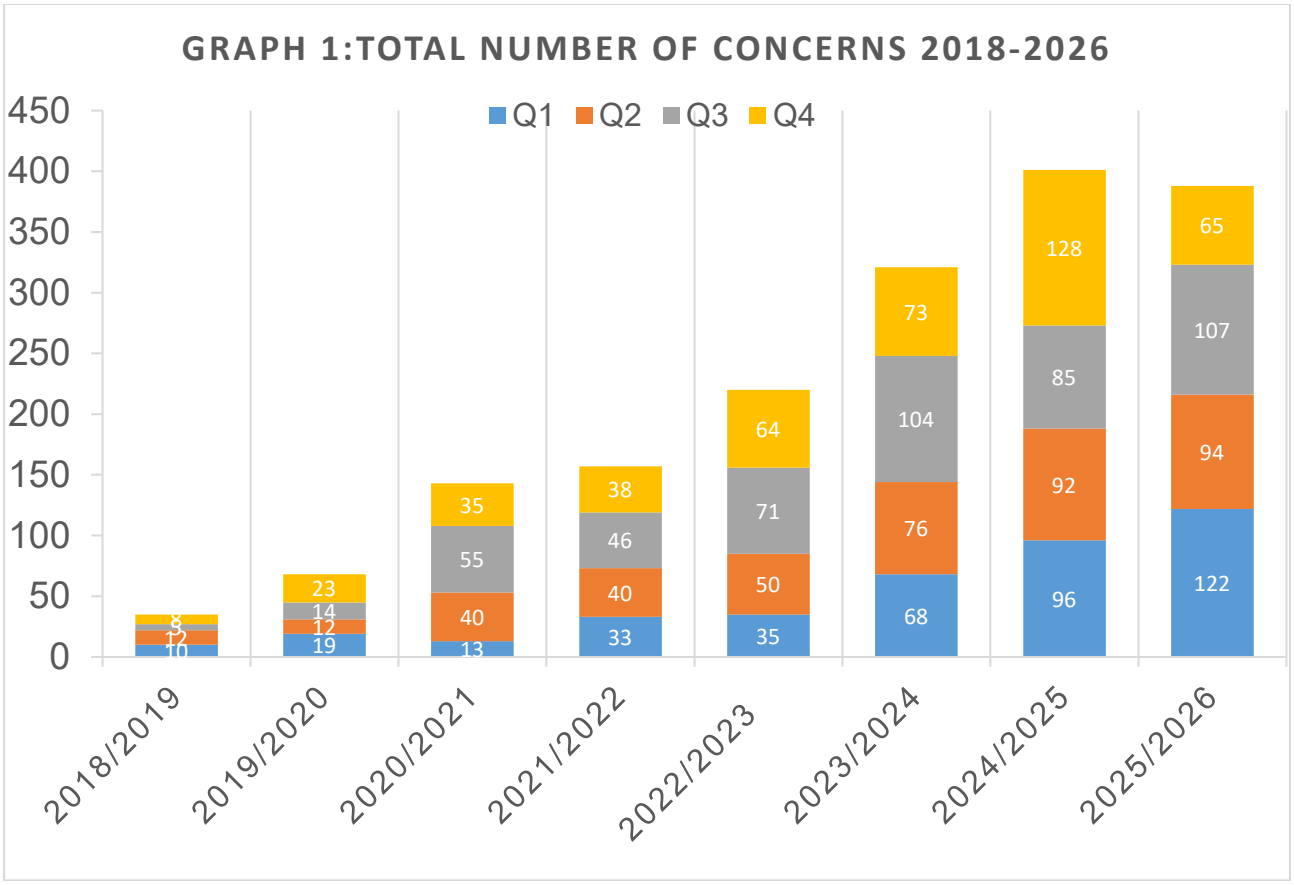
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Group Grievance Policy and Procedure (GP024)
- Group Conflict Resolution Policy (GP026)
- Ulysses Incident Management System

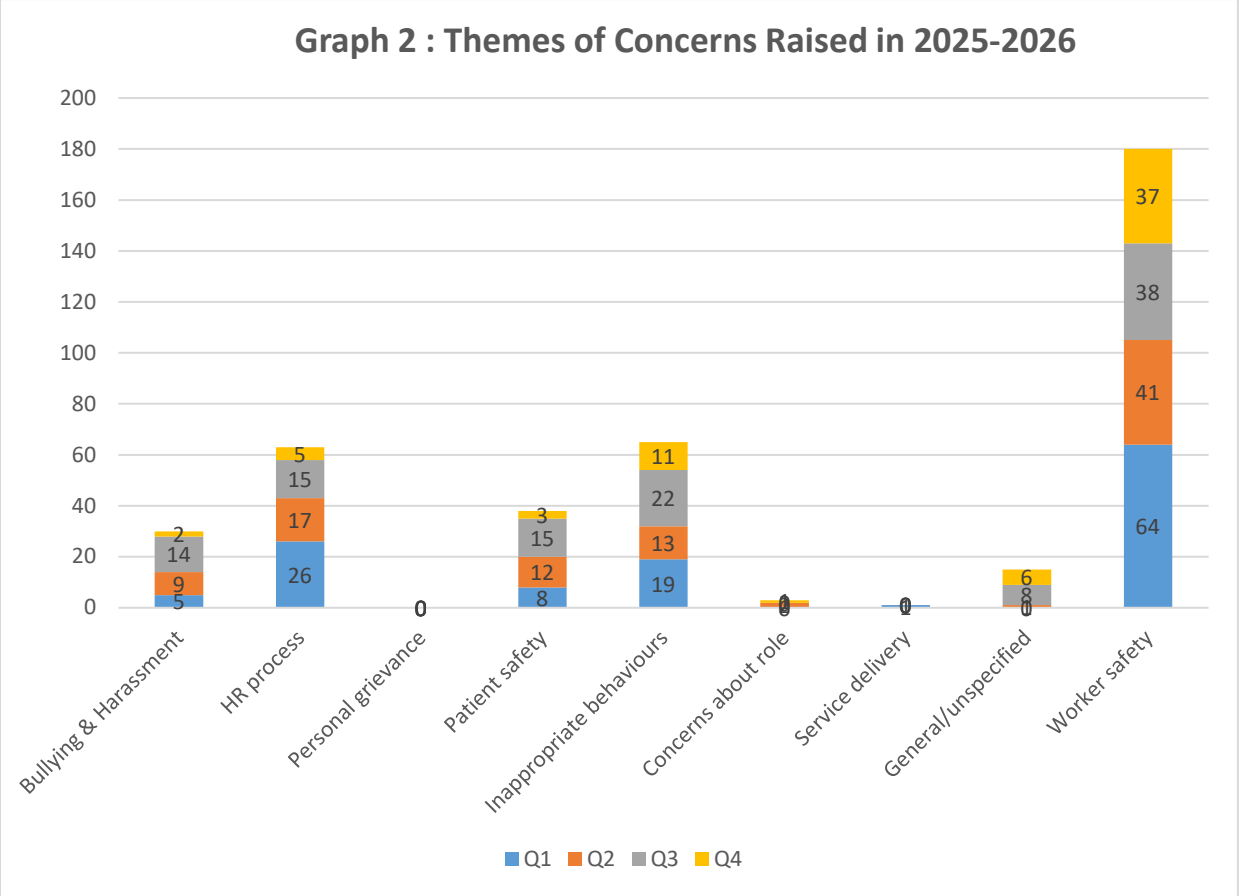
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

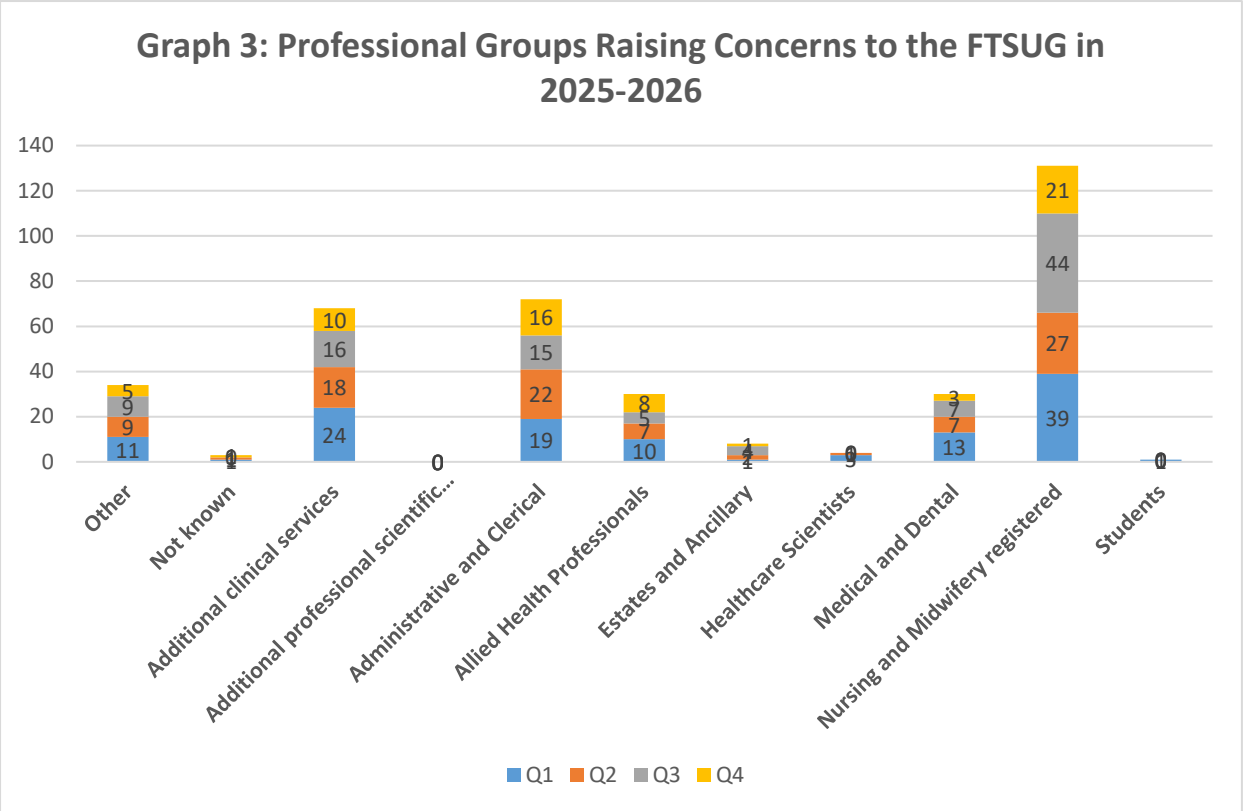
4. FTSU concerns raised during 1st January to 31st March 2026 (Q4) and Annual data for year ending March 2026 – data, comments and assessment.

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 The following graphs show the number of FTSU concerns by year up to March 2026, the themes and the professions who contacted the FTSUG during 2025-26 (reporting year: April 2025-March 2026).




Graph 2 : Themes of Concerns Raised in 2025-2026
200
180
160
140
120
100
80
60
40
20
0
Bullying & Harassment
HR process
Personal grievance
Patient safety
Inappropriate behaviours
Concerns about role
Service delivery
General/unspecified
Worker safety
Q1
Q2
Q3
Q4


Graph 3: Professional Groups Raising Concerns to the FTSUG in 2025-2026
140
120
100
80
60
40
20
0
Other
Not known
Additional clinical services
Additional professional scientific...
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery registered
Students
Q1
Q2
Q3
Q4

4.3 In Q4 2025-26, 65 concerns were received.

Q4 had the lowest quarterly figure for 2025-26. 13% were closed on the same day after giving advice or signposting.

3 concerns were raised anonymously in Q4, all through the Staff App.

- Most colleagues asked for their name to be kept confidential initially, although some did consent to give their details later in the process.

- In Q4 the top themes were worker safety, inappropriate behaviours, HR Process and General concerns.

- Analysis of the theme 'inappropriate behaviours' for Q4 shows that the majority were 'colleague on colleague'.

- Analysis of the theme 'worker safety' for Q4 shows that the majority were related to either not feeling psychologically safe to speak up, or the impact the working environment was having on wellbeing.

Analysis of 2025-2026 data:

In 2025-26, 388 concerns were raised with the FTSUG, this is just below the figure of 401 from 2024-2025 and is the first time there has not been a year-on-year increase for seven years

10 concerns (2.5%) were raised anonymously, which is below the national average of 9.5%.

One colleagues (0.25%) reported that they had been subjected to detriment or disadvantageous treatment as a result of raising a concern, which is below the national average of 4%.

The top themes reported for 2025-2026 were worker safety (47%), inappropriate behaviours (17%) and HR Process (16%).

Nationally in 2024-25, the top themes were worker safety, inappropriate behaviours and bullying & harassment (2025-26 national data not available at time of writing report). 39% of cases nationally had an element of Worker Safety and was the most common theme staff accessed a FTSUG, this mirrors the picture at the Trust.

Nurses and Midwives were the highest professional group that raised concerns with the FTSUG, this mirrors the national picture.
The diversity of different professions across all care groups contacting the FTSU Guardian is an indicator of increased awareness of the role amongst colleagues in the Trust and the value and importance of having an effective communications plan.

Analysis of the FTSU concerns indicates the importance of managers creating psychologically safe work environments. The Group now include the Health Education England (HEE)/National Guardian Office (NGO) module 'Listen Up' in the managers' bite size learning package.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

For the year 2025-2026	Feedback received	Would you speak up again? Yes
2025-2026	32	32 Yes

Data analysis of the completed evaluation forms indicates colleagues aged between 18-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds and 'other' accessed the FTSUG during 2025-26.

Within the feedback received, the following are extracts of qualitative feedback received:

Liz was supportive, easy to talk to and she listened to my concerns and responded in a compassionate and positive way, it felt good to be able to share my concerns in a safe and confidential space

Liz is so helpful, knowledgeable and empathetic as to the situation I was going through, even just talking to her and sending her the initial email made me feel much better, knowing that somebody was there to listen. Her role in the Trust is so valuable and she genuinely cares.

Liz is prompt in replying and dealing with my query. I would highly recommend FTSUG to all my colleagues

4.7 Case Study

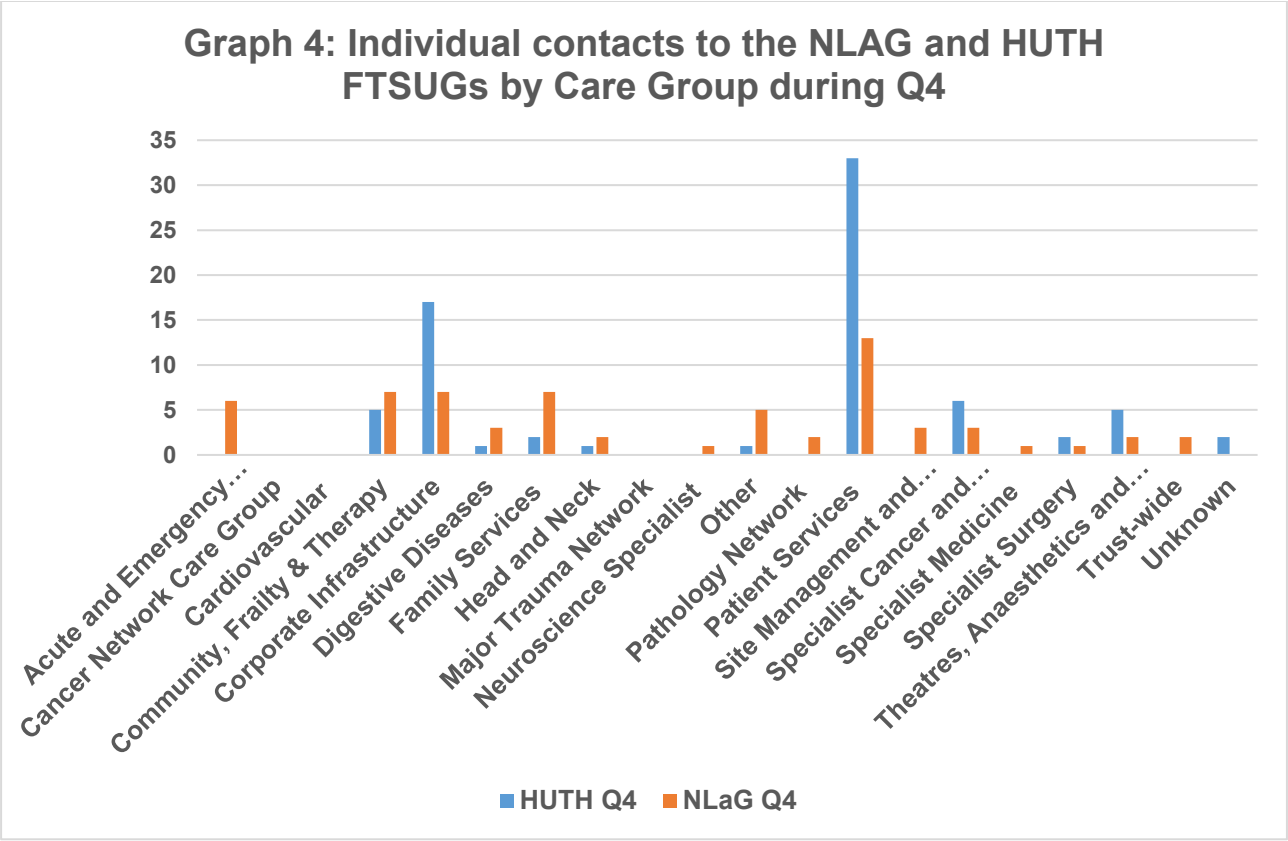
The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for

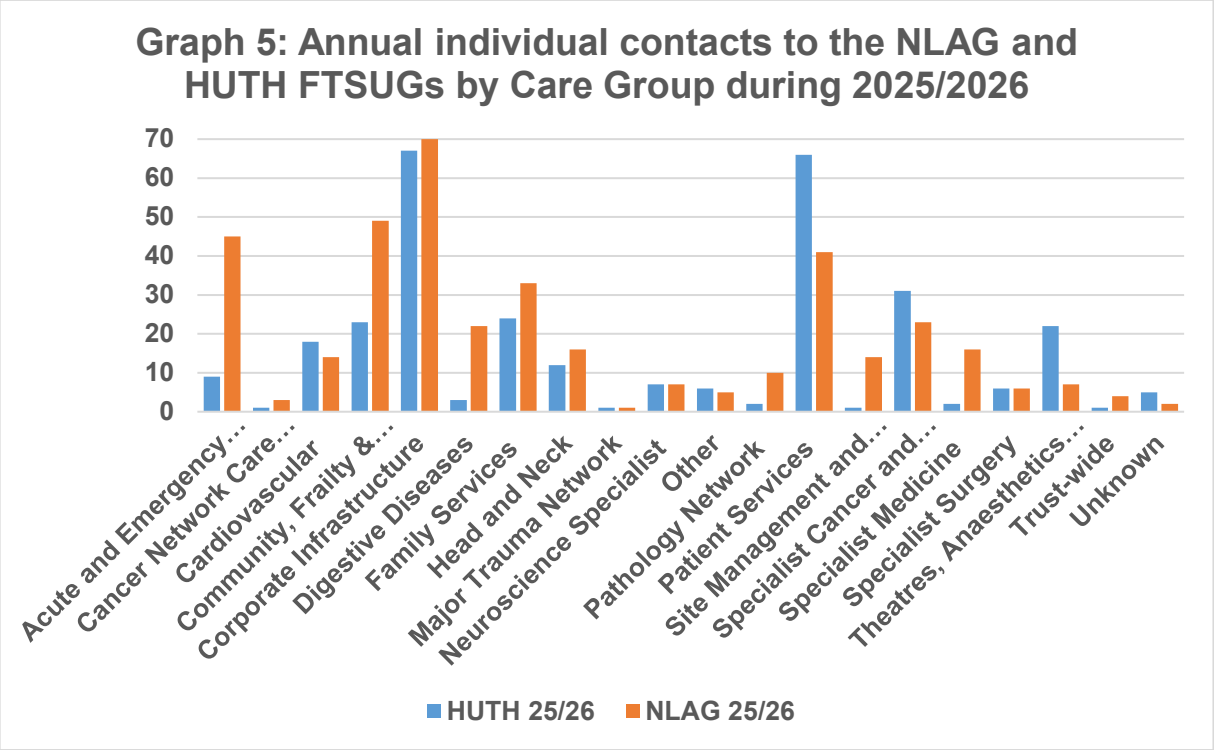
staff and the subsequent benefits to patient care and experience.

The FTSUG received a concern from a colleague about treatment of IENs on a ward. The colleague gave examples of IENs being continually rostered to cover bays that had a high level of acuity of patients, and the effect this was having on them, lack of equal opportunities for IENs e.g. not being given the opportunity to shift lead and concerns about lack of support following an incident. After meeting the FTSUG the colleague decided that they would like the matron to be aware of their concerns and wanted all colleagues to be treated fairly and given equal opportunities. The FTSUG contacted the matron who took the following actions: Bay allocations have been changed with colleagues being asked if they have a preference, all staff are now being encouraged to shift lead. The matron reports that more colleagues are requesting to do this and enjoying the opportunity and finally the matron has spoken to colleagues and encouraged them to take time out to talk through incidents and also to reach out to the management team if needed. The colleague has reported to the FTSUG that they have noticed these changes and are pleased with the outcome.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined during Q4.
Graph 5 provides the annual overview of concerns raised by sovereign organization.





5. FTSUG activities and proactive work during Q4

5.1 A high level summary of the activities are detailed below:

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Drop in/Walk round at both SGH and DPOW
- Attendance at all Trust inductions
- Champions network meeting
- Joint working with Guardian of Safe Working – walk rounds
- Joint presentation with HUTH FTSUG and GMC Regional Advisor to Medics
- NGO Overseas-trained Worker's review – gap analysis completed and will be monitored by Stay & Thrive Committee

5.2 Future plans:

- Work to deliver against the objectives in the FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- FTSU concerns included in Power BI information
- Attendance at all relevant meetings
- Development of Action Plan with Boards and ongoing work to deliver against it.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and Northeast regional meetings to discuss best practice and contribute to active discussions. During Q4 the FTSUG attended a meeting to involve FTSUGs in the GMC consultation for professional standards and also discussions about the future support for FTSUGs when the NGO closes.

6.2 National update

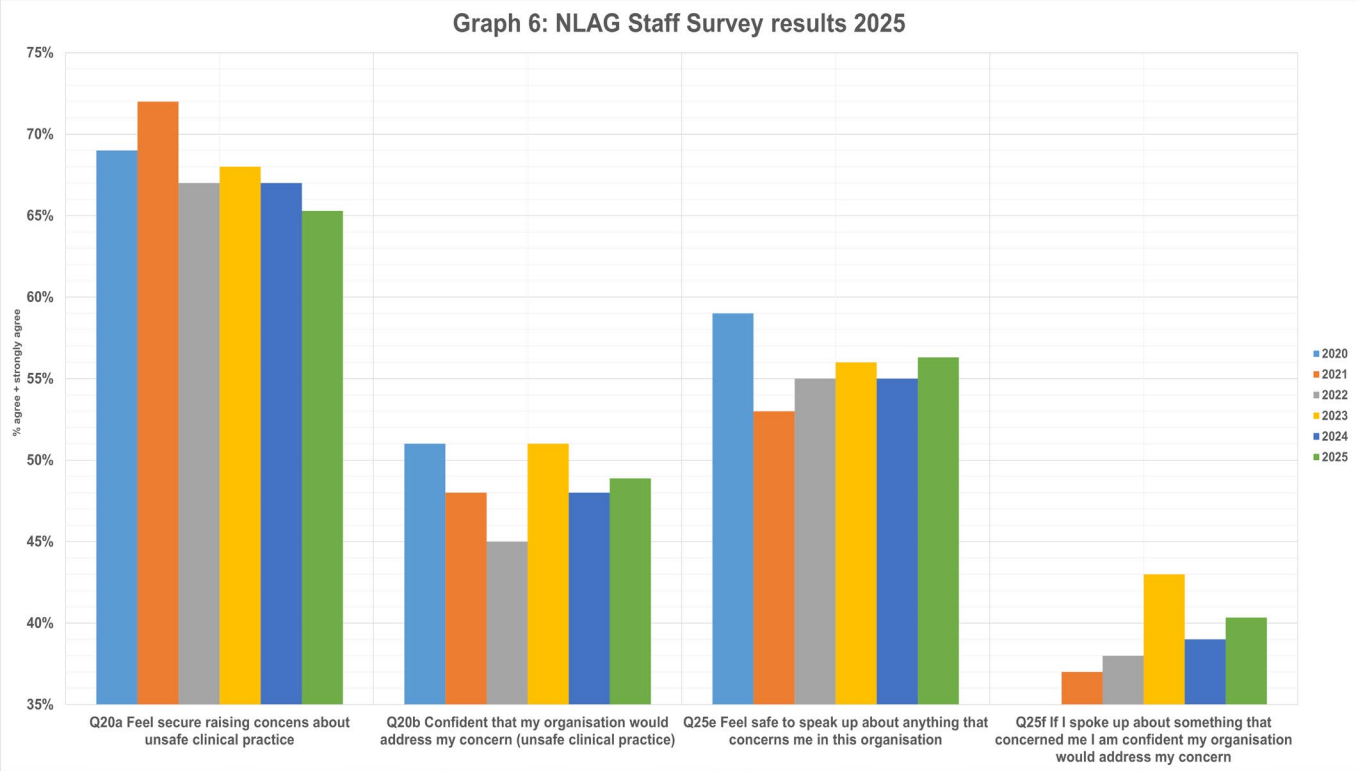
There has been confirmation that the National Guardian Office will now close on 30th June 2026 with their responsibilities transferring into NHSE. The extension allowed for an engagement process with NGO staff, guardians, NHS leaders and other stakeholders about the future of the Freedom To Speak Up programme, its functions and ensures continued support of guardians during the transition. The FTSUG contributed to the engagement sessions, in their capacity as both a FTSUG and a FTSUG mentor. Confirmation of the remit and scope of FTSU when it transfers into NHSE from 1st July has now been published the Future of Freedom to Speak Up which details the changes. NHSE will assume delivery of some activities previously done by the NGO, with employers being asked to take on greater responsibility and accountability for embedding effective Freedom To Speak Up arrangements.

6.3 Staff Survey Results and FTSU

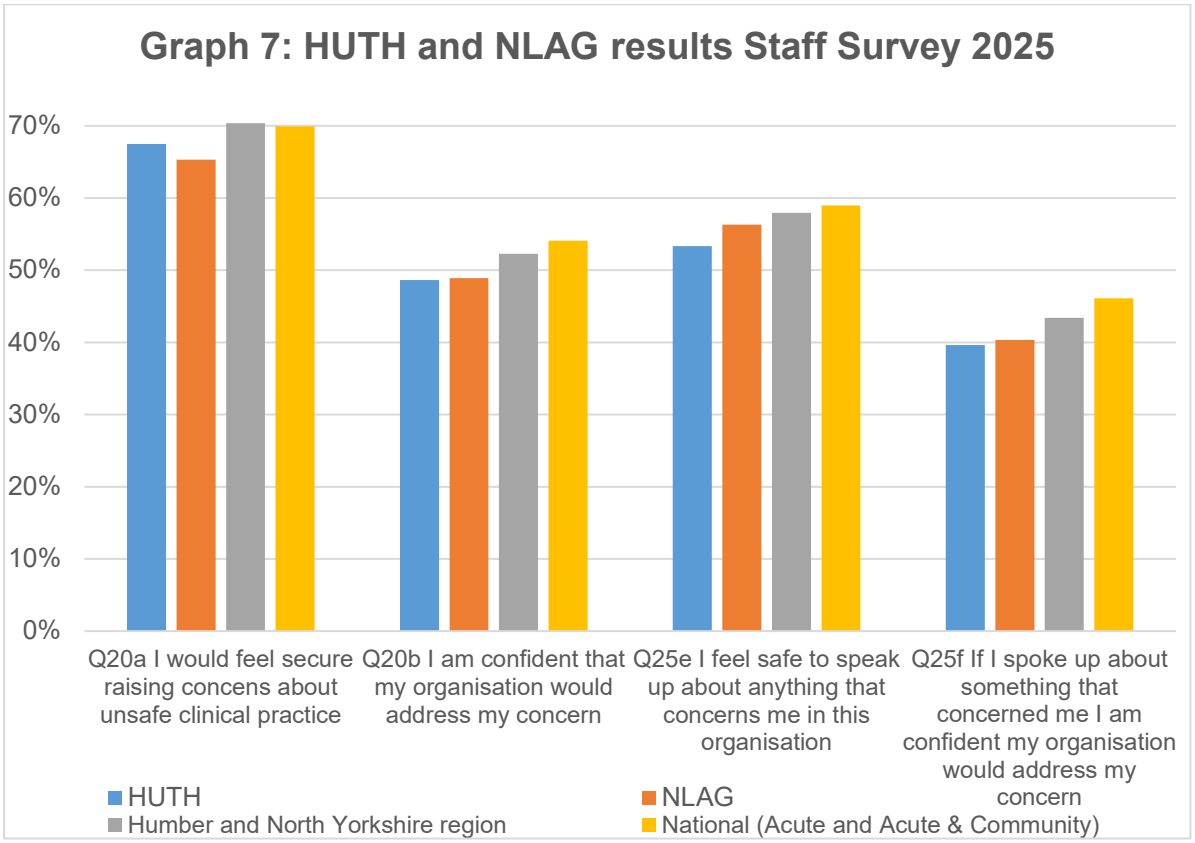
The NHS Staff Survey provides a crucial insight into what and how colleagues feel about the organisation. In relation to the FTSU questions in the staff survey, the 2025 results show a decline in staff feeling safe to raise concerns about unsafe clinical practice from the previous year, however there is an increase in confidence that the organisation would address the concern. There is also an increase in staff feeling confident to raise concerns about anything and that the organisation would address these. (Graph 6).

Data analysis shows an increase in confidence in staff recruited outside of the UK in raising both unsafe clinical practice or anything else with an increase in confidence that the organisation would address concerns relating to unsafe clinical practice. There was a decrease in confidence from white colleagues that the organisation would address concerns but an increase in other ethnic groups and those with long term health conditions.

The NGO highlight that the number of cases brought to FTSUGs continues to rise and highlights the importance of staff having access to multiple routes to speak up, with the guardian being a trusted and crucial role.



Graph 7 shows the Group position benchmarked with national and regional data. All results are below the national average for Acute and Community Trusts.



7. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objectives of 'Our People – we will look after the health and wellbeing of our people' and 'Quality & Safety – we will keep our patients safe and reduce avoidable harm'.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Liz Houchin
16th April 2026

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 4 Report January 2026 to March 2026 and Annual Report April 2025 to March 2026

Fran Moverley
April 2026

Hull University Teaching Hospitals NHS Trust
Freedom to Speak Up Guardian Report
Quarter 4 and Annual Report 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during 1st January 2026 to 31st March 2026 quarter four (Q4) and the annual report of the 2025/2026 reporting year (1st April 2025 to 31st March 2026). The paper includes the details of the relevant regional and national updates for comparison and context. Collated Care Group data with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) within the NHS Humber Health Partnership (the Group), is also provided.

1.2 This paper is presented in line with the suggested information FTSUGs should provide in the 'Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts' published by NHS England (NHSE).

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current Group Strategic Objectives of 'Our People', 'We will look after the health and wellbeing of our people', 'Quality & Safety' and 'We will keep our patients safe and reduce avoidable harm'.

2.2 The report aims to provide assurance to the Group Trusts Boards-in-Common on promoting a 'speaking up' culture at HUTH for workers.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are several processes at HUTH in place that allow staff to raise concerns dependent on the situation, including, but not limited to:

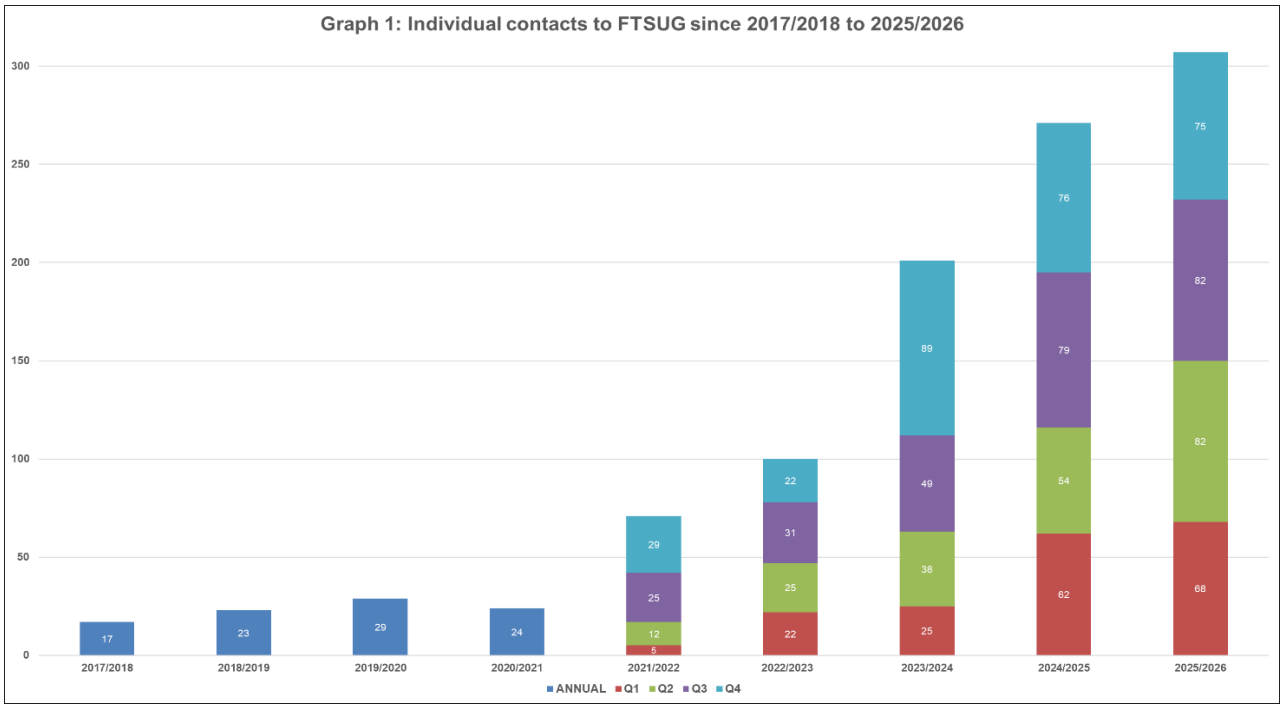
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Group Freedom to Speak Up Policy for the NHS (GP083)
- Group Conflict Resolution Policy (GP026)
- Group Grievance Policy and Procedure (GP024)
- Ulysses incident management system

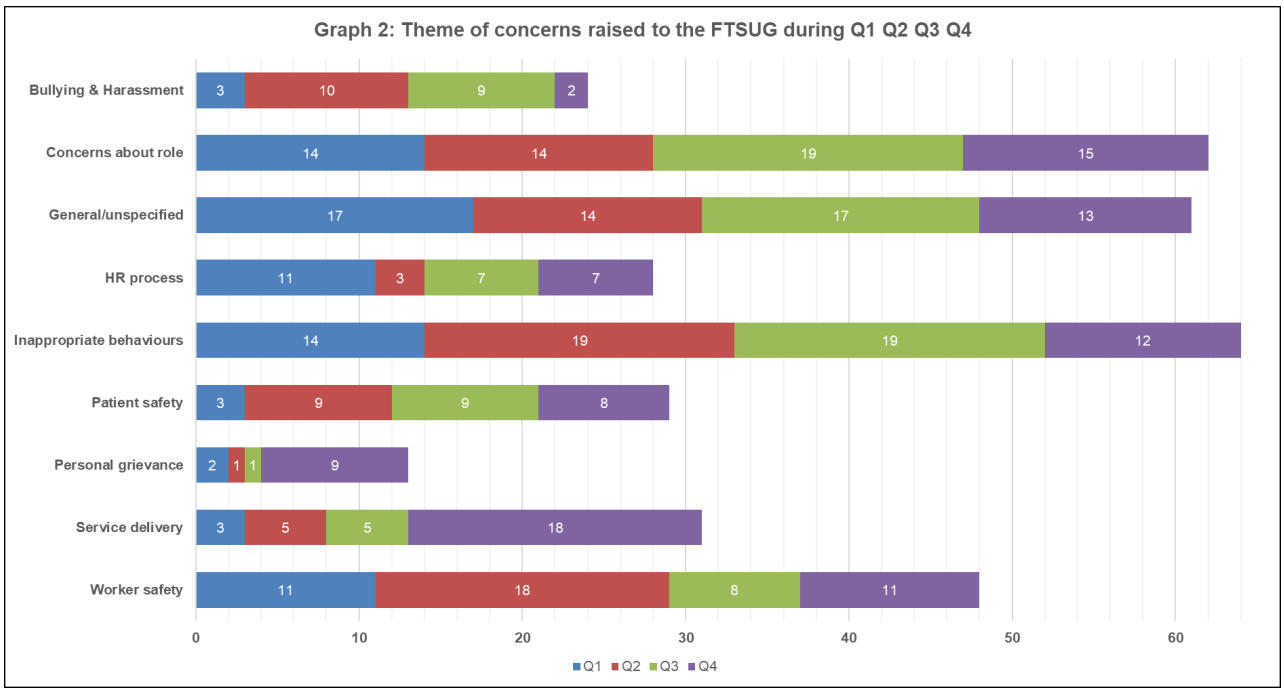
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during Q4 (1st January 2026 to 31st March 2026) and the annual reporting year (1st April 2025 to 31st March 2026) – data, comments and assessment

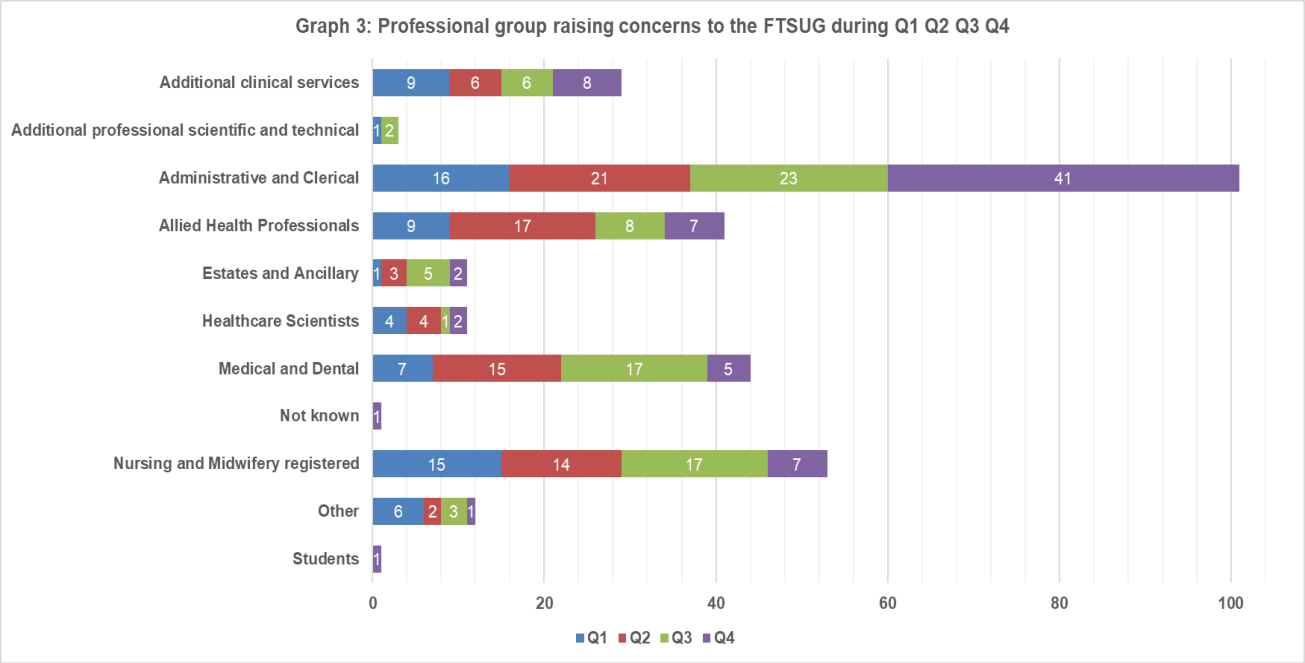
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office (NGO).

4.2 Graphs 1, 2 and 3 summarise the Q4 data and the annual data:





NB. Please note some concerns may have more than one element



4.3 Observation and comments during Q4:

- The number of concerns slightly decreased from 82 (Q3) to 75 and was similar to the previous Q4 reporting period in 2024/2025 (76).
- For the first time since Q4 2024/2025, 1 concern was raised anonymously and the FTSUG made an appeal internally encouraging the individual to make contact to discuss the concern further.
- 81% (61) of concerns were either within the remit of a line manager to be resolved or about the line manager, of which 89% (54) individuals had already spoken up to their line manager or through another route, before approaching the FTSUG. This was a further increase from Q2 and Q3.
- The number of individuals asking the FTSUG to protect their identity continued to decrease, from 12% (Q3) to 5.4% (Q4).
- The FTSUG had consent to directly escalate 28% (21) of concerns via an appropriate route, for example to a senior manager. NB several cases are still in progress and may still involve escalation from the FTSUG.
- For the first time, service delivery issues were the most frequently reported concern to the FTSUG, and the main themes included workloads and the organisation of work impacting productivity.
- Other most frequently raised concerns were about role and general issues. Themes for role concerns were varied and included changes without communication and flexible working processes. Themes of general concerns included employment entitlements and improvement ideas.
- There was a substantial increase in Administrative and Clerical staff raising concerns (54% of all cases).
- Examples of learning points from cases include staff being aware of the routes to escalate concerns up to senior management if needed and feeling confident to do so.

4.4 Observation and comments during annual 2025/2026:

- 307 concerns in total were raised to the FTSUG (Graph 1), representing a 13% increase since the previous 2024/2025 reporting year and the highest recorded for the Trust since the FTSUG role was implemented.
- During 2025/2026 0.3% (1) concern was raised anonymously. The level of anonymous reporting is often seen as an indicator of a transparent and open culture, and the Trust is below the previous national average in 2024/2025 of 11.6% (2025/2026 annual results not yet available).
- The most common ways individuals were aware of the FTSUG role were they had previously raised a concern, recommendation from colleagues or signposting from Speak Up Champions.
- 15% (47) individuals requested to be anonymous throughout the speaking up process (where the FTSUG knew the names of the individuals but did not have consent to release their identities), a reduction from 21% (58) in 2024/2025. Many staff expressed worries about negative impact if they were identified.
- The number of concerns relevant to or within the remit of the line manager to resolve increased from 55% (149) (2024/2025) to 79% (243); of which 78% (189) of individuals had already spoken up to their line manager or though another route, before approaching the FTSUG.
- There were increases in the number of concerns reported with an element of role, general issues, personal grievance, service delivery and worker safety. The most popular reasons for staff approaching the FTSUG, were due to concerns with an element of inappropriate behaviours followed jointly by concerns about role and general issues. This was unchanged from the 2024/2025 reporting year.
- The number of concerns increased from Medical and Dental, Allied Health Professionals, Administrative and Clerical and Additional Clinical Services staff from 2024/2025 to 2025/2026. The most significant was a 68% increase in reporting by Administrative and Clerical staff.
- There has been no change to the number of staff members (9) reporting concerns to the FTSUG stating they had been subjected to detriment or disadvantageous treatment during the speaking up process. Of the 9, 5 were escalated for investigation via formal processes.
- Model Hospital compares the numbers of cases raised to FTSUGs. The 12-month rolling average (data to Q3 2025/2026) shows HUTH in the highest 25% (quartile 4) compared to all other Trusts in England. HUTH is in quartile 3 (12-month rolling average) for each of the total numbers of cases reported for bullying and harassment, patient safety and quality, worker safety and inappropriate attitudes and behaviours.

4.4 FTSU Guardian Feedback/Evaluation:

The FTSUG offers a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. The survey is split– firstly the worker's experience of the HUTH FTSUG, and secondly, their experience of speaking up to the wider Trust. During Q4, a further 16 responses to the survey were received and the annual results for 2025/2026 are detailed below.

Part 1 results (speaking up to the FTSUG):

	Very easy	Fairly easy	Not easy	Difficult
How easy was it to make contact with the FTSUG?	93% (37)	5% (2)	0	3% (1)
	Excellent	**Good**	**Fair**	**Poor**
How was your experience of the FTSUG?	90% (36)	8% (3)	3% (1)	0
	Yes	**No**	**Not sure**	
Did you feel supported when speaking up to the FTSUG?	100% (40)	0%	0%	
Given your experience, would you speak up again to the FTSUG?*	100% (40)	0%	0%	
Did you feel your concerns were listened to and taken seriously?	100% (40)	0%	0%	
	Highly likely	**Likely**	**Unlikely**	**Highly unlikely**
How likely are you to recommend to a work colleague to contact the FTSUG?	98% (39)	3% (1)	0%	0%

Comments and observations:

- *100% of staff answered yes to the NGO mandatory question; '*Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'* and will be reported back to the national team.
- The most common way respondents found out about the FTSUG role was through recommendation from a colleague (12).

Examples of feedback about why the individual would speak up again and what went well with the FTSUG included:

- Feedback highlighted an empathetic, supportive and professional approach, where individuals felt able to speak openly in a safe and confidential environment. Individuals felt able to understand the options for raising concerns and often leading to resolution.
- There was a strong overall theme that the FTSUG responded quickly, listened and gave clarity on next steps.
- Example included: *"I felt genuinely listened to, taken seriously and treated with fairness and impartiality throughout. Communication was consistently timely and thoughtful", "That process of calmly exploring the situation and potential next steps made me feel listened to and more confident about how to raise concerns appropriately and constructively" and "Fran was empathetic and support over several occasions and I cannot thank her enough for valuing my concerns, taking them extremely seriously and escalating agreed concerns with the Director".*

Individuals were asked what could improve the speaking up process:

- The feedback was largely positive, and most individuals stating that no improvements are needed.
- Examples included ensuring the FTSUG role is safeguarded and visible organisational backing and holding monthly sessions for staff.

Part 2 results (speaking up to the wider Trust):

	Yes	No	Not sure	I chose not to raise my concern	In part
Did you feel your concern was treated confidentially?	73% (29)	15% (6)	10% (4)	3% (1)	
Did you feel your concerns were listened to and taken seriously?	70% (28)	23% (9)	5% (2)	3% (1)	
Given your experience, would you speak up again?	83% (33)	3% (1)	15% (6)		
Has your concern been addressed?	48% (19)	20% (8)	3% (1)	3% (1)	3% (11)
Have you experienced any detriment, disadvantageous and/or demeaning treatment, or any negative impact, as a direct result of speaking up?	31% (11)	61% (22)	8% (3)		

Comments and observations:

- Only 4 completing the survey chose not to go onto raise their concern.
- The NGO mandatory question was also asked in respect of the individual's experience of speaking up to the wider Trust – *'Give your experience, would you speak up again?'.* In comparison, this was lower than the response about the FTSUG, however has increased from 77% to 83% since 2024/2025 in respect of the wider organisation which is positive.
- There was an increase from 5 (2024/2025) to 11 individuals reporting they had received negative treatment or detriment as a result of speaking up.

Examples of feedback about what went well with speaking up to the wider Trust, included:

- The feedback was mixed – many individuals felt well supported, listened to and valued and sometimes positive outcomes. Other individuals reported dismissive attitudes and lack of action to their concerns.
- Examples included: *"The manager checked back with me to see how things were going which I really appreciated", "I have been able to proceed to the next stage in getting my issues resolved", "The speak up champions support me though a hard time and listened. Great that the trust have them as support", "Nothing my direct manager was dismissive" and "It was brushed under the carpet".*

Examples of feedback to improve speaking up to the wider Trust included:

- There were key themes of ensuring that leaders take accountability and encourage an open and non-defensive environment to welcome concerns.
- Example quotes included: *"More visible messaging from senior leaders and managers, along with clear communication about confidentiality, non-retaliation, and the positive value of speaking up, could help reduce that anxiety and encourage more staff to come forward earlier".*

Planned action from the survey results:

- Key learning points about the role of leaders in encouraging speaking up, will be circulated to all leaders across the Trust.
- Monthly drop-in sessions, will continue to be organised and publicised to encourage different formats for raising concerns.

4.5 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, learning for the Trust, the positive impact that 'speaking up' can have for staff and patients.

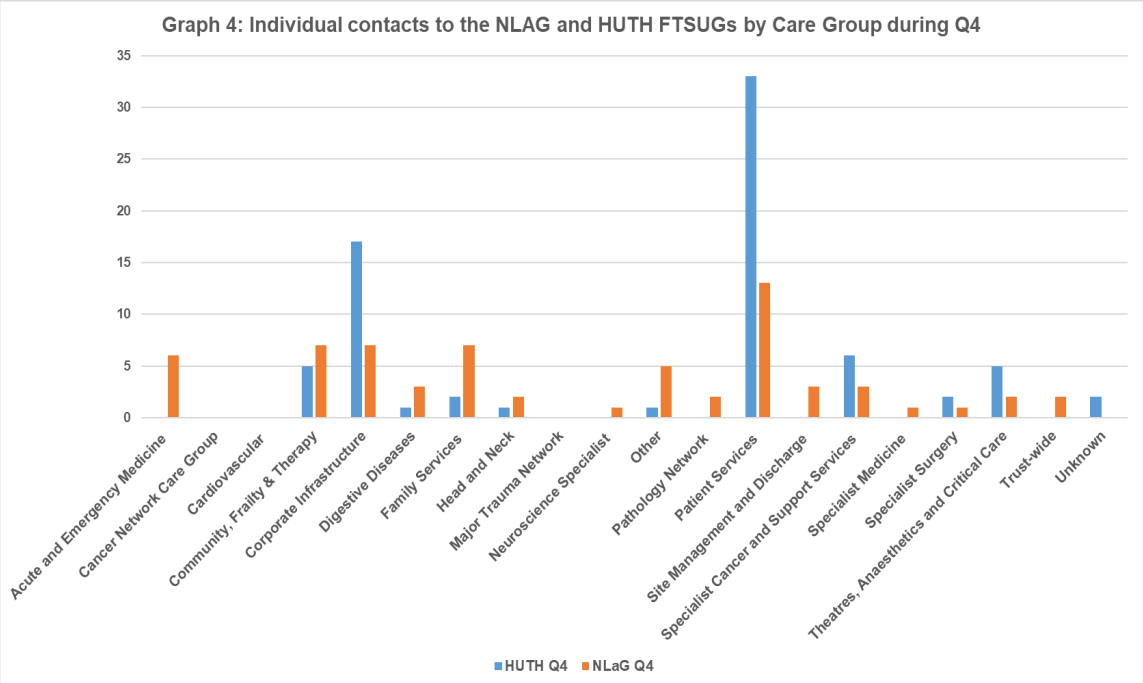
The FTSUG was contacted by an individual who was experiencing incivility from a colleague leading to the breakdown of their working relationship. The staff member was upset and was keen to ensure their working environment remained professional and did not feel their concerns were being acted upon.

The FTSUG supported the staff member on different occasions and gave guidance on the different ways to resolve the issues, including raising to their senior management and considering mediation. The FTSUG also had consent from the staff member to escalate the concerns to a member of the Human Resources team for further support.

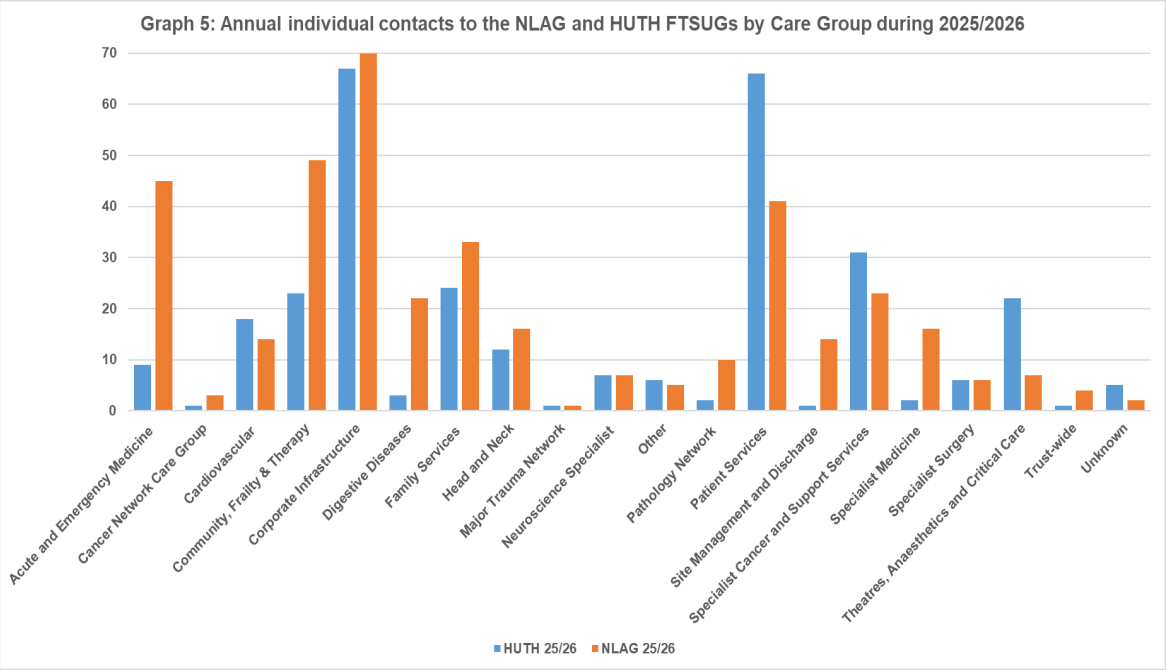
Overall, the concerns were resolved and the staff member feedback:
"Once again, I would really like to thank you for all your help, guidance and support you have given me over the past several months. Your continued guidance, and help has made a huge impact on myself now being able to reach a positive outcome. You are a real asset to the NHS. Thank you again".

4.6 Care Groups – concerns combined

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised during Q4 to the HUTH and NLAG FTSUGs. At HUTH, the highest number of concerns were received about Patient Services (33), Corporate Infrastructure (15) and Specialist Cancer and Support Services (6). Graph 4 is sent to the Care Group Triumvirates and HR Business Partners and information such as themes are offered, to enable triangulation alongside other workforce metrics.



Graph 5 provides an annual overview of the concerns received during 2025/2026 by Care Group. Combined, the highest number of concerns were received for Patient Services (66), Corporate infrastructure (65) and Specialist Cancer and Support Services (31).



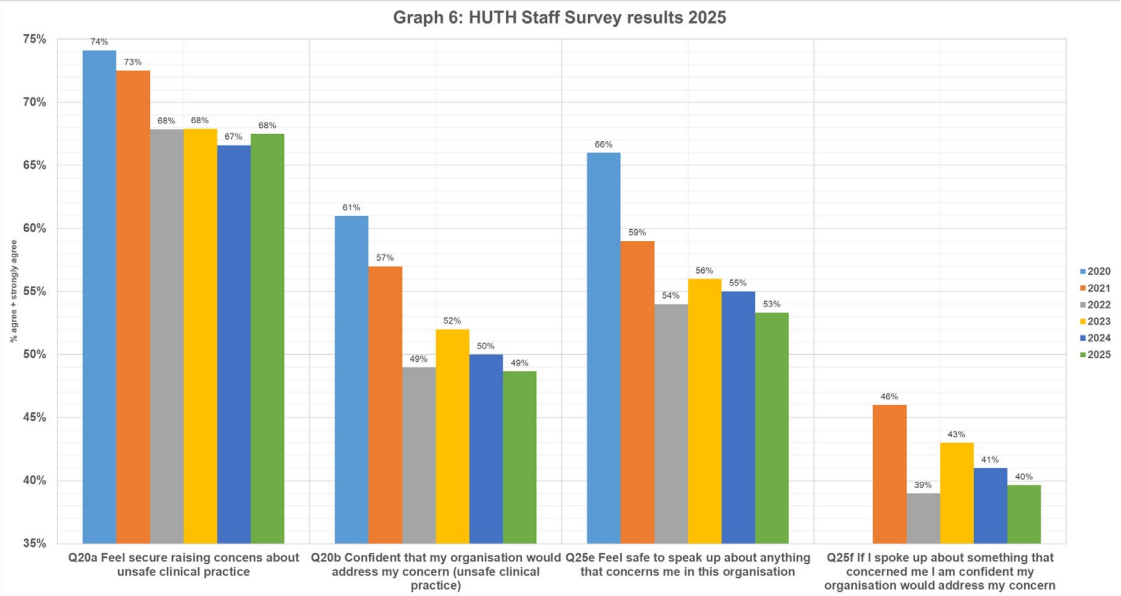
5. FTSUG activities and proactive work during Q4

5.1 A high level summary of the FTSUG activities are detailed below:

- The FTSUG presented at the Senior Leader Engagement meeting for learner's experience. Positively, NHSE identified good practice in the published report: *'NHS England noted that the guardians operate a positive environment in encouraging inclusivity within the organisation which could be shared amongst other trusts in the region'.*
- Worked collaboratively with the NLAG FTSUG to publish the mandated NHSE 'freedom to speak up in the NHS' policy in a single Group version.
- The FTSUG assisted in the facilitation of a student forum event for physiotherapy and occupational therapy students to promote speaking up. Positive feedback was received and the event will be repeated during 2026.
- Presented at the international-educated staff wellbeing support group to promote speaking up and raising concerns.
- Participated as a stakeholder for the recruitment of the new Group Chair.
- A further two cohorts of Speak Up Champions were trained, increasing the total number of HUTH Speak Up Champions to 59.
- Supported a GMC Professional Standards webinar to local medical staff with the GMC Regional Advisor.
- Provided information to Trust publications including EDS22, Annual Report and the Quality Accounts.
- Supported department walkarounds to promote speaking up to staff.
- Ongoing 2026 monthly face to face drop-in sessions arranged for Hull Royal Infirmary, Castle Hill Hospital and MS Teams to promote visibility and accessibility to the FTSUG. The Speak Up Champions continue to assist in promoting the drop ins within their teams.

6. Staff Survey results 2025

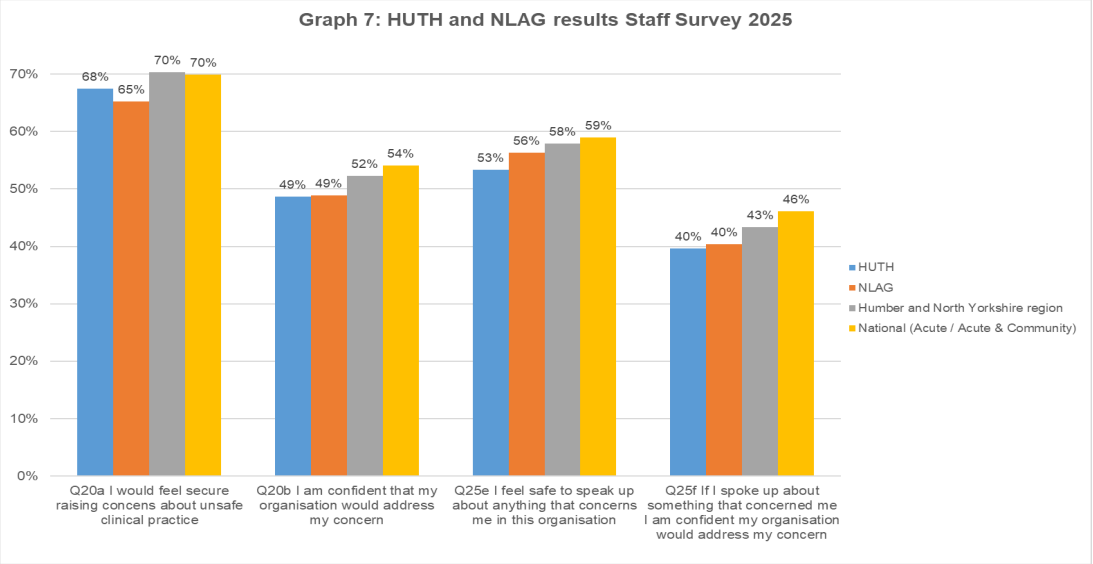
The 2025 Staff Survey included four questions related to staff feeling secure about speaking up at the organisation and the confidence that concerns will be addressed. Graph 6 provides the 2025 results for the Trust in comparison to previous results. The results are based on the percentage of staff answering 'strongly agree' and 'agree' to each question. The scores increased for question Q20a and showed a slight decrease for questions Q20b, Q25e and Q25f.



The Staff Survey provides a wide range of metrics, examples included:

- Staff from all other ethnic groups combined scored more positively than white staff, across all four questions. For example, (Q20b) staff from all other ethnic groups (56.21%) are more likely than white staff (47.47%) to feel that the organisation would address this concern they raised.
- For a consecutive year, staff with a long-term health condition or illnesses scored lower to all four speaking up questions. For example, (Q25e) 32.9% of staff with a health condition/illness felt safe to raise a concern as opposed to 42.31% of staff without any illnesses.
- Individuals in the 16 to 20 years age bracket scored higher than all other ages across all four questions.
- For question Q20a staff recruited from outside of the UK felt slightly less safe to raise concerns about clinical practice (67.06%), than staff recruited within the UK (68.25%).
- Each summary occupational group reported an increase in feeling safe to raise concerns about unsafe clinical practice, with Registered Nursing and Midwifery staff feeling the safest for a second consecutive year (76.29%). For all other concerns, Nursing and Healthcare Assistants reported feeling the safest (58.14%).

Graph 7 shows the comparison regionally and nationally. Both Trusts within the Group are slightly below the national average and regional average, albeit closer to the regional average.



7. Regional and National Information and Data

7.1 Regional update

The FTSUG continues to attend the Yorkshire and the Humber and Northeast regional meetings to discuss and share best practice. In January 2026, the regional network participated in the GMC consultation for professional standards and received an update on the national NGO position.

7.2 National update

There has been confirmation that the NGO will now close on 30th June 2026 with their responsibilities transferring into NHSE. The extension allowed for an engagement process with NGO staff, guardians, NHS leaders and other stakeholders about the future of the Freedom to Speak Up programme, its functions and ensures continued support of guardians during the transition. The FTSUG contributed to the engagement sessions.

Confirmation of the remit and scope of FTSU when it transfers into NHSE from 1st July 2026 has been published the Future of Freedom to Speak Up which details the changes. NHSE will assume delivery of some activities previously undertaken by the NGO, with employers being asked to take on greater responsibility and accountability for embedding effective FTSU arrangements.

8. Conclusion

8.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up.

8.2 The FTSUG has continued to be active in promoting speaking up and using different methods to raise awareness.

9. Recommendations

9.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's FTSUG arrangements.

9.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the FTSUG role and speaking up arrangements in the Trust.

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(26)140

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 June 2026
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Rebecca Crashley, Deputy Director of Assurance and Alison Hurley, Deputy Director of Assurance
Title of Report	**Provider Licence and Code of Governance compliance for 2025-26**
Executive Summary	This report provides an overview of the NHS England Code of Governance requirements, noting best practice across NHS corporate governance matters for all Trusts, and demonstrates adherence for the Group against these standards. The report also details the legacy requirement for the Boards to report compliance against two remaining elements of the **Provider Licence**, with regard to supporting: • our aim to reduce inequalities between persons with respect to their ability to access services (2b); and • our current registration with the CQC (G6) The Code sets out a series of standards that the Trusts are required to detail within the Annual Report, or via a 'comply or explain' statement. Corporate Assurance has undertaken a detailed assessment of the Trust's compliance against the Code of Governance standards in order that each Trust's Annual Report is compliant (around 90 standards in total). As part of the year-end processes, External Audit are required to review the Annual Reports to ensure the content reflects the specified requirements against this Code and the requirements laid out in the DHSC group accounting manual 2025 to 2026. By taking this item in the public Boards, this report can also be referenced within the Annual Report. **Recommendation, the Trust Boards-in-Common are requested to:** • Accept the statements relating to the Provider Licence for HUTH and NLaG, as stated above; and • Accept the assessment regarding the Code of Governance requirements.

Background Information and/or Supporting Document(s)	See above
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

Code of Governance review - 2025/26

This report details each disclosure (both a summary and detail) from Schedule A: Disclosure of corporate governance arrangements, NHS England, 2023. It indicates whether the disclosure is compulsory or a 'comply or explain' disclosure. Each has a brief assessment against the draft annual reports for NLAG and HUTH, together with the additional material to be added prior to its completion where necessary to ensure compliance.

The Code of Governance relates to all Trusts, and any additional FT specific disclosures are indicated in blue text and NHS Trust specific disclosures are indicated in green.

The provisions listed as 'requirement' mean that a supporting explanation in a trust's annual report is required, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

For the provisions listed as 'comply or explain', the disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the Code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the Code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the Code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Comply or explain

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.10 **Complete** Complusory: *X* **Assessment:**	**Board must manage conflicts of interest and prevent third-party influence from overriding independent judgement.** The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement. The annual report meets the criterion satisfactorily. It demonstrates a structured and transparent approach to managing conflicts of interest and protecting independent board judgment. While this section could be strengthened by referencing specific conflict scenarios or enforcement actions, the formal structures and policies are in place and described clearly.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.11	**Board concerns must be recorded. Departing non-executives with concerns should submit a statement to the chair.**
Complete Complusory: X **Assessment:**	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board. The Annual Report provides **clear evidence** that board concerns are formally recorded, and that departing non-executive directors are invited to submit a written statement where concerns remain unresolved. The report also confirms that no such statements were received during the reporting period, which strengthens assurance and transparency
Section A, 2.2	**Board should define and report the trust's vision and values, aligned with system strategies and collaboration.**
Complete Complusory: X **Assessment:**	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICB's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions. The annual report meets the criterion comprehensively. It articulates a formally adopted vision and values framework that is clearly aligned with the ICB strategy and the trust's role within system and provider collaboratives. The values are embedded in behaviours, culture, leadership development, and operational planning—demonstrating coherence and intentional implementation.
Section A, 2.4	**Board must monitor and report on delivery effectiveness, quality, risk, and performance against plans and obligations.**
Complete Complusory: X **Assessment:**	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives. The annual report clearly meets the criterion. The report demonstrates that the Board has structures and processes in place to monitor delivery effectiveness, quality, risk and performance against plans. The Report describes reporting through the Integrated Performance Report and oversight of quality, performance and risk through the formal committees.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.5	**Board must define metrics and seek independent advice for assurance on complex or high-risk matters.**
Complete Complusory: X **Assessment:**	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance. The annual report clearly satisfies this criterion. It demonstrates the formal KPI reporting through the IPR, monthly BAF/risk reviews, access to independent professional advice for directors and external input in senior appointments and assurance processes. It demonstrates the use of robust and dynamic performance measurement tools (e.g. SPC-based IPR), and links metrics to national targets and local priorities. Independent internal audit is embedded within governance processes and is used effectively in high-risk and complex areas to deliver assurance to the board.
Section A, 2.6	**Report the trust's clinical governance approach and quality improvement plans in line with regulatory guidance.**
Complete Complusory: X **Assessment:**	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered. The annual report meets the criterion. It describes the Trust's clinically led improvement plan, identifies quality priorities, refers to Quality and Safety Committees-in-Common and evidences CQC inspection activity and associated action planning. in full. It outlines a comprehensive and nationally aligned clinical governance structure, clear leadership roles, and multiple levels of operational and strategic oversight. The board demonstrates accountability for quality improvement and ensures that guidance from regulatory bodies (CQC, NHS England, DHSC) is embedded within its quality governance and assurance processes.
Section A, 2.7	**Chair and committee chairs must engage stakeholders and ensure stakeholder views are understood and reported.**
Complete Complusory: X **Assessment:**	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B. The annual report demonstrates that the Trust has governance routes through which stakeholder views can be heard, particularly the Council of Governors, member engagement, community dialogue and partnership structures.

Reference, coverage and assessment	Disclosure and assessment
Section A, 2.9	**Board must enable staff to raise concerns confidentially and ensure proper investigation and follow-up.**
Complete Complusory: ✗ **Assessment:**	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action. The annual report meets the criterion effectively. The trust has robust mechanisms for staff to raise concerns confidentially and anonymously through the Freedom to Speak Up Guardians, regular board-level committees have oversight of these concerns, and procedures for independent investigation and follow-up.

SECTION B

Section B, 2.1	**Chair sets board and council agendas, ensuring time is allocated to strategic discussions.**
Complete Complusory: ✗ **Assessment:**	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues. This criterion is met. The annual report states a direct statement of the Chair's responsibility for managing time allocation and notes that adequate time is allocated for the discussion of all agenda items, with particular emphasis on strategic matters, including organisational transformation, workforce, quality of care, financial sustainability, and system-level collaboration. The Chair ensures that board meetings are structured to support effective scrutiny and decision-making on these areas, in alignment with the Trust's vision and the wider system strategy.
Section B, 2.10	**Only committee members may attend key meetings unless invited.**
Complete Complusory: ✗ **Assessment:**	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee. These sections confirm that the Trust complies with the governance expectation that only committee members are entitled to attend, with others present only by invitation.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.11	**A senior independent director should be appointed to support and appraise the chair. Annual appraisals should occur.**
Complete Complusory: X **Assessment:**	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework. The Annual Report 2024/25 confirms compliance with the governance expectation.
Section B, 2.12	**Non-executives appoint and oversee executives, meet without executives, and hold them accountable.**
Complete Complusory: X **Assessment:**	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present. These disclosures demonstrate that the Trust complies with the governance expectation regarding the role of NEDs in executive appointments, performance oversight, and independent meetings with the Chair.
Section B, 2.14	**Directors must disclose other commitments. The board must approve any new ones and explain time expectations.**
Complete Complusory: X **Assessment:**	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the Chairship of such an organisation. These disclosures demonstrate that the Trust complies with the governance expectations regarding director time commitments, external appointments, and transparency. An explicit statement has been added to the report stating that any new significant external appointment or commitment undertaken by a director requires prior Board approval.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.15 **Complete** Complusory: X **Assessment:**	**All directors must have access to the company secretary for governance advice. Board decides on appointment/removal.** All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board. The function of the company secretary is clearly fulfilled by the Group Director of Assurance, and directors have access to governance advice. The appointment and removal of the Group Director of Assurance is a matter reserved for the full board, ensuring appropriate oversight and alignment with the trust's governance framework.
Section B, 2.16 **Complete** Complusory: X **Assessment:**	**All directors must challenge constructively, monitor performance, and ensure controls and reporting are robust.** All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. These disclosures confirm that the Trust meets the governance expectation for active and informed board engagement, particularly by non-executive directors, in shaping strategy, scrutinising performance, and ensuring robust governance.
Section B, 2.16 *Schedule A* **Complete** Complusory: X **Assessment:**	**Board is collectively responsible for healthcare quality, training and research, following clinical governance standards.** The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies. The Annual Report confirms that the board of directors collectively holds responsibility for the quality and safety of healthcare services, education, training, and research, in line with the expectations of the Department of Health and Social Care (DHSC), NHS England, the Care Quality Commission (CQC), and other relevant NHS bodies. This is evidenced through the Committees-in-Common.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.17	**Board should meet regularly and reserve certain matters for its own decisions.**
Complete Complusory: X **Assessment:**	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. These disclosures confirm that the board meets regularly and retains clear oversight of key decisions through a defined schedule of reserved matters.
Section B, 2.17 *Schedule A*	**Board members share joint responsibility for decisions, with specific duties remaining for the chief executive.**
Complete **Complusory: X** **Assessment:**	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer. These disclosures confirm that the Trust complies with the governance expectation that all directors share collective responsibility for board decisions, while recognising the distinct statutory role of the Chief Executive as accounting officer.
Section B, 2.2	**Chair ensures timely, clear information for directors and governors and supports governor development.**
Complete Complusory: X **Assessment:**	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role. The Chair is responsible for ensuring that all members of the Board of Directors and the Council of Governors receive accurate, timely, and clear information to support informed decision-making and effective fulfilment of their statutory responsibilities. This includes access to performance reports, strategic updates, and committee outputs, ensuring transparency and alignment across governance structures. For the Council of Governors, the Chair also oversees the provision of development opportunities and ensures that governors have the necessary knowledge and skills to undertake their role. This includes: Access to briefings and development sessions on key service priorities and system changes Participation in structured visits, review activities, and NHS England-aligned training Annual individual development reviews for governors to assess support needs Through these arrangements, the Chair supports a well-informed and capable governance body that contributes effectively to the trust's success and accountability to its stakeholders.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.3 **Complete** Complusory: X **Assessment:**	**Chair promotes a culture of openness and supports effective relationships between executive and non-executive directors.** The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors, and ensuring a constructive relationship between executive and non-executive directors The Chair plays a key role in promoting a culture of openness, honesty, respect and constructive challenge within the Board. Through effective leadership and facilitation, the Chair ensures that all directors are able to contribute meaningfully to board debate and assurance processes.
Section B, 2.4 **Complete** Complusory: X **FTs only** **Assessment:**	**Chair ensures effective collaboration between the board and council of governors.** A foundation trust chair is responsible for ensuring that the board and council work together effectively. The draft Annual Report 2025/26 does provide evidence that the Chair is fulfilling the responsibility of ensuring the Board and Council of Governors (CoG) work together effectively, though the references are more implicit than explicit.
Section B, 2.5 **Complete** Complusory: X **Assessment:**	**Chair must be independent at appointment. Chair and CEO roles must be separate. Chair should not sit on the audit committee.** The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director. The draft Annual Report 2024/25 provides clear evidence that the Trust complies with the governance expectations outlined.

Reference, coverage and assessment	Disclosure and assessment
Section B, 2.7 **Complete** Complusory: X **Assessment:**	**At least half the board, excluding the chair, should be independent non-executive directors.** At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent. The draft Annual Report 2024/25 provides clear evidence that the Board of Directors meets the requirement that at least half of its members, excluding the Chair, are independent Non-Executive Directors (NEDs).
Section B, 2.8 **Complete** Complusory: X **FTs only** **Assessment:**	**No one should serve simultaneously as a director and governor of any NHS foundation trust.** No individual should hold the positions of director and governor of any NHS foundation trust at the same time. The Annual Report provides sufficient evidence that the Trust complies with the criterion. There is no indication that any individual simultaneously holds both a director and governor position.
Section B, 2.9 **Complete** Complusory: X **Assessment:**	**Committee membership should rotate. Councils should seek diverse, skilled non-executive directors.** The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience. The Annual Report 2025/26 provides strong evidence that the trust is actively refreshing committee membership and avoiding undue reliance on individuals, including NEDs with clinical backgrounds on the board and prioritising diversity in board appointments through structured governance and EDI strategies.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.1	**Nominations committees identify and plan for director appointments, considering future risks and required skills.**
Complete Complusory: ✗ **FTs only**	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.
Assessment:	The trust's nominations and appointments processes are supported by external advice where appropriate. For senior appointments, including the Chair and Chief Executive, the selection panel includes an external assessor from NHS England and/or a representative from the Integrated Care Board (ICB), in line with best practice. The trust engages with NHS England to agree the approach to these appointments. Succession planning is reviewed annually to ensure the board maintains the skills and experience needed to meet future challenges and strategic priorities.
Section C, 2.2	**Committees should review board composition and skills annually and define requirements for appointments.**
Complete Complusory: ✗ **FTs only**	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.
Assessment:	The Annual Report 2025/26 confirms that the trust operates with two distinct nominations committees, each with clearly defined responsibilities, but it only partially meets the full expectations of the NHS Foundation Trust Code of Governance regarding board composition review and succession planning. The Remuneration Committees-in-Common review the board's structure, size and composition. This includes an evaluation of the balance of skills, knowledge, experience and diversity. The findings inform succession planning and the development of role specifications for future appointments. The trust is committed to maintaining a board that reflects the communities it serves and is equipped to meet future strategic challenges.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.3	**Nominations committees must be chaired by the chair or independent director; governors may chair for non-exec roles.**
Complete Complusory: ✗ **FTs only** **Assessment:**	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair. These arrangements demonstrate that the Trust complies with the governance requirement regarding the appropriate chairing of nominations committees.
Section C, 2.4	**Governors must agree a clear nominations process and receive committee recommendations for appointments.**
Complete Complusory: ✗ **FTs only** **Assessment:**	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors. These disclosures confirm that the Trust has a clear, governor-led process for nominating and appointing the Chair and NEDs, with final decisions resting with the full Council of Governors.
Section C, 2.5	**Chair and non-executive appointments should use open advertising and NHS England advice.**
Complete Complusory: ✗ **FTs only** **Assessment:**	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors. Open advertising and advice from NHS England's Non-Executive Talent and Appointments team was used in the recruitment of Non-Executive Directors (NEDs), as recommended by the Code of Governance.

Reference, coverage and assessment	Disclosure and assessment
Section C, 2.6	**Non-executive nominations must involve a governor/independent majority in committees and interview panels.**
Complete Complusory: ✗ **FTs only**	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.
Assessment:	The interview panel for the appointment of Non-Executive Directors includes a majority of governors and/or independent members, in line with the NHS Foundation Trust Code of Governance
Section C, 2.7	**Governors should consider the board and committee views on skills needed when appointing non-executive directors.**
Complete Complusory: ✗ **FTs only**	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.
Assessment:	The NLAG Annual Report 2025/26 confirms that the Council of Governors (CoG) works closely with the Appointments and Remuneration Committee (ARC) to appoint Non-Executive Directors (NEDs), including the Chair, and that the process includes consideration of the qualifications, skills, and experience required for each role.
Section C, 3.1	**NHS England appoints trust non-executives. Executive appointments involve panels including external assessors.**
Complete Complusory: ✗ ***NHS Trusts only***	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.
Assessment:	The Annual Report 2024/25 confirms that the trust follows a two-committee structure for executive and non-executive appointments, but it does not fully meet the NHS Trust governance expectation. Section C, 2.1. refers to NHS England engagement in the appointment process for the Chair or NEDs and that a representative from NHS England or the Integrated Care Board (ICB) served as an external assessor on any selection panel. NHS England was consulted to agree the approach for executive appointments.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.1	**Directors and governors must meet the fit and proper persons test, including qualifications, integrity, and conduct.**
Complete Complusory: ✗	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.
Assessment:	The Annual Report 2025/26 confirms that the trust has policies and processes in place to ensure that directors and governors meet the 'fit and proper persons' test, as required by the NHS provider licence and CQC Regulation 5.
Section C, 4.10	**Governors may be removed for misconduct. Disputes should be resolved by an independent assessor if needed.**
Complete Complusory: ✗ **FTs only**	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.
Assessment:	The Trust is compliant with the requirement to have a fair and transparent process for the removal of governors. The policy is clearly documented and aligns with NHS England's expectations. The Trust could enhance transparency by explicitly stating the voting threshold for removal (e.g. 75%) and confirming whether an independent assessor would be used in cases of dispute.
Section C, 4.11	**Board must maintain skills and plan for succession with the council of governors.**
Complete Complusory: ✗	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.
Assessment:	The Trust is compliant with the requirement to retain the necessary skills across its board and to work with the Council of Governors on succession planning. The governance framework includes structured appointment processes, regular evaluations, and strategic workforce planning. While the Trust outlines its approach to board composition and succession planning, future reports could benefit from more detailed examples of how succession risks are identified and mitigated in practice.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.12	**Remuneration committee must conduct risk assessments before approving early executive departures.**
Complete Complusory: ✗ **Assessment:**	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment. The Trust confirms that executive departures are managed in accordance with contractual terms and subject to appropriate oversight. While the report outlines the governance framework for executive exits, there is limited explicit reference to the use of formal risk assessments prior to departure decisions. The Trust is broadly compliant with the requirement to manage executive departures in line with contractual terms and national guidance. The Remuneration Committees-in-Common oversee all such decisions, and there is no indication of inappropriate severance arrangements. The Trust should explicitly document and disclose the completion of a formal risk assessment prior to any executive departure that deviates from standard terms, in line with NHS England's Code of Governance expectations.
Section C, 4.3	**Chair should not serve beyond nine years unless extended for succession planning, with reasons clearly explained.**
Complete Complusory: ✗ **Assessment:**	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England. Tenure: Alan Downey was appointed as Chair in April 2026. Conclusion: The report meets the criterion. The Chair's tenure is within the acceptable limits, and no extension has been made that would require additional scrutiny or explanation.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.4	**Governors must face re-election every three years. Biographies and performance info should be provided.**
Complete Complusory: ✗ **FTs only**	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.
Assessment:	The Annual Report demonstrates that the Trust is compliant with the requirement that elected foundation trust governors are subject to re-election at intervals not exceeding three years. It also aligns with best practice by limiting governors to a maximum of three consecutive terms.
Section C, 4.5	**Annual board and individual director evaluations must occur, with NHS England or governors leading as appropriate.**
Complete: Complusory: ✗	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.
Assessment:	For all board members, the Trust has introduced appraisal processes based on the NHS Leadership Competency Framework.
Section C, 4.6	**Chair and directors must act on evaluation outcomes and address development needs.**
Could enhance Complusory: ✗	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.
Assessment:	Whilst the Trust is compliant with the requirement that the Chair and directors act on the results of board evaluations, the report does not provide specific examples of development actions taken by individual directors. Including such examples in future reports would enhance transparency and demonstrate impact.

Reference, coverage and assessment	Disclosure and assessment
Section C, 4.8	**Governors must assess and communicate their impact and effectiveness, including accountability and engagement.**
Complete Complusory: ✗ **FTs only**	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: holding the non-executive directors individually and collectively to account for the performance of the board of directors communicating with their member constituencies and the public and transmitting their views to the board of directors contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.
Assessment:	The Annual Report confirms that the Council of Governors (CoG) at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) has a structured approach to evaluating its performance and communicating its impact to members and the public. While the CoG's engagement activities are well-documented, future reports could benefit from more explicit examples of how member and public feedback has directly influenced board decisions or strategic plans.
Section C, 5.10	**Board and council must receive high-quality, relevant information and agree their needs with executive directors.**
Complete Complusory: ✗	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides strong evidence that both the Board of Directors and the Council of Governors are provided with high-quality, timely, and relevant information to support effective decision-making. The Trust demonstrates a robust approach to ensuring that both the Board and Council of Governors receive concise, accurate, and timely information. The use of SPC charts, structured committee reporting, and regular engagement between executives and governors supports effective oversight and decision-making. While the report outlines the provision of information, it could be strengthened by including examples of how feedback from governors or NEDs has influenced the format or content of reports. The Trust may consider publishing a summary of how information needs are reviewed and agreed annually between the Board, governors, and executive team.

Section C, 5.1	All directors and governors should receive induction and regular training updates.
Complete Complusory: X	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered**.**
Assessment:	The Trust provides structured induction and ongoing development opportunities for both directors and governors. These programmes are designed to ensure that all individuals are equipped with the knowledge and skills necessary to fulfil their roles effectively. The Trust is compliant with the requirement to provide appropriate induction and ongoing development for directors and governors. The governance framework includes structured onboarding, regular training, and performance reviews. While the Trust outlines a strong framework for induction and development, future reports could include more detail on how the effectiveness of these programmes is evaluated and how feedback is used to improve them.

Section C, 5.11	**Non-executives should challenge management when needed and seek deeper analysis or external advice if necessary.**
Complete Complusory: X	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides clear evidence that Non-Executive Directors (NEDs) are empowered to challenge executive assurances and are supported with the information and mechanisms necessary to make informed decisions. The Trust has established a governance framework that enables NEDs to challenge executive assurances effectively. The use of structured performance reporting, access to internal and external audit, and the ability to seek independent advice ensures that the Board can make informed decisions and request deeper analysis when necessary. The report could be strengthened by including specific examples of instances where NEDs requested further analysis or external assurance on complex or high-risk issues. It may be helpful to include a summary of how often NEDs have exercised their right to seek independent advice or escalate concerns through formal channels.

Section C, 5.12	**Board should provide directors with access to independent advice when needed, approved by non-executive majority.**
Complete Complusory: ✗	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that Non-Executive Directors (NEDs) have access to independent professional advice at the Trust's expense when necessary to discharge their responsibilities. The Trust has appropriate provisions in place to ensure that NEDs can access independent professional advice when needed. This supports their ability to provide effective oversight and challenge. The availability of this support is clearly stated in the Annual Report and aligns with good governance practice. The report could be enhanced by including a statement confirming that the availability of independent advice is made clear to NEDs at the time of appointment. It would be beneficial to include examples or a summary of instances where external advice was sought, or to confirm whether this occurred during the reporting period.
Section C, 5.13	**Committees and councils must have enough resources to perform duties, agreed in advance.**
Complete Complusory: ✗	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides evidence that both Board committees and the Council of Governors are supported with appropriate resources to carry out their duties effectively. The Trust has established robust support mechanisms for both its Board committees and the Council of Governors. These include administrative, professional, and developmental resources that enable effective governance, oversight, and engagement. The arrangements are clearly documented and appear to be functioning well.

Section C, 5.14	**Non-executives must evaluate if they receive timely information and can apply their skills to challenge decisions.**
Complete Complusory: ✗ **Assessment:**	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles. The Trust is compliant with this criterion. The Annual Report demonstrates that Non-Executive Directors (NEDs) are supported to apply their experience and judgement and are provided with the information necessary to challenge recommendations and make informed decisions. The Trust has created an environment where NEDs are empowered to apply their leadership experience and professional judgement. They are provided with timely and relevant information and are encouraged to challenge executive recommendations. The governance structure supports their active involvement in decision-making and oversight.
Section C, 5.16	**Board should consider and respond to governor input on forward plans, explaining what was or wasn't included.**
Complete Complusory: ✗ **FTs only** **Assessment:**	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included. The Trust is compliant with this criterion. The Annual Report provides evidence that the Council of Governors (CoG) is consulted on the Trust's forward planning and that their views are considered and responded to appropriately. The Trust has demonstrated that it engages the Council of Governors in the development of its forward plans and provides opportunities for governors to contribute views. The Trust also communicates which views have been incorporated and explains its rationale where they are not, through structured meetings and briefings.

Section C, 5.17	**Trusts should provide indemnity and/or insurance for directors and governors where appropriate.**
Complete Complusory: ✗	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.
Assessment:	The Trust is compliant with this criterion. The Annual Report confirms that appropriate insurance arrangements are in place for directors, and that governors are protected from liability when acting in good faith. The Trust has confirmed that it maintains appropriate insurance to protect its directors from legal liability. While not legally required, the Trust acknowledges the low risk of liability for governors acting in good faith and references the Trust Constitution as the source of any indemnity provisions.
Section C, 5.2	**Chair must support continuous learning and training, including for recruitment and diversity topics.**
Complete Complusory: ✗	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality, diversity and inclusion, including unconscious bias.
Assessment:	The Trust provides structured support to ensure that both directors and governors continually update their skills, knowledge, and familiarity with the organisation and its obligations. The Chair plays an active role in promoting development, and the Trust offers resources and training aligned with national expectations. The Trust is compliant with the requirement to ensure that directors and governors regularly update their skills and knowledge. The Chair actively supports development, and the Trust provides structured opportunities for learning and engagement. The Trust should explicitly confirm that directors and governors involved in recruitment receive training on equality, diversity and inclusion, including unconscious bias, to fully align with NHS England's Code of Governance.

Section C, 5.3 **Directors need access to trust information, operations, and policies to function effectively.**

Complete
Complusory: ✗

To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

Assessment: The Trust ensures that directors and governors have access to the organisation's operations and staff, and are appropriately briefed on its values, policies, and procedures. This supports their ability to fulfil their roles effectively and in alignment with the Trust's strategic objectives.The Trust is compliant with the requirement to ensure that directors and governors have access to operations, staff, and are briefed on values and policies. The governance framework supports transparency, engagement, and alignment with the Trust's mission.

Section C, 5.4 **New directors and governors must receive tailored induction and access training aligned with development needs.**

Complete
Complusory: ✗

The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

Assessment: The Trust provides a structured and tailored induction for new directors and governors, with opportunities to engage with stakeholders and access development resources. This supports effective governance and alignment with NHS England's Code of Governance. The Trust is compliant with the requirement to provide tailored induction and stakeholder engagement opportunities for directors and governors. The Chair plays an active role in ensuring that new appointees are well-prepared and supported.

Section C, 5.5 **Chair should review and agree each director's training needs.**

Complete
Complusory: ✗

The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

Assessment: The Trust is compliant with the requirement that the Chair ensures directors regularly review and update their training and development needs. The annual evaluation process and board development programme provide a structured mechanism for this. The Trust could strengthen its compliance by explicitly confirming that the Chair conducts individual development reviews with each director, separate from the collective board evaluation.

Section C, 5.6	**Foundation boards must ensure governors have necessary skills and knowledge.**
Complete Complusory: X **FTs only**	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.
Assessment:	The Trust demonstrates a clear commitment to ensuring that governors are equipped with the skills and knowledge necessary to discharge their duties effectively. This is achieved through structured induction, ongoing development, and regular engagement with the Trust's leadership and operations. The Trust is compliant with the requirement to ensure that governors are equipped with the skills and knowledge to discharge their duties. The governance framework includes structured induction, ongoing training, and active engagement with Trust leadership and operations. Future reports could include more detail on how the effectiveness of governor training is evaluated and how feedback is used to improve the development programme.
Section C, 5.8	**Chair must ensure directors and governors receive timely and clear information. Clarification should be sought as needed.**
Complete Complusory: X	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.
Assessment:	The Trust demonstrates compliance with this criterion. There is clear evidence of structured governance processes, regular reporting, and mechanisms for directors and governors to access and clarify information.The Trust has established robust governance mechanisms to ensure that directors and governors receive accurate, timely, and clear information. The use of structured reporting tools (e.g. IPR), regular meetings, and transparent publication of materials supports effective oversight. Governors are actively engaged and supported in their role, and there is a clear culture of accountability and openness. Timeliness of Information: While the IPR is comprehensive, the report does not specify the timeliness of data delivery to directors and governors. Clarifying lead times for report circulation could strengthen assurance. Digital Access and Tools: The report references the use of intranet platforms (e.g., Bridget), but further detail on how digital tools support real-time access to information for directors and governors would be beneficial. Feedback Loops: While governors can raise concerns, the report could better articulate how feedback from governors is systematically captured and acted upon by the Board.

Section C, 5.9	**Chair must ensure effective information flow across the board, council, and committees, and support development.**
Complete Complusory: ✗	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.
Assessment:	The Trust is compliant with this criterion. The Annual Report provides clear evidence that the Chair has facilitated effective information flow across the Board, between directors and governors, and supported induction and development activities. The Annual Report demonstrates that the Chair has fulfilled responsibilities for ensuring effective communication and governance across the Board and Council of Governors. The Chair has actively supported induction, development, and performance oversight of Board members and governors, contributing to a well-functioning governance structure.
Section D, 2.1	**Board must have an independent audit committee with at least two to three members, including financial expertise.**
Could enhance Complusory: ✗	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.
Assessment:	The Trust is fully compliant with Criterion. The Audit, Risk and Governance Committee-in-Common is properly constituted, independent, and financially competent. The committee's structure, membership, and operations align with NHS governance expectations and demonstrate a strong commitment to effective oversight.

Section D, 2.2 **Audit committee oversees financial integrity, internal controls, audit effectiveness, and stakeholder reporting.**

Complete

Complusory: X

The main roles and responsibilities of the audit committee should include: monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors reviewing and monitoring the external auditor's independence and objectivity reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.

Assessment: The Trust is compliant with Criterion. The Audit, Risk and Governance Committee-in-Common performs all expected duties, including oversight of financial reporting, internal and external audit, and internal controls. The committee's structure, reporting lines, and documented activities demonstrate a mature and effective governance function.

Section D, 2.3 **Trusts must rotate external auditors: NHS trusts every five years, foundation trusts every 10 years or sooner.**

Complete

Complusory: X

A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.

Assessment: The Trust is fully compliant with Criterion. The external audit function was re-tendered in 2023, well within the 10-year expectation and 5-year statutory requirement. The process was transparent, involved NHS England support, and resulted in a multi-year contract with appropriate review mechanisms.

Section D, 2.5 **Trusts must have a policy for non-audit services provided by external auditors.**

Complete
Complusory: ✗
Assessment:

Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.
The Trust is fully compliant with Criterion. It has implemented a clear and effective policy on the engagement of its external auditor for non-audit services, with appropriate oversight by the Audit, Risk and Governance Committee-in-Common. The absence of non-audit engagements during the reporting year further reinforces the auditor's independence.

Section E, 2.1 **Executive performance pay must align with public interest and patient care priorities.**

Could enhance
Complusory: ✗
Assessment:

Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
The Trust has a structured and transparent approach to executive remuneration, including annual appraisals and benchmarking. However, the absence of performance-related pay mechanisms means there is no direct alignment between executive remuneration and outcomes for patients, service users, or taxpayers. The Trust's approach is consistent with public sector norms but does not meet the full intent of this criterion.

Section E, 2.2 **Chair and non-executive pay should follow the established NHS remuneration structure.**

Complete
Complusory: ✗
Assessment:

Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.
The Trust demonstrates full compliance with the criterion. The remuneration structure for the Chair and NEDs is clearly defined, appropriately benchmarked, and transparently disclosed. The governance process ensures that remuneration reflects responsibilities and is subject to oversight by the Council of Governors.

Section E, 2.4 **Contracts should avoid rewarding poor performance. Include claw-back clauses for re-employment in the NHS.**

Complete

Complusory: ✗

Assessment:

The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice. The Annual Report outlines the Trust's approach to early termination and compensation for executive directors. While it confirms that there are no contractual provisions for payments on termination and that severance payments are subject to national guidance, it does not mention claw-back provisions or mitigation clauses.

Where applicable, director-level contracts of employment include provisions for payments in lieu of notice and claw-back in line with national guidance. Also, any severance payment that requires NHSE approval, obtains that approval prior to payment.

Section E, 2.5 **Any director severance must be discussed early with the NHS England regional director.**

Complete

Complusory: ✗

Assessment:

Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.

The Annual Report confirms that the Trust adheres to national guidance on severance payments, including the requirement for Treasury approval for special severance payments. Explicit reference to discussions with the NHS England regional director occurring at the earliest opportunity are captured in Section E 2.4.

Section E, 2.7 **Remuneration committee sets pay for executives and monitors senior management remuneration, as defined by the board.**

Complete

Complusory: ✗

Assessment:

The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

The Trust fully meets the criterion. The Remuneration Committees-in-Common have clear delegated authority to set and monitor remuneration for executive directors and senior management. The governance structure is well-defined, and the use of national benchmarking tools ensures consistency and fairness.

Section A, 2.1 | **Board must ensure effectiveness, efficiency, and quality, address partnership opportunities, and report on sustainability risks and governance in the annual report.**

Complete

Complusory: ✓

The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

Assessment:

A Group governance model with aligned structures between NLAG and HUTH supports integrated decision-making. This includes joint boards, shared performance frameworks, and coordinated committee workplans.

The Audit, Risk and Governance Committee-in-Common evaluates internal controls, oversees the internal audit plan, and monitors implementation of audit recommendations. These activities directly support delivery and compliance.

Board evaluation and development are built into an annual cycle, with formal reviews under the NHS “Well-led” Framework, and alignment with the Code of Governance for Foundation Trusts.

The Integrated Performance Report (IPR) provides ongoing oversight of strategic delivery, supported by a Scheme of Delegation and metrics to monitor accountabilities.

Clinical governance is underpinned by a structured chain of accountability from the Group Chief Nurse and Group Chief Medical Officer through to divisional and site-level leadership. The trust meets the criterion effectively. It has clearly articulated governance arrangements that are embedded within a dual-trust group model. There is comprehensive evidence of risk management integration, strategy alignment, and systematic board oversight across operational and strategic priorities.

Section A, 2.3 | **Board must assess and monitor culture, ensure alignment with trust values, take corrective action, and report workforce wellbeing initiatives in the annual report.**

Complete

Complusory: ✓

The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust’s vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board’s activities and any action taken, and the trust’s approach to investing in, rewarding and promoting the wellbeing of its workforce.

Assessment:

The annual report meets the criterion comprehensively. It explains the board’s structure, evaluations, and actions clearly. The trust outlines a robust and evidence-based approach to workforce investment, reward, and wellbeing—supported by formal strategies, performance indicators, and structured engagement mechanisms.

Section A, 2.8 **Annual report should describe stakeholder engagement, list key partnerships, and explain governance of collaboration and risk management.**

Complete

Complusory: ✓

The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.

Assessment:

The annual report meets the criterion thoroughly. It provides robust evidence that the board integrates stakeholder interests in decision-making, has entered key regional and system-level collaborations, maintains effective engagement mechanisms, and oversees those partnerships through formal governance and risk management systems.

Section B, 2.13 **Responsibilities of the chair, CEO, SID, board, and committees should be clearly defined, agreed, and published.**

Complete

Complusory: ✗

The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.

Assessment:

This confirms that the Trust meets the governance requirement for transparency and clarity in leadership roles and committee responsibilities.

Section B, 2.13 **State the number of board and committee meetings and each director's attendance in the annual report.**

Complete
Complusory: ✓

The annual report should give the number of times the board and its committees met, and individual director attendance.

Assessment: The annual report fully meets the criterion. It states the number of Board and committee meetings held and discloses individual attendance for every director at each relevant meeting, including:

- Trust Board
- Audit, Risk and Governance Committee-in-Common
- This satisfies the full requirement under the NHS Foundation Trust Code of Governance.

Section B, 2.17 **Annual report should explain the roles of governors, how disputes are resolved, and how decision-making is structured.**

Complete
Complusory: ✓
FTs only

For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.

Assessment:
The annual report meets this criterion. While it does not provide a formal "schedule of matters" table, it clearly describes the roles and responsibilities of the Council of Governors, outlines the approach to dispute resolution, and provides a summary of the governance structure and decision-making distribution across the Board, CoG, committees, and executives.

Section B, 2.6	**Identify independent non-executive directors in the annual report and justify their independence if any potential conflicts exist.**
Complete Complusory: ✓	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: has been an employee of the trust within the last two years has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme has close family ties with any of the trust's advisers, directors or senior employees holds cross-directorships or has significant links with other directors through involvement with other companies or bodies has served on the trust board for more than six years from the date of their first appointment is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Assessment:	In accordance with the Code of Governance, the Board of Directors has reviewed Non-Executive Directors' continued service and their registered interests, and considers them to remain independent due to their consistent objectivity, lack of operational involvement, and continued constructive challenge.
Section C, 2.5	**Name any external consultants in the annual report, along with any links to the trust or directors.**
Complete Complusory: ✓ **FTs only**	If an external consultancy (for Board recruitment) is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Assessment:	The Trust did not engage any external consultants for Board recruitment in the reporting period was noted

Section C, 2.8 | **Annual report must describe how governors appoint the chair and non-executives and outline the nominations committee's role.**

Complete
Complusory: ✓
FTs only
Assessment:

The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

The Annual Report provides a clear and comprehensive description of the process followed by the Council of Governors (CoG) to appoint the Chair and Non-Executive Directors (NEDs). It confirms that the CoG has an Appointments and Remuneration Committee (ARC) responsible for these appointments and outlines the committee's remit and activities. The narrative is assessed as Complete.
The Trust demonstrates full compliance with the requirement to describe the process for appointing the Chair and NEDs. The Annual Report outlines the structure, responsibilities, and activities of the Appointments and Remuneration Committee, including its role in reviewing appointments, remuneration, and reappointments. The narrative is transparent and well-documented.

Section C, 2.9 | **Governors must be re-elected at least every three years with performance and biography shared for informed voting.**

Complete
Complusory: ✗
FTs only
Assessment:

Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.
The Trust is compliant with this criterion. The Annual Report confirms that elected governors are subject to re-election at intervals not exceeding three years and that biographical and performance information is provided to support informed voting.
The Trust meets the requirement for regular re-election of governors and provides sufficient information to support transparency and accountability. The election process is clearly documented, and governors' performance is monitored and reported.
The report could be strengthened by explicitly stating that biographical details and prior performance information (e.g. attendance, engagement) are shared with members during the election process.

Section C, 4.13	**Annual report must explain the nominations process, board evaluation, succession planning, diversity policy, and board demographics.**
Incomplete Complusory: ✓ **Assessment:**	The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports. To fully meet the Code of Governance, the trust should: Include a summary of the board's ethnic composition and how it compares to the workforce and community. Provide a succession planning narrative that explicitly links to diversity goals. Confirm the timing and provider of the next externally facilitated Well-led review, and disclose any connections.
Section C, 4.2	**Board must publish statements on its balance and suitability, and post these on the website.**
Complete Complusory: ✗ **Assessment:**	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website. The Trust is compliant with this criterion. The Annual Report includes a clear statement from the Board affirming the appropriateness of its composition and governance arrangements, and this information is also made available on the Trust's website. The Trust has made a clear and formal statement regarding the appropriateness of the Board's composition and governance arrangements. This is supported by detailed disclosures in the Annual Report and supplemented by information available on the Trust's website, meeting the expectations of the NHS Code of Governance.

Section C, 4.2 **Include in the annual report a description of each director's skills, expertise, and experience.**

Complete: The board of directors should include in the annual report a description of each director's skills, expertise and experience.

Complusory: ✓

Assessment: The Annual Report 2024/25 does not include a dedicated section that provides a description of each director's individual skills, expertise, and experience. It refers to details available on the trust's website. This approach partially meets the NHS Foundation Trust Code of Governance requirement.

Section C, 4.7 **Trusts should undergo external Well-led reviews every 3–5 years. Reviewers and any trust links must be reported.**

Complete All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.

Complusory: ✓

Assessment: A Well-led review will be conducted during 2026/27 and this is included in the Annual Report.

Section C, 4.9 **Governors who fail to attend or have serious conflicts may be removed, using a fair and shared policy.**

Complete The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.

Complusory: ✗

FTs only

Assessment: The Trust is compliant with this criterion. The Annual Report confirms that a clear and fair policy exists for the removal of governors who fail to attend meetings or have conflicts of interest, and that this policy is shared with governors.

The Trust has adopted and communicated a clear and fair process for the removal of governors who do not fulfil their duties. This includes non-attendance and conflicts of interest. The process is embedded in the Trust's governance framework and is supported by transparent reporting of attendance.

Section C, 5.15 | **Governors must gather public and member views on the trust's plans and report how this was done in the annual report.**

Complete

Complusory: ✓

FTs only

Assessment:

Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

The NLAG Annual Report 2025/26 confirms that the Council of Governors (CoG) has fulfilled its statutory duty to canvass the views of members and the public on the trust's forward plan, including its objectives, priorities, and strategy, and to communicate those views to the Board of Directors.

Section C, 5.7 | **Board and governors must receive timely, relevant info. Governors need updates on ICS plans affecting the trust.**

Complete

Complusory: ✗

FTs only

Assessment:

The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

The Trust is compliant with this criterion. The Annual Report confirms that both the Board of Directors and the Council of Governors are provided with timely, relevant, and high-quality information, including updates on Integrated Care System (ICS) plans and decisions that affect the Trust and its patients.

The Trust has established effective mechanisms to ensure that both the Board and Council of Governors receive timely and relevant information. This includes updates on ICS plans and decisions that impact the Trust and its patients. The Trust's approach aligns with statutory guidance and supports informed oversight and engagement.

The report could be strengthened by explicitly referencing the NHS England document Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors and how its requirements are operationalised.

Section D, 2.4	**Annual report must address key audit issues, auditor independence, and details on audit function and non-audit services.**
Complete Complusory: ✓	The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
Assessment:	The Trust demonstrates full compliance with the audit-related disclosure requirements. The Annual Report outlines the ARG CiC's responsibilities and activities, including oversight of financial reporting, internal and external audit, and auditor independence. The report provides clarity on auditor tenure, appointment process, and safeguards for independence, with no non-audit services reported.
Section D, 2.6	**Directors must confirm the annual report is fair, balanced, and understandable, reflecting performance and strategy.**
Complete Complusory: ✓	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Assessment:	The Trust meets the requirement to explain the directors' responsibility for preparing the annual report and accounts. The report includes a clear and formal declaration that the report is fair, balanced and understandable, and provides the necessary information for stakeholders to assess the Trust's performance, business model and strategy.
Section D, 2.7	**Board must assess and report on principal risks, following reporting manual guidance.**
Complete Complusory: ✓	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Assessment:	The Trust demonstrates full compliance with Criterion. The Annual Report provides a detailed and structured overview of the Board's approach to identifying, assessing, and managing both emerging and principal risks. The integration of risk oversight into governance structures and the use of formal frameworks such as the BAF and Risk Register provide strong assurance of effective risk management.

Section D, 2.8 **Board must monitor and annually review internal controls and report on their effectiveness in the governance statement.**

Complete

Complusory: ✓

The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

Assessment: The Trust demonstrates compliance with Criterion. The Annual Report outlines a robust and systematic approach to monitoring and reviewing internal controls and risk management. The inclusion of the Annual Governance Statement, supported by internal and external audit functions, provides strong assurance that the Board is fulfilling its responsibilities in this area.

Section D, 2.9 **Board must confirm if going concern accounting is appropriate and explain any material uncertainties.**

Complete

Complusory: ✓

In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.

Assessment: The Trust is compliant with Criterion. The Annual Report includes a clear and unambiguous statement on the going concern basis of accounting, supported by appropriate governance oversight and in line with national reporting guidance. The absence of material uncertainties further reinforces the Trust's financial and operational stability.

Section E, 2.3 **Annual report should disclose if directors retain earnings from external roles.**

Complete

Complusory: ✓

Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

Assessment: Whilst there is no explicit statement in the remuneration report or elsewhere in the Annual Report that addresses whether any executive director who exited the Trust during the year retained earnings from subsequent appointments, the report lists all directors who left the Trust in 2025/26 and provides their remuneration up to the point of departure. It includes detailed tables of salary, pension, and benefits for all directors, including those who exited. It confirms that no bonuses were paid and that exit packages were disclosed where applicable.

Section E, 2.6 **Board must establish a remuneration committee of at least three independent non-executives, with terms publicly available.**

Complete:

Complusory: X

The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

Assessment:

The Trust fully meets the structural and governance expectations for its remuneration committee. It is composed of independent NEDs, has a clearly defined remit, and includes HR advisory input. The only minor omission is the lack of a statement regarding the use (or non-use) of external remuneration consultants and any potential conflicts of interest.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)141

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11th June 2026
Director Lead	Tom Myers – Group Director of Estates & Facilities
Contact Officer / Author	Bill Parkinson- Group Associate Director of Health & Safety, Fire and Security
Title of Report	Health & Safety Annual Policy Statement
Executive Summary	This is the annual public statement of the Board's commitment to Health & Safety at Work. There are only minor amendments (highlighted in yellow).
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Health, Safety & Fire Group (NLaG); Security, Fire, Health & Safety Group (HUTH), EF& D Governance Group, Performance, Estates & Finance Group
Financial Implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

Humber Health Partnership

Health & Safety Policy Statement

Document control use only	
Reference	DCM814
Directorate / Care Group	Estates, Facilities & Development
Version	
Result of last review	Minor changes
Issue date	24/07/25

Author / Owner Use Only	
Group or Trust specific document	HHP (Group)
Date approved by owner (for minor changes only outside committee)	N/A
Date approved	12/06/25
Approving body	Trust Board
Next full review date	June 2026
Lead Director	Tom Myers – Director of Estates, Facilities & Development
Document type	Miscellaneous
Author / Contact	Bill Parkinson – Associate Director of Safety & Statutory Compliance
Key words	Health & Safety Policy Statement

Printed copies valid only if separately controlled

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1. Summary

1.1 Every public sector organisation must have an annual board approved health and safety policy statement. This policy is for Humber Health Partnership Trust Board approval.

2. Definitions / Glossary

2.1 Humber Health Partnership (HHP) – Partnering group consisting of Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole NHS FT (NLaG)

3. Purpose, Legal Requirements and Background

3.1 Public policy statement of the Group's commitment to fulfil the duties under the Health & Safety at Work Act 1974, the Management of Health & Safety at Work Regulations 1999 (as amended) and the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

4. Scope

4.1 Covers the health and wellbeing of employees, patients, contractors and other members of the public.

4.2 This statement outlines the Group and its partnering Trusts' commitment and approach to the management of health & safety and does not provide detail on the management of specific health & safety risk topics.

4.3 Policies and procedures covering the assessment and control of specific health & safety risks (Lone working, Violence and Aggression etc.) are in place for each Trust as part of their statutory duties. However, as part of the direction of the Group and its strategy of working collaboratively, Group policies and procedures will be developed where appropriate.

4.4 Some policies, procedures and reports will remain within the sovereign organisations due to legal requirements.

5. Responsibilities, Accountabilities and Duties

5.1 Group Chief Executive – ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Risk Management Strategy.

5.2 Group Chief Financial Officer – Delegated executive responsibility for all elements in relation to health and safety (with the exceptions noted below)

5.3 Group Medical Director and Group Chief Nurse - delegated operational responsibilities within their own specific areas.

5.4 Hospital Site Managing Directors for the North and South sites – delegated responsibilities for health and safety within those services assigned to north or south operations

5.5 Group Director of Estates, Facilities and Development – delegated responsibilities for day-to-day health and safety issues and escalation to CFO, Executive Team and Trust Boards in Common.

6. Policy Statement

6.1 Proactive approach

6.1.1 The Group recognises that a proactive approach to the management of health & safety is considered an essential element in a good safety management system. As part of its approach, the Group has in place a system of formal and informal inspections, visits, and audit processes which includes Directors.

6.1.2 Where appropriate, the Group also sources external verification of its health and safety management arrangements.

6.2 Commitments

6.2.1 In complying with its duties to its employees as outlined in the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999 (as amended) the Group is committed to: -

- Introducing, developing and maintaining safe systems of work which employees and others working for the Group and partnering Trusts are expected to follow, supervise, manage and review existing systems to improve and raise standards.
- Increasing the knowledge and skill base of its employees in relation to health & safety, ensuring that staff are competent to identify, assess and manage health & safety risks within their working environment.
- Supporting the Care Groups, Directorate and Corporate Group functions and their governance forums to ensure engagement and active involvement in improving health and safety performance.
- Using data from reactive and proactive monitoring to enable information to be communicated to staff, managers and directors on performance and facilitate benchmarking both internally and externally.
- Developing and setting annual and longer-term strategic objectives in relation to health and safety performance which are embedded within the business planning process.
- Maintaining a robust incident reporting system which facilitates learning lessons through corrective action and enables the identification of trends and root causes.
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff have received adequate instruction and training, as well as required maintenance and

inspections are carried out.

- Maintaining a comprehensive risk register and central risk assessment system (at Group and partnering Trust level) which includes specific health and safety risks and is used to assist in setting priorities and the allocation of resources as well as in the development of health & safety strategic planning.
- Developing a positive safety culture throughout the Group and creating good leadership in the implementation of the safety management systems through the vision and values of the Group.
- Ensuring the promotion and improvement of the mental health and wellbeing of the staff across the Group and where appropriate/required ensuring health surveillance is undertaken.
- Ensuring that sufficient allocation of resources in relation to health & safety management as well as competent persons who are able to offer support and advice at all levels and in all areas of health & safety.
- The development of a safety management system to a recognised certifiable standard.

In addition to the responsibilities of the Group and partnering Trusts as an employer, all employees and other persons working as part of its activities (i.e. volunteers, contractors etc.), are expected to participate and co-operate with the systems of work implemented by the Group/Trust as part of their statutory duties. This involves taking reasonable care of themselves and others who may be affected by their acts (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

7. Monitoring Compliance and Effectiveness Process

7.1 Statutory obligations under the Safety Representatives and Safety Committees Regulations 1996 (as amended) and the Health and Safety Information for Employees Regulations 1989 (as amended) for health and safety are overviewed for the partnering Trusts via the Security, Fire, Health & Safety Group (HUTH) and the Health, Fire & Safety Group (NLaG). These bodies consist of union appointed health and safety representatives, management representatives, competent advisors and senior managers. These groups have delegated authority to approve health & safety related policies and procedures and meet at least once per quarter to review performance and compliance issues as well as considering measures to improve the effectiveness of the safety management system.

7.2 These groups can escalate any issues to the appropriate sub-board groups and submit regular highlight reports to the Performance, Estates & Finance (PEF) Committee.

8. Associated Documents

DCP086	Governance & Risk Management Strategy
DCR013	General Risk Assessment Procedure
CP137	Health & Safety At Work Policy

9 References

9.1 Health and Safety at Work etc. Act. 1974. Available at: Legislation.gov.uk (Accessed: 9th March 2026)

9.2 Management of Health & Safety at Work Regulations 1999. UK Statutory Instruments No 3242 Available at: legislation.gov.uk/si/1999/3242 (accessed 9th March 2026)

10 Consultation

10.1 Security, Fire, Health & Safety Group (HUTH) and the Health, Fire & Safety Group (NLaG) overview this document to recommend submission to the Trust Board.

10.2 This statement is reviewed on an annual basis and signed off by the Group Chief Executive and Chief Financial Officer (as executive lead for the implementation of health and safety management across the Group) as shown in Appendix A.

11 Dissemination and Implementation

11.1 This document is a public document to be posted on Intranet and Internet sites so available to anyone. Any member or staff, patients or the public are entitled to receive a copy should they request one.

12 Document History / Version Control

Date	**Version**	**Revision description** [provide a brief summary of the changes from the previous version made to the document]
3/7/24	1.0	Changed to Group template format and updated to include roles of Chief Executive North and South, and Group Director of Estates, Facilities and Development.

9/3/26	1.2	Only minor changes - job titles and updated reference access etc.

13 Equality Act (2010)

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

13.2 The Partnership is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best

possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

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

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

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

14 Freedom to Speak Up

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

15 Appendix A

This policy statement was reviewed at the following Trust Board meeting

[Insert date of Board meeting] and is signed accordingly below.

Lyn Simpson
Acting Group Chief Executive

Emma Sayner
Group Chief Financial Officer

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)142

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 June 2026
Director Lead	Paul Bunyan, Deputy Group Chief People Officer
Contact Officer / Author	Karl Portz, Equality Diversity & Inclusion Lead Jackie Railton - Deputy Director for Performance and Planning Lucy Vere, Group Director of Learning and Organisational Development
Report of Equality Delivery System (EDS) 2025/26 – Humber Health Partnership Group Report	**Equality Delivery System (EDS) 2025/26 – Humber Health Partnership Group Report**
Executive Summary	To present the Humber Health Partnership (HHP) Equality Delivery System (EDS) 2025/26 Group Report, including overall rating, key findings across the three domains, and priority actions for improvement. The attached report is in the national format required and is spilt into three sections: • Action/Activity completed and related equality objectives • EDS Rating and Score Card • Actions plans for 26/27 To **alert** Trust Boards to the following issue/s: • Workforce experience indicators remain variable, particularly staff recommendations as a place to work, with declining or static scores across both Trusts • Gaps remain in capturing consistent patient experience data in some services (e.g. Diabetic Eye Screening Programmes (DESP) Friends and Family Test implementation and survey coverage) • Some areas of workforce safety and inclusion (e.g. bullying, harassment) are rated as developing, requiring further improvement and cultural embedding • Gaps exist on staff wellbeing for specific input on for support to manage obesity, diabetes, asthma and COPD beyond our usual Occupational Health services To **advise** Trust Boards on the following issue/s: • The HHP EDS submission reflects a **partnership-level approach** across NLAG and HUTH, with shared governance through Equality, Diversity and Inclusion (EDI) (Staff) team and Planning and Performance team (Patients).

	Domain ratings indicate: • **Domain 1 (Services): Achieving** across key services including Community Diagnostic Centres (CDCs) and DESP, with strong access and safety evidence • **Domain 2 (Workforce): Developing–Achieving**, with strong wellbeing offers but mixed staff experience outcomes • **Domain 3 (Inclusive Leadership): Developing**, with good foundations but further work required on consistent impact assessment and governance maturity A comprehensive EDS Action Plan is planned focusing on: • Improving equality data and insight for patient services • Strengthening workforce experience and safety through tools such as our Zero Tolerance Frameworks • Embedding inclusive leadership accountability and governance at all levels from Board to Ward, with a focus on good governance to support care groups and directorates to develop/deliver relevant objectives for staff and patients To **assure** the Trust Boards about the following: A structured EDS process has been completed for 2025/26, including evidence review across services, workforce, and leadership domains. Strong examples of good practice include: • Expanded wellbeing, psychological, and pastoral support offers across both Trusts • Active Freedom to Speak Up Guardian networks and increasing utilisation • Established EDI governance via Steering Groups, WECC, and Board reporting Clear improvement trajectories are in place through a **detailed, time-bound action plan**, aligned to organisational priorities and NHS EDI requirements for staff and patients.
Background Information and/or Supporting Document(s) (if applicable)	The report attached is using a set national framework.
Prior Approval Process	**None**
Financial Implication(s) (if applicable)	**None**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The EDS 2025/26 report demonstrates that while the Trust has made measurable progress in embedding equality, diversity and inclusion across services, workforce and leadership, there remain key gaps, particularly in workforce experience, consistent use of equality data, and patient insight, which require targeted action to reduce health inequalities and ensure equitable access, experience and outcomes for all staff and communities
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System 2022

EDS Reporting Template

Version 1, 15 August 2022

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Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**North Lincolnshire and Goole NHS Foundation Trust (NLaG) Hull University Teaching Hospitals (HUTH)**	**Organisation Board Sponsor/Lead**		
			Andy Haywood/ Simon Nearney		
Name of Integrated Care System					

EDS Lead	Jackie Railton/Karl Portz		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	2025/ 2026		**Individual organisation**	
			Partnership* (two or more organisations)	Humber Health Partnership (HHP), comprising: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG); Hull University Teaching Hospitals NHS Trust
			Integrated Care System-wide*	

Date completed		**Month and year published**	
Date authorised		**Revision date**	

	Action/activity	Related equality objectives
Domain 1: Target Lung Health Check	To discuss further with the local Cancer Alliance and begin planning to capture local Traveller populations in 2025. **Multiple further attempts to engage with this community have occurred, although it has been found that there are many non-smokers and patients reported within incorrect age categories. As such, it has been difficult to identify a sufficient cohort of patients.**	Patients (service users) have required levels of access to the service
	To review the availability of flagging for LD patients within the EPR. **It has been established that this capability does exist within the currently used systems, although this cohort of patients are currently identified via an alternative method.**	Individual patients (service users) health needs are met
	To ensure that examples of excellent patient care/ where staff make adjustments for individual patient needs are recorded. **These are recorded within Lorenzo/ SystmOne, as appropriate.**	Individual patients (service users) health needs are met
	To develop and implement a process to ensure the regular collection and review of patient feedback **Work is ongoing to implement the Friends and Family Test across the service.**	Patients (service users) report positive experiences of the service
	To ensure that patient feedback is retained and reported on. **Work is ongoing to implement the Friends and Family Test across the service**	Patients (service users) report positive experiences of the service
	To explore the potential for collecting patient experience data via the TLHC website. This would include an explanation of the purpose behind the data collection, to encourage more patients to participate.	Patients (service users) report positive experiences of the service

	Work is being currently being carried out by the Cancer Alliance to identify potential ways to reduce DNA rates.	
Domain 1: Virtual Ward	To continue working with system partners to extend step-up care from GPs to a 7- day service in the future. **Work continues to progress with this, though there are no significant gaps. There are clear plans in place to escalate to Consultant cover over weekends and bank holidays, as required.**	Patients (service users) have required levels of access to the service
	To continue work with the Transitional Lead Nurse in relation to care plans for patients with Learning Disabilities, and providing education on the care plans **Complete. "My Life Book" is now in place, and will be uploaded to WebV and SystmOne by the appropriate teams.** **Currently awaiting the implementation of a suitable code within the Reasonable Adjustment Flag by the national team.**	Individual patients (service users) health needs are met
	To discuss with patient experience/ incident reporting to see if it would be possible to introduce a system for reporting positive feedback/ examples of good practice ('Greatix') **Complete. Positive feedback can now be recorded on Ulysses, allowing staff to leave comments and report examples of good practice.**	Patients (service users) report positive experiences of the service
	To review physical copies of previously received feedback, as there were noted issues with FFT reporting due to data collection being within the short stay ward **Complete. Monthly FFT reports are now received via email by the Virtual Ward team, Team Lead and Matron.** **Feedback is also shared with the wider team during monthly Governance Board meetings.** **Patients can provide feedback via text message, scanning a QR code, or by completing a paper copy of the form.** **Staff continue to offer support to patients to ensure feedback can be provided.**	Patients (service users) report positive experiences of the service

Completed actions from previous year		
	Action/activity	**Related equality objectives**
Domain 2: Workforce health and well-being (NLaG)	• Offerings in relation to general health for staff including Health and Wellbeing Ambassadors, wellbeing programme/conversations, coaches, mentors and cultural ambassadors in some areas. • Occupational Health can refer for counselling and staff can self-refer via Employee Assistance and CIC. • We have a menopause peer to peer support group. • Mental Health First Aiders in some areas • Promoted Health Awareness Campaigns to support a variety of health conditions. • We adopted Trauma, Risk Incident Management (TRiM)	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions
	• We have recently signed up to a sexual harassment charter. • We promote a just and learning culture. • Proved Unconscious Bias training challenging thoughts and behaviour Introduced • Zero Tolerance to Racism, Zero Tolerance to LGBTQIA+ and Zero Tolerance to Ableism Discrimination frameworks rolled out.	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
	• The Freedom to Speak up Guardian established a network of Champions in some areas and attends numerous committee meetings. • Staff Networks are set up • Trade Union Partnership is in place. • Occupational Health support through CIC. • An HR helpline is in place and staff can access HR team support. • Established pastoral support nursing team within the Nursing Directorate.	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source
	• 52.9% of staff recommend the Trust as a place to work, this has increased from 44.8% the previous year. • 52.% are happy with the care provided for a friend or relative which has increased from 45% the previous year.	2D: Staff recommend the organisation as a place to work and receive treatment

Completed actions from previous year		
	Action/activity	**Related equality objectives**
Domain 2: Workforce health and well-being (HUTH)	• We have mature offerings in relation to General Health for staff, Coaches, Mentors, Mediators. • Dedicated psychologists for Staff Support in ICU • OH can refer for counselling and Staff can self-refer • EDI can refer directly for counselling for people with protected characteristics when required • Staff can also directly receive support by accessing the groupwide Confidential Care Employee Assistance Programme • We have embedded Trauma Risk Incident Management • Staff have access to the Tobacco Dependence Treatment Team • We promoted a number Health Awareness Campaigns to support a variety of health conditions.	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions
	• Reviewed Staff Conflict Resolution & Professionalism Policy • The Trust launched a Period Dignity with discreet support, for topics such as menopause, domestic violence & women's health. • Established in 2024 Domestic Abuse Champions. • We re-launched Zero Tolerance framework re-launched Zero Tolerance to Racism Framework & Reporting tool being utilised by staff	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
	• The Freedom to Speak up Guardian established a network of Champions and attends numerous committee meetings and is also now Full Time dedicated to the role. • Access to a Communications Officer across a number of communication channels. • The number of concerns being raised has risen year on year, indicating that staff are increasingly aware of the role and comfortable with raising their concerns. • The Trust operates a Speak Up Champion Network, with local volunteers promoting speaking up and signposting their colleagues to the Guardian role. • Staff Networks are active and provide support with all network chairs in promoting wellbeing • Staff-side are also influential in providing impartial support to staff	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source

	• Support is available from Occupational Health, Psychological Counselling services, Coaching networks and Mentoring networks • We have independent support groups led by some ethnic minority staff • The nursing directorate has an established pastoral support team	
	• 48% of staff recommend the Trust as a place to work • 52% are happy with the care provided for a friend or relative	2D: Staff recommend the organisation as a place to work and receive treatment

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Community Diagnostic Centres (CDCs)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Patients who are eligible are able to access CDC services. This is demonstrated via referrals/bookings, patient feedback and staff feedback. CDC facilities meet minimum national access requirements ie imaging, physiological and pathology testing and have been built in central locations to provide improved physical access to diagnostic services away from hospital sites. Services are not yet at capacity and work is needed to increase utilisation of CDCs.	2	Leah Stabler
	1B: Individual patients (service users) health needs are met	Patients attend the CDCs for the diagnostic tests for which they have been referred. During the period of the test(s), their health needs are met, ie are able to undergo the test(s) and are supported during the procedure(s). In a number of instances patients have been able to attend once at a CDC for multiple tests, negating the need for multiple hospital attendances. Reasonable adjustments are made where appropriate.	2	Leah Stabler

	1C: When patients (service users) use the service, they are free from harm	Diagnostic testing is undertaken in accordance with national standards to ensure patient safety. Any incidents are reported via Trust incident reporting systems and processes and analysed. Reports for Incidents and PALS/Complaints used as evidence.	2	Leah Stabler
	1D: Patients (service users) report positive experiences of the service	Patient survey results have reported that the majority of patients have had a positive experience of the CDCs with the locations being easy to find and access, friendly staff, timeliness of appointments, clean and modern environment.	2	Leah Stabler
Domain 1: Commissioned or provided services overall rating			8	

Domain 1: Commissioned or provided services

Diabetic Eye Screening Programme (DESP)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	All eligible patients living with diabetes are offered a screening or surveillance appointment in line with NHSE DES guidance. Robust NHSE DES failsafe processes in place to ensure eligible cohort are invited. Those with additional needs are offered an appointment at an accessible venue/ can access patient transport. The service works with local prisons and secure mental health facilities to identify and enable eligible patients within these cohorts to access Diabetic Eye Screening. Furthermore, the Open Door GP based in Grimsby provides primary healthcare to vulnerable groups, including homeless people –registration with this practice will result in the patient receiving a formal invitation for DESP, where required. An annual Health Equity Audit is also carried out by the DESP, which provides a great deal of information on patient attendance split across a range of different cohorts.	3	Ms Helen Cook/ Natalie Holmes
	1B: Individual patients (service users) health needs are met	Humber DESP operates in line with NHSE DES guidance and HUTH Trust guidance. All staff are trained in line with NHSE DES requirements. Reasonable adjustments are made to facilitate screening if required, although it is not possible to	2	Ms Helen Cook/ Natalie Holmes

		identify all needs via the Electronic Patient Record, so this can sometimes be reliant on patients getting in touch with the service to inform them.		
	1C: When patients (service users) use the service, they are free from harm	Harm incidents are recorded via Datix/ Ulysses incident reporting. A very small number of harms have been recorded over the last 12 months, none of which relate to harms that have occurred as a result of/ during the screening process (e.g. 1 patient fall; 1 patient seizure; 1 patient experiencing a hypoglycaemic episode). Any service risks and patient harms are routinely monitored by the service.	2	Ms Helen Cook/ Natalie Holmes
	1D: Patients (service users) report positive experiences of the service	The service notes that a patient survey has not been undertaken for an extended period of time, due to a number of factors, including staffing vacancies and changes in Friends and Family system at HUTH. There have been a total of 5 formal compliments received in the last 12 months, with no formal complaints and 5 PALS contacts (relating to administrative queries). As such, with approximately 62,000 patients, it is encouraging that very few patients have reported negative experiences.	1	Ms Helen Cook/ Natalie Holmes
Domain 1: Commissioned or provided services overall rating			8	

Domain 2: Workforce health and well-being (NLaG)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Occupational Health continues support staff with long-term physical and mental health conditions. Staff have access to confidential Occupational Health assessments with onward signposting to counselling and psychological support where clinically indicated. Work Related Stress Risk Assessment available for staff if required. Equality, Diversity and Inclusion Steering Group has been reviewed and meetings scheduled in diary for the year. Staff have access to newly appointed H&WB practitioners as of August 2025-March 2026. Staff are invited and encouraged to join physical activity sessions such as yoga, tai chi, running and walking groups to help with weight management, general movement and social inclusion. Along with this a group-wide Strava group has been set up to allow for accountability and progress and connect with colleagues on a group level. There is a self-help portal 'ELE' that be accessed for a range of wellbeing topics or to enhance their knowledge on various wellbeing aspects Autism Peer Support Project has been newly launched to support parents with children with autism and give shared experiences	2	Oluwaseun Akindolie Peter OSullivan Karl Portz Kerrie Fletcher Alex Dwyer Nicola Hellewell

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Sexual harassment charter signed, and circle group meetings set up and commenced to review reports. Unconscious Bias training rolled out group wide to educate, challenge behaviours and to give staff the support. Zero Tolerance to Racism and Zero Tolerance to LGBTQIA+ Discrimination and Zero Tolerance to Ableism frameworks embedded. Zero Tolerance circle groups have action plans following incident reviews, including escalation, education, and HR processes. We follow the safeguarding procedures for adults and children as required. We provide safeguarding training in line with the Intercollegiate Documents for adults and children. We have policies for Domestic Abuse and can signpost to specialist DA services (Domestic Abuse Guidance for NLAG Staff / Trust Domestic Abuse Policy DCM060) Co located IDVA (independent domestic Violence Advocate) based within the safeguarding team Sexual Safety Strategy and staff referral process in place to include the sexual harassment charter' to 'sexual safety charter'	1	Mano Jamieson Karl Portz Lynne Benefer Vicky Thersby Ben Greenwood Nicola Hellewell

		Roll out of HIV confident campaign and charter mark and the connection to psychological support services. Mediation Skills for Managers training is provided via online webinar to give managers and supervisors the knowledge and skills to resolve staff-staff conflict in-house through mediated dialogue.		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Staff continue to have access to independent support via Occupational Health Employee Assistance Programme (CIC) and signposting for psychological support REACH programme being rolled out Mental health crisis support and suicide prevention work underway. TRIM service for traumatic events to being embedded. Pastoral and spiritual care teams in supporting staff rolled out across the Trust Health and wellbeing ambassadors and HR as sources of independent support, reinforcing resources are being rolled out across the Trust Signposting staff members to the Domestic Abuse Coordinator/Safeguarding Team when indicated. The number of staff contacting the NLaG FTSUG has increased year on year since the current FTSUG came into post, and it is expected that this trend will continue for the current financial year. This indicates that staff are aware that they have access to independent support and are using it. The concerns coming to the FTSUG include stress, bullying & harassment and physical violence	2	Oluwaseun Akindolie Peter OSullivan Liz Houchin Fran Moverley Ben Greenwood Nicola Hellewell Patricia Mckenna

		The NLaG FTSUG continues to be promoted through a variety of communications and sees staff at a location of your choice across the Trust footprint. The NLaG Speak Up Champion Network has increased to c.24 Champions across the Care Groups and Corporate services. The HHP Mediation Service provides independent advice and support to managers and other staff where there has been a breakdown in a working relationship that is suitable for informal resolution through mediated dialogue.		
	2D: Staff recommend the organisation as a place to work and receive treatment	The NSS 2024 (most recent published score) Score for recommending the trust as place to work at NLAG 47% down on the previous year 53% In NLAG 49% would be happy for a relative to receive treatment at NLAG	1	
Domain 2: Workforce health and well-being overall rating			6	

Domain 2: Workforce health and well-being (HUTH)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Occupational Health continues support staff with long-term physical and mental health conditions. Employee Assistance Programme (CIC) and signposting for psychological support REACH programme being rolled out Mental health crisis support and suicide prevention work underway Staff have access to confidential Occupational Health assessments with onward signposting to counselling and psychological support where clinically indicated. Work Related Stress Risk Assessment available for staff if required. Equality, Diversity and Inclusion Steering Group has been reviewed and meetings scheduled in diary for the year. Staff Support Psychology provides the following: i)1:1 support and evidence- based therapy for staff. ii)Post incident group support to complement TRiM for using	2	Oluwaseun Akindolie Pete OSullivan Karl Portz Kerry Smith Amy Stuart Kerrie Fletcher Alex Dwyer Nicola Hellewell

		a cold debriefing model (CISM). iii)Psychological wellbeing psychoeducation and preventative team support. Staff have access to newly appointed H&WB practitioners as of August 2025-March 2026. Autism Peer Support Project has been newly launched to support parents with children with autism and give shared experiences There is a self-help portal 'ELE' that be accessed for a range of wellbeing topics or to enhance their knowledge on various wellbeing aspects Staff are invited and encouraged to join physical activity sessions such as yoga, tai chi, running and walking groups to help with weight management, general movement and social inclusion. Along with this a group-wide Strava group has been set up to allow for accountability and progress and connect with colleagues on a group level.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Staff Support Psychology can be accessed for support following workplace incidents. There is an EMDR therapy pathway for staff who have experienced trauma in the workplace. Zero Tolerance to Racism and Zero Tolerance to LGBTQIA+ Discrimination and Zero Tolerance to Ableism frameworks embedded. Zero Tolerance circle groups have action plans following incident reviews, including escalation, education, and HR processes. We provide safeguarding training in line with the Intercollegiate Documents for adults and children. We have policies for Domestic Abuse and can signpost to specialist DA services (Domestic Abuse Guidance for NLAG Staff / Trust Domestic Abuse Policy DCM060) Co located IDVA (independent domestic Violence Advocate) based within the safeguarding team Sexual Safety Strategy and staff referral process in place Sexual Safety Strategy and staff referral process in place to include the sexual harassment charter' to 'sexual safety charter'	2	Kerry Smith Karl Portz Mano Jamieson Lynne Benefer Vicky Thersby Ben Greenwood Nicola Hellewell

		Roll out of HIV confident campaign and charter mark and the connection to psychological support services. Conflict Avoidance and Resolution Training is a mandatory requirement for all patient facing staff. The training is provided both in the classroom and via online webinar and is supported by a national eLearning for Health package. Mediation Skills for Managers training is provided both in the classroom and via online webinar to give managers and supervisors the knowledge and skills to resolve staff-staff conflict in-house through mediated dialogue.		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Staff continue to have access to independent support via Occupational Health Employee Assistance Programme (CIC) and signposting for psychological support REACH programme being rolled out Mental health crisis support, and suicide prevention work underway. TRIM service for traumatic events to being embedded. Pastoral and spiritual care teams in supporting staff rolled out across the Trust Health and wellbeing ambassadors and HR as sources of independent support, reinforcing resources are being rolled out across the Trust Signposting staff members to the Domestic Abuse Coordinator/Safeguarding Team when indicated. We follow the safeguarding procedures for adults and children as required. We provide safeguarding training in line with the Intercollegiate Documents for adults and children. We have policies for Domestic Abuse and can signpost to specialist DA services (Domestic Abuse Guidance for NLAG Staff / Trust Domestic Abuse Policy DCM060)	3	Oluwaseun Akindolie Pete OSullivan Lynne Benefer Vicky Thersby Liz Houchin Fran Moverley Kerry Smith Ben Greenwood Nicola Hellewell Karen Mechen Michio Abe

		The number of staff contacting the HUTH FTSUG increased 35% from 2023/2024 to 2024/2025 and is predicted to further increase in 2025/2026. This has included cases related to bullying, harassment, stress, abuse and physical violence. The HUTH FTSUG continues to be promoted through a variety of communications and since June 2025 has consistent monthly drop ins advertised at HRI, CHH and MS Teams to promote visibility and accessibility to the FTSUG. The HUTH Speak Up Champion Network has increased to c.60 Champions across the Care Groups and Corporate services. The feedback survey provided to staff who have spoken up, regularly shows that 100% of staff would speak up to the FTSUG again. In February 2025, the HUTH FTSUG was requested by NHS Resolution as a keynote speaker at a Board level Just Culture event. Staff Support Psychology can assess the impact on individuals of stress, bullying and harassment and offer psychological therapies including first line low intensity interventions, High Intensity Therapy or signpost appropriately to other services.		

		The HHP Mediation Service provides independent advice and support to managers and other staff where there has been a breakdown in a working relationship that is suitable for informal resolution through mediated dialogue.		
	2D: Staff recommend the organisation as a place to work and receive treatment	The NSS 2024 (most recent published score) Score for recommending the trust as place to work at HUTH is 50% down on the previous year 55%. In HUTH 52% would be happy for a relative to receive treatment at HUTH	1	
Domain 2: Workforce health and well-being overall rating			8	

Domain 3: Inclusive leadership (NLAG/HUTH)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding	The Trust Board received a development session on Equality, Diversity and Inclusion which included the subject of Health Inequalities.	2	Matt Smith Karl Portz Mano Jamieson Nicolla Hellewell

	of, and commitment to, equality and health inequalities	Performance monitoring through reporting on gender pay gap, workforce race equality, workforce disability equality standard, accessible information standards, and EDS 22 An independent Equality Diversity and Inclusion Steering Group has recently been formed. We have the Tailored Adjustment Form to support staff with long term conditions and disabilities and also a disability policy is in place. Staff equality networks and recently each network has an executive lead/sponsor. EDI steering group is established. REACH service for support of managers to meet reasonable adjustments is now in place		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Equality, Diversity and Inclusion Steering Group is now established in the Board governance process. Workforce Education & Culture Committee (WECC) consider all EDI related papers. The Trust has an Equality Impact Assessment policy and framework to ensure Policies, Procedures and Functions identify and address equality and health inequalities. Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board	1	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board	2	
Domain 3: Inclusive leadership overall rating			5	
Third-party involvement in Domain 3 rating and review				

Trade Union Rep(s):	Independent Evaluator(s)/Peer Reviewer(s):

EDS Organisation Rating (overall rating):
Organisation name(s):
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
EDS Sponsor	**Authorisation date**

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Community Diagnostic Centres (CDCs)** • To review data recorded via Business Intelligence systems to establish whether this would be suitable for use in assessing how different cohorts of patients linked to the EDS are accessing these services.	**Community Diagnostic Centres (CDCs)** • To request data from the BI team to establish which patient cohorts relating to the EDS can be identified, and how each cohort of patients has accessed services via the CDCs • Review and utilisation of data on an ongoing basis to ensure equality of access to services where appropriate.	March 2026 Ongoing

	1B: Individual patients (service users) health needs are met	**Community Diagnostic Centres (CDCs)** • To gather further patient experience information from service users	**Community Diagnostic Centres (CDCs)** • To conduct a locally-developed patient survey to incorporate demographic information and questions focused on the key outcomes of the EDS	December 2026
	1C: When patients (service users) use the service, they are free from harm	**Community Diagnostic Centres (CDCs)** • To ensure that the General Manager of the Community Diagnostic Centres receives information on all risks and incidents occurring within the CDCs, regardless of the specialty under which these are reported.	**Community Diagnostic Centres (CDCs)** • To continue discussions with colleagues in Risk Management and Patient Safety to ensure that information on all risks and incidents occurring within the CDC sites are automatically shared with the General Manager.	April 2026

	1D: Patients (service users) report positive experiences of the service	**Community Diagnostic Centres (CDCs)** • To ensure that the General Manager of the Community Diagnostic Centres receives information on all patient feedback relating to services provided within the CDCs, regardless of which specialty area the feedback relates to. • To gather further patient experience information from service users **Humber DESP** • To gather patient experience information from service users	**Community Diagnostic Centres (CDCs)** • To continue discussions with colleagues in Patient Experience to ensure that information on all risks and incidents occurring within the CDC sites are automatically shared with the General Manager. • To continue discussions with colleagues in Patient Experience to facilitate the implementation of the Friends and Family Test for both of the CDCs. • To conduct a locally-developed patient survey to incorporate demographic information and questions focused on the key outcomes of the EDS **Humber DESP** • To ensure the Friends and Family Test is implemented, and that data is collected and reviewed on an ongoing basis.	April 2026 April 2026 December 2026 April 2026

			• To conduct a patient survey focusing on specific aspects of the service (e.g. the implementation of OCT (Optical Coherence Tomography) scanning). • To include patient demographics and protected characteristics within future survey activity, to monitor service provision and any specific needs of these patient groups.	December 2026 December 2026

EDS Action Plan

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To identify what support is needed for each condition and scope out what capacity is needed to offer the level of support required.	To complete capacity and demand exercise for each condition To look at adequacy of mental health support and benchmarking against occupational health actions, and have a comprehensive gap analysis While psychological services are offered to all groups, data on protected characteristics is not routinely captured, suggesting future review to maximise impact. Need to incorporate health and wellbeing strategy updates, professional nurse advocates PNA service usage, ICU staff support, and safeguarding and restorative clinical supervision. To prioritise interventions using the Health and Wellbeing MDT to identify and allocate resources	March 2026

			Roll out or promote interventions identified To roll out the Health and Wellbeing framework – including to training staff in health coaching	
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reduce number of staff reporting experiences of abuse, harassment, bullying & physical violence in the staff survey	To further review and further embed Zero Tolerance to discrimination frameworks and reporting tools focussing on Race, Disability and LGBTQ+ and Ableism To create clear roles and responsibilities for line managers in protecting their staff form harm including supporting them to upskill and increase their confidence in dealing with challenging situations To roll out the Inclusivity Academy including our in house more in depth EDI mandatory training model for the whole group.	April 2026 October 2026 September 2026

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To ensure that a full range of support is available that enables staff to speak up, get support and get their issue resolved without having a permanent impact on their work life and health.	To fully review current routes of advice and ensure that they are fully accessible. To fully maximise the Freedom to Speak Up Guardian Services including the network of FTSU Champions with a focus on EDI related complaints. To further embed and support our Network Chairs and Vice Chairs to offer support and advice including creating a regular supervision and support sessions for them led by the FTSUG and the Director of Learning and OD. To encourage our staff from protected characteristics to join a union to allow them access to external and impartial support.	June 2026 June 2026 April 2026 April 2026

	2D: Staff recommend the organisation as a place to work and receive treatment	Develop a values led culture that ensures all staff feel valued, welcome and creates a safe working environment, which ultimately translates into better and safer patient care.	Creation of a single door to development offer via the Learning Improvement and Safety Academy which will support individual and team development including career development, coaching and mentoring, CQI, bespoke team development, clinical and non-clinical training. Maintain a strong leadership development and people management approach that is compassionate and inclusive through a wide range of interventions: • Development programmes • Bespoke work with teams • Coaching and mentoring • Clear metrics and feedback to managers on their progress Design and rollout a group wide Professionalism and Civility Programme to ensure all staff understand what is expected of them in creating a healthy work culture.	September 2026

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To embed Equality, Diversity and Inclusion, and Health Inequalities into the personal performance objectives for our Band 9 and VSM leaders	Include Care Group measures on EDI, staff survey scores in accountability to Trust Board along with Action Plans for improvement All relevant managers have EDI and Health Inequality objectives built into their appraisals. Care Group and Director Level WRES/WDES/LGBTQ objectives and progress tracking built into reporting and governance structures for the Group	June 2026 December 2026 December 2026
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Introduce accountability for Equality, Diversity and Inclusion activity and Health Inequalities at Board Committee level	Ensure Equality and Health Inequality impact assessments are reviewed at relevant Board Committee when service changes are introduced Develop Training and Coaching for NED's to ensure that they are able to critically challenge the Exec team when impact assessments are being discussed and agreed at committees and Trust Board.	July 2026 October 2026

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To demonstrate that we have clear metrics and governance in place that allow both executives and non-executives to identify and track improvements for both staff and patients.	To ensure that the new Group Structure governance arrangements are able to identify improvements, hold our Care Groups and Corporate Directorates to account for both remedial and proactive actions required. To work with executive and site teams to ensure that they are pursuing performance for these objectives as part of their routine performance meetings and structures.	September 2026 September 2026

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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(26)143

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday 11 June 2026
Director Lead	David Sulch, Committee Chair of Quality & Safety CiC
Contact Officer / Author	David Sulch, Committee Chair of Quality & Safety CiC
Title of Report	Quality & Safety Committees in Common Minutes – April 2026
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 30 April 2026
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 28 May 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 30 April 2026 at 9.00am to 1.30pm via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
Dr Pete Sedman	Deputy Group Chief Medical Officer
Jo Ledger	Interim Group Chief Nurse

In Attendance:

Hilda Gwilliams	Group Chief Patient Safety Officer
David Sharif	Group Director of Assurance
Sam Peate	Group Chief Delivery Officer
Rebecca Crashley	Deputy Group Director of Assurance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Tracy Campbell	Director of Nursing (North)
Wendy Wigglesworth	Deputy Director of IPC
Nicola Buckle	Senior Matron IPC
James Illingworth	Research & Development Manager
Kevin Allen	Governor Observer
Helena Lelew	Operations Manager CQC - observing
Jo Palmer	PA to the Committees-in-Common (Minutes)

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

0.1 Patient Story

Tracy Campbell presented a positive story from a patient who had attended the plastics and day surgery service at Castle Hill Hospital. It had been a first-class experience for the patient, along with his wife, and it was clear that patient experience was a high priority in this area and was a perfect example of what the organisation aspired to in all areas.

Julie Beilby was pleased to hear this story and asked whether there were any plans to share it with all staff as a positive news story and highlight the difference that good care makes. Tracy Campbell, along with Jo Ledger, agreed with this suggestion and would ensure this was shared with the Comms team.

ACTION: Tracy Campbell to share patient story with the Comms team

Dr Pete Sedman praised the service in that although it was a high-volume service, the excellent standard of care was commonplace and was delighted to see that the story had been brought to the meeting.

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair, David Sulch, welcomed those present to the meeting and a round of introductions was made. Apologies for absence were received from Dr Kate Wood, Group Chief Medical Officer and Michela Littlewood, Associate Director of Quality Governance (HUTH).

1.2 Staff Charter & Values

The Chair reminded colleagues to be mindful of these throughout the course of the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 26 March 2026

The minutes of the meeting held on 26 March 2026 was accepted as a true and accurate record.

1.5 Matters Arising

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.6 Review of Action Tracker

The following updates to the Action Tracker were noted:

Item 4.1 30 October 2025 – action closed
Item 5.1 26 February 2026 – a further update to be provided at the October meeting
Item 3.2 26 March 2026 – an update to be provided at the July meeting
Item 4.5 26 March 2026 – action closed
Item 4.9 26 March 2026 – EQIA to remain as a standing agenda item for the foreseeable future. Hilda Gwilliams advised that a tabletop exercise of all the CIP programmes would be undertaken in May with an update provided at the June meeting. Julie Beilby reinforced that it was important the organisation remained focused on EQIA compliance

1.7 Operational Pressures Update

Sam Peate advised colleagues that a Deep Dive report was to be presented at the Performance, Estates & Finance CiC the following week in relation to UEC activity and the improvement work underway and it showed significant improvements on the HUTH site over the course of the last six months, particularly against the four-hour standard and the twelve hours in the department standard and was beginning to see improvement in the time to be seen in ED standard. NLaG had seen a general improvement in compliance and changes with the triage and assessment model were starting to be embedded. Despite a busy month since the last meeting, improvements had been sustained in the use of temporary escalations spaces (TES). Improvements were also noted against the Faster Diagnosis Standard within Cancer Waiting Times following the work undertaken within the breast radiology service, which had been highlighted in a recent Comms bulletin. Improvements had also been noted from a RTT elective care perspective over the last six to eight weeks around overall RTT compliance across the Group and a reduction in the number of patients waiting 65 weeks+. Sam Peate acknowledged that there was a large amount of work underway with specialities involved in elective care in reviewing capacity and clinical models and several deep dive reports were expected at the business case review group in the next few weeks.

Hilda Gwilliams highlighted to colleagues the improvement in the Duty of Candour performance after a period of non-compliance and added that a three-month recovery programme was in place. She also spoke of the safety programmes that were now in place monthly where the learning and themes around Never Events was discussed and she was pleased to point out that the organisation's position on the national database was improving. Dr Pete Sedman added that the organisation was unchanged in terms of VT prophylaxis and David Sulch welcomed this update.

Nicola Buckle joined the meeting at 9.27am

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

There were no matters referred.

3. RISK & ASSURANCE

PATIENTS - SAFETY

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report & recommendations to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances

There were no external reports, recommendations or assurances to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Quality & Safety

4.1 Integrated Performance Report (IPR): Quality & Safety Metrics

Richard Dickinson spoke of the improvement with Duty of Candour compliance and associated this with reducing the interval between incidents and producing the letters. The SHMI position had been maintained but the septicemia rate was higher than expected. HUTH were now in a better position in terms of pressure ulcers, but the NLaG data was being reviewed. He was pleased to advise that there had been progress with the bed rails alert and that work was being reviewed by the Facilities team to ensure there was a full inventory of beds.

Jo Ledger stated that the findings of a Deep Dive on pressure ulcers would be included on the May agenda. She referred to the spike in falls at HUTH in January, following conversations with the team and she was pleased to share that these had now reduced in line with the reduction in temporary escalation spaces (TES).

Hilda Gwilliams acknowledged the work undertaken to improve the HSMR and SHMI rates, considering the organisation had been an outlier in this area and Dr Pete Sedman added that DPoW had performed consistently well with their SHMI data with HUTH having improved significantly. He was pleased to share that Fractured Neck of Femur (FNOF) no longer appeared in the report, having been an outlier in the past.

Julie Beilby referred to the VT risk assessment rate at HUTH and a deterioration in achievement against target and questioned where this was of particular concern, but added that she was pleased to see active recruitment into vacancies within the complaints team. In relation to VT, Dr Pete Sedman responded that it was the focus of every Care Group Performance & Accountability (P&A) meeting and was pleased to share that compliance was generally good in terms of spot checking on the wards. Hilda Gwilliams added that the matter had been discussed in the midwifery and nursing forums and the nursing teams were supporting the medics in ensuring the assessments were being completed.

David Sulch was pleased to see that the Duty of Candour performance was improved, but asked that for the future, the graphical data was presented in a way that more clearly demonstrates the improvement. He also referred to the pressure ulcers spike at HUTH since October 2025 but understood that it was in relation to a change in data collection rather than deteriorating performance. Richard Dickinson confirmed that this was correct; previously both Datix and Ulysses had been used to report the data but now Ulysses was Group-wide, which would alleviate issues in some areas not being categorized. David Sulch was pleased to see progress being made on the patient safety alert in that no incidents had been reported. Richard Dickinson confirmed that this was correct, and Jo Ledger added that an assessment process and appropriate interventions had been embedded and the organisation was using a point prevalence system to check on compliance across the Group.

4.2 **IPC – Current Overview**

Wendy Wigglesworth highlighted that only Pseudomonas had met the threshold targets and other key infections were over the trajectory, particularly at NLaG. There had been outbreaks of Norovirus on wards H9 and H90 at HRI and continued outbreaks were obviously affecting patient flow. A reactive cleaning service had been introduced on the South bank during outbreaks which was temporarily being funded to maintain patient safety. The aged hospital site was highlighted as a major risk, in relation to poor ventilation and deteriorating building

conditions and there was limited solutions to fix structurally due to the major investment required. Training was underway on the ICNet system rollout, which was expected to improve reporting and enable the IPC team to be out and about where appropriate. Wendy Wigglesworth was pleased to share that fifteen IPC policies had now been aligned across the Group with more planned in the next couple of months and meetings were in place with Care Groups to meet with leaders and clinical teams to understand specific IPC issues

Nicola Buckle added that some of the IPC audits were out of date due to previous changes in the audit process, therefore some IPC specific audits had been recommenced and there was a plan in place to bring them all up to date within the next six to eight weeks.

Jo Ledger added that the reactive cleaning service would be included with the harmonization programme for cleaning within the organisation and the learning from the CPE outbreak would continue. She confirmed that the outcome of the conversations with the Care Group tri's would be included in the next update.

Julie Beilby asked whether there should be any concern over the three red RAG rated risks and Nicola Buckle explained the background around the three issues.

Hilda Gwilliams commented that she was pleased to see that the issue around ventilation was now receiving some overdue focus.

Sam Peate questioned whether there was any new technology that could assist with the issue around ventilation in the tower block. David Sulch pointed out that the aged Estate was top of a list of concerns, which included ventilation and questioned whether any mitigations were possible via the Estates team to enable more visibility on what was being done to improve IPC performance. Hilda Gwilliams was of the view that it was important to review the membership of the CiCs to ensure feedback to an appropriate CiC.

ACTION: Hilda Gwilliams to review CiC membership to ensure appropriate feedback on relating issues

Julie Beilby suggested a formal referral to PEF in relation to the ventilation risk at the tower block.

David Sulch referred to the challenging post-infection review process related to C.Difficile and asked Wendy Wigglesworth and Nicola Buckle whether they considered that the process was working and that staff engagement was satisfactory. Wendy Wigglesworth replied that as well as the reviews with Chiefs of Service and nursing directors, a new governance template was in use for each Care Group which enabled shared learning and she was confident that good improvement would soon be seen.

The CiC received limited assurance but were encouraged to see the developments underway to improve the metrics.

Yvonne McGrath joined the meeting at 10am and Nicola Buckle left at 10.05am

4.3 **Establishment Review of Safe Staffing**

Jo Ledger outlined that the proposal was in line with the requirements of the National Quality Board to present the Safer Staffing papers bi-annually to the Trust Board. She confirmed that the Safer Nursing Care Tool (SNCT) was used to ensure data was being collected correctly. A revised paper was planned for submission to Trust Board in August 2026. Jo Ledger advised colleagues that the process had been reviewed by NHSE workforce leaders who were significantly assured and added that the submissions would be added to the Trust website monthly, as per requirements and the carers per patient data included within the IPR. Hilda Gwilliams added that the paper clearly set out the mandated requirements for safer staffing which would be presented at Trust Board and filtered through the appropriate CiCs.

Julie Beilby advised that she was accepting of the process but questioned the reporting mechanisms in ensuring that the same paper was not being presented at various CiCs and ultimately Trust Board and was of the view this may be supported by reviewing the individual Terms of Reference. Hilda Gwilliams accepted this point and agreed that it was important to ensure individual elements of the paper were discussed at the appropriate CiC. Jo Ledger added that she would provide an overview of what was expected to be presented at each CiC and how often.

ACTION: Jo Ledger to provide an overview of which elements of the Safer Staffing paper required discussion at an appropriate CiC

David Sulch spoke of the triangulation of staffing against the quality metrics and reminded colleagues of the challenge at the Board Safety Summit in February 2026 in considering whether the organisation could confidently say it was aware of the areas of concern at ward and speciality level. He asked for an idea on the timescale for the CiC having sight of more detail of the link between staffing and patient outcomes at both ward and speciality level and Jo Ledger responded that she had asked for it to be a priority for the Digital and Information teams.

The CiC noted and acknowledged the process and the planned reporting schedule, but David Sulch suggested a further metric be included around the use of security staff to aid enhanced therapeutic observations. He added that the CiC would support any attempt to automate the manual data collection process.

The CiC were reasonably assured on the process but considered there was still work to do in terms of linking the findings with the quality metrics.

4.4 **Maternity & Neonatal Assurance Report (including Ockenden, CNST, MIS, incidents/MNSI)**

Yvonne McGrath was pleased to confirm that the CQC Section 31 had been lifted and a Comms bulletin would be circulated to all staff. U/s capacity at HRI remained a clinical risk around the ability to deliver a service within the KPIs and timeframes and appeared on the Risk Register. Later in the meeting, in the absence of Yvonne McGrath, Sam Peate updated that there had been a recent non-obstetric ultrasound visit from the regional team and others to explore different models of provision for ultrasound in general. Sam Peate was to arrange a discussion between the radiology and obstetric teams to look at whether the process could be worked differently which would improve waiting times. Action was progressing at DPoW in terms of existing issues around staff behaviour and a leadership review

across the Band 7 matron workforce across the whole service would soon be underway in moving towards a standard operating plan and procedures for all staff. Yvonne McGrath was delighted to say that many staff had received a Shining Lights nomination across the service. Jo Ledger added that in relation to the fill rates for NICU, she had met with the teams and reviewed the rotas to ensure all eventualities were covered and a workforce model had been produced which indicated what was required from a recruitment perspective. This had already received Trust Board approval but was more about ensuring it was a working plan.

Julie Beilby congratulated Yvonne McGrath and her team for the hard work undertaken resulting in the removal of the Section 31 notice. She asked whether there was an opportunity to triangulate the Shining Lights achievements with the data from PALS and from Friends & Family test results and, in relation to the progress table at section 2.5 of the Maternity & Neonatal Safety Improvement Plan, where there were a high number of actions in the delay/issue box in the workstream related to assurance and asked what these may be related to and whether the CiC could support in alleviating these in any way. Yvonne McGrath responded that she would provide this detail in an email to the CiC.

ACTION: Yvonne McGrath to provide detail of issues/delays within the Assurance workstream

David Sulch queried the induction of labour delays and the current position and asked if this could be indicated as a run chart and Yvonne McGrath confirmed that she would include this data in the reports going forward.

Yvonne McGrath confirmed that progress was being made in terms of new staffing which would hopefully improve the flow and hopefully be apparent over the next few months.

Hilda Gwilliams clarified that all the work Yvonne McGrath had outlined was part of the enhanced recovery programme and, being pleased with the improvements to date, she commended the whole team for their efforts, which was echoed by the Chair.

The CiC were reasonably assured and welcomed the lifting of the Section 31 notice and again acknowledged the efforts of all staff in achieving this.

Yvonne McGrath shared her presentation in relation to MIS Y8 and the new expectations. She updated colleagues that the Perinatal Health Inequality Steering Group would be launched internally in early June 2026, with the involvement of external stakeholders.

Hilda Gwilliams thanked Yvonne McGrath for the overview, noting the clear differences in expectations to previous years and asked for some clarification in terms of the training in relation to NLaG. Yvonne McGrath replied that some training was being brought forward but there had been issues with some medical staff being taken off their planned training and this had been escalated. At NLaG there was a requirement to have 100% of the consultants trained, due to the smaller numbers than at HUTH where this was not so much of an issue.

David Sulch was conscious that a conversation was needed with Yvonne McGrath in terms of the Maternity Safety Champion.

ACTION: David Sulch to liaise with Yvonne McGrath in terms of the Maternity Safety Champion role.

The meeting paused for a break at 10.41am

Jacqueline Fenwick joined the meeting at 10.51am

Rachel Hoggarth joined the meeting at 10.56am

4.5 **Learning from Harm and Never Events**

Hilda Gwilliams introduced the paper and explained it had been in development over the last few months in terms of learning from experience and listening to patients and was pleased to advise that the report now contained qualitative as well as quantitative data. She particularly highlighted the PSII and reminded colleagues that there were still a good number of historical cases remaining open. A three-month recovery plan had been put into place in terms of responding appropriately to patients and their families but also in terms of sharing learning amongst staff. She was pleased to note the good commitment from clinical teams through regular meetings and emphasized that this linked into the Improvement Plan and the Quality Priorities of the organisation. Hilda Gwilliams was also pleased to share with colleagues that a rolling programme of patient safety and learning days across the Group had been set up, with the first one due to be held on 8 May 2026 within the Theatre and Critical Care (TACC) Care Group. She added that a variety of action plans were being integrated into one overall plan and the engagement from the clinical teams was excellent. This would align with the Improvement Plan and work was underway with the support of NHSE colleagues. Hilda Gwilliams informed colleagues that there would be a specific governance framework for the Improvement Plan with the CEO holding the appropriate people to account for delivery and this would feed into Trust Board and subsequently through to the organisation's system partners. It was anticipated that through the monthly patient safety and learning days, learning would be shared amongst the Care Groups.

Julie Beilby acknowledged that the report noted some positive training compliance but in relation to the patient safety incident reporting at figure 2 for those incidents with moderate or more severity grading, she asked for an explanation around the different grades and also clarity on the number of cases under review by Care Group nursing directors. In terms of the grading, Hilda Gwilliams replied that the organisation referred to the national framework for this and the details of this was shared.

Richard Dickinson added that the process was ongoing in terms of reviewing, assessing and determining the actual harm and broadly explained the different grades of harm.

James Illingworth joined the meeting at 11am

Julie Beilby was pleased to see the report presented in an improved format and thanked all those involved for their efforts. She also referred to there being a section on PALS themes and learning and the fact that the Governors have ongoing concerns around communication, so this was a positive move. She

specifically asked about the discharge planning process and whether there were any adverse comments about the length of time taken or any barriers. Jo Ledger advised that she would investigate this further and report back at the next meeting.

ACTION: Jo Ledger to update at the next meeting in terms of barriers or negative comments relating to the discharge planning process

Hilda Gwilliams added that communication was to be a high priority focus across every aspect of the Improvement Plan.

David Sharif agreed that the format of the report was much improved, but questioned where IPC would feature and in relation to the two-year patient safety chart for HUTH and NLaG, questioned whether there was confidence that the actions taken were maintaining levels as there did not appear to be significant movement and also asked whether benchmarking was being implemented. Richard Dickinson responded that the organisation featured favourably within the LFPSE dataset where all the patient safety incidents were reported and this reflected a good level of engagement. Richard Dickinson stated he would include some comparative data in future reports.

Jo Ledger acknowledged IPC featuring in this report but stressed the importance of continuing to report in a more detailed way and welcomed the CiC's support on this. David Sulch agreed with this request, considering it was on the organisation's critical priorities.

David Sulch also praised the report on how the details were presented. He also referred to the patient safety incidents, specifically the fatal ones, and assumed that they were graded before investigation, which Richard Dickinson confirmed was correct. He also confirmed that the cases had occurred over the period of a month. David Sulch also referred to the significant reduction in TES spaces in March and was pleased to see that this was sustained into April but questioned the likelihood of this continuing, in view of the expectation to have these eradicated by the summer. Sam Peate responded that work remained ongoing in relation to this and that this target would be achieved.

In terms of assurance, Julie Beilby reminded colleagues that at the last discussion of this paper, the CiC only had limited assurance in anticipation of some visible improvement over the next three to six months. At this point, she determined that she was reasonably assured on the process, but in terms of outcomes, was limited. David Sulch agreed and confirmed the CiC had limited assurance.

TAVI Update

4.6

Dr Pete Sedman gave some background into the TAVI service and a significantly high mortality rate which was at a time when the team within the cardiology department were not well aligned. Since this time, there had been a lot of work ongoing and he was pleased to share that in January 2026, the Royal College of Physicians who had originally visited the organization and provided recommendations had formally written to state they no longer need to monitor performance against standards and also of note was that the 2022-2025 data showed that mortality was now within the normal accepted range.

David Sulch considered that Simon Thackeray's presentation in September 2025 gave a clear picture of a suitably robust governance framework within the service and was pleased to see that outcomes were within national standards.

The CiC remained significantly assured and welcomed the lifting of oversight by the Royal College of Physicians.

4.7 **Enhanced Therapeutic Observation and Care (ETOC) and Restraint and Restriction**

Jo Ledger welcomed this piece of work and acknowledged the efforts of the team. She explained that the initiative had been presented to the Senior Leadership Team (SLT) and subsequently a task and finish group had been set up, meeting weekly, to discuss the issue, particularly at HUTH, relating to the use of security guards in one-to-one supervision. Jacqueline Fenwick explained that the paper detailed the training requirements of the initiative, and that three red lines had been introduced to determine which patients were appropriate for security watch. It was determined that if a patient required two people to observe, then one would be a security guard and one a member of the nursing team, rather than two security guards. Any patient that had required security bed watch for more than twenty-four hours would necessitate a multi-disciplinary team meeting (MDT) to develop a plan for stepping down. The funding for a pilot to recruit two Band 3 non-registered nurses to be able to introduce a model of care from observation to therapeutic care was being sought and there were plans to use volunteers in specific areas with a pilot on three wards. It was noted that since the SLT oversight and an improved system put into place, there had been a reduction in the use of security bed watch and a cultural shift towards looking at other options of observation rather than security.

Rachel Hoggarth stated that ETOC and the programme alongside NHSE had enabled the organisation to relook at restraint and restriction. There had been some increased use of security at HUTH in 2021 and 2023; this was noted as a correction from the dates of 2001 and 2003 stated in the paper. In areas such as ED and paediatrics, with a higher use of physical restraint, staff were being taught about therapeutic restraint to align with Deprivation of Liberty and Mental Capacity Acts. This teaching had been funded but funding was unfortunately not available to provide the refresher training which would have sustained competence and the Trust compliant with standards such as the Restraint and Restriction Network and the British Institute of Learning Disabilities. Rachel Hoggarth defined the plan was to identify groups of staff to be included in a pilot on the North bank who would have access to additional training, but this required the recruitment of the two trained trainers and there was a possibility of receiving some funding from NHSE as part of the ETOC programme, but without the guarantee of future funding, these staff would no longer be competent or compliant. In conclusion, the request was for agreement to recruit the trained trainers, a guarantee for future funding and to consider a restraint and restriction lead who would oversee implementation across the organisation and implement the necessary policies to enable this.

Julie Beilby was pleased to receive the report and thanked colleagues for their efforts. However, she had been concerned about sustainability and funding but welcomed the intention to use existing resources as much as possible. She was also pleased to hear of the cultural shift and was of the view that appropriate conversations were essential. Julie Beilby recalled a discussion at an Audit, Risk &

Governance CiC where a paper highlighted the high cost of using security staff and was of the view it may be helpful to reflect the cost reduction expected. She added that this should be considered within the tower block risk assessment.

Tracy Campbell praised Jacqueline Fenwick, Rachel Hoggarth and Karen Harrison for their absolute commitment to delivering the work and trying to make a difference and considered they were the catalysts in the cultural shift.

David Sulch asked whether the security team had been staffed specifically to assist with the one-to-one care and Tracy Campbell replied that an agency was being used. He asked for confirmation that there would be a genuine reduction in cost and this was provided. David Sulch thanked everyone concerned in enabling good progression in a relatively small amount of time.

Hilda Gwilliams anticipated, with the utilization of appropriate staff with the right skill, the benefits would soon be realized.

The CiC commended the three named members of staff to Board and was reasonably assured at this point, but with evidence of improved and sustained outcomes, this would move to significant. The CiC asked for an update to be presented at a future meeting.

ACTION: An update on progress to be provided at the July meeting

Jacqueline Fenwick and Rachel Hoggarth left the meeting at 11.43am

5. ANNUAL REPORTS

5.1 Research, Innovation & Development Annual Report (including Q3 & Q4 update)

James Illingworth introduced the paper and highlighted the significant progress in terms of recruitment of nearly 16000 participants to research studies. The focus in 2025/26 was on ensuring that opportunities were available for professional groups across all disciplines to engage in research and liaise with appropriate research innovation networks. In excess of £3m was received from grant awards and strategic initiatives in 2025/26 included a digital sponsorship request process which would improve efficiency on how studies were managed as well as a digital platform for governance which would assist in highlighting barriers.

Dr Pete Sedman praised James Illingworth and the team in their efforts during a challenging period for the organisation and this was echoed by the Chair. Hilda Gwilliams noted a well-written report and welcomed the call for all professional groups to become involved in research.

Julie Beilby thanked James Illlingworth for the quality of his report, presentation and the work ongoing.

David Sulch concluded in thanking James Illingworth and the team for an excellent research year. Organisations who participated in research were known to deliver better quality clinical care.

The CiC approved the annual report.

6. *James Illingworth left the meeting at 11.55am*

6.1 **HIGHLIGHT REPORTS**

Patient Safety and Learning Group

6.2 This was noted.

Patient Experience Group

6.3 This was noted.

Maternity and Neonatal Assurance Group

6.4 This was noted.

Risk and Compliance

This was noted.

Hilda Gwilliams updated that several external reviews and recommendations had been integrated into the Improvement Plan and all high risks had been validated.
7. Updates to this would be included in future reports.

7.1 **ITEMS FOR INFORMATION**

Unplanned Care Board Minutes & Highlight Report

Sam Peate advised that in terms of the Unplanned Care Board, the approach had been refreshed into seven key workstreams and updates would be provided in future minutes.

Julie Beilby welcomed sight of the minutes and noted plans to use the frailty nurse team in a different way to assess whether a seven-day model could be considered and questioned whether there had been any progress. Sam Peate responded that the South bank FSDEC model commenced at the beginning of March and the
8. progress had been positive.

8.1 **ANY OTHER BUSINESS**

Any Other Urgent Business

9. There was no other urgent business.

9.1 **MATTERS TO BE REFERRED BY THE COMMITTEES**

Matters to be referred to other Board Committees

The following matter would be referred to the Performance, Estates & Finance CiC:

- Estates ventilation risk in HRI Tower Block

9.2

Matters to be escalated to the Trust Boards including any proposed changes to the BAFs

The following items would be escalated to Trust Board:

- The septicaemia SHMI was higher than expected but noted as a Quality Priority for 2026/27
- VT performance managed via Care Group performance meetings and nursing teams supporting clinicians. A review has shown there has not been a rise in thrombotic events
- The CiC gave reasonable assurance to the process for Safer Staffing
- Maternity ultrasound attain rates at NLaG and the induction of labour capacity was concerning with work ongoing to address the issues. The CiC gave reasonable assurance
- The CiC noted a recovery programme in place in relation to Learning from Harm. The CiC gave limited assurance but noted the improvements underway
- ED target performance and RTT compliance was improving at both HUTH and NLaG.
- Duty of Candour - a recovery programme was in place, and the outputs were above those forecast
- Never Events national position was improving
- The CiC noted that the CQC Section 31 notice had been lifted in terms of the maternity service
- In relation to the TAVI service, the RCP were no longer monitoring the service
- Three members of staff commended to Board because of their work around ETOC and restriction and restraint. A notable shift from using security staff was reported
- IPC – wards H9 and H90 closed to norovirus but enhanced IPC support in place. C.Difficile threshold breached but plans in place to address this. IPC audit plan in place. The CiC gave limited assurance due to the current outcomes, but improvements were recognised

10.

- Research, Innovation & Development Annual Report was approved

DATE OF THE NEXT MEETING

The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 28 May 2026 at 9.00am-1.30pm via MS Teams

The Chair closed the meeting at 12.03pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2026/2027

Name	Title	2026 / 2027											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y											
Julie Beilby	Non-Executive Director (NLaG)	Y											
Dr Kate Wood	Group Chief Medical Officer	D											
Jo Ledger	Interim Group Chief Nurse	Y											
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y											
Rebecca Crashley	Group Deputy Director of Assurance	Y											
Yvonne McGrath	Group Director of Midwifery	Y											
Sam Peate	Group Chief Delivery Officer	Y											
Hilda Gwilliams	Group Chief Patient Safety Officer	Y											
Michela Littlewood	Associate Director of Quality Governance (HUTH)	N											
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y											
Kevin Allen	Governor Observor	Y											
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	N											

***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(26)144

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**11 June 2026**
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	**Philippa Russell, Group Deputy Director of Finance** **Brian Shipley, Operational Director of Finance**
Title of Report	**Finance Report – Month 1**
Executive Summary	This report highlights the reported financial position for April 2026.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	**Presented at Performance, Estates & Finance Committees-in-Common 2 June 2026**
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:



NHS
Humber Health
Partnership

Finance Report Month 1
April – 2026/27

Finance Overview

In-month I&E Performance – page 3 to 4

(£2.2m) The Group reported an in-month deficit for month 1 of (£10.0m), (£2.2m) adverse to plan. The position includes (£1.3m) of expenditure relating to Industrial Action cover.

Year to Date I&E Performance – page 3 to 4

(£2.2m) The Group reported a year-to-date deficit of (£10.0m), (£2.2m) adverse to plan. The position includes (£1.3m) of expenditure relating to Industrial Action cover.

I&E Forecast Outturn & Risk – page 5 to 6

(£40.2m) The Group is formally forecasting a plan compliant position. However, an adjusted straight-line projection would give a deficit of (£138.7m). Mitigating actions reduce the deficit leaving an unidentified gap of (£40.2m).

YTD Cost Improvement Plan – page 7 to 8

(£4.9m) The Group has delivered £2.7m in CIP against a YTD target of £7.6m, (£4.9m) behind target.

The Group are forecasting CIP delivery of £72.4m, (£46.7m) adverse to plan.

Underlying I&E – page 9

(£116.2m) The Group's underlying position is estimated at a deficit of circa (£116.2m). In year recurrent CIP delivery will be the key driver of its underlying financial position.

System Performance – page 10

(£6.0m) The ICS reported a YTD deficit of (£17.4m), (£6.0m) adverse to plan at month 1. The ICS is forecasting a (£100.9m) deficit for the year in line with plan.

Capital Expenditure – page 11

(£2.2m) The Group has spent £1.2m on capital expenditure against a plan of £3.5m, (£2.2m) behind plan.

Balance Sheet & Cash – pages 12 to 13

£70.5m The Group's cash balance at the end of month 1 was £70.5m. The Group did not require additional external cash support for April but has requested £6.35m in additional external cash support for May and £7.98m for June.

Variable Pay – pages 14 to 20

(£0.6m) The Group has spent £9.2m on variable pay (£0.6m) more than the same period in 2025/26. However, this includes (£1.7m) of IA expenditure (£1.3m cost pressure after staff deductions).

Key Risks

- ❑ High value of unidentified CIP and high-risk CIP opportunities.
- ❑ Variable Income Risk - CDC under-performance claw back.
- ❑ Inflation above Tariff assumptions.
- ❑ Further Industrial Action.
- ❑ Slippage on Capital Expenditure profile
- ❑ Requirement for additional Revenue Cash Support.

Key Actions

- ❑ Reducing cost pressures: reliance on premium variable pay; 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.

Financial Performance Summary

The Group ended month 1 with a year-to-date (YTD) deficit of (£10.0m), (£2.2m) adverse to plan.

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.3	75.5	0.1	75.3	75.5	0.1	46.8	46.1	(0.7)	46.8	46.1	(0.7)	122.1	121.5	(0.5)	122.1	121.5	(0.5)
Other Income	6.1	5.9	(0.2)	6.1	5.9	(0.2)	4.5	4.6	0.1	4.5	4.6	0.1	10.6	10.5	(0.1)	10.6	10.5	(0.1)
Total Operating Income	**81.4**	**81.4**	**(0.1)**	**81.4**	**81.4**	**(0.1)**	**51.3**	**50.7**	**(0.6)**	**51.3**	**50.7**	**(0.6)**	**132.7**	**132.1**	**(0.6)**	**132.7**	**132.1**	**(0.6)**
Pay Costs																		
Clinical Pay	(41.4)	(42.9)	(1.5)	(41.4)	(42.9)	(1.5)	(29.6)	(29.2)	0.4	(29.6)	(29.2)	0.4	(71.0)	(72.1)	(1.1)	(71.0)	(72.1)	(1.1)
Other Pay	(8.8)	(8.6)	0.2	(8.8)	(8.6)	0.2	(7.2)	(7.3)	(0.0)	(7.2)	(7.3)	(0.0)	(16.1)	(15.9)	0.2	(16.1)	(15.9)	0.2
Total Pay Costs	**(50.2)**	**(51.5)**	**(1.3)**	**(50.2)**	**(51.5)**	**(1.3)**	**(36.8)**	**(36.5)**	**0.4**	**(36.8)**	**(36.5)**	**0.4**	**(87.1)**	**(88.0)**	**(0.9)**	**(87.1)**	**(88.0)**	**(0.9)**
Clinical Non Pay	(20.0)	(19.8)	0.2	(20.0)	(19.8)	0.2	(8.1)	(8.2)	(0.1)	(8.1)	(8.2)	(0.1)	(28.1)	(28.0)	0.1	(28.1)	(28.0)	0.1
Other Non Pay	(12.2)	(12.9)	(0.8)	(12.2)	(12.9)	(0.8)	(6.1)	(6.6)	(0.5)	(6.1)	(6.6)	(0.5)	(18.3)	(19.5)	(1.3)	(18.3)	(19.5)	(1.3)
Total Non Pay Costs	**(32.2)**	**(32.8)**	**(0.6)**	**(32.2)**	**(32.8)**	**(0.6)**	**(14.2)**	**(14.8)**	**(0.6)**	**(14.2)**	**(14.8)**	**(0.6)**	**(46.4)**	**(47.5)**	**(1.2)**	**(46.4)**	**(47.5)**	**(1.2)**
Total Operating Expenditure	**(82.4)**	**(84.3)**	**(1.9)**	**(82.4)**	**(84.3)**	**(1.9)**	**(51.0)**	**(51.3)**	**(0.2)**	**(51.0)**	**(51.3)**	**(0.2)**	**(133.4)**	**(135.6)**	**(2.1)**	**(133.4)**	**(135.6)**	**(2.1)**
EBITDA	**(1.0)**	**(2.9)**	**(2.0)**	**(1.0)**	**(2.9)**	**(2.0)**	**0.2**	**(0.6)**	**(0.8)**	**0.2**	**(0.6)**	**(0.8)**	**(0.7)**	**(3.5)**	**(2.8)**	**(0.7)**	**(3.5)**	**(2.8)**
Depreciation	(2.7)	(2.7)	0.0	(2.7)	(2.7)	0.0	(2.3)	(1.8)	0.5	(2.3)	(1.8)	0.5	(5.0)	(4.5)	0.5	(5.0)	(4.5)	0.5
Non Operating Items	(1.5)	(1.5)	(0.0)	(1.5)	(1.5)	(0.0)	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1	(2.2)	(2.1)	0.1	(2.2)	(2.1)	0.1
Surplus/(Deficit)	**(5.2)**	**(7.1)**	**(1.9)**	**(5.2)**	**(7.1)**	**(1.9)**	**(2.8)**	**(3.0)**	**(0.2)**	**(2.8)**	**(3.0)**	**(0.2)**	**(8.0)**	**(10.1)**	**(2.1)**	**(8.0)**	**(10.1)**	**(2.1)**
NHSE Allowable Adjustments	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)
Adjusted Surplus / (Deficit)	**(5.2)**	**(7.2)**	**(2.0)**	**(5.2)**	**(7.2)**	**(2.0)**	**(2.6)**	**(2.9)**	**(0.3)**	**(2.6)**	**(2.9)**	**(0.3)**	**(7.8)**	**(10.0)**	**(2.2)**	**(7.8)**	**(10.0)**	**(2.2)**

- **The Group reported a (£10.0m) deficit in month, (£2.2m) adverse to plan. The Group incurred (£1.3m) to cover Industrial Action in April.**
- The Group is behind on its CIP programme by (£4.9m). This is only partly mitigated through vacancy factors and other underspends.
- The Group cash balance decreased by (£2.6m) in month to £70.5m (£27.7m HUTH / £42.8m NLAG). The Group has requested £6.35m in additional external cash support for May (HUTH) and £7.98m for June (£6.0m HUTH / £1.98m NLAG) and is awaiting NHSE approval.

See Appendix A on Page 22 to 23 for Detailed I&E Position

Financial Performance Summary: By Care Group

Directorate	Directorate 2	Care Group	YTD Budget	YTD Actual	YTD Variance
			£000's	£000's	£000's
Central Income			124,756	124,318	(438)
Corporate Directorates			(21,052)	(21,049)	2
Finance Technical			(7,299)	(6,704)	595
Operations	**Operations North**	Cancer Network	(744)	(755)	(11)
		Cardiovascular	(4,335)	(4,796)	(460)
		Chief Delivery Officer	(71)	(120)	(49)
		Digestive Diseases	(5,722)	(6,308)	(586)
		Head & Neck	(4,698)	(4,893)	(195)
		Major Trauma Network	(313)	(317)	(4)
		Patient Services	(3,800)	(3,817)	(17)
		Specialist Cancer And Support Services	(24,186)	(24,863)	(677)
		Theatres, Anaesthetics And Critical Care	(11,416)	(12,011)	(595)
	Operations North Total		**(55,284)**	**(57,878)**	**(2,594)**
	Operations South	Acute And Emergency Medicine South	(3,395)	(3,999)	(604)
		Acute And Emergency Medicine North	(5,682)	(5,942)	(260)
		Chief Delivery Officer	(77)	(60)	17
		Community, Frailty & Therapy	(7,457)	(7,979)	(522)
		Family Services	(9,708)	(10,177)	(470)
		Neuroscience	(3,235)	(3,317)	(82)
		Pathology Network Group	(4,185)	(4,305)	(120)
		Site Management & Discharge Teams	(623)	(640)	(17)
		Specialist Medicine	(6,131)	(6,451)	(320)
		Specialist Surgery	(5,532)	(5,529)	3
	Operations South Total		**(46,025)**	**(48,399)**	**(2,374)**
Operations Total			**(101,309)**	**(106,277)**	**(4,968)**
Reserves			(3,057)	(386)	2,670
Grand Total			**(7,960)**	**(10,099)**	**(2,139)**
Adjusted Financial Performance			163	62	(101)
Adjusted Financial Performance (surplus / (deficit)			**(7,797)**	**(10,037)**	(2,240)

See Appendix A on Page 23 for Detailed I&E Position

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£120.2m) based on an adjusted straight-line projection. Seasonal variation and other mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£40.2m) across the Group.

At this early stage of the year the Group is forecasting to deliver the planned deficit, but there remains a significant level of risk to delivery due to the challenging £119.1m efficiency target (6.8% including FYEs), which at the point of reporting had a risk adjusted forecast of only £54.17m.

A straight-line forecast based on the YTD deficit position would leave the group with a £120.2m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent slippage in the year-to-date position, this deficit increases to £138.7m.

To bring back the forecast deficit to the planned level the Group needs to:

- Deliver improved efficiency of at least £33.4m including currently undeveloped opportunities.
- **Identify further mitigations of £40.2m** to close the efficiency gap and cover other emerging risks including the unplanned cost of industrial action.

The forecast also assumes a level of mitigation through additional non recurrent income that would routinely be expected to be allocated later in the year.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m
YTD deficit (M1)	(7.1)	(2.9)	(10.0)
Straight line forecast	**(85.6)**	**(34.6)**	**(120.2)**
Seasonality	(7.5)	(2.5)	(10.0)
Industrial Action	11.4	3.0	14.4
Investment Expenditure Profile	(4.9)	(3.8)	(8.7)
Expected changes to run-rate	(7.0)	(4.4)	(11.4)
Depreciation, Interest Received & PDC	-	(2.9)	(2.9)
Adjusted Run Rate	**(93.6)**	**(45.1)**	**(138.7)**
Forecast CIP delivery (improvement in run-rate)	25.7	7.7	33.4
Additional Non Recurrent Income	2.0	-	2.0
Forecast deficit	**(65.9)**	**(37.4)**	**(103.3)**
Plan	**(39.4)**	**(23.7)**	**(63.1)**
Unmitigated Variance	**(26.5)**	**(13.7)**	**(40.2)**

Financial Performance – Recovery Plan

Focus on workforce, given the growth in both pay costs and headcount in recent years, with particular attention to two key elements: variable pay reduction and headcount reduction.

- Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target.
- Confirmed Care Group CIP allocations including the variable pay reduction and an allocation for headcount reduction based on total WTE - transacted in Month1 budgets to ensure accountability.
- Weekly monitoring of variable pay where data is available - shared with Care Groups.
- Revised vacancy control process supported by a new form and tracker - to be implemented from 1st June.
- Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments.
- Session on the 16th of June being arranged for each Care Group to present their CIP position to the Board to include: overall progress against target; headcount reduction trajectory; barriers and limitations: mitigations; and support required.
- At this stage plans to reduce headcount are the least developed but remains a key area of focus and scrutiny.
- Finance training to be included in LISA programme being developed to support operational managers.
- Enhanced communications strategy to support ownership of the finance agenda.
- Alignment with clinical priorities through the Integrated Recovery Plan.

Financial Performance – Forecast Outturn (FOT) - RISKS

At Month 1 the Group reported a net risk to delivery of the (£63.1m) deficit plan of (£135.6m). Whilst this is an improvement compared to the (£151.2m) net risk reported in the final plan submission it is still material with risk to CIP delivery the key risk.

Updated Risk Position	Plan 31/03/2027 Year Ending £'000	Forecast 31/03/2027 Year Ending £'000	Forecast 31/03/2027 Year Ending £'000	Forecast 31/03/2027 Year Ending £'000	Comments	Current risk status	Risk adjusted £'000	Risk adjusted £'000	Risk adjusted £'000
Risks and mitigations	Group	HUTH	NLAG	Group		RAG	Group	HUTH	NLAG
Forecast variance	**(63,065)**	**(39,400)**	**(23,665)**	**(63,065)**			(63,065)	(39,400)	(23,665)
(Risks):									
Growth risk	(4,160)	(4,160)	0	(4,160)	Growth likely but not currently included: Endoscopy, Acute theatre sessions, Renal external contracts & CT Neuro outsourcing, cancer performance#		(2,080)	(2,080)	0
Additional cost risk (inflation)	(1,000)	(2,000)	(1,000)	(3,000)	Inflationary pressures above CUF		(1,500)	(1,000)	(500)
Efficiency Opportunity likely to be non cash releasing	(10,000)	(10,000)	0	(10,000)	Outpatient / Theatre productivity		(5,000)	(5,000)	0
Efficiency risk	(72,025)	(34,815)	(32,758)	(67,573)	High Risk Schemes / Unidentified		(54,869)	(26,111)	(28,758)
Unidentified Income	0			0	Confirmed in final plan submission		0	0	0
Variable Income Risk - CDC	(3,581)	(1,850)	(2,340)	(4,190)	Mismatch between allocations and activity plan		(3,143)	(1,388)	(1,755)
Funding Allocations not yet confirmed	(3,000)	(3,000)	0	(3,000)	Lung Health Check / Mechanical Thrombectomy		(750)	(750)	0
Pressure on flow incl NCTR / SDEC implentation	(3,000)	(3,000)	0	(3,000)			(1,500)	(1,500)	0
PDC Dividend	(480)	(1,400)	(1,000)	(2,400)	Revenue Support PDC impact if deficit plan not achieved		(1,200)	(700)	(500)
Additional costs to deliver constitutional standards	(500)	(1,000)	0	(1,000)	Majority of available Reserve allocated for Q1		(750)	(750)	0
Impact of 25/26 adverse movement on underlying deficit vs plan	(3,000)	(3,700)	(3,374)	(7,074)	Offset by non recurrent income in M12		(7,074)	(3,700)	(3,374)
Industrial Action		(1,030)	(280)	(1,310)	M1 only		(1,310)	(1,030)	(280)
							0		0
Mitigations/benefits:									0
Additional income	1,300	1,300		1,300	Potential funding allocation to support PFI adjustment previously funded NR - mentioned in initial national guidance		325	325	0
Efficiency mitigation	0			0			0	0	0
Variable Income Opportunity	5,000	5,000	3,500	8,500	Elective Activity / Specialist Top Ups / HCDs & Devices		4,250	2,500	1,750
Non-recurrent mitigation	6,303	1,000	1,595	2,595	Potential slippage on investments		2,095	500	1,595
							0	0	0
				0			0	0	0
Total Provider Net Risk	**(151,208)**	**(98,055)**	**(59,322)**	**(157,377)**			**(135,571)**	**(80,084)**	**(55,487)**

Financial Performance – CIP Delivery

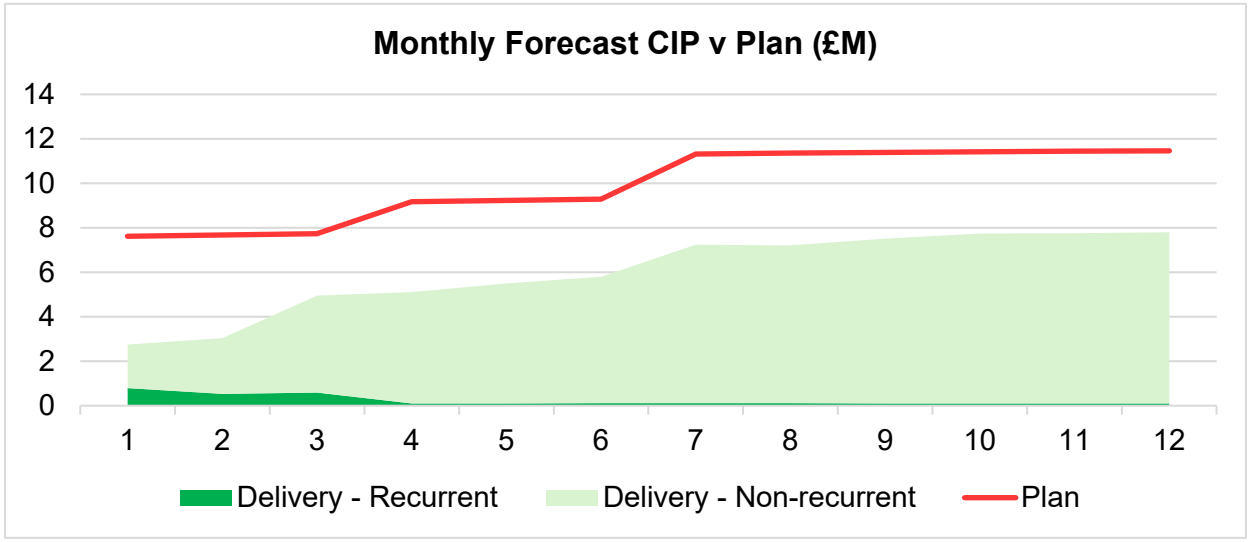
The Group has delivered £2.7m CIP year-to-date against a target of £7.6m, (£4.9m) adverse. The Group is forecasting CIP delivery of £72.4m (£46.7m) adverse to plan.

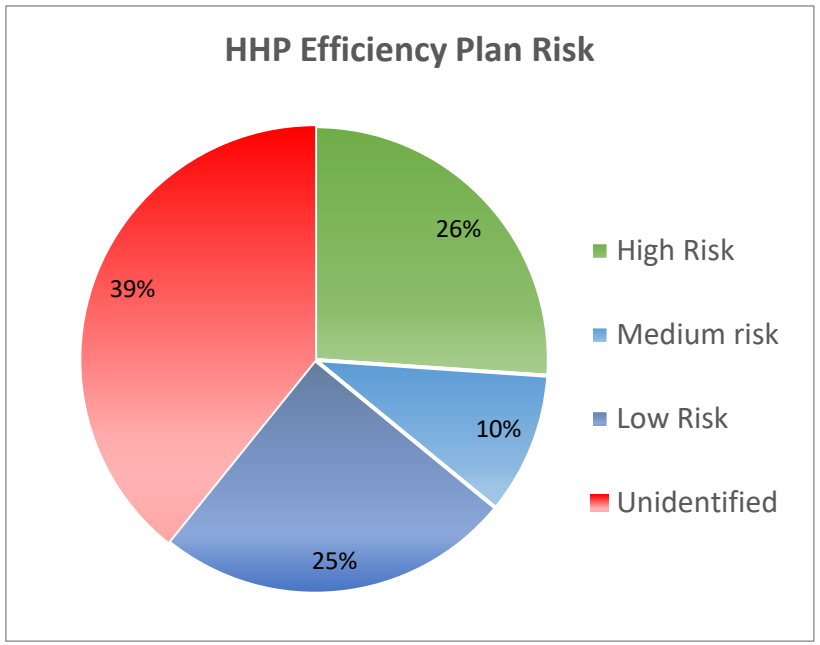
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute and Emergency Medicine (North)	231	1	(230)	2,771	794	(1,977)	0	0	0	0	0	0	231	1	(230)	2,771	794	(1,977)
	Acute and Emergency Medicine (South)	0	0	0	0	0	0	430	40	(390)	5,163	1,221	(3,942)	430	40	(390)	5,163	1,221	(3,942)
	Cancer Network	17	0	(17)	205	0	(205)	11	0	(11)	133	0	(133)	28	0	(28)	337	0	(337)
	Cardiovascular	177	37	(140)	2,122	1,376	(746)	45	33	(12)	538	207	(331)	222	70	(152)	2,661	1,584	(1,077)
	Chief Delivery Officer	4	0	(4)	54	0	(54)	5	0	(5)	58	0	(58)	9	0	(9)	112	0	(112)
	Community, Frailty & Therapy	180	8	(172)	2,163	668	(1,495)	215	33	(183)	2,586	966	(1,620)	396	41	(355)	4,749	1,634	(3,115)
	Digestive Diseases	150	17	(133)	1,796	867	(929)	151	46	(105)	1,818	382	(1,436)	301	63	(238)	3,614	1,249	(2,365)
	Family Services	251	5	(247)	3,017	270	(2,747)	255	65	(190)	3,060	403	(2,657)	506	69	(437)	6,076	673	(5,404)
	Head & Neck	165	120	(45)	1,981	1,310	(670)	107	25	(82)	1,279	413	(867)	272	145	(127)	3,260	1,723	(1,537)
	Major Trauma Network	13	3	(10)	161	31	(130)	1	0	(1)	9	0	(9)	14	3	(11)	170	31	(139)
	Neuroscience	111	45	(66)	1,331	416	(915)	52	12	(41)	628	291	(336)	163	57	(107)	1,958	707	(1,251)
	Pathology Network Group	53	45	(8)	635	543	(92)	171	0	(171)	2,048	775	(1,273)	224	45	(178)	2,683	1,319	(1,365)
	Patient Services	95	13	(82)	1,140	334	(806)	81	11	(70)	972	240	(733)	176	24	(152)	2,112	573	(1,539)
	Site Management & Discharge Teams	14	0	(14)	169	74	(95)	18	1	(17)	218	78	(140)	32	1	(31)	387	153	(234)
	Specialist Cancer And Support Services	460	56	(404)	5,521	1,435	(4,086)	323	23	(300)	3,875	2,164	(1,711)	783	79	(704)	9,396	3,599	(5,797)
	Specialist Medicine	145	13	(131)	1,736	207	(1,529)	107	9	(98)	1,283	362	(921)	252	23	(229)	3,019	569	(2,450)
	Specialist Surgery	177	34	(143)	2,123	669	(1,454)	121	94	(27)	1,452	483	(969)	298	128	(170)	3,575	1,152	(2,423)
	Theatres, Anaesthetics And Critical Care	334	8	(326)	4,012	665	(3,347)	227	9	(217)	2,719	945	(1,773)	561	17	(544)	6,731	1,610	(5,121)
Total Operations		**2,578**	**405**	**(2,173)**	**30,936**	**9,660**	**(21,276)**	**2,320**	**401**	**(1,919)**	**27,837**	**8,929**	**(18,909)**	**4,898**	**806**	**(4,092)**	**58,773**	**18,589**	**(40,184)**
Corporate	Chief Executive	1	0	(1)	14	0	(14)	0	0	(0)	5	0	(5)	2	0	(2)	20	0	(20)
	Chief Medical Officer	60	17	(43)	721	200	(521)	17	0	(17)	201	0	(201)	77	17	(60)	922	200	(722)
	Chief Nurse	50	19	(31)	602	225	(377)	47	9	(38)	565	108	(456)	97	28	(69)	1,166	333	(833)
	Director Of Assurance	2	0	(2)	25	83	58	4	0	(4)	53	44	(9)	7	0	(7)	78	127	49
	Director Of People	64	19	(45)	764	274	(490)	53	5	(48)	638	84	(555)	117	24	(93)	1,402	357	(1,044)
	Finance - E&F	428	74	(354)	5,138	2,782	(2,356)	243	15	(229)	2,921	1,916	(1,005)	672	89	(582)	8,059	4,698	(3,361)
	Finance - Finance	24	14	(10)	289	166	(123)	20	10	(9)	239	125	(113)	44	24	(20)	527	291	(236)
	Finance - Procurement	10	0	(10)	124	0	(124)	7	0	(7)	87	0	(87)	18	0	(18)	212	0	(212)
	Finance - S & P	33	16	(17)	397	189	(208)	39	0	(39)	464	0	(464)	72	16	(56)	861	189	(672)
	Strategy, Partnerships and Digital	72	1	(71)	862	197	(665)	60	14	(46)	718	378	(340)	132	15	(117)	1,580	575	(1,005)
Total Corporate		**745**	**160**	**(585)**	**8,936**	**4,116**	**(4,820)**	**491**	**53**	**(438)**	**5,891**	**2,655**	**(3,236)**	**1,236**	**212**	**(1,023)**	**14,827**	**6,771**	**(8,056)**
Total Allocated CIPCore Programme		**3,323**	**565**	**(2,758)**	**39,872**	**13,776**	**(26,096)**	**2,811**	**453**	**(2,357)**	**33,729**	**11,584**	**(22,145)**	**6,133**	**1,018**	**(5,115)**	**73,600**	**25,360**	**(48,240)**
Trustwide	Reserves	0	189	189	0	566	566	0	313	313	0	929	929	0	502	502	0	1,495	1,495
	Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unallocated	299	50	(249)	22,029	27,000	4,971	21	12	(10)	9,471	4,556	(4,916)	321	62	(259)	31,500	31,555	55
	Full Year Effects	915	916	1	10,981	10,981	0	252	252	0	3,023	3,023	0	1,167	1,168	1	14,004	14,004	0
Total Technical & Unallocated		**1,214**	**1,154**	**(60)**	**33,010**	**38,546**	**5,537**	**273**	**577**	**303**	**12,495**	**8,508**	**(3,987)**	**1,488**	**1,731**	**243**	**45,504**	**47,054**	**1,550**
TOTAL		**4,537**	**1,719**	**(2,818)**	**72,881**	**52,322**	**(20,559)**	**3,084**	**1,030**	**(2,054)**	**46,223**	**20,092**	**(26,131)**	**7,621**	**2,749**	**(4,872)**	**119,104**	**72,414**	**(46,690)**

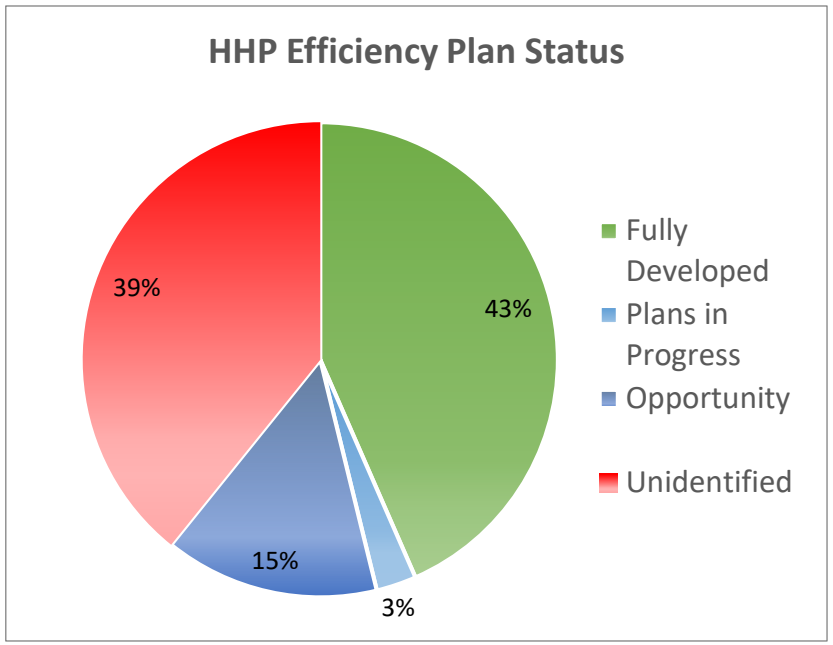
Financial Performance – CIP

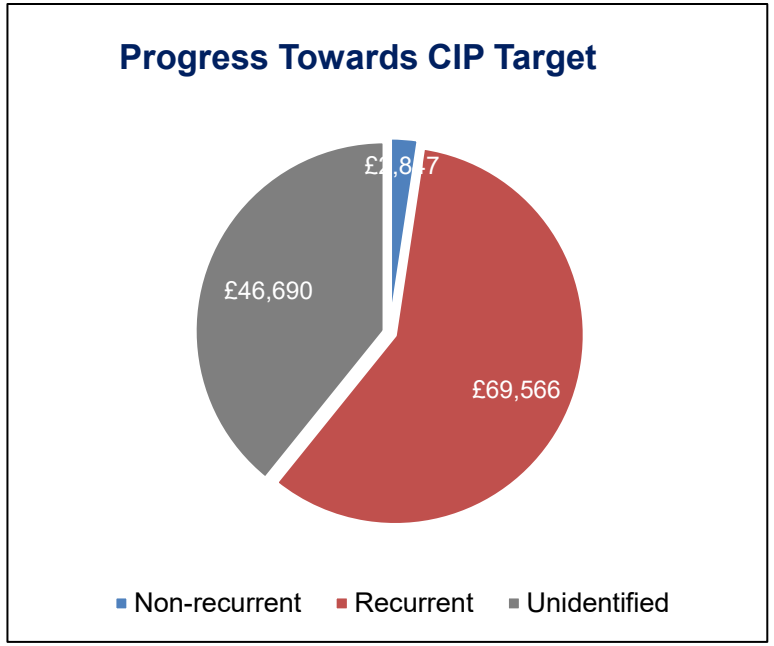
Efficiency Forecast Risk	HUTH	NLAG	HHP
High Risk	17,267	13,797	31,064
Medium risk	10,716	1,012	11,729
Low Risk	24,338	5,282	29,620
Unidentified	20,559	26,131	46,690
TOTAL	**72,881**	**46,223**	**119,104**

Efficiency Forecast Status	HUTH	NLAG	HHP
Fully Developed	33,870	17,868	51,738
Plans in Progress	2,372	886	3,258
Opportunity	16,080	1,338	17,417
Unidentified	20,559	26,131	46,690
TOTAL	**72,881**	**46,223**	**119,104**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£116.2m)

Bridging from the (£63.1m) planned deficit for 2026-27 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income support totalling (£13.8m).
2. The Group currently has unidentified and non recurrent CIP of (£45.6m).
3. The in year CIP schemes have a potential FYE of £14.7m if delivered in full in year.
4. The Groups has committed investments with a full year effect of (£8.5m).

CIP delivery will be the key driver for the Trust's underlying financial position both in year and the potential full year effects of in year schemes.

£million	NLAG	HUTH	HHP
2026/27 - Planned Surplus/(Deficit)	**(23.7)**	**(39.4)**	**(63.1)**
Non-recurrent Adjustments			
NR Additional Income Support	(3.0)	(10.8)	(13.8)
NR CIP (Forecast incl Unidentified)	(27.4)	(18.2)	(45.6)
FYE 26/27 CIP	8.2	6.5	14.7
FYE 26/27 Investments	(3.0)	(5.4)	(8.5)
Underlying Deficit	**(48.9)**	**(67.3)**	**(116.2)**

System Financial Performance – Month 1, April 2026

The ICS reported a YTD deficit of (£17.4m), (£6.0m) adverse to plan. The ICS is forecasting a (£100.9m) deficit at the year end in line with plan.

Month 1 Heads Up Position

Name	Commissioner / Provider	Plan YTD £000s	Actual YTD £000s	Variance YTD £000s	Plan £000s	FOT £000s	Variance £000s
NHS Humber and North Yorkshire ICB	Commissioner	0	0	0	0	0	0
Harrogate and District NHS Foundation Trust	Provider	(1,480)	(4,866)	(3,387)	(15,279)	(15,279)	0
Hull University Teaching Hospitals NHS Trust	Provider	(5,195)	(7,159)	(1,964)	(39,400)	(39,400)	0
Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0
Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(2,601)	(2,881)	(280)	(23,665)	(23,665)	0
York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(2,087)	(2,470)	(383)	(22,646)	(22,646)	0
TOTAL		**(11,362)**	**(17,376)**	**(6,014)**	**(100,990)**	**(100,990)**	**0**

CIPS	-8,500
Industrial Action	-1,750
Vacancies, slippage on developments etc..	4,236
TOTAL	**-6,014**

Capital Expenditure

The Group has spent £1.2m year to date on capital expenditure against a plan of £3.5m plan, (£2.2m) behind plan.

£million	NLAG Year to Date			HUTH Year to Date			HHP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	0.5	0.0	(0.5)	0.0	0.0	0.0	0.5	0.0	(0.5)
Constitutional Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Theatre upgrades and ventilation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HRI Tower Block	0.0	0.0	0.0	1.0	0.0	(1.0)	1.0	0.0	(1.0)
SDEC	0.0	0.0	0.0	0.5	0.0	(0.5)	0.5	0.0	(0.5)
Total Estates Major Schemes	**0.5**	**0.0**	**(0.5)**	**1.5**	**0.0**	**(1.5)**	**2.0**	**0.0**	**(2.0)**
Other Estates Schemes	0.0	0.0	0.0	0.1	0.1	(0.0)	0.1	0.1	(0.0)
IM&T Programme	0.1	0.1	(0.0)	0.0	0.1	0.1	0.1	0.2	0.1
EPR	0.2	0.1	(0.1)	0.0	0.1	0.1	0.2	0.2	(0.0)
Equipment Renewal	0.0	0.0	0.0	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Facilities Maintenance	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1
Other Capital Expenditure	0.0	0.1	0.1	1.1	0.7	(0.4)	1.1	0.8	(0.3)
Total Capital Programme	**0.8**	**0.3**	**(0.5)**	**2.7**	**0.9**	**(1.8)**	**3.5**	**1.2**	**(2.3)**
Funded By:									
Internally Generated	0.8	0.3	(0.5)	1.2	0.9	(0.3)	2.0	1.2	(0.8)
PDC Funded	0.0	0.0	0.0	1.5	0.0	(1.5)	1.5	0.0	(1.5)
Donated	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
IFRS16	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**0.8**	**0.3**	**(0.5)**	**2.7**	**0.9**	**(1.8)**	**3.5**	**1.2**	**(2.2)**

Key areas of slippage in Month 1 relate to HRI: the reconfiguration required to facilitate SDEC and the Tower Block improvements. There have been delays in obtaining planning permission for the Lansdown building, finalising the SDEC configuration and in obtaining Building Safety Regulation (BSR) sign off as this process is taking longer than expected.

The Trust has submitted a revised profile to NHSE for the Tower Block funding to reduce the expenditure in 26/27 and is awaiting approval.

With the exception of the Gamma Cameras, funding for Constitutional standards schemes is yet to be approved, pending approval of the HNY System plan. This could impact on delivery due to lead time requirements.

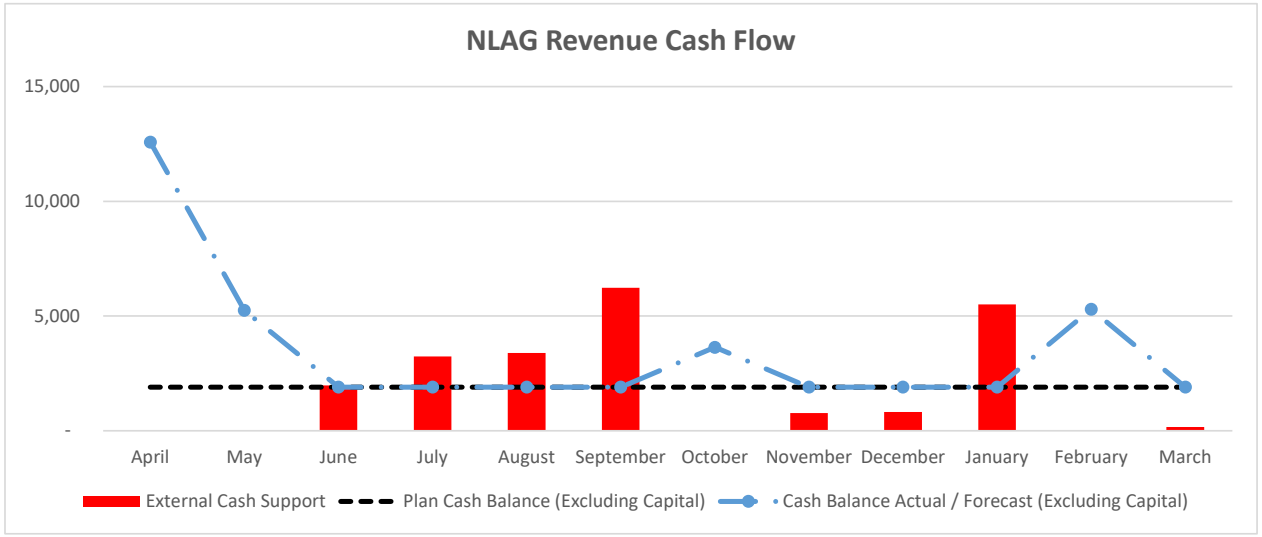
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 31-Mar-26	Actual 30-Apr-26	In month movement	Actual 31-Mar-26	Actual 30-Apr-26	In month movement	Actual 31-Mar-26	Actual 30-Apr-26	In month movement
Fixed Assets	312.8	311.3	(1.5)	546.4	544.8	(1.6)	859.2	856.1	(3.1)
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	4.9	4.7	(0.2)	20.4	20.1	(0.3)	25.2	24.8	(0.4)
Trade and Other Debtors	21.2	19.7	(1.5)	36.8	40.4	3.6	58.0	60.1	2.1
Cash	39.9	42.8	2.8	33.1	27.7	(5.4)	73.1	70.5	(2.6)
Total Current Assets	**66.0**	**67.2**	**1.2**	**90.3**	**88.2**	**(2.1)**	**156.3**	**155.4**	**(0.9)**
Current Liabilities									
Trade and Other Creditors	(84.9)	(78.6)	6.3	(98.9)	(82.6)	16.2	(183.7)	(161.2)	22.5
Accruals	(17.2)	(22.6)	(5.4)	(27.8)	(42.4)	(14.5)	(45.0)	(65.0)	(20.0)
Other Current Liabilities	(5.5)	(9.4)	(3.9)	(17.9)	(23.4)	(5.5)	(23.4)	(32.8)	(9.4)
Total Current Liabilities	**(107.5)**	**(110.5)**	**(3.0)**	**(144.6)**	**(148.4)**	**(3.8)**	**(252.2)**	**(259.0)**	**(6.8)**
Net Current Liabilities	**(41.5)**	**(43.3)**	**(1.8)**	**(54.3)**	**(60.2)**	**(5.9)**	**(95.9)**	**(103.6)**	**(7.7)**
Debtors Due > 1 Year	0.7	0.7	0.0	2.0	2.0	0.0	2.7	2.7	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	(2.9)	(2.9)	0.0	(3.1)	(3.1)	0.0	(6.0)	(6.0)	0.0
Finance Lease Obligations > 1 Year	(7.0)	(6.7)	0.3	(70.3)	(70.0)	0.3	(77.4)	(76.7)	0.7
Provisions - Non Current	(3.3)	(3.3)	0.0	(2.2)	(2.2)	0.0	(5.5)	(5.5)	0.0
Total Assets/(Liabilities)	**258.8**	**255.8**	**(3.0)**	**418.9**	**411.8**	**(7.1)**	**677.7**	**667.6**	**(10.1)**
TOTAL CAPITAL & RESERVES	**258.8**	**255.8**	**(3.0)**	**418.9**	**411.8**	**(7.1)**	**677.7**	**667.6**	**(10.1)**

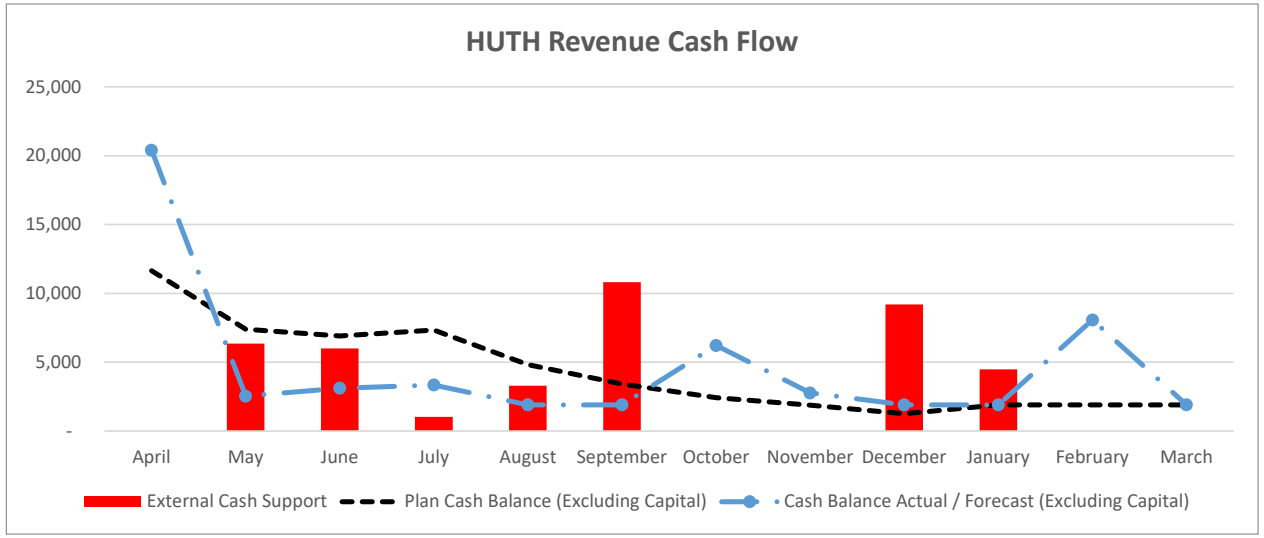
Cash Flow

The Group's cash balance at the end of month 1 was £70.5m. No external cash support was required for Month 1. However, the Group has received £6.35m for HUTH in May and has applied for £7.98m for June (£6.0m HUTH / £1.98m NLAG), (£0.96m) more than planned. CIP delivery will be the key risk to requiring additional external cash support above planned levels.

NLAG



HUTH



External Cash Drawdown Plan v's Actual/Forecast

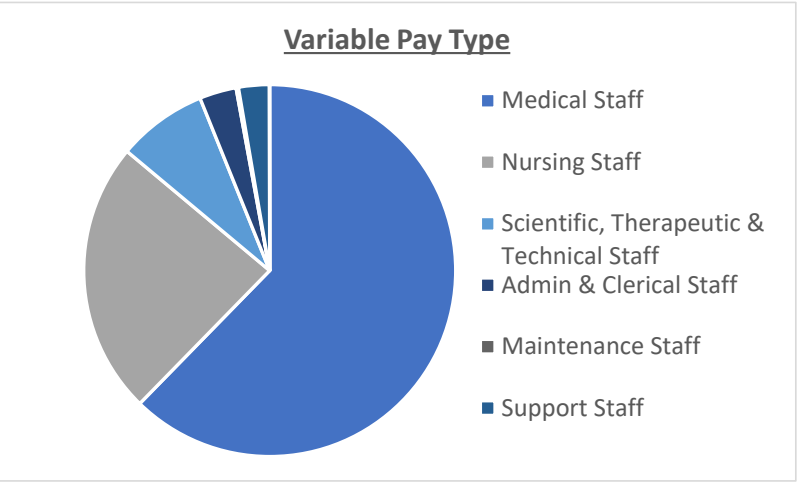
		AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	TOTAL
HUTH	Plan	0	6,894	5,071	0	7,136	3,030	0	2,146	4,592	3,594	0	8,687	**41,150**
	Actual	0	6,350	6,000	1,022	3,290	10,820	0	0	9,200	4,468	0		**41,150**
	Variance	0	544	(929)	(1,022)	3,846	(7,790)	0	2,146	(4,608)	(874)	0	8,687	0
NLAG	Plan	0	0	1,400	390	1,840	5,115	0	1,890	3,555		2,650	6,450	**23,290**
	Actual	0	0	1,977	3,238	3,393	6,232	0	770	815	5,503	0	1,362	**23,290**
	Variance	0	0	(577)	(2,848)	(1,553)	(1,117)	0	1,120	2,740	(5,503)	2,650	5,088	0
HHP	Plan	0	6,894	6,471	390	8,976	8,145	0	4,036	8,147	3,594	2,650	15,137	64,440
	Actual	0	6,350	7,977	4,260	6,683	17,052	0	770	10,015	9,971	0	1,362	64,440
	Variance	0	544	(1,506)	(3,870)	2,293	(8,907)	0	3,266	(1,868)	(6,377)	2,650	13,775	0

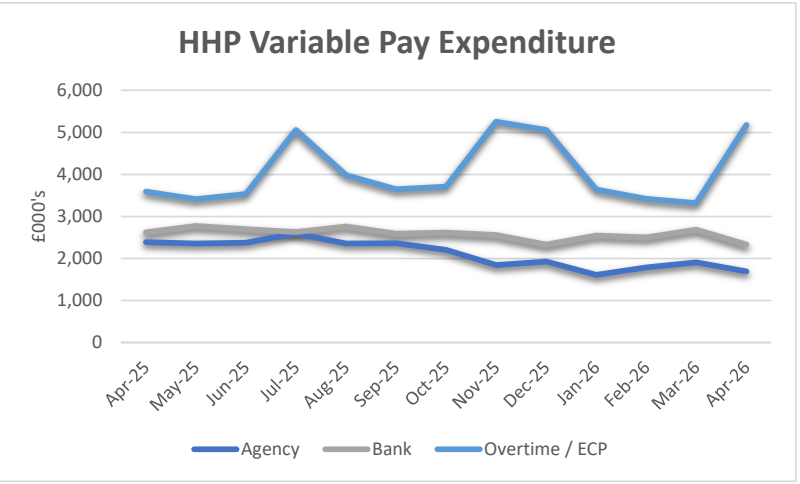
Variable Pay Summary

The Group has spent £9.2m on variable pay YTD. This is (£0.6m) more than the same period in 2025/26. The position includes £1.6m of expenditure covering Industrial Action.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Agency	Medical Staff	766	451	315	1,111	851	261	1,877	1,301	576
	Nursing Staff	68	119	(51)	290	88	202	359	207	151
	Scientific, Therapeutic & Technical Staff	23	25	(2)	118	153	(36)	140	178	(38)
	Admin & Clerical Staff	(6)	5	(11)	4	0	4	(2)	5	(7)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	13	0	13	0	2	(2)	13	2	10
Agency Total		**863**	**600**	**263**	**1,523**	**1,095**	**429**	**2,386**	**1,694**	**692**
Bank	Medical Staff	390	415	(25)	250	169	80	640	584	56
	Nursing Staff	354	333	22	1,000	941	59	1,354	1,274	81
	Scientific, Therapeutic & Technical Staff	39	33	6	116	100	16	155	133	22
	Admin & Clerical Staff	87	28	59	169	151	18	257	179	77
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	11	15	(4)	202	145	57	214	161	53
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**883**	**824**	**58**	**1,737**	**1,507**	**231**	**2,620**	**2,331**	**289**
Overtime / ECP's	Medical Staff	1,211	2,342	(1,132)	1,045	1,506	(462)	2,255	3,849	(1,593)
	Nursing Staff	608	575	33	155	131	24	763	706	57
	Scientific, Therapeutic & Technical Staff	218	257	(39)	128	151	(23)	346	407	(62)
	Admin & Clerical Staff	107	88	20	25	23	2	132	111	22
	Maintenance Staff	17	13	3	5	6	(1)	22	19	3
	Support Staff	62	72	(11)	11	12	(1)	73	85	(12)
	Other Staff	0	0	0	0	0	0	0	0	0
Overtime / ECP's Total		**2,222**	**3,347**	**(1,125)**	**1,369**	**1,829**	**(461)**	**3,591**	**5,176**	**(1,586)**
Grand Total		**3,968**	**4,771**	**(803)**	**4,629**	**4,431**	**198**	**8,597**	**9,202**	**(605)**

Agency Spend v's Agency CAP			
Bank Spend v's Bank CAP			





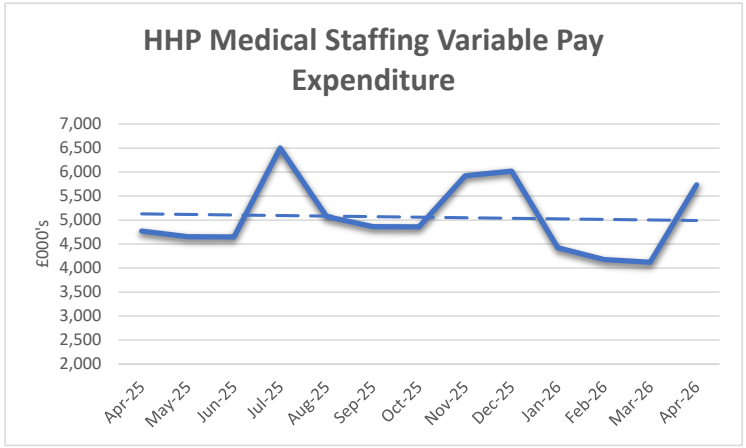
Variable Pay Summary – Directorate / Care Group

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	718	1,008	(290)	0	0	0	718	1,008	(290)
	Acute and Emergency Medicine (South)	0	0	0	1,257	1,226	32	1,257	1,226	32
	Cancer Network	42	3	39	7	3	4	49	6	43
	Cardiovascular	248	336	(89)	48	63	(15)	295	399	(104)
	Chief Delivery Officer	0	0	(0)	3	3	(0)	3	3	(0)
	Community, Frailty & Therapy	334	463	(129)	297	287	10	631	750	(119)
	Digestive Diseases	195	321	(126)	192	310	(119)	387	631	(244)
	Family Services	303	627	(325)	443	557	(114)	746	1,185	(438)
	Head & Neck	262	172	90	277	249	27	539	421	118
	Major Trauma Network	0	0	0	0	0	0	0	0	0
	Neuroscience	172	154	18	125	126	(0)	297	280	17
	Pathology Network Group	14	5	9	107	73	34	121	78	43
	Patient Services	148	72	76	111	77	34	259	149	110
	Site Management & Discharge teams	59	23	35	32	29	3	91	53	38
	Specialist Cancer and Support Services	409	504	(95)	380	387	(7)	789	891	(103)
	Specialist Medicine	120	191	(71)	304	235	69	424	425	(1)
	Specialist Surgery	266	246	20	287	185	101	553	431	122
	Theatres, Anaesthetics and Critical Care	568	508	60	494	435	59	1,062	943	119
Total Operations		**3,858**	**4,634**	**(776)**	**4,364**	**4,246**	**118**	**8,222**	**8,880**	**(658)**
Corporate	Corporate Directorates	110	137	(27)	266	185	80	375	322	53
Total Corporate		**110**	**137**	**(27)**	**266**	**185**	**80**	**375**	**322**	**53**
Grand Total		**3,968**	**4,771**	**(803)**	**4,629**	**4,431**	**198**	**8,597**	**9,202**	**(605)**

Variable Pay Summary – Medical Staffing

The Group has spent £5.7m on Medical Staffing agency variable pay YTD. This is (£1.0m) more than the same period in 2025/26 but does include £1.6m of Industrial Action Cover.

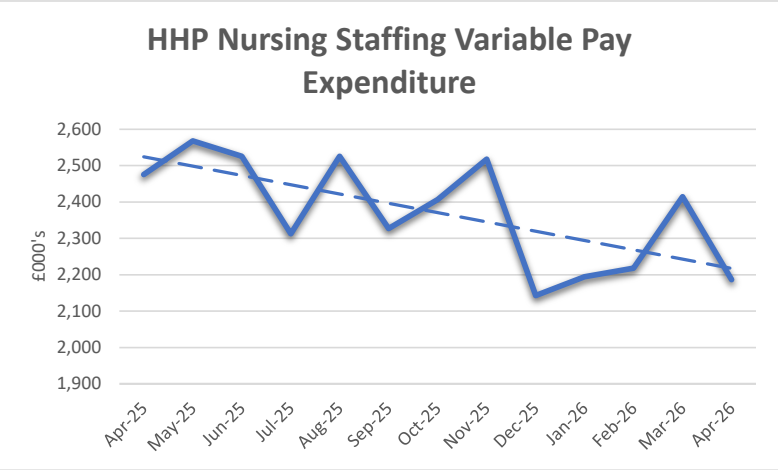
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	519	760	(241)	0	0	0	519	760	(241)
	Acute and Emergency Medicine (South)	0	0	0	755	808	(52)	755	808	(52)
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	189	261	(72)	20	19	2	209	280	(71)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	186	285	(100)	139	118	21	325	403	(79)
	Digestive Diseases	100	217	(117)	88	216	(128)	188	432	(245)
	Family Services	163	461	(298)	158	380	(222)	321	841	(520)
	Head & Neck	238	155	83	232	193	39	470	348	122
	Major Trauma Network	0	0	0	0	0	0	0	0	0
	Neuroscience	98	111	(13)	62	72	(11)	160	184	(24)
	Pathology Network Group	12	0	12	27	21	6	38	21	18
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	175	212	(38)	160	93	67	335	306	29
	Specialist Medicine	63	129	(67)	194	157	38	257	286	(29)
	Specialist Surgery	207	202	5	229	150	79	436	351	85
	Theatres, Anaesthetics and Critical Care	418	414	4	341	296	45	759	710	49
Total Operations		**2,367**	**3,208**	**(841)**	**2,405**	**2,522**	**(117)**	**4,772**	**5,730**	**(958)**
Corporate	Corporate Directorates	0	0	0	0	4	(4)	0	4	(4)
Total Corporate		**0**	**0**	**0**	**0**	**4**	**(4)**	**0**	**4**	**(4)**
Grand Total		**2,367**	**3,208**	**(841)**	**2,405**	**2,526**	**(121)**	**4,772**	**5,734**	**(962)**



Variable Pay Summary - Nursing

The Group has spent £2.2m on Nursing variable pay YTD. This is £0.3m less than the same period in 2025/26.

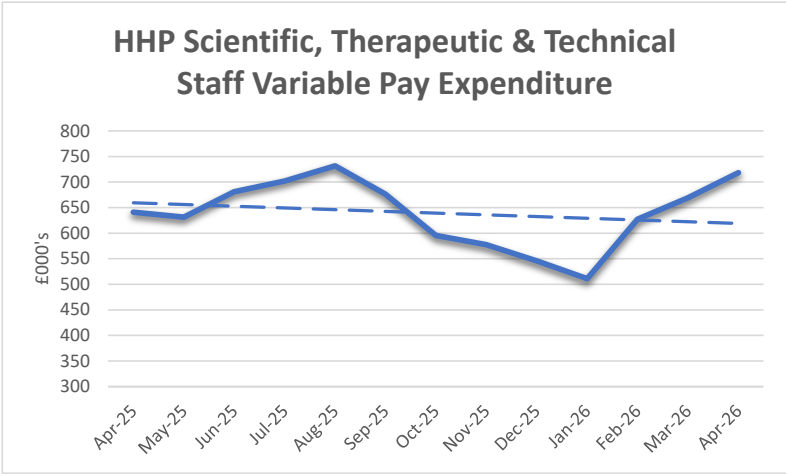
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	193	242	(50)	0	0	0	193	242	(50)
	Acute and Emergency Medicine (South)	0	0	0	487	394	94	487	394	94
	Cancer Network	1	2	(1)	0	0	0	2	2	(0)
	Cardiovascular	42	59	(17)	20	32	(13)	61	91	(30)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	122	154	(32)	124	126	(1)	246	279	(33)
	Digestive Diseases	90	101	(10)	104	94	9	194	195	(1)
	Family Services	139	166	(27)	285	175	109	423	341	82
	Head & Neck	13	10	3	7	11	(4)	20	20	(0)
	Major Trauma Network	0	0	0	0	0	0	0	0	0
	Neuroscience	68	41	26	59	51	8	127	92	34
	Pathology Network Group	0	0	0	0	0	0	0	0	0
	Patient Services	5	6	(1)	16	1	15	21	7	14
	Site Management & Discharge teams	56	20	36	32	29	3	88	50	39
	Specialist Cancer and Support Services	81	55	26	17	24	(7)	98	79	19
	Specialist Medicine	51	56	(4)	106	77	29	157	133	25
	Specialist Surgery	58	42	15	57	35	22	115	78	37
	Theatres, Anaesthetics and Critical Care	104	69	36	120	106	14	225	175	50
Total Operations		**1,023**	**1,022**	**1**	**1,435**	**1,156**	**280**	**2,458**	**2,178**	**280**
Corporate	Corporate Directorates	7	4	3	10	5	5	17	9	8
Total Corporate		**7**	**4**	**3**	**10**	**5**	**5**	**17**	**9**	**8**
Grand Total		**1,030**	**1,026**	**4**	**1,445**	**1,160**	**285**	**2,476**	**2,187**	**289**



Variable Pay Summary – Scientific, Therapeutic & Technical Staff

The Group has spent £0.7m on AHP variable pay YTD. This is (£0.8m) more than the same period in 2025/26.

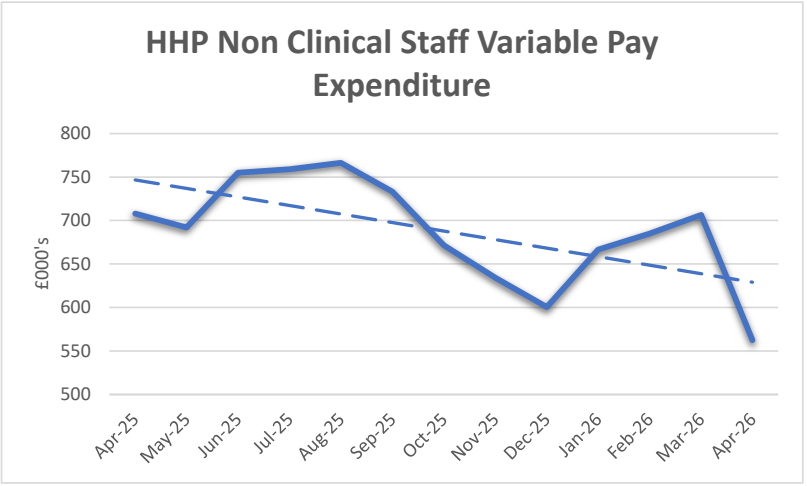
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine (South)	0	0	0	0	0	0	0	0	0
	Cancer Network	26	0	26	0	0	0	26	0	26
	Cardiovascular	16	14	3	8	11	(3)	24	25	(1)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	23	19	4	19	21	(2)	42	40	2
	Digestive Diseases	0	1	(1)	0	0	(0)	0	1	(1)
	Family Services	0	0	0	0	0	0	0	0	0
	Head & Neck	10	7	3	32	43	(11)	43	50	(8)
	Major Trauma Network	0	0	0	0	0	0	0	0	0
	Neuroscience	3	1	3	5	0	5	8	1	7
	Pathology Network Group	2	5	(3)	76	50	26	78	55	23
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	141	228	(88)	189	247	(58)	330	475	(145)
	Specialist Medicine	5	3	3	1	0	1	7	3	4
	Specialist Surgery	1	2	(1)	0	0	0	1	2	(1)
	Theatres, Anaesthetics and Critical Care	46	24	22	27	30	(3)	73	53	19
Total Operations		**275**	**304**	**(29)**	**357**	**402**	**(45)**	**632**	**706**	**(74)**
Corporate	Corporate Directorates	5	11	(6)	4	2	3	9	12	(3)
Total Corporate		**5**	**11**	**(6)**	**4**	**2**	**3**	**9**	**12**	**(3)**
Grand Total		**280**	**315**	**(35)**	**361**	**404**	**(42)**	**641**	**719**	**(77)**



Variable Pay Summary – Non-Clinical Staff

The Group has spent £0.6m on Non-Clinical variable pay YTD. This is £0.1m less than the same period in 2025/26.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	6	6	1	0	0	0	6	6	1
	Acute and Emergency Medicine (South)	0	0	0	15	20	(6)	15	20	(6)
	Cancer Network	15	1	13	6	3	4	21	4	17
	Cardiovascular	1	3	(2)	0	0	(0)	1	3	(2)
	Chief Delivery Officer	0	0	(0)	3	3	(0)	3	3	(0)
	Community, Frailty & Therapy	4	5	(1)	15	23	(8)	19	28	(9)
	Digestive Diseases	5	2	2	0	0	0	5	2	2
	Family Services	1	0	1	1	1	(1)	2	2	(0)
	Head & Neck	1	0	0	6	2	4	6	3	4
	Major Trauma Network	0	0	0	0	0	0	0	0	0
	Neuroscience	2	0	2	0	3	(3)	3	3	(1)
	Pathology Network Group	0	0	0	4	2	2	4	2	2
	Patient Services	143	66	77	95	76	18	238	142	95
	Site Management & Discharge teams	2	3	(1)	0	0	(0)	2	3	(1)
	Specialist Cancer and Support Services	12	8	4	13	23	(10)	25	31	(6)
	Specialist Medicine	1	3	(2)	3	1	2	4	4	(1)
	Specialist Surgery	1	0	1	0	0	0	1	0	1
	Theatres, Anaesthetics and Critical Care	0	1	(1)	6	3	3	6	5	1
Total Operations		**194**	**100**	**94**	**166**	**162**	**4**	**360**	**262**	**98**
Corporate	Corporate Directorates	97	122	(25)	251	179	72	348	301	48
Total Corporate		**97**	**122**	**(25)**	**251**	**179**	**72**	**348**	**301**	**48**
Grand Total		**291**	**222**	**69**	**417**	**341**	**77**	**708**	**562**	**146**



Variable Pay v's 30% Target Reduction

The Group has seen a marginal decrease in its increase variable pay expenditure in April once adjusting for industrial Action expenditure. However, this falls well short of the 30% targeted reduction. A straight-line projection would be (£19.4m) higher than target.

Directorate / Care Group	February	March	Annual Target	Target/mth	April	April less IA	Variance to Target	April*12	Forecast Variance to Target
Acute And Emergency Medicine North	690	691	5,754	479	1,011	663	(183)	7,953	(2,199)
Acute And Emergency Medicine South	1,297	1,322	10,912	909	1,223	1,126	(217)	13,510	(2,598)
Cancer Network	7	5	126	10	6	6	4.2	76	50.1
Cardiovascular	191	232	2,068	172	399	268	(96)	3,216	(1,148)
Chief Delivery Officer	3	3	0	0	3	3	(3)	39	(39)
Community, Frailty & Therapy	701	733	5,468	456	750	634	(178)	7,605	(2,137)
Digestive Diseases	551	570	4,395	366	631	461	(95)	5,535	(1,140)
Family Services	792	772	7,552	629	1,185	805	(176)	9,660	(2,108)
Head & Neck	394	383	4,262	355	421	390	(35)	4,684	(422)
Neuroscience	205	218	2,222	185	280	240	(55)	2,879	(657)
Pathology Network Group	90	93	1,060	88	78	78	10.3	937	123.7
Patient Services	175	191	1,583	132	149	149	(17)	1,787	(204)
Site Management & Discharge Teams	75	68	633	53	53	53	0.1	632	1.6
Specialist Cancer And Support Services	695	719	6,621	552	891	855	(303)	10,255	(3,634)
Specialist Medicine	312	345	3,211	268	425	320	(52)	3,838	(627)
Specialist Surgery	336	310	3,571	298	431	309	(11)	3,707	(136)
Theatres, Anaesthetics And Critical Care	782	847	7,665	639	943	829	(191)	9,953	(2,288)
Sub Total Operations	**7,295**	**7,503**	**67,103**	**5,592**	**8,880**	**7,189**	**(1,597)**	**86,264**	**(19,161)**
Chief Executive	2	1	13	1	2	2	(1)	22	(9)
Chief Medical Officer	0	1	20	2	1	1	0.3	17	3.1
Chief Nurse Office	18	16	181	15	16	16	(1)	192	(11)
Director of Assurance	-	-	0	0	-	-	0.0	-	0.0
Director of People	15	13	227	19	24	24	(5)	283	(56)
Director of Finance, Estates & Facilities	360	364	3,038	253	263	263	(10)	3,153	(114)
Strategy and Partnerships	17	13	133	11	16	16	(5)	195	(62)
Sub Total Operations	**412**	**408**	**3,613**	**301**	**322**	**322**	**(21)**	**3,863**	**(250)**
TOTAL	**7,707**	**7,910**	**70,716**	**5,893**	**9,201**	**7,511**	**(1,618)**	**90,127**	**(19,411)**

Appendices



Appendix A – Trust I&E & Divisional Budgetary Performance

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.3	75.5	0.1	75.3	75.5	0.1	46.8	46.1	(0.7)	46.8	46.1	(0.7)	122.1	121.5	(0.5)	122.1	121.5	(0.5)
Other Income	6.1	5.9	(0.2)	6.1	5.9	(0.2)	4.5	4.6	0.1	4.5	4.6	0.1	10.6	10.5	(0.1)	10.6	10.5	(0.1)
Total Operating Income	**81.4**	**81.4**	**(0.1)**	**81.4**	**81.4**	**(0.1)**	**51.3**	**50.7**	**(0.6)**	**51.3**	**50.7**	**(0.6)**	**132.7**	**132.1**	**(0.6)**	**132.7**	**132.1**	**(0.6)**
Pay Costs																		
Medical Staff	(17.5)	(19.2)	(1.7)	(17.5)	(19.2)	(1.7)	(10.6)	(10.7)	(0.1)	(10.6)	(10.7)	(0.1)	(28.1)	(29.9)	(1.8)	(28.1)	(29.9)	(1.8)
Nursing Staff	(16.5)	(16.5)	0.0	(16.5)	(16.5)	0.0	(13.6)	(13.0)	0.6	(13.6)	(13.0)	0.6	(30.1)	(29.5)	0.6	(30.1)	(29.5)	0.6
Scientific Therapeutic & Technical Staff	(7.4)	(7.3)	0.1	(7.4)	(7.3)	0.1	(5.4)	(5.5)	(0.1)	(5.4)	(5.5)	(0.1)	(12.8)	(12.8)	0.0	(12.8)	(12.8)	0.0
Total Clincial Pay	**(41.4)**	**(42.9)**	**(1.5)**	**(41.4)**	**(42.9)**	**(1.5)**	**(29.6)**	**(29.2)**	**0.4**	**(29.6)**	**(29.2)**	**0.4**	**(71.0)**	**(72.1)**	**(1.1)**	**(71.0)**	**(72.1)**	**(1.1)**
Admin & Clerical Staff	(6.6)	(6.4)	0.2	(6.6)	(6.4)	0.2	(5.4)	(5.3)	0.0	(5.4)	(5.3)	0.0	(12.0)	(11.8)	0.3	(12.0)	(11.8)	0.3
Maintenance Staff	(0.3)	(0.3)	0.0	(0.3)	(0.3)	0.0	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0	(0.5)	(0.5)	0.0	(0.5)	(0.5)	0.0
Support Staff	(1.7)	(1.7)	0.0	(1.7)	(1.7)	0.0	(1.5)	(1.6)	(0.1)	(1.5)	(1.6)	(0.1)	(3.2)	(3.3)	(0.1)	(3.2)	(3.3)	(0.1)
Other Staff	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Apprentice Levy	(0.2)	(0.2)	(0.0)	(0.2)	(0.2)	(0.0)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)
Total Other Pay	**(8.8)**	**(8.6)**	**0.2**	**(8.8)**	**(8.6)**	**0.2**	**(7.2)**	**(7.3)**	**(0.0)**	**(7.2)**	**(7.3)**	**(0.0)**	**(16.1)**	**(15.9)**	**0.2**	**(16.1)**	**(15.9)**	**0.2**
Total Pay Costs	**(50.2)**	**(51.5)**	**(1.3)**	**(50.2)**	**(51.5)**	**(1.3)**	**(36.8)**	**(36.5)**	**0.4**	**(36.8)**	**(36.5)**	**0.4**	**(87.1)**	**(88.0)**	**(0.9)**	**(87.1)**	**(88.0)**	**(0.9)**
Drugs	(11.3)	(11.5)	(0.1)	(11.3)	(11.5)	(0.1)	(3.4)	(3.5)	(0.1)	(3.4)	(3.5)	(0.1)	(14.7)	(14.9)	(0.2)	(14.7)	(14.9)	(0.2)
Clinical Supplies & Services	(8.7)	(8.4)	0.3	(8.7)	(8.4)	0.3	(4.7)	(4.7)	(0.0)	(4.7)	(4.7)	(0.0)	(13.3)	(13.1)	0.3	(13.3)	(13.1)	0.3
Total Clinical Non Pay	**(20.0)**	**(19.8)**	**0.2**	**(20.0)**	**(19.8)**	**0.2**	**(8.1)**	**(8.2)**	**(0.1)**	**(8.1)**	**(8.2)**	**(0.1)**	**(28.1)**	**(28.0)**	**0.1**	**(28.1)**	**(28.0)**	**0.1**
Admin & Clerical Staff - Non Execs	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
General Supplies & Services	(2.0)	(2.1)	(0.1)	(2.0)	(2.1)	(0.1)	(0.7)	(0.7)	0.0	(0.7)	(0.7)	0.0	(2.7)	(2.7)	(0.1)	(2.7)	(2.7)	(0.1)
Establishment Expenses	(0.3)	(0.4)	(0.0)	(0.3)	(0.4)	(0.0)	(0.4)	(0.3)	0.1	(0.4)	(0.3)	0.1	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1
Establishment Expenses Op Lease	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
Establishment Expenses Transport	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)	(0.4)	(0.5)	(0.1)	(0.4)	(0.5)	(0.1)
Other Establishment Costs	(0.2)	(0.3)	(0.1)	(0.2)	(0.3)	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.3)	(0.4)	(0.1)	(0.3)	(0.4)	(0.1)
Other Establishment Costs Clinical Negligence	(2.5)	(2.3)	0.1	(2.5)	(2.3)	0.1	(1.6)	(1.6)	(0.0)	(1.6)	(1.6)	(0.0)	(4.0)	(3.9)	0.1	(4.0)	(3.9)	0.1
Premises and Fixed Plant	(3.3)	(3.0)	0.3	(3.3)	(3.0)	0.3	(2.0)	(1.9)	0.2	(2.0)	(1.9)	0.2	(5.3)	(4.8)	0.5	(5.3)	(4.8)	0.5
Premises and Fixed Plant - Rates	(0.4)	(0.4)	(0.0)	(0.4)	(0.4)	(0.0)	(0.2)	(0.3)	(0.0)	(0.2)	(0.3)	(0.0)	(0.6)	(0.7)	(0.1)	(0.6)	(0.7)	(0.1)
Purchase of Healthcare Services NHS and other DHSC bodies	(1.9)	(2.0)	(0.2)	(1.9)	(2.0)	(0.2)	(0.3)	(0.3)	0.1	(0.3)	(0.3)	0.1	(2.2)	(2.3)	(0.1)	(2.2)	(2.3)	(0.1)
Purchase of Healthcare Services Non NHS	(0.9)	(1.7)	(0.9)	(0.9)	(1.7)	(0.9)	(0.2)	(1.0)	(0.8)	(0.2)	(1.0)	(0.8)	(1.0)	(2.7)	(1.7)	(1.0)	(2.7)	(1.7)
Miscellaneous Expenditure	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Miscellaneous Expenditure Statutory Audit	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Education Expenditure	(0.5)	(0.5)	0.0	(0.5)	(0.5)	0.0	(0.2)	(0.1)	0.1	(0.2)	(0.1)	0.1	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1
Consultancy Expenditure	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Total Other Non Pay	**(12.2)**	**(12.9)**	**(0.8)**	**(12.2)**	**(12.9)**	**(0.8)**	**(6.1)**	**(6.6)**	**(0.5)**	**(6.1)**	**(6.6)**	**(0.5)**	**(18.3)**	**(19.5)**	**(1.3)**	**(18.3)**	**(19.5)**	**(1.3)**
Total Non Pay Costs	**(32.2)**	**(32.8)**	**(0.6)**	**(32.2)**	**(32.8)**	**(0.6)**	**(14.2)**	**(14.8)**	**(0.6)**	**(14.2)**	**(14.8)**	**(0.6)**	**(46.4)**	**(47.5)**	**(1.2)**	**(46.4)**	**(47.5)**	**(1.2)**
Total Operating Expenditure	**(82.4)**	**(84.3)**	**(1.9)**	**(82.4)**	**(84.3)**	**(1.9)**	**(51.0)**	**(51.3)**	**(0.2)**	**(51.0)**	**(51.3)**	**(0.2)**	**(133.4)**	**(135.6)**	**(2.1)**	**(133.4)**	**(135.6)**	**(2.1)**
EBITDA	**(1.0)**	**(2.9)**	**(2.0)**	**(1.0)**	**(2.9)**	**(2.0)**	**0.2**	**(0.6)**	**(0.8)**	**0.2**	**(0.6)**	**(0.8)**	**(0.7)**	**(3.5)**	**(2.8)**	**(0.7)**	**(3.5)**	**(2.8)**
Depreciation	(2.7)	(2.7)	0.0	(2.7)	(2.7)	0.0	(2.3)	(1.8)	0.5	(2.3)	(1.8)	0.5	(5.0)	(4.5)	0.5	(5.0)	(4.5)	0.5
Non Operating Items	(1.5)	(1.5)	(0.0)	(1.5)	(1.5)	(0.0)	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1	(2.2)	(2.1)	0.1	(2.2)	(2.1)	0.1
Surplus/(Deficit)	**(5.2)**	**(7.1)**	**(1.9)**	**(5.2)**	**(7.1)**	**(1.9)**	**(2.8)**	**(3.0)**	**(0.2)**	**(2.8)**	**(3.0)**	**(0.2)**	**(8.0)**	**(10.1)**	**(2.1)**	**(8.0)**	**(10.1)**	**(2.1)**
NHSE Allowable Adjustments	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)
Adjusted Surplus / (Deficit)	**(5.2)**	**(7.2)**	**(2.0)**	**(5.2)**	**(7.2)**	**(2.0)**	**(2.6)**	**(2.9)**	**(0.3)**	**(2.6)**	**(2.9)**	**(0.3)**	**(7.8)**	**(10.0)**	**(2.2)**	**(7.8)**	**(10.0)**	**(2.2)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine (North)	(3.4)	(4.0)	(0.6)	(3.4)	(4.0)	(0.6)	0.0	0.0	0.0	0.0	0.0	0.0	(3.4)	(4.0)	(0.6)	(3.4)	(4.0)	(0.6)
	Acute and Emergency Medicine (South)	0.0	0.0	0.0	0.0	0.0	0.0	(5.7)	(5.9)	(0.3)	(5.7)	(5.9)	(0.3)	(5.7)	(5.9)	(0.3)	(5.7)	(5.9)	(0.3)
	Cancer Network	(0.5)	(0.5)	(0.0)	(0.5)	(0.5)	(0.0)	(0.3)	(0.3)	0.0	(0.3)	(0.3)	0.0	(0.7)	(0.8)	(0.0)	(0.7)	(0.8)	(0.0)
	Cardiovascular	(3.5)	(3.9)	(0.5)	(3.5)	(3.9)	(0.5)	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0	(4.3)	(4.8)	(0.5)	(4.3)	(4.8)	(0.5)
	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.2)	(0.0)	(0.1)	(0.2)	(0.0)
	Community, Frailty & Therapy	(3.5)	(3.9)	(0.4)	(3.5)	(3.9)	(0.4)	(4.0)	(4.0)	(0.1)	(4.0)	(4.0)	(0.1)	(7.5)	(8.0)	(0.5)	(7.5)	(8.0)	(0.5)
	Digestive Diseases	(3.1)	(3.8)	(0.7)	(3.1)	(3.8)	(0.7)	(2.6)	(2.6)	0.1	(2.6)	(2.6)	0.1	(5.7)	(6.3)	(0.6)	(5.7)	(6.3)	(0.6)
	Family Services	(5.0)	(5.5)	(0.5)	(5.0)	(5.5)	(0.5)	(4.7)	(4.7)	0.1	(4.7)	(4.7)	0.1	(9.7)	(10.2)	(0.5)	(9.7)	(10.2)	(0.5)
	Head & Neck	(3.4)	(3.4)	(0.1)	(3.4)	(3.4)	(0.1)	(1.3)	(1.5)	(0.1)	(1.3)	(1.5)	(0.1)	(4.7)	(4.9)	(0.2)	(4.7)	(4.9)	(0.2)
	Major Trauma Network	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)
	Neuroscience	(2.4)	(2.4)	(0.0)	(2.4)	(2.4)	(0.0)	(0.9)	(0.9)	(0.0)	(0.9)	(0.9)	(0.0)	(3.2)	(3.3)	(0.1)	(3.2)	(3.3)	(0.1)
	Pathology Network Group	(1.9)	(2.1)	(0.2)	(1.9)	(2.1)	(0.2)	(2.2)	(2.2)	0.1	(2.2)	(2.2)	0.1	(4.2)	(4.3)	(0.1)	(4.2)	(4.3)	(0.1)
	Patient Services	(2.2)	(2.2)	0.0	(2.2)	(2.2)	0.0	(1.6)	(1.6)	(0.0)	(1.6)	(1.6)	(0.0)	(3.8)	(3.8)	(0.0)	(3.8)	(3.8)	(0.0)
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)	(0.3)	(0.4)	(0.0)	(0.3)	(0.4)	(0.0)	(0.6)	(0.6)	(0.0)	(0.6)	(0.6)	(0.0)
	Specialist Cancer and Support Services	(18.3)	(18.8)	(0.5)	(18.3)	(18.8)	(0.5)	(5.9)	(6.0)	(0.2)	(5.9)	(6.0)	(0.2)	(24.2)	(24.9)	(0.7)	(24.2)	(24.9)	(0.7)
	Specialist Medicine	(4.1)	(4.4)	(0.3)	(4.1)	(4.4)	(0.3)	(2.1)	(2.1)	(0.0)	(2.1)	(2.1)	(0.0)	(6.1)	(6.5)	(0.3)	(6.1)	(6.5)	(0.3)
	Specialist Surgery	(3.7)	(3.7)	(0.0)	(3.7)	(3.7)	(0.0)	(1.9)	(1.8)	0.0	(1.9)	(1.8)	0.0	(5.5)	(5.5)	0.0	(5.5)	(5.5)	0.0
	Theatres, Anaesthetics and Critical Care	(7.3)	(7.7)	(0.4)	(7.3)	(7.7)	(0.4)	(4.1)	(4.3)	(0.2)	(4.1)	(4.3)	(0.2)	(11.4)	(12.0)	(0.6)	(11.4)	(12.0)	(0.6)
Total Operations		**(62.7)**	**(67.0)**	**(4.3)**	**(62.7)**	**(67.0)**	**(4.3)**	**(38.6)**	**(39.3)**	**(0.7)**	**(38.6)**	**(39.3)**	**(0.7)**	**(101.3)**	**(106.3)**	**(5.0)**	**(101.3)**	**(106.3)**	**(5.0)**
Corporate	Chief Executive	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.4)	(0.1)	(0.2)	(0.4)	(0.1)
	Chief Medical Officer	(0.4)	(0.4)	(0.0)	(0.4)	(0.4)	(0.0)	(0.6)	(0.6)	0.0	(0.6)	(0.6)	0.0	(1.1)	(1.0)	0.0	(1.1)	(1.0)	0.0
	Chief Nurse Office	(3.3)	(3.2)	0.0	(3.3)	(3.2)	0.0	(2.4)	(2.4)	0.1	(2.4)	(2.4)	0.1	(5.7)	(5.6)	0.1	(5.7)	(5.6)	0.1
	Director of Assurance	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
	Director of People	(0.9)	(0.9)	(0.0)	(0.9)	(0.9)	(0.0)	(0.8)	(0.7)	0.1	(0.8)	(0.7)	0.1	(1.7)	(1.6)	0.1	(1.7)	(1.6)	0.1
	Director of Finance, Estates & Facilities	(6.4)	(6.4)	(0.0)	(6.4)	(6.4)	(0.0)	(4.2)	(4.2)	(0.0)	(4.2)	(4.2)	(0.0)	(10.6)	(10.6)	(0.0)	(10.6)	(10.6)	(0.0)
	Strategy and Partnerships	(0.9)	(0.8)	0.1	(0.9)	(0.8)	0.1	(0.8)	(0.9)	(0.1)	(0.8)	(0.9)	(0.1)	(1.7)	(1.7)	0.0	(1.7)	(1.7)	0.0
Total Corporate		**(12.0)**	**(12.0)**	**0.0**	**(12.0)**	**(12.0)**	**0.0**	**(9.0)**	**(9.0)**	**0.0**	**(9.0)**	**(9.0)**	**0.0**	**(21.1)**	**(21.0)**	**0.0**	**(21.1)**	**(21.0)**	**0.0**
Central Income, Reserves & Technical	Central Income	76.3	76.4	0.0	76.3	76.4	0.0	48.4	47.9	(0.5)	48.4	47.9	(0.5)	124.8	124.3	(0.4)	124.8	124.3	(0.4)
	Central Technical	(4.4)	(4.3)	0.1	(4.4)	(4.3)	0.1	(2.9)	(2.4)	0.5	(2.9)	(2.4)	0.5	(7.3)	(6.7)	0.6	(7.3)	(6.7)	0.6
	Reserves	(2.4)	(0.2)	2.2	(2.4)	(0.2)	2.2	(0.7)	(0.2)	0.5	(0.7)	(0.2)	0.5	(3.1)	(0.4)	2.7	(3.1)	(0.4)	2.7
Total Central Income, Reserves & Technical		**69.5**	**71.9**	**2.4**	**69.5**	**71.9**	**2.4**	**44.9**	**45.3**	**0.5**	**44.9**	**45.3**	**0.5**	**114.4**	**117.2**	**2.8**	**114.4**	**117.2**	**2.8**
Surplus / (Deficit)		**(5.2)**	**(7.1)**	**(1.9)**	**(5.2)**	**(7.1)**	**(1.9)**	**(2.8)**	**(3.0)**	**(0.2)**	**(2.8)**	**(3.0)**	**(0.2)**	**(8.0)**	**(10.1)**	**(2.1)**	**(8.0)**	**(10.1)**	**(2.1)**
Adjustments to adjusted financial performance		0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)	0.2	0.1	(0.1)
Adjusted financial performance Surplus / (Deficit)		**(5.2)**	**(7.2)**	**(2.0)**	**(5.2)**	**(7.2)**	**(2.0)**	**(2.6)**	**(2.9)**	**(0.3)**	**(2.6)**	**(2.9)**	**(0.3)**	**(7.8)**	**(10.0)**	**(2.2)**	**(7.8)**	**(10.0)**	**(2.2)**

NHS
Hull University Teaching Hospitals
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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)145

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 11th June 2026
Director Lead	Julie Beilby, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees In-Common held on Wednesday 25th March 2026
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 25th March 2026.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 25th March 2026 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Peter Sedman	Deputy Group Chief Medical Officer (attending for Group Chief Medical Officer)
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement (attending for Group Chief People Officer)
Jo Ledger	Deputy Group Chief Nurse (attending for Interim Group Chief Nurse)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Myles Howell	Director of Communications & Engagement
Lucy Vere	Group Director of Learning and Organisational Development
Leah Coneyworth	Head of Quality Compliance and Risk (HUTH) (item 3.2)
Tracy Campbell	Group Director of Patient Safety and Quality Governance

Observers:

Marian Davison	Governor Observer
Ben Smith	Deputy Improvement Director for NHSE
Stacey Howard	Workstream Lead for NHSE

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees-in-Common Chair welcomed those present to the meeting. Apologies for absence were noted for Dr Kate Wood, Group Chief Medical Officer,

Simon Nearney, Group Chief People Officer, and Heather McNair, Interim Group Chief Nurse.

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 28th January 2026**

The minutes of the meeting held on 28th January 2026 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to raise.

1.6 **Committees-in-Common Action Tracker**

Updates to the Action Tracker were provided within the agenda items.

1.7 **Urgent and Emerging Issues**

Paul Bunyan described the 'Target Operating Model for People Services', a national model being rolled out by NHSE to support the delivery of transactional people services at a regional level. NHSE had provided the Group with a presentation and requested that Boards-in-Common members begin to be familiarised with the proposed delivery models.

Action: Karena Groom to add the 'Target Operating Model for People Services' to the agenda for the next meeting.

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 Report**

David Sharif took the report as read and updated that the people risk score remained at 20. He highlighted that a discussion took place at Boards-in-Common regarding the enhancement of the BAF with considerations made to a strategic risk around leadership, and work was underway with a further update to be provided in due course. He noted that the BAF should signpost specific updates around control and assurances with the introduction of a flag to highlight where they had been introduced.

David Sharif provided an update on the Risk Report and advised that work was underway with Hilda Gwilliams to develop a risk management training module for staff, aimed at improving the consistent application of risk management across the Group. He acknowledged that risk reporting was not yet where it needed to be, noting that the appendix currently contained only high-level actions and updates, and that significant work was ongoing.

Leah Coneyworth joined the meeting at 09:15 hours.
Tracy Campbell joined the meeting at 09:19 hours.

David Sulch highlighted that risk owners would need to be updated following recent changes within the senior leadership team. David Sharif confirmed that work was underway to amend the risk owners.

David Sulch noted the risk score of 20 which implied a likely catastrophic outcome and he queried the definition of a 'catastrophic outcome' in a workforce setting. David Sharif explained that a catastrophic outcome would prevent the Group from fully achieving its inspirational leadership objective and people strategy. He queried whether the current risk score accurately reflected the level of risk.

David Sulch mentioned that the risks included in the executive summary of the risk register report felt 'clinical' and that WEC CiC had limited ability to influence them. He queried whether they would be more appropriately overseen by the Quality and Safety CiC. David Sharif shared that the allocation of the risks would be monitored through Group Executive Risk and Assurance Committee (GERAC).

Julie Beilby advocated a review of the risk scores and questioned whether the investment in Nursing and Midwifery staffing levels had been reflected. Jo Ledger noted that the overall nursing risk at HUTH was scored at 20 however, further clarity was required regarding the risk associated with ED.

Action: Jo Ledger to review the nursing risk linked to ED.

Julie Beilby highlighted a disabled access risk and proposed that it be referred to Performance, Estates and Finance (PEF) CiC, as it related to Estates rather than Workforce.

Tony Curry shared that the flags and ratings for controls and assurance within the BAF provided a useful mechanism for monitoring the completeness of controls mitigating strategic risks and the sources of assurance.

The Committees-in-Common agreed limited assurance.

3.2 **CQC Actions Group Report**

Leah Coneyworth updated that work was underway to review outstanding CQC actions in line with the improvement plan. Actions where performance targets remained challenging would be managed through usual performance management processes and escalated through CiCs and Care Group performance and accountability meetings, providing full oversight to the Boards-in-Common of where risk remained. There was currently 1 open action at NLaG relating to maternity, with maternity service requesting to keep this action open due to it being linked to

the investment approved by Boards-in-Common. Two actions remained open at HUTH, with 1 relating to maternity staffing specifically in the Antenatal Day Unit (ADU) which would remain open until progress was made, and 1 relating to restraint training which remained open to reflect the significant work underway across the Group. All closed actions transitioned to a business-as-usual (BAU) approach and managed via the risk register would continue to be monitored on a quarterly basis. Several inspections had recently taken place within ED, Medicine, End-of-Life (EOL) and Outpatients across the Group, which identified training as an area of non-compliance. Following discussions at the Leadership Team (SLT) meeting on 24 February 2026, it was agreed that the training non-compliance must be addressed within the next six months.

Julie Beilby raised concerns regarding the restraint policy and the response to the use of restraints, emphasising the need to better understand current practice and to harmonise a Group policy.

Tracy Campbell shared that significant work was underway to address the inappropriate use of security watch, and a proposal had been presented to SLT on 24 February 2026. She noted that a cultural shift was required to progress this work, although early signs of improvement were emerging.

Jo Ledger shared that a trajectory around training for high risk areas with an agreed training schedule was being developed and would be shared at a future WEC CiC meeting.

The Committees-in-Common agreed reasonable assurance.

Leah Coneyworth left the meeting at 09:41 hours.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate**

None to note.

3.4 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 **Workforce Integrated Performance Report**

Paul Bunyan shared that work was underway across the Group to co-ordinate metrics within the Integrated Performance Reports (IPRs) into a single framework, enabling comparison of clinical, workforce and financial metrics in one place. He advised that this report would also be amended in the form of a highlight report to allow CiC members to review the workforce element in greater detail. A reduction in the vacancy position was reported which attributed to reduced Agency usage, and while Agency usage had fallen below 30% for the first time in 2025/26, the Group expected to return to a more balanced position due to the cumulative

overspend from months 1–10. The Group had set a target to achieve a £30 million reduction across all areas of variable pay. An operating model was agreed at SLT yesterday, which proposed that variable pay targets would be set at Care Group level to define the total variable pay budget, including the £30 million reduction built into the target. This would ensure the Group remained within the allocated £30 million reduction. A safety mechanism would also be embedded within the governance process where variable pay was critical to maintaining patient safety and productivity. The Group faced a significant deficit against its target, resulting in a substantial level of unidentified Cost Improvement Programme (CIP) within the plan. This included headcount reductions across Corporate, Estates and Facilities, and Care Groups. It was agreed that a review of corporate reconfiguration would be undertaken in order to support a reduction in corporate headcount. A reduction was seen in turnover. Of the 33 organisations against which the Group was benchmarked, HUTH performed best with the lowest sickness rate. NLaG was just below average and ranked within the top 5 performers at 5.3%, compared to a regional average of between 5.5% and 6.6%. The highest area of sickness across the Group was psychological related and although the Group had achieved 19% against an 18% target, a slight increase in psychological-related sickness was seen over the last month. Work was underway as part of the 2026/27 plan to target areas of known high sickness with the aim of further reducing sickness levels.

Julie Beilby queried whether voluntary resignations referenced in the report were linked to the Mutually Agreed Resignation Scheme (MARS). Paul Bunyan confirmed that these related to normal turnover.

Julie Beilby queried whether sickness levels within Nursing and Midwifery were expected to improve following recent investment. Paul Bunyan explained that a significant proportion of the investment had been allocated to HUTH sites, which had lower sickness levels, and that further work was required to understand the drivers of sickness and identify actions to improve it. Jo Ledger noted that NLaG was in the top quartile for staffing from a Care Hours per Patient Day (CHPPD) perspective and that further discussion was required to understand the balance between acute and long-term sickness. She added that the flexible working policy launched in 2025/26 was beginning to have a positive impact according to staff survey results.

Julie Beilby advised that it would be helpful for the CiC to see CHPPD data cross-referenced with sickness levels in a more triangulated way. Jo Ledger advised that a staffing report was currently in draft stage, with the intention for it to be presented to the CiC on a bi-monthly basis however, a discussion was required with Murray MacDonald outside of the meeting to agree the format and content of the report.

Action: Jo Ledger to present a detailed analysis at a future meeting on sickness levels in nursing and midwifery, including triangulation with Care Hours per Patient Day, and a breakdown of acute versus long-term sickness.

Tracy Campbell highlighted the absence of mental health nurses in the occupational health service and suggested this be an area for review, given the data on psychological sickness.

Julie Beilby queried what actions were being taken to address delays in shortlisting at HUTH and the provision of interview outcomes at NLaG. Paul Bunyan explained

that the delays at HUTH related to non-consultant medical roles with a high volume of applications. Work was underway to support the shortlisting process and to review timescales for providing interview outcomes. The Group were implementing additional recruitment screening questions to filter applications and deter inappropriate applicants, and exploring the use of artificial intelligence (AI)-assisted shortlisting, with human oversight remaining central to the process.

The CiC confirmed that this report was for information only moving forward.

4.2 **Group Gender Pay Gap Report**

Lucy Vere updated that women constituted the majority of the workforce in the Group with 76% at HUTH and 79% at NLaG however, women were under-represented in senior and medical roles which resulted in pay gaps. The median gap had reduced by 2.87% at HUTH to 14.4%, while NLaG saw a larger reduction of 4.48% to 21.25%. She explained that there was a bonus gap of 67% at HUTH which was significantly larger in comparison to NLaG and was attributed to the long service awards that were in place at HUTH and had not been in place at NLaG for a long time. EDI governance was being strengthened through the EDI Steering Group, supported by the implementation of an action plan. There was an occupational segregation with women in lower-banded, administrative, support and part-time roles across the Group and work was underway with a focus on medical workforce representation, inclusive recruitment, flexible working, strengthening staff networks, and supporting staff development.

David Sulch suggested that an analysis on pay gaps for staff appointed over the last 10 years could mitigate the impact of historic workforce patterns, such as the senior male consultant profile, and provide a clearer view on whether current policies were addressing pay gaps.

The Committees-in-Common endorsed the report for Boards-in-Common approval.

4.3 **National Staff Survey Annual Results**

Myles Howell updated that a slight improvement was seen across the Group since 2024/25. NLaG showed improvement in 7 of the 9 key themes, while HUTH improved in 4 key themes. He reflected that in 2025/26 there had been a focus on the Putting People First programme, engagement with managers to develop local improvement plans, and the establishment of a cultural BI dashboard. National Staff Survey results had significantly deteriorated, particularly across 3 domains: recommending the Organisation as a place to receive care, recommending the Organisation as a place to work, and whether care was considered a top priority. He explained that these 3 questions formed the advocacy score, which was a key component of the staff engagement score, and the Group would focus efforts on addressing this in 2026/27. The advocacy score at HUTH had reduced from 6.6 to 5.9, while the advocacy score at NLaG had remained at 6 over the past 5 years. Results revealed that staff that did not feel satisfied with the care that they are able to provide, they did not feel safe to speak up and were concerned about the consequences of raising concerns. Challenges were identified in relation to civility and respect between teams. The results also highlighted that barriers between line management and support services were limiting staff ability to drive improvement which would be addressed. It was also acknowledged that Black, Asian and Minority Ethnic (BAME) and disabled staff experienced inequalities in progression

opportunities and that their representation within senior teams required improvement.

Myles Howell outlined a 5-point action plan for 2026/27 that was currently in draft stage and would be shared at a future meeting. The plan focused on several key areas including: a safety culture reset supported by the Learning Improvement and Safety Academy (LISA), alignment of reward and recognition schemes to safety objectives, a review of team-based interventions relating to safety, staff voice and involvement, a review of the raising concerns process; particularly the response to concerns raised.

Julie Beilby expressed disappointment regarding ongoing civility and bullying challenges and noted the challenge in reconciling positive Freedom to Speak Up (FTSU) Guardian reports with the data showing that staff did not feel psychologically safe to speak up. She suggested that greater clarity on data triangulation would be helpful. Myles Howell confirmed that use of the FTSU process was increasing and clarified that the ongoing challenges were around whether staff would feel comfortable to raise issues of safety and bullying with their manager, through the incident reporting system, and whether they would be confident that the Group would follow it through.

David Sulch suggested reviewing data in comparison to other Organisations with similar challenges.

David Sharif welcomed a concentrated version of the 2026/27 action plan feeding into the BAF. He raised concerns around whether the Group were at risk of diluting the impact of the actions within the plan due to the wide range of actions.

Myles Howell explained that several improvement initiatives were already underway which were not solely a response to the staff survey. The focus was on refining messaging and emphasis particularly around safety, recognition, and communication rather than introducing new workstreams, with the expectation that this approach would positively influence organisational culture.

The Committees-in-Common agreed limited assurance.

Myles Howell left the meeting at 10:55 hours.

4.4 **Guardian of Safe Working Hours Quarter 3 Report – HUTH and NLaG**

Peter Sedman took both reports as read. He noted that the exception reporting system had changed in line with national guidance and the Group had received praise from the British Medical Association (BMA) regarding the speed of which they managed to get the new processes in place which made it easier for exception reports to be made. Efforts were underway to encourage resident doctors to undertake exception reporting and the process in how those reports were managed had also changed with rise in exception reporting seen across the Group as a result of this. Fines varied slightly in scale across the Group. An ongoing challenge was noted within the paediatric surgical department, where approximately £60k of fines had been incurred during 2025/26 through exception treatment reports due to resident on-call arrangements, and a business case had been submitted to support the recruitment of an additional post. Resident doctor fill rates had reduced slightly and were currently at 90%. A slight variation was seen

across the Group in relation to doctor's retention, with a higher rate of internal transfers on the South Bank compared to the North Bank, resulting in rota gaps. These gaps were being filled through internal bank staff and external agency usage. On the North Bank, a significant number of additional shifts were filled by internal locums, with around 20% covered by external agency locums, compared to a more even split on the South Bank. On the North Bank, the most challenging areas for out-of-hours extra sessions were Emergency Medicine and the Emergency Department, particularly at middle-grade level which was a longstanding issue. Gaps on the South Bank were predominantly within Frailty and General Medicine. Peter Sedman confirmed that maintaining fill rates remained a significant challenge and was a primary concern.

David Sulch queried whether exception reporting was being utilised to identify patterns of repeated submissions by individual doctors, with the aim of identifying those who may need support with time management, prioritisation and ensuring that feedback was shared with clinical and educational supervisors.

Action: Peter Sedman to investigate whether exception reporting analysis was conducted at an individual doctor level and if it was used to identify patterns and support doctors with time management and prioritisation, including feedback to supervisors.

Julie Beilby noted the costs associated with backfilling unfilled shifts and queried whether this was a concern. Peter Sedman confirmed that this was a significant challenge and was being actively monitored.
Julie suggested including a headline message under the financial implications on the front sheet of future reports.

The Committees-in-Common agreed reasonable assurance.

4.5 **Learning Improvement and Safety Academy (LISA)**

Lucy Vere updated that the purpose of the Learning Improvement and Safety Academy (LISA) was to support staff to feel safe, empowered, and drive improvement within the Group while looking at how to learn from experiences and make it a positive learning experience. It features a phased offer of support, a steering group, and a phased implementation plan. The programme brings together organisational development, clinical and medical education including nursing and Allied Health Professionals (AHP), clinical simulation, the quality improvement team, and the learning and development team. There would be a specific focus on each quarter, with Q1 focusing on exploration and discovery, capability, capacity, engagement and how to ensure that LISA aligns with the Group values. Discussions were underway around how to support individual Care Groups and services to deliver their improvement plan. Work had commenced to support theatres and surgery around Never Events. She emphasised that LISA should be co-developed across the Group and noted that its development was expected to be a 2–3 year programme, with the first three months being crucial.

Julie Beilby noted that the report was shared for assurance purposes however, it was a work in progress and would be difficult to provide assurance on something in its early stages.

David Sharif proposed that the next update should provide the governance arrangements, including where the steering group reports through, how it interfaces with the Clinical Policy Group (CPG) and the Senior Leadership Team (SLT), and the extent to which patient representation could be incorporated into the programme. Lucy Vere highlighted the recent changes within the senior leadership team and advised that discussions were ongoing. She emphasised the need for the work to be operationally connected.

The Committees-in-Common took the report for information.

4.6 **Medical and Dental Job Planning – Monthly Update**

Peter Sedman updated that job planning compliance was currently 93.8%, with 12 doctors requiring sign-off on 27 March 2026 which would result in the Group achieving their 95% target by the end of March 2026. All Care Groups had achieved over 80% compliance, with 3 Care Groups achieving 100%. The next step was to review capacity and demand modelling which would be undertaken through the Clinical Policy Group.

Julie Beilby was delighted with the progress that was made and praised everyone involved in achieving this. She acknowledged that the Group had moved to a much better place and emphasised that maintaining that progress was crucial.

The Committees-in-Common agreed significant assurance.

4.7 **GMC National Training Survey External Visit Update**

Peter Sedman shared that while the Group had made significant improvements in training over the last few months, challenges remained and the Group did not perform well in the recent National Education Training Standards (NETS) survey, reinforcing the need for LISA and further development. Following a recent General Medical Council (GMC) visit, they acknowledged the ongoing efforts to improve the working environment for resident doctors however, further improvements were required and the outcome of the GMC survey was awaited. Resident doctors at NLaG raised concerns about understaffing and limited opportunities to undertake required training, and actions were being taken to address this. Work was underway to improve rota arrangements and working patterns. The Gastroenterology service was under scrutiny, with changes being made to working practices at NLaG, including the operation of a 1 inpatient ward across 2 sites. The Perfect Weeks demonstrated that a different approach to working during the day enabled resident doctors to have more time and autonomy to carry out their tasks. Resident doctors were engaging positively through the weekly medicine support group and reported that they were beginning to feel listened to.

David Sulch highlighted that resident doctor experience continued to be adversely affected by workforce shortages, creating a “catch-22” whereby improvements were difficult to achieve without additional resident doctors. Concerns were also raised around the level of Boards-in-Common oversight on medical education and the Group had previously raised concerns around the risk of losing resident doctors. Julie Beilby acknowledged that while it had been referenced and briefly discussed at Boards-in-Common, this challenge had not been sufficiently escalated.

David Sulch referred to the report, which stated that 'feedback from NHSE was disappointing and that the visiting team had overlooked positive developments within the department'. He noted that this was concerning and could give the impression that NHSE feedback was not being given sufficient weight. While significant changes were being made to the Gastroenterology service, recent resident doctor feedback indicated that these changes had not yet resulted in a sustained improvement in experience, and this required further attention.

Julie Beilby wondered what the barriers were to implementing rotas and online training at NLaG. Peter Sedman explained that fill rates at NLaG remained challenging due to a significant number of doctors leaving posts early, which had created additional pressure. He advised that work was underway to review rotas, although this would take time.

David Sulch queried whether there were innovative approaches to reviewing the General Internal Medicine (GIM) rota and suggested engaging with other Organisations that had demonstrated success.

David Sharif requested that the next iteration of the update include clear timescales for when the Group expected actions to be delivered.

The Committees-in-Common agreed limited assurance.

4.8 **Health and Well-Being Y1 Delivery Report**

Paul Bunyan updated that despite remaining below the national average, the Group had achieved their agreed target for Y1. Improvements were seen in psychological-related sickness however, the Group did not meet their sickness target. Significant engagement with managers was undertaken through the aide programme to strengthen health and well-being training and support improved frontline staff engagement. The flexible working programme was successful, enabling clearer reporting of flexible working arrangements. The Group aimed to train 30% of the organisation through the programme and achieved 33% participation through engagement. Burnout was identified as the most significant factor across all non-core health and wellbeing metrics and was a key driver impacting overall staff health and wellbeing. Due to the expiry of CPD funding on 31 March 2026, the in-reach and centralised health and well-being programmes would cease, and the two Band 5 Health and Wellbeing Practitioners that supported those programmes would exit the programme. Targeted health and well-being support would continue via the Workforce Programme Management Office (PMO), focusing on long-term and ward-based sickness and delivered through a wider MDT approach supported by Occupational Health, Clinical Psychology and Physiotherapy. Workshops were due to commence over the next few weeks to review which elements of the core programme should be retained, taking into account the available capacity to deliver core and central health and well-being programmes. The Group expected the greatest impact on health and well-being to be delivered through LISA. Feedback from the Perfect Week, when the Group achieved Operational Pressures Escalation Level (OPEL) 2, was positive with staff reporting that they felt in control and able to deliver safe care.

David Sharif asked for an update on staff spaces and queried whether there had been a growth in staff networks. Paul Bunyan explained that growth was seen in attendance of the menopause and autism networks. £198k funding support from

WISHH and NHS charities together was allocated to refurbish 13 staff spaces however, NHS charities had declined a similar bid for NLaG as they were currently looking to distribute their funding into regional projects. A discussion would take place to review opportunities and prioritise neglected staff environments.

The Committees-in-Common agreed limited assurance.

5. ITEMS FOR INFORMATION

5.1 Workplan

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

The CiC thanked Tony Curry for his support, guidance and contribution to the meeting over the years and wished him the very best for the future.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

Action: Julie Beilby to refer the risk relating to disabled access improvements to PEF CiC.

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:

- Changes were ongoing within the BAF and risk report, with further risk management to be undertaken as part of LISA.
- The CiC agreed reasonable assurance on CQC actions due to the processes in place. They were still reviewing maternity mandatory training and restraint training.
- IPR - unidentified CIP and Care Group reconfiguration were being reviewed.
- National Staff Survey results – slight improvements were seen across the Group however, staff felt unhappy around the safety of services provided and the CiC agreed limited assurance.
- The CiC received a presentation around LISA detailing the initial stages.
- Health and Well-Being Y1 Delivery – Limited assurance was agreed due to the outcomes.
- HUTH were in the top 5 Organisation for the lowest sickness score.
- Significant assurance was agreed for Job Planning and the Group expected to meet their 95% compliance target by the end of March 2026.
- The CiC requested further information regarding restraint training across the Group – an update would be provided at the next meeting.
- Reasonable assurance was agreed for the GoSW reports. There were challenges regarding the backfilling of unfilled rotas and the impacts of the 90% resident doctor fill rates.
- The Gender Pay Gap report was endorsed for Boards-in-Common approval.

- The GMC training survey was given limited assurance.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 27th May 2026 at 9am till 12:30pm, Location TBC.

The Committee Chair closed the meeting at 12:06 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025/26											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Tony Curry	Non-Executive Director (HUTH) / Chair	D	Y	D	Y	Y	Y	Y	Y	Y	Y		Y
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		D
Amanda Stanford	Group Chief Nurse	D				D	Y	D					
Heather McNair	Interim Group Chief Nurse		Y	D	Y				Y	Y	Y		D
Kate Wood	Group Chief Medical Officer	Y	D	Y	Y	Y	D	Y	D	Y	Y		D
David Sulch	Non-Executive Director (HUTH)	N	Y	Y	Y	Y	Y	Y	D	Y	N		Y
Sue Liburd	Non-Executive Director (NLaG)	N	Y	Y	Y	Y	N	Y	Y	Y	Y		
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	N	N	Y	Y	Y	N		
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)148

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11 June 2026
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2026 and December 2026.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2026 - V20

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

	Quarter 4 (25/26)			Quarter 1 (26/27)			Quarter 2 (26/27)			Quarter 3 (26/27)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (including Board Development) (Thursdays - Public - 10.00 am - 5.00 pm)		12.02.26 **Boardroom, DPOW**	12.03.26 **Boardroom, DPOW**	09.04.26 **Boardroom, DPOW**	14.05.26 **Boardroom, HRI**	11.06.26 **Boardroom, HRI**	09.07.26 **Boardroom, DPOW**		10.09.26 **Boardroom, HRI**	08.10.26 **Boardroom, HRI**	12.11.26 **Boardroom, DPOW**	10.12.26 **Boardroom, DPOW**
HUTH Annual General Meeting & NLaG Council Of Governors Annual Members Meeting (Virtual Meeting)										14.10.26 (2.30 pm - 5.00 pm)		
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	06.01.26 **Virtual Meeting**	03.02.26 **Virtual meeting**	03.03.26 **Virtual Meeting**		05.05.26 **Virtual Meeting**	02.06.26 **Virtual Meeting**	07.07.26 **Virtual Meeting**	04.08.26 **Virtual Meeting**	01.09.26 **Virtual Meeting**	29.09.26 **(please note falls in September) Virtual Meeting**	03.11.26 **Virtual Meeting**	01.12.26 **Virtual Meeting**
Strategic Programmes & Partnerships (Thursdays - 9.00 am - 12.00 pm with exceptions as stated)						30.06.26 **Virtual Meeting**			17.09.26 **Virutal Meeting**			15.12.26 (Tuesday - 1.30 pm - 4.30 pm) **Virtual Meeting**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		26.02.26 **Virtual Meeting** (1.00 pm - 4.00 pm)	26.03.26 **Virtual Meeting**	30.04.26 **Virtual Meeting**	28.05.26 **Virtual Meeting**	25.06.26 **Virtual Meeting**	23.07.26 **Virtual Meeting**		24.09.26 **Virtual Meeting**	29.10.26 **Virtual Meeting**	26.11.26 **Virtual Meeting**	17.12.26 **Virtual Meeting**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)					26.05.26			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26 **Virtual Meeting**		25.03.26 **Virtual Meeting**		27.05.26 **Virtual Meeting**		22.07.26 **Virtual Meeting**	26.08.26 **Virtual Meeting**	23.09.26 **Virtual Meeting**	28.10.26 **Virtual Meeting**	25.11.26 **Virtual Meeting**	16.12.26 **Virtual Meeting**
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26 **Virtual Meeting**			23.04.26 (subject to NHSE Submission Deadline **Virtual Meeting**		18.06.26 HUTH & NLaG **Annual Accounts** 1.30 pm - 4.30 pm **Virtual Meeting**	30.07.26 **Virtual Meeting**				11.11.26 (Wednesday) **Virtual Meeting**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26 **Boardroom, DPOW**			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			20.11.26	
Executive Team Meetings												
Group Cabinet Meeting	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	07.05.26 27.05.26	03.06.26 09.06.26 17.06.26 25.06.26	07.07.26 21.07.26	04.08.26 18.08.26	01.09.26 15.09.26 29.09.26	13.10.26 27.10.26	10.11.26 24.11.26	08.12.26 22.12.26
SLT (Tuesdays - 2.00 pm - 5.00 pm)					05.05.26 19.05.26	02.06.26 16.06.26 30.06.26	14.07.26 28.07.26	11.08.26 25.08.26	08.09.26 22.09.26	06.10.26 20.10.26	03.11.26 17.11.26	01.12.26 15.12.26
Financial Planning & Improvement Board (Mondays - 2.00 pm - 4.00 pm)	12.01.26 26.01.26	09.02.26 23.02.26	09.03.26 23.03.26	13.04.26 27.04.26	11.05.26	08.06.26 22.06.26	13.07.26 27.07.26	10.08.26 24.08.26	14.09.26 28.09.26	12.10.26 26.10.26	09.11.26 23.11.26	14.12.26
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	08.01.26	25.02.26 (2.30 pm - 5.00 pm) **(ARM - NED & Governor only Meeting)**		15.04.26			16.07.26	20.08.26 **(NED only Meeting - 4.00 pm - 5.30 pm)**			04.11.26	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			03.03.26			02.06.26			22.09.26		24.11.26	
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		19.02.26			28.05.26				24.09.26			
NED & CEO Meetings												
NED & CEO Meetings (Wednesdays - 10.30 am - 12.30 pm - exceptions ast stated)	14.01.26 (2.00 pm - 4.00 pm)		18.03.26	21.04.26 (11.30 am - 1.30 pm)	20.05.26	17.06.26	15.07.26	19.08.26	16.09.26	14.10.26 (10.00 am - 12.00 pm)	18.11.26	08.12.26 (2.00 pm - 4.00 pm)
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	19.01.26	16.02.26	16.03.26	20.04.26	18.05.26	15.06.26	20.07.26	17.08.26	14.09.26	19.10.26	16.11.26	14.12.26
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	08.01.26		05.03.26		07.05.26		02.07.26		03.09.26		05.11.26	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	20.01.26	17.02.26	17.03.26	21.04.26	19.05.26	16.06.26	21.07.26	18.08.26	15.09.26	20.10.26	17.11.26	15.12.26
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	14.01.26		18.03.26		20.05.26		15.07.26		16.09.26		18.11.26	
Performance Meetings												
Specialist Medicine				27.04.26 (10.00 am - 11.30 am)		04.06.26 (1.30 pm - 3.00 pm)						
Cardiovascular				29.04.26 (2.00 pm - 3.30 pm)		08.06.26 (10.00 am - 11.30 am)						
Cancer Network				29.04.26 (3.30 pm - 5.00 pm)		15.06.26 (10.00 am - 11.30 am)						
Specialist Surgery					08.05.26 (9.00 am - 10.30 am)	16.06.26 (10.00 am - 11.30 am)						
Pathology Network					08.05.26 (2.00 pm - 3.30 pm)	18.06.26 (1.30 pm - 3.00 pm)						
Head & Neck					13.05.26 (1.30 pm - 3.00 pm)							
Specialist Cancer & Support Services						03.06.26 (2.30 pm - 4.00 pm)						
CFT					18.05.26 (10.00 am - 11.30 am)							
AEM North & Major Trauma Network					19.05.26 (10.00 am - 12.00 pm)							
Digestive Diseases					28.05.26 (1.30 pm - 3.00 pm)							
AEM South					28.05.26 (3.30 pm - 5.00 pm)							
Family Services						01.06.26 (10.00 am - 11.30 am)						
Neurosciences						03.06.26 (10.00 am - 11.30 am)						
TACC						10.06.26 (2.00 pm - 3.30 pm)						
Community & Frailty						22.06.26 (2.00 pm - 3.30 pm)						

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Trust Boards-in-Common – Front Sheet

NHS
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BIC(26)149

Meeting name	Trust Boards-in-Common
Meeting date	11 June 2026
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Rebecca Crashley, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q3 current risks and scores: 1. People – 20 (8 points from its tolerable score) 2. Performance, Patient Access – 20 (11 points from the tolerable score) 3. Patients, Safety – 20 (11 points from the tolerable score) 4. Pioneer – 12 (matching tolerable score) 5. Public Purse – 20 (8 points from the tolerable score). Following the Performance, Estates and Finance CIC it was agreed that the Patient Access risk description and the tolerable risk score should be updated.

For all Group risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders.

This edition introduces the use of a green flag to indicate where controls or assurances have been added. The number of controls and assurances without an indication of their strength continues to reduce with each review. Names have also been replaced with job titles.

There are actions underway addressing all the listed BAF risks. Executives are in the process of refreshing all the BAF risk actions as part of a refreshed approach and fresh perspectives. In addition, an intensive recovery programme designed to review the existing high-scoring risks (numbering over 100 across the Group) is also underway. A schedule of Care Group and Corporate Directorate review meetings have been arranged between the end of May and August.

Members are invited to consider the current risk score factors.

Recommendations:

The Boards-in-Common are asked to:

- Note and review the BAF risks

Background information and/or Supporting Document(s) (if applicable)	All BAF risks are updated following discussion between the Executive Team and the Group Director of Assurance.
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.
Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns
Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group
Recommended action(s) required	☑ Approval ☑ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other

Board Assurance Framework

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Partnership

Purpose of the report

The purpose of the report is to update the Committee regarding the Group's strategic culture and leadership risk. The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for the finance risk:

- The risk description;
- The risk owner/s;
- The current risk score (and whether a change from the previous report);
- The target score (the maximum acceptable);
- The optimum score; and
- The risk appetite category.

The subsequent pages additionally set out, by each risk (over three pages each):

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information) with a circle indicated for each of the risk scores; current, tolerable and target.

#2

- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Summary

NHS Humber Health Partnership

The following table summarises the 5 strategic risks facing the Group and the key aspects including their current score with current mitigations towards the target score. There are 4 risks scoring 15 or over. The risks coloured red indicate those risks scoring above the maximum score set by the appetite score.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk	Last reviewed
1	People	WEC	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.	Group Chief People Officer	20		23/09/2025	Balanced	12	8	21/01/2026
2	Patients - Access	PEF	We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.	Group Chief Delivery Officer	20	0	24/01/2025	Cautious	9	4	03/02/2026
3	Patients - Safety	QS	We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.	Group Chief Medical Officer, Group Chief Delivery Officer	20		26/01/2026	Cautious	9	4	19/02/2026
4	Pioneers	QS	We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.	Group Chief Strategy, Partnerships and Digital Officer, Group Chief Medical Officer	12	0	05/09/2025	Open	12	4	03/02/2026
8	Public Purse	PEF	We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.	Group Chief Financial Officer	20	4	27/01/2026	Open	12	9	27/01/2026

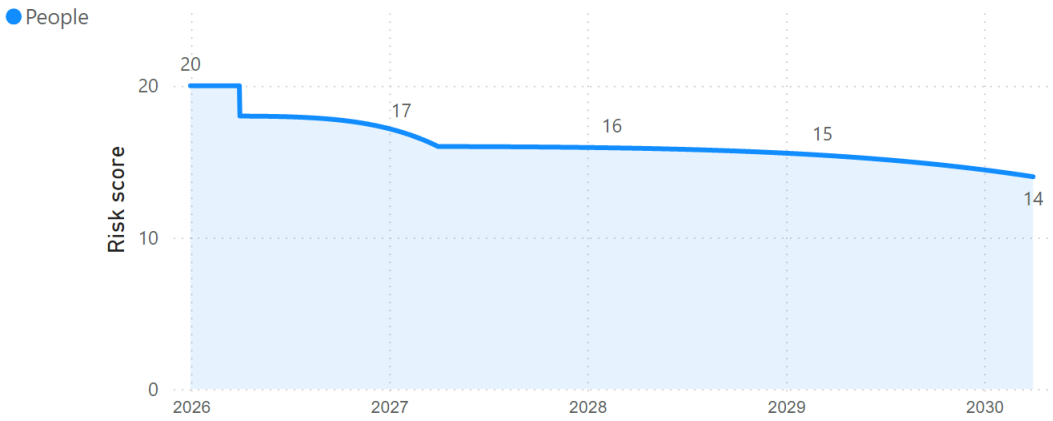
1. People

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 21 January 2026. In full, the risk is:

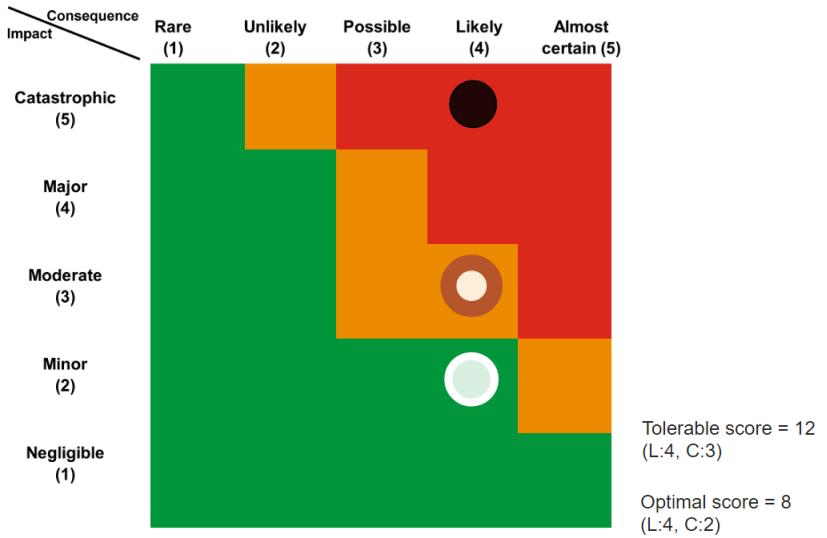
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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
Clinical Policy Group (CPG)	Limited
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Executive Team	Limited
Freedom to Speak Up Guardian	Reasonable
FTSU Group Strategy 2025-28	Reasonable
Group Leadership Strategy	Limited
Group People Strategy 2025-28	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Reasonable
Resident Doctor 10 Point Plan Oversight Delivery Group	Reasonable
Senior Leadership Team (SLT)	Limited
Talent management team for international recruitment	Limited
Vacancy Control Panel	Reasonable
Workforce Transformation Group	Reasonable

Gaps in control (and Action ID)	6	7	8	69	Total
Gaps in hard to recruit roles in medical specialities		✓	✓		2
Instability among Board-level leadership				✓	1
Insufficient attraction, to recruit and retain staff to work in the area		✓	✓	✓	3
Low clinical engagement across specialities and Group	✓				1
Management and Leadership inconsistency in delivering the People Promise to staff			✓		1
Total	1	2	2	1	8

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
External	External Safer Staffing report on application of model	Reasonable
External	GMC and NHSE (deanery) visits	Limited
External	GMC National Training Survey	Limited
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Never events	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequency of culture and staff experience measures	✓	1
Lack of assurance re short term additional hours / overtime from Care Groups	✓	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	✓	1
Plans to address ageing workforce profile	✓	1
Poor levels of mandatory training compliance	✓	1
Total	4	5

A green flag or arrow indicates a recent addition / change to the report.

1. People

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.	21/01/26	Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	People First programme to evolve and support Safety agenda	21/01/26	Group Chief People Officer	Reasonable
8	Group Leadership network and training programme	30/12/25	01/04/27	New leadership programme for the Group ongoing (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	21/01/26	Group Chief People Officer	Reasonable
69	Development of Executive Team programme of development	31/03/27	31/03/27	Draft plan agreed	21/01/26	Group Chief People Officer	Limited

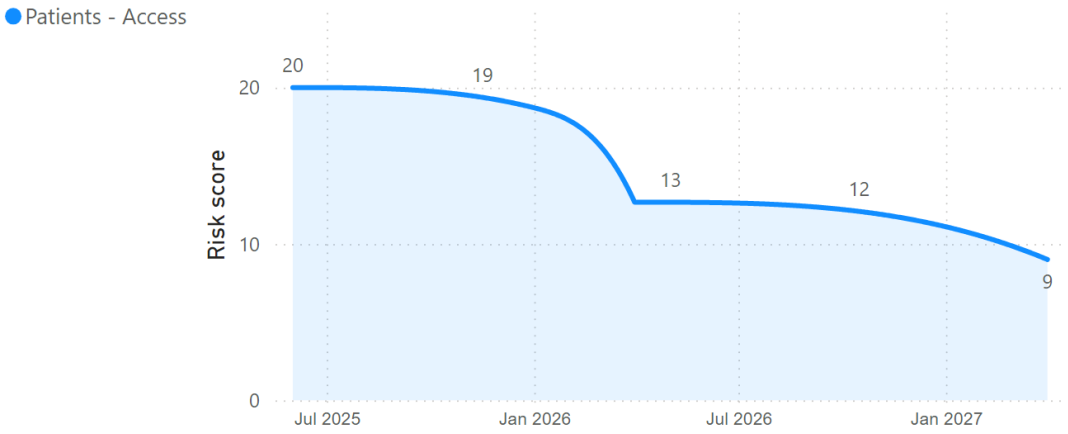
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Sam Peate, 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 03 February 2026. In full, the risk is:

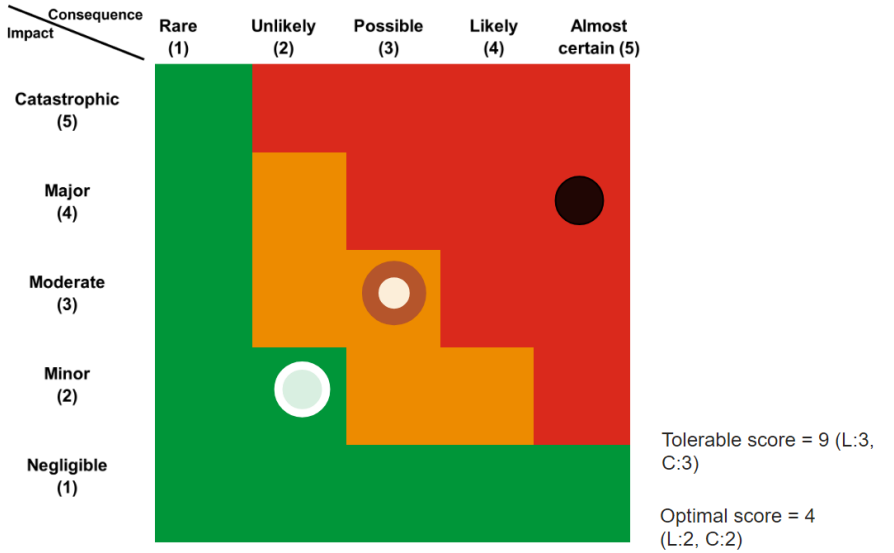
We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.

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 (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)

Meeting our consitutional standard targets are a key objective for the Group. Our willingness to accept operational risk that puts achievement of this objective is therefore cautious. We will accept some degree of risk to improving performance, providing the actions are more likely to improve agreed aspects of constitutional standards.

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
Bed modelling project	Limited
Care Group Performance and Accountability	Limited
Daily / weekly PTL meetings (cancer and elective)	Reasonable
Executive Team	Limited
Flow programme	Limited
Fortnightly check-in with NHSE / ICB	Reasonable
National oversight framework (for support and scrutiny)	Reasonable
Operating plan 2026-27 (draft)	Limited
Operations Director meetings (weekly)	Reasonable
Planned Care Board	Limited
Quality Improvement Group (NHSE led)	Reasonable
Senior Leadership Team (SLT)	Limited
Site Tri meetings	Reasonable
Tier 1 review processes - UEC, Cancer, Elective and Diagnostics	Reasonable
Unplanned Care Board	Limited

Gaps in control (and Action ID)	37	68	75	76	78	79	Total
Challenge in resolving numerous national expectations / targets with available finance, space and resources, degrading or overriding control	✓		✓				2
Embryonic culture of improvement/change management and siloed working	✓	✓					2
Full adherence to planned actions agreed at QIG					⚑	⚑	2
Inert behaviour towards addressing system solutions by ICB	✓						1
Lack of clarity arising from the Care Group structure within the partnership	✓						1
Lack of positive medical engagment in delivery	✓						1
Lack of sufficient capacity to identify and implement service improvement gains from exemplar sites or best practice	✓						1
Weak pockets of team working within the Group partnership				⚑			1
Total	4	2	1	1	1	1	1	11

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	2026-28 Operational Plan with Assurance Statements	Limited
External	GIRFT reviews - identifying progress towards modernising services and improving experiences and outcomes for patients	Reasonable
Internal	Global daily emails on UEC performance	Limited
Internal	Integrated Performance Report	Reasonable
External	National Operating Framework segment	Limited
External	NHS tiering arrangements and support or freedoms	Reasonable
External	NHSE Provider Board Capability assessment	Minimal
Internal	Planned Care Board reporting to Performance, Estates & Finance CiC	Limited
External	Provider licence compliance	Minimal
Internal	Unplanned Care Board reporting to Performance, Estates & Finance CiC	Limited

Assurance gaps (and Action ID)	53	74	78	79	Total
Absence of a sophisticated demand and capacity (bed) model that supports scenario analysis and planning	✓	✓			2
Capability Rating of Red			⚑	⚑	2
Non compliance with provider licence condition NHS2.2, NHS2.5 (a to g), NHS2.6 (a to f)			⚑	⚑	2
Total	1	1	2	2	6

A green flag or arrow indicates a recent addition / change to the report.

2. Patients - Access

NHS Humber Health Partnership

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

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
37	Developing skills and capability of Care Group leadership to support D&C planning and associated operational tasks	31/03/26	01/04/27	B7 to 8b ops courses made available but yet to identify recurrent resources to support	18/12/25	Group Chief Delivery Officer	Limited
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 domains of finance, activity and workforce	18/12/25	Group Chief Delivery Officer	Reasonable
68	Separation and clarification of north and south operations where structural change is not required e.g. bed meetings	31/12/25	31/03/26	Weekly PTL meetings in place and reinvigorated	18/12/25	Group Chief Delivery Officer	Reasonable
74	Produce an internal bed modelling tool to achieve appropriate bed balance (site, elective / non-elective). To also interface with wider system bed modelling.	30/09/26	31/03/27	Initial bed modelling work presented to SLT (24/2/26). Noted some limitations in the model (north more advanced than south). Further 'what-if' work to follow with clinical and inclusion of positive factors; frailty SDEC, admission avoidance, Teletracking.	24/02/26	Group Chief Delivery Officer	Reasonable
75	Execution of RTT recovery actions (65 and 52-week waiters to zero, for elective, diagnostics and cancer pathways)	31/03/27	31/03/27		03/02/26	Group Chief Delivery Officer	Limited
76	Execution of UEC recovery plan	31/12/26	31/03/27	Latest actions: Red lines and Professional standards being agreed	24/02/26	Group Chief Delivery Officer	Limited
78	Improvement Plan and Operating Plan submission and delivery	31/03/26	31/03/27	Work underway to produce an Integrated Improvement Plan	25/02/26	Group Chief Delivery Officer	Reasonable
79	Enforcement actions	31/03/27	31/03/28	In response to Feb-26 letter an action plan is being produced that will also incorporate the recommendations of the ValueCircle review	25/02/26	Group Chief Delivery Officer	Limited

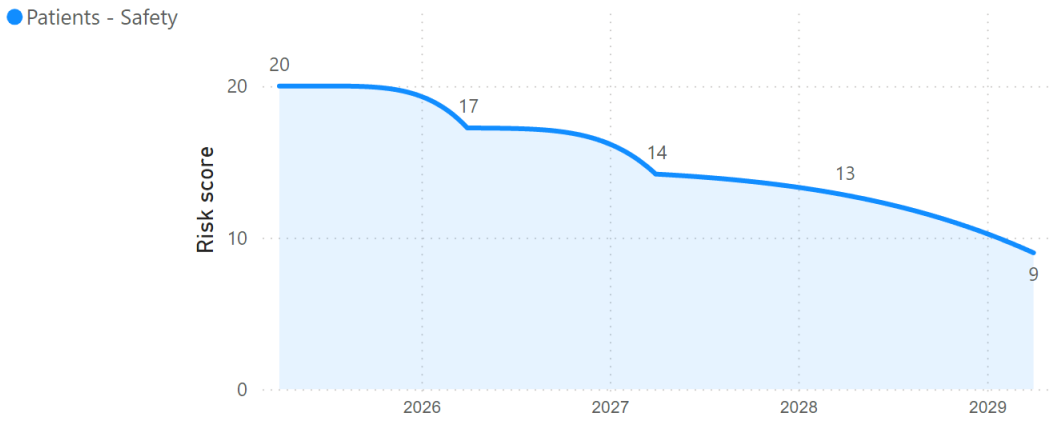
3. Patients - Safety

The strategic risk affecting our objective, 'Patients - Safety' is led by Kate Wood, Group Chief Medical Officer; Sam Peate, Group Chief Delivery Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Patients - Safety, the risk's current score is 20 and its score last changed on 26/01/2026. The actions were last reviewed on 19 February 2026. In full, the risk is:

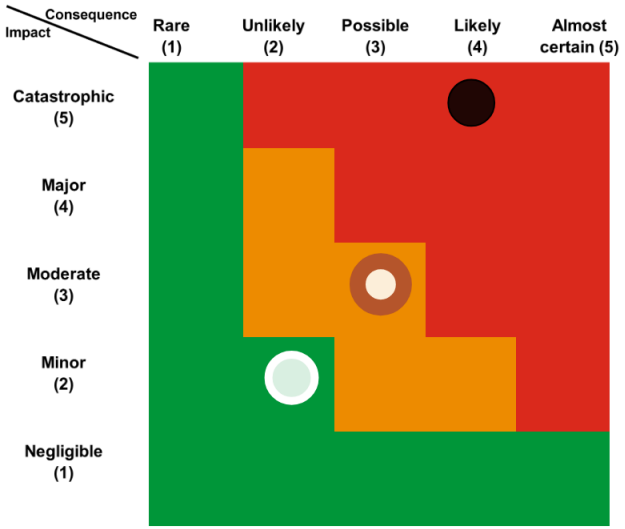
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

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

Control	Rating
Accreditation Frameworks	Limited
Care Group Performance and Accountability	Limited
Clinical Policy Group (CPG)	Limited
Continuous Professional Development for all health professionals	
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 Group	
Patient Safety and Learning Group	
Patient Safety Partners involvement	
Peer Review Process	
Professional standards	Reasonable
Quality and Safety Strategy	Reasonable
Risk and Compliance Group	Limited
Safe Staffing Models	Reasonable
Senior Leadership Team (SLT)	Limited

Gaps in control (and Action ID)	12	13	15	52	54	Total
Fully safe staffing levels (North)		✓				1
Inconsistent evidence of embedded improved processes	✓					1
Instances of data quality issues in supporting metrics		✓				1
Insufficiently strong speak up and reporting culture			✓			1
Lack of comprehensive safety culture		✓	✓	✓	✓	4
Lack of consistent basic hygiene compliance			✓			1
Lack of involvement in national quality audits				✓		1
Lack of positive medical engagment in delivery					✓	1
Poor Martha's Rule compliance					✓	1
Total	1	2	2	3	1	3	12

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Clinical audit outcomes	Reasonable
Internal	CQC Action Plan	Significant
Internal	Daily OPEL status	Limited
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	Reasonable
Internal	Incident reporting	Limited
Internal	Infection Preventation and Control BAF report	Minimal
Internal	Integrated Performance Report	Reasonable
Internal	Mandatory training levels	Limited
Internal	Maternity Neonatal Dashboard	
External	National Patient Survey	Limited
Internal	Never events	Limited
Internal	Ouputs from QI Programme	Limited
Internal	Patient complaints via Patient Experience Quarterly report	Minimal
Internal	Risk Register compliance and coverage	Limited
Internal	Statutory and mandatory compliance levels	Limited
Internal	Ward accreditation metrics	

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

A green flag or arrow indicates a recent addition / change to the report.

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
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	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/06/25	31/03/29	1st Draft to NMB end of Jan	04/02/25	Group Chief Medical Officer, Group Chief Delivery Officer	
15	Develop and embed the Patients First 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.	19/02/26	Group Chief Medical Officer, Group Chief Delivery Officer	Significant
52	Developing and implementing a robust clinical audit programme	31/03/26	31/03/27	Programme developed, now in process of implementation	12/09/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
54	Implementing programme of Martha's Rule actions (for pilot phase)	31/03/26	01/04/27	Piloting six wards, using feedback to inform rollout for organisation. Phase 2 in operation (to Mar 26). Patient Well Being questionnaire already implemented across the group - reporting to Q&S - except for staff gaps to enable paediatric second opinion	12/09/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
55	***** QS ***** Patient decision-making					Group Chief Medical Officer, Group Chief Delivery Officer	
67	Implementation of Staffing business cases for maternity services	31/12/27	31/12/27		02/12/25	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable
73	***** QS ***** Risk Summit and Safety Summit actions					Group Chief Medical Officer, Group Chief Delivery Officer	
77	Implementation of Nurse Safer Staffing level	31/12/26	31/03/27	Business case approved by Board in Feb-26. Implementation phase underway.	19/02/26	Group Chief Medical Officer, Group Chief Delivery Officer	Reasonable

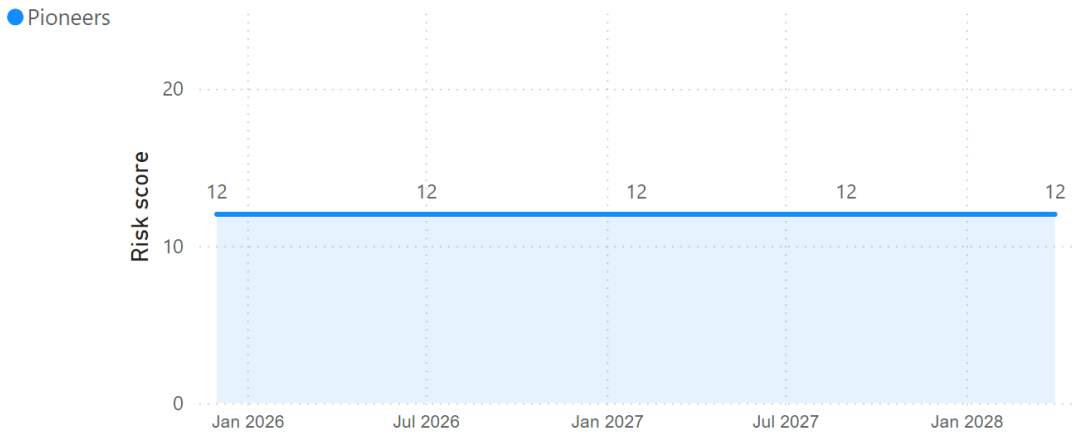
4. Pioneers

The strategic risk affecting our objective, 'Pioneers' is led by Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer; Kate Wood, Group Chief Medical Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Pioneers, the risk's current score is 12 and its score last changed on 05/09/2025. The actions were last reviewed on 03 February 2026. In full, the risk is:

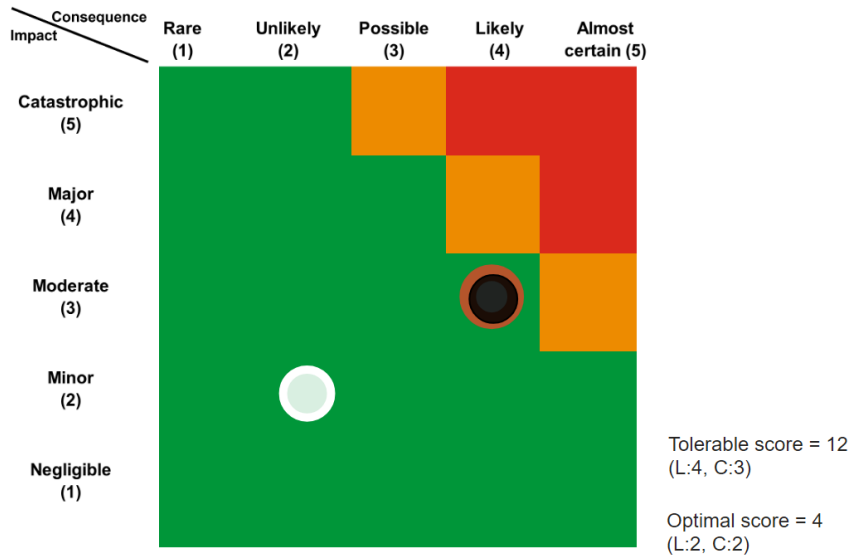
We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.

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

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



Current score and risk appetite



Risk appetite statement (Open)

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

4. Pioneers

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

Control	Rating
Available research service capacity eg labs	Limited
Business cases for investment / disinvestment decisions	Limited
Digital governance group	Reasonable
Digital Strategy	Significant
EPR Programme Board	Reasonable
Financial clarity over existing research resources	Reasonable
Financial management education for directors and budget holders	Reasonable
Financial Strategy	Limited
Full EPR Business Case	Significant
ICB / CAP Digital Governance	Limited
LISA (in development)	Limited
Long term Financial Model	Limited
Protected time	Limited
Research and innovation strategy	Significant
Research Committee	Reasonable
Senior digital leadership team	Reasonable
Senior research team	Reasonable

Gaps in control (and Action ID)	56	64	65	70	Total
Embryonic culture of improvement/change management and siloed working	✓	✓		✓	3
Insufficient capacity within research team for expansion	✓				1
Lack of comprehensive digital asset register			✓		1
Lack of comprehensive oversight of all digital investment and management		✓	✓		2
Research resources being part of CIP	✓				1
Weak commercial and contractual grip and control	✓				1
Total	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
External	DSPT IA led	Reasonable
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	Research, Innovation and Development quarterly report	Reasonable
Internal	Self-assessment of CAF	Reasonable

Assurance gaps (and Action ID)	56	Total
Gaps in financial tracking and funding	✓	1
Lack of available protected time for research	✓	1
Lack of skilled resources to develop innovation	✓	1
Weak understanding and resources from ICB and broader external relationships	✓	1
Total	2	4

A green flag or arrow indicates a recent addition / change to the report.

4. Pioneers

NHS Humber Health Partnership

The table below details the 4 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	Group Chief Strategy, Partnerships and Digital Officer, Group Chief Medical Officer	Reasonable
64	Digital Foundations Business case	30/11/25	30/09/26	Review of applicability / need undeway. Financial profile included in 5 year plan	05/09/25	Group Chief Strategy, Partnerships and Digital Officer, Group Chief Medical Officer	Limited
65	Centralisation of digital resource, governance and oversight, including a single group-wide asset register	31/03/26	31/03/27	Asset register due for completion in next few months. Management arrangements to be determined.	03/02/26	Group Chief Strategy, Partnerships and Digital Officer, Group Chief Medical Officer	Limited
70	Development of LISA	31/03/27	31/03/28	Part of the Improvement Plan, work well underway.	03/02/26	Group Chief Strategy, Partnerships and Digital Officer, Group Chief Medical Officer	Significant

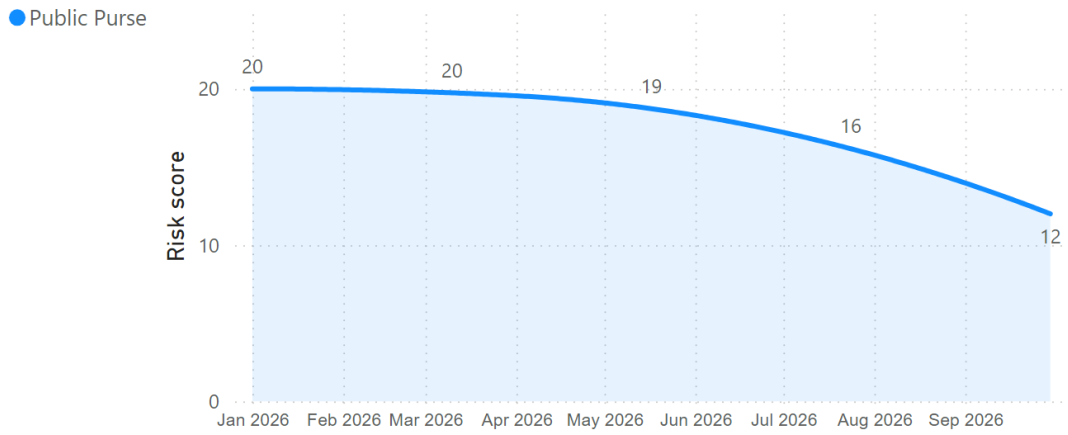
5. Public Purse

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 27/01/2026. The actions were last reviewed on 27 January 2026. In full, the risk is:

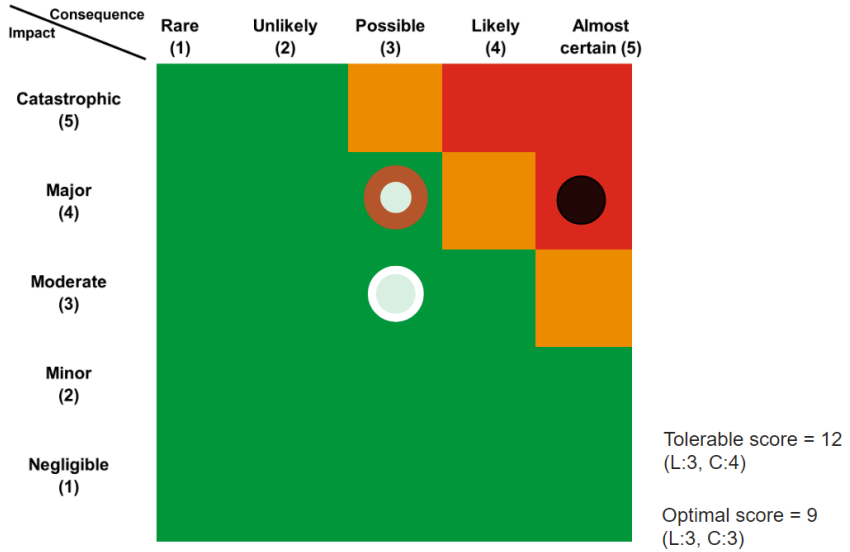
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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.

5. 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
Agency Approval Panel	Reasonable
Board capability and education	Reasonable
Budgetary control system	Reasonable
Business case compliance group	Reasonable
Business case review group	Reasonable
Business cases for investment / disinvestment decisions	Limited
Care Group Performance and Accountability	Limited
Cash Committee	Reasonable
Cash management controls	Significant
Cost Improvement Programme	Limited
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	33	35	36	Total
Absence of comprehensive Estates Strategy / 10-year plan	✓				1
Absence of Group Clinical Strategy	✓				1
Absence of Group Finance Strategy founded on clinical and estates strategies		✓			1
Embryonic culture of improvement/change management and siloed working			✓	✓	2
Fragmented systems and processes for financial control, planning and safety	✓				1
Inert behaviour towards addressing system solutions by ICB		✓			1
Instability among Board-level leadership	✓				1
Lack of accountability and consequence for non-delivery	✓				1
Lack of ICB direction and supporting guidance (e.g. for trust income)					1
Lack of understanding of current financial pressure and need to live within means			✓	✓	2
Out of date Long Term Financial Model inc investments		✓			1
Unsustainable PMO / CIP Engine room capability to deliver transformation and financial savings	✓				1
Total	7	2	1	2	2	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	2026-28 Operational Plan with Assurance Statements	Limited
Internal	Budget control reports	Reasonable
Internal	EQIA reports	Reasonable
Internal	Exception reporting on Standing Financial Instructions and Standing Orders compliance	Reasonable
Internal	FPIB and PMO reporting on transformation and run-rate	Limited
External	Internal audit review of key financial systems	Reasonable
Internal	In-year operational plan progress	Limited
External	NHSE external assurance reviews	Reasonable
Internal	Service Line Reporting	Limited
Internal	Vacancy control and Discretionary Spend Panel	Reasonable
Internal	Workforce planning updates	Reasonable

Assurance gaps (and Action ID)	22	Total
SLR not fully developed and embedded	✓	1
Total	1	1

A green flag or arrow indicates a recent addition / change to the report.

5. Public Purse

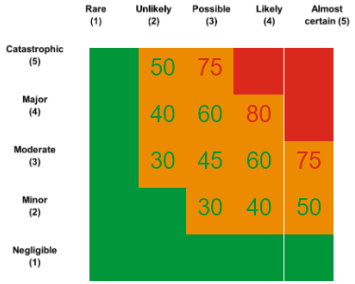
NHS Humber Health Partnership

The table below details the 6 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	31/03/27	31/03/27	Linked to Operational Plan (three-year plan provides financial model) and Improvement Plan and its Stabilisation / Transitional Plan development.	03/03/26	Group Chief Financial Officer	Reasonable
33	Business Case Compliance and Recommending Groups to engage and prioritise clinical and operational future developments	31/12/25	30/09/26	Both now fully operational. Review of progress to be undertaken in six months	27/01/26	Group Chief Financial Officer	Significant
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation and accountability	31/03/26	31/03/27	Pending ValueCircle assessment, likely area to strengthen. Some changes instigated from w/c 16 February 2026.	03/02/26	Group Chief Financial Officer	Limited
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need add value	31/03/26	30/09/26	Directorate team meeting used to feedback issues and take group-wide actions	27/01/26	Group Chief Financial Officer	Reasonable
62	Workforce pay and agency control programme	31/03/26	31/03/26	Triple lock in place plus internal arrangements established to approve pay spend.	27/01/26	Group Chief Financial Officer	Limited
63	Corporate services efficiency programme	31/03/26	31/03/26	Progress becoming more complex and lengthy. People Services reducing staff (thereby giving leaders less capacity to transform)	21/01/26	Group Chief Financial Officer	Reasonable

Risk Appetite Statement

Risk category	Current risk appetite level	Risk appetite statement
Clinical Quality and Safety	Cautious	Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
Financial / Value for Money	Open	Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.
Operational performance	Cautious	Meeting our consitutional standard targets are a key objective for the Group. Our willingness to accept operational risk that puts achievement of this objective is therefore cautious. We will accept some degree of risk to improving performance, providing the actions are more likely to improve agreed aspects of constitutional standards.
Transformation delivery	Open	Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.
Workforce	Balanced	Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.



Board Assurance Framework
Next steps and recommendations

Next steps

The development of the risks informing the BAF has progressed. The two slides overleaf describe a series of actions designed to strengthen risk reporting and address external recommendations. When presented to the Audit, Risk and Governance CiC on 24 April it included an intensive recovery programme designed to review the existing high-scoring risks (numbering over 100 across the Group). Since then, a schedule of Care Group review meetings have been arranged between the end of May and August.

Recommendations

The Boards-in-Common are asked to:

- Note and review the BAF risks

Improvement Plan

The risk register needs to better inform and influence decision-making and contribute to the level of contingency possible and confidence in relation to safety, quality and finance. To achieve this, a range of work is required to strengthen the current risk register and to embed enhanced reporting and management arrangements on a continuous basis.

Business as usual proposal

Subject to SLT and Executive approval, it is proposed that:

- From 27 May, an Executive-led monthly Operational Risk Management group will meet Chiefs of Service and Corporate leads to review new, high-scoring and overdue risks.
- An agreed corporate dataset will support this meeting (in addition to terms of reference and standardised agenda).
- The essential management module within the Learning, Improvement, Safety, Academy (LISA) will include risk management training.
- The existing Performance and Accountability framework includes the consideration of risk for each Care Group. However, a renewed focus will be driven by the GCDO utilising better information.
- High-scoring risks are added to the BAF.

The assignment of a Subject Matter Expert Groups in Ulysses and Executive sponsor should sharpen the Operational Risk Management Group oversight, providing robust information is available in support.

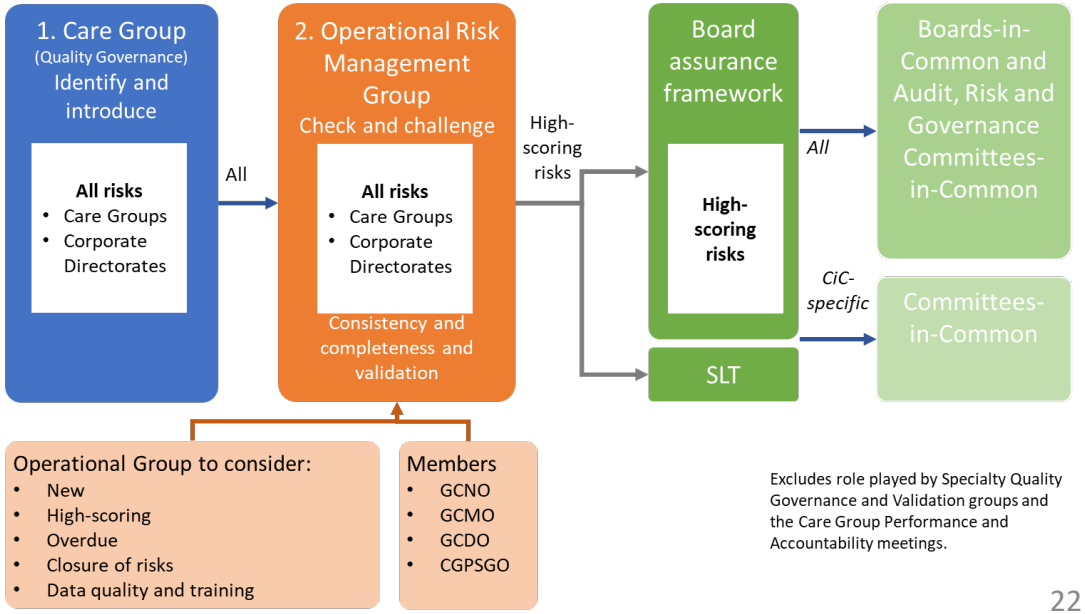
Intensive recovery programme

We plan to undertake an intensive three-month recovery programme of Operational Risk Management Group whereby all high-scoring risk entries are reviewed and validated. The schedule overleaf sets out an indicative timescale for completion.

Internal Audit

In addition, we anticipate the KPMG soft intelligence survey to inform our future work.

Proposed schematic



Excludes role played by Specialty Quality Governance and Validation groups and the Care Group Performance and Accountability meetings.

Intensive recovery programme

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Acute And Emergency Medicine																					
Cancer Network																					
Cardiovascular																					
Community, Frailty & Therapy Services																					
Digestive Diseases																					
Family Services																					
Head And Neck																					
Neuroscience																					
Pathology Network																					
Specialist Cancer And Support Services																					
Specialist Medicine																					
Specialist Surgery																					
Theatres, Anaesthetics And Critical Care																					

This timeline illustrates how the Executive can meet with each Care Group over a 21-week period to review ~80 risks across 13 Care Groups. Each weekly meeting envisages reviewing five risks in detail.

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(26)150

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 June 2026
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 April 2026. 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 ☐ Assurance ☐ Other – please detail below:

Use of Trust Seal – June 2026

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			
2026/01	HUTH and Hull and Andrew Johnson Construction Ltd To undertake the refurbishment of theatres 5 and 6 at Castle Hill Hospital	Lyn Simpson & David Sharif	14.05.2026
2026/02	HUTH and Connexin Limited and Pixel Media Technologies Ltd Licence to assign relating to lease of land on the corner of Argyle Street and Anlaby Road situated at HRI	Lyn Simpson & Emma Sayner	14.05.2026

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(26)151

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	11th June 2026
Director Lead	**Performance** Sam Peate, Group Chief Delivery Officer **Quality & Safety** Hilda Gwilliams, Group Chief Patient Safety Officer Jo Ledger, Deputy Chief Nurse Mr Peter Sedman, Deputy Chief Medical Officer
Contact Officer/Author	**Performance** Chris Fry, Associate Director, Performance and Insights Louise Topliss, Head of Performance **Quality & Safety** Richard Dickinson & Michaela Littlewood, Associate Directors of Quality Governance
Title of the Report	**Integrated Performance Report**
Executive Summary	**Performance** Paper presented in refreshed format for first time to Trust Board including all access measures in first iteration and will be expanded out to include all key domains in the next month. The report is published using the making data count methodology and separation of all metrics into Advise, Assure, Alert methodology for improved oversight of performance. UEC performance shows improving performance across key metrics at HUTH with 4-hour performance at its highest level in over two years, however, there has been some minor deterioration on the previous month for metrics at NLAG reflective of ongoing higher levels of demand. Cancer performance shows improvement on key metrics at HUTH on the previous month with 28-day FDS showing further improvement to 76.6%. 62-day performance at NLAG reached 74.2% compliance which is its highest level in over a year.

	RTT compliance across both HUTH and NLAG is static on previous month, with continued high levels of patients waiting beyond 52 weeks in both Trusts. **Quality & Safety** The individual reports has been shared with the Quality & Safety Committees-in-Common at the May 2026 meeting.
Background Information and/or Supporting Document(s) (if applicable)	**Performance** Performance, Estates and Finance Committees-in-Common Business Assurance Framework report included within this paper. **Quality & Safety** Quality & Safety Committees-in-Common at the May 2026 meeting.
Prior Approval Process	Paper presented to PEF June 2026 – Performance Paper presented to Q&S May 2026 – Quality & Safety
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 ☐ Assurance ☐Information ☐Other – please detail below:

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
April 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

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1. Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. The IPR is underpinned by a broader range of metrics and evidence for clinical governance and operational management.

SAFE: Safety is a priority for everyone and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

EFFECTIVE: People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

RESPONSIVE: People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality.

CARING: People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

WELL LED: There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

2. Regulation and Compliance

CQC assessment ratings per hospital site and service can be found on the CQC website.

Hull University Teaching Hospitals (HUTH) was rated as **Requires Improvement** by the Care Quality Commission on 23 March 2023.

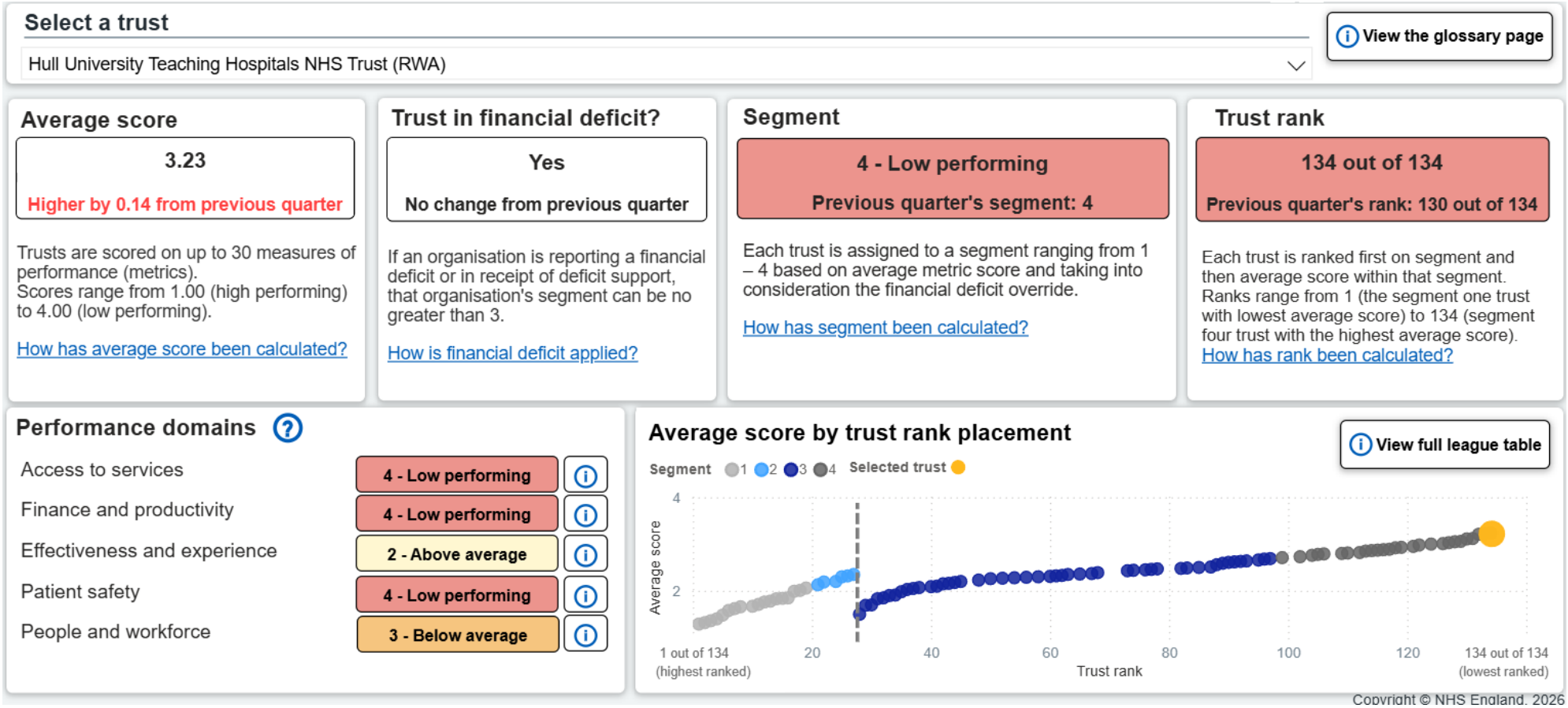
Safe	Effective	Caring	Responsive	Well-Led	Overall
Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Northern Lincolnshire and Goole Hospitals (NLAG) was rated as **Requires Improvement** by the Care Quality Commission on in December 2022.

Safe	Effective	Caring	Responsive	Well-Led	Overall
Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

3. National Oversight Framework

HUTH Overview



Comparative League table in Appendices

NLAG Overview

Select a trust

Northern Lincolnshire and Goole NHS Foundation Trust (RJL)

View the glossary page

Average score

2.86

Higher by 0.01 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

114 out of 134

Previous quarter's rank: 115 out of 134

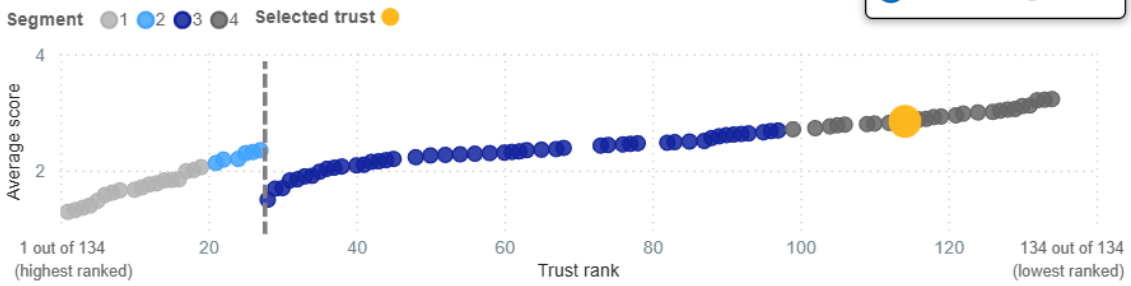
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	3 - Below average
Effectiveness and experience	1 - High performing
Patient safety	4 - Low performing
People and workforce	4 - Low performing

Average score by trust rank placement

View full league table

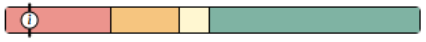
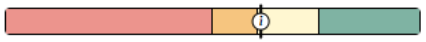
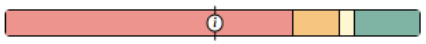
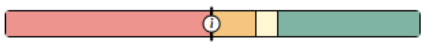


Comparative League table in Appendices

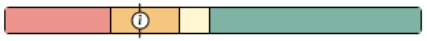
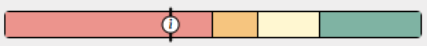
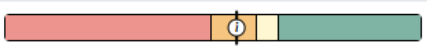
Regional Context

Access to Services

HUTH

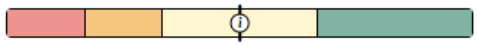
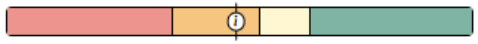
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q4 25/26	75.00%	**53.44%**			3.95
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q4 25/26	80.0%	**68.0%**			3.67
Community Services - Patients waiting over 52 weeks	Jan 25	0.00%	0.00%			1.00
ED - Attendances managed within 4 hours QTD	Q4 25/26	78.00%	**61.43%**			3.75
ED - Attendances over 12 hours in department QTD	Q4 25/26	0.0%	**11.3%**			2.43
RTT - Patients waiting 18 weeks or less	Mar 26	0.00%	56.31%			3.93
RTT - Patients waiting over 52 weeks	Mar 26	1.00%	**3.45%**			3.90
RTT - Planned v actual 18 week performance	Q3 25/26	0.0%	**-4.7%**			3.50

NLAG

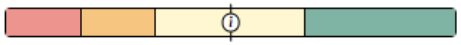
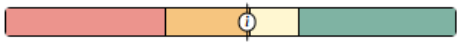
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q4 25/26	75.00%	**66.63%**			3.14
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q4 25/26	80.0%	**66.2%**			3.75
Community Services - Patients waiting over 52 weeks	Mar 26	0.00%	0.00%			1.00
ED - Attendances managed within 4 hours QTD	Q4 25/26	78.00%	**70.23%**			3.01
ED - Attendances over 12 hours in department QTD	Q4 25/26	0.0%	**17.8%**			3.70
RTT - Patients waiting 18 weeks or less	Mar 26	0.00%	61.57%			3.45
RTT - Patients waiting over 52 weeks	Mar 26	1.00%	**2.05%**			3.43
RTT - Planned v actual 18 week performance	Q3 25/26	0.0%	**-3.0%**			3.13

Effectiveness & Experience

HUTH

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Avg Days Ready Date to Discharge (inc 0 day delays)	Mar 26	0.0	**0.7**			2.25
CQC inpatient survey satisfaction rate	2024	0.0	4.0			2.00
Summary Hospital Mortality Indicator	Dec 25	0.00	**1.03**			2.85

NLAG

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Avg Days Ready Date to Discharge (inc 0 day delays)	Mar 26	0.0	**0.8**			2.42
Community - Urgent response 2 hours performance QTD	Q2 25/26	70.00%	98.69%			1.00
CQC inpatient survey satisfaction rate	2024	0.0	4.0			2.00
Summary Hospital Mortality Indicator	Dec 25	0.00	**1.00**			2.62

Patient Safety

HUTH

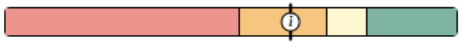
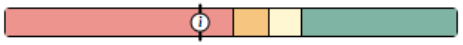
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC Safe inspection score	2025	0.0	2.0			3.00
Number of MRSA bacteraemia cases	Mar 26	0	**4**			2.81
Proportion of C-Difficile infections against threshold	Mar 26	1.00	**1.83**			3.90
Proportion of E-Coli bacteraemia against threshold	Mar 26	1.00	**1.56**			3.74
Staff Survey - Raising Concerns sub-score	2024	0.00	6.06			3.71

NLAG

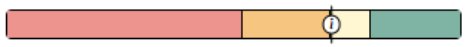
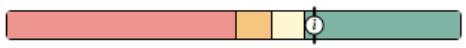
Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC Safe inspection score	2025	0.0	2.0			3.00
Number of MRSA bacteraemia cases	Mar 26	0	**4**			2.81
Proportion of C-Difficile infections against threshold	Mar 26	1.00	**1.83**			3.90
Proportion of E-Coli bacteraemia against threshold	Mar 26	1.00	**1.56**			3.74
Staff Survey - Raising Concerns sub-score	2024	0.00	6.06			3.71

Finance & Productivity

HUTH

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Finance - Combined finance score	Q3 25/26	0	4			4.00
Finance - Planned surplus/deficit	Q3 25/26	0.0%	-1.4%			2.35
Finance - Variance year-to-date to financial plan	Q3 25/26	0.00%	-1.87%			3.09
Productivity - Implied productivity level	Oct 25	0.0%	-1.6%			3.57

NLAG

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Finance - Combined finance score	Q3 25/26	0	4			4.00
Finance - Planned surplus/deficit	Q3 25/26	0.0%	-2.4%			2.89
Finance - Variance year-to-date to financial plan	Q3 25/26	0.00%	-0.97%			2.49
Productivity - Implied productivity level	Oct 25	0.0%	5.3%			1.54

People & Workforce

HUTH

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Sickness Absence Rate QTD	Q4 25/26	0.00%	**5.02%**			1.72
Staff Survey - Engagement Theme Score	2024	0.00	6.47			3.84

NLAG

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Sickness Absence Rate QTD	Q4 25/26	0.00%	**5.52%**			2.35
Staff Survey - Engagement Theme Score	2024	0.00	6.43			3.89

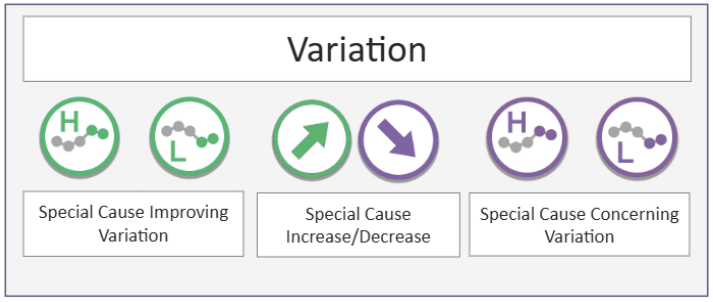
4. HHP Key Metric Oversight Scorecard

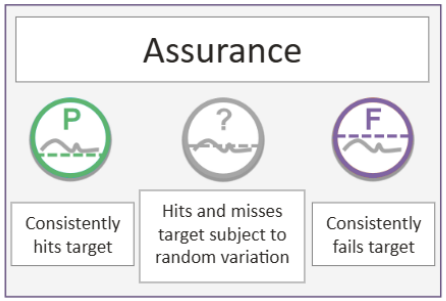
Oversight Group	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Access to Services	Cancer Care	➤ SCORE: Cancer Care		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
		Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	57.2%	55.6%	55.5%	56.2%	62.2%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	
		Cancer - 62 Day All Referral Sources	≥ 66.0%	46.9%	49.7%	56.1%	55.9%	52.9%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	
	Elective Care	➤ SCORE: Elective Care		1.80	2.60	1.80	1.80	1.80	1.80	2.60	2.60	1.80	1.80	1.80	1.80
		RTT - Incomplete 18 Week Standard	≥ 65.0%	58.8%	59.6%	58.5%	57.5%	57.6%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%
		RTT - Patients waiting 52+ weeks for Community Services				13.2%	13.8%	14.1%	14.4%	14.7%	15.0%	16.0%	15.6%	15.3%	15.7%
		RTT - Percentage of 52+ Week Waits	≤ 1.3%	3.2%	3.1%	3.2%	3.6%	3.5%	3.5%	3.6%	3.3%	3.4%	3.3%	3.0%	3.1%
	Urgent & Emergency Care	➤ SCORE: Urgent & Emergency Care		1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29
		A&E - 4 Hour Standard (All)	≥ 78.4%	64.0%	64.4%	67.1%	68.5%	65.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.1%	67.8%
		A&E - Patients Waiting > 12 hours in Department	≤ 15.0%	15.5%	14.4%	13.0%	12.1%	15.3%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%
Effectiveness & Experience	Effectiveness	➤ SCORE: Effectiveness		2.17	2.17	2.17	2.17	2.17	2.33	2.17	2.17	2.20	2.20	2.20	2.20
		Inpatient - Days between DRD and Discharge Date	≤ 4.4	4.4	4.4	4.4	4.6	4.5	4.1	4.5	4.6	4.3	5.5	5.1	5.2
		Mortality - SHMI	≤ 1.0	1.04	1.04	1.03	1.02	1.02	1.02	1.01	1.01				
	Experience	➤ SCORE: Experience													
		CQC Inpatient Survey Satisfaction Mean Score		8.15	8.15	8.15	8.15	8.15	8.15	8.15	8.15	8.15	8.15	8.15	8.15
Finance & Productivity	Financial Balance	➤ SCORE: Financial Balance													
		Finance - CIP YTD against plan		66.4%	74.2%	83.0%	85.1%	85.3%	81.5%	77.6%	75.8%	74.9%			
		Finance - Variance YTD to Financial Plan		0	(2,864)	(3,030)	(3,035)	(3,276)	(4,779)	(7,922)	(18,306)	(29,300)	(36,357)	(36,521)	
Patient Safety	Patient Safety	➤ SCORE: Patient Safety		2.50	2.50	2.50	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
		CQC Safe Inspection Score		1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50
		Infections - C.Difficile (per 1,000 bed days)		0.16	0.19	0.23	0.20	0.21	0.20	0.18	0.28	0.36	0.25	0.29	
		Infections - E.Coli (per 1,000 bed days)		0.68	0.87	0.85	0.80	0.91	0.83	0.62	0.58	0.49	0.87	0.50	
		Infections - MRSA (per 1,000 bed days)		0.00	0.00	0.00	0.02	0.00	0.02	0.00	0.04	0.02	0.02	0.05	
		Staff Survey - Raising Concerns sub-score		12.15	12.15	12.15	12.15	12.15	12.15	12.15	12.15	12.15	12.15	12.15	12.15
People & Workforce	People & Workforce	➤ SCORE: People & Workforce		2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	
		Staff Sickness Absence Rate	≤ 4.0%	4.7%	4.7%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%	4.7%	4.8%	4.8%	
		Staff Survey - Engagement Theme Score													
		Staff Turnover Annual FTE Rate	≤ 10.0%	8.1%	8.0%	7.7%	7.9%	7.2%	7.4%	7.2%	7.0%	6.7%	6.9%	6.9%	
Reducing Inequalities	Primary Prevention	➤ SCORE: Primary Prevention		2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33
		Diagnostics - 6 Week Standard	≤ 27.0%	29.6%	30.4%	31.4%	36.2%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%

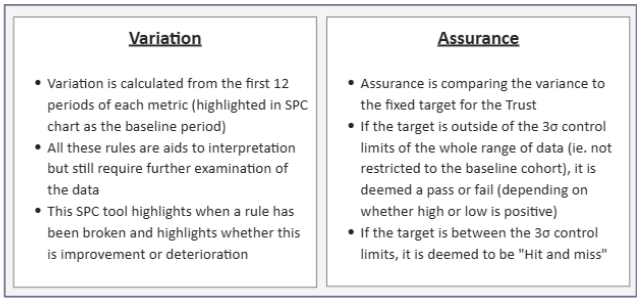
5. Using Data Insights to identify Alert, Advise and Assure status

Making Data Count is a means to express the variation in trend and, somewhat separately, the achievement of a singular target (assurance).

In most cases, this will yield a continual 'Fail' throughout the year in terms of the MDC Assurance trigger (described below) as this wants a static target.







Equally, in the context of traditional 'National' compliance targets (e.g. ED 4hr =95%) being beyond reach, we require a focus upon what we have agreed to achieve over a performance cycle, with the Medium-Term Plan helping to set this in several key areas.

If the Trust has established a target, these are our Performance Measures for the year and if we have established a target, best practice would be to generate a trajectory to monitor its delivery.

'Assurance' would be better demonstrated by the combination of variation – still using SPC insight – and whether the latest reporting period is matching trajectory.

Using this approach, we will identify the AAA status of each Performance Measure every month based upon the matrix below.

Variation status	Status v Trajectory	AAA Group
Improving	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert
Normal	Meeting	Assure

6. HHP Group Executive Summary – Performance

Executive Lead: Sam Peate, Group Chief Delivery Officer Accountable to: Performance, Estate and Finance Committee

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All)	Apr-26	≥ 71.9%	65.7%		
A&E - 4 Hour Standard (Type 1)	Apr-26	≥ 45.0%	54.1%		
A&E - 4 Hour Standard (Type 3)	Apr-26	≥ 95.0%	92.6%		
A&E - Ambulance Handovers within 45 minutes	Apr-26	≥ 96.0%	96.3%		
A&E - DTA to Admission > 12 hours	Apr-26	≤ 0.0%	9.2%		
A&E - Patients Waiting > 12 hours in Department	Apr-26	≤ 14.7%	6.9%		
Cancer - 28 Day Faster Diagnosis Standard	Mar-26	≥ 80.0%	76.6%		
Cancer - 31 Day All Stages	Mar-26		78.4%		
Cancer - 62 Day All Referral Sources	Mar-26	≥ 63.7%	56.0%		
Diagnostics - 6 Week Standard	Apr-26	≤ 30.0%	38.1%		
Diagnostics - Total Activity Levels	Apr-26	≥ 19,497	18,996		
Inpatient - Bed Days Lost to NCTR Patients	Apr-26		6,785		
Inpatient - Patients Discharged on No Criteria to Reside Day	Apr-26		33.8%		
RTT - 52+ Week Waits	Apr-26	≤ 3,472	2,888		
RTT - 65+ Week Waits	Apr-26		89		
RTT - Incomplete 18 Week Standard	Apr-26	≥ 54.2%	56.3%		
RTT - Total Incomplete Pathways	Apr-26	≤ 84,727	83,615		
Theatres - Capped Theatre Utilisation	Apr-26	≥ 85.0%	81.2%		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All)	Apr-26	≥ 74.2%	69.6%		
A&E - 4 Hour Standard (Type 1)	Apr-26	≥ 50.0%	51.2%		
A&E - 4 Hour Standard (Type 3)	Apr-26	≥ 99.0%	99.1%		
A&E - Ambulance Handovers within 45 minutes	Apr-26	≥ 88.0%	77.2%		
A&E - DTA to Admission > 12 hours	Apr-26	≤ 0.0%	21.5%		
A&E - Patients Waiting > 12 hours in Department	Apr-26	≤ 17.9%	15.8%		
Cancer - 28 Day Faster Diagnosis Standard	Mar-26	≥ 80.0%	66.4%		
Cancer - 31 Day All Stages	Mar-26		98.1%		
Cancer - 62 Day All Referral Sources	Mar-26	≥ 63.0%	74.2%		
Diagnostics - 6 Week Standard	Apr-26	≤ 35.0%	33.0%		
Diagnostics - Total Activity Levels	Apr-26	≥ 25,866	17,662		
Inpatient - Bed occupancy classed as clinically ready for dis...	Apr-26		17.2%		
Inpatient - Days between DRD and Discharge Date	Apr-26	≤ 3.4	4.9		
RTT - 52+ Week Waits	Apr-26	≤ 1,273	915		
RTT - 65+ Week Waits	Apr-26		41		
RTT - Incomplete 18 Week Standard	Apr-26	≥ 56.1%	61.4%		
RTT - Total Incomplete Pathways	Apr-26	≤ 40,302	40,793		
Theatres - Capped Theatre Utilisation	Apr-26	≥ 85.0%	83.7%		

Both Trusts remain in Tier 1 oversight for UEC, Cancer, Diagnostics and RTT (NLAG only) and National Oversight Framework (NOF) 5 nationally. Whilst national constitutional performance standards remain, the Operational Planning trajectories have been agreed for 26/27 and are referenced within this report. These have been further enhanced to specialty and tumour site level and work is underway to replicate this work for diagnostic modalities relevant to DM01 reporting.

Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. For RTT, there is ongoing focus on ensuring the very longest waiters receive their treatment, there is not yet consistent improvement/achievement across the core metrics.

Patient Not Present reporting has been implemented and will help to reduce unnecessary follow up appointments and drive additional RTT clock stops with £33 payment received per pathway.

a. Hull University Teaching Hospitals Assurance Summary

No Change in Assurance	ALERT	New ALERT Indicators
• RTT 52-week breaches • 62-day cancer performance • 104-day cancer backlog • Diagnostic performance • UEC 4-hour performance • UEC 12-hour performance • Ambulance handovers • No Criteria to Reside	• RTT 65-week breaches	•

No Change in Assurance	ADVISE	New ADVISE Indicators
• RTT waiting list stable	• Diagnostics showing early signs of recovery • Waiting list size stabilised, supported by validation and improvement initiatives	• Positive improvements in UEC: HUTH, Ambulance waits, corridor care, 12 hour waits, 4-hour performance, sustained reduction for the past 4 weeks in 12 hour waits, corridor care. • Core constraint themes consistent across pathways: Diagnostic capacity (radiology, endoscopy, pathology). Workforce gaps and productivity constraints. Outpatient delays impacting downstream performance

No Change in Assurance	ASSURE	New ASSURE Indicators
• Corridor care on plan to eradicate by end July	• RTT and Diagnostic Delivery Groups • Cancer Tier 1 oversight with regional assurance • RTT active backlog reduction and validation programmes • Targeted capacity expansion initiatives • Improvement plans established across all major pathways	• Tumour-site specific cancer recovery trajectories • UEC recovery programme in place

b. Northern Lincolnshire and Goole Hospitals Assurance Summary

No Change in Assurance	ALERT	New ALERT Indicators
• RTT 52-week breaches • RTT Residual 65- and 78-week breaches • 62-day cancer performance • 104-day cancer backlog • Diagnostic performance • UEC 4-hour performance • UEC 12-hour performance • Ambulance handovers • No Criteria to Reside	• RTT 65-week breaches	•

No Change in Assurance	ADVISE	New ADVISE Indicators
• RTT waiting list stable	• Diagnostics showing early signs of recovery • Waiting list size stabilised, supported by validation and improvement initiatives	• Positive improvements in UEC: HUTH, Ambulance waits, corridor care, 12 hour waits, 4-hour performance, sustained reduction for the past 4 weeks in 12 hour waits, corridor care. • Core constraint themes consistent across pathways: Diagnostic capacity (radiology, endoscopy, pathology). Workforce gaps and productivity constraints. Outpatient delays impacting downstream performance

No Change in Assurance	ASSURE	New ASSURE Indicators
•	• RTT and Diagnostic Delivery Groups • Cancer Tier 1 oversight with regional assurance • RTT active backlog reduction and validation programmes • Targeted capacity expansion initiatives	• Tumour-site specific cancer recovery trajectories • Improvement plans established across all major pathways • UEC recovery programme in place

c. Unplanned Care

In April 2026, A&E 4-hour performance remained challenged at both Trusts and below the 2026/27 Operating Plan trajectory.

At HUTH, all-type performance was 65.7% against a plan of 71.9%; however, Type 1 performance at 54.1% was above the plan target of 45%, while Type 3 performance at HRI UTC was 92.6% against a 95% target. The percentage of patients seen by a clinician within 60 minutes of arrival was 50.7%, representing an improvement on the previous month.

At NLAG, combined A&E 4-hour performance was 69.6% against a target of 74.2%; Type 1 performance was 51.2%, above the 50% plan, and Type 3 performance was 99.1%, in line with the 99% target. Time to treatment within 60 minutes was 37.7% in April, which represented a deterioration on the previous month.

- HUTH: 6.9% of patients spent over 12 hours in the department, an improvement on the previous month.
- NLaG had 15.8% of patients waiting over 12 hours in the department, a deterioration on the March position.
- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED
    - HUTH's performance improved in April was 319 minutes average
    - NLaG has performed consistently in 265-300 mins range since late Spring 2024. April 2026 performance was 296 mins.
- Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC
- Streaming pathway improvements aligned to GIRFT principles was launched in April 2026 to ensure UTC and SDEC treat the most appropriate patients to support flow and performance.
- HUTH – Rapid Assessment taking place in ECA & Majors. Model under review for further improvement
- HUTH – consultant cover 24 hours Mon – Thurs. When team is fully established this will cover the 7 days.

Ambulance handover performance at HUTH has shown significant and sustained improvement since the joint work with YAS commenced in December 2024. In April 2026, average ambulance handover time was 18.6 minutes, with 96.3% of handovers completed within 45 minutes against a 96% target. Total ambulance conveyances in the month were 4,178, and time to initial assessment was 18 minutes.

At NLAG, average ambulance handover time in April was 36 minutes, with 77.2% of handovers completed within 45 minutes against a target of 88%. The percentage of ambulance handovers exceeding 60 minutes was 16% in April 2026. Total ambulance conveyances were 3,459, and time to initial assessment was 41 minutes against a target of 15 minutes.

HUTH

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Domain	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Effective	Urgent & Emergency Care	➤ SCORE: Urgent & Emergency Care		1.57	1.57	1.57	1.71	1.43	1.29	1.57	1.57	1.29	1.71	1.86	1.86
		A&E - 4 Hour Standard (All)	≥ 79.4%	56.2%	56.6%	58.9%	61.9%	58.5%	55.8%	57.2%	60.1%	57.0%	60.3%	64.0%	65.7%
		A&E - 4 Hour Standard (Type 1)	≥ 60.7%	42.8%	42.2%	44.0%	46.3%	42.1%	40.9%	42.6%	47.1%	42.6%	46.3%	50.7%	54.0%
		A&E - Ambulance Average Handover Time	≤ 20.0	26.5	24.3	22.8	20.8	23.1	23.8	23.9	23.8	26.6	20.4	19.2	18.6
		A&E - Ambulance Handovers within 45 minutes	≥ 90.0%	95.7%	97.5%	95.4%	96.8%	95.3%	94.6%	92.8%	93.2%	91.1%	90.4%	98.2%	96.3%
		A&E - Conversion Rate (over 65s)		48.9%	51.7%	50.3%	49.1%	49.9%	50.2%	51.4%	52.8%	49.9%	51.4%	51.1%	51.4%
		A&E - Conversion Rate (under 18s)		20.8%	20.4%	19.8%	20.4%	22.1%	21.2%	25.6%	25.5%	25.1%	24.6%	24.3%	23.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 14.2%	13.7%	12.9%	12.3%	10.1%	14.9%	17.4%	14.2%	13.9%	18.3%	11.8%	9.0%	6.9%

NLAG

Tier 1 - Foundation Scorecard

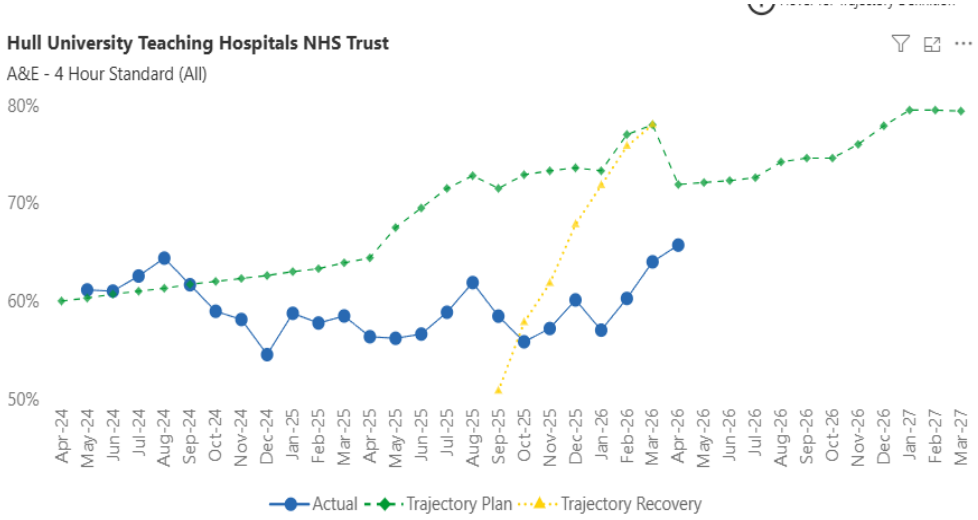
Right click metric to drill through to SPC chart or view metric breakdown

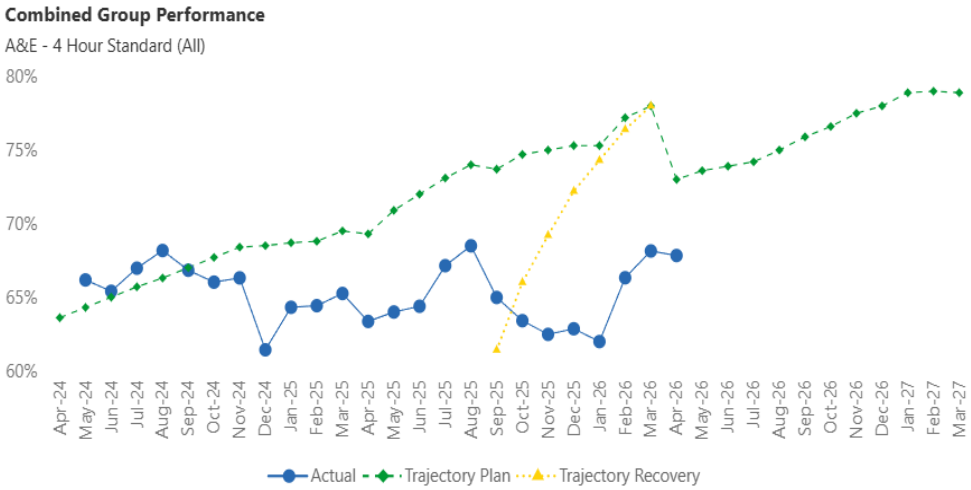
Domain	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Effective	Urgent & Emergency Care	➤ SCORE: Urgent & Emergency Care													
		A&E - 4 Hour Standard (All)	≥ 79.4%	70.5%	71.0%	74.2%	74.1%	70.6%	69.8%	67.1%	65.3%	66.2%	71.4%	71.6%	69.6%
		A&E - 4 Hour Standard (Type 1)	≥ 60.7%	47.2%	48.5%	54.5%	55.4%	48.9%	48.0%	43.7%	42.3%	41.8%	54.5%	54.9%	51.2%
		A&E - Ambulance Average Handover Time	≤ 20.0												
		A&E - Ambulance Handovers within 45 minutes	≥ 90.0%	74.5%	77.1%	83.6%	82.3%	83.3%	86.5%	75.6%	65.5%	57.0%	71.5%	81.7%	77.2%
		A&E - Conversion Rate (over 65s)		46.0%	46.6%	46.8%	45.7%	44.7%	45.5%	48.1%	48.6%	48.1%	49.9%	53.7%	52.8%
		A&E - Conversion Rate (under 18s)		8.2%	11.5%	8.0%	9.8%	10.9%	10.0%	9.8%	10.0%	9.8%	8.1%	10.8%	8.7%
		A&E - Patients Waiting > 12 hours in Department	≤ 14.2%	17.3%	15.9%	13.7%	14.2%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%	15.8%

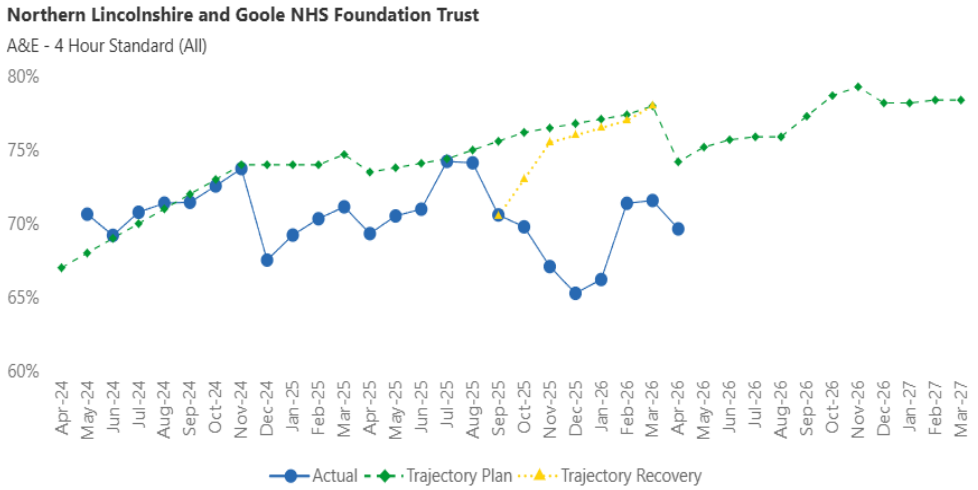
i. Emergency Care Standards – 4-hour Performance

Making Data Count Badges **(For example only)**

	Variation	Assurance
HUTH	Common Cause	Not capable
NLAG	Improvement (Low)	Not capable







ii. Enabler Metric 1 – Mean Time to Treatment

Making Data Count Badges **(For example only)**

HUTH

Variation Common Cause

Assurance Not capable

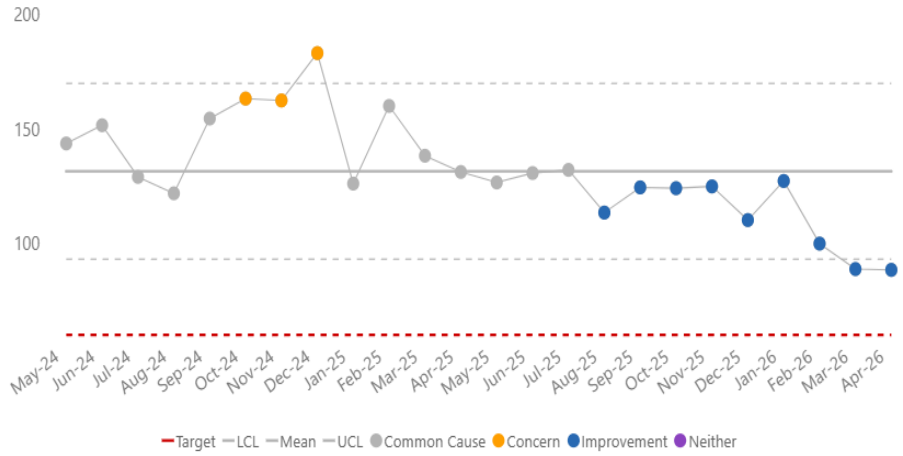
NLAG

Variation Improvement (Low)

Assurance Not capable

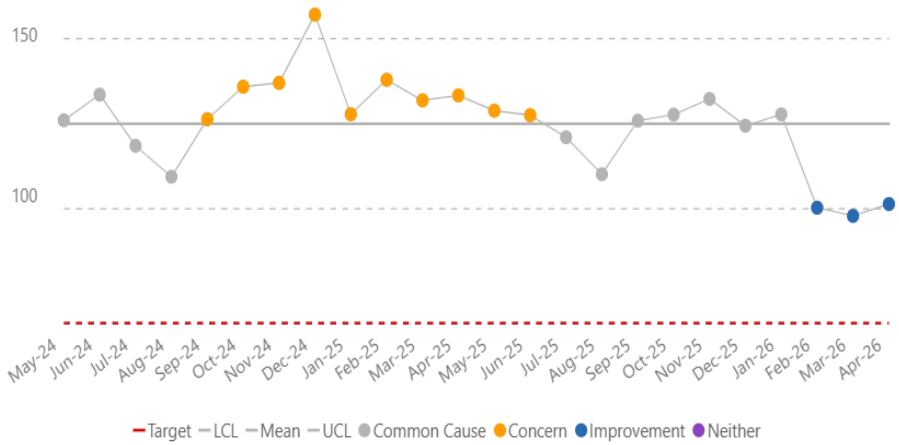
Hull University Teaching Hospitals NHS Trust

A&E - Time to Treatment



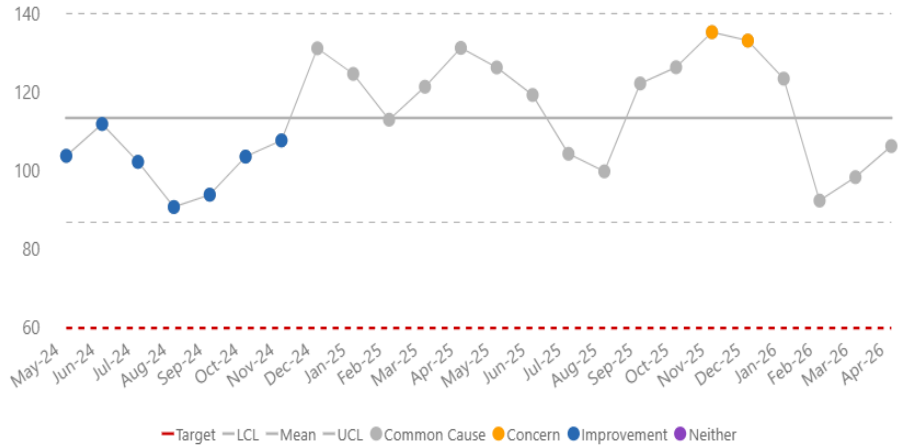
Combined Group Performance

A&E - Time to Treatment



Northern Lincolnshire & Goole NHS Foundation Trust

A&E - Time to Treatment



iii. Enabler Metric 2 – Non-Admitted Total Time in Department

Making Data Count Badges (For example only)

HUTH

Variation Common Cause

Assurance Not capable

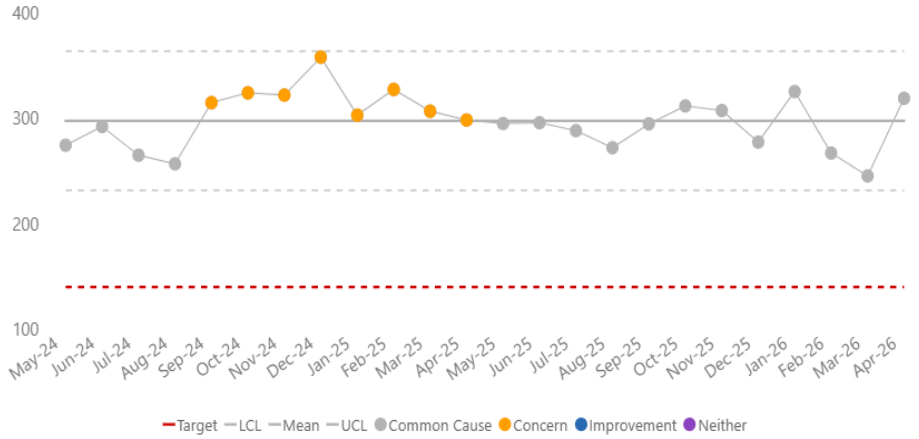
NLAG

Variation Improvement (Low)

Assurance Not capable

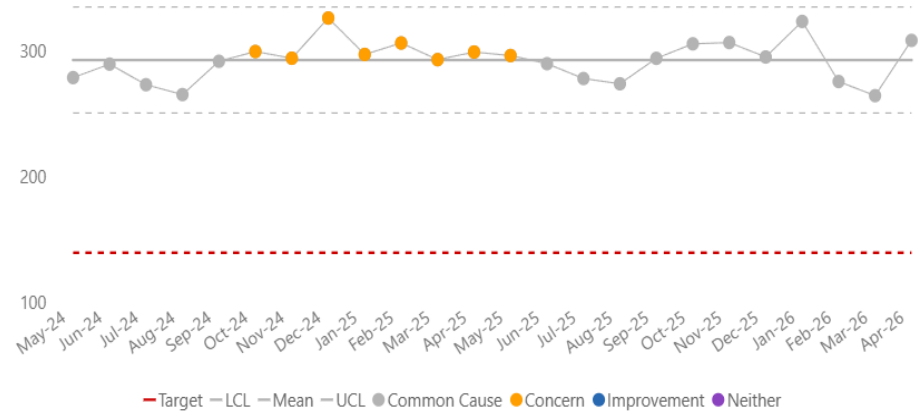
Hull University Teaching Hospitals NHS Trust

A&E - Total Time in A&E (Non-Admitted)



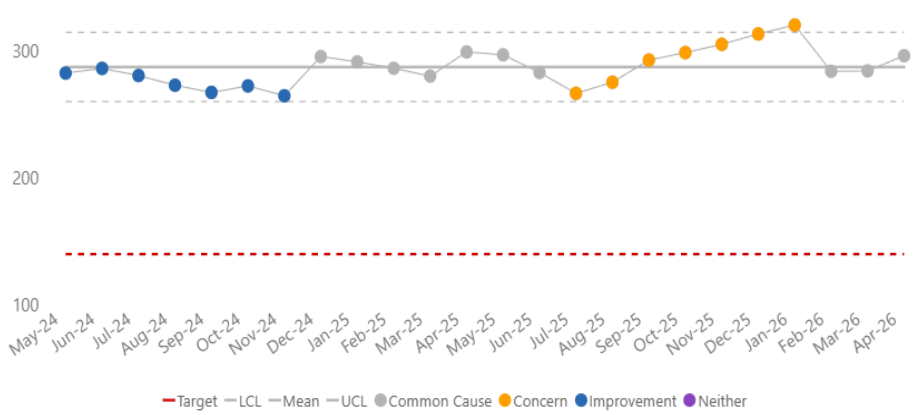
Combined Group Performance

A&E - Total Time in A&E (Non-Admitted)



Northern Lincolnshire & Goole NHS Foundation Trust

A&E - Total Time in A&E (Non-Admitted)



iv. A&E Attendances – All Types

Making Data Count Badges (For example only)

HUTH

Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

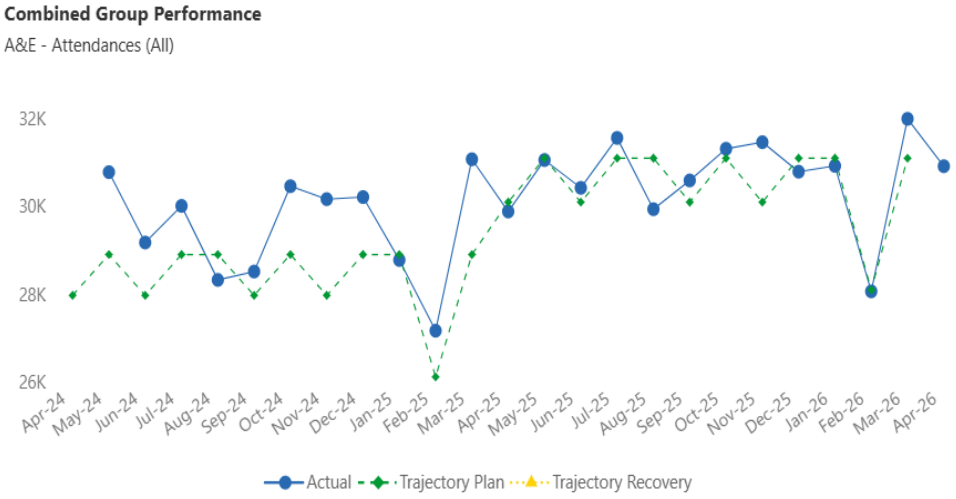
Hull University Teaching Hospitals NHS Trust

A&E - Attendances (All)



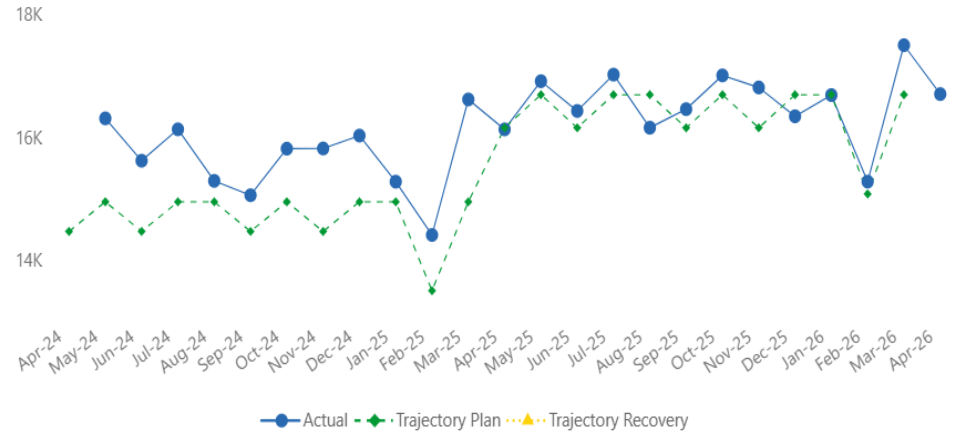
Combined Group Performance

A&E - Attendances (All)



Northern Lincolnshire and Goole NHS Foundation Trust

A&E - Attendances (All)



v. A&E Attendances – Type 1 Attendances

Making Data Count Badges (For example only)

HUTH

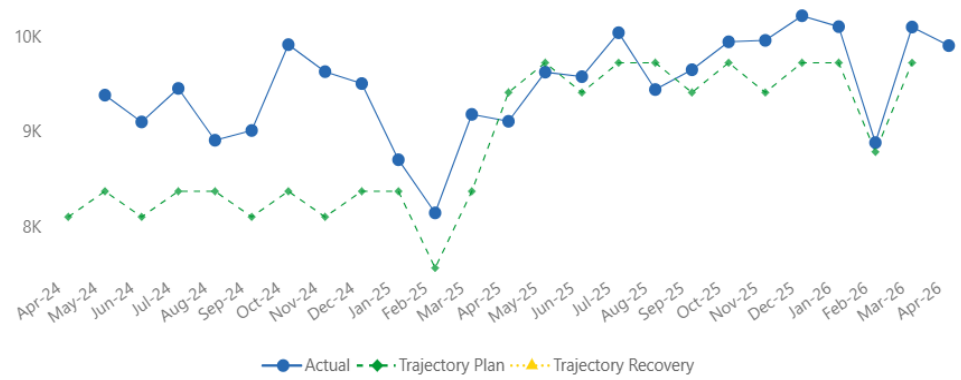
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

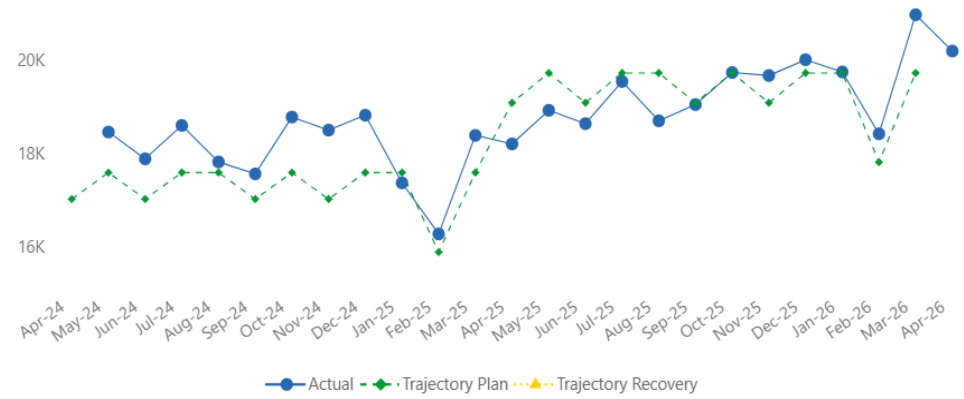
Hull University Teaching Hospitals NHS Trust

A&E - Attendances (Type 1)



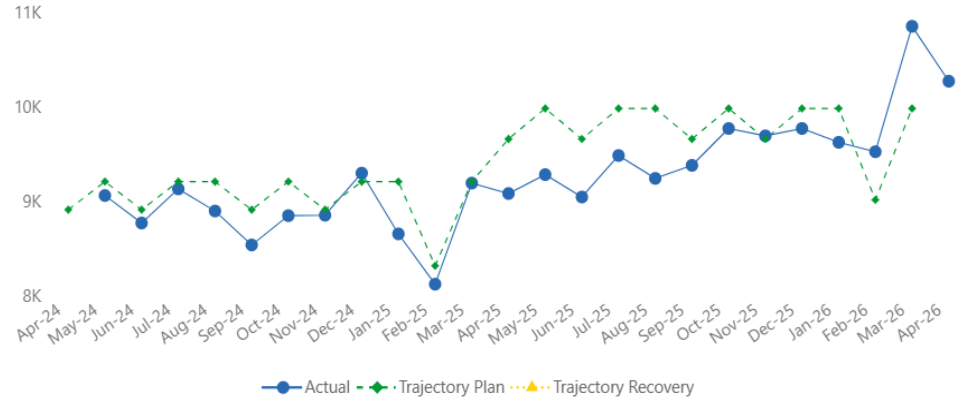
Combined Group Performance

A&E - Attendances (Type 1)



Northern Lincolnshire and Goole NHS Foundation Trust

A&E - Attendances (Type 1)



vi. A&E Attendances – Type 3 Attendances

Making Data Count Badges (For example only)

HUTH

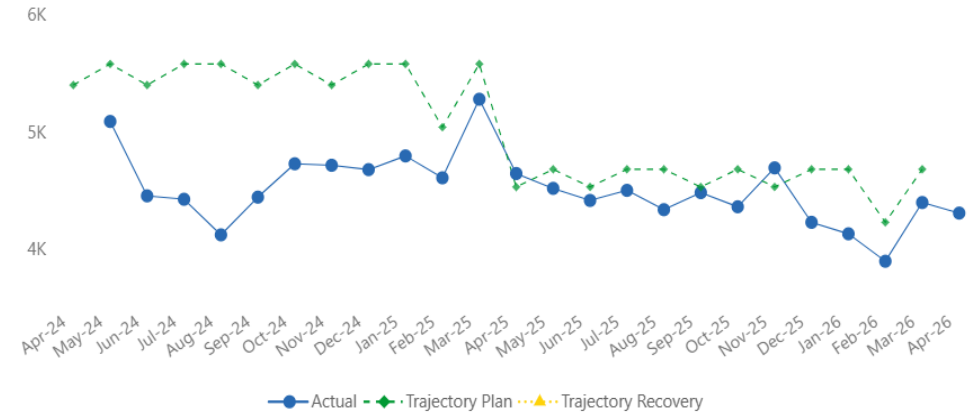
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

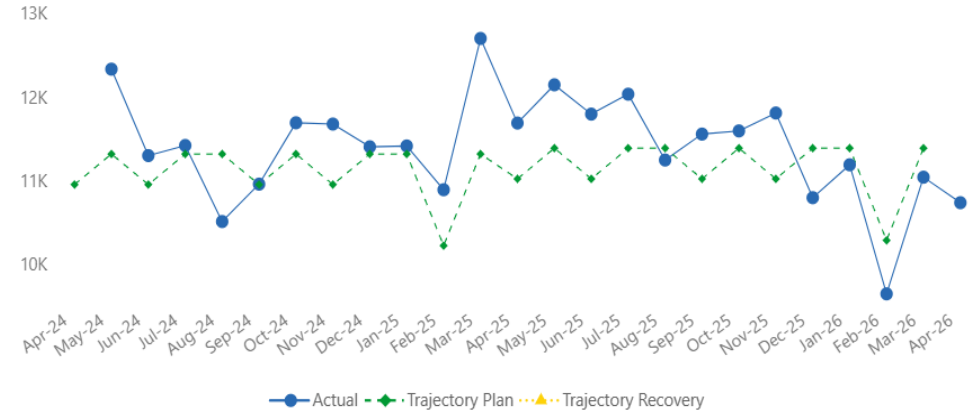
Hull University Teaching Hospitals NHS Trust

A&E - Attendances (Type 3)



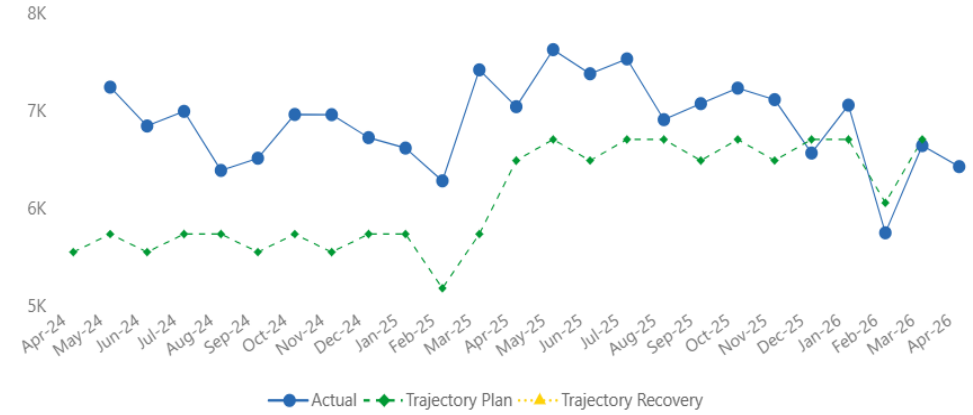
Combined Group Performance

A&E - Attendances (Type 3)



Northern Lincolnshire and Goole NHS Foundation Trust

A&E - Attendances (Type 3)



d. Planned Care

The Planned Care position remains challenging across both Trusts. HUTH reported one 78-week breach (Plastic), while 65-week breaches increased month on month at both organisations, rising by 24 at HUTH and by 9 at NLAG. Similarly, 52-week breaches increased by 76 at HUTH and 104 at NLAG.

- For HUTH Referrals are marginally up by 2.1% on last year, and below the 3% planning assumption.
- 56% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in Ophthalmology, ENT, Gynaecology, Dermatology, Neurology, and Plastic Surgery
- At NLAG. April performance of 61.4% which is a slight reduction on the previous month, although the previous month position had an extended deadline and targeted validation. The performance is above the planning trajectory.

- Risks relating to delivery: -
    - ENT – additional weekend audiology and outpatient capacity is being delivered through DMC. Additional weekend theatre lists in place from December with HEYAS.
    - Plastic Surgery – additional sessional requirement to support delayed DIEPs and hand surgery
    - Breast Surgery – gender surgery – acknowledgement from NHSE and Spec Comm that due to increased referral demand no performance sanctions on long wait breaches

Total waiting list size was broadly static across both Trusts, but overall performance deteriorated compared with the previous month.

Both Trusts remain in Tier 1 for Cancer delivery and continue to work with the North East and Yorkshire Regional Office on recovery assurance. Despite these pressures, 62-day cancer performance improved to 56.0% at HUTH, an increase of 4.4 percentage points, and to 74.2% at NLAG, an increase of 10.9 percentage points.

Delays at the front of the pathway, particularly in outpatient and diagnostic services, continue to drive increases in the number of patients waiting for cancer assessment or treatment, and the over 104-day Urgent Suspected Cancer backlog remains a significant challenge, with 237 patients at HUTH and 40 at NLAG.

Within Diagnostics, April performance deteriorated by 4.6 percentage points at HUTH to 33.4%, although this remained above trajectory, with the largest decreases seen in MRI, Echo, Flexi and Sleep. At NLAG, April performance deteriorated by 3 percentage points and was just below the planning trajectory, with the most significant deterioration seen in Flexi, NOUS and Gastroscopy.

HUTH

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Domain	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Effective	Cancer Care	➤ SCORE: Cancer Care		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
		Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	55.6%	52.9%	50.8%	52.1%	59.8%	70.7%	60.2%	58.7%	52.9%	74.6%	76.6%	
		Cancer - 62 Day All Referral Sources	≥ 66.0%	46.3%	48.6%	54.9%	48.8%	50.2%	55.5%	57.4%	53.7%	52.0%	51.6%	56.0%	
	Elective Care	➤ SCORE: Elective Care		1.80	2.60	2.60	2.60	1.80	2.60	2.60	2.60	2.60	1.80	2.60	1.80
		RTT - Annual Change in Waiting List Size	≤ 10.0%	2.4%	2.6%	2.8%	1.8%	1.3%	1.0%	1.6%	2.1%	1.8%	1.8%	3.2%	7.2%
		RTT - Incomplete 18 Week Standard	≥ 65.0%	57.8%	59.0%	57.9%	56.7%	56.7%	56.5%	56.0%	55.6%	54.9%	54.6%	56.3%	56.3%
		RTT - Percentage of 52+ Week Waits	≤ 1.3%	3.6%	3.4%	3.7%	4.0%	4.0%	4.0%	4.1%	3.8%	3.9%	3.8%	3.5%	3.5%
Responsive	Primary Prevention	➤ SCORE: Primary Prevention		2.00	2.33	2.33	2.00	2.00	2.00	1.67	1.67	2.00	2.00	2.00	2.00
		Diagnostics - 6 Week Standard	≤ 27.0%	21.8%	25.7%	26.2%	32.4%	30.0%	31.3%	34.5%	40.2%	42.8%	35.9%	33.8%	38.1%

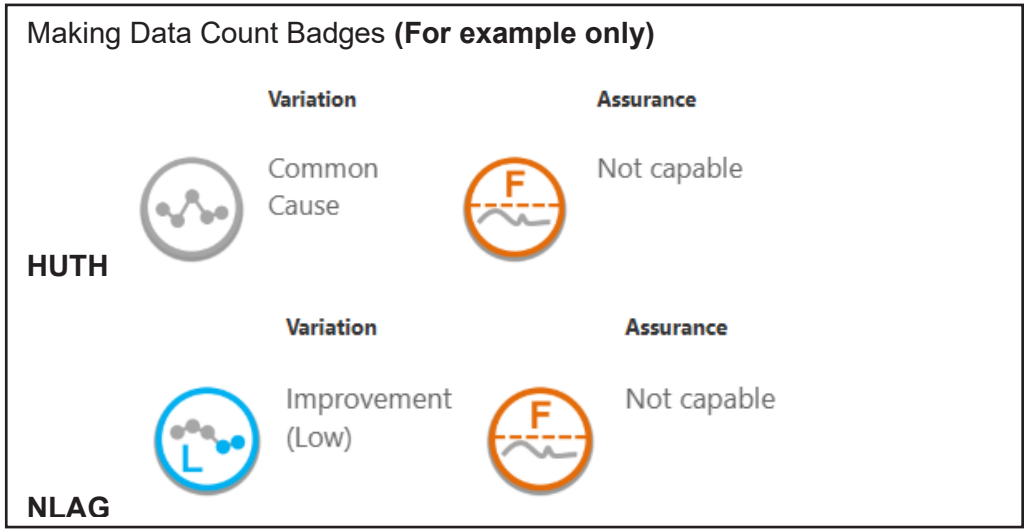
NLAG

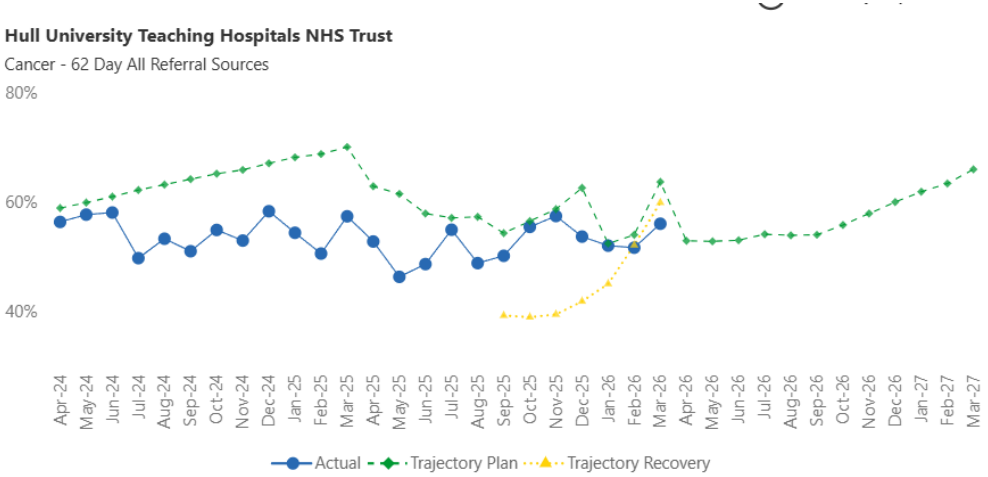
Tier 1 - Foundation Scorecard

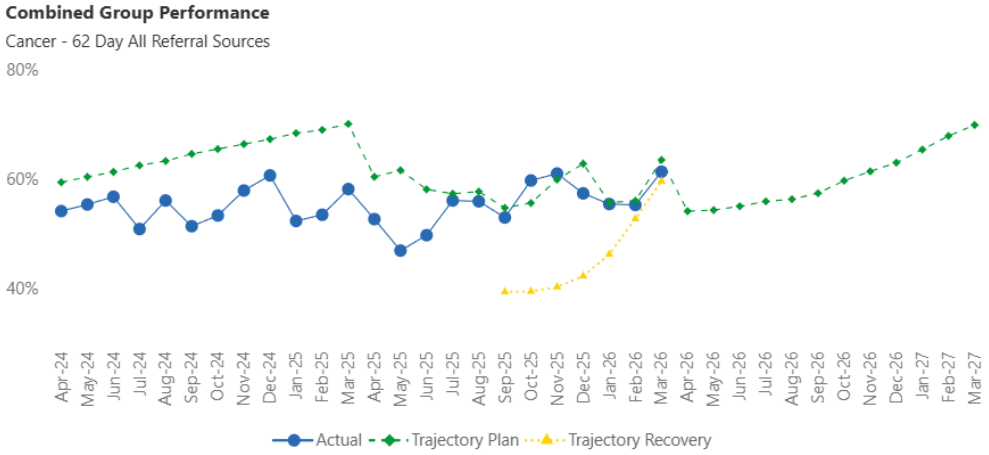
Right click metric to drill through to SPC chart or view metric breakdown

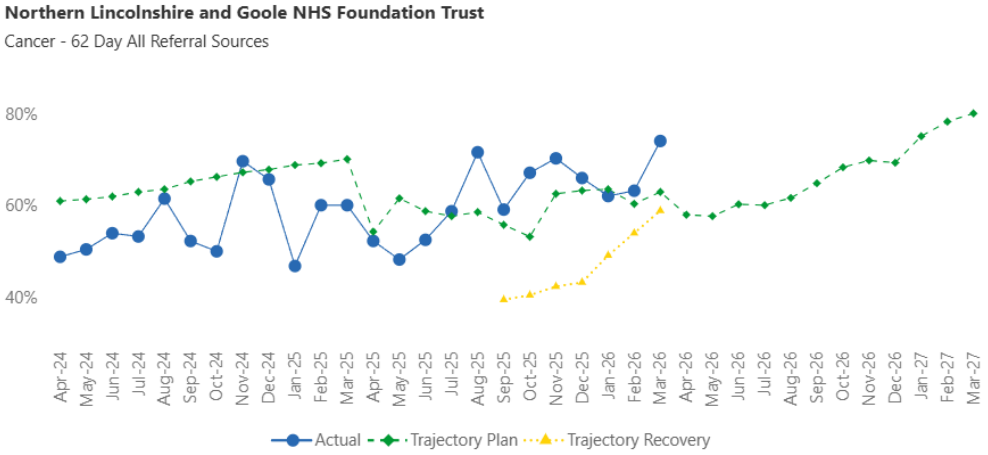
Domain	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Effective	Cancer Care	➤ SCORE: Cancer Care		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
		Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	60.2%	60.7%	65.0%	64.3%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%	
		Cancer - 62 Day All Referral Sources	≥ 66.0%	48.2%	52.5%	58.8%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	
	Elective Care	➤ SCORE: Elective Care		2.60	2.60	1.80	1.80	1.80	1.80	2.60	2.60	1.80	1.80	1.80	2.60
		RTT - Annual Change in Waiting List Size	≤ 10.0%	-12.5%	-15.3%	-15.1%	-8.3%	-6.3%	-10.4%	-9.6%	-8.7%	-6.7%	-8.2%	-6.2%	-1.1%
		RTT - Incomplete 18 Week Standard	≥ 65.0%	60.8%	60.8%	59.9%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	61.4%
		RTT - Patients waiting 52+ weeks for Community Services				13.2%	13.8%	14.1%	14.4%	14.7%	15.0%	16.0%	15.6%	15.3%	15.7%
		RTT - Percentage of 52+ Week Waits	≤ 1.3%	2.4%	2.4%	2.3%	2.6%	2.6%	2.5%	2.5%	2.3%	2.4%	2.2%	2.1%	2.2%
Responsive	Primary Prevention	➤ SCORE: Primary Prevention		2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	1.67
		Diagnostics - 6 Week Standard	≤ 27.0%	35.1%	33.6%	35.1%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	33.0%

i. Cancer 62 Day First Definitive Treatment





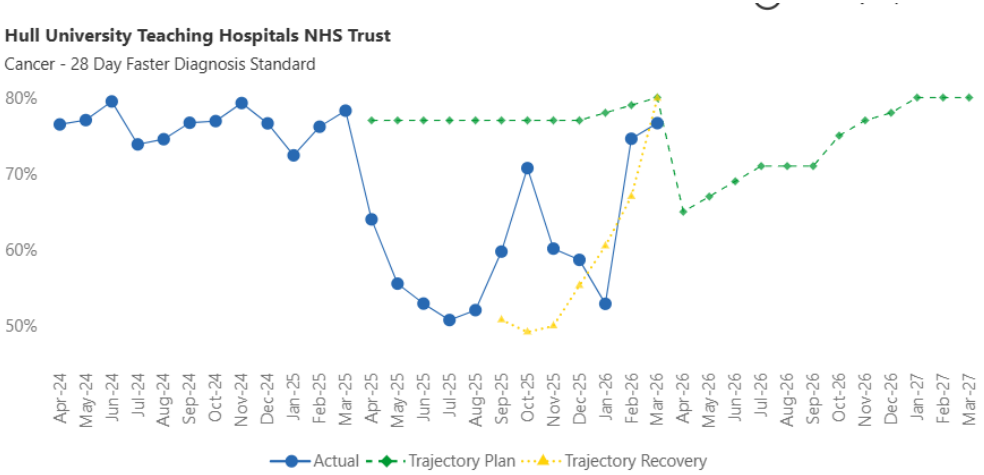


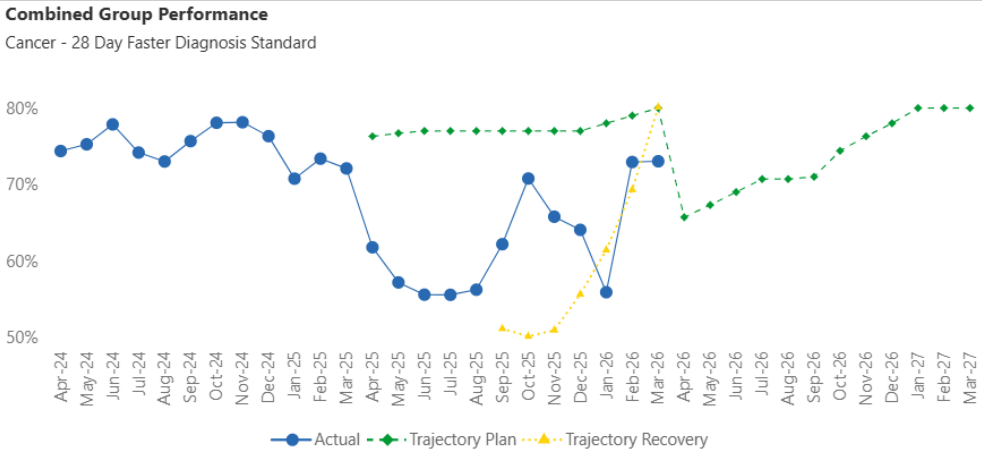


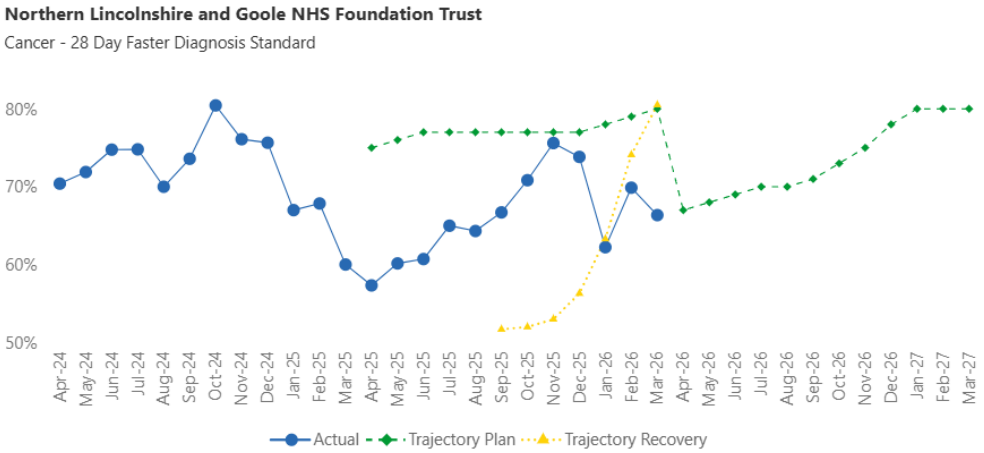
ii. Cancer 28-day Faster Diagnosis Performance

Making Data Count Badges **(For example only)**

	Variation	Assurance
HUTH	Common Cause	Not capable
NLAG	Improvement (Low)	Not capable







iii. Diagnostic 6-Week Standard

Making Data Count Badges **(For example only)**

HUTH

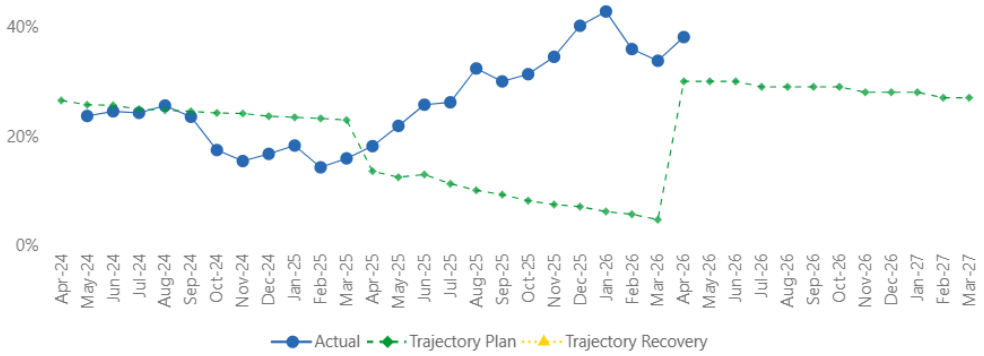
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

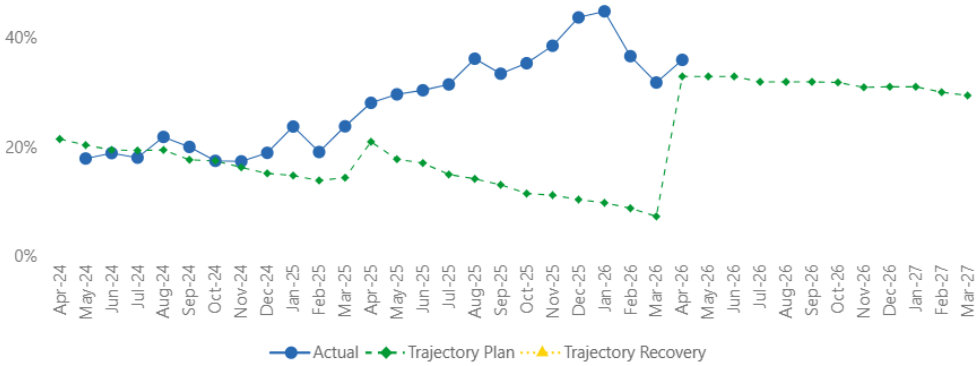
Hull University Teaching Hospitals NHS Trust

Diagnostics - 6 Week Standard



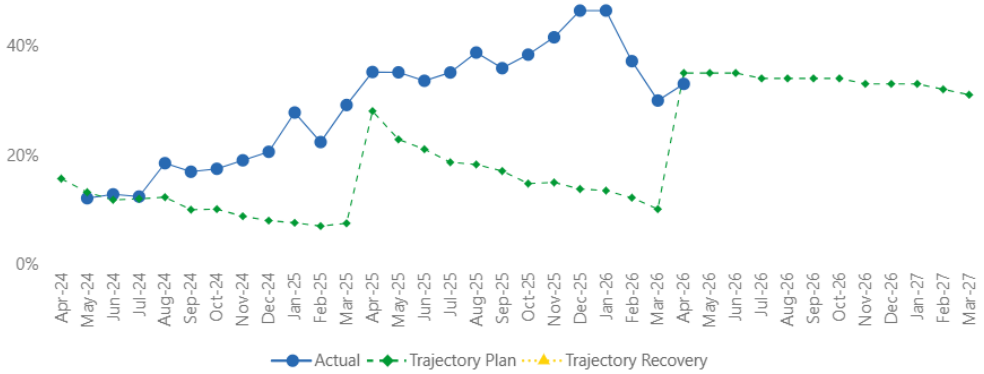
Combined Group Performance

Diagnostics - 6 Week Standard

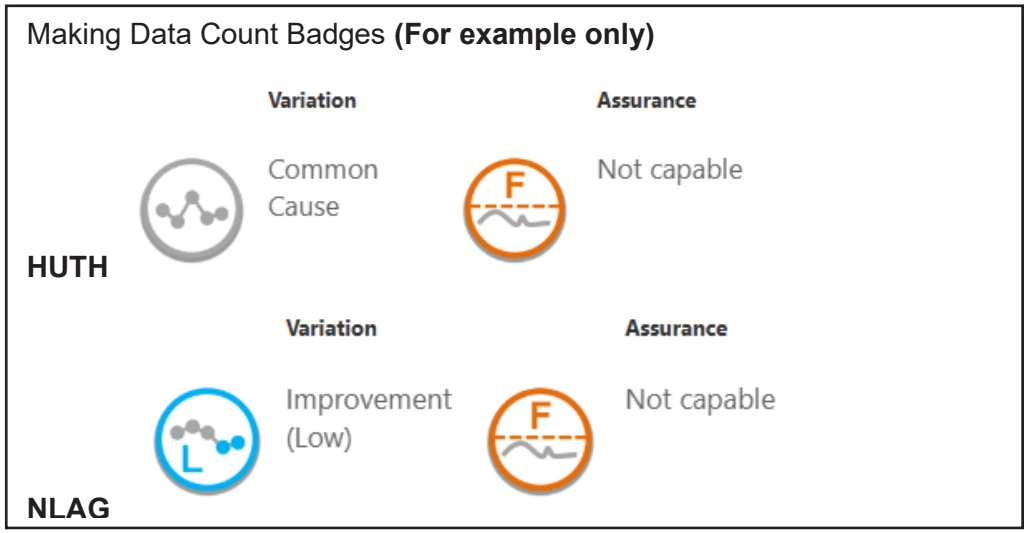


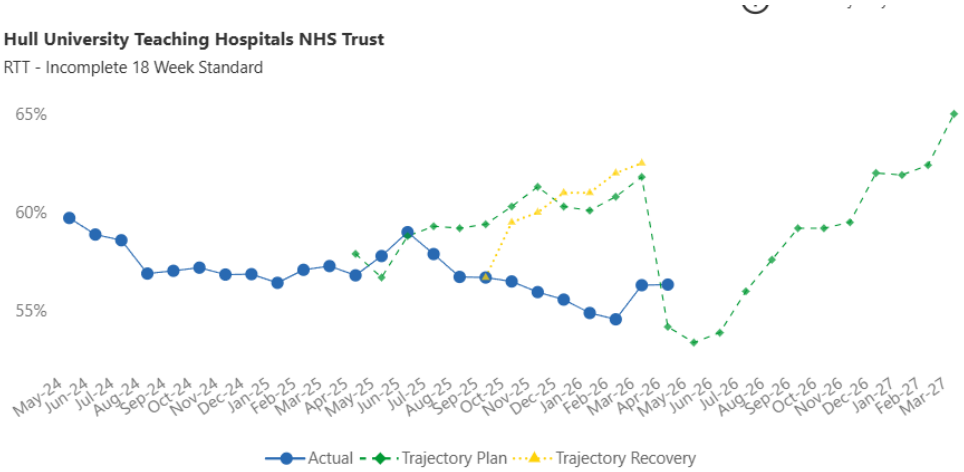
Northern Lincolnshire and Goole NHS Foundation Trust

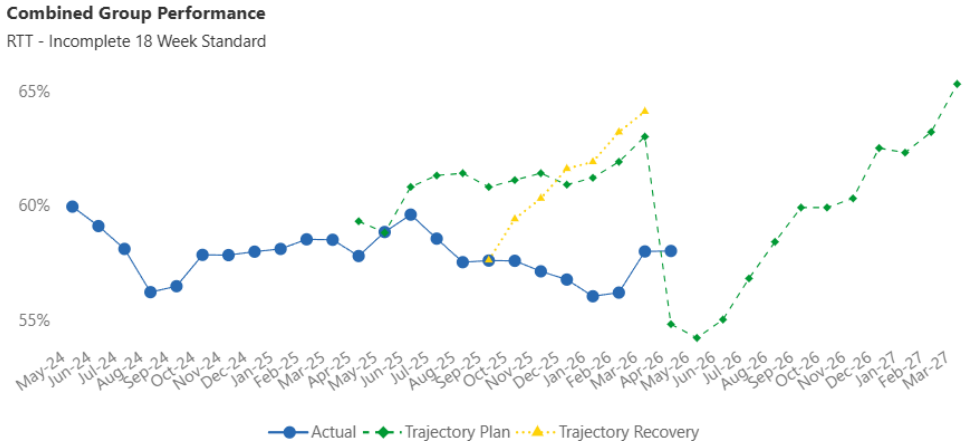
Diagnostics - 6 Week Standard

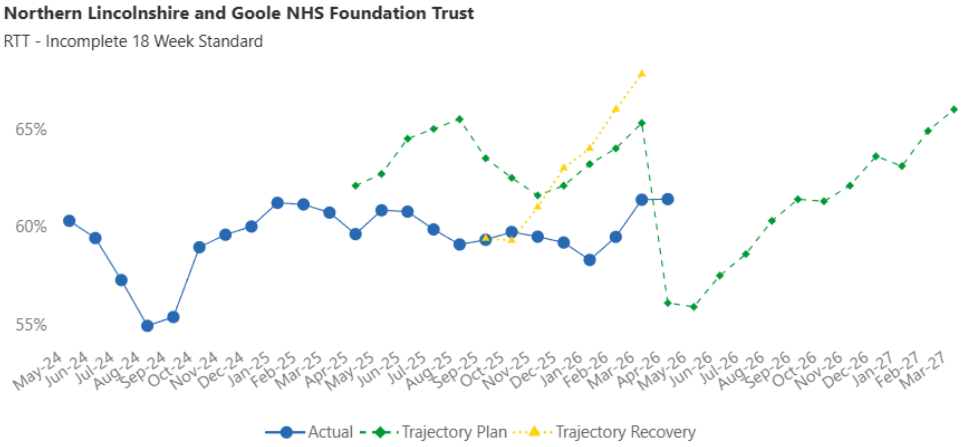


iv. RTT Incomplete Performance









v. RTT 65 week waits

Making Data Count Badges **(For example only)**

HUTH

Variation

Common Cause

Assurance

Not capable

NLAG

Variation

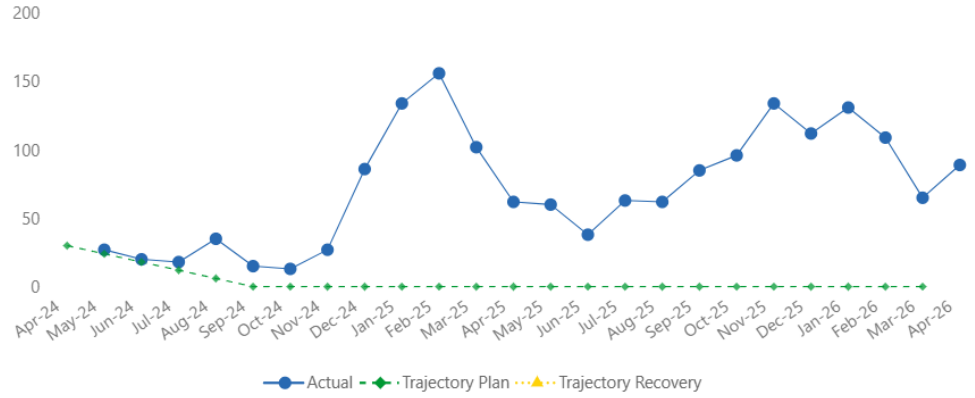
Improvement (Low)

Assurance

Not capable

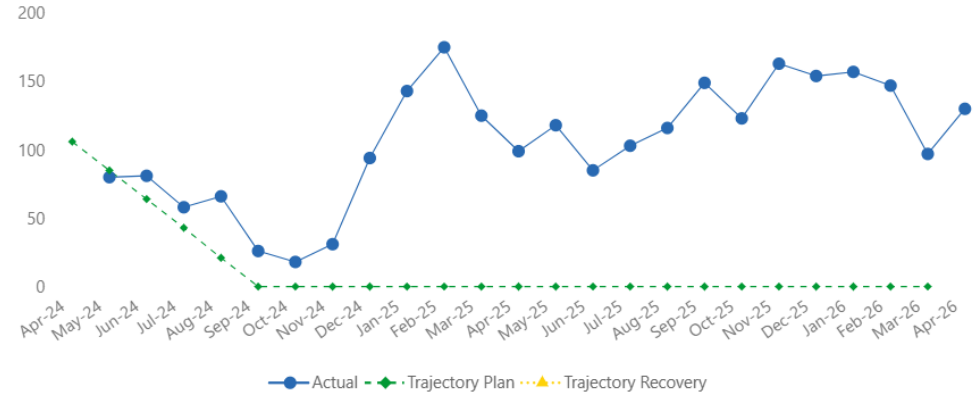
Hull University Teaching Hospitals NHS Trust

RTT - 65+ Week Waits



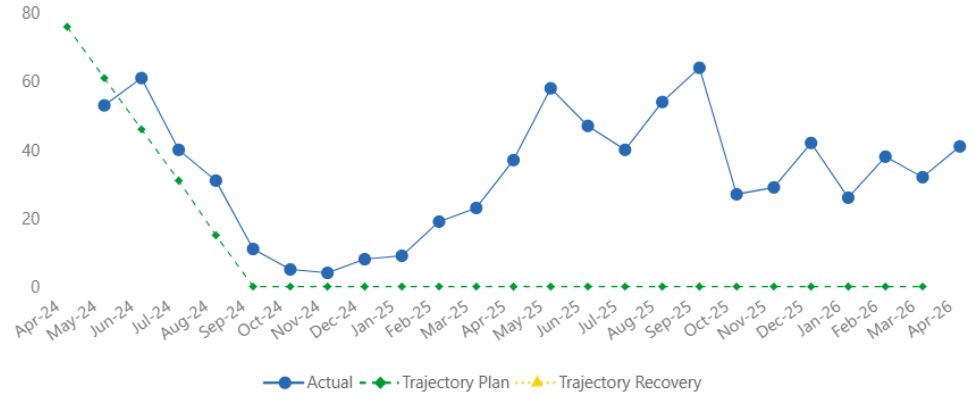
Combined Group Performance

RTT - 65+ Week Waits

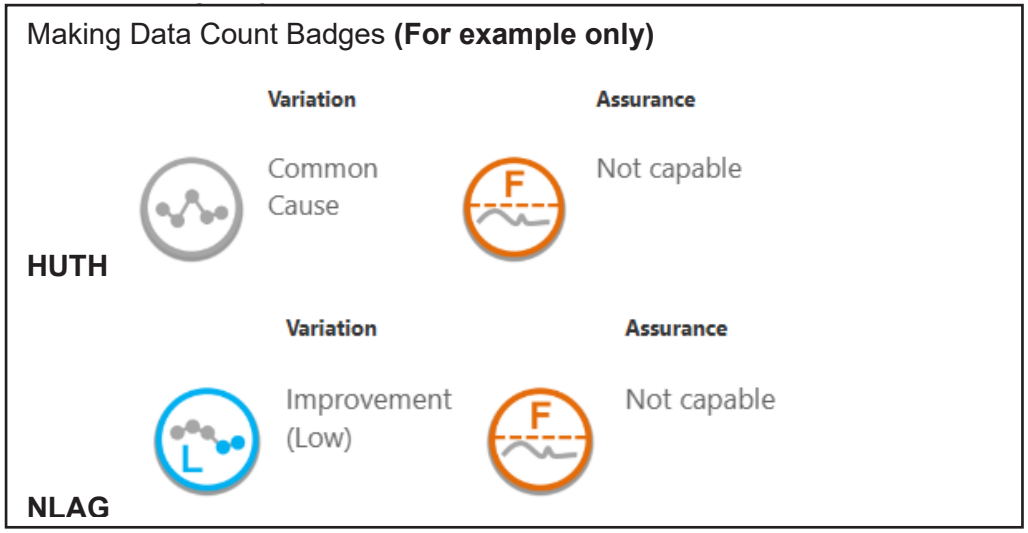


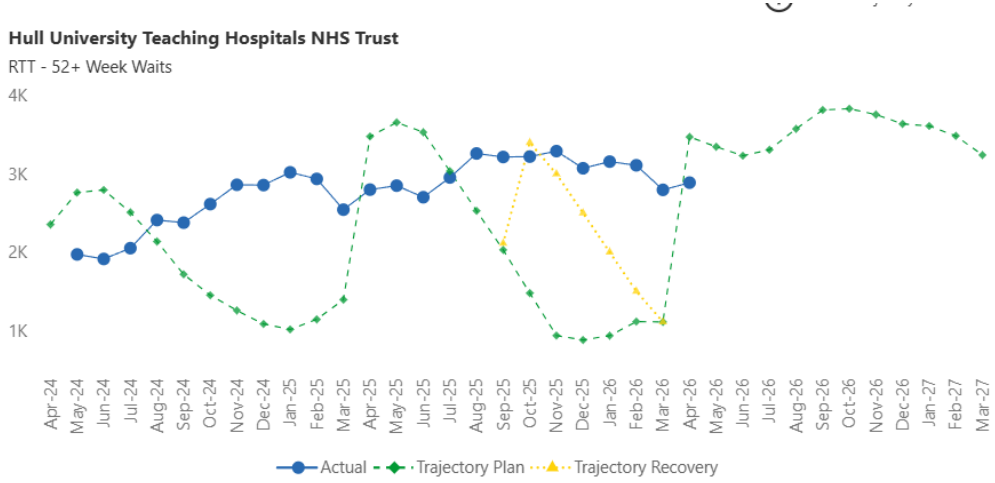
Northern Lincolnshire and Goole NHS Foundation Trust

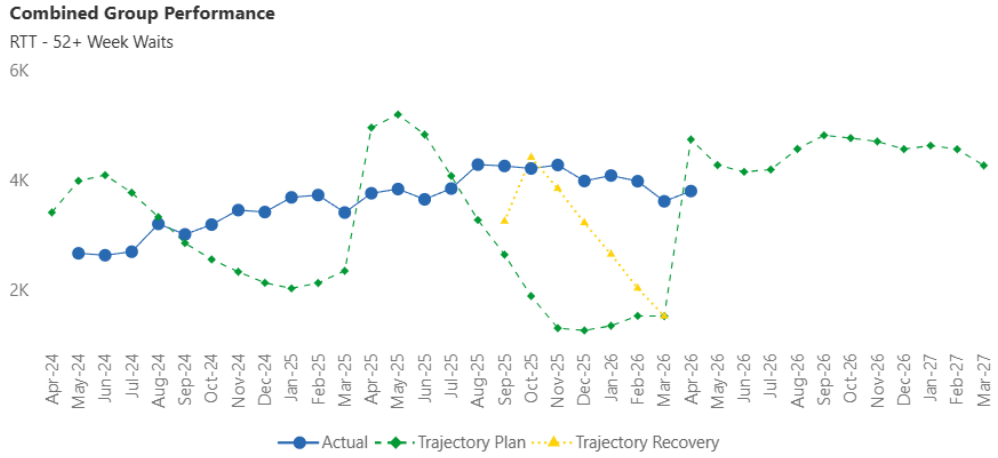
RTT - 65+ Week Waits

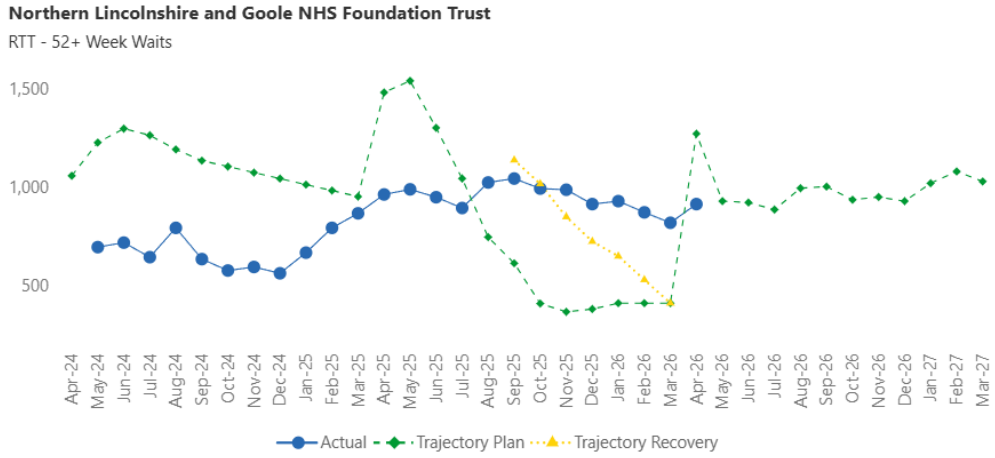


vi. RTT 52 week waits









vii. Time to First Appointment (%)

Making Data Count Badges **(For example only)**

HUTH

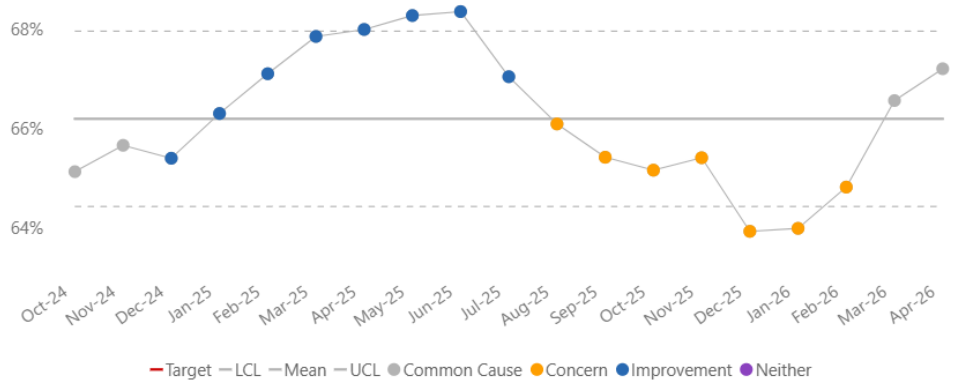
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

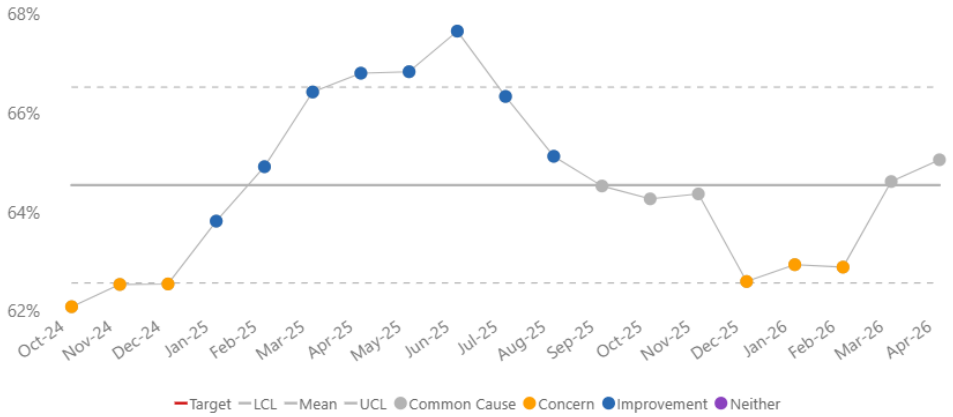
Combined Group Performance

RTT - Patients waiting <= 18 weeks for 1st appointment



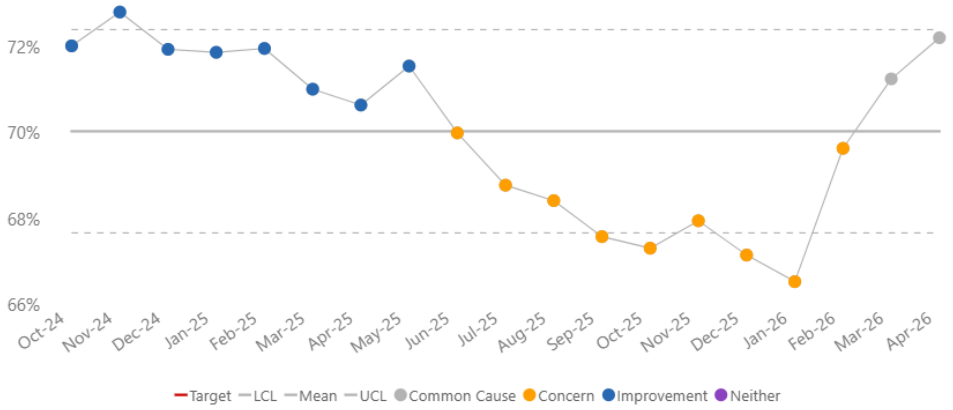
Hull University Teaching Hospitals NHS Trust

RTT - Patients waiting <= 18 weeks for 1st appointment



Northern Lincolnshire & Goole NHS Foundation Trust

RTT - Patients waiting <= 18 weeks for 1st appointment



viii. RTT Data Quality

Making Data Count Badges **(For example only)**

HUTH

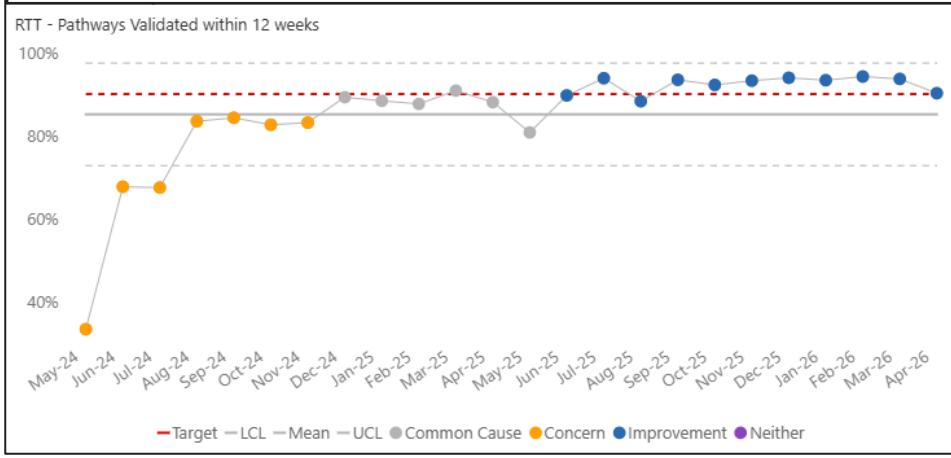
Variation Common Cause

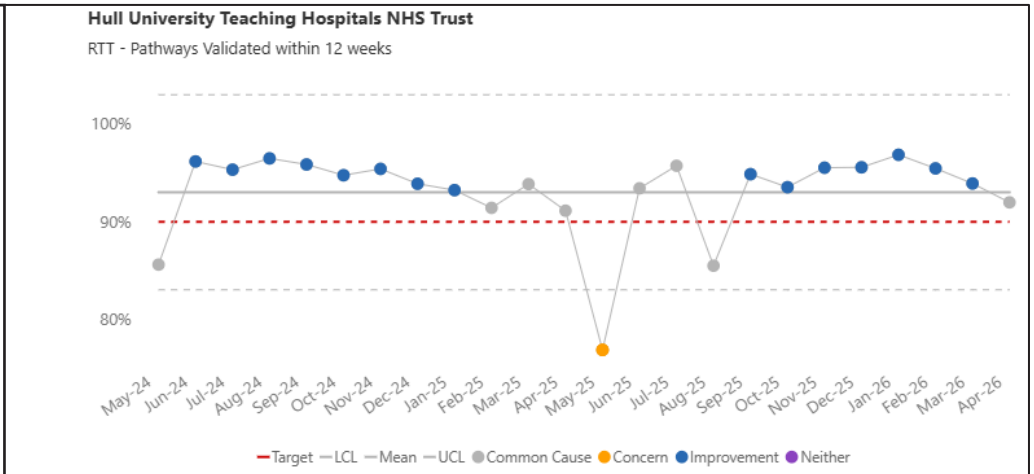
Assurance Not capable

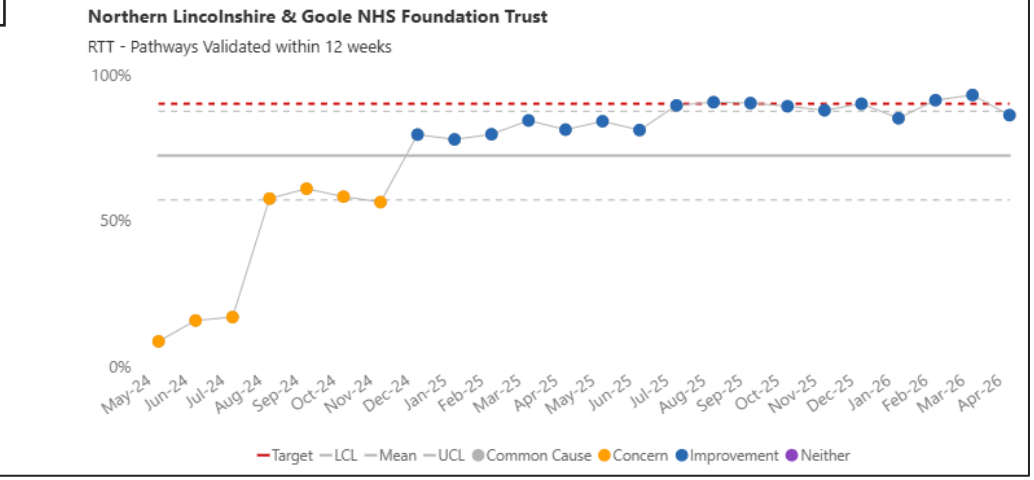
NLAG

Variation Improvement (Low)

Assurance Not capable







ix. Capped Theatre Utilisation

Making Data Count Badges **(For example only)**

HUTH

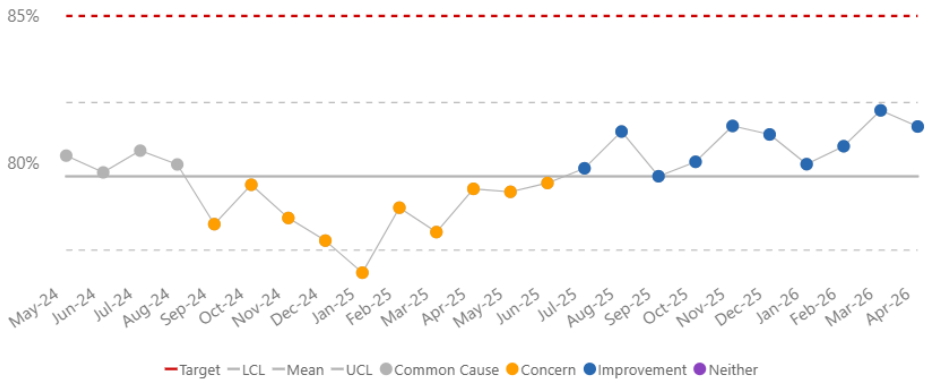
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

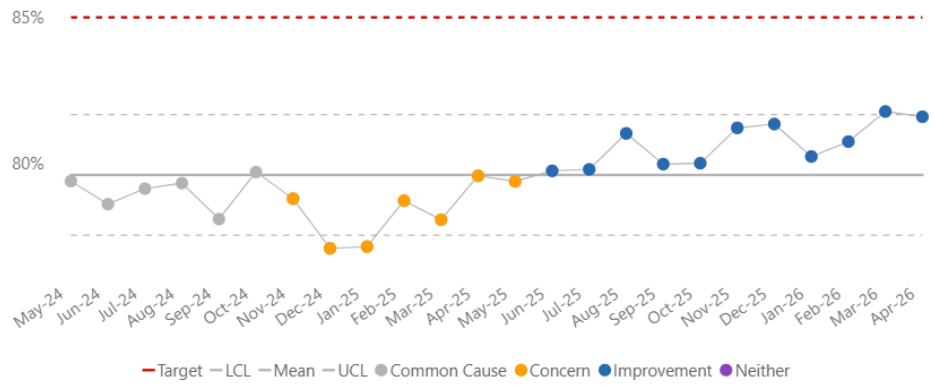
Hull University Teaching Hospitals NHS Trust

Theatres - Capped Theatre Utilisation



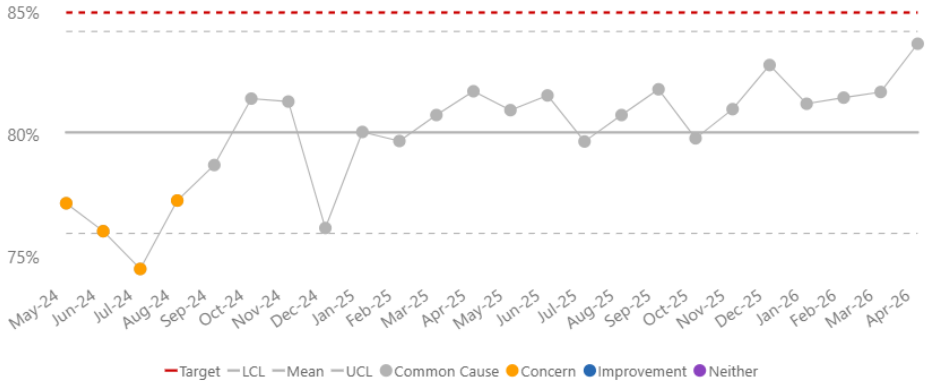
Combined Group Performance

Theatres - Capped Theatre Utilisation



Northern Lincolnshire & Goole NHS Foundation Trust

Theatres - Capped Theatre Utilisation



x. Cancelled Operations

Making Data Count Badges **(For example only)**

HUTH

Variation

Common Cause

Assurance

Not capable

NLAG

Variation

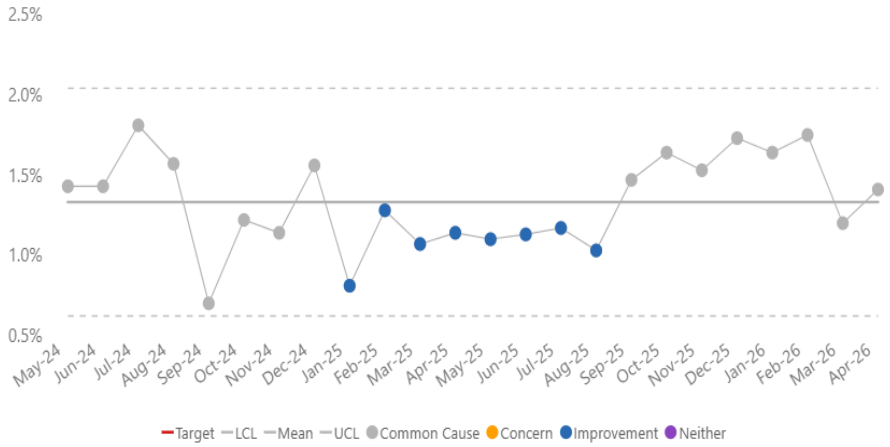
Improvement (Low)

Assurance

Not capable

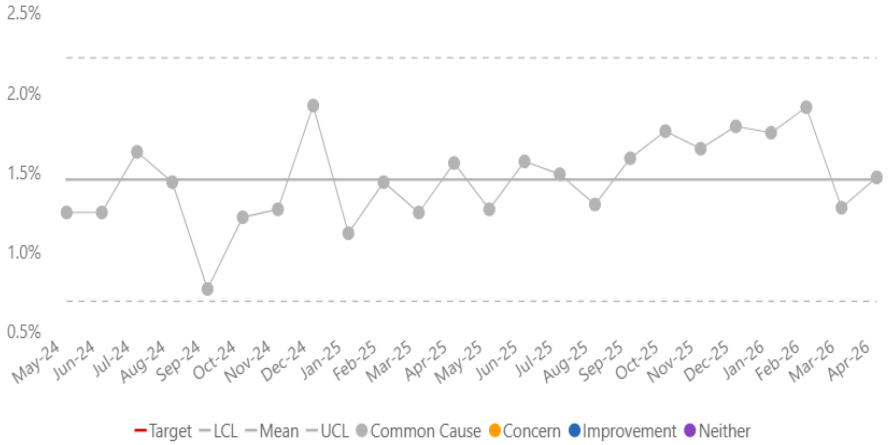
Hull University Teaching Hospitals NHS Trust

Inpatient - Cancelled Operations (%)



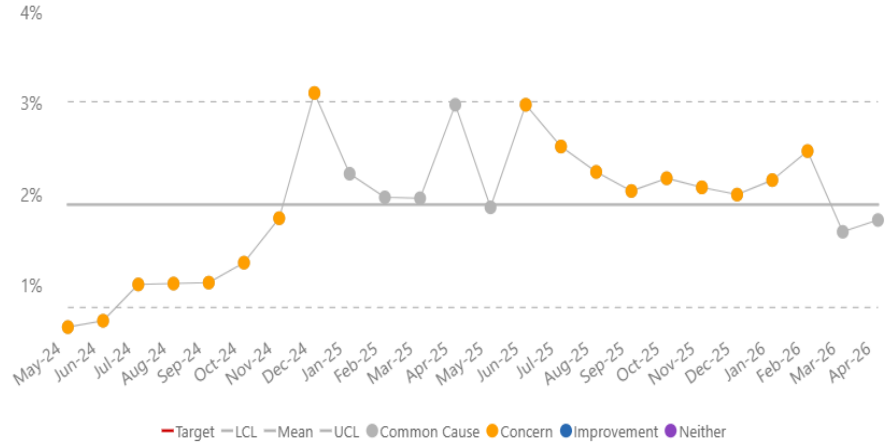
Combined Group Performance

Inpatient - Cancelled Operations (%)



Northern Lincolnshire & Goole NHS Foundation Trust

Inpatient - Cancelled Operations (%)



xi. Cancelled Operations – 28-day Breaches

Making Data Count Badges **(For example only)**

HUTH

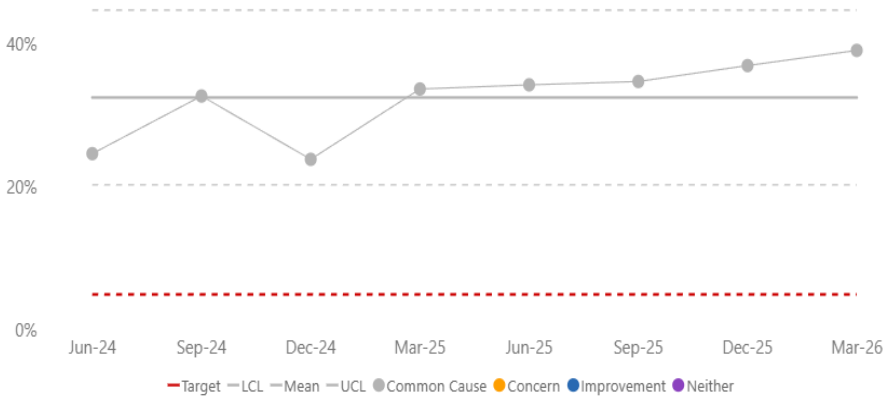
Variation	Assurance
Common Cause	Not capable

NLAG

Variation	Assurance
Improvement (Low)	Not capable

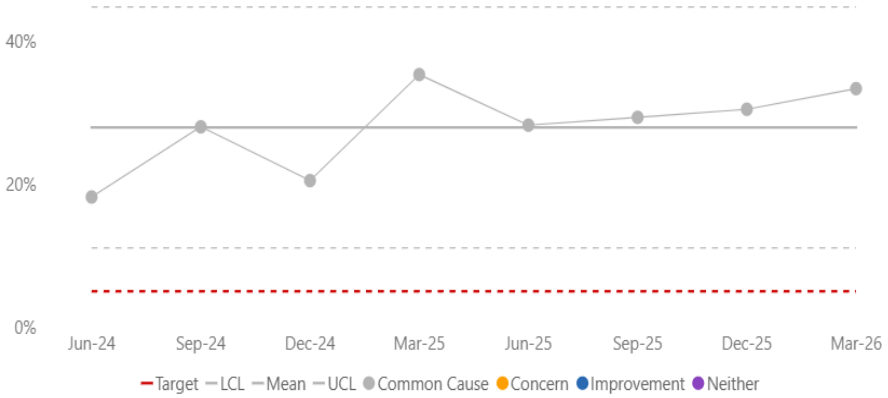
Hull University Teaching Hospitals NHS Trust

Inpatient - Cancelled Operations 28 Day perfomance



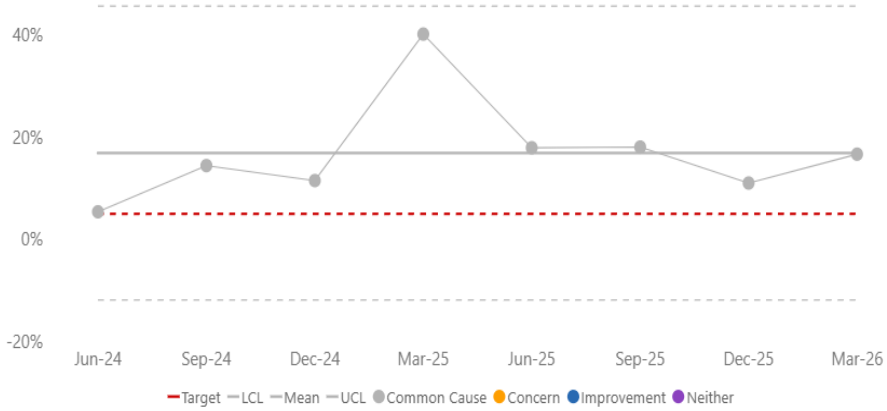
Combined Group Performance

Inpatient - Cancelled Operations 28 Day perfomance



Northern Lincolnshire & Goole NHS Foundation Trust

Inpatient - Cancelled Operations 28 Day perfomance



Appendices

1. Key to Statistical Process Control (SPC) Charts

Variation of the data

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

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

Improving, declining or staying the same:



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

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

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

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

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

Assurance of the target

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

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

Can we reliably hit the target:



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

Passing: Variation indicates consistently passing the target

Failing: Variation indicates consistently failing the target

2. National Oversight Framework Definitions

Establishing Average Scores

Step one: score individual metrics

Metric	Value	Score
% of patients waiting over 52 weeks	0.7%	1.00
% of patients waiting less than 18 weeks	59%	2.62
% of urgent cancer referrals diagnosed in 4 weeks	81.5%	1.00
% of cancer treatments within 62 days	82.6%	1.00
% of patients managed in A&E within four hours	80.4%	1.00
% of patients spending over 12 hours in A&E	3.1%	1.4
Planned surplus or deficit	£0.00	1.00
Latest surplus or deficit	-0.73%	3.00
NHS staff survey engagement score	7.17	1.36
NHS staff survey safety score	6.70	1.45
CQC safety rating	Good	2.00

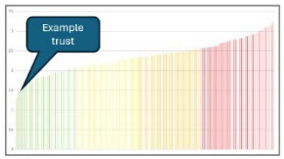
Step two: determine overall score

Sum total of metric scores
16.83

Total number of scores
11

Overall score (Sum total of metric scores / total number of scores)
1.53

Step three: Calculate initial delivery score



All raw domain scores for the organisation type are plotted and evenly quartiles. The example trust's raw score of 1.53 is in the lowest quartile giving a delivery score of 1

After this an adjustment is made for Financial Deficit:

Any provider with a segment of 1 or 2 based on its operational delivery score that is reporting a deficit or is in receipt of deficit support will automatically have its segment downrated to 3. This will be based on organisational not system-wide financial performance.

Then National segmentation is applied as follows:

An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

All providers in the PIP will be placed in segment 5.

3. Trust League Tables

a. HUTH – Filtered to Teaching Hospitals

Quarter	Select trust type(s)	Select trust(s)	Statistics methodology	Return to overview
Q3 2025/26	Acute - Teaching	All		

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Teaching	Hull University Teaching Hospitals NHS Trust (RWA)	3.23	4	Yes	134	104 to 134	130
Acute - Teaching	Nottingham University Hospitals NHS Trust (RX1)	3.21	4	Yes	132	115 to 134	113
Acute - Teaching	York and Scarborough Teaching Hospitals NHS Foundation Trust (RCB)	3.12	4	Yes	131	103 to 134	127
Acute - Teaching	Lancashire Teaching Hospitals NHS Foundation Trust (RXN)	3.06	4	Yes	129	98 to 134	131
Acute - Teaching	James Paget University Hospitals NHS Foundation Trust (RGP)	3.03	4	Yes	127	99 to 133	129
Acute - Teaching	East Kent Hospitals University NHS Foundation Trust (RVV)	3.00	4	Yes	124	80 to 134	96
Acute - Teaching	Wirral University Teaching Hospital NHS Foundation Trust (RBL)	3.00	4	Yes	124	95 to 133	110
Acute - Teaching	University Hospitals Sussex NHS Foundation Trust (RYR)	2.95	4	Yes	121	89 to 132	113
Acute - Teaching	University Hospitals Plymouth NHS Trust (RK9)	2.93	4	Yes	119	86 to 131	106
Acute - Teaching	Northern Care Alliance NHS Foundation Trust (RM3)	2.87	4	Yes	115	81 to 130	112
Acute - Teaching	Liverpool University Hospitals NHS Foundation Trust (REM)	2.85	4	Yes	113	80 to 129	111
Acute - Teaching	Mid Yorkshire Teaching NHS Trust (RXF)	2.82	4	Yes	112	62 to 131	103
Acute - Teaching	Blackpool Teaching Hospitals NHS Foundation Trust (RXL)	2.79	4	Yes	106	66 to 129	115
Acute - Teaching	Warrington and Halton Teaching Hospitals NHS Foundation Trust (RWW)	2.79	4	Yes	106	65 to 130	125
Acute - Teaching	Barking, Havering and Redbridge University Hospitals NHS Trust (RF4)	2.71	4	Yes	99	56 to 128	66
Acute - Teaching	University Hospitals of Leicester NHS Trust (RWE)	2.71	4	Yes	99	56 to 128	94
Acute - Teaching	University Hospitals of Derby and Burton NHS Foundation Trust (RTG)	2.69	3	Yes	97	60 to 122	89

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b. NLAG – Filtered to Medium

Quarter	Select trust type(s)	Select trust(s)	Statistics methodology	Return to overview
Q3 2025/26	Acute - Medium	All		

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Medium	North Cumbria Integrated Care NHS Foundation Trust (RNN)	3.11	4	Yes	130	104 to 134	128
Acute - Medium	Northampton General Hospital NHS Trust (RNS)	3.01	4	Yes	126	91 to 134	119
Acute - Medium	Wrightington, Wigan and Leigh NHS Foundation Trust (RRF)	2.89	4	Yes	117	85 to 130	119
Acute - Medium	Medway NHS Foundation Trust (RPA)	2.88	4	Yes	116	78 to 131	133
Acute - Medium	Northern Lincolnshire and Goole NHS Foundation Trust (RJL)	2.86	4	Yes	114	76 to 131	115
Acute - Medium	Royal United Hospitals Bath NHS Foundation Trust (RD1)	2.73	4	Yes	102	75 to 122	105
Acute - Medium	Croydon Health Services NHS Trust (RJ6)	2.69	3	Yes	97	61 to 124	115
Acute - Medium	Great Western Hospitals NHS Foundation Trust (RN3)	2.50	3	Yes	85	47 to 112	82
Acute - Medium	The Shrewsbury and Telford Hospital NHS Trust (RXW)	2.47	3	Yes	78	38 to 119	96
Acute - Medium	Bolton NHS Foundation Trust (RMC)	2.45	3	Yes	76	40 to 110	55
Acute - Medium	The Dudley Group NHS Foundation Trust (RNA)	2.39	3	Yes	68	39 to 103	39
Acute - Medium	Gateshead Health NHS Foundation Trust (RR7)	2.36	3	Yes	65	37 to 103	62
Acute - Medium	Surrey and Sussex Healthcare NHS Trust (RTP)	2.35	3	Yes	63	34 to 108	59
Acute - Medium	Sherwood Forest Hospitals NHS Foundation Trust (RK5)	2.31	3	Yes	60	34 to 103	56
Acute - Medium	Ashford and St Peter's Hospitals NHS Foundation Trust (RTK)	2.28	3	Yes	54	35 to 92	62
Acute - Medium	Bedfordshire Hospitals NHS Foundation Trust (RC9)	2.27	3	Yes	52	35 to 90	66
Acute - Medium	Stockport NHS Foundation Trust (RWJ)	2.20	3	Yes	45	33 to 86	62

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4. HHP Foundation Scorecards

Embedded in the HHP NOF Scorecard are 4 Foundation Scorecards:

- Quality (CQC: Caring, Safe, Effective),
- Performance (CQC: Responsive)
- Finance (CQC: Effective, Well-led)
- Workforce (CQC: Effective, Well-led)

Each Foundation Scorecard will contain every relevant metric signed off by lead Exec.

Subject to available thresholds each metric will be RAG rated. All RAG rated metrics will be used to derive sub-domain and domain assessment scores

Each metric will also be identified as a defined or enabling NHSE NOF Indicator along with the defined Subject Area (Elective Care, Cancer, UEC, Financial Balance, Productivity).

Each metric will be allocated a unique identifier allowing any combination of summary scorecards to be generated

Every Metric has clear definitions and SPC graphs to support further understanding and act as presentational templates for Care Group performance updates

a. Performance

Domain	Subject Area	Metric	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Effective	Cancer Care	➤ SCORE: Cancer Care		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
		Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	57.2%	55.6%	55.5%	56.2%	62.2%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	
		Cancer - 62 Day All Referral Sources	≥ 66.0%	46.9%	49.7%	56.1%	55.9%	52.9%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	
	Effectiveness	Inpatient - Annual Growth Under 18s Elective Activity		13.8%	12.4%	9.7%	5.1%	1.8%	1.5%	-1.9%	-1.6%	-3.7%	-6.0%	-6.4%	-6.5%
		Inpatient - Average Length Of Stay (Elective)		0.4	0.5	0.5	0.5	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.5
		Inpatient - Average Length Of Stay (Non-Elective)	≤ 8.0	3.2	3.0	2.9	3.1	3.1	3.1	2.9	3.3	3.0	3.1	3.1	3.3
		Inpatient - Bed Occupancy (General & Acute)	93.4%	91.2%	91.1%	90.4%	89.9%	87.7%	89.1%	88.6%	89.3%	91.0%	91.3%	91.0%	91.9%
		Inpatient - Bed occupancy classed as clinically ready for discharge					23.0%	23.9%	24.4%	25.3%	26.9%	25.1%	25.8%	25.9%	24.2%
		Inpatient - Day Case Rate	≥ 85.0%	90.6%	90.8%	90.8%	90.2%	91.1%	90.2%	89.6%	89.2%	90.1%	90.3%	89.8%	90.0%
		Inpatient - Days between DRD and Discharge Date	≤ 4.4	4.4	4.4	4.4	4.6	4.5	4.1	4.5	4.6	4.3	5.5	5.1	5.2
		Inpatient - Emergency Readmissions within 30 days		10.3%	10.8%	10.8%	10.9%	10.9%	10.9%	10.5%	10.9%	10.6%	10.9%	10.7%	
	Elective Care	➤ SCORE: Elective Care		1.80	2.60	1.80	1.80	1.80	1.80	2.60	2.60	1.80	1.80	1.80	1.80
		RTT - Annual Change in Waiting List Size	≤ 10.0%	-3.3%	-4.1%	-3.9%	-1.8%	-1.4%	-3.1%	-2.3%	-1.7%	-1.2%	-1.7%	-0.1%	4.3%
		RTT - Difference between actual and planned 18 week performance		0.0%	-1.2%	-2.8%	-3.9%	-1.6%	-2.7%	-3.8%	-4.5%	-5.5%	-6.3%	-5.5%	3.2%
		RTT - Incomplete 18 Week Standard	≥ 65.0%	58.8%	59.6%	58.5%	57.5%	57.6%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%
		RTT - Patients waiting 52+ weeks for Community Services				13.2%	13.8%	14.1%	14.4%	14.7%	15.0%	16.0%	15.6%	15.3%	15.7%
		RTT - Percentage of 52+ Week Waits	≤ 1.3%	3.2%	3.1%	3.2%	3.6%	3.5%	3.5%	3.6%	3.3%	3.4%	3.3%	3.0%	3.1%
	Productivity	➤ SCORE: Productivity		2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
		Theatres - Capped Theatre Utilisation	≥ 85.0%	79.4%	79.8%	79.8%	81.0%	80.0%	80.0%	81.2%	81.4%	80.2%	80.8%	81.8%	81.6%
	Urgent & Emergency Care	➤ SCORE: Urgent & Emergency Care		1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29
		A&E - 4 Hour Standard (All)	≥ 78.4%	64.0%	64.4%	67.1%	68.5%	65.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.1%	67.8%
		A&E - 4 Hour Standard (Type 1)	≥ 57.9%	44.9%	45.3%	49.1%	50.8%	45.4%	44.4%	43.1%	44.8%	42.2%	50.6%	52.8%	52.6%
		A&E - Ambulance Average Handover Time	≤ 20.0	32.3	30.2	26.4	25.9	26.1	24.9	30.5	37.4	43.8	32.7	25.6	27.3
		A&E - Ambulance Handovers within 45 minutes	≥ 97.0%	86.0%	88.3%	90.1%	90.4%	89.8%	90.8%	85.2%	80.9%	75.9%	82.2%	90.7%	87.6%
		A&E - Conversion Rate (over 65s)		47.4%	49.0%	48.5%	47.3%	47.1%	47.6%	49.6%	50.6%	49.0%	50.6%	52.5%	52.2%
		A&E - Conversion Rate (under 18s)		15.2%	16.5%	14.5%	15.6%	17.2%	16.3%	17.9%	18.0%	17.8%	16.5%	17.9%	16.7%
		A&E - Patients Waiting > 12 hours in Department	≤ 15.0%	15.5%	14.4%	13.0%	12.1%	15.3%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 27.0%	29.6%	30.4%	31.4%	36.2%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%

b. Quality – Work In Progress

c. Workforce – Work in Progress

d. Finance & Productivity – Work in Progress

4. National Benchmarking – To be included based upon deep dive reviews.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda Item No: 4.1

Name of the Meeting	**Quality and Safety Committees-in-Common**
Date of the Meeting	28 May 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer Jo Ledger, Interim Group Chief Nurse Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance Michela Littlewood, Associate Director of Quality Governance
Title of the Report	**Integrated Performance Report - Quality**
Executive Summary	There is a workstream undertaking a revision of the Integrated Performance Report, which will align to the National Outcome Framework (NOF) and CQC Regulatory Framework, with a focus on the quality components of Safety, Effective and Caring, with operational performance aligned to Responsive and other people related elements under Well Led. While this is in development, this report provides some refreshed narrative structure to support the latest available data. Highlights are provided in more detail for both Trusts within the body of the attached report. • Mortality metrics for HSMR and SHMI is improved or sustained for both Trusts, except for the diagnosis group of septicaemia which is higher than expected. • Duty of Candour compliance across the Group has improved and the timeliness of provision has also improved. • There have been no more Never Events to for April 2026, with a reduction in the rolling 12-month rate. • Safety Alert status, with plans for resolution outlined. ○ HUTH Bedrails alert remains open and actions to remedy inventory and maintenance oversight are being progressed, with reports progressed to capture the inventory and plan for outsourced management. • IPC alert organism trajectory challenges which impact on the NOF Safe domain, 12-month rates, impacting C.Difficile, E. coli and MRSA blood stream infections. • Complaint response times are below the timescale response target. • Introduction of the Care Hours per Patient Day data is in development with Publicview data provided in this report. Further details are summarized in the highlights and lowlights summary and within the charts and narrative provided. The committee is asked to note the contents.
Background Information and/or Supporting Document(s) (if applicable)	This report has been reported to the Patient Safety Learning Group.
Prior Approval Process	None
Financial implication(s) (if applicable)	None

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval by CiC ☐ Endorse for approval by Trust Board(s) ☐ Other – please detail below: ☐ Assurance ✓ Information

NHS
Humber Health
Partnership

Quality Integrated Performance Report (IPR) and Performance Metrics

April 2026

United By Compassion: Driving For Excellence

Quality IPR dashboard (Safe)

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Falls - Moderate and above (per 1,000 bed days)	Apr-26		0.03		
Falls - per 1,000 bed days	Apr-26		6.27		
Falls - Serious harm or death	Apr-26		1		
Falls - Serious harm or death (per 1,000 bed days)	Apr-26		0.03		
Falls - Total incidents	Apr-26		222		
Medication Incidents	Apr-26		100		
Medication Incidents - Moderate harm	Apr-26		2		
Medication Incidents - per 1,000 bed days	Apr-26		2.82		
Medication Incidents - Serious harm	Apr-26		0		
Mixed Sex Accommodation Breaches	Mar-26		0		
Patient Incidents	Apr-26		2,167		
Patient Safety Incidents - % Harmful	Apr-26		1.5%		
Patient Safety Incidents - Fatal	Apr-26		2		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Sep-25		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Sep-25		3		
Patient Safety Incidents - Low harm	Apr-26		475		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Apr-26		0.93		
Patient Safety Incidents - Moderate harm	Apr-26		29		
Patient Safety Incidents - No harm	Apr-26		1,659		
Patient Safety Incidents - Severe harm	Apr-26		2		
Pressure Ulcers - Category 1	Apr-26		12		
Pressure Ulcers - Category 2	Apr-26		69		
Pressure Ulcers - Category 3	Apr-26		0		
Pressure Ulcers - Category 4	Apr-26		0		
Pressure Ulcers - Device related	Apr-26		20		
Pressure Ulcers - Hospital acquired	Apr-26		146		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Apr-26		4.12		
Pressure Ulcers - Hospital acquired moderate and above (p...	Apr-26		0.23		
Pressure Ulcers - Suspected deep tissue injury	Apr-26		32		
Pressure Ulcers - Total community acquired	Apr-26		0		
Pressure Ulcers - Unstageable	Apr-26		8		
VTE Risk Assessment	Apr-26	≥ 95.0%	91.9%		
VTE Risk Assessment 14 Hour Standard	Mar-26	≥ 95.0%	91.1%		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Falls - Moderate and above (per 1,000 bed days)	Apr-26		0.30		
Falls - per 1,000 bed days	Apr-26		6.26		
Falls - Serious harm or death	Apr-26		0		
Falls - Serious harm or death (per 1,000 bed days)	Apr-26		0.00		
Falls - Total incidents	Apr-26		125		
Medication Incidents	Apr-26		65		
Medication Incidents - Moderate harm	Apr-26		2		
Medication Incidents - per 1,000 bed days	Apr-26		3.25		
Medication Incidents - Serious harm	Apr-26		0		
Mixed Sex Accommodation Breaches	Mar-26		7		
Patient Incidents	Apr-26		1,629		
Patient Safety Incidents - % Harmful	Apr-26		2.8%		
Patient Safety Incidents - Fatal	Apr-26		0		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Apr-26		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Apr-26		0		
Patient Safety Incidents - Low harm	Apr-26		375		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Apr-26		2.30		
Patient Safety Incidents - Moderate harm	Apr-26		46		
Patient Safety Incidents - No harm	Apr-26		1,208		
Patient Safety Incidents - Severe harm	Apr-26		0		
Pressure Ulcers - Category 1	Apr-26		11		
Pressure Ulcers - Category 2	Apr-26		92		
Pressure Ulcers - Category 3	Apr-26		5		
Pressure Ulcers - Category 4	Apr-26		0		
Pressure Ulcers - Device related	Apr-26		12		
Pressure Ulcers - Hospital acquired	Apr-26		210		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Apr-26		10.51		
Pressure Ulcers - Hospital acquired moderate and above (p...	Apr-26		1.20		
Pressure Ulcers - Suspected deep tissue injury	Apr-26		35		
Pressure Ulcers - Total community acquired	Apr-26		0		
Pressure Ulcers - Unstageable	Apr-26		23		
VTE Risk Assessment	Apr-26	≥ 95.0%	96.9%		
VTE Risk Assessment 14 Hour Standard	Mar-26	≥ 95.0%	93.3%		

Quality IPR dashboard (Mortality)

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Apr-26		2.6%		
Mortality - HSMR	Jan-26	≤ 100.0	99.4		
Mortality - SHMI	Nov-25	≤ 1.0	1.023		
Mortality - Still Births (per 1,000 births)	Apr-26		10.526		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Apr-26		1.9%		
Mortality - HSMR	Jan-26	≤ 100.0	85.2		
Mortality - SHMI	Nov-25	≤ 1.0	1.001		
Mortality - Still Births (per 1,000 births)	Apr-26		3.425		

Quality IPR dashboard (Patient Experience)

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Apr-26	≥ 85.0%	38.7%		
Complaints - 60 day compliance	Apr-26	≥ 85.0%	64.5%		
Complaints - Average response time	Apr-26	≤ 40.0	47.5		
Complaints - Received	Apr-26		18		
Complaints - Received (per 1,000 bed days)	Apr-26		0.51		
Complaints - Reopened	Apr-26		0		
Friends & Family - A&E Score	Mar-26	≥ 85.0%	90.0%		
Friends & Family - Antenatal Score	Mar-26	≥ 95.0%	50.0%		
Friends & Family - Birth Score	Mar-26	≥ 95.0%	100.0%		
Friends & Family - Inpatient Score	Mar-26	≥ 95.0%	96.1%		
Friends & Family - Outpatient Score	Mar-26	≥ 95.0%	96.1%		
Friends & Family - Postnatal Score	Mar-26	≥ 95.0%	85.7%		
PALS - Complaints	Apr-26	≤ 1	64		
PALS - Complaints compliance within 5 working days	Apr-26		46.6%		
PALS - Compliments	Sep-25		0		
PHSO Referrals	Sep-25		0		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Apr-26	≥ 85.0%	39.3%		
Complaints - 60 day compliance	Apr-26	≥ 85.0%	78.6%		
Complaints - Average response time	Apr-26	≤ 40.0	45.8		
Complaints - Received	Apr-26		46		
Complaints - Received (per 1,000 bed days)	Apr-26		2.30		
Complaints - Reopened	Apr-26		3		
Friends & Family - A&E Score	Mar-26	≥ 85.0%	76.4%		
Friends & Family - Antenatal Score	Mar-26	≥ 95.0%	87.0%		
Friends & Family - Birth Score	Mar-26	≥ 95.0%	75.0%		
Friends & Family - Community Score	Mar-26	≥ 95.0%	99.1%		
Friends & Family - Inpatient Score	Mar-26	≥ 95.0%	98.7%		
Friends & Family - Outpatient Score	Mar-26	≥ 95.0%	95.5%		
Friends & Family - Postnatal Community Score	Mar-26	≥ 95.0%	100.0%		
Friends & Family - Postnatal Score	Mar-26	≥ 95.0%	100.0%		
PALS - Complaints	Apr-26	≤ 1	253		
PALS - Complaints compliance within 5 working days	Apr-26		66.9%		

Quality IPR dashboard (Infection Prevention)

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
CQC Inpatient Survey Satisfaction Mean Score	Apr-26		8.2		
CQC Safe Inspection Score	Apr-26		1.0		
Infections - C.Difficile	Mar-26		11		
Infections - C.Difficile (Cumulative)	Mar-26		108		
Infections - C.Difficile (per 1,000 bed days)	Mar-26		0.29		
Infections - E.Coli	Mar-26		14		
Infections - E.Coli (Cumulative)	Mar-26		214		
Infections - E.Coli (per 1,000 bed days)	Mar-26		0.37		
Infections - Klebsiella	Mar-26		10		
Infections - Klebsiella (Cumulative)	Mar-26		77		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Mar-26		0.27		
Infections - MRSA	Mar-26		1		
Infections - MRSA (Cumulative)	Mar-26		5		
Infections - MRSA (per 1,000 bed days)	Mar-26		0.03		
Infections - MSSA	Mar-26		8		
Infections - MSSA (Cumulative)	Mar-26		93		
Infections - MSSA (per 1,000 bed days)	Mar-26		0.21		
Infections - Pseudomonas aeruginosa	Mar-26		2		
Infections - Pseudomonas aeruginosa (Cumulative)	Mar-26		29		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Mar-26		0.05		

Northern Lincolnshire and Goole NHS Foundation Trust

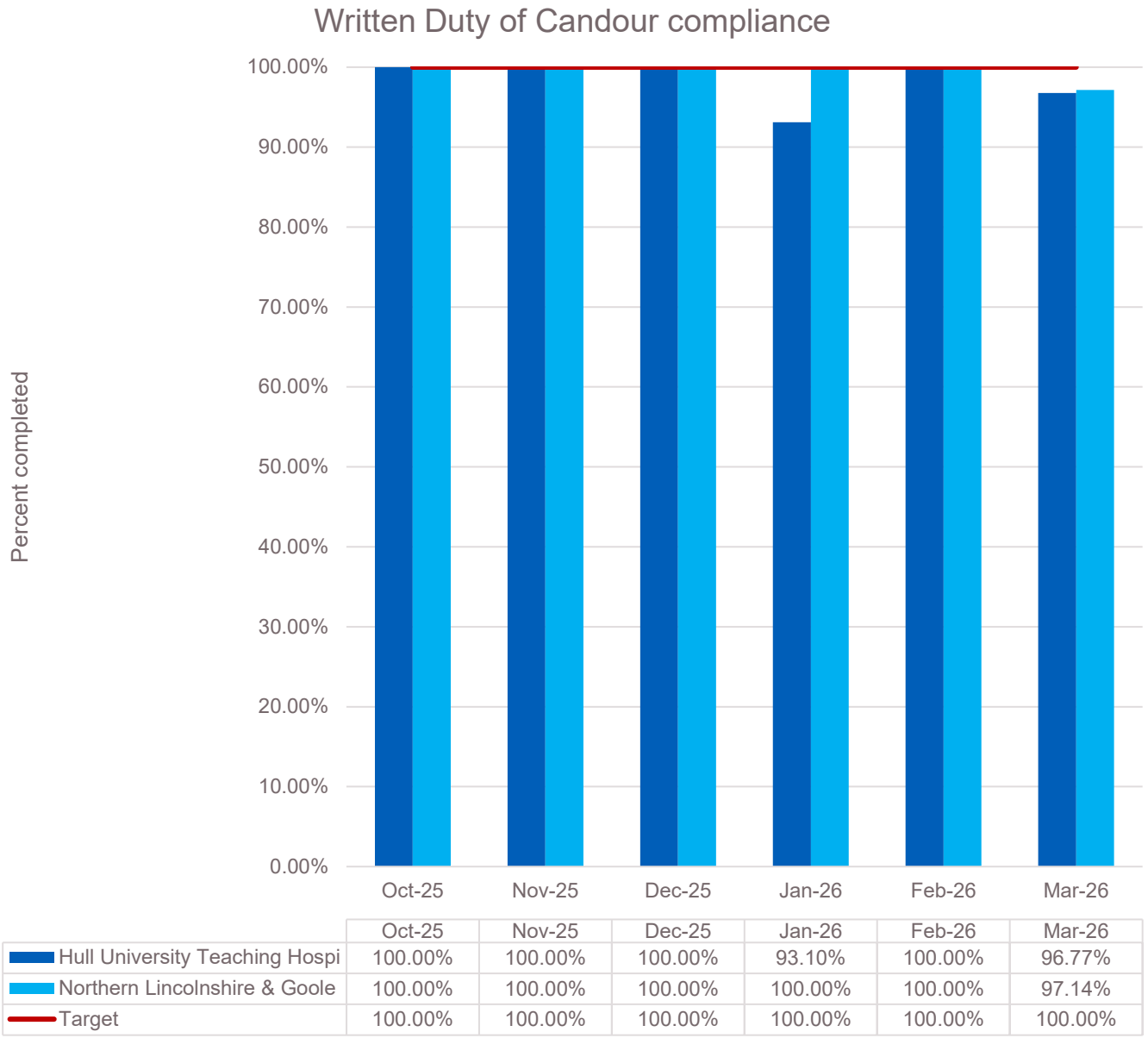
Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
CQC Inpatient Survey Satisfaction Mean Score	Apr-26		8.1		
CQC Safe Inspection Score	Apr-26		2.0		
Infections - C.Difficile	Mar-26		6		
Infections - C.Difficile (Cumulative)	Mar-26		48		
Infections - C.Difficile (per 1,000 bed days)	Mar-26		0.30		
Infections - E.Coli	Mar-26		15		
Infections - E.Coli (Cumulative)	Mar-26		266		
Infections - E.Coli (per 1,000 bed days)	Mar-26		0.74		
Infections - Klebsiella	Mar-26		9		
Infections - Klebsiella (Cumulative)	Mar-26		122		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Mar-26		0.44		
Infections - MRSA	Mar-26		2		
Infections - MRSA (Cumulative)	Apr-26		0		
Infections - MRSA (per 1,000 bed days)	Mar-26		0.10		
Infections - MSSA	Mar-26		4		
Infections - MSSA (Cumulative)	Mar-26		77		
Infections - MSSA (per 1,000 bed days)	Mar-26		0.20		
Infections - Pseudomonas aeruginosa	Mar-26		2		
Infections - Pseudomonas aeruginosa (Cumulative)	Mar-26		35		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Mar-26		0.10		

Duty of Candour

HUTH

NLAG



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Hull University Teaching Hospi	100.00%	100.00%	100.00%	93.10%	100.00%	96.77%
Northern Lincolnshire & Goole	100.00%	100.00%	100.00%	100.00%	100.00%	97.14%
Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

There is a 10-working day target for completing written DoC and an improvement plan to achieve completion and improve timeliness. Additional measures of oversight have been introduced to improve timeliness across the group and resolve historical casework.

HUTH

- The chart illustrates that there is >93% compliance across each month shown. March reported data is not included as has not all yet reached the 10 days target time.
- At the time of reporting April data had not reached the 10 working day target so completed target periods are shown.

Group Actions being taken to improve:

- Ulysses closure requirement ensures DoC section of the manager forms is completed.
- Dashboard on Ulysses provides real-time data.
- Care Group weekly performance reporting through the weekly monitoring report and ADQG reminders to all care groups.
- Bi-weekly meetings with Group Chief Patient Safety Officer:
    - Commitment to clear historical backlog cases in March
    - Commitment to focus on 10 working day target for newly reported incidents
    - Sharing of good practice.
- Further training for teams that require support.to prompt act

NLAG

- The chart illustrates >97% compliance for written DoC across the months shown.
- At the time of reporting April data had not reached the 10 working day target so completed target periods are shown.

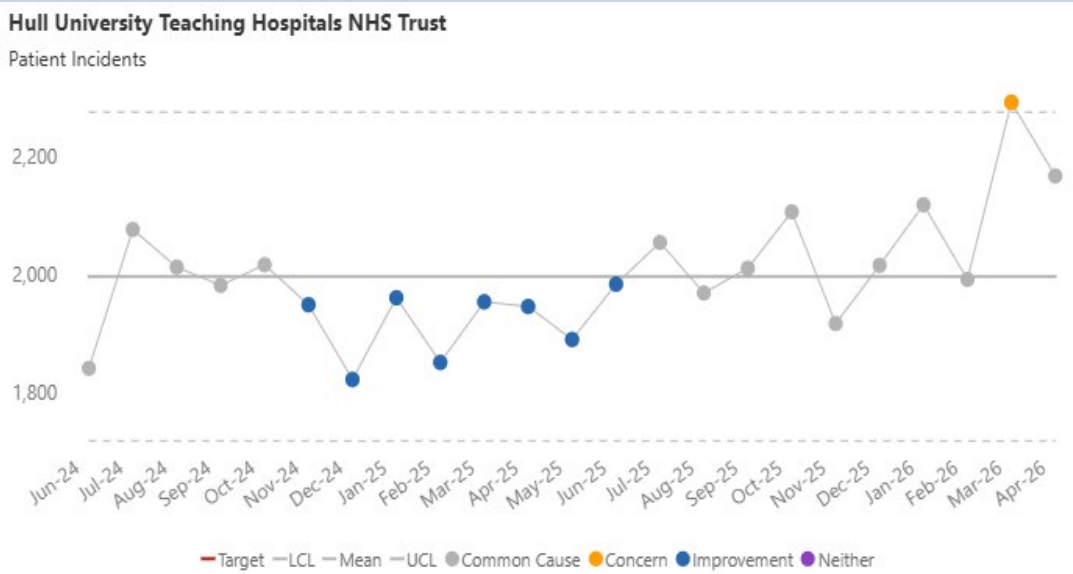
Never Events

HUTH	• There have been 5 Never Events in HUTH in the rolling 12 months up to the end of April 2026, with the last identified in February 2026 relating to a procedure in 2023 where a guidewire was retained. • The latest published data for 2025/26 shows that HUTH has the joint 12th highest number of Never Events from all NHS providers in England.
NLAG	• There have been 5 Never Events in NLAG in the rolling 12 months up to the end of April 2026, with the last case identified in December 2025. • The latest published data for 2025/26 shows that NLAG has the joint 12th highest number of Never Events from all NHS providers in England.

	There have been no never events identified for patients recent episodes of care provided since December 2025 at NLAG and November 2025 at HUTH.
	
	Group wide actions
	• There is an action plan in place inclusive of:
	  • ongoing audit of compliance including record keeping and observation for theatre environments, incorporating observation of Team Brief and debrief. Documentation of checklist completion. Observation of NAtSSIPS2 steps with theatre safety checklists.
	  • Feedback to staff
	  • TACC training sessions
	  • Simulation training

Patient Safety Incident (PSI) reporting

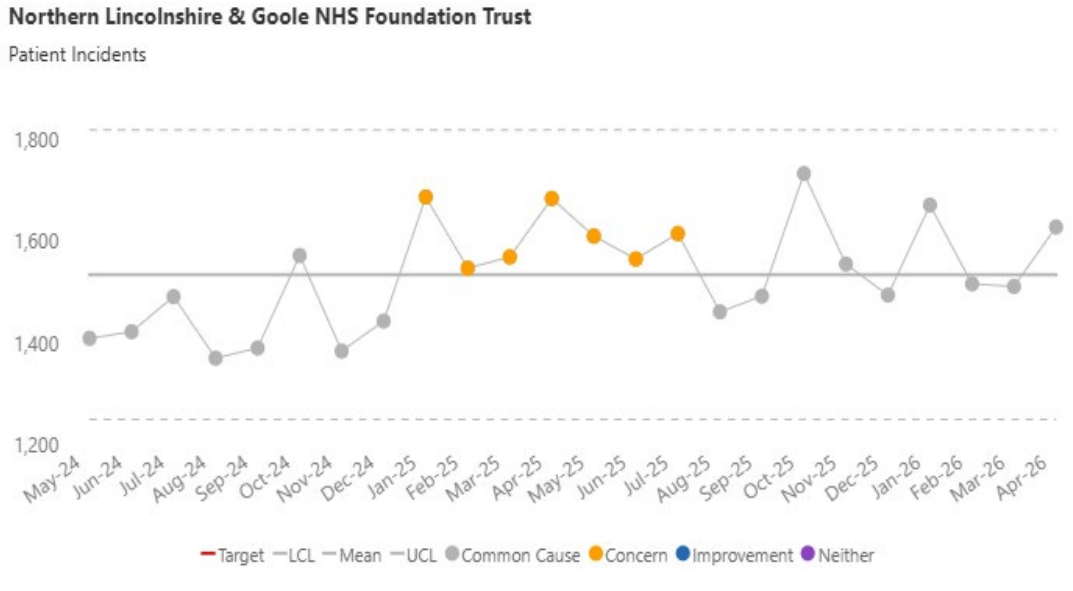
HUTH



Key themes

- There is a moderate increase in reporting for March, returning to common cause variation. This correlates with 4 Care Groups that have similar increases in March. The highest proportion of incidents remain as pressure ulcers on admission and patient falls, although patient falls remains within common cause variation.
- HUTH has Quartile 3 rates of Patient Safety Incident rates of reporting, with proportionally lower harm levels than the national data from LFPSE.
- Proportional rates of reporting harm show higher no harm and low harm reporting than the national benchmark from LFPSE.

NLAG



Key themes

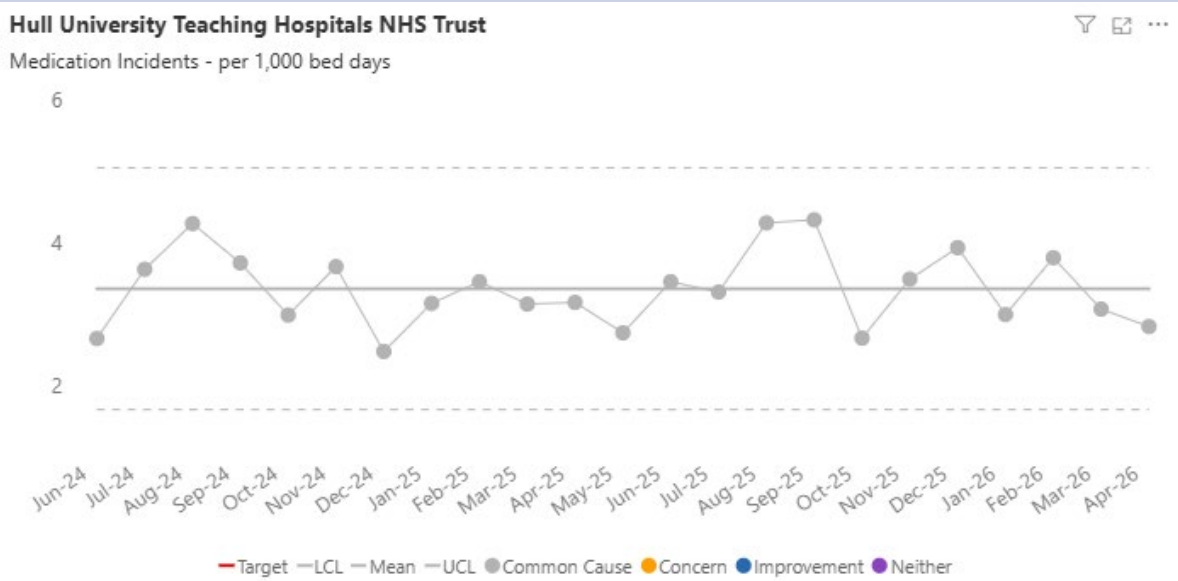
- Normal variation seen in this chart for the recent period.
- NLAG has Quartile 4 rates of Patient Safety Incident rates of reporting, with proportionally lower harm levels than the national data from LFPSE.
- Proportional rates of reporting harm show higher no harm and low harm reporting than the national benchmark from LFPSE.

Controls, Oversight and Assurance

- Daily Safety Huddles – Monday to Friday include focus on incidents that have been reported on the previous day raising moderate and greater harm patient safety issues for early intervention
- The Care Group teams undertake a review of their incidents on a weekly basis, with urgent clinical reviews leading to reporting at the group wide weekly meeting.
- Learning Response Panel meets each week, where decisions are made for commissioning PSII and other learning responses and sharing immediate learning..
- Alternate weekly PSIRF Oversight meetings monitor activity and review completed learning responses, consider wider learning benefits to other teams and services.
- Monthly oversight is then provided by the Patient Safety and Learning Group, which reports to the Quality and Safety Committees-in-Common

Patient Safety Incident (PSI) – Medication incidents per 1000 bed days

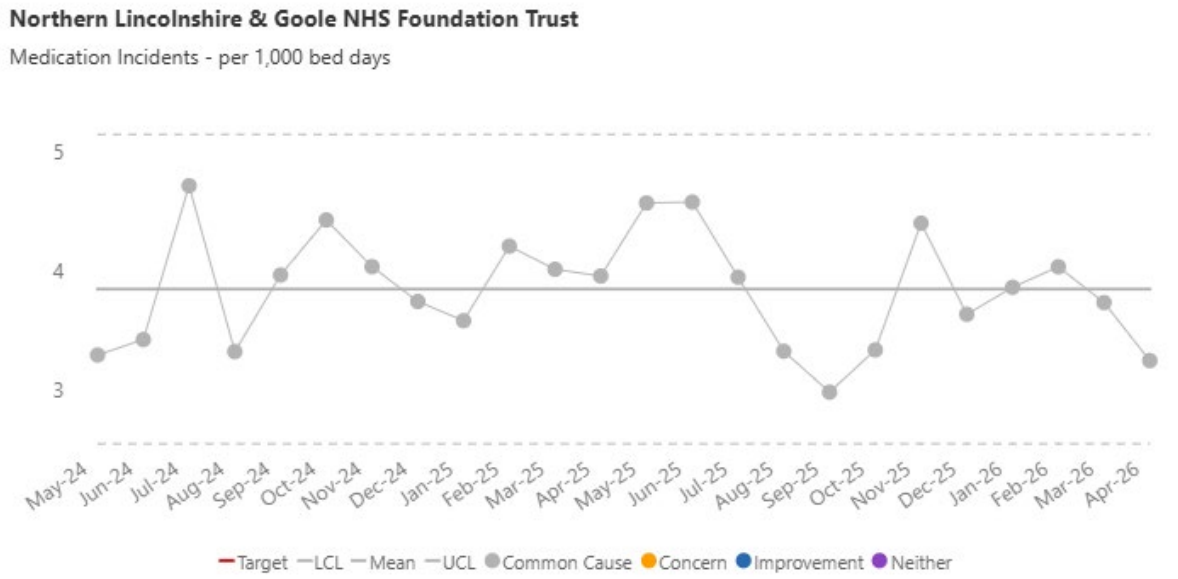
HUTH



Key themes

- Common cause variation seen on the chart illustrating no change to reporting patterns.
- There are no Fatal or Severe harm incidents for the recent period

NLAG



Key themes

- Common cause variation seen on the chart illustrating no change to reporting patterns.
- There are no Fatal or Severe harm incidents for the recent period

Controls, Oversight and Assurance
The Safer Medication Group review of incidents and learning points, policy and prescription form oversight. The Safer Medication Group reports to the Patient Safety Learning Group and Annual reporting to the Quality and Safety Committees-in-Common.

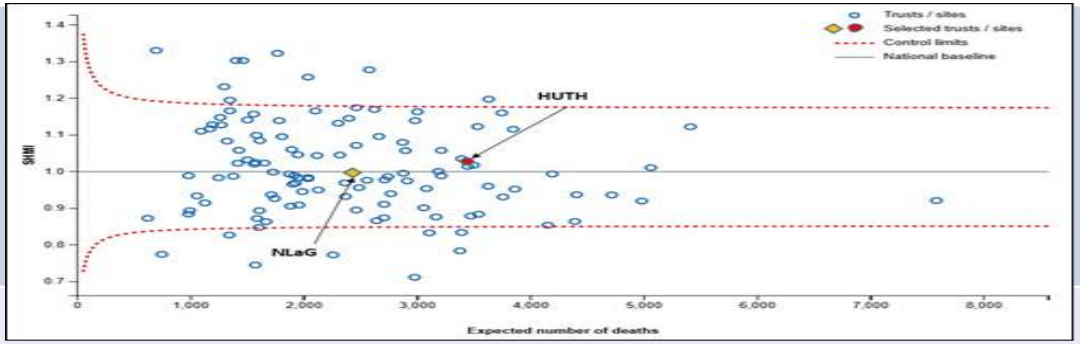
Improvement activities:
- Quality Priority workstreams on Insulin Safety are in place for 2026/27.
- Infection control quality priorities include oversight of IV/Oral switch of antibiotics.

Patient Safety Alerts

HUTH	**Overdue – 1 alert:** • Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. Closure report and evidence collation has 2 actions that lack evidence for: Action 3 - Inventory/database of assets (incomplete ~90% capture on Tagnos system) and Action 4 - subcontracted maintenance process oversight. Escalation for resolution with Estates and Clinical Engineering. • Estates and Clinical Engineering are working together to ensure there is a solution to ensure a full inventory and maintenance tracking database is in place, replicating the NLAG database and Clinical Engineering accountability. A report of the inventory was expected on 20 April 2026, with further analysis required. A contract for a managed service is being explored with oversight arrangements, as an adjustment to the existing contract.
Group	**Current open Alerts and in time:** • NatPSA/2025/006/NHSPS - Harm from incorrect recording of a penicillin allergy as a penicillamine allergy, due by 20 November 2026. • The first internal meeting took place on 27 March. The group will continue to meet monthly to discuss progress. • NatPSA/2025/008/NHSPS - Risk associated with adult breathing circuits lacking a patent exhalation route. Due on 12 June 2026. **Completed Alerts:** • None to report.
NLAG	**Overdue:** • None to report.

Mortality - SHMI

Benchmark

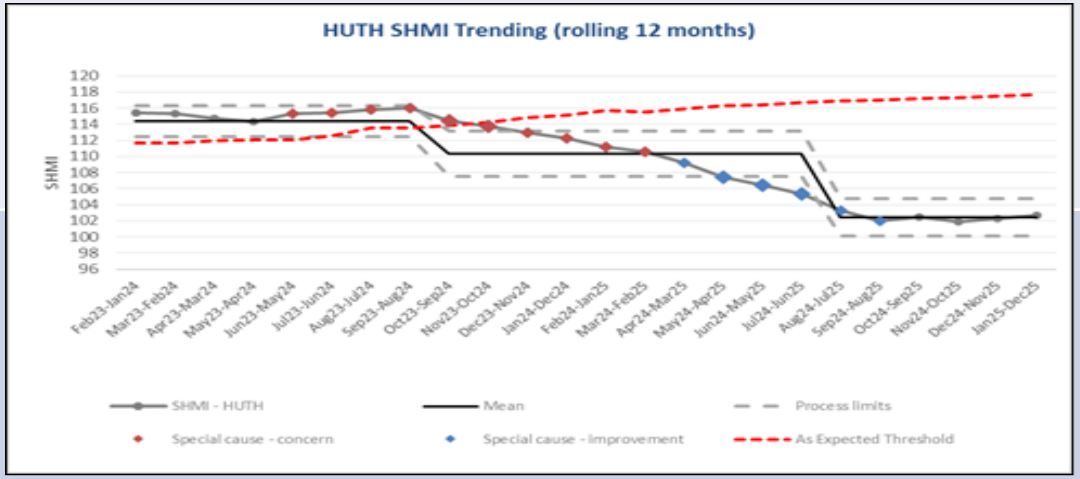


SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings..

The latest SHMI values for each site are:

- Castle Hill – 0.9800; 'as expected' (previously 0.9722 and 'as expected')
- Hull – 1.0468; 'as expected' (previously 1.0452 and 'as expected')
- Grimsby – 0.9332; 'as expected' (previously 0.9480 and 'as expected')
- Scunthorpe – 1.0734; 'as expected' (previously 1.0621 and 'as expected')
- Goole – insufficient activity for SHMI to be calculated

HUTH



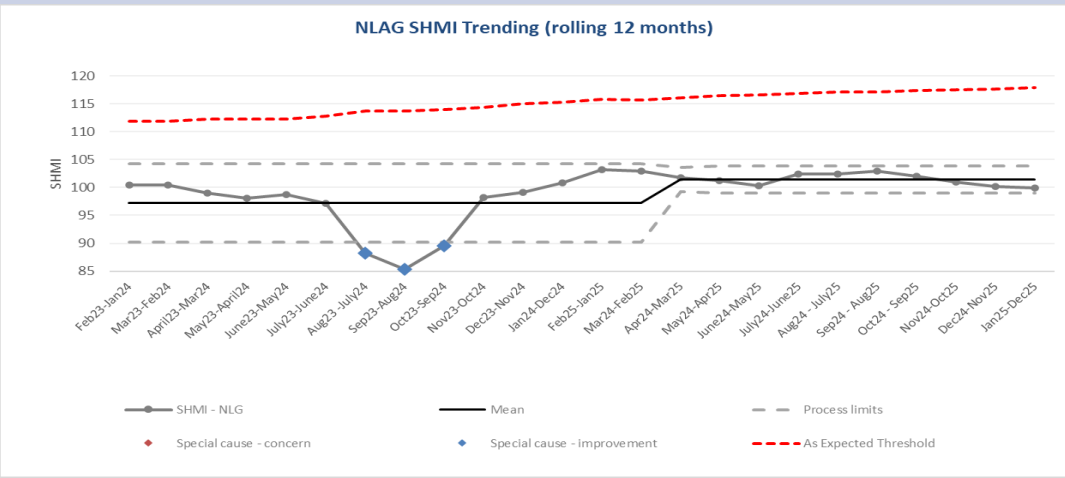
Key themes

- HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0268. This is higher than last month's value of 1.0231.

For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher than expected SHMI for:

- Septicaemia

NLAG



Key themes

- NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 0.9989. This is lower than last month's value of 1.0013.

For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher than expected SHMI for:

- Septicaemia

NLAG had a data issue shown in July-September 2024 that is no longer impacting on the 12 month rolling data.

Controls, Oversight and Assurance

- Mortality Improvement Group (MIG) meets monthly and has a workplan to report on workstreams investigating and reviewing areas for improvement identified through analysis, to investigate causes of concern in the data and triangulated qualitative and quantitative sources.
- Care Groups report their mortality and morbidity activities to MIG
- MIG reports to the Patient Safety and Learning Group and Quarterly Learning from deaths reports are also reported to the Quality and Safety Committee.

Actions being taken to improve across the Group:

- Septicaemia is a Quality Priority for the group and remains an area of focus through the Mortality Improvement Group.

Highlights and Lowlights

NHS Humber Health Partnership

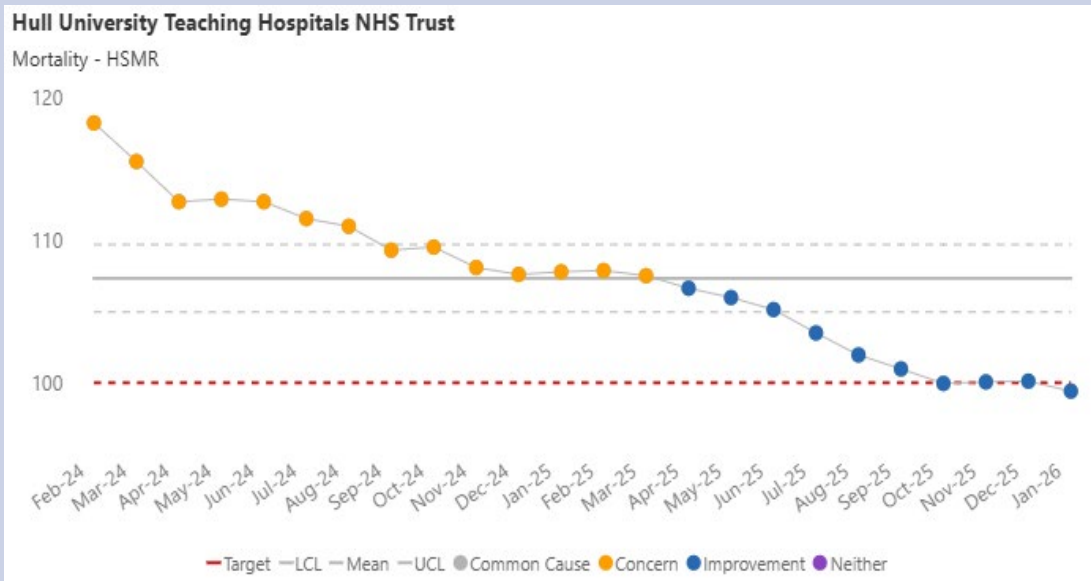
The IPR is now published following development with the Information Team, building a refreshed reporting tool for the Group. There are some datasets being worked on as DQ issues identified through deployment. Most of the report used BI data from Information Services. A glossary is provided on the last slide.

	HUTH	NLAG
Highlights	• Duty of candour compliance has improved significantly, with improving timeliness. • HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0268. This is higher than last month's value of 1.0231.. • The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 99.4. • Pressure Ulcer rates are higher due to the incident extract being used is includes moisture lesions which was not counted previously, prior to October 2025 when HUTH started using Ulysses, with an updated position to be provided to information services. • There were no Never Events in April 2026 and there have been 5 cases in the rolling 12 months. • The FFT data collection was been interrupted with the contract ending and a new process has been successfully introduced.	• Duty of candour compliance has improved and demonstrates reliability and timeliness. • NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 0.9989. This is lower than last month's value of 1.0013. • There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 23 months, and at 85.2. This figure is the lowest level on record. • All current safety alerts are managed within the timeframe. • VTE data remains is achieved at >95% target at 24 hours. • There were no Never Events in April 2026 with 5 in the rolling 12 months, and none in January or February 2026.

Lowlights	• Safety Alert for Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls is overdue. (all others are in progress and within timeframes)
	• For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher-than-expected SHMI for:
	  • Septicaemia
	• Patient complaint rate of completion within timescales remains below target consistently.
	• Infection control trajectories are reset from April, with C.difficile, e.coli, Pseudomonas, and Klebsiella are over the month 1 trajectory.
	• VTE data remains below the 95% target overall and at 14 hours from admission.
		• There were no Never Events in March 2026 with 6 in the rolling 12 months, and none in January or February 2026.
		• For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher-than-expected SHMI for:
		  • Septicaemia
		• Patient complaint rate of completion within timescales remains below target consistently.
		• Infection control trajectories are reset from April, with C.difficile and Klebsiella are over the month 1 trajectory.
		• The latest position at 14 hours from admission is below target for VTE risk assessment,

Mortality - HSMR

HUTH

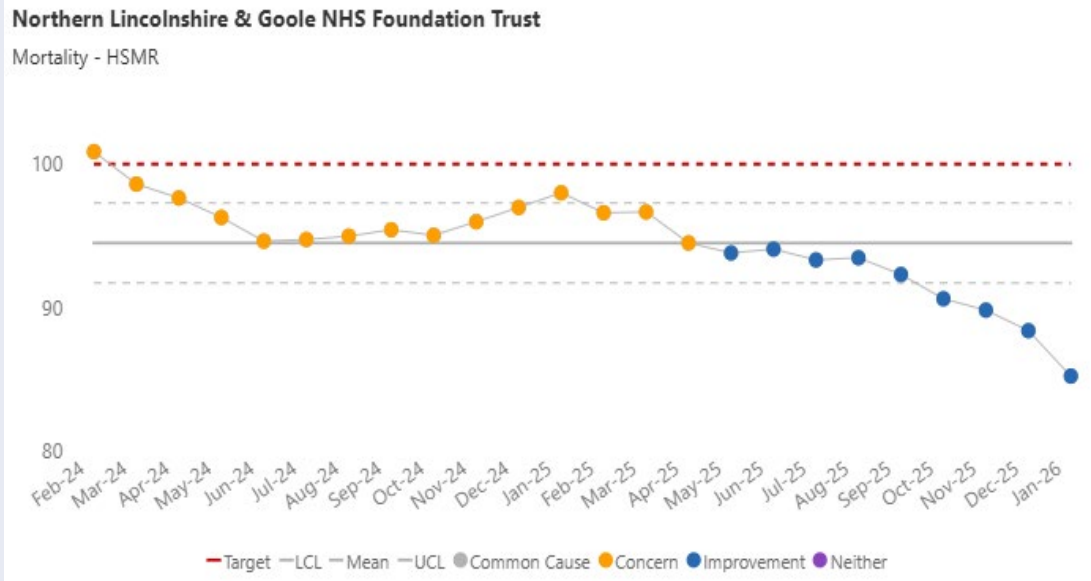


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 99.4.

NLAG



Key themes

There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 23 months, and at 85.2. This figure is the lowest level on record.

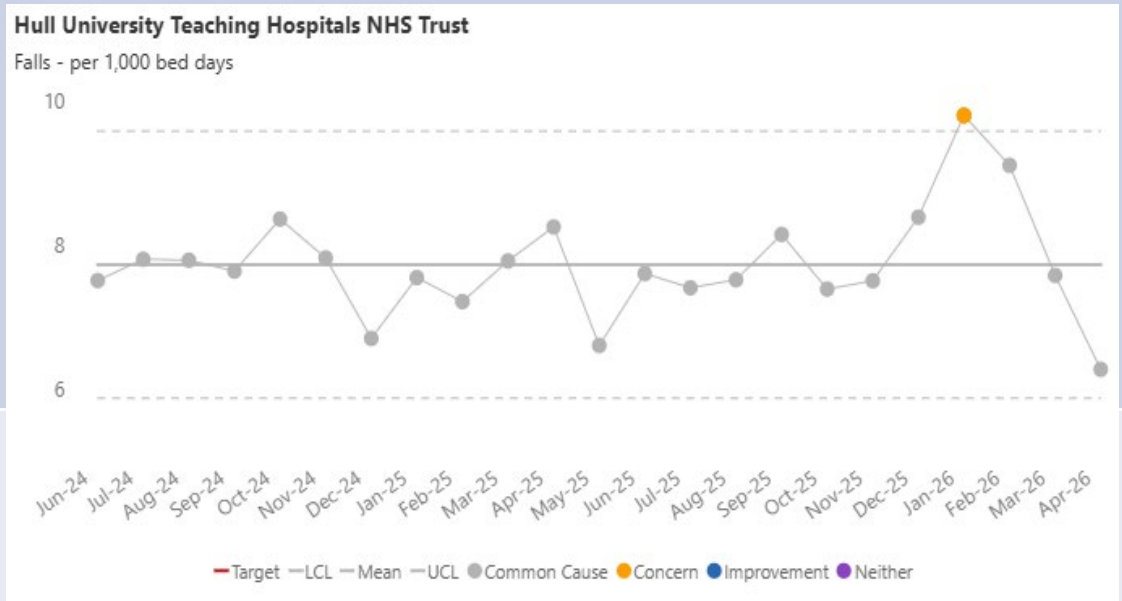
Actions are included in the same way for the SHMI description, and HSMR is used as part of the analysis of the mortality data, recognising a different methodology and risk adjustment is applied.

Controls, Oversight and Assurance

The same process are in place for MIG as set out in the SHMI section of this report.

Falls

HUTH

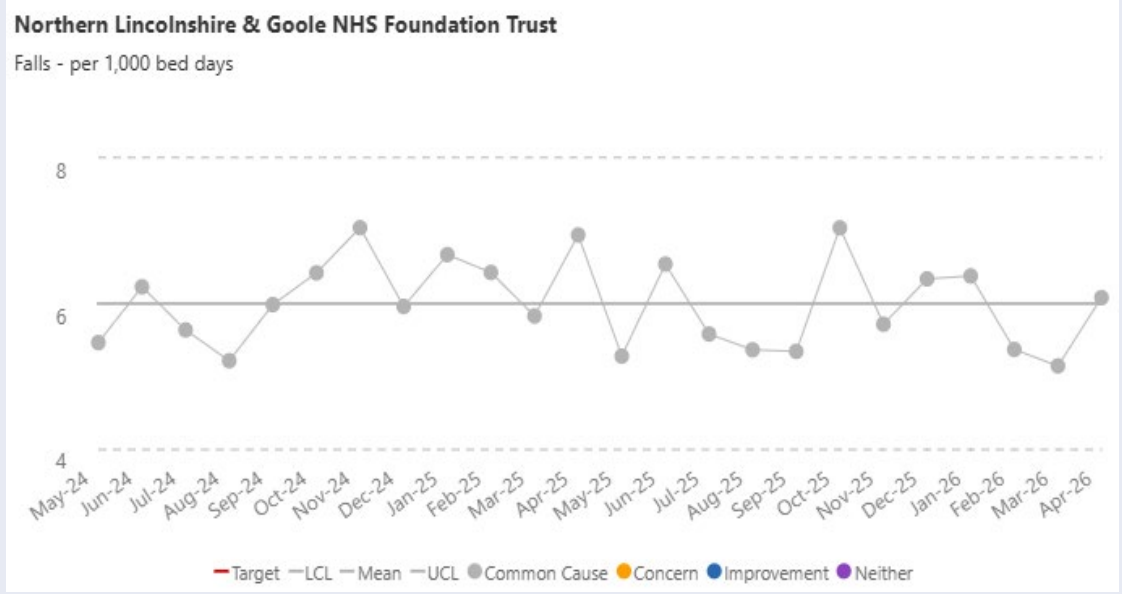


Key themes

HUTH – The Falls Improvement Programme has been successful in driving a reduction in the number of falls across the Trust, through the appointment of key leads, focus on risk assessments and environment and learning from incidents.

There is an increased rate of falls per 1000 bed days in January 2026 with a return to common cause variation.

NLAG



Key themes

NLAG Falls rate data shows common cause variation.

Controls, Oversight and Assurance

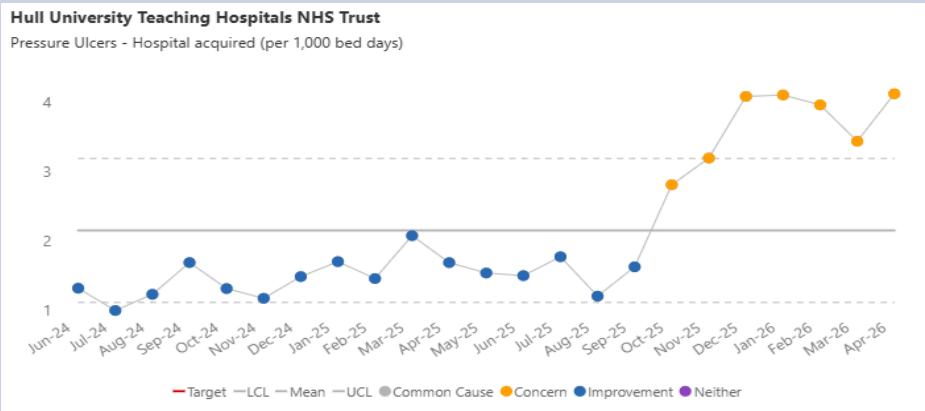
- Falls are reported as part of the daily safety huddle, flagging repeated fall patients, and significant injuries.
- Falls team review all repeated fall cases and potentially significant injuries
- All significant injuries following a fall are reviewed with a Swarm Huddle which is then reported to weekly falls group.
- Weekly review of all falls incidents and Swarm huddle reports.
- Escalation of concerns, including fatal outcomes are reported to the Weekly Learning Response Panel.

Actions being taken to improve across the Group:

- Consideration of falls impact on workstreams for:
    - reducing patient deconditioning from prolonged hospital stays
    - improving Enhanced Therapeutic Observation and Care.

Pressure Ulcers

HUTH



Key themes

- There is an increase in the rate of hospital acquired pressure ulcers from October 2025 to March 2026 and has been attributed to hospital acquired moisture lesions that were not included in the Datix dataset, prior to the change to Ulysses in October 2025.
- Further analysis is being taken to interrogate the data and rebase the data moving forward.

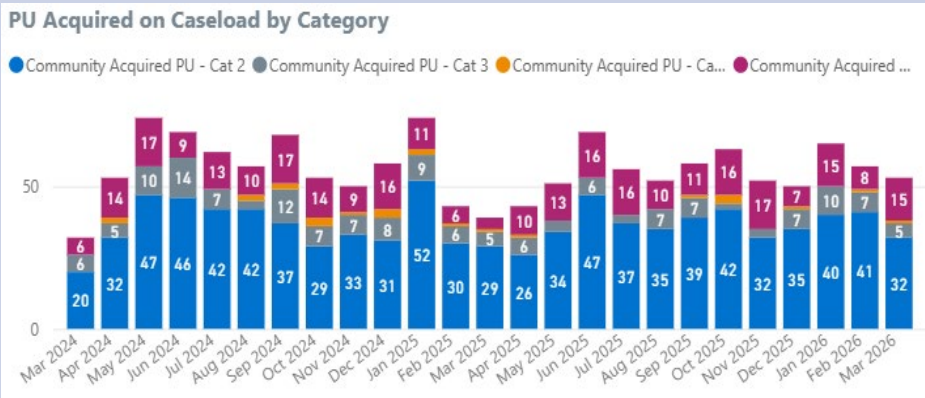
NLAG



Key themes

- The chart shows the NLAG hospital rate with a mean of 5.31 for the year.
- North Lincolnshire Community nursing team data is provided also.

NL Community



Controls, Oversight and Assurance

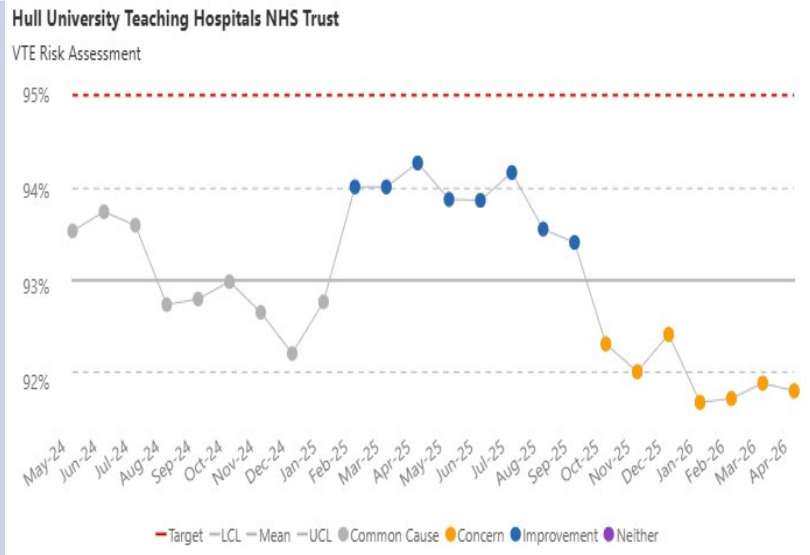
- Groupwide Pressure Ulcer Group has been established
- Weekly Pressure Ulcer Incident review process.

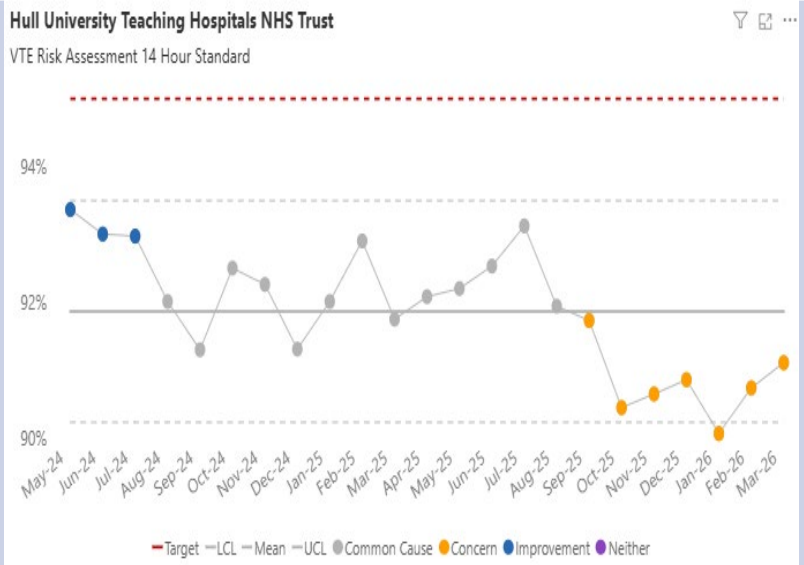
Actions being taken to improve across the Group:

- A deep dive is being presented to QSCiC in May 2026.
- Contributes to the metrics for measurement of patient deconditioning.

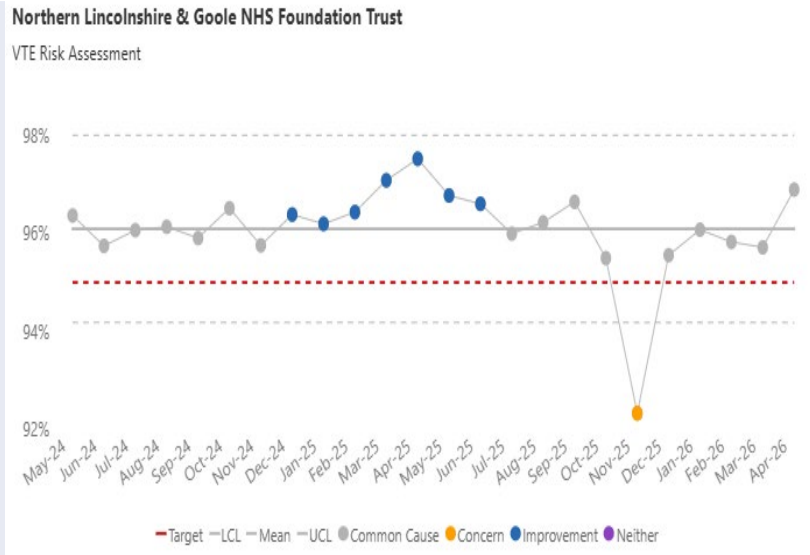
VTE Risk assessment rate

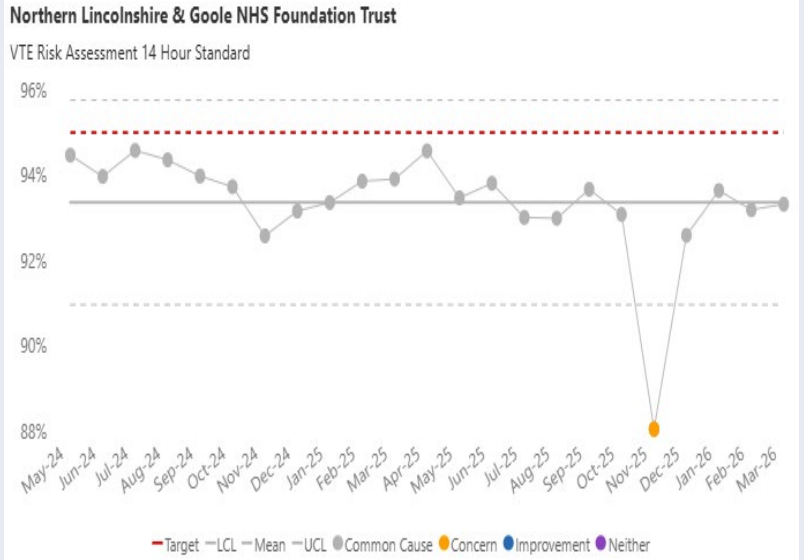
HUTH





NLAG





Key themes

- VTE risk assessment compliance has been measured historically, which is the chart to the left, is within one day of admission.
- HUTH data demonstrate that the 95% target is not achieved for these measures, with a deterioration since October 2025.
- NLAG has completion.achieving >95% compliance at 24 hours, but not at 14 hours.

Controls, Oversight and Assurance

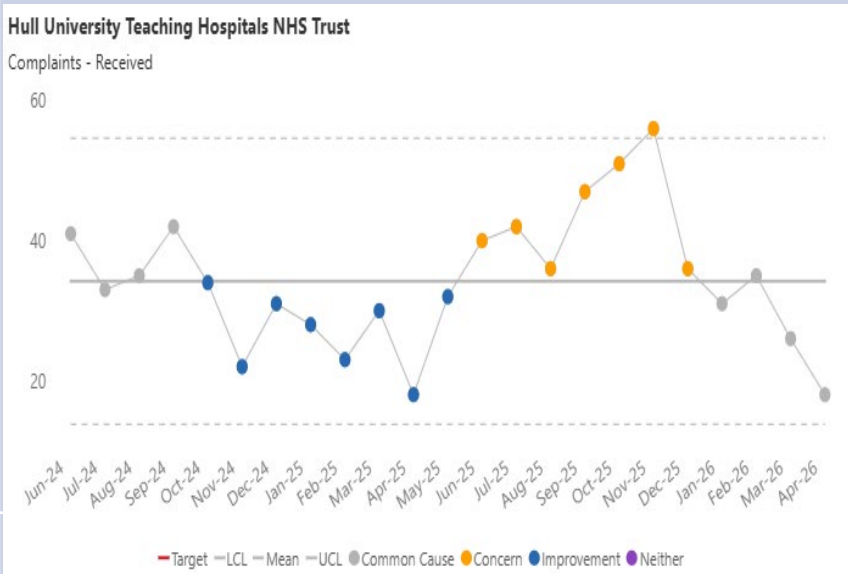
Rates of VTE harm are reviewed to determine if associated with risk assessment on admission with no evidence of harm being identified. On discharge and restarting treatment following surgery, there are some examples of harm identified through WLRP.

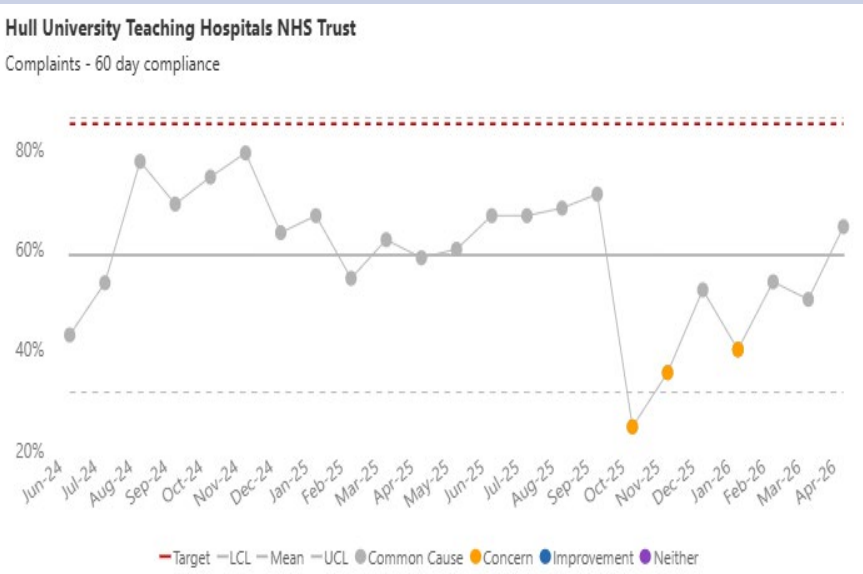
Actions being taken to improve:

- Care Group data is available to provide focus on the relevant teams to address their performance and will be used in the Performance Review meetings and at the Patient Safety and Learning Group as part of Care Group Highlight reports.
- A review has been undertaken for initial risk assessment for VTE and there is no evidence of causation for harm.
- Each care group has been asked to take forward recovery plans.

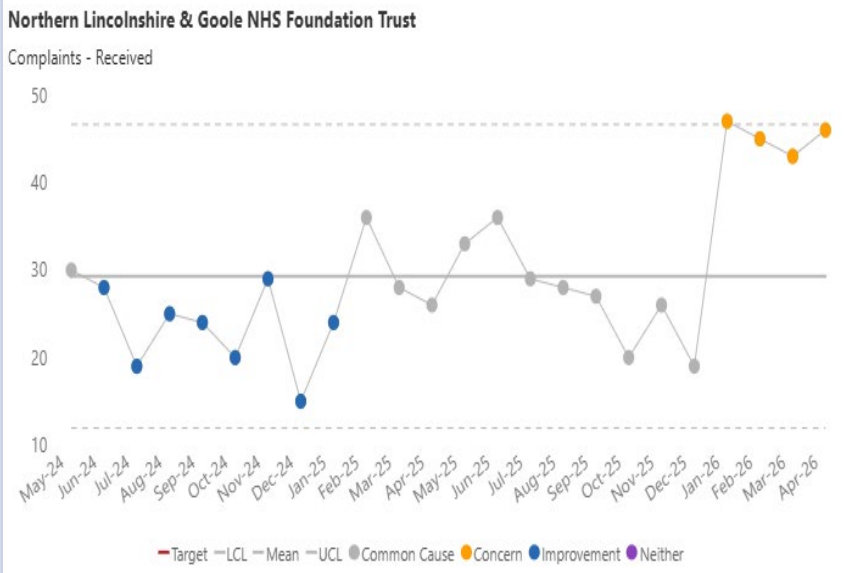
Patient Experience: Complaints – received and compliance with KPIs

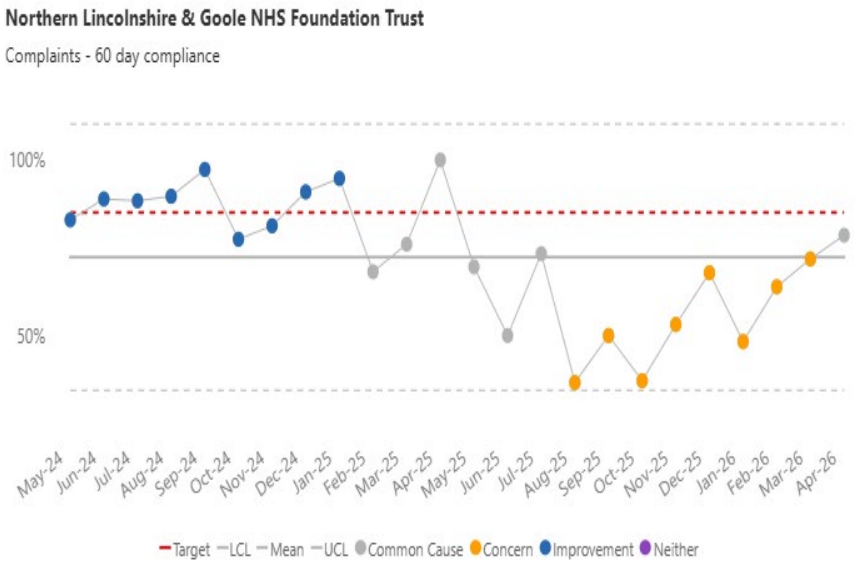
HUTH





NLAG





Key themes

- HUTH complaints have returned to common cause variation, following a moderate increase, Acute and Emergency Medicine is still receiving more complaints than other care groups.
- Previously there has been a reduced rate from November 2024 –August 2025 at HUTH.
- Compliance with timescales remains below the 85% target at 65% in April.

Actions to improve:

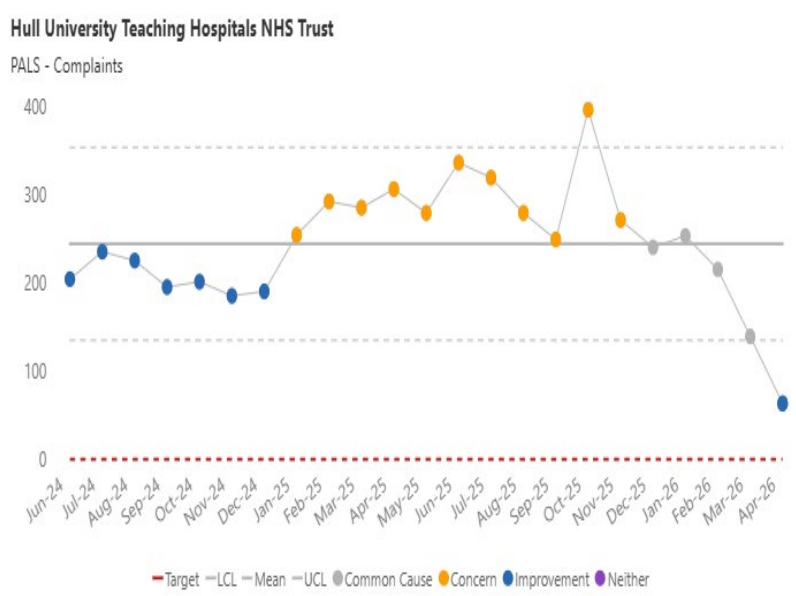
- A dedicated action plan focus being undertaken on
  - Patient Experience a user of service,
  - Operational process Complaints/ Pals
  - HR/Staffing
  - IT/Telephony
- Central team NLAG investigation and response model being introduced
- Reporting of Care Group performance
- Weekly meetings with Care Group and Central team case handlers.
- Care Group Performance Meeting with Site Nurse Director
- QI programme in development established , with Care Group accountability for their improvement plans

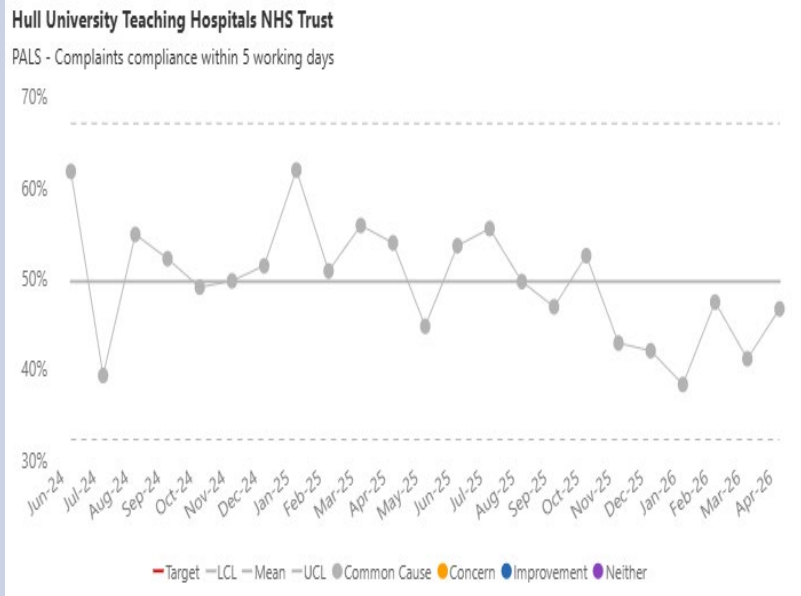
Key themes

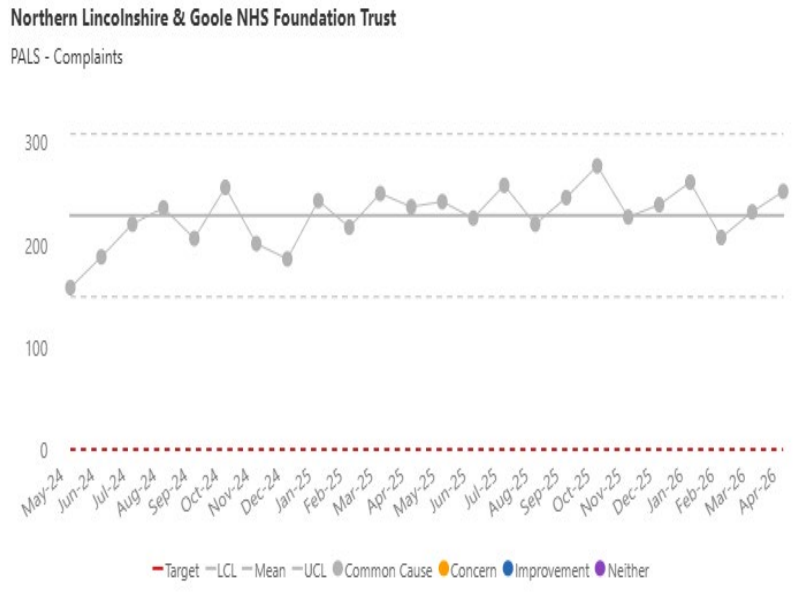
- The rate of complaints has started to show a decrease during Q4 2026 and at 78.6% in April.
- Ongoing work, with processes is taking place to achieve 60-day KPI to support.
- Working with HUTH PALs team will prevent PALs escalation to complaints

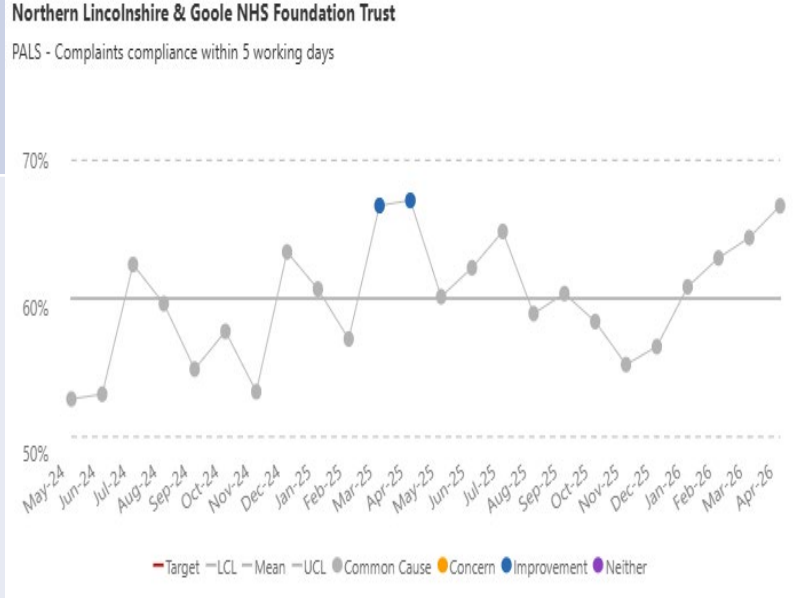
PALS – received and response times

HUTH









Key themes

- PALS received for HUTH is starting to decrease, this has remained relatively static returned to normal variation.
- There is no specific correlating increase for a care group. The Patient Experience Quarterly report provides further details.
- HUTH have challenges of completion of PALS concerns within 5 days (KPI 60%) and are not achieving 50%.
- Improvement plan agreed with interim chief nurse to improve inputting of HUTH PALs data
- There are challenges in achieving the 5day response KPI, due to:
  - Delay in IT / Telephony work expected date was 8/2025
  - Recruitment into PALs posts
  - Aligning processes for PALs

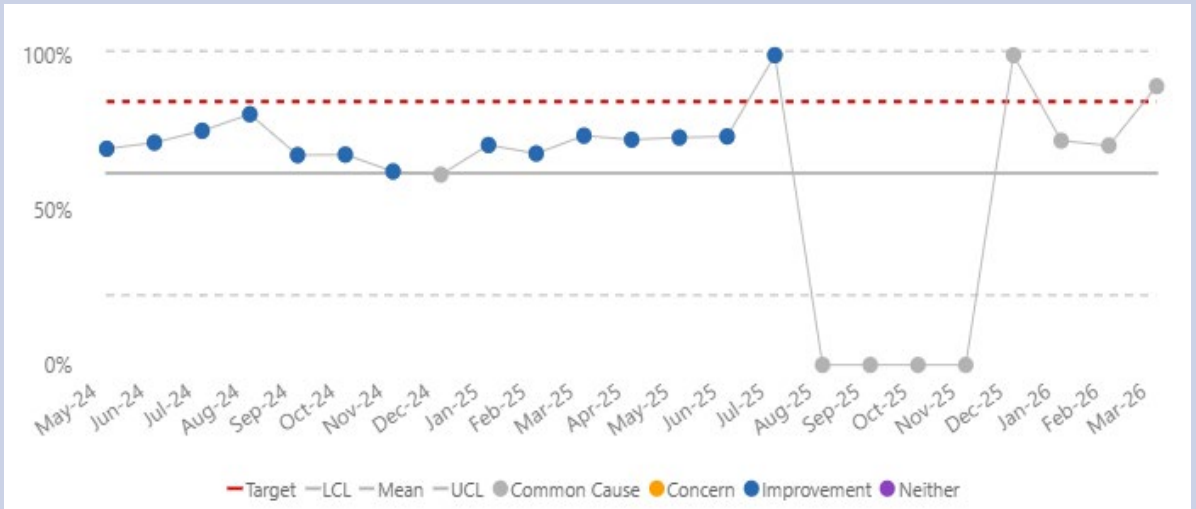
NLAG

Key themes

- NLAG PALs have remined consistent with common cause variation.
- NLAG have returned to achieving >60%

Patient Experience – Friends and Family Test A&E

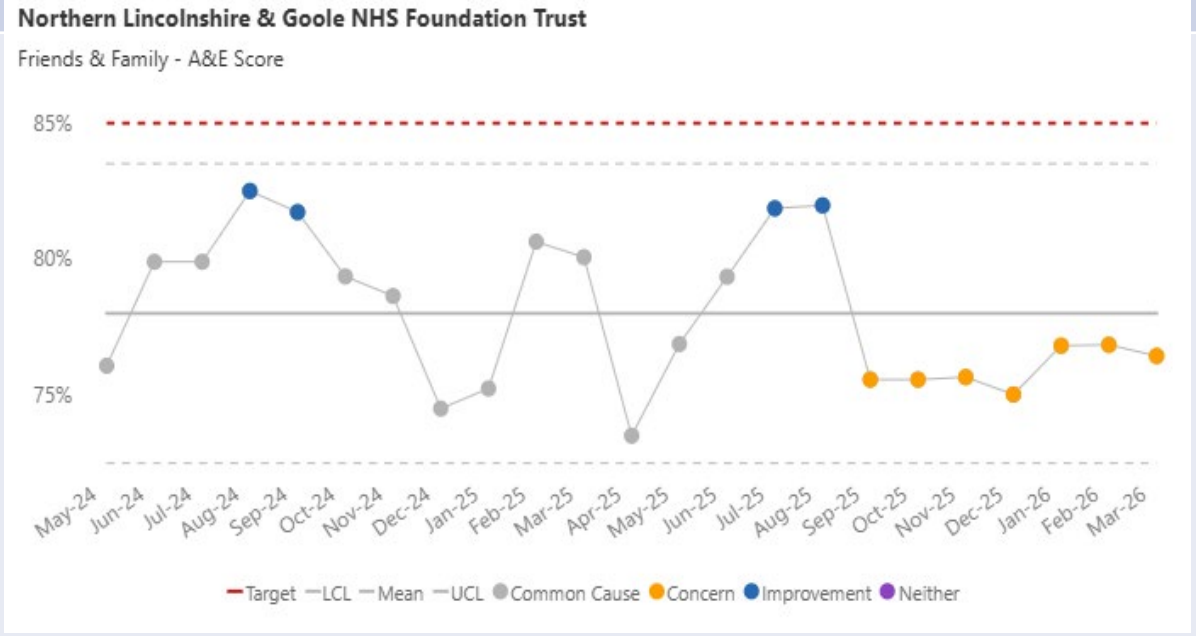
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- No FFT data has been collected for 4 months from August to November 2025. Smaller samples obtained for January 2026 and July 2025 are the likely caused for the high scores of 100%. NHS England aware and being updated with resolution plan.
- Common cause variation is found for the last 4 data points.

NLAG



Key themes

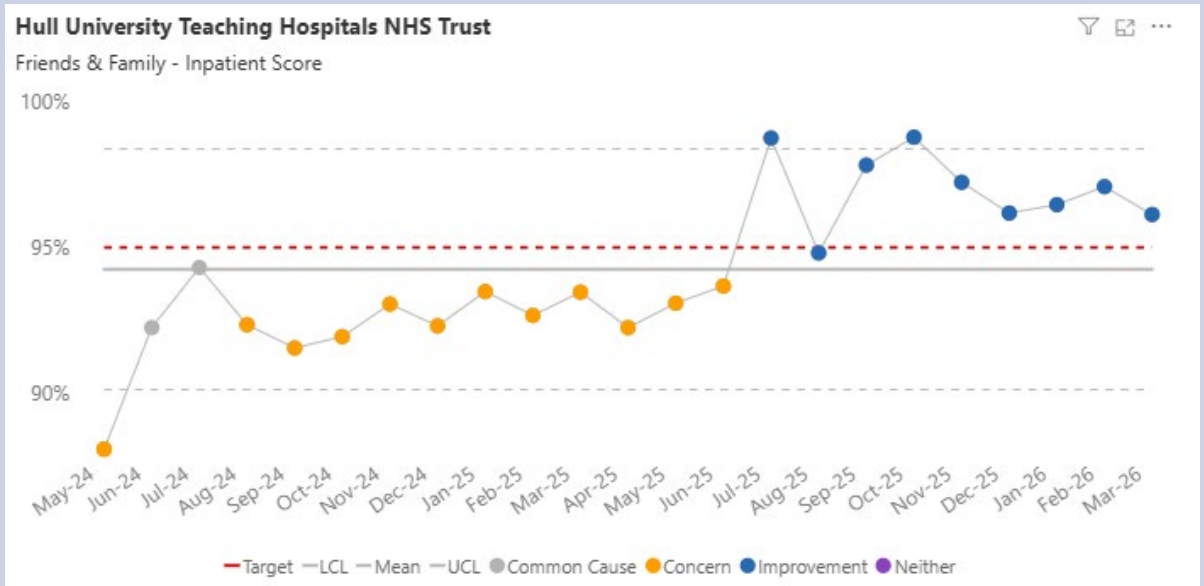
- There is a trend of reduced scores below the mean triggered.
- Remains below the target.

Actions being taken to improve across the Group:

- Performance data available in the Care Group
- Initiatives to improve timely ambulance handover delays
- Initiatives to support patients despite crowding in the EDs.

Patient Experience – Friends and Family Test Inpatient and daycase

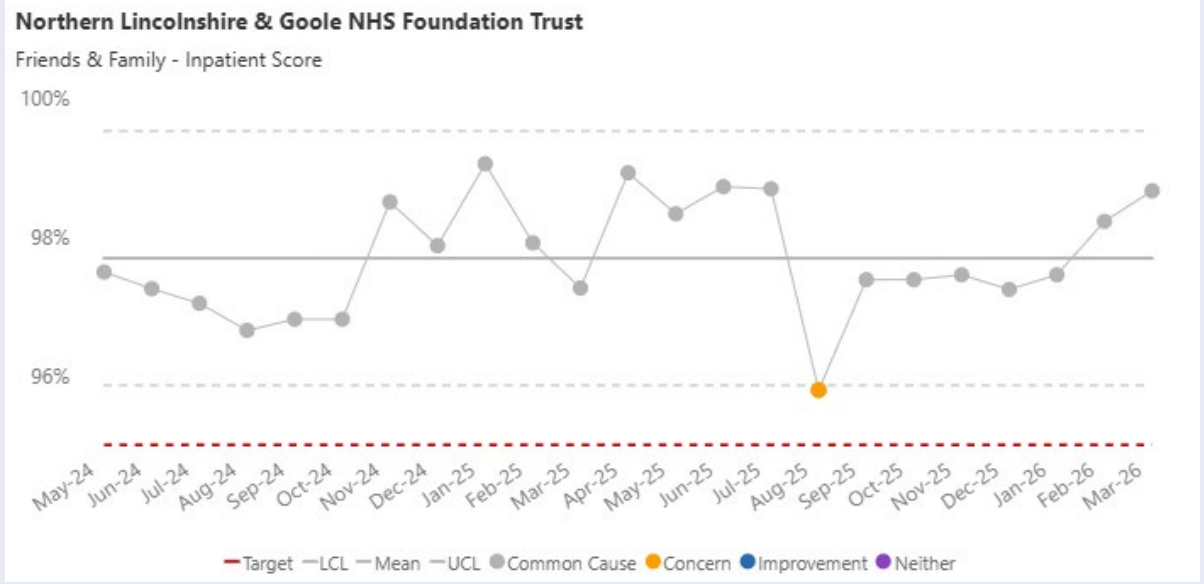
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- There is an improvement evident with both the attainment of the target of 95% and the increase above the mean.

NLAG

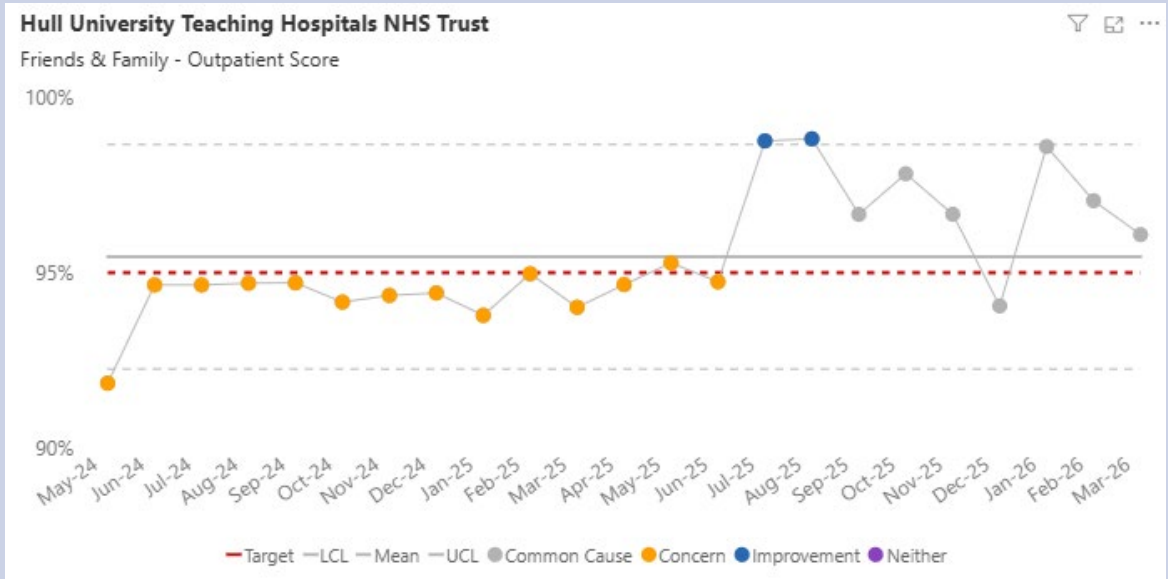


Key themes

- Consistency in achievement of the 95% target.
- Common cause variation is evident

Patient Experience – Friends and Family Test Outpatient

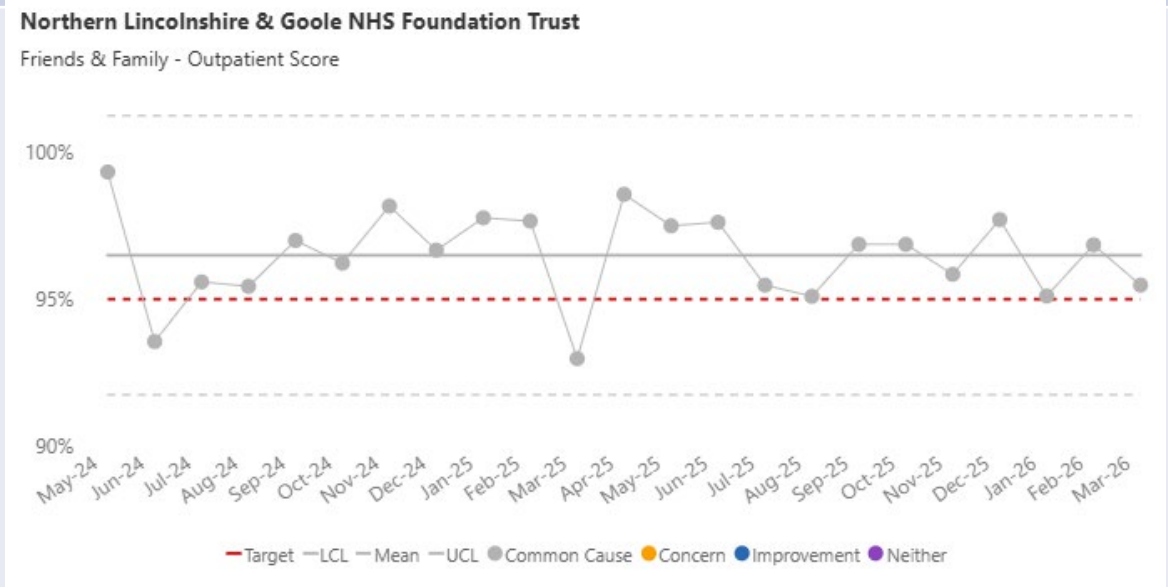
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- Common cause variation evident, with achievement of >95% target since January 2026.

NLAG

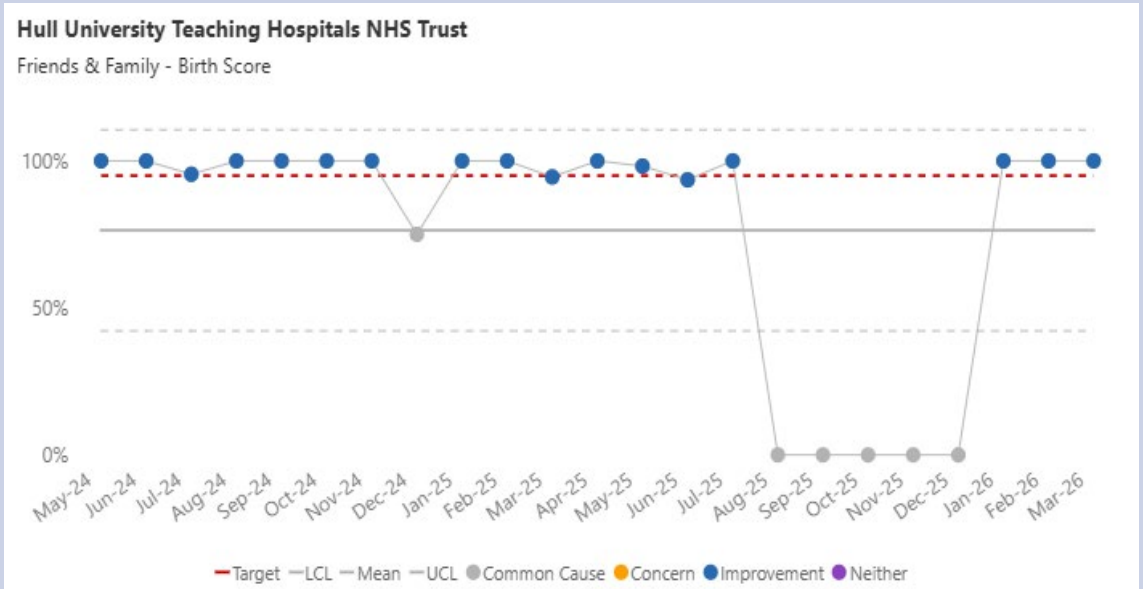


Key themes

- Previously sustained achievement over the target of 95%.
- Common cause variation demonstrated.

Patient Experience – Friends and Family Test Maternity (Birth)

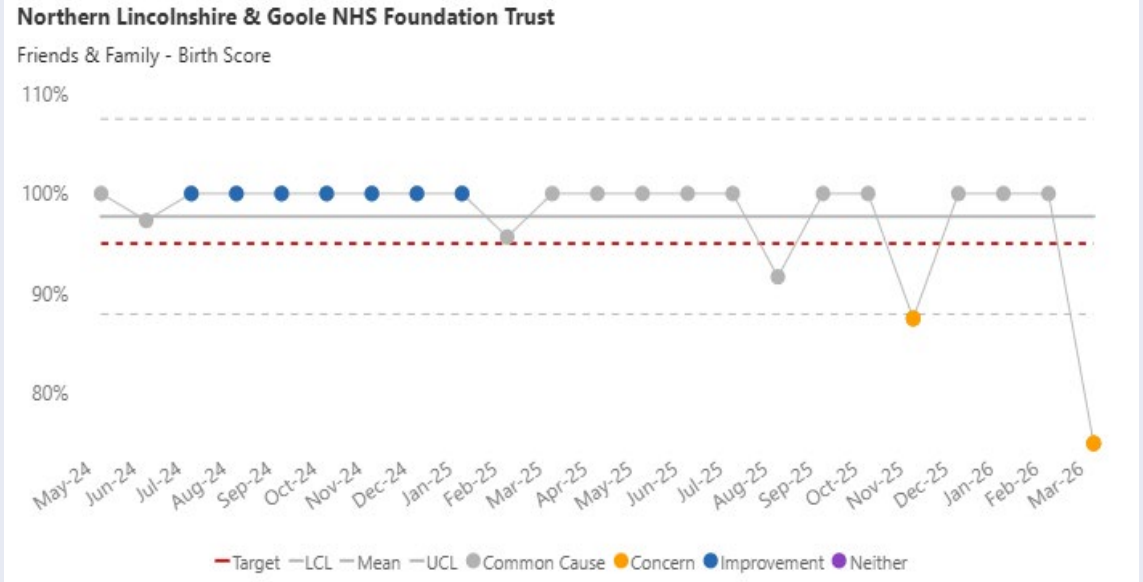
HUTH



Key themes

- Some positive results following the data collection changes implemented from January 2026.
- A new system for collection of FFT for HUTH has been successfully implemented.

NLAG

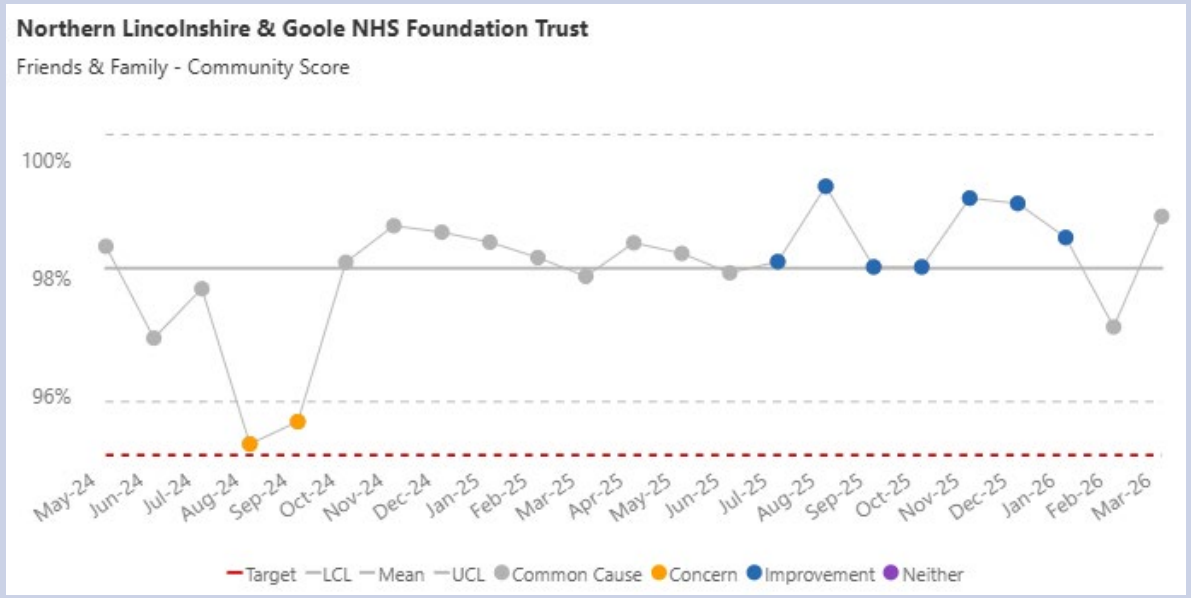


Key themes

- There is a reduced score shown for March 2026. Further analysis is being undertaken.

Patient Experience – Friends and Family Test Community (NLAG only)

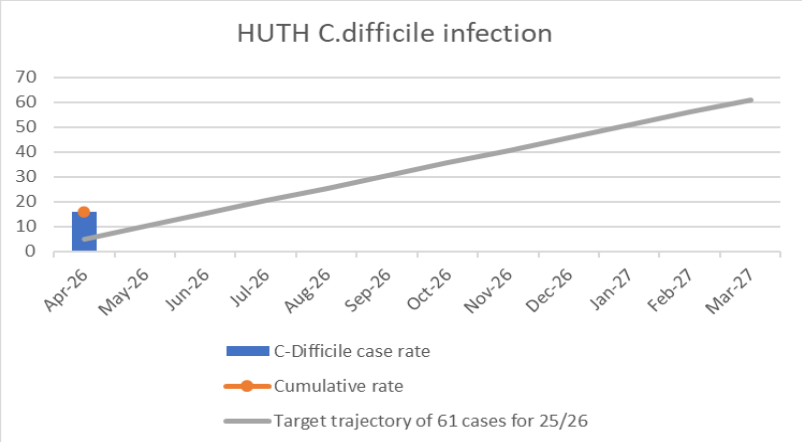
NLAG

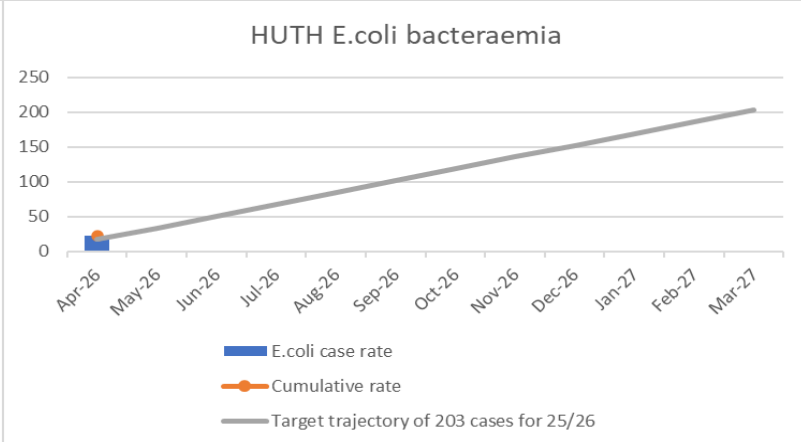


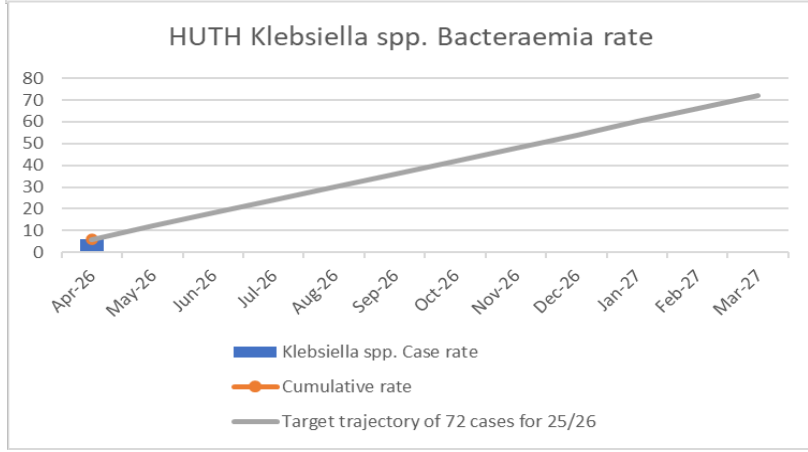
Key themes

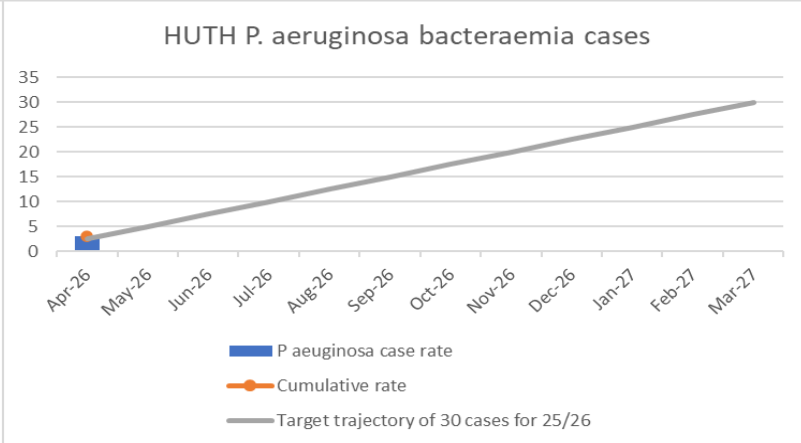
- Common cause variation continues.
- Trust is consistently achieving the 95% target with a mean of 98%.

Infection Control - HUTH









HUTH	2025/26 Target	M1	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	61	16	16	115	1.89	1.75	3.85
E. Coli	203	23	23	213	1.04	1.05	2.13
P. Aeruginosa	30	3	3	26	0.87	NA	NA
Klebsiella spp.	72	6	6	80	1.11	NA	NA
MRSA bacteraemia	0	0	0	2	NA	5	3.12
MSSA bacteraemia	No target	11	11	98	NA	NA	NA

The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the April 2026 position.

- MRSA has zero cases in the last month
- The other organisms are over trajectory.

National Outcomes Framework

Publicview data from the latest available period: February 2026 is provided.

- C.Difficile – The ratio is currently higher than the February 2026 data and so not expected to change the NOF banding in the near future.
- E.Coli – The ratio is slightly improved, but likely to remain in Quartile 2.
- MRSA – The rolling 12 month rate is 2 and lower than the February 2026 data so may improve the NOF score and band.

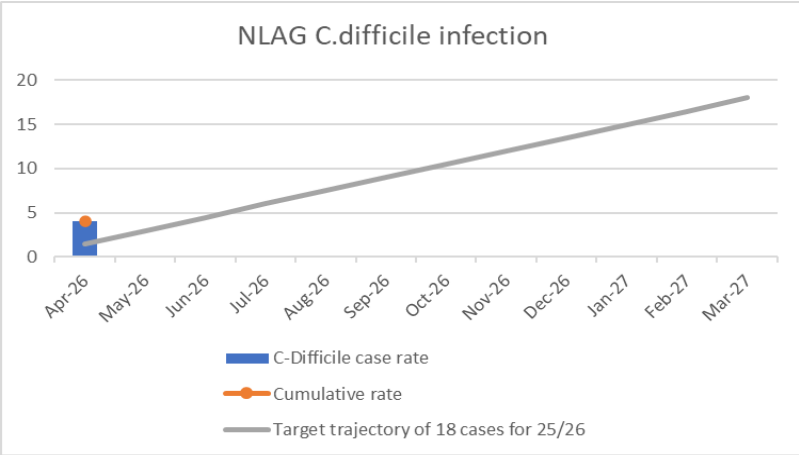
Improvement plans

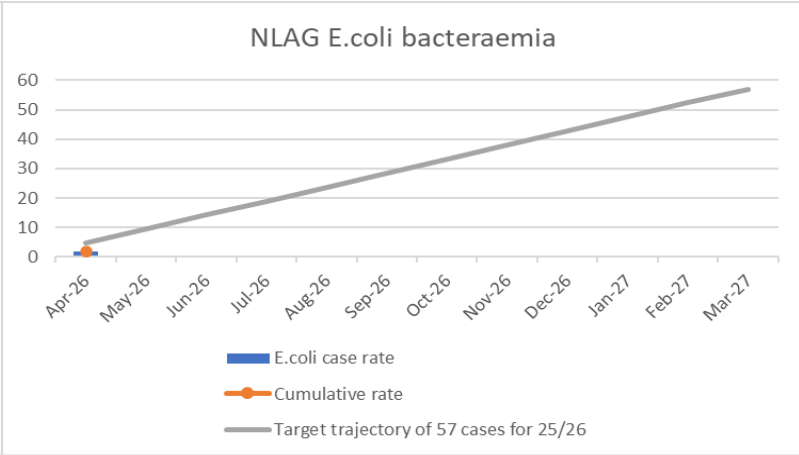
- The Quality Priorities for 2026/27 include the infection control KPI's that are part of the Safe section of the National Outcomes Framework. Which is shown using Publicview data from the latest available period: February 2026.

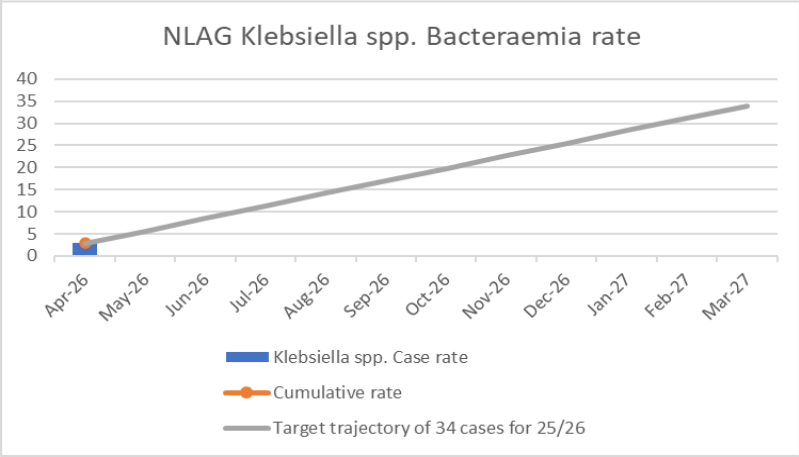
- SPC charts for trend monitoring are shown on the following charts.

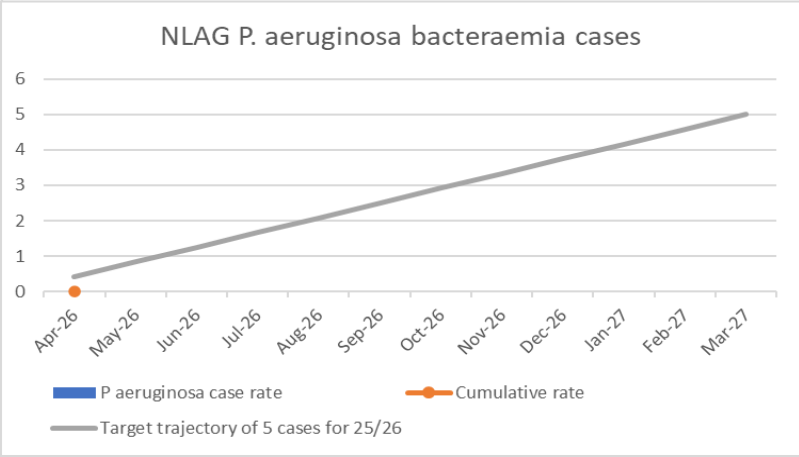
Key	In year Trajectory performance	NOF quartile ranking of Trusts
	Over the annual target	Quartile 4 (worst)
	Over the trajectory	Quartile 3
	-	Quartile 2
	Below the trajectory	Quartile 1 (best)

Infection Control - NLAG









NLAG	2025/26 Target	M1	YTD rate	12 month rolling rate	Current ratio	NOF rolling 12-month cases /target ratio	NOF score & band
C. Difficile	18	4	4	35	1.94	1.67	3.77
E. Coli	57	2	2	86	1.51	1.06	2.16
P. Aeruginosa	5	0	0	12	2.40	NA	NA
Klebsiella spp.	34	3	3	41	1.21	NA	NA
MRSA bacteraemia	0	0	0	6	NA	4	2.88
MSSA bacteraemia	No target	3	3	36	NA	NA	NA

The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the April 2026 position.

- MRSA and Pseudomonas has zero cases in the last month
- E.Coli is under trajectory.
- The C.difficile and Klebsiella are over trajectory.

National Outcomes Framework

Publicview data from the latest available period: February 2026 is provided.

- C.Difficle – The ratio is currently higher than the February 2026 data and so not expected to change the NOF banding in the near future.
- E.Coli – The current ratio is higher than February 2026, so may move from Quartile 2 to 3.
- MRSA – The rolling 12 month rate is 2 higher than the February 2026 data so may increasethe NOF score and band.

Improvement plans

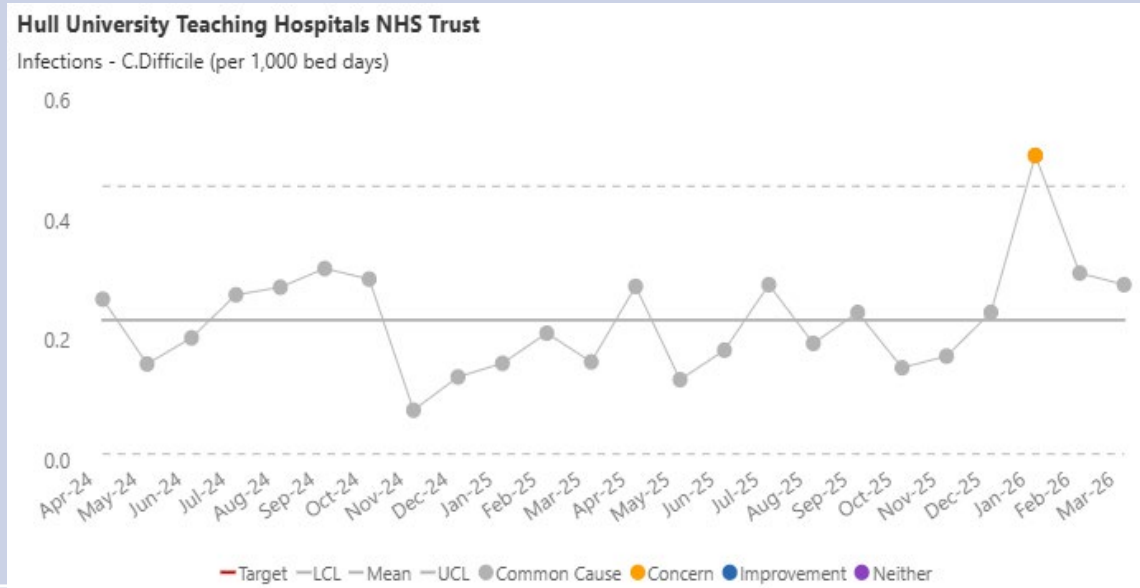
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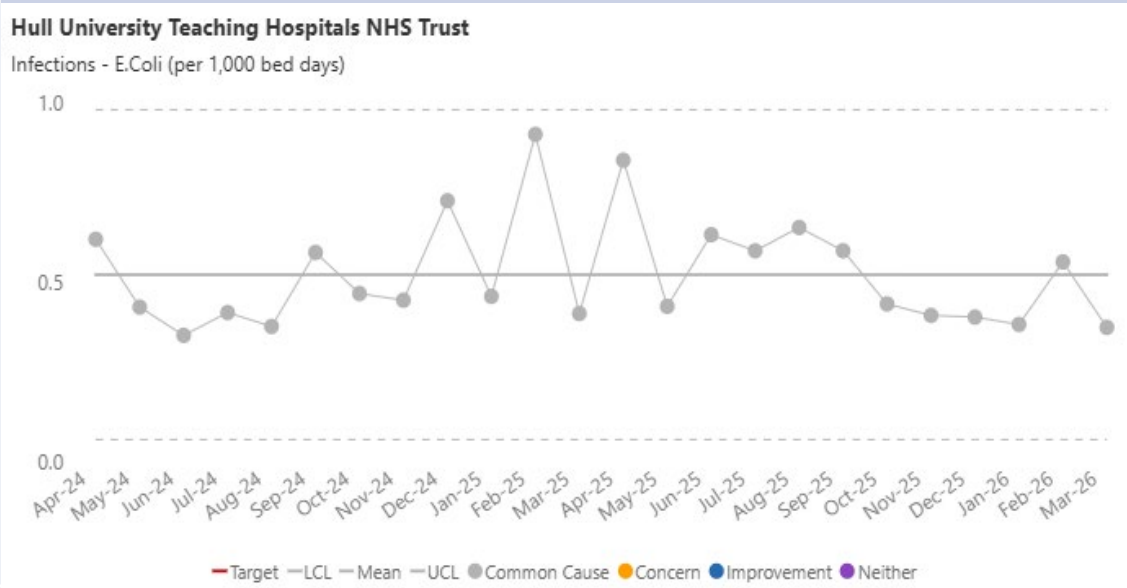
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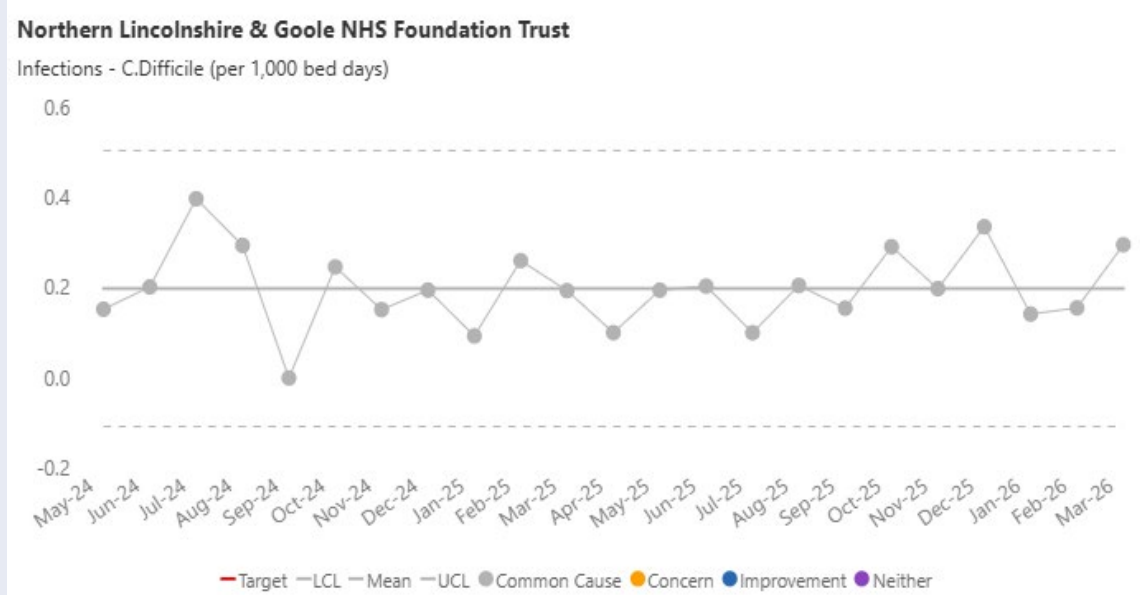
Infection control rates per 1000 bed days – C-difficile and E.Coli bateraemia

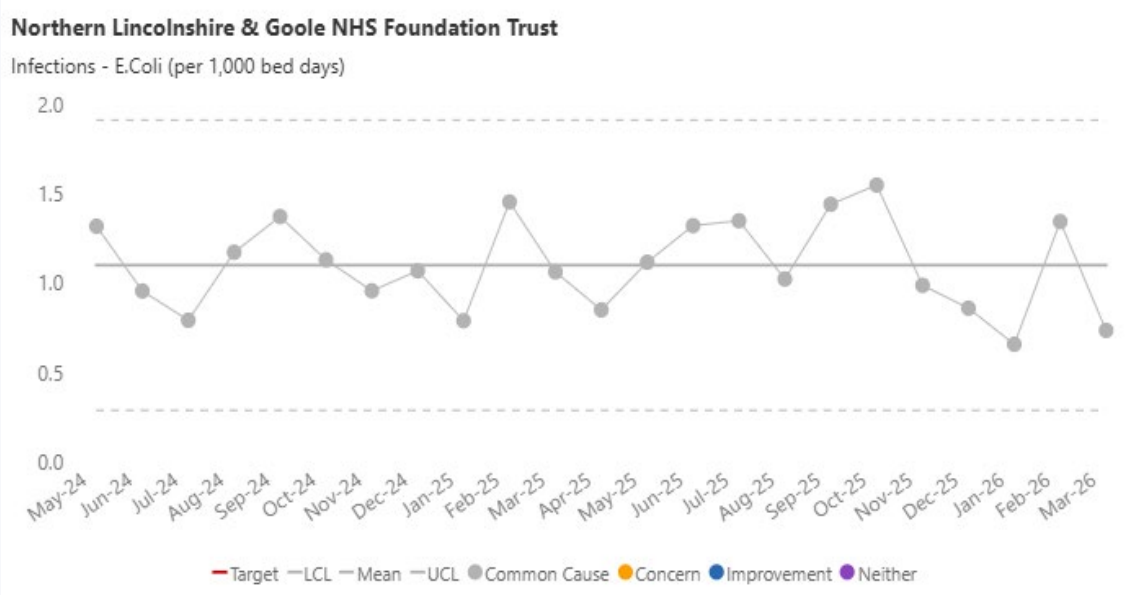
HUTH





NLAG



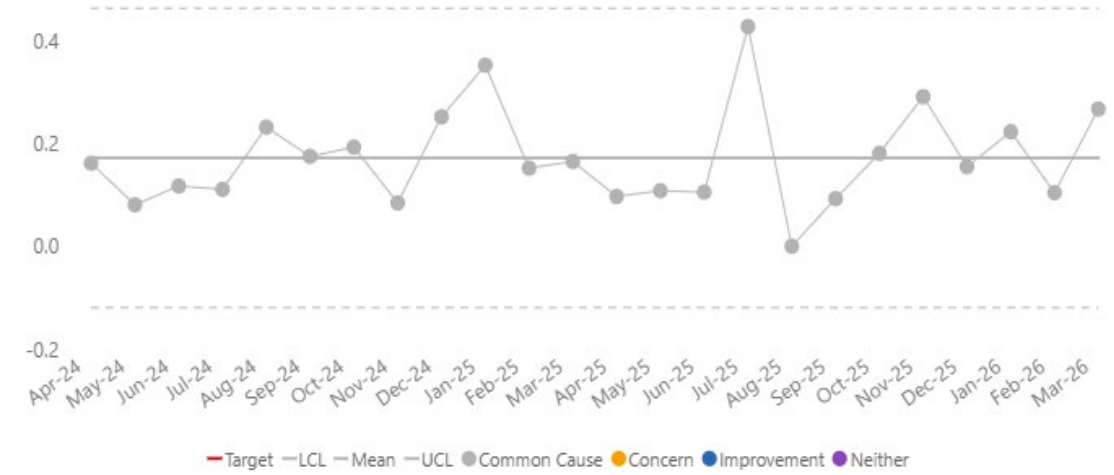


Infection control rates per 1000 bed days – Klebsiella and Pseudomonas aeruginosa bacteraemia

HUTH

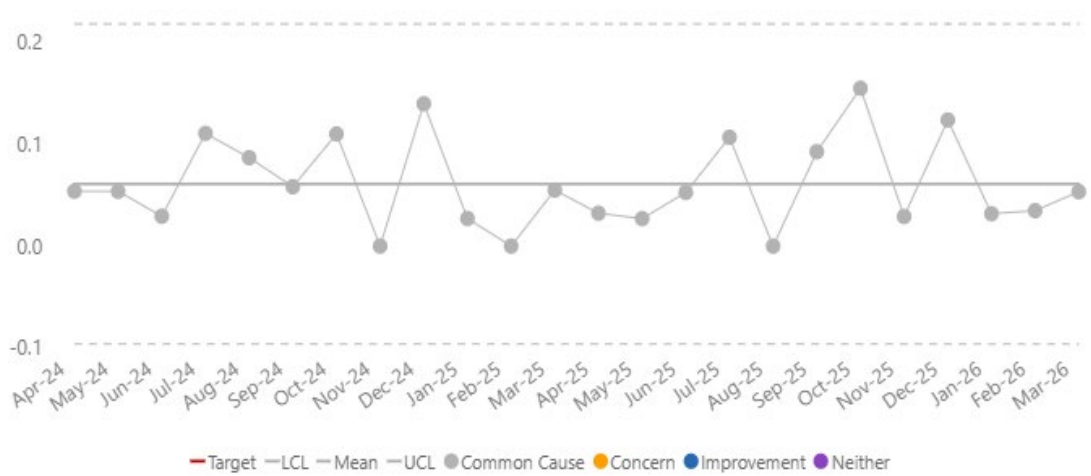
Hull University Teaching Hospitals NHS Trust

Infections - Klebsiella bacteraemia (per 1,000 bed days)



Hull University Teaching Hospitals NHS Trust

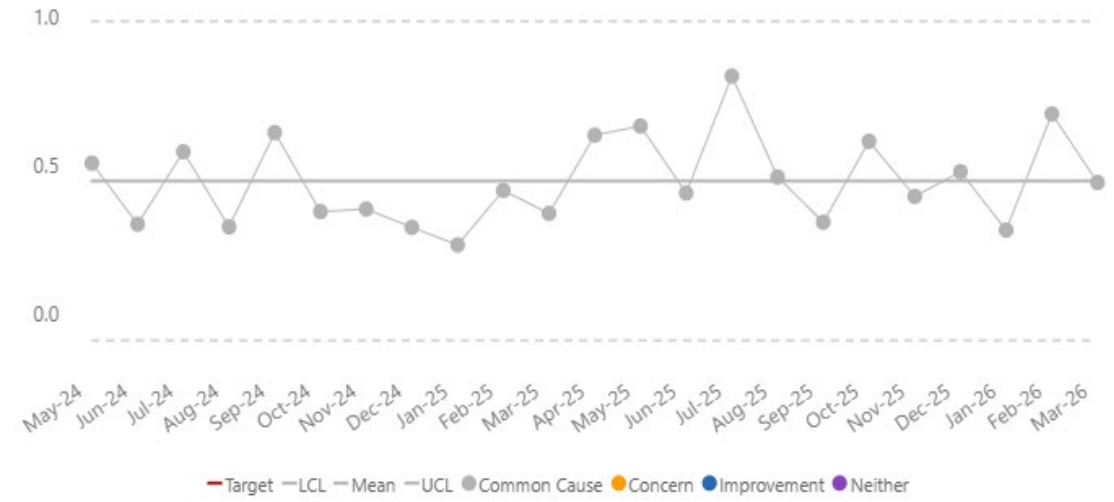
Infections - Pseudomonas aeruginosa bacteraemia (per 1,000 bed days)



NLAG

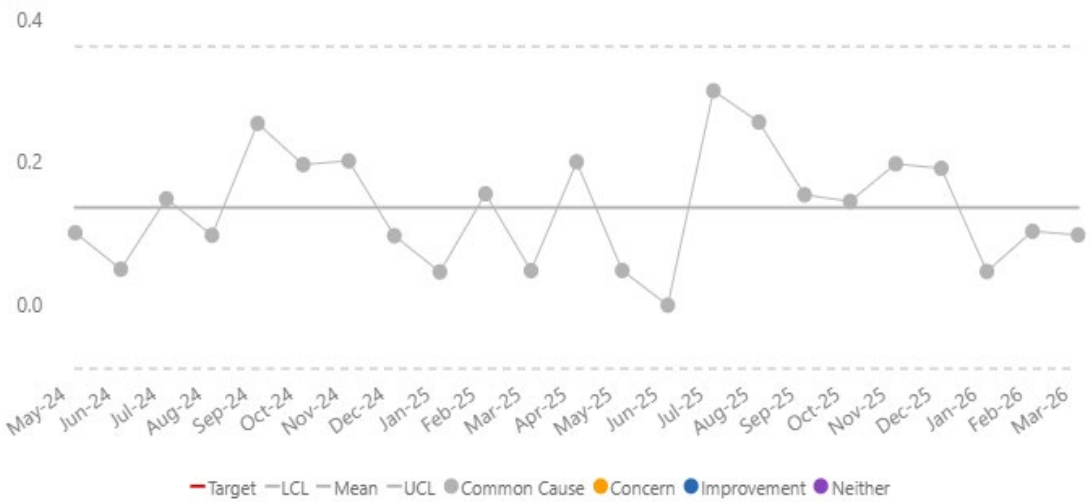
Northern Lincolnshire & Goole NHS Foundation Trust

Infections - Klebsiella bacteraemia (per 1,000 bed days)



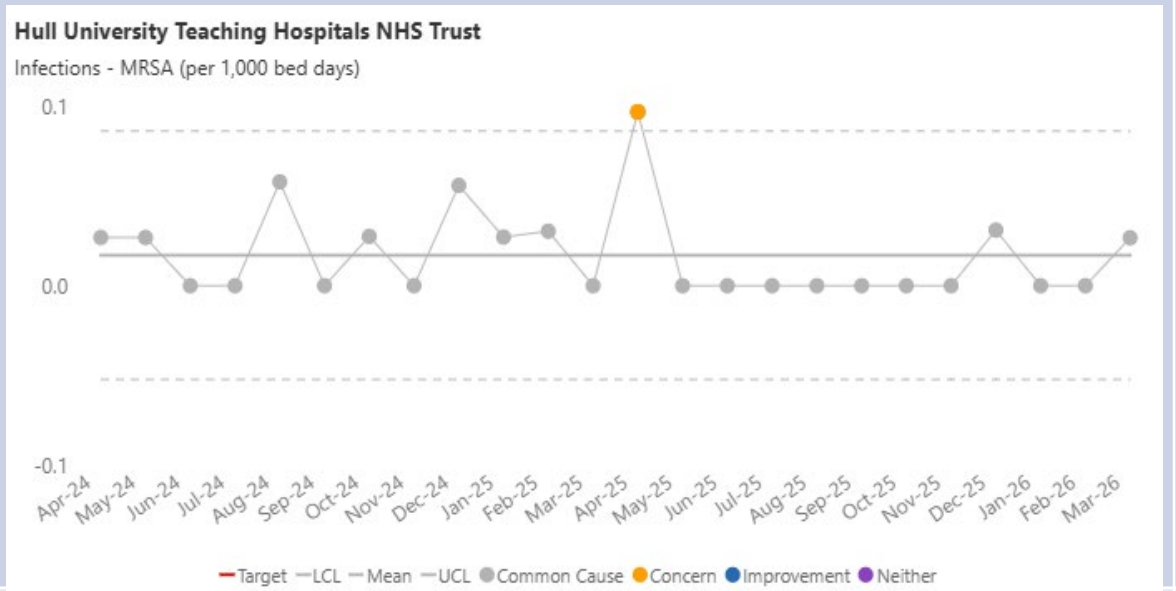
Northern Lincolnshire & Goole NHS Foundation Trust

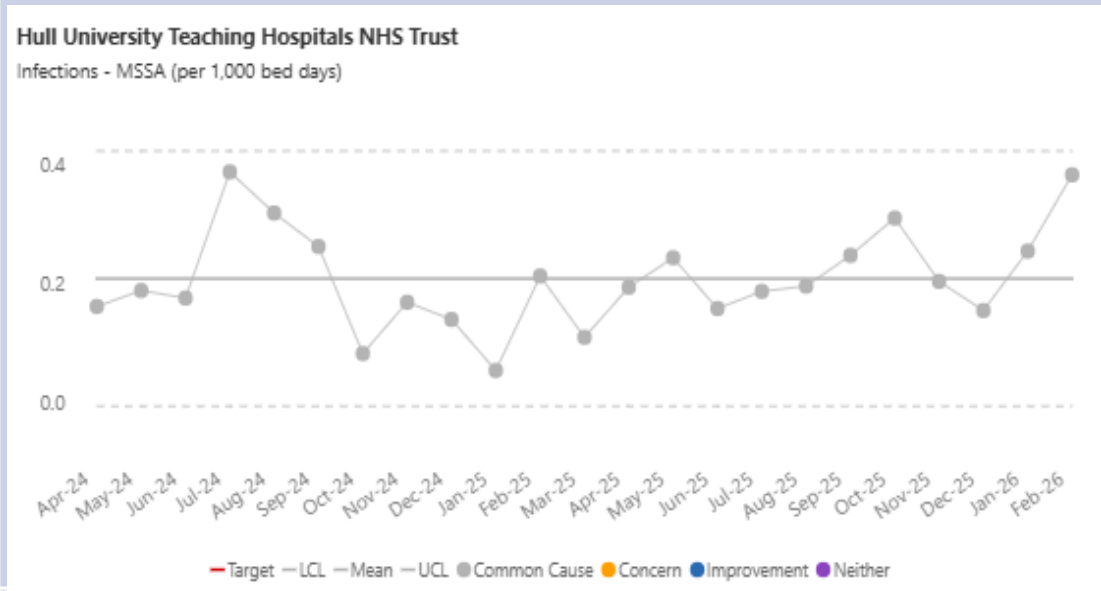
Infections - Pseudomonas aeruginosa bacteraemia (per 1,000 bed days)



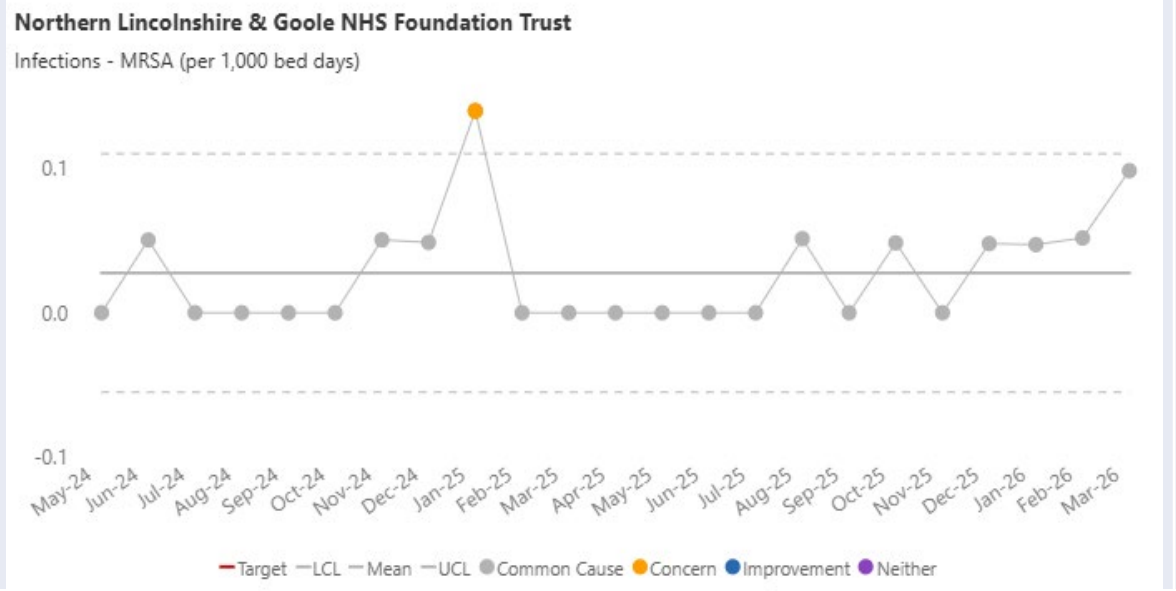
Infection control rates per 1000 bed days – MRSA and MSSA bateraemia

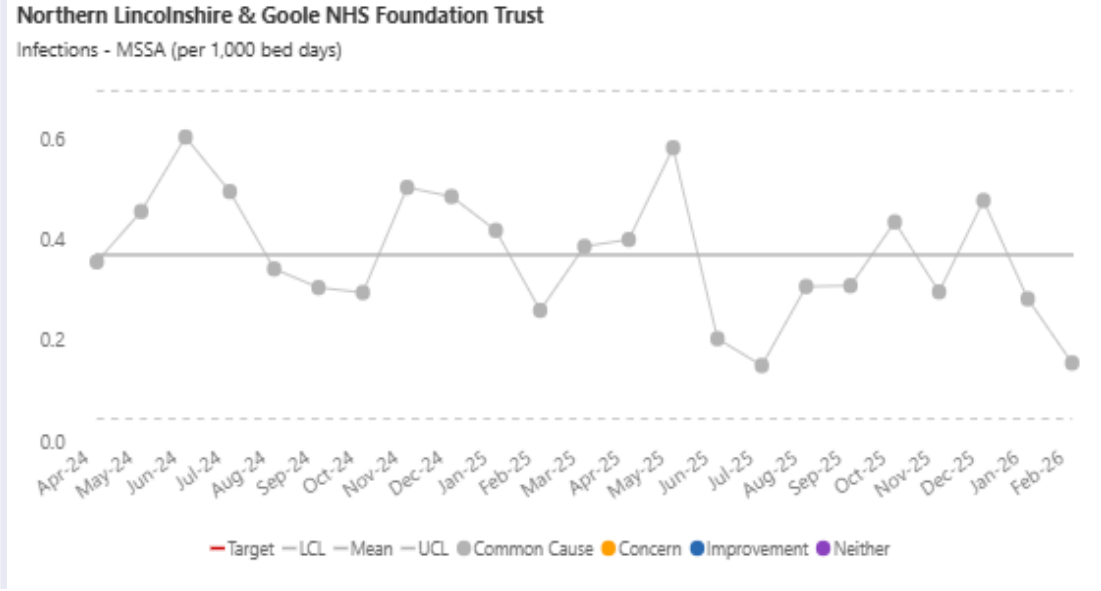
HUTH





NLAG





Care Hours per Patient Day

HUTH

Organisation	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
York and Scarborough Hospitals	7.6	7.6	7.6	7.5	7.4	7.5	7.2	-	-	-	-	-
Harrogate and District	8.5	9.1	8.9	9.3	8.4	8.7	8.3	-	-	-	-	-
Northern Lincolnshire and Goole	9.4	9.4	10.0	9.5	9.2	9.3	9.0	-	-	-	-	-
Hull University Teaching Hospitals	7.4	7.4	7.3	7.2	7.6	7.6	7.5	-	-	-	-	-
Humber	14.4	13.8	14.0	13.7	13.7	13.4	11.9	-	-	-	-	-

- This metric is being introduced to the Quality IPR.
- Development will include the Registered and Non-Registered workforce for both Trusts.
- This is latest data published nationally, benchmarking the HNY ICS region, from Publicview.
- HUTH is in the lowest quartile nationally.

NLAG

5 Providers

Care Hours per Patient Day - Overall (57)

The total hours worked divided by the daily average number of patients

- Higher values are good
- Frequency: Monthly
- **Default** target value: 9.0

Items which meet the target are shown in green text.

Heat Map

Off On

Worst Best

Centiles Based on: National Values ICS Values

0 - 25% | 25 - 50% | 50 - 75% | 75 - 100%

- NLAG is in the above mean quartile until December then below the mean.

Glossary

NHS
Humber Health
Partnership

- C.difficile – clostridium difficile is a type of bacteria that can cause bowel infection
- CCS – Clinical Classification Software
- CHH – Castle Hill Hospital
- COPD – Chronic Obstructive Pulmonary Disease
- CQC – Care Quality Commission
- CT – Computerised Tomography scan, using x-ray techniques to build detailed images.
- CVP – Central Venous Pressure lines are used to monitor haemodynamic status in critically unwell patients and can also be used to provide medicines into the large veins returning blood to the heart.
- DPOW – Diana Princess of Wales Hospital, Grimsby
- E.coli – Escherichia coli are a group of bacteria that are found in the gut of nearly all people, and can cause infections if gets into new areas, such as wounds, urinary catheter sites and can cause blood stream infections.
- ED/ A&E – Emergency Department
- FFT – Friends and Family Test
- GDH – Goole District Hospital
- HHP – Humber Health Partnership
- HSMR – Hospital Standardised Mortality Ratio, a measure to assess the in-hospital death rate
- HRI – Hull Royal Infirmary
- HUTH – Hull University Teaching Hospitals NHST
- ICB – Integrated Care Board
- IPC – Infection prevention and control
- Klebsiella – Klebsiella Pneumoniae are normally harmless bacteria that are found in the gut and can cause infections in the blood stream and pneumonia.
- LFPSE – Learning from Patient Safety Events is a national database that provider organisations automatically submit patient safety incidents to from their incident reporting systems.
- MRSA – Methicillin-resistant Staphylococcus aureus, which is resistant to the normal treatments for staphylococcus infections and can be difficult to treat in wound and blood stream infections.
- Never Event/NE – Considered to be wholly preventable due to safety measures available from national safety notices and defined by the Never Event List provided by NHS England.
- NLAG – Northern Lincolnshire and Goole NHSFT
- NPSA – National Patient Safety Alert
- NRFIT – An injection connection device to specifically reduce risk of error for spine and other anaesthetic blocks.
- PALS – Patient Advice and Liaison Service
- PIR – Post Infection Review
- Pressure Ulcer/PU – Tissue damage from pressure from prolonged pressure from sitting, laying or devices causing ulceration.
- PSI – Patient Safety Incident
- PSII – Patient Safety Incident Investigation, a detailed investigation as part of the response to an incident where there may be significant learning.
- RAG – Red, Amber, Green colour coded ranking, worst to best,
- RCEM – Royal College of Emergency Medicine
- SGH – Scunthorpe General Hospital
- SHMI – Summary Hospital-level Mortality Indicator, a measure to assess the in-hospital and for 30 days following discharge death rate.
- VTE – Venous thromboembolism, linked with risk assessment and prophylaxis.