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, 14 May 2026 at 10.00 am to 12.00 pm in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** 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, 9 April 2026** Alan Downey, Group Chair	BIC(26)103 Attached	Approval	
1.7	**Matters Arising** Alan Downey, Group Chair	Verbal	Assurance	
1.8	**Action Tracker** - **Public** Alan Downey, Group Chair	BIC(26)104 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Group Chair's Briefing** Alan Downey, Group Chair	BIC(26)105 Attached	Assurance	**10:35**
2.2	**Interim Group Chief Executive's Briefing** Lyn Simpson, Interim Group Chief Executive	BIC(26)106 Attached	Assurance	**10:45**
2.3	**National Reports and Guidance** Lyn Simpson, Interim Group Chief Executive	BIC(26)107 Attached	Assurance	**10:55**
3.	**PATIENT SAFETY UPDATE**			
3.1	**Monthly Patient Safety Update** Mr Peter Sedman, Deputy Chief Medical Officer & Jo Ledger, Deputy Chief Nurse	BIC(26)108 Attached	Assurance	**11:00**
4.	**STRATEGIC PROGRESS**			
4.1	**Staff Survey Results** Paul Bunyan, Director of Planning, Recruitment, Wellbeing & Improvement	BIC(26)109 Attached	Assurance	**11:15**
4.2	**Public Purse (including Assurance Committee update)** Emma Sayner, Group Chief Financial Officer & NED Committee Chair	BIC(26)110 Attached	Assurance	**11:25**

5.	**OTHER ITEMS FOR ASSURANCE**			
5.1	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report** Jane Hawkard, NED Committee Chair	BIC(26)111 Attached	Assurance	**11:35**
5.2	**Trust Constitution** David Sharif, Group Director of Assurance	BIC(26)126 Attached	Assurance	**11:45**
6.	**OTHER ITEMS FOR APPROVAL**			
6.1	**Draft Strategic Objectives 2026 / 27** Lyn Simpson, Interim Group Chief Executive	BIC(26)128 Attached	Approval	**11:50**
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		**11:55**
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, 11 June 2026**			

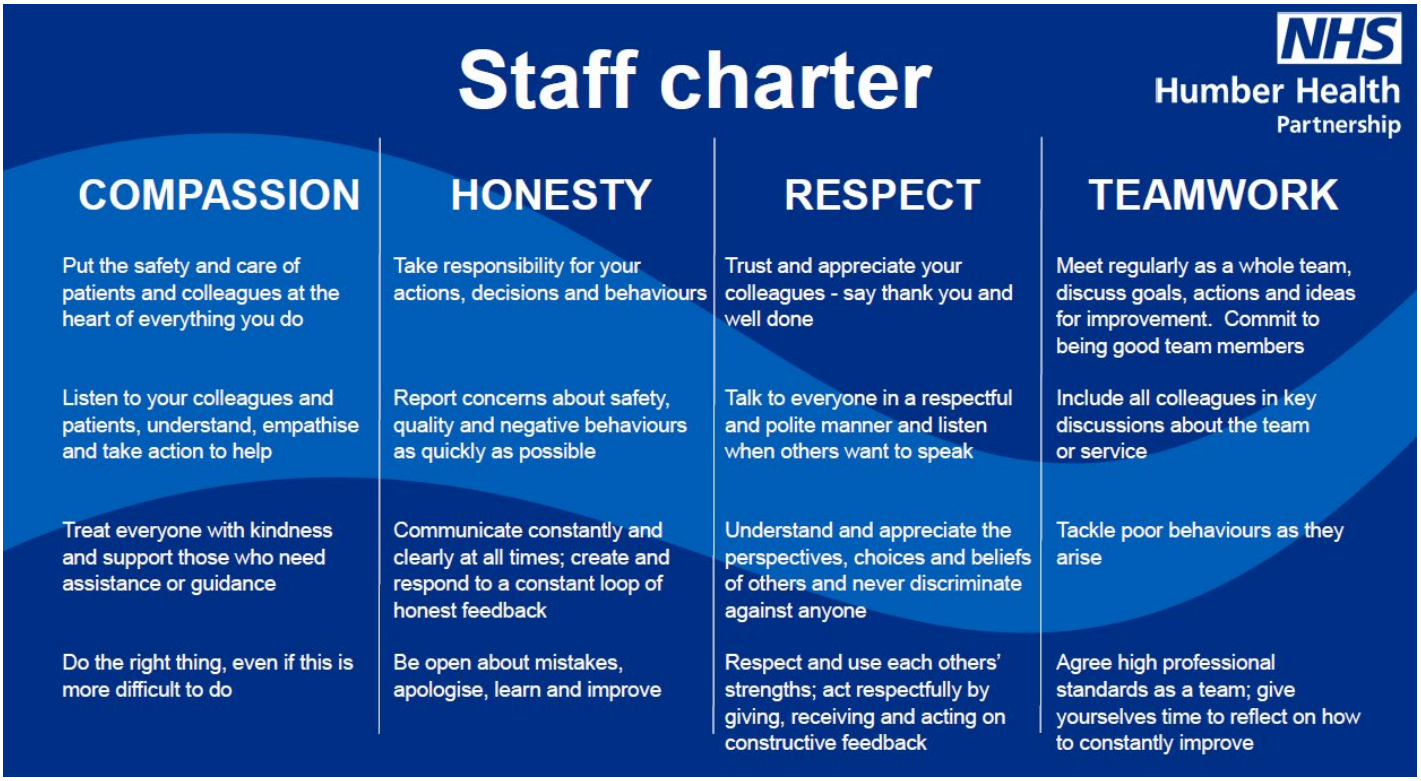
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

7.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – March 2026** Dr David Sulch, Non-Executive Director Committee Chair	BIC(26)112 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Finance Report – Month 12** Emma Sayner, Group Chief Financial Officer	BIC(26)113 Attached
7.3	**Workforce, Education & Culture Committees-in-Common**	
7.3.1	None	
7.4	**Audit, Risk & Governance Committees-in-Common**	
7.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – January 2026** Jane Hawkard, Non-Executive Director Committee Chair	BIC(26)114 Attached
7.5	**Other**	
7.5.1	**Group Performance Report – NLaG and HUTH** Chris Fry, Group Director of Performance	BIC(26)115 Attached
7.5.2	**Trust Boards & Committees Meeting Cycle – 2026** David Sharif, Group Director of Assurance	BIC(26)116 Attached
7.5.3	**Board Assurance Framework (BAF)** David Sharif, Group Director of Assurance	BIC(26)117 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

DRAFT

TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 9 April 2026 at 10.00 am

in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Alan Downey	Group Chair
Lyn Simpson	Interim 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 (representing Dr Kate Wood)
Julie Beilby	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Murray Macdonald	Vice Chair (HUTH) & Non-Executive Director (NLaG)

In Attendance:

Mark Blakeman	NHS England
Paul Bunyan	Covering Group Chief People Officer
Yvonne McGrath	Group Midwifery Director (for item 3.1.2)
John Palmer	Member of the Public
Alastair Pickering	Interim Group Chief Digital Officer
Ian Reekie	Lead Governor (attended virtually)
Henry Sanderson	Health Service Journal (member of the public)
David Sharif	Group Director of Assurance
Vicky Sharman	Site Director (for item 1.3)
Hilda Gwilliams	Group Chief Patient Safety Governance Officer
Kevin Woolass	Member of the Public
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

KEY

HUTH - Hull University Teaching Hospitals NHS Trust

NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

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

Alan Downey welcomed Board members and observers to the meeting and declared it open at 10.00 am.

He thanked Murray Macdonald for undertaking the Interim Group Chair role over the past six months and for his helpful introduction to the organisation, noting the value of his advice and wisdom during this period.

Apologies for absence were received from:

Dr David Sulch	Non-Executive Director (HUTH)
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**

Alan Downey welcomed the inclusion of patient stories, noting their value in highlighting where care had not met expectations and how learning was being taken forward by the organisation.

Jo Ledger advised that the story related to the use of Temporary Escalation Spaces (TES), which remained a national issue for trusts. She noted that positive progress was being made locally to improve these areas and that the story demonstrated the impact such pressures had on patient experience.
Vicky Sharman presented a patient story relating to Mr R, who had attended Diana, Princess of Wales Hospital (DPoWH) with chest pain and neurological symptoms. While his initial clinical assessment was positive, his overall experience deteriorated due to operational pressures. This resulted in poor communication regarding treatment, ward moves and discharge. Owing to bed capacity issues, Mr R spent his first night in a reclining chair in the Same Day Emergency Centre (SDEC), where basic care needs were not adequately met due to limited washing facilities and hot food provision. This contributed to increased anxiety and reduced confidence in the care received. It was acknowledged that SDEC was not designed to provide overnight care and should only be used for patients expected to be discharged the same day; however, this had not been possible on this occasion due to bed pressures.

Vicky Sharman advised that national guidance on corridor care identified it as a significant safety concern, which should be eliminated wherever possible, and stated that no patient should remain in an emergency department for more than 24 hours.

She confirmed that learning had been taken from this case and that actions had been implemented following the complaint. Washing facilities had been installed within SDEC and arrangements had been put in place to ensure access to hot meals should patients need to be cared for there again. It was acknowledged that patient pathways required improvement and that SDEC should only be used as a temporary area until patients were discharged or admitted to a ward.

Learning had also been identified in relation to communication, as complaints frequently highlighted poor communication; earlier and clearer discussions with patients were required to manage expectations. It was noted that such circumstances also carried an increased risk of patient harm.

Vicky Sharman advised that a corridor care induction programme was in place and had resulted in a 50% reduction on the north bank, with monitoring

continuing on the south bank. TES areas were being formalised and would operate only as part of the formal Operations Pressure Escalation Level (OPEL) 4 escalation plan, closing once Trusts moved out of OPEL 4. She noted that while the clinical care provided had largely been appropriate, operational pressures had significantly undermined the patient experience.

Jo Ledger advised that the organisation expected to provide an improved level of assurance to the Boards on TES arrangements by the end of July 2026. Oversight was being provided through the Quality & Safety Committees-in-Common. She reiterated that effective communication with patients was critical and required further improvement.

Alan Downey commented that the story was helpful in highlighting patient flow challenges and welcomed the mitigations put in place for future use of SDEC. Jane Hawkard queried whether the reported 50% reduction at HUTH meant that corridor care was still occurring and sought assurance on whether reductions were due to active interventions or reduced operational pressures. In response, Vicky Sharman confirmed that NHS England had introduced a Corridor Care Reduction Programme, requiring elimination of corridor care by 31 July 2026. The organisation had set a trajectory of a 25% monthly reduction to meet this target, supported by the ‘perfect week’ work, which had enabled faster progress in some areas. She advised that some TES areas did not currently meet required standards and would need further work before being included. By 31 July 2026, all TES areas would be formalised and agreed.

As Non-Executive Director Chair of the Quality & Safety Committees-in-Common, Julie Beilby advised that a comprehensive report had been reviewed by the Committees, with detailed discussion. The Committees had confirmed that corridor care was never acceptable and that eradication of the practice must be adhered to.

Vicky Sharman agreed that NHSE enablers were specific and included expansion and redesign of SDEC pathways to improve patient flow. A key focus was developing alternatives to admission as part of the improvement programme.

Hilda Gwilliams advised that reductions had been achieved through multiple interventions, including setting clear standards on unacceptable practice and supporting actions. She noted that recent improvements in OPEL ratings reflected this progress and that further assurance should be provided through the Integrated Performance Report (IPR).

Sam Peate advised that the reduction of some escalation spaces in recent weeks had been appropriate, with daily decisions taken to balance risk across the organisation. Work continued with teams to embed national best practice. Lyn Simpson advised that the NHSE correspondence on corridor care had been issued nationally and reinforced that such care was unacceptable. She thanked staff for their work in addressing the issues and embedding processes to meet the July 2026 target, noting the scale of achievement within a short timeframe and the importance of sustaining progress ahead of winter.

Alan Downey thanked Vicky Sharman for presenting the patient story.

Julie Beilby referred to the Patient Safety Highlight Report and welcomed the clarity of governance arrangements set out within it, suggesting this approach be replicated in future reports.

1.4 **Questions from the Public and Governors**

David Sharif advised that two questions had been received from members of the public for the meeting.

John Palmer had asked if the central booking system now live and was working ok. David Sharif advised that the longer-term aim in conjunction with the NHS national strategy was to use the NHS app as the main source for communication between patients and hospitals. As part of that the organisation was developing a central booking hub, with every process under one management team. At present all appointment letters were made available via the patient engagement platforms with different platforms in place for NLAG and HUTH at present, however, plans to harmonise those arrangements would be implemented later in 2026.

John Palmer had also asked if there was any update with services been restored at Goole & District Hospital (GDH) i.e. clinics. He was still getting reports of elderly people being asked to travel for appointments which could be done at GDH, given transport links were abysmal from Goole and surrounding areas without a car and took the best part of the day and was impossible for early appointments. David Sharif advised that they welcomed the question as it helped inform work between the Trust and the Integrated Care Board (ICB) over the services provided. He added that arrangements would be made for John Palmer to meet with Sam Peate and discuss his specific concerns. A full update to the question would be provided following the meeting with an update shared at the May 2026 meeting.

Action: Sam Peate to arrange to meet with John Palmer

Action: Updated response to question following meeting between Sam Peate and John Palmer to be provided at May 2026 meeting

Murray Macdonald referred to the administrative functions for patients as he felt that this had not been reviewed to ensure it was working effectively. He questioned whether the Performance, Estates & Finance Committees-in-Common should review this to highlight whether there was assurance.

Action: Performance, Estates & Finance Committees-in-Common to review administrative functions to provide assurance to the Trust Boards-in-Common

1.5 **Declarations of Interest**

Alan Downey sought declarations of interest from Board members, none were received. As the new Group Chair, he advised that he Chaired an educational charity, Nurture UK. Further to this his wife was a partner at Pricewaterhouse Cooper (PwC), adding that if they were to bid for any work with the organisation, he would recuse himself from any related decision-making on contract awards.

1.6 **To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 12 March 2026 – BIC(26)069**

The minutes of the meeting held on the 12 March 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)070**

Murray Macdonald referred to the action tracker for the meeting.

He advised that the nursing establishment paper was referred to on the tracker and would be discussed during the meeting.

- Item 2.2, 12 March 2026 meeting – Mr Peter Sedman apologised as he had no update in respect of this item, he advised he would provide an update at the next meeting.
- Item 4.1, 12 March 2026 meeting – this item had been closed as Emma Sayner had held a session with the Care Groups. She added that discussion in respect of this would be held at the Performance, Estates & Finance Committees-in-Common as part of a deep dive, any update on this would then be shared with the Trust Boards-in-Common.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Chair's Report**

Alan Downey advised he had not provided a written report for the meeting as he had only started in the role on the 1 April 2026. He reported that he felt it was a privilege to be taking on the role and that he was aware of the significant issues that needed to be addressed across the partnership. He was positive that changes would be made as he had already met some very dedicated staff across the organisations that wanted to support improvements being made. He had been encouraged by the level of clinical engagement at the organisations which had been highlighted when he had jointly met with the NLaG consultants the previous evening. He had also met with the Chiefs of Service and amongst various colleagues within the system.

Whilst acknowledging the issues facing the organisation, he emphasised the importance of also recognising and celebrating the positive work taking place across the Group. He advised that he had begun meeting with local Members of Parliament and intended to meet with all of them over the coming weeks. Alan Downey concluded by thanking colleagues for the warm welcome he had received.

2.2 **Group Chief Executive's Briefing – BIC(26)071**

Lyn Simpson referred to the report and advised that in respect of the resident doctors' strike planning for this had gone extremely well and that she was grateful to colleagues that had supported this. She advised that close monitoring of staffing

and patient flow had been in place throughout the period. She also noted a particularly busy period at the Diana, Princess of Wales Hospital site, reflecting an increased demand linked to use of local holiday parks.

Lyn Simpson advised that the report provided an opportunity to reflect on the clinically led improvement plan, which set out key priorities relating to patient safety, patient flow, and service stabilisation. Stabilising services included reviewing identified risk areas and ensuring consistent care delivery for patients across all five hospital sites at all times. She acknowledged that historical issues were being addressed and that there was clarity on the actions required to support improvement.

In relation to the National Operating Framework (NOF), Lyn Simpson advised that while the organisations remained in the lowest tier, the metrics aligned with the improvement plan demonstrated a clear understanding of the areas requiring focus. She emphasised the importance of fully embracing external reviews and incorporating their findings into the overarching improvement plan. While the group model remained the correct strategic approach, she acknowledged that there had been challenges in implementing the operating model, which now required targeted attention.

She highlighted that the organisation had strong clinical practice and a committed workforce, which were supporting improvement. This was reflected in recent Getting It Right First Time (GIRFT) reviews, which identified measurable improvements, including the performance in four-hour emergency department waits, twelve-hour waits, reductions in corridor care, ambulance handover delays, and fourteen-day length of stay. These indicators demonstrated that progress was being made.

Jane Hawkard referred to the NOF in respect of clarifying accountability, she queried whether there was progress with this. In response, Lyn Simpson advised that work was ongoing to ensure staff in key roles were clear about delivery expectations. This included work with Chiefs of Service to ensure Care Groups understood their responsibilities, supported by assurance processes and clearly identified accountable leads.

Julie Beilby referred to accountability and explained that at the Workforce, Education & Culture and Quality & Safety Committees-in-Common mandatory training had been discussed and its lack of compliance against Care Quality Commission (CQC) requirements. She noted that the report now reflected that individuals failing to complete mandatory training would be subject to a human resources process, providing clearer consequences.

Julie Beilby also advised that she did not feel the Board yet had sufficient assurance regarding 247 working and specifically weekend and bank holiday staffing arrangements to support patient flow, an issue previously raised. Lyn Simpson agreed that a Board development session would be appropriate to provide further information and assurance. She confirmed that staffing models were generally sufficient, while acknowledging that pressures could arise due to vacancies or unplanned sickness absence, and that assurance was required on how such risks were managed.

Acton: Board Development Session on 247 staffing provision to include holiday periods and weekend cover

Sam Peate advised there was an annual seven-day return that had to be submitted in respect of staffing later in the year that would provide further information on this.

Alan Downey emphasised the importance of continuing to be open and honest about performance. He acknowledged recent negative media coverage relating to the Group and the need to respond appropriately, while also ensuring that successes were recognised and communicated.

2.3 **National Reports and Guidance - BIC(26)072**

Lyn Simpson referred to the report and advised that it had been provided to ensure Board members were sighted on relevant national correspondence received by the organisation. She invited Board members to indicate whether they wished any additional information to be included and highlighted key points from the report for assurance.

Murray Macdonald referred to community health service waiting times and queried whether these were included within the organisation's overall reporting framework. He further asked at what level this information was reported to the Boards and how it was monitored. Sam Peate advised that community health service waiting times had been a reportable measure for some time and should be included within the IPR, noting that they were already captured through community waiting list data. Murray Macdonald requested that the IPR include a clear distinction between South Bank community services and North Bank services to enable comparison and support an improved understanding of patient flow across the Group.

Julie Beilby welcomed the report but requested that a named lead be included to clarify who was responsible for overseeing and progressing the initiatives. Lyn Simpson confirmed that this information would be added to the report.

Action: Lead to be added to report to highlight who was overseeing initiatives

3. PATIENT SAFETY UPDATE

3.1 **Monthly Patient Safety Update (including Assurance Committee Update) – BIC(26)073**

Hilda Gwilliams referred to the report and took it as read. She noted that it included a number of historical investigations that remained open beyond the expected timescales and advised that plans were now in place to address these, with clear trajectories for improvement. The report also identified key themes arising from the data sources reviewed. It was noted that, as the IPR continued to be developed, it would align improvement plans, regulated activities and NOF activity, to demonstrate progress and trajectories.

Hilda Gwilliams further advised that a session with the National Provider Improvement Programme (NPIP) was scheduled for 23 April 2026 to co-design the IPR, including the governance framework, key workstreams, and to identify Senior

Responsible Officers (SROs). It was anticipated that the redesigned IPR would be shared with the Boards by June 2026.

Action: IPR to be shared with Boards once it had been redesigned

Hilda Gwilliams acknowledged that there was a need to capture improvements to highlight progress.

Mr Peter Sedman advised that the Group had reported 19 Never Events over the preceding 24 months, resulting in both Trusts being jointly ranked sixth nationally. He confirmed that the elimination of Never Events remained a priority, supported by a programme of Safety Summits commencing the following month and continued work with clinical teams to strengthen and embed safer processes. It was appreciated that no Never Events had been reported across the organisation in the previous three months.

Alan Downey acknowledged the absence of Never Events over the last three months and queried what period would be considered indicative of sustained improvement. Mr Peter Sedman advised that a minimum period of twelve months would be an appropriate benchmark.

Jane Hawkard queried whether the recent improvements reflected the actions being taken or whether the absence of reported Never Events was attributable to chance rather than sustained improvement. In response, Mr Peter Sedman advised that the initial approach had focused on raising awareness with staff, including discussions with Chiefs of Service to ensure learning was disseminated across services. He noted that Never Events had previously occurred across a number of specialties and that roadshows had been held to highlight the issues identified. A revised process for investigating Never Events had been introduced to support improvement. Following reported Never Events, simulation exercises had been undertaken to identify contributory factors, with emerging themes identified for further action.

Hilda Gwilliams advised that two-thirds of the Never Events related to national safety frameworks and noted that some of these had not been embedded as robustly as required. Mr Peter Sedman added that new checklists had been introduced at the time of the Never Events but acknowledged that these had not been consistently embedded. He further advised that a monthly surgical safety day had been introduced across all sites, taking place on the second Friday of each month.

Julie Beilby advised that a patient safety report had been received by the Committees; however, she noted discrepancies between that report and the version presented to the Board. She requested that future reports be aligned and include consistent information.

Murray Macdonald welcomed the content of the report but requested that future reports also included information on corridor care and infection control. He emphasised that the report should function as an escalation report, focusing on key highlights rather than detailed operational content.

Action: Infection control and corridor care to be included within future patient safety reporting

Hilda Gwilliams explained that reporting could be reduced in the future as the IPR should provide all the detail required in one report rather than sharing different reports. Lyn Simpson advised Board members that there was limited support within the performance team at the moment, although this was now being addressed to ensure that progress would be made with improved reporting.

3.1.1 **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(26)074**

The Maternity & Neonatal Safety Champions report was noted.

3.1.2 **Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH – BIC(26)075**

Yvonne McGrath referred to the report and advised that Maternity Incentive Scheme (MIS) for year seven had been submitted and that some information had been received back in respect of this that would be shared. In respect of MIS year eight there was significant changes that would be reported to the Boards in June 2026, work in respect of this would be overseen through the Maternity & Neonatal Advisory Group (MNAG). It had highlighted that there would be focus on the links between the Boards and Maternity in the new Standards.

Yvonne McGrath explained that there had been some concerns raised at DPoWH in respect of culture and behaviours, meetings had been held with staff to address this including work with HR. This would be discussed further at the required forums.

In respect of post-natal readmissions NLaG had been flagged as high on the national average, a deep dive had been undertaken to review this which had identified that women coming in for review were being admitted which had been reported incorrectly. The review had shown that NLaG were, therefore, around the national average. There was improvement work being undertaken in respect of respiratory transition for babies particularly at NLaG.

In respect of compliance with Birmingham Symptom-specific Obstetric Triage System (BSOTS) this had been inconsistent particularly at HUTH. This had been due to staff new to the organisation not rotating, this was now being addressed. Yvonne McGrath referred to the dashboards within report for both Trusts.

In respect of Saving Babies Lives it was hoped that a pre-term midwife would be appointed as the role had been advertised. The oversight for this had previously been undertaken by Local Maternity & Neonatal System (LMNS) and the ICB, however, this would now require Boards oversight due to that disbanding.

Yvonne McGrath advised that in respect of Ockenden there was an intention to share a paper in June 2026 to highlight actions that could not be progressed to identify whether they were still relevant and required. Yvonne McGrath provided detail in respect of Perinatal Mortality Review Tool (PMRT) cases.

Further to a previous query regarding neonatal nursing fill rates, Yvonne McGrath advised that staffing was flexed across the Group to maintain required numbers, protect Level 3 capacity and ensure patient safety. She noted that additional neonatal nurses had been recruited, although numbers remained below the

required establishment. Whilst vacancy rates had improved, staff sickness continued to impact staffing levels at times.

The service user feedback for Hull Royal Infirmary (HRI) had improved and had been noted at MNAG as patients receiving an improved experience. There had been some poor feedback at DPoWH during telephone calls with patients resulting in targeted work being undertaken.

Spring Board to Midwifery events had been held and been successful across the group, further sessions would be held. It was reported that Midwifery apprenticeships would also be available.

Yvonne McGrath advised that the maternity and neonatal safety champion walk arounds had taken place at both sites. There had been an increase in neonatal deaths in 2024 / 25, however, for 2025 / 26 there had been no common themes identified. A peer review would be undertaken in respect of this.

Jo Ledger explained that the Neonatal Intensive Care Unit (NICU) staffing review would be undertaken in respect of fill rates. In respect of Section 31 it was acknowledged that there had been great progress towards this improving which was credit to Yvonne McGrath and the team.

Julie Beilby referred to section 2.5 of the Maternity & Neonatal Safety Improvement Plan and queried the difference between, “signed off and evidenced” and “complete”. Yvonne McGrath explained that “complete” referred to this being undertaken, however, it did not necessarily mean that the audits had been evidenced as completed. She added that “signed off and evidenced” related to this being checked and evidenced.

Alan Downey thanked Yvonne McGrath for sharing the report with Board members.

4. STRATEGIC PROGRESS

4.1 Patients Performance (including Assurance Committee Update) – BIC(26)076

Sam Peate referred to report and took it as read advising that the Trusts continued to be in tier one for performance despite some improvements. From a referral to treatment (RTT) perspective there had been a change in the waiting lists for NLaG with a significant reduction, however, this continued to be high for HUTH. There had been relevant stabilisation in RTT, however, not in recovery.

The 65-week wait had reduced since the christmas period with March 2026 showing the lowest reporting position in the last year. In respect of cancer access the faster diagnosis was a key metric which had been off course for several months with focussed work being undertaken with the Cancer Alliance to address this and with strong recovery being seen.

In respect of imaging there would be additional capacity at the Scunthorpe Community Diagnostic Centre (CDC), and although there had been some improvements it was still not meeting national standards. He noted that unplanned care performance had shown improvement, supported by the embedding of revised processes. The ICB had achieved the four-hour emergency care standard at 70%, representing an improvement for the first time in several years. He advised that the

report would continue to be refined to provide key information and welcomed feedback from Board members on any additional detail required.

Jane Hawkard queried the position of RTT 65-week waits at the end of March 2026, noting that previous assurance had been provided that this would reduce to zero. She asked whether this had not been achieved due to delays in utilising the private sector.

Sam Peate advised that the month-end position for 65-week waits remained within the agreed trajectory. He noted that the North Bank had experienced an increase in referrals, following a period of comparatively lower activity, and that overall referral volumes continued to present a challenge. He confirmed that a demand and capacity review would be undertaken, applying a single methodology across each specialty. He also advised that an educational delivery programme would be introduced from the following week. There was a need for greater clarity on the ongoing requirements to ensure sustained delivery against commitments. It was acknowledged that the use of the independent sector had progressed more slowly than anticipated.

Julie Beilby requested that accountability be given by job role rather than by individual name. She also noted that the relevant risk had been set at this level for a considerable time and that there was a lack of clarity regarding when it would change. She queried whether there had been sufficient challenge through the Committees and the Board. Sam Peate advised that he was keen to refresh the report going forward.

David Sharif advised that, as governance arrangements for the integrated improvement plan continued to mature, a streamlined report would be provided to Committees. This would focus on strategic risks and actions, aligning the Board Assurance Framework (BAF) with progress against the improvement plan.

4.2 People – BIC(26)077

Paul Bunyan referred to the report and advised that improvements would be made to the report going forward to highlight important themes and triangulation with the improvement plan. He explained that there had been some marginal gains in respect of the staff survey. Some pressures had been highlighted in respect of how patients were managed particularly at HUTH. There had been improvements in scoring in respect of work life balance, however, it was noted this was still behind the national average. He added that a response had been put together on what the organisational actions would be, in addition to this staff would be spoken to, to ensure there was a deeper understanding on key issues staff experienced.

In relation to variable pay, it was acknowledged that the organisation had overspent at the beginning of the year, largely due to agency usage. This position improved later in the year, resulting in spend being 30% below the benchmarking target. Paul Bunyan advised that this placed the organisation in a more controlled position at the start of 2026/27. He also noted that sickness absence at HUTH was the lowest across the region. The primary driver of sickness absence across the Group was identified as psychological safety. He reported that job planning compliance had reached 95.2%, representing a significant achievement.

Julie Beilby, in her role as Non-Executive Director Chair of the Committees, advised that the high-risk issue relating to disabled access had been referred to the Performance, Estates & Finance Committees-in-Common for further discussion. She welcomed the improvement in job planning and stated that this should be recognised as a significant success, given the level of challenge involved. She emphasised the need for a clear job planning timetable for the coming year to sustain this position and advised that capacity and demand considerations had been discussed at Committee level.

Julie Beilby also referred to issues relating to restraint training, which were due to be reviewed by the Quality & Safety Committees-in-Common. Mr Peter Sedman advised that plans were in place to ensure job planning compliance was maintained during the next year. Julie Beilby further advised that two job planning appeals had been received; one had been considered by the Trust Boards-in-Common, with the second considered at a private Committees-in-Common meeting under delegated authority.

Jo Ledger advised that restraint training was included on the agenda for the next Quality & Safety Committees-in-Common meeting. She confirmed that the issue had also been escalated to the Senior Leadership Team and that significant progress had been made. A training delivery model had been agreed at Senior Leadership Team level to support further improvement.

5. OTHER ITEMS FOR ASSURANCE

5.1 Briefing on Ward Accreditation Programme – BIC(26)077

Hilda Gwilliams referred to the report and advised that the new process was clinically owned. She noted that it had been positively embraced by clinical staff and provided improved oversight and assurance in relation to patient safety and performance metrics.

She explained that the process would support earlier intervention through the availability of daily insights, with a focus on patients, families, and staff to identify and address concerns promptly. Accreditation outcomes were intended to act as a positive and rewarding mechanism for staff, supporting sustained change. The programme would drive quality and safety improvements across the Group and would be aligned to key organisational priorities and the National Operating Framework.

Hilda Gwilliams advised that the accreditation programme had been formally launched, with 25% of areas included within cohort one across the Group. Governance and oversight of performance and outcomes would be provided through the Quality & Safety Committees-in-Common.

Hilda Gwilliams acknowledged that queries had previously been raised in respect of NED and governor support for the programme. She explained that the report provided detail and that this was welcomed as part of the process. Jo Ledger advised that sessions had been delivered to clinical staff and had been well received.

Jane Hawkard referred to the report and noted that it did not make explicit reference to patient experience. In response, Hilda Gwilliams advised that the

accreditation process incorporated approximately 300 indicators, with patient experience forming the foundation of the programme. She confirmed that key lines of enquiry were also embedded. Jane Hawkard emphasised the importance of engaging directly with patients as part of the process. Hilda Gwilliams confirmed that this was built into the tool and that the accreditation system had been co-designed with patients and families. She agreed that an appendix could be included in future reports to set out the full range of indicators.

Action: Appendix of indicators to be included within future reports

Murray Macdonald welcomed the accreditation process, noting that it represented a positive step towards delivering improvements. He queried whether the outputs would include a ward-to-board dashboard, to which Hilda Gwilliams confirmed this would be the case. He also referred to NED engagement within the accreditation process and noted that this was not reflected in the detail presented. Hilda Gwilliams advised that the programme would be shared with NED and governor colleagues to support their involvement, including opportunities to engage directly with staff and patients. Murray Macdonald requested that a programme of dates be shared to enable visits to be scheduled, emphasising the importance of this as part of the NED role. Hilda Gwilliams agreed to circulate the programme.

Action: Hilda Gwilliams to share accreditation programme of dates with NED and governor colleagues

Alan Downey felt that ward accreditation programmes were a way of driving engagement and performance improvement for organisations and where staff could take pride in the work they were undertaking which was important.

Sam Peate explained that his previous organisation had undertaken this process and it had been well received. He asked if colleagues would appreciate some time with those colleagues to discuss how this had been received that that organisation. Board members agreed with the proposal made.

Action: Sam Peate to schedule session on ward accreditation programme with colleagues using the system from previous organisation

5.2 Establishment Review of Safe Staffing – BIC(26)079

Jo Ledger explained that the action tracker referred to two actions in respect of safe staffing, one related to governance arrangements and the other referred to financial arrangements. She added that a paper was due to be shared at the Workforce, Education & Culture Committees-in-Common in May 2026 which would provide further detail in respect of this.

Jo Ledger advised the Boards that she would undertake a review of each establishment and provide an overview of any identified issues, including timelines for staff recruitment. She confirmed that safer staffing reviews would be reported to the Boards on a twice-yearly basis. The format of this reporting was currently under review to ensure it provided the appropriate level of detail. She added that an external review of establishment processes was being undertaken with NHSE, which had provided confidence in the processes in place. It was noted that the key

issues related to how this information was presented and how it was triangulated with other required standards.

In the future the plan would be to share the paper twice a year with an agreed format of the report firstly being shared in August 2026.

Action: Safer Staffing paper to be shared with Boards in August 2026, to be shared six monthly thereafter

Emma Sayner advised that members of the Finance Team were actively supporting this work to ensure that governance arrangements aligned with those previously agreed by the Boards. She reminded Boards that a commitment had been made regarding resourcing levels and the parameters within which the partnership would operate. She added that this work would also align with service flow and design to ensure that resources were deployed effectively.

Jane Hawkard advised that an overall workforce plan should be presented in advance to ensure that agreed targets were being met. She queried whether there were any issues at this stage that required immediate action. In response, Jo Ledger advised that maternity staffing had been identified as a priority area and that this had been addressed following approval of a business case. She noted that the current process focused on ward and ED staffing and did not encompass outpatient areas. She added that the previously approved staffing business cases were expected to have a significant positive impact; however, there remained a need to realign services to ensure future investment was appropriate and that the organisation operated efficiently.

Hilda Gwilliams referred to the sequencing of the proposed twice-yearly reporting and noted that solutions were not always investment-led. She explained that changes to the staffing matrix would take time to be realised, as posts first needed to be recruited to. As a result, improvements in staffing metrics may not be evident for up to 12 months; however, assurance could be provided to demonstrate that progress remained on track.

Murray Macdonald advised that the Boards should receive the report on a six-monthly basis to provide oversight of establishment and fill rates. He felt that the current process had become overly complex and included more detail than was required at Board level. He noted that detailed scrutiny should take place at Committee level, with a more streamlined, high-level report provided to the Boards. He advised that he would be meeting with the relevant team to ensure a simplified reporting format was developed going forward, while maintaining appropriate governance arrangements.

Julie Beilby added that there needed to be clear triangulation between workforce and financial planning to ensure that workforce requirements were appropriately supported and affordable.

5.3 The Value Circle Report – BIC(26)081

David Sharif referred to the report and advised that it provided a summary of emerging arrangements being developed with the NPIP, including actions arising from the integrated improvement work. He confirmed that oversight and assurance

of delivery would be provided through the Audit, Risk & Governance Committees-in-Common.

Julie Beilby referred to the number of recommendations contained within the report and noted that it would have been helpful for these to have been prioritised by Value Circle. She expressed concern regarding how the various strands of integrated work would be brought together to ensure they were progressed as a single, coherent programme rather than as separate pieces of work.

Lyn Simpson advised that work was ongoing between NPIP and Value Circle colleagues to ensure alignment of high-level summaries. She agreed that there was a need for a single integrated programme to bring all actions together and advised that further work was required to consolidate recommendations into one integrated report, to be managed through the Performance Management Office (PMO).

Alan Downey noted the importance of clearly identifying priorities arising from this work and stated that further engagement was required to determine where focus should be applied to ensure the work delivered tangible benefit. Lyn Simpson confirmed that there would be increased alignment between the NPIP and Value Circle workstreams to clarify priorities and required actions.

Action: Value Circle priorities to be clarified

6. OTHER ITEMS FOR APPROVAL

6.1 Quality Priorities – BIC(26)082

Jo Ledger referred to the report and advised that the detail of the Quality Priorities had been considered through the appropriate governance forums and formally approved by the Quality & Safety Committees-in-Common. She noted that eight priorities had initially been identified and, following discussion, four had been agreed for progression, as set out in the report. It was confirmed that the agreed priorities aligned with key issues currently being addressed by the Trusts.

Murray Macdonald referred to the target relating to insulin safe practice, noting that while a 20% reduction had been identified, no current position was included. Jo Ledger agreed to review this and provide a further update, adding that the Trusts were not currently an outlier in this area.

Action: Jo Ledger to review current position for insulin safe practice and incorporate into the Quality Priorities

Julie Beilby noted that the report clearly stated that the Quality Priorities had been approved by the Quality & Safety Committees-in-Common, which she welcomed as good practice in setting out prior approval routes before papers were presented to the Boards. She requested that this approach be replicated across all reports submitted to the Boards, as it supported members in understanding the governance pathway. She further suggested that reports presented at Committee level should also indicate whether they had been reviewed by Executive colleagues and the Senior Leadership Team. It was agreed that this would be reviewed further with report authors.

Action: Report authors to include required detail within reports in respect of prior approval process, using the front sheet as a minimum

The Trust Boards-in-Common approved the Quality Priorities.

6.2 Capital Plan – BIC(26)083

In addition to presenting the Capital Plan, Emma Sayner advised that work was underway to close the revenue position for 2025/26, including review of the month 12 position. She confirmed that all indications were that the trusts remained on track to deliver the revised forecast outturn for 2025/26.

Emma Sayner referred to the report and took it as read. She advised that the Capital Plan covered both Trusts and had been developed following significant engagement across the wider organisation. She noted that the future process would seek to embed a clinically led prioritisation approach. The report also detailed the sources of capital funding and referenced the complex brokerage arrangements associated with the Electronic Patient Record (EPR) programme. She highlighted a small over-commitment at HUTH, reflecting the scale of the capital programme planned for 2026/27, with flexibility built in to reallocate resources as required.

Murray Macdonald expressed concern that the Boards had not previously discussed how capital allocations were prioritised and requested that this be included as part of planning arrangements for future years.

Emma Sayner agreed to review how this information was presented in future reports and advised that, while this had formed part of the operational planning process through the relevant governance groups, she would ensure that capital allocation priorities were brought forward for Board consideration. Sam Peate advised that this would ordinarily be reviewed through the Performance, Estates & Finance Committees-in-Common.

Action: Emma Sayner and David Sharif to include Capital planning within the Boards timetable

The Trust Boards-in-Common approved the Capital Plan noting that this would be scheduled into planning for consideration by the Boards in the future.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 Items for Information / Supporting Papers

The following items for information were shared.

- Quality & Safety CiC Minutes – February 2026
- End of Life Annual Report
- Finance Report – Month 11
- Workforce, Education & Culture CiC Minutes – January 2026
- Guardian of Safe Working Hours – Quarter Three Report
- Trust Boards & Committees Meeting Cycle - 2026
- Board Assurance Framework (BAF)

- Documents Signed Under Seal

Jane Hawkard referred to the End of Life Report and queried where this had been shared previously. Jo Ledger advised this had been shared at the Quality & Safety Committees-in-Common for oversight in respect of actions.

8. ANY OTHER URGENT BUSINESS

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

Alan Downey summarised that key discussions for the meeting had included focus on challenging issues that needed to be progressed around patient safety amongst other issues which had identified changes were being made. He wanted to thank Lyn Simpson and executive colleagues for making good progress. It was noted that the reporting to Committees and the Trust Boards-in-Common needed to be reviewed in respect of formatting to provide necessary detail.

Alan Downey also acknowledged that in respect of the Ward Accreditation Programme it had been agreed to formalise this in diaries for NED and governor colleagues wishing to take part.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 It was noted that the back office and IT systems should be referred the Performance, Estates & Finance Committees-in-Common for consideration in respect of systems working appropriately.

It was noted that restraint training would be focussed through the Quality & Safety Committees-in-Common.

In respect of the safe staffing report, it was acknowledged that this would be reviewed to ensure it was clearer.

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 14 May 2026 at 10.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 12.30 pm.

Cumulative Record of Board Director's Attendance 2026/27

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

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(26)104

BOARDS-IN-COMMON - PUBLIC ACTION TRACKER

2026 / 27

ACTION TRACKER - CURRENT ACTIONS - 14 MAY 2026

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									
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
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 to be 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		
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 - 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	June 2026	To be shared at PEF meeting in June 2026		
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	Update to be provided at May 2026 meeting		
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		
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	May 2026	Update to be provided at May 2026 meeting		
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	To be covered in future Board Development session		
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 - IPR update shared		IPR to be shared with Boards once it had been redesigned	David Sharif	May 2026	Update to be provided at May 2026 meeting		
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 - 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.		
5.1	09.04.26	Briefing on Ward Accreditation Programme - Session with colleagues 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.		
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	August 2026	Update to be provided at August 2026 meeting		
5.3	09.04.26	The Value Circle Report		Value Circle Priorities to be clarified	David Sharif	May 2026	Confirmation received from Value Circle to undertake further work to prioritise the recommendation waiting date of completion		
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		
6.1	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.		
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	Sam Peate / David Sharif	May 2026	Update to be provided at May 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		

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)105

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**14 May 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

My first six weeks as Chair have been both rewarding and challenging. Rewarding because of the warm welcome I have received and the many fascinating conversations I have had with colleagues in Humber Health Partnership (HHP) and with stakeholders across the region. Challenging because, although I have learned a great deal, I am conscious of how much I still have to learn. I have been impressed and often moved by the commitment and dedication of the people who work in HHP, in all disciplines and at all levels. At the same time, I have gained a better understanding of the frustrations that colleagues feel as they attempt to deliver high-quality care in what continues to be a difficult environment.

Since my arrival on 1 April 2026 I have spent time at all five hospitals within HHP. I said when I was going through the recruitment process that I wanted to be visible across the group, and I will continue to spend much of my time either on the road or walking corridors and visiting wards, theatres and departments. I have not forgotten that we also provide vital community services, and I look forward to spending time with the community and therapy team in the near future.

Our reason for existing is to care for the people who live in our area, but it is not always easy as a chair to gain a first-hand insight into the patient experience. I had a very encouraging conversation a few days ago with a young patient and her family, and I will look for similar opportunities wherever possible. Community groups are often powerful advocates for the interests of local people, and that is certainly true of the Goole Hospital action group. Along with Lyn Simpson, our Chief Executive, I have had a very positive meeting with that group within the last couple of weeks. The NLaG Governors provide another lens through which to understand the way patients experience our services, as well as having an important constitutional role. I have already met on several occasions with the Council of Governors and look forward to developing a close and trusting working relationship.

The quality of the care we provide depends, of course, on having a dedicated and highly motivated workforce. Staff wellbeing has to be a priority, so in addition to meeting with individual members of staff, I am keen to engage with those who have roles as representatives and advocates. I have had initial meetings with one of our Freedom to Speak Up Guardians, one of our Staff Side representatives, and the Group Equality, Diversity & Inclusion Manager. More meetings to follow.

Our success as a group depends not only on what happens within our two acute trusts, but also on the strength and effectiveness of our working relationship with our partners, both within and outside the NHS. I have therefore had recent conversations with trust chairs and chief executives, local authority leaders and chief executives, the chairs of voluntary sector providers, and donors who have generously supported our services. I am conscious, however, that I have barely scratched the surface.

We cannot escape the reality that we are under intense scrutiny by our regulators and political masters. I have frequent conversations with colleagues in NHS England and the Humber and North Yorkshire Integrated Care Board as well as attending regular oversight meetings. I also look forward to having a good working relationship with the Care Quality Commission. And I will continue to meet with local MPs, of whom I have met six so far.

I will conclude by saying that I have thoroughly enjoyed working with Lyn Simpson, our Chief Executive, with her executive team and with my fellow non-executive directors. We are all very aware of the scale of the challenge we face, as we work our way out of special measures and up the NHS league table. The many colleagues I have met since joining HHP have reinforced my strong sense of optimism that we will succeed.

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)106

Name of Meeting	Boards in Common – Public
Date of the Meeting	14 May 2026
Director Lead	Lyn Simpson, Interim Group Chief Executive
Contact Officer / Author	Lyn Simpson, Interim Group Chief Executive
Title of Report	**CEO Briefing**
Executive Summary	This report provides an overview of the Partnership's current position, highlighting early improvement in urgent and emergency care, patient safety and staff experience, alongside national support through the Intensive Recovery Programme.
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:

TRUST BOARDs-IN-COMMON - PUBLIC
Thursday 14 May 2026

INTERIM GROUP CHIEF EXECUTIVE UPDATE

1. Introduction

Since my previous updates, the Humber Health Partnership (the Partnership) has continued to move from establishing a clear understanding of its position into a more focused phase of delivery.

As set out in earlier papers, 2026/27 is a year of stabilisation, focused on strengthening patient safety, improving operational grip and creating the conditions for sustainable improvement. This continues to be underpinned by our clinically led improvement plan, developed with colleagues across both Trusts.

Encouragingly, we are beginning to see early signs of progress across a number of areas, reflecting the impact of a more consistent focus on patient safety, flow and clinical leadership.

2. National support and Intensive Recovery Programme (IRP)

As the Board is aware, the Partnership has now been included in NHS England's (NHSE) Intensive Recovery Programme (IRP), reflecting national recognition of the longstanding structural and financial challenges described in previous updates.

The IRP focuses on a small number of organisations where underlying issues cannot be resolved through organisational action alone, and which require coordinated system and national support.

I have met with the NHS England Chief Executive (CE), Sir James Mackey, and there is a shared understanding of both the progress made to date and the nature of the remaining challenges.

Our focus remains on continuing to deliver the clinically led improvement plan, while working with NHSE and system partners to address the underlying structural and financial factors that sit beyond the control of the organisation.

3. Urgent and emergency care improvement

In urgent and emergency care (UEC), recent national benchmarking highlights the Partnership as one of the most improved organisations over recent months.

Across a combination of key measures, including four-hour Accident and Emergency (A&E) performance, twelve-hour waits, ambulance handovers, length of stay (LoS) and corridor care, the Hull Royal Infirmary (HRI), was ranked within the top 20 most improved Trusts nationally over the period December 2025 to February 2026.

This includes:

- a 3.4% improvement in Type 1 four-hour A&E performance
- a reduction in 12+ hour waits
- improvement in ambulance handover performance
- a reduction in long LoS
- a 30.7% reduction in the use of temporary escalation spaces

This reflects the sustained effort of clinical and operational teams working together to improve patient flow and reduce pressure, alongside continued work with local authority (LA) partners to reduce delays for people requiring social care support before they can leave hospital.

4. Clinically led improvement and patient safety

The Partnership is already beginning to demonstrate what is possible when clinical leadership is at the heart of how we improve.

We have strengthened the voice of our clinicians in decision-making, ensuring that those delivering care are shaping how services are run and how safety is improved.

This is translating into impact. March 2026 marked the first time since the Partnership's formation, that we have achieved three consecutive months without a clinical 'never event', an important indicator of improved focus on patient safety.

We are also beginning to see early signs of improvement in how it feels to work across our services.

The latest NHS Staff Survey shows that more colleagues now recommend Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) as a place to work, making it one of a small number of organisations nationally to see an improvement in this measure.

This reflects the continued focus on listening to colleagues and ensuring that frontline teams are actively involved in shaping the changes we are making.

5. Group Chief Executive (CE) Dashboard

Included with this report is the Group CE dashboard which encompasses key headlines around strategic updates, patient and staff experience, safety and quality priorities, operational performance, finance and workforce.

ENDS

CEO DASHBOARD

May 2026 (linked to latest Board IPR)

NHS Humber Health Partnership

STRATEGIC UPDATE

2025-30 GOALS

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

PROGRESS UPDATE

- **Patients**

Early improvements are evident in urgent and emergency care, with Hull Royal Infirmary among the most improved nationally. Gains include reduced waits, improved flow and a 30.7% reduction in escalation space use, supported by ongoing work with local authority partners to reduce discharge delays. Three consecutive months without a Never Event (to March 2026) signals improved focus on patient safety.

- **People**

Staff experience is beginning to improve, with more colleagues recommending NLAG as a place to work. This reflects a stronger focus on listening to frontline teams and increasing clinical leadership in decision-making, supporting a more positive and engaged workforce.

- **Population**

Inclusion in the Intensive Recovery Programme reflects national recognition of longstanding structural challenges. Work continues with NHS England and system partners to address underlying issues and support sustainable, equitable service delivery across the Humber.

MONTHLY TREND KEY

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

SAFETY AND QUALITY PRIORITIES

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

OPERATIONAL PERFORMANCE (MARCH 26)

IPR

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

HUTH

A&E 4hr wait (73.6% by March 2026)	**64.0%**	↑↓ 57.1% in Jan
62-day cancer (58.7% in March 2026)	***51.6%**	↓↓ 53.7% in Jan
28-day FDS (77% in March 2026)	***74.6%**	↑↓ 58.7% in Jan
18-week RTT (60.3% in March 2026)	**54.6%**	↓↓ 54.9% in Jan
6 week wait (93% by March 2026)	**66.2%**	↑↓ 57.2% in Jan

*December 2025

NLAG

A&E 4hr wait (76.8% by March 2026)	**71.6%**	↑↑ 66.1% in Jan
62-day cancer (62.6% in March 2026)	***63.3%**	↓↓ 66.1% in Jan
28-day FDS (77% in March 2026)	***69.9%**	↓↓ 73.8% in Jan
18-week RTT (62.1% in March 2026)	**59.5%**	↑↓ 58.3% in Jan
6 week wait (95% by March 2026)	**70.1%**	↑↔ 53.5% in Jan

*December 2025

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- The average response times for complaints has reduced from 101 days in August 2025 to 53 days in March 2026.
- The Partnership's Putting Patients First quality accreditation programme launched in March 2026, with 25% of wards across five sites engaged in the initial pilot cohort, including ED, critical care and children's services. Rollout to theatres, outpatients, maternity and community services is planned over the next 12 months. Early activity includes self-assessment, peer audit and improvement planning, strengthening assurance of consistent, high-quality patient experience.

STAFF EXPERIENCE

- In line with the Partnership's clinically led Improvement Plan, work is continuing to enable the establishment of a Learning Improvement and Safety Academy (LISA) to strengthen staff experience by bringing together education, improvement, and safety into a single, coordinated faculty.
- Initial mobilisation work is focusing on aligning existing expertise, reducing duplication, and supporting priority services, with a structured planned rollout being developed to build capability, improve team effectiveness, and enhance staff support across the organisation

PEOPLE (MAR 26)

IPR

Group sickness absence	**4.8%**	↔ 4.8% in Jan
Appraisal rate (AfC)	**86.2%**	↑ 82.2% in Jan
Turnover rate (12 months)	**6.8%**	↓ 6.7% in Jan
Agency spend as % Total Pay	**2.6%**	↑ 2.7% in Jan
Mandatory training	**87.3%**	↔ 87.3% in Jan
Role specific training	**85.1%**	↓ 84.2% in Jan
Job planning	**92.6%**	↑ 86.0% in Jan

GROUP FINANCIAL POSITION (M11)

Finance. rep

Indicator	£M
YTD I&E Performance	(£36.3m)
I&E Forecast Outturn	(£36.6m)
Capital Expenditure	(£42.9m)
CIP YTD	(£30.4m)
Balance Sheet & Cash	£66.7m

DISCHARGE (MAR 26)

MH

HUTH

Bed occupancy classed as clinically ready for discharge (lower is better)
28.4% ↑↓ 29.9% in Jan

NLAG

Bed occupancy classed as clinically ready for discharge (lower is better)
21.6% ↓↓ 21.1% in Jan

THEATRE UTILISATION (MAR 26)

IPR

HUTH touch-time capped utilisation (Elective 85% standard)	**81.3%**	↑↓ 78.7% in Jan
NLAG touch-time capped utilisation (Elective 85% standard)	**81.8%**	↑↓ 81.0% in Jan

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)107

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	14 May 2026
Director Lead	Lyn Simpson, Interim 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 during April 2026 from:
	
	• NHS England (NHSE)
	  ○ Nursing and midwifery educator framework
	  ○ Supporting young people to transition into adolescent and adult services
	• Department of Health and Social Care (DHSC)
	  ○ No items
	• Health Services Safety Investigations Body (HSSIB)
	  ○ Prisoner and acute provider treatment collaboration.
	
	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	Date reported to Board	Lead officer
Healthcare provision in prisons.url	Health Services Safety Investigations Body	Healthcare provision in prisons	It sets out proposed actions for integrated care boards, providers and clinical teams to enable safe and effective transition between services.	02/04/2026	10/05/2026	FITZGERALD, Scott (NHS HUMBER HEALTH PARTNERSHIP - RWA)
Nursing and midwifery educator framework.url	NHS England (NHSE)	Nursing and midwifery educator framework	The Nursing and midwifery educator framework supports the development of a sustainable educator workforce by encouraging nurses, nursing associates and midwives into educator roles and helping employers and education bodies build future capacity.	14/04/2026	10/05/2026	PAGE, Wendy (NHS HUMBER HEALTH PARTNERSHIP - RWA)
Supporting young people to transition into adolescent and adult services.url	NHS England (NHSE)	Supporting young people to transition into adolescent and adult services	This guidance supports services to provide developmentally appropriate care for 0 to 25-year-olds.	08/04/2026	10/05/2026	BRAY, Deborah (NHS Humber Health Partnership - RJL)

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)108

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 14 May 2026
Director Lead	Jo Ledger – Interim Group Chief Nurse Mr Pete Sedman – Deputy 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	**Monthly Patient Safety Update**
Executive Summary	The purpose of the report is to demonstrate the oversight of the processes that enable learning from harm, including patient safety and experience. Identification of themes are included, with analysis and an overview in respect of the following areas: • Patient safety incidents from March 2026 • Infection control alert organisms outturn position • Corridor care reduction programme • Current workstreams for PSIRF learning responses and PSII tracking • There have been no further Never Events in March 2026. • Inquests and Regulation 28 Prevention of future deaths letters update • Patient Experience contacts from March and improvement plans • Learning from experience examples The committee is asked to take assurance from the processes outlined the content of the report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	The report sections for patient safety has been reported to the Patient Safety Learning Group in April.
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 ü Assurance ☐ Other – please detail below:

Monthly Patient Safety Report, March 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.

	NLAG	HUTH	HHP
Fatal	0	7	7
Severe/Major	0	5	5
Moderate	47	40	87
Total	**47**	**52**	**99**

All 99 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, in terms of year end 2025/2026, with the comparable year end data for 2024/2025.

Figure 3: HUTH current HCAI figures:

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					

Figure 4: NLAG Current HCAI figures:

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					

Of note, there have been 3 areas of improvement at both HUTH and NLAG against HCAIs from 2024/2025 to 2025/2026. However, CDI has deteriorated at HUTH, (in keeping with the national picture) and the recognition there has been an increase in diarrhoea and vomiting cases during Q3/Q4, resulting in increased sampling which may represent some level of increase noted. Further investigation and deep dive are required at HUTH to gain greater insights, and this is under review at present.

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 is planned for approval at the Professional Practice Development & Education (PPDE) committee in April 2026. In addition, the IPC teams have planned events and activities for the upcoming World Hand Hygiene Day on the 5 May 2026.

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.

Section 3: Corridor Care Reduction Programme

Context

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.

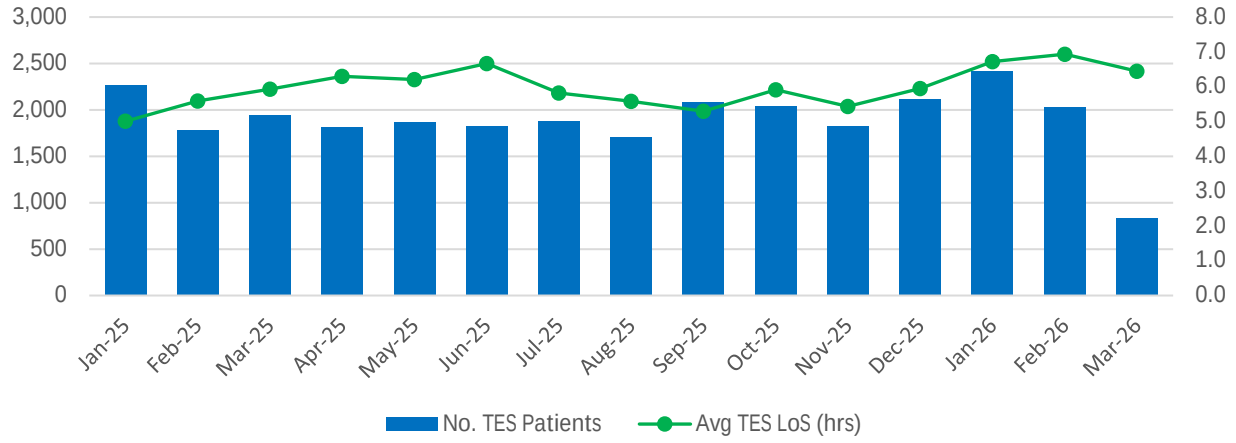
National expectations require NHS organisations to eliminate corridor care wherever possible and ensure strong operational flow across the urgent and emergency care pathway.

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).

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 5: 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 one 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. Five PSII reports are the final report stage with engagement reviews. There are 12 cases expected to be completed over the next 3 months. One MNSI and two PSII investigation are finalised and completed during March 2026.

Figure 6: PSII open casework

NLAG PSII													
Year	**2023**	**2024**		**2025**								**2026**	**Total**
Month	**Oct**	**Oct**	**Nov**	**Mar**	**May**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Mar**	
Grand Total	**1**	**1**	**1**	**1**	**2**	**3**	**2**	**2**	**2**	**1**	**2**	**1**	**19**

*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 current position as of March 2026, in relation to the total number of open Proportional Learning Responses is 36, with 15 cases in the quality checking process for completion. Ten reports are being written and 11 cases in progress.

Figure 7: Proportional Learning Responses

NLAG Proportional Learning Responses														
Year	**2025**										**2026**			**Total**
	Feb	**Mar**	**Apr**	**May**	**Jun**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Assurance	1		2	1	1		1	3	3	3				15
Report						1	3	1	2	2	1			10
Review		1			1				1		2	2	4	11
Grand Total	**1**	**1**	**2**	**1**	**2**	**1**	**4**	**4**	**6**	**5**	**3**	**2**	**4**	**36**

PSII Position HUTH

- For HUTH there are 38 open PSII cases with 4 of these being externally investigated by MNSI.
- 2 cases are going through draft report engagement with patients and their families.
- 9 PSII reports are at various stages of sign off through the Report QA process.

Figure 6: HUTH PSII open casework

	2024				2025								2026			Grand Total
HuTH PSII	Aug	Oct	Nov	Dec	Jan	Mar	Apr	May	Jun	Jul	Sep	Nov	Dec	Jan	Feb	
Grand Total	1	2	2	1	2	4	4	2	4	1	4	4	2	2	3	38

Footnote: There are 4 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 March 2026, in relation to the total number of open Proportional Learning Responses is 48, with 4 cases in the quality checking process for completion. In addition, there are 3 cases to be presented at the next PSIRF Oversight Group.

Figure 9 - HUTH Proportional Learning Responses

Proportional Learning Responses	2024		2025							2026					Grand Total
	Jul	Aug	Dec	Feb	May	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
In progress	2	1	1	1	3	6	2	4	2	2	3	4	4	6	41
Sign off processes					1	1			2	2			1		7
Grand Total	2	1	1	1	4	7	2	4	4	4	3	4	5	6	48

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 has not been 0 never events reported for 3 consecutive months at the time of writing a 4th month 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 learning themes have been 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.

Improvement actions include:

- A safety summit is planned for May 2026 supporting improvements in patient safety and culture for TACC care group.
- A Surgical Safety series of engagement sessions are planned from throughout 2026, including professional standard setting.

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 have been two Regulation 28 Letters issued:

January 2026, linked to staffing associated with a patient fall and the supervision provided. In response to this letter the organisation has taken then action to mitigate further falls and supervision concerns by increasing the HCA workforce. In addition, a new national NHSE model of care has been adopted by the Group, for providing additional support to at risk patients, known as Enhanced Therapeutic of Care (ETOC). This has been responded to inside the timescales required.

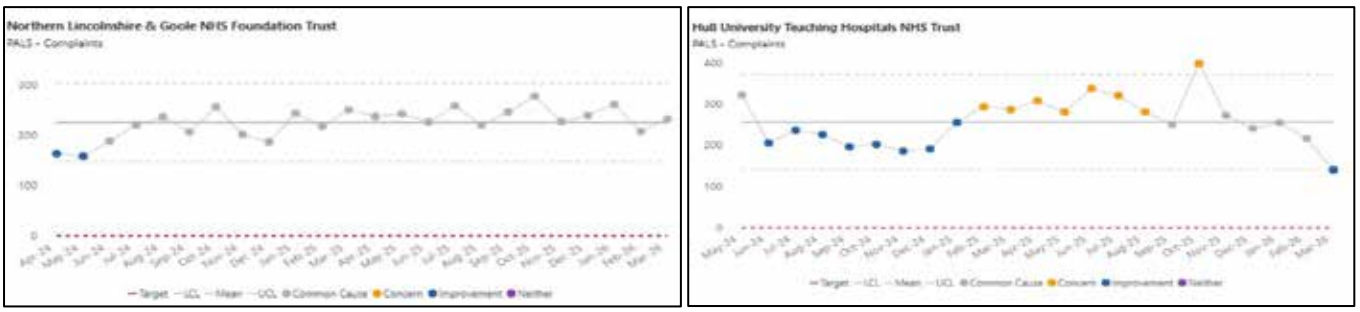
February 2026, with late notification in April. The Coroners concerns were that evidence was heard at inquest that the falls risk assessment was inaccurate, not updated as it should have been, and the documentation was incomplete. The response is being prepared by the Legal Team and will be taken through the Inquest Panel meeting for their consideration prior to submission.

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 1/3/2026 to 31/3/2026. 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.

There have been at total of 350 PALs cases for the Group during March 2026. With 44 PALs resolved during March 2026. A number of PALs cases will become formal complaints.

Figure 10. PALs cases logged

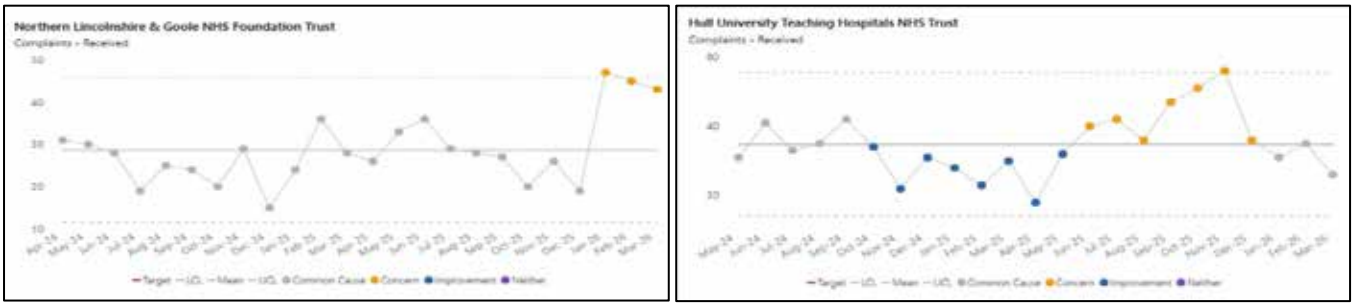


HUTH have challenges in the logging and completion of PALS concerns within 5 days (KPI is 60%) HUTH achieved around 50% resolution in the target timeframe and NLAG achieved 60%.

HHP PALS Themes and Learning

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

Figure 11. Complaints Received



HUTH complaints have reduced, following an increase, Acute and Emergency Medicine is still receiving more complaints than other care groups. Compliance with 60 day response timescales remains below the 85% target for HUTH/ NLAG.

There have been 8 new complaints opened in March with no second complaints. However, the number of historic complaints mean that there are 343 open complaints Appendix 1 shows the detail of Complaints Data HUTH/ NLAG until 30 March 2026. Complaints closed in March were only 11 with a further 30 in the final Quality checking stages.

Complaints linked to Incidents

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

HUTH, MP case for a lady who had concerns re her maternity care, a review was undertaken and Duty of Candor process was followed by the Patient safety team. The follow up on a scan did not take place. 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

- Delays in IT / Telephony work expected date was 8/2025
- Recruitment into PALs posts, agreement via Panel and recruitment has started
- Aligning processes for HUTH/NLAG PALs, workshop taking place in April 2026
- Lost property, processes developing with wards/ ED
- Car parking, raised with estates
- The NLAG investigation and response model being introduced for the group
- Care Group Performance Meetings with Site Nurse Director held weekly/ Biweekly
- QI programme established, - Learning from Complaints and PALS Improvement Programme. The aim is to target Care Group areas of concern. Using Patient Experience data which has identified themes, 12 Care Groups are developing their own tailored QI initiatives, with Care Group accountability for their improvement
- Leadership, Improvement & Safety Academy, (LISA) discussions to build the learning from Patient Experience themes and trends into staff development programmes.

MP complaints

The majority of MP concerns arrive via the Chief Executive office or into the PALs email inbox. The number of MP complaints in March was 18, HUTH 11 and NLAG 7.

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 30.

- HUTH has 22, with 11 for ongoing investigation with the remainder being requests for information
- NLAG 8, 3 of these are being investigated with the remainder being requests for information and suggested mediation)

A benchmarking review with PHSO referrals and found to be similar to other organisations of a similar size.

Section 8: Learning from experience safety actions

Summarised examples of finalised learning responses are provided below:

PSII 2024 10090

79 year old man, with heart failure was referred fro treatment under cardiology, with delays in decisions through different subspecialty MDT meetings, covering surgical intervention, mitral valve and endocarditis, and TAVI separately. The decision was reached in 20 days from admission, and by the time that this decision was made, the patient had deteriorated and was critically unwell, negating the opportunity for treatment.

Safety actions

- To embed the Rapid Assessment Valve Clinic (RVAC) to improve the TAVI pathway and to achieve >90% compliance of patient's being urgently referred to the RVAC to be assessed within two weeks of referral.

AAR 350868

Multiple delays occurred due to service and system complications resulting in a delay of 15 months from initial referral to ENT. When the final diagnosis was agreed following the biopsy results the patient had extensive squamous cell carcinoma of the nasal sinuses, and treatment options were only palliative.

Safety actions

- Discussion and presentations done within the ENT team around nasal tumours both benign and malignant, refresher training for ENT doctors.
- Feedback to external company, Everlight, about the lack of use of the alert system with the CT imaging.
- Review of the current service parameters for the process for reviewing and triaging images received from radiology for patients, for clinical and administrator duties.

MDT 350759

The patient was referred by their GP on a 2 Week Wait (2WW) cancer tracking pathway in February 2025. The patient was removed from the cancer tracking pathway, by the Consultant, in March 2025 following a review of completed investigations. The patient continued to be reviewed under Urology on a general pathway and during this time the patient had multiple inpatient admissions relating to urinary problems. Despite investigations, inpatient admissions and outpatient appointments the patient did not receive a formal diagnosis until August 2025.

Safety actions

For Urology services:

- Pathway development for Haematuria – create a standard practice for CT scans to be completed before the Flexible Cystoscopy.
- CT images to be reviewed by the clinician before completing the Cystoscopy.
- Discuss the implementation of reviewing any imaging for colour coded Radiological reports at the Urology Business Meeting.
- Educational gap identified in Haematuria pathway - Incident to be shared at the Urology Audit Meeting to showcase the importance of sending for GA Cystoscopy following CT.

For radiology:

- Specific wording to be added to all Haematuria CT reports - ‘superficial bladder lesions not excluded and Cystoscopy is required’
- Present case at Urology Audit Meeting and Radiology RELM Meeting for wider learning.

MDT 355383

A 56 year old woman contacted the ward to report that district nurses had identified what appeared to be retained gauze within the pectoral wound. The patient was unable to attend for review that day, and an appointment was arranged for the following day. This was found to have been intentionally placed for a wound dressing but had not been removed.

Safety action

For nursing and medical staff to clearly document on the dressing where a gauze is in situ, by writing on the dressing. This is to ensure all teams are aware of how to manage the wound.

MDT 356553

A patient had keyhole surgery using a surgical robot, to remove a tumour from the left kidney, the rest of the kidney was left in place; this is known as left robotic assisted laparoscopic partial nephrectomy. After discharge, the patient was diagnosed with a pulmonary embolism (a blood clot in the lung) and received treatment at his local hospital in York. The patient has since made a full recovery. For this type of surgery, the usual practice is to prescribe 28 days of enoxaparin, an anticoagulant medication on discharge to prevent blood clots forming in the veins. Patients normally leave hospital with the medication and are taught how to self-administer it. On this occasion, the patient did not receive the anticoagulant medication.

Safety actions

- Pre-op assessments to include awareness and post op prophylaxis in order to empower patient (patients expecting to be given injectable medications on discharge.)
- Op note template revisions
- Use of Poster or guideline for ACP’s/Resident Doctors and discharge teams Robotic Cancer surgery
- Training programme for new doctors, nurses and discharge coordinators

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

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)109

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 14th May 2026
Director Lead	Paul Bunyan, Group Deputy Chief People Officer
Contact Officer / Author	Myles Howell, Group Director of Communications & Engagement
Title of Report	**National Staff Survey 2025 Recovery Plan**
Executive Summary	The 2025 National Staff Survey (NSS) confirmed that significant challenges remained, particularly around advocacy, safety culture, and staff confidence in care. However, the shift in improvement indicated that HHP had built the infrastructure, leadership capability and governance required for sustained improvement. This report sets out a more detailed action plan (see appendix 2) to address 5 key areas for improvement from the 2025 staff survey results including a safety culture reset, civility and respect framework, staff voice and involvement, equity and inclusion action plan and advocacy recovery programme.
Background Information and/or Supporting Document(s) (if applicable)	Included in this report are free text comments (appendix 1), detailed action plan (appendix 2) and action cards (appendix 3)
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

NHS HUMBER HEALTH PARTNERSHIP

NATIONAL STAFF SURVEY 2025 RECOVERY PLAN

SUMMARY

Since 2023, Humber Health Partnership (HHP) has delivered a deliberate, system-wide programme of cultural transformation, aligned to the NHS People Promise, CQC Well-Led framework and NHSE workforce priorities.

This work has moved from diagnosis and engagement (2023) to structured delivery and embedding (2024–2025) and is now entering a phase of targeted intervention, standardisation and scaling (2026).

While the 2025 National Staff Survey (NSS) confirms that significant challenges remain, particularly around advocacy, safety culture, and staff confidence in care, the shift in improvement indicates that HHP has built the infrastructure, leadership capability and governance required for sustained improvement.

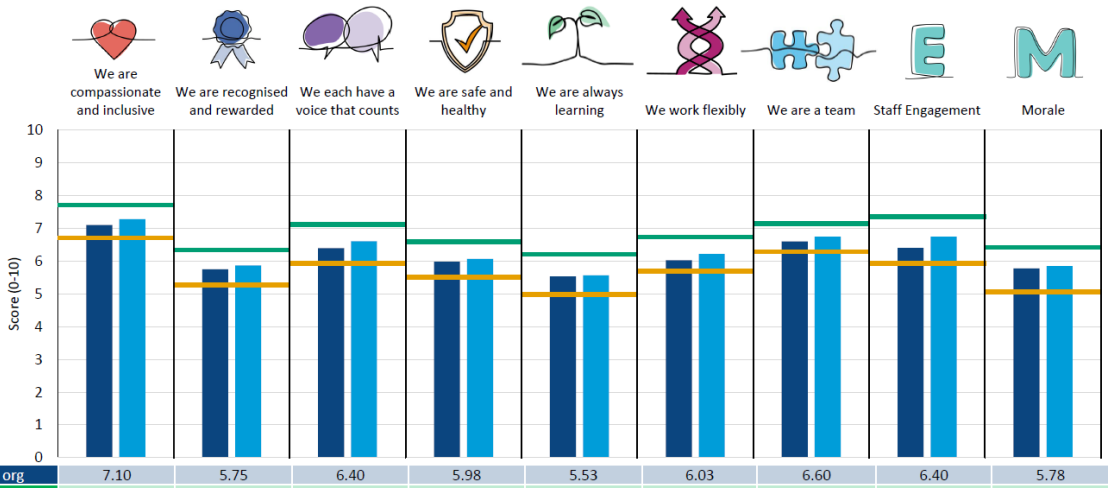
This report sets out a more detailed action plan (see appendix 2) to address 5 key areas for improvement.

BACKGROUND

In the 2025 HUTH and NLaG surveys 'overall engagement' has slipped. This is largely due to an unwillingness to recommend the organisations as a place to receive care or work (the advocacy element of staff engagement). There is a strong indication that staff feel they are suffering a 'moral injury' through the distress of being unable to provide the safe, effective care our patients require (see free text comments in Appendix 1).

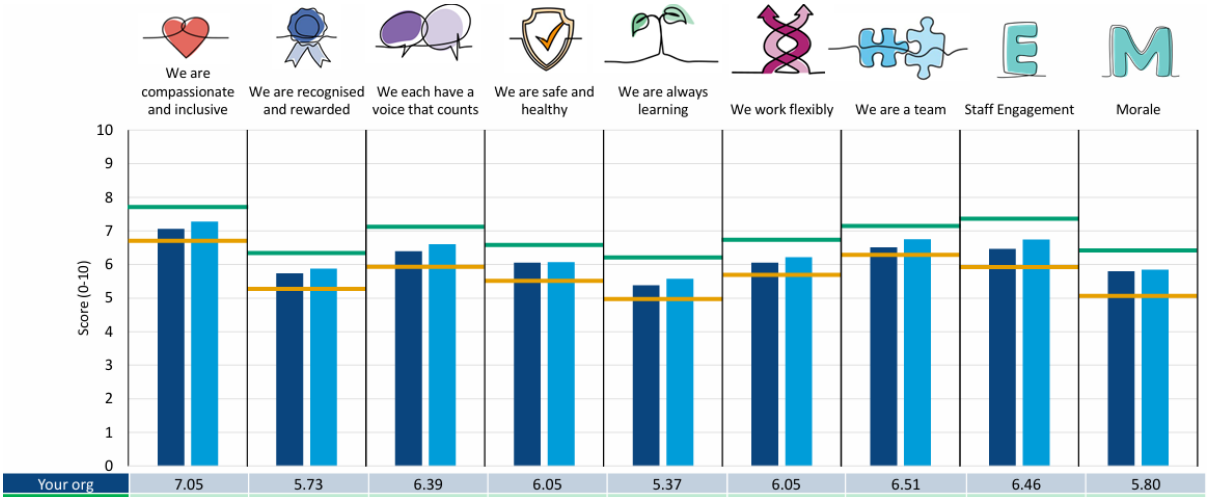
Against the nine key themes both HUTH and NLaG have improved however in almost all cases the scores are below the national average:

HUTH -



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.10	5.75	6.40	5.98	5.53	6.03	6.60	6.40	5.78
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4704	4700	4681	4684	4369	4676	4699	4707	4705

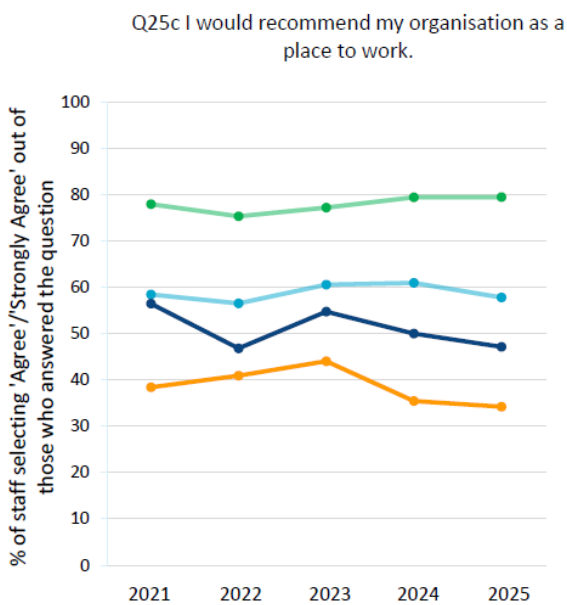
NLaG –



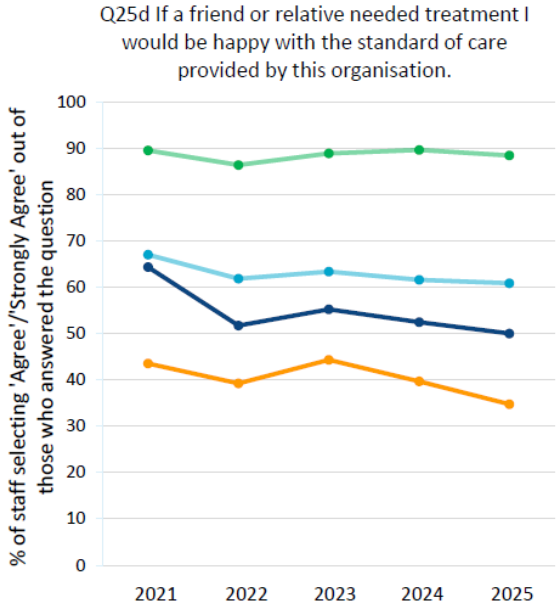
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.05	5.73	6.39	6.05	5.37	6.05	6.51	6.46	5.80
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3272	3273	3251	3248	3053	3253	3273	3275	3274

Staff engagement is comprised of three key areas: motivation, involvement, advocacy. Advocacy is the percentage of staff who would recommend the organisation as a place to work or for the standard of care. For both HUTH and NLaG this is well below the national average:

HUTH –

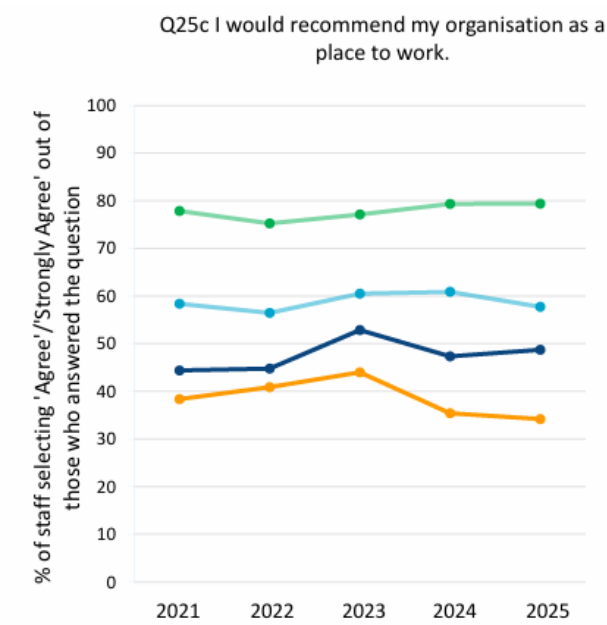


	2021	2022	2023	2024	2025
Your org	56.42%	46.77%	54.69%	49.95%	47.08%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	3756	3147	4574	4443	4688

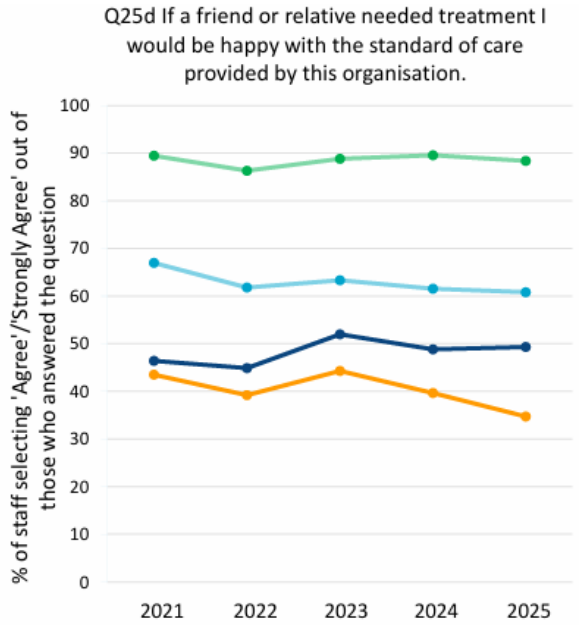


	2021	2022	2023	2024	2025
Your org	64.30%	51.68%	55.17%	52.41%	49.99%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	3757	3147	4574	4443	4683

NLaG –



	2021	2022	2023	2024	2025
Your org	44.41%	44.78%	52.88%	47.37%	48.74%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2436	2352	3473	3199	3267



	2021	2022	2023	2024	2025
Your org	46.41%	44.89%	51.98%	48.82%	49.31%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2433	2349	3477	3195	3265

Organisational focus on patient safety, safety culture and acting on/learning from incidents will not only benefit patients it will help to reduce that moral injury/stressor for frontline staff. Giving the workforce a voice in terms of raising concerns, learning from incidents and improving the safety of care provision would be beneficial in improving workforce pride and consequently organisational culture.

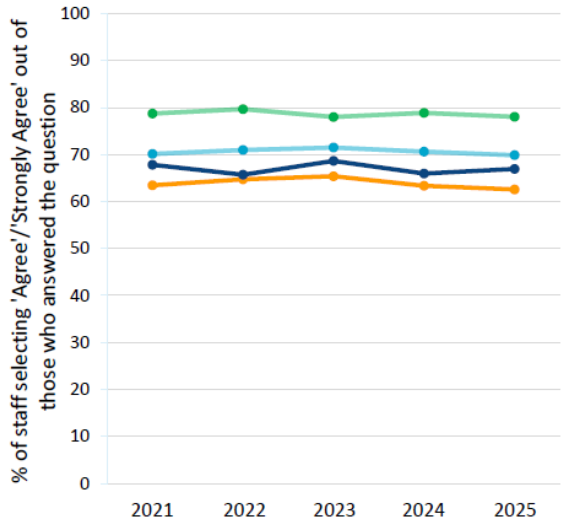
Furthermore, where Involvement is concerned our staff score lower than the national average for being able to make suggestions as well as make improvements happen.

This is a key measure of engagement. Engaged staff will report feeling listened to and having the suggestions acted upon. Being enabled to deliver improvements themselves further enhances the feeling that they are engaged with the organisation's objectives and priorities.

The response to this has to be a programme of work where staff can make suggestions and be supported to put these in to action or have them acted upon by senior leaders.

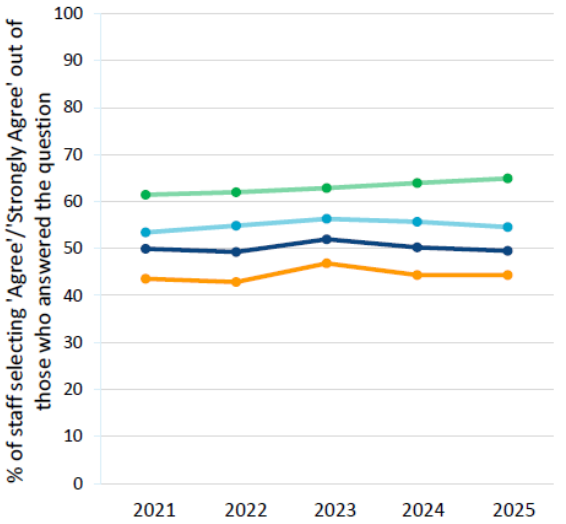
HUTH -

Q3d I am able to make suggestions to improve the work of my team / department.



	2021	2022	2023	2024	2025
Your org	67.82%	65.70%	68.63%	65.94%	66.93%
Best result	78.70%	79.67%	78.00%	78.84%	78.03%
Average result	70.10%	70.97%	71.47%	70.61%	69.85%
Worst result	63.42%	64.70%	65.38%	63.33%	62.56%
Responses	3928	3156	4590	4446	4705

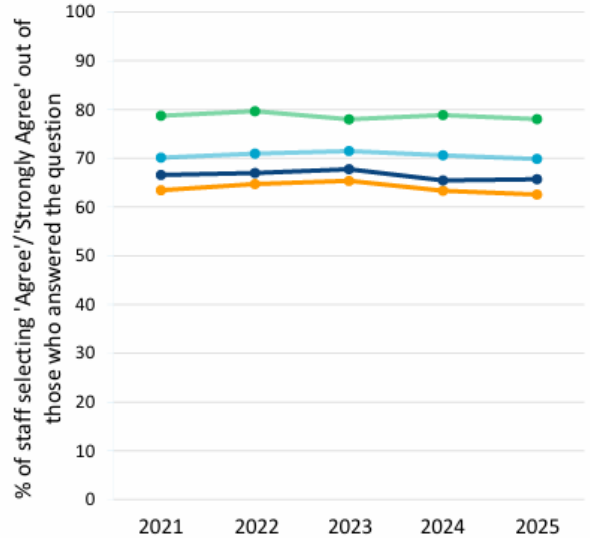
Q3f I am able to make improvements happen in my area of work.



	2021	2022	2023	2024	2025
Your org	49.94%	49.26%	51.96%	50.23%	49.51%
Best result	61.43%	61.98%	62.84%	63.94%	64.90%
Average result	53.41%	54.86%	56.30%	55.71%	54.54%
Worst result	43.54%	42.85%	46.84%	44.35%	44.33%
Responses	3924	3157	4593	4442	4697

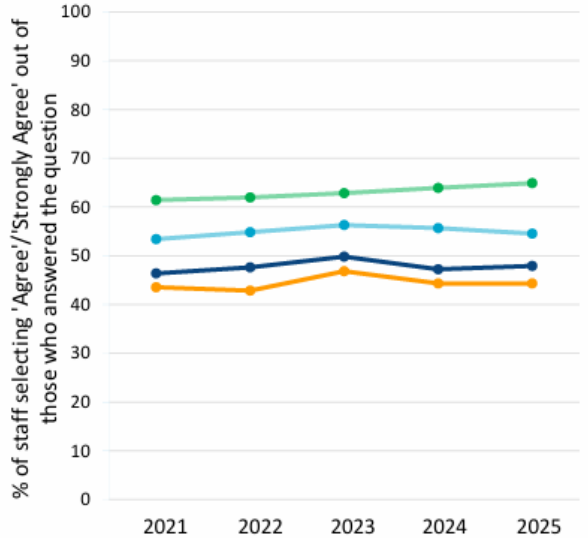
NLaG –

Q3d I am able to make suggestions to improve the work of my team / department.



	2021	2022	2023	2024	2025
Your org	66.57%	66.96%	67.75%	65.46%	65.72%
Best result	78.70%	79.67%	78.00%	78.84%	78.03%
Average result	70.10%	70.97%	71.47%	70.61%	69.85%
Worst result	63.42%	64.70%	65.38%	63.33%	62.56%
Responses	2478	2356	3488	3206	3272

Q3f I am able to make improvements happen in my area of work.



	2021	2022	2023	2024	2025
Your org	46.38%	47.64%	49.83%	47.22%	47.93%
Best result	61.43%	61.98%	62.84%	63.94%	64.90%
Average result	53.41%	54.86%	56.30%	55.71%	54.54%
Worst result	43.54%	42.85%	46.84%	44.35%	44.33%
Responses	2472	2354	3488	3198	3265

While there has been some improvement to both the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) both organisations fall short in the area of providing equal opportunities to both BAME and disabled colleagues:

Workforce Race Equality Standard (WRES)

Indicator	NLAG – Ethnically Diverse Staff	HUTH – Ethnically Diverse Staff	Insight
Bullying/harassment from patients	30% vs 21% for White staff	32% vs 23% for White staff	Higher exposure across both trusts
Bullying/harassment from staff	28% vs 24% for White staff	27% vs 20% for White staff	Both trusts show concern; trust-level hotspots vary
Equal opportunities	46% vs 52% White	51% vs 54% White	Persistent progression inequity
Discrimination from staff	16% vs 6% White	17% vs 6% White	Major concern; mirrors free-text themes

Workforce Disabilty Equality Standard (WDES)

Indicator	NLAG – Disabled staff	HUTH – Disabled staff	Insight
Bullying/harassment from patients, staff and managers	46% vs 36% for non-disabled	45% vs 36% for non-disabled	Higher exposure across both trusts
Pressure to work when unwell	27% vs 21% for non-disabled	27% vs 21% for non-disabled	Similar gap across trusts
Equal opportunities	47% vs 51% for non-disabled	25% vs 51% for non-disabled	Persistent progression inequity
Organisation values my work	28% vs 37% for non-disabled	28% vs 37% for non-disabled	Major concern
Staff engagement	6 vs 6.4 non-disabled	5.9 vs 6.4 for non-disabled	Stubbornly consistent across several years

Inequalities, specifically around opportunities for progression, need to be acted upon.

5-POINT PLAN

Five key areas have been proposed as key priority areas for action across NHS HHP, with a number of key programme of work associated with these areas.

The focus on addressing safety issues is a significant enabler for improving the staff survey performance, helping to reduce the ‘moral injury’ associated with delivering what is seen as sub-standard care.

A widespread programme of senior leader-led staff engagement sessions, delivered in each quarter of the year is designed to allow staff to suggest areas for improvement as well as offer support to them to enact improvements where appropriate. Other suggestions may simply be delivered by the management team. This will fall under the Learning Improvement

and Safety Academy programme supported by colleagues in OD, Learning and Development, Improvement and Communications.

1. Safety Culture Reset

- Ward/patient area accreditation scheme
- Launch and promotion of Learning Improvement and Safety Academy
- Safety-focused quality improvement projects
- Reward and recognition aligned to safety objectives

2. Civility and Respect Framework

- Hotspot identification and team-level interventions
- Compassionate leadership behaviours embedded in leadership training

3. Staff voice & Involvement

- Executive/SLT-led Big Conversations – 64 sessions per quarter. Each conversation to identify top 3 actions that would make a difference to engagement
- Improve responses to concerns and reinforce psychological safety
- Staff-led improvement projects
- Team huddles, team meetings, Care Group cascade structures formalised
- Strengthened staff network influence

4. Equity and Inclusion Action Plan

- Civility and anti-bullying/harassment campaign – with strong focus on BAME incidents
- Sustained and strong focus on addressing equal opportunities for disabled and BAME employees
- Strengthening inclusive behaviours and understanding/awareness

5. Advocacy Recovery Programme

- Executive visibility
- Reward and recognition, including executive-led reward schemes (employee of the month)
- Widespread promotion of safety and staff-led improvements
- Infrastructure improvement plan – rest rooms/parking/restaurants etc

MONITORING

The fortnightly Staff Survey Improvement Group will drive the delivery of this plan, reporting into the Workforce Education and Culture Committee.

Some of the specific actions, including the executive/SLT big conversation engagement sessions will form part of the Learning Improvement and Safety Academy programme of works and as such that group will have oversight of the subsequent action plan.

RECOMMENDATION

The board is asked to approve the action plan to improve performance against the 2025 national staff survey.

APPENDIX 1 - FREE TEXT COMMENTS

“I am proud of my colleagues and the individual departments in our hospitals and do feel everyone does their very best clinically to look after patients . I feel this is not always appreciated by senior staff and it does feel as though we are always being told we are failing and not doing enough .... We work hard , work extra hours , do lots that is unrecognised (or cared for by senior people) we are dedicated and we try our very best . It is just extremely hard to give the care we want to give at the moment . The staffing levels (nurses / doctors) are awful - we need more staff , not less . There needs to be support to free up beds and end corridor care - just moving the problem from ED to Wards is not appropriate . We need to be able to discharge people safely into the community and until something happens to resolve that , we will be unable to improve care and prevent constant re - admissions . I am struggling to pay my bills and have no money left for a work life balance . It would be helpful to be paid for all the extra work I have to do to keep patients safe but am constantly told there is no money so just have to keep doing all the extra work for free (& ironically get told off for working late but told off if the work is not done so really I can not win) . I need help and support and the opportunity to have clinical supervision but there is no - one there to do this . - It is terrifying sometimes . I need someone to cover my work on weekends (if not working) or holidays .... there is no - one to do this so I dread not being at work , I dread holidays . - This should not be the case . I have raised concerns about safety and nothing ever happens ? I am just not sure what to do anymore .”

“I appreciate that times are difficult and the pressure on the trust is at times higher than expected - but nursing Pt 's on corridors on beds / in chairs does not make it right and I worry about the safety of all concerned . I am but one voice and have made my concerns known on the ward - but that is as far as this goes ! ! ! !”

“Patients left in corridor near ED - not enough physiotherapy and occupational therapy staff - not enough rehab space or facilities - not enough space to store equipment - wards not have appropriate equipment- I.e. chairs (no drop down arms or height adjustable) , moving and handling equipment.”

“As an allied health professional , often working in ED at HRI and witnessing the current lengthy corridor waits I would like to know what is being done to improve the situation ? I often go home hoping that nobody I know needs to come to ED at HRI ……..There are many lovely , individuals who make work life survivable and the majority of patients I meet are extremely grateful . It is just a shame that some staff members lack empathy , patient - centred care and compassion for other staff members.”

“Care is not a priority when the bed pressures are on ..... discharging patients unsafely , boarders acutely unwell left on corridors with no handover given.”

“Clinical managers do not work with their staff or engage with them . Pan group meetings / management are not effective , there are no discussions on how to improve services with the front line staff . Finances are the number one priority for the Trust behind safer care.”

“Feel embarrassed that patients are being " cared " for on corridors . Lack of privacy and dignity. I feel like leaving the trust.”

“I feel patient and staff welfare is not prioritised within the organisation , patients moved to temporary spaces and corridors on wards at all times day and night does not allow staff to feel like they can provide the best care . Staff moved during the night to open areas such as endoscopy to move patients to , leaving high acuity short staffed . Inadequate equipment leaves nurses sharing and patients having to wait , lack of drip stands and pillows so IVs are hung on light fixtures and blankets rolled under heads . Patients nursed in corridors with no privacy or dignity . Staff to patient ratio unsafe in most areas according to national guidelines.”

“I have been working in the organisation for 2 and a half years . When I started I was passionate and felt the job was right for me . Sadly , recent changes and demands mean that the focus at management and organisational level now seems to be on money and finance and not on patient care or safety , and definitely not on staff wellbeing . I am sad to say that patients and staff have been forgotten - ideas are not listened to , suggestions are not acted on , and most demoralising of all - when concerns are raised they are dismissed or you are branded as a trouble maker for trying to bring the focus back to providing the best possible care for patients.”

“I think the department on the whole is very good and supportive of staff members . The clinical leads on many of the sections are incredibly supportive of staff members and ensure safe work environments . I find that they can be left frustrated at times when their feedback to managers is not acted on etc . I think there has been improvement in the opportunities provided to speak up about feedback etc.”

“I work in the emergency department and at present we are overwhelmed with corridor patients and departmental crowding is directly leading to patient harm . Multiple safety measures have been put in place internally , however it would seem that the wider trust / other departments are unable or unwilling to take broader ownership of the stress placed on the emergency department medical , nursing and auxiliary staff . This directly impacts staff morale , retention of staff and satisfaction due to the persistent moral injury sustained on nearly every shift.”

“It is incredibly disheartening to witness the steady decline in the standard of care we are able to provide to patients each day . More often than not , it feels like we are forced to deliver care that falls way below the level we know is acceptable . Instead of focusing on what is best for our patients , we are constantly having to choose the option that will cause the least harm- a heartbreaking and ethically exhausting position to be in . Working in a persistently unsafe and under - resourced environment has taken a significant toll . The daily unrelenting demand and constant moral injury faced at work has made me consider leaving the profession altogether — something I never imagined , given the years of dedication , training , and personal sacrifice I ’ve invested in a career I once truly loved and took pride in.”

“My department has really good leadership , particularly the Clinical Director . We have a good safety culture although the pressure the department is under leads to safety issues . The wider organisation values cost improvement above all with performance a close second . They do see the importance of the quality and safety agenda but they don't know how to address it . They have tried and failed to address flow due to the fact they don't want to or can't invest . " There is no money " is the catch phrase .”

APPENDIX 2 - ACTION PLAN

Proposed priorities and areas for action across NHS HHP:	Available programmes/in progress	Deadline	TBC/not started / required	SRO
Safety Culture Reset				
Launch and promotion of Learning Improvement and Safety Academy (LISA)	LISA	1 June 26	On plan	Director of L&D and OD
Ward/patient area accreditation scheme – Putting Patients First	LISA	23 March 26	Launched 23.3.26	Chief Nursing Officer
Safety-focused quality improvement programme	LISA	1 June 26	On plan	Associate Director of Quality Improvement
Reward and recognition aligned to safety objectives	Golden Stars/Shining Lights/Employee-Team of the Month	1 July 26	On plan	Director of Communications
Safety First communications and marketing plan	Communications plan 2026/2027	1 Feb 26	Launched 1.2.26 – on plan	Director of Communications
Civility and Respect Framework				
Civility and Respect Framework	National management and leadership behavioural framework alignment Team development Human factors	1 August 26	In development	Director of L&D and OD
Hotspot identification and team-level interventions	OD bespoke work programme / LISA	N/A	On plan and ongoing	Director of L&D and OD

Compassionate leadership behaviours embedded in leadership training	OD	1 July 26	Leadership programme on plan	Director of L&D and OD
Staff voice & Involvement				
Review raising concerns processes	LISA	TBA	In development	Director of Patient Safety
Improve responses to concerns and reinforce psychological safety	FTSU / EDI / OD		In development	Chief Medical Officer
Executive/SLT-led Big Conversations – 64 sessions per quarter. Each conversation to identify top 3 actions that would make a difference to engagement.	LISA	1 June 26	To launch at the end of May	Director of Communications
Staff-led improvement programme – Pioneer Teams	LISA	1 Nov 26	In development	Director of L&D and OD, Director of Communications
Team huddles, team meetings, Care Group cascade structures formalised	Communications plan 2026/2027	1 July 26	On plan	Director of Communications
Strengthened staff network influence	Current EDI action plan	1 June 26	On plan	Director of L&D and OD
Equity and Inclusion Action Plan				
Civility and anti-bullying/harassment campaign – with strong focus on BAME incidents	Current EDI/OD plans	1 Sept 26	In review/ development	Director of L&D and OD, Director of Communications
Sustained and strong focus on addressing equal opportunities for disabled and BAME employees	Current EDI action plan	1 Nov 26	In development	Chief Nursing Officer, Director of L&D and OD
Strengthening inclusive behaviours and understanding/awareness	Current EDI action plan Communications plan 2026/2027	Ongoing	In review	Director of L&D and OD, Director of Communications
Advocacy Recovery Programme				

Executive visibility programme	Shining Lights visits Big tent events Weekly/monthly bulletins and videos	1 May 26 1 July 26 Ongoing	On Plan In development In review – exec visibility	Director of L&D and OD, Director of Communications
Widespread promotion of safety and staff-led improvements	Communications plan 2026/2027	Ongoing	On plan	Director of Communications
Infrastructure improvement plan – rest rooms/parking/restaurants	Estates strategy	TBC	In development	Director of Estates
NLAG-Specific				
Civility and kindness - targeted and focused interventions.	Team development - OD programme/ LISA Improvement Plan	Ongoing - LISA	On plan	Director of L&D and OD
Address issues relating to career development and access to learning	Scope 4 Growth Talent management Succession planning Learning Organisation	1 Jan 27	In development	Director of L&D and OD
HUTH-Specific				
Focused programme on reasonable adjustments with network engagement and involvement	REACH	1 July	In development	Director of Communications
Urgent need to address corridor care concerns – moral injury to staff	Improvement Plan	TBC	On plan	Chief Delivery Officer

National Staff Survey Themes 1–2

Safety Culture Reset and Civility & Respect Framework

Theme 1: Safety Culture Reset

What the survey is telling us

- Staff feedback identified moral injury as a primary concern, with staff describing pressure and demand as barriers to providing safe and effective care.
- Corridor care was cited repeatedly as a staff concern.
- Many staff said finances were being prioritised over staff and patient care.

Actions linked to this theme

- Launch and promotion of the Learning, Improvement and Safety Academy (LISA).
- Ward / patient area accreditation scheme Safety-focused quality improvement programme.
- Reward and recognition aligned to safety objectives.
- Safety First communications and marketing plan.

Theme Objectives

1. Reduce moral injury experienced by staff due to sub-standard of care
2. Address perception that care is not the organisation's top priority

Expected impact on next year's survey

Improvement to:

- Advocacy score
- Staff engagement score
- Morale score

Theme 2: Civility and Respect Framework

What the survey is telling us

- Staff feedback identifies lack of respect between and within teams
- Issues are not addressed and go unresolved
- Staff report feeling undervalued by managers

Actions linked to this theme

- Civility and Respect Framework
- Hotspot identification and team-level interventions
- Compassionate leadership behaviours embedded in leadership training

Theme Objectives

1. Reduce incidences of poor behaviour
2. Strengthen awareness of staff charter
3. Promote compassionate leadership

Expected impact on next year's survey

Improvement to:

- We are Compassionate and Inclusive
- Would recommend s a place to work
- Managers taking action to address concerns

National Staff Survey Themes 3–4

Staff Voice & Involvement and Equity & Inclusion Action Plan

Theme 3: Staff Voice and Involvement

What the survey is telling us

- Staff say there are barriers to raising concerns
- Staff do not believe concerns will be addressed
- Staff cannot suggest ideas for improvement or deliver improvements
- Two-way communications structures need strengthening

Actions linked to this theme

- Review raising concerns processes
- Improve responses to concerns and reinforce psychological safety
- Executive/SLT-led Big Conversations – 64 sessions per quarter. Each conversation to identify top 3 actions that would make a difference to engagement.
- Staff-led improvement programme – Pioneer Teams
- Team huddles, team meetings, Care Group cascade structures formalised

Theme Objectives

1. Improve psychological safety
2. Address logistical barriers to raising concerns
3. Enable managers to remove barriers to delivering improvement
4. Improve engagement with operational teams

Expected impact on next year's survey

Improvement to:

- We each have a voice that counts
- Staff engagement
- We are Safe and Healthy

Theme 4: Equity and Inclusion

What the survey is telling us

- BAME staff experience more issues of bullying and harassment and discrimination than white staff
- BAME and disabled colleagues report less equity in opportunities for progression

Actions linked to this theme

- Civility and anti-bullying/harassment campaign – with strong focus on BAME incidents
- Sustained and strong focus on addressing equal opportunities for disabled and BAME employees
- Strengthening inclusive behaviours and understanding/awareness
- Strengthen network influence

Theme Objectives

1. Reduce the gap between BAME and white staff in terms of incidences of discrimination
2. Remove progression barriers for BAME and disabled colleagues
3. Improve awareness of inclusive behaviours and allyship

Expected impact on next year's survey

Improvement to:

- We are Compassionate and Inclusive
- We Each Have a Voice that Counts
- WRES and WDES staff survey reporting

National Staff Survey Theme 5

Advocacy Recovery Programme

Theme 5: Advocacy Recovery Programme

What the survey is telling us

- Advocacy and staff-led improvement were identified as primary improvement areas.
- Advocacy scores have reduced, particularly at HUTH.
- Overall engagement has slipped at both HUTH and NLaG, with advocacy and involvement behind the national average.

Theme Objectives

Increase leadership visibility across the group

Enable staff to deliver local improvements – staff benefits

Actions linked to this theme

- Executive visibility programme including Shining Lights visits, big tent events and weekly / monthly bulletins and videos.
- Widespread promotion of safety and staff-led improvements.
- Infrastructure improvement plan covering rest rooms, parking and restaurants.

Why this will improve advocacy

Advocacy improves when staff see leaders, hear consistent messages and can point to tangible improvements in their working environment.

Promoting staff-led improvements helps connect daily experience with organisational change.

Expected impact on next year's survey

Improvement to:

- Advocacy scores – recommendation of group as place to work/receive treatment
- Staff engagement
- Morale
- Each Have a Voice That Counts
- Manager Values my Work
- We are Recognised and Rewarded

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)110

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	14 May 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Emma Sayner, Group Chief Financial Officer
Title of Report	**Public Purse (including Assurance Committee update)**
Executive Summary	After a challenging financial year, I am pleased to report that the Group delivered the forecast outturn position for 2025/26 in terms of both the revenue and capital plan. The annual accounts for both Trusts were submitted to the national team in line with the required deadline, having been reviewed in detail by Audit Risk and Governance ahead of submission. The accounts are now in the process of being reviewed by the external audit teams, Mazars Fortis for Hull University Teaching Hospitals NHS Trust (HUTHT) and Sumer NI for Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) respectively. It is early in the audit process but at the time of writing, there are no issues to report in terms of potential changes to the numbers or disclosures. There is particular focus on the value for money conclusion in the context of the underlying position for both Trusts, as well as the implications of the formal undertakings/ national oversight framework by NHS England. Whilst delivery of the absolute financial position for 2025/26 was positive the performance against the underlying expenditure with the ongoing reliance on non-recurrent income / actions continues to be a cause of concern particularly given many of the income streams have not been made available in 2026/27 so are directly contributing to the plan deficit. Board colleagues are well sighted on the development of the financial plan for 2026/27 which improved by £7m for NLAG following a leveling up of ambition in relation to reduction in operating spend across the Integrated Care System and by £10.8m at HUTHT following receipt of additional non recurrent income from the HNY Integrated Care Board. The plan remains subject to Regional and National oversight and a meeting is being held on 8 May 2026 ahead of a national meeting going into diaries later in May. 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 c 633 WTE reduction. It has been vital that we have immediate focus on the run rate from day one of 2026/27 and as previously reported enhanced controls and oversight is in place this includes: • Weekly monitoring of variable pay – the latest report is

	showing material reduction in run rate but is below the level required to achieve the full year target. • WTE tracking – care group / corporate service level reductions have been allocated and are being monitored through Financial Planning and Improvement Board and Senior Leadership Team. Organisational ownership of the financial challenges is improved but there is still more work to do in this regard and targeted support to areas where this remains problematic are being held through the performance and accountability meetings. Bi-weekly FPIB meetings as well as presentations and discussions with Clinical policy Forum have been held which included a briefing on the significant scale of workforce growth that has occurred across the Group in the last 5/6 years. This work is a direct attempt to quell the myth that the Trusts do not have enough staff and that services have been cut. This is clearly and categorically not true and in fact it is quite the opposite, but this message and understanding is taking time to percolate through the organisations. A series of Board Sessions to review the detailed Cost Improvement Programme, Workforce and Productivity for 2026/27 with the Care Groups is being scheduled for the early part of Q1 with the aim of increasing visibility even further on these elements of the position and plan.
Background Information and/or Supporting Document(s) (if applicable)	BAF extract PEF AAA Report included from 5 May 2026 Month 12 Financial Position included in the appendices for information section of the agenda
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Financial considerations are an integral element of the update provided so no further updates in this section.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	It is important as we are considering changes and plans for the use of resources these considerations are taken into account through a robust EQIA process.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

ADVISE, ALERT and ASSURE	
Meeting:	Performance, Estates and Finance Committees in Common
Meeting Date:	5 May 2026
Chair:	Jane Hawkard/Julie Beilby, Non-Executive Director

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**
Finance				
Revenue Support PDC application required for HUTH for May and June 2026	An application for cash support has been submitted to NHS England for HUTH, to request £6.894m for May 26 and £10.19m for June 26. NLAG will require cash support from June 26 NHSE Regional team have supported the application.	**The CIC agreed it was too early for an assurance rating on this item**	Awaiting confirmation from NHSE on May PDC application. Cash forecast reviewed daily to confirm future requirements. Application for June cash support.	Confirmation of outcome / Memorandum of Understanding due 8th May 26 Deadline 13th May 26

Cost Improvement Plan	The 26/27 CIP is still in development to deliver a CIP target of £105m. £73m of this target has been identified as opportunities and subject to approval has been allocated to responsible areas. To date the Group has developed plans for delivery of £34m (this excludes the variable pay plans which equate to a further £18m).	**Limited assurance – concerns relating to the underlying position going into 2026**	Variable pay is being reviewed by Care Group CIP reviewed monthly through FPIB meetings Focus on WTE continues and monthly trajectory is required	2026/27
Performance				
UEC 4-hour performance remains below plan:	• HUTH 49.5% against a plan 70% (March 26) • NLaG 54.6% against a plan of 64% (March 26) UEC 12-hour performance remains below plan but in both HUTH and NLaG improving over the past 3 months. • NLaG 14.1% against a target of 6.6%. (March 26) • HUTH 9.2% against a target of 7.1%. (March 26) UEC ambulance handover times are below plan at NLaG; • NLaG 31.4mins against 25min plan	**Limited assurance was given on the basis we need some improvements on outcomes**	Recovery work is starting: time to being seen, SDEC, bed modelling, pediatric 4 hour compliance, ED diverts to community services, winter planning is in place to support the organisation being promoted from NOF 5. The CIC asked for trajectories and smart objectives relating to these areas.	2026/27
GPR - RTT	Long wait cohorts (65 and 52 week waits) are improving due to recovery programmes. Any 104 and 78 week breaches will be subject to RCAs.	**Limited assurance**	Integrated Improvement Plan NOF Framework being utilised	2026/27

	Waiting list size has been static for a number of months.			
GPR-RTT	62 day performance is variable. HUTH showing slight deterioration whereas NLAG showing improvements	**Limited assurance**	Integrated Improvement Plan NOF Framework being utilised	2026/27
Estates				
Tower Block enforcement notice	The enforcement notice issued by HFRS expires 16th July 2026 and a request to extend this enforcement by 12 months will be requested 28th Days prior to expiry	**Significant assurance was given due to the work carried out by the team.**	Good progress against action plan. All documentation has been submitted to HFRS	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
Finance				
Impact on cash forecast of limited progress in progressing CIP plans / Cash Releasing savings	It is currently challenging to forecast the impact of efficiencies on future cash flow.	**Limited assurance**	Once the efficiency programme has been finalised, savings will need to built into the cashflow forecast and any residual gap highlighted.	May 26
Cost Improvement Programme	Further assurance required on Care Group CIP plans as part	**Limited assurance**	£73.5m has now been allocated to all the Care	

	of their annual planning cycle in line with the national expectations on efficiency.		Groups budgets for Month 1	
Performance				
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. • NLaG, Ambulance waits, corridor care, 12 hour waits. NCTR position higher than previously agreed against target. • HUTH 100+ against trajectory of 73, caveat over the past 4 weeks continual reduction in days waiting and overall bed occupancy by NCTR pts. • NLaG – work with Lincs has seen a positive reduction from 50 to a sustained 30.	**Limited assurance**	UEC Improvement next steps • Develop performance trajectories specific to non-admitted pathways, enabling targeted improvement and clearer oversight of 4-hour metrics across all sites. • Implement refreshed general medical model across DPoW and SGH • Review and agree the General Medical model for HUTH to enable implementation later in the calendar year. • Bed modelling work will be completed with recommendations for change that meets needs of services • Continue progress against the UEC plan, working closely with system partners to ensure delivery against their actions to support patient flow and patients being cared for in the right place, first time. Single point of access both internally and externally worked through and implemented. • 30/60/90 days care group plans will be implemented and tracked through care group performance meetings.	Trajectories to be agreed

			• SDEC working group formation and implementation to national standards. • EMAS -embed escalation process to reduce ambulance delays. • Work with East Riding and Lincs to reduce NCTR numbers. • IPS review and update against National GIRFT standards and disseminate by end June for immediate adoption.	
Estates				
Cleaning harmonisation Group Car Parking and Security Tender	Cleaning harmonisation – the decision has been made to keep the service delivery model the same at both organisations Group Car Parking & Security Tender – this contract will be presented to PEF 4th August with a requirement for an extraordinary Trust Board to achieve approvals allowing for a compliant award notification to commence 1st October 2026	**Significant assurance** **Significant assurance**	Market analysis has taken place. Tender the cleaning contract on the North bank currently held by OCS. Harmonising management of the services was being reviewed. Delegated responsibility required from the Boards-in-Common to allow for tender approval by PEF. This is due to the BIC being cancelled in August 2026	May 2026 August 2026

ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Procurement				
Procurement Improvement Plan	Over delivered in 2025/26 this includes savings and cost avoidance. Price increase requests from suppliers have been refused.		Plans are in place for 2026/27. Single e-Procurement now in York and Scarborough. Expired contracts position has improved and the number has reduced to 52 with a value of just over £1m.	**May 2026**
Estates				
Retail Catering	No bidders for the North Bank due to TUPE issues	Significant Assurance	Investment in HRI restaurant, resulting in an increase in people using the service	May 2026
Finance				
Year-End forecast	The year-end adjusted forecast was met	**Reasonable assurance given due to meeting year-end target**		31 March 2026

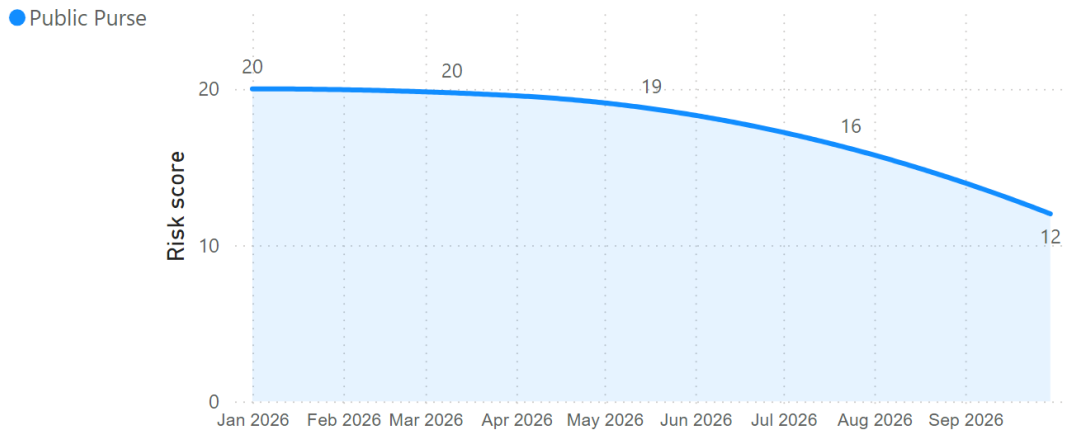
5. Public Purse

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:

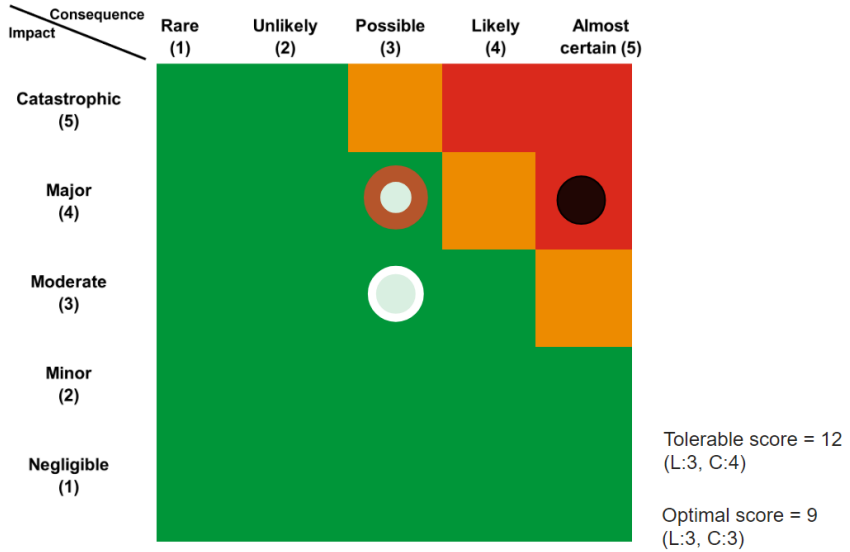
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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

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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)111

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	14 May 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit, Risk and Governance Committee-in-Common
Contact Officer / Author	Jane Hawkard, Non-Executive Director / Chair of HUTH Audit, Risk and Governance Committee-in-Common
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – April 2026 - Public**
Executive Summary	The attached highlight / escalation report summarises the key matters presented to and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting on 23 April 2026. The Trust Boards-in-Common are asked to: • Note the public highlight report from the April 2026 ARC CiC meeting and consider as necessary. • Approve the recommendation from the ARG CiC that the 2025/26 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 23 April 2026
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ✓ Other – please detail below: For noting and consideration as necessary

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	14 May 2026 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	23 April 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 23 April 2026 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- Accounting Policies 25/26 HUTH & NLAG
- Going Concern Reports 25/26 – HUTH & NLAG
- Draft Annual Accounts 25/26 – HUTH & NLAG
- Draft Annual Governance Statement 25/26 – HUTH & NLAG
- Status of Trust Annual Reports 25/26
- Draft Head of Internal Audit Conclusion 25/26 – HUTH & NLAG
- External Audit Updates – HUTH & NLAG
- Group Internal Audit Progress Report 25/26
- Draft Group IA Plan 26/27
- Group LCFS Progress Report
- Group Annual Counter Fraud Operational Plan 26/27
- Group Fraud & Corruption Policy
- Value Circle Findings and Implementation Plan
- Governance Framework for the Integrated Quality Improvement Plan
- Operational Governance Framework
- Risk Governance Framework
- CQC Action Plan Update
- Group Board Assurance Framework
- Group Risk Register
- Group Waiving of Standing Orders Report 25/26
- Group Losses and Compensations Report 25/26
- Group Standards of Business Conduct Declarations 25/26
- Salary Overpayments 25/26 – NLAG
- Group Document Control Report

*[*Items marked with an asterisk are on the boards' agenda as a standalone item in accordance with the board reporting framework – as applicable]*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The ARG CiC agreed the following matters for reporting / escalation to the Trust Boards:

3.1.1 Items for reporting to the Boards:

a) **Going Concern Reports 2025/26 – NLAG & HUTH** – The Going Concern reports for both HUTH and NLAG were received and accepted by the ARG CiC who endorsed the recommendations that the HUTH and NLAG Trust Boards can assume the 2025/26 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis. The External Auditors raised no concerns in this regard. It was agreed to recommend this to the Boards.

b) **Draft Annual Accounts 2025/26 – NLAG & HUTH** – Both sets of draft annual accounts were received by the Committees, with key points highlighted in writing and questions responded to by the Assistant Director of Finance – Planning and Control and the Group Chief Financial Officer. The ARG CiC thanked the Finance team for their hard work in producing two sets of draft accounts simultaneously. The draft accounts will be submitted to NHS England by the submission deadline of Monday 27 April 2026. External Auditors at both Trusts will also commence their audits of the draft accounts on 27 April 2026. The ARG CiC were assured with regards to the production of the draft accounts.

c) **Draft Annual Governance Statements (AGS) 2025/26 – NLAG & HUTH** – The Committees received the initial draft AGS for both Trusts and discussed a number of sections therein. Members suggested revisions to various sections to be clearer on the issues regarding low assurance on risk management, BAF governance and Care Group Governance arrangements and the action plans currently being implemented. The Committees also asked that the Chief Executives opinion include these issues in the conclusion to the document. The final drafts will be formally received by the ARG CiC in June 2026 for approval and inclusion in the Trust's Annual Reports for 2025/26, however it was agreed that the revised drafts would be circulated at an earlier stage for further review in advance of the June ARG CiC meeting.

d) **Draft Head of Internal Audit Conclusion 2025/26** – It was highlighted that this is now in a new format as a result of changes in January 2025 and is now referred to as a Conclusion of four domains rather than an overall Opinion. The four domains are concluded in draft as follows:

- Governance – **Amber Red** conclusion
- Risk Management – **Amber Red** conclusion
- Financial Reporting & Management – **Amber Green** conclusion
- Data Capture & Used by the Organisation – **Amber Green** conclusion

These conclusions were based on the internal audit reviews carried out in 2025/26, their conclusions and the organsiations response to internal audit management actions. As there are a limited number of audit reports to finalise the final version of the Head of Internal Audit Conclusion will be received at the June 2026 ARG CiC meeting, as part of the Internal Audit Annual Report for 2025/26.

e) **Draft Group Internal Audit Plan 2026/27 –** KPMG presented the final draft Group Internal Audit Plan for 2026/27, which had been discussed previously with Executives and a long list received at the January 2026 ARG CiC meeting. KPMG stated that the plan would remain fluid and topics may be flexed during the year if the Group felt amendments were necessary. Following discussion, the plan was approved by the Committees. KPMG will commence the first two pieces of scheduled 2026/27 work imminently

f) **NLAG and HUTH External Audit Service –** Contract Extensions 2026/27 – The Committees were informed that its recommendations to extend the existing External Audits for HUTH and NLAG for a further year, in line with the contract terms, had been approved by the Council of Governors (NLAG service) and the Trust Board (HUTH service). It had also been agreed to undertake a procurement exercise for a Group External Audit service.

3.1.2 Items for Escalation to the Board:

g) **Group Internal Audit Progress Report 2025/26 inc. Status of Management Actions –** the Committees received the latest report from KPMG on progress with the 2025/26 plan. The Committees discussed the Digital Resilience Report and were concerned with its findings and whether the actions would be implemented as per the agreed timescales. As a result of not being assured, the ARG CiC requested further assurance be brought back to the June 2026 ARG CiC meeting.
The status of management actions resulting from Internal Audit reviews also continued to be of concern for the Committees, with KPMG reporting a lack of engagement from officers with assigned actions resulting in 26 overdue actions. The Committees were advised that this issue had once again been discussed at the latest Group Executive Risk and Assurance (GERAC) and the Group Chief Patient Safety Officer had taken an action to work with relevant officers to address the overdue actions. The ARG CiC stated that the next update report on overdue actions due at the June 2026 meeting needed to be significantly improved to provide assurance, and officers requesting a second extension to the implementation date of their action(s) would be asked to attend the ARG CiC meeting to explain the rationale for further extensions.

h) **Overdue reviews of policies and procedures -** A report on overdue policies and procedures raised potential patient safety concerns with significantly overdue clinical policies which required review. The ARG CiC asked for a further update at the next meeting on the policies with a high risk rating.

i) **Group Governance Documents –** The Committees received a draft organogram of the governance for the Groups Integrated Improvement Plan (IIP). The ARG CiC asked for further assurance with regards to reporting progress on the IIP through the Groups Committees and the Boards which was not obvious from the presentation received.

4.0 Matters on which the committees have requested additional assurance:

4.1 The ARG CiC requested additional assurance be brought back to future meetings in relation to the Digital Resilience Internal Audit report; Waivers benchmarking data results; results of work underway to standardise Overseas Visitors processes within the Group; and in relation to Document Control, a view on overdue clinical policies.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The ARG CiC received its routine item on the Board Assurance Framework (BAF). The Group Director of Assurance noted the fairly static report in terms of the current position. Meetings have taken place with the new Interim Group Chief Nurse and the Group Chief Delivery Officer and it is hoped to see a marked improvement on the position in the next iteration of the report. The Committees wanted to see action taken to shift the dial on risks and expected that a fully revised version would be bought back to the next meeting

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the highlight / escalation report from the ARG CiC.
- Approve the recommendation from the ARG CiC that the 2025/26 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.

Jane Hawkard
HUTH ARG CiC Chair / Non-Executive Director
23 April 2026

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)112

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday 14 May 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 – June 2025
Executive Summary	The Quality & Safety Committees in Common minutes from the meeting held on 26/3/26
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 26 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:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 26 March 2026 at 9.30am to 1.00pm via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Tony Curry	Non-Executive Director (HUTH)
Julie Beilby	Non-Executive Director (NLaG)
Sam Peate	Group Chief Delivery Officer
Dr Peter Sedman	Deputy Group Chief Medical Officer
David Sharif	Group Director of Assurance
Hilda Gwilliams	Group Chief Patient Safety Governance Officer

In Attendance:

Michela Littlewood	Associate Director of Quality Governance (HUTH)
Yvonne McGrath	Group Director of Midwifery
Rebecca Crashley	Deputy Group Director of Assurance
Jo Ledger	Deputy Chief Nurse
Linsay Cunningham	Director of Strategic Development
Austin Smithies	Associate CMO for Quality and Safety
Vicky Sharman	Site Nurse Director (HUTH)
Wendy Millard	Assistant Chief Nurse/Deputy Director of IP&C
Debbie Bray	Nurse Director for Paediatrics
Michelle Drinkell	Lead Nurse – Projects
Karen Harrison	Deputy Head of Safeguarding
Stacy Kirby	PMO Transformation Programme Manager
Stacey Howard	National Provider Improvement Programme, NHSE (Observing)
Jo Palmer	PA (Minutes)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair welcomed those present to the meeting. The following apologies for absence were noted:

Dr Kate Wood	Group Chief Medical Officer

Heather McNair	Interim Group Chief Nurse
Tracy Campbell	Group Director of Patient Safety & Quality Governance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Vicky Thersby	Head of Safeguarding (NLaG)
Kevin Allen	Governor

1.2 **Staff Charter & Values**

The committee 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 meetings held on 26 February 2026**

The minutes of the meetings held on 26 February 2026 were accepted as a true and accurate record.

1.5 **Matters Arising**

The committee Chair invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.6 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

Item 4.6 – 24 July 2025 – Sam Peate to provide a further update on the Harm Review on Elective Surgery at the May meeting. Action closed
Item 4.1 – 30 October 2025 – update on colour coded alert flags to be provided at a future meeting
Item 7.1 – 30 October 2025 – report to be brought to the April meeting
Item 1.3-1.12 – 23 January 2026 – Rebecca Crashley advised that an update would be shared at the May meeting
Item 4.1 – 26 February 2026 – Michela Littlewood advised that work was ongoing in respect of a bed stock inventory and an update had been provided in the IPR. The inventory was expected to be complete within the next couple of months

1.7 **Operational Pressures Update**

Sam Peate updated that the Perfect Weeks focussing on flow, handovers and reducing ED delays were now complete across the HUTH and NLaG sites of SGH & DPoW. There had been some positive progress, which appeared to have been more sustainable on the North bank. Learning from these events was currently being captured with the aim to incorporate the changes as normal activity. The South bank had experienced significant pressure with increased twelve-hour ED waits and delays with ambulance handover and escalation processes were being reviewed by site teams, Ops Directors and clinical leads. Sam Peate thanked Vicky Sharman, HUTH Site Nurse Director for her work in reducing the reliance on Temporary Escalation Spaces (TES) with a view to stopping the use of these altogether. There had been some noted improvement in the Transfer of Care

delays during the Perfect Weeks but there was some focussed work underway with Lincolnshire County Council and the ICB in relation to the number currently on the South bank, and numbers were increasing on the North bank also. Sam Peate also shared that there had been agreement to continue with insourcing and outsourcing in some specialities. He was pleased to advise colleagues that breast radiology provision within the organisation was being maintained, which would help improve the performance against the cancer Faster Diagnosis Standard.

Julie Beilby again raised her concern over the ICB geography footprint which did not include East and West Lindsey and therefore these residents were not factored in any care provided by HHP. She was pleased to hear of the discussions with Lincolnshire County Council and Sam Peate acknowledged her concern and would raise accordingly.

David Sulch spoke of the upcoming Easter Break, immediately followed by a six-day resident doctor strike and noted that the last period of strike action had been managed effectively. Sam Peate responded that he had met with the Chiefs of Service, and a clear plan of action had been agreed.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee Chair reported that the following matter had been referred by the Workforce, Education & Culture Committees-in-Common (WEC) for consideration by the committees:

- Quality & Safety Committees-in-Common to have oversight of issues around patient restraint and the involvement of security staff.

Hilda Gwilliams updated that the organisation has had approval in using a new model, based on national initiatives and was currently in the process of recruitment.

ACTION: Jo Ledger to present a paper detailing the new model around patient restraint at the April meeting

Julie Beilby added that this had featured in other forums, as well as being featured in an Internal Audit report and CQC recommendation and considered it was indeed appropriate for discussion at this Committee.

3. RISK & ASSURANCE

3.1.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

- **CQC Action Plan IA Review**

Michela Littlewood referred to the internal audit by KPMG and actions were being addressed with considerable progress in terms of processes. The presented paper had been shared at the Group Risk & Assurance Committee, and some significant assurance had been received.

3.1.2 • **CQC Improvement Plan**

Michela Littlewood advised that there was now only one open action at NLaG and two at HUTH. There had been four unannounced inspections in the last six months from the CQC, and improvement actions were ongoing with good engagement from the Care Groups. Jo Ledger added it was proving to be a very positive approach and David Sulch commented on the update provided at WEC on the new way of working on the plan and the Committee was reasonably assured.

Hilda Gwilliams referred to an open action from a 2022 report on training and indicated she would be happy to work with Michela Littlewood and the education team to address the issues and close the action down.

Julie Beilby stressed that red flag issues needed to be highlighted more clearly in future reports, which were expected to be of AAA style.

David Sulch queried the disparity in the rating within the CQC review of September on ED service provision and what was indicated on the CQC website. In terms of maternity service review, Hilda Gwilliams expected this would be within the next six to twelve months, as the organisation had requested for the Section 31 to be reviewed.

Assurance was noted as reasonable. Julie Beilby remained concerned over longstanding issues but was pleased to note an appropriate HR process was proposed for non-compliance of mandatory training. David Sulch was reassured by the KPMG internal audit findings and agreed with the decision of reasonable assurance.

3.2 **Review of Relevant External Reports, Recommendations & Assurances**

• **Process of External Report Review, including Breast Screening & Cervical Screening Review**

Hilda Gwilliams highlighted the paper detailing the Process of External Report review and confirmed that a standard operating procedure (SOP) was in place with a database used on receipt of a report and rated appropriately. She offered to bring the report back in Quarter 2 to emphasise that the correct process was being followed.

ACTION: Hilda Gwilliams to present an update at a meeting in Quarter 2 to show compliance

David Sulch questioned at what point concerns about failure to fulfil an action would be escalated to this Committee. Michela Littlewood clarified that discussions and oversight took place at the Risk & Compliance meetings and the activity would be discussed at the Care Group Performance & Accountability (P&A) meetings.

Julie Beilby found the report to be helpful in clarifying the process and gave assurance that the correct actions were being taken.

Assurance on the process for reviewing external reports was noted as reasonable.

The breast screening and cervical screening review papers were noted.

David Sharif joined the meeting at 9.47am

4. COMMITTEE SPECIFIC BUSINESS ITEMS

PATIENT SAFETY

Quality & Safety

4.1 Integrated Performance Report (IPR): Quality & Safety metrics

Hilda Gwilliams emphasised the Executive Summary and advised colleagues that there was to be a review of the complaints/Patient Advice & Liaison Service (PALS) with some approved external support to bring some improvement and initiatives at ward and departmental level with a view to reducing the number of official complaints.

ACTION: Hilda Gwilliams to present a paper at the June meeting on the complaints/PALS review

Michela Littlewood welcomed this update and the support that would be offered. She was pleased to note drop-in session posters being displayed on wards and anticipated that the adoption of the Quality Priorities would assist in reducing complaints.

Jo Ledger spoke of the increase in the number of falls and the team was now looking at strategic action plans to see where they can be enhanced. The number of pressure ulcers had also increased, particularly on the North bank and some focussed work was ongoing and she offered to present the findings as a deep dive to a future meeting. There had been some uncertainty about the validation of data, but Jo Ledger was certain that the data was correct and that a deep dive was required particularly due to a recent Category 4 incident which had not been seen for some time.

ACTION: Jo Ledger to present a deep dive on pressure ulcers at a future meeting

Julie Beilby was encouraged by the work underway relating to patient experience and reminded colleagues that the Governors were particularly interested in this area and asked that they were included in the circulation of the escalation report.

ACTION: Escalation report to be forwarded to the Governors

Austin Smithies was disappointed to note that following receipt of reported incidents via Ulysses, there appeared to be no deep dives performed on appearing themes or any robust action taken on how to avoid incidents recurring. He was also of the view that it would be helpful to have a limit on the number of questions being asked of staff involved by the complaints team as it was proving difficult to adhere to the time frame allocated, resulting in an increasing number of complaints concerning the time taken to resolve an initial complaint. Hilda Gwilliams responded and agreed that improvements were indeed required and considered the questions could be divided into themes for ease.

4.2 Quality Priorities 2026/27

Jo Ledger highlighted the proposed list of Quality Priorities and Hilda Gwilliams pointed out that many of the workstreams did appear in the Improvement Plan and the groups and sub-committees that reviewed the work within the Quality Priorities was to be reviewed to ensure appropriate leadership, membership and focus.

Austin Smithies commented that Quality Priorities in the past had received low assurance from this Committee and welcomed this new approach. Hilda Gwilliams considered some time was needed to look at strengthening all elements for the best outcome of the approved Quality Priorities.

David Sharif added that the Governors were keen that communication was a focus and asked how this could be incorporated into the chosen Quality Priorities. Jo Ledger was confident that this was being addressed through the various workstreams linked to the Quality Priorities.

Austin Smithies was disappointed that the good engagement already seen in areas such as Martha's Rule and improving the quality of RESPECT conversations was not apparent and patient representation seemed to be poor within the organisation and noted there was no patient representative at Committee meetings. Hilda Gwilliams agreed and stressed that during the review of the subgroup membership, it would be agreed that a patient representative would be required. Michela Littlewood pointed out that there was patient representation at the Patient Experience Group.

Julie Beilby considered that the Governor suggestions were acknowledged but not actually being embedded into the Quality Priorities. There were frequent discussions at Governor meetings around issues related to appointments in that the location of patient appointments was not always clear and there was potential discrimination around the lack of IT knowledge for some patients in being able to access the DrDoctor app. This was having an impact on DNA rates and so on and it was clear that these very basic issues needed to be resolved.

Sam Peate spoke of the National Oversight Framework scoring system and emphasised that within the Quality Priorities, there were some key areas that would enhance the scoring, and these would require close attention in relation to the quality aspect. Additionally, there needed to be close review of actions taken to improve performance with feedback to the appropriate forums and this Committee over the next few months.

The Committee approved the proposed five recommended Quality Priorities with a clear link between IPC, hospital acquired infections and sepsis.

Jo Ledger offered to bring a further paper to a future meeting which demonstrated how the various elements were addressed and triangulated.

ACTION: Jo Ledger to bring a further paper to a future meeting detailing triangulation

4.3.1 **IPC – Current Overview**

Wendy Millard highlighted the report and was pleased to confirm that the longstanding CPE outbreak at NLaG had ended and that the NHSE and UKHSA

had recognised that this had been well managed by the organisation. The findings of the external review following the initial CPE review from NHSE and UKHSA were awaited but initial feedback was positive. Estates issues relating to ventilation and the ageing estate remained. A current VRE outbreak on the SGH site was being well managed.

Jo Ledger added that the organisation would carry out an internal review of its own on the CPE outbreak and the findings would be brought back to the Committee.

ACTION: CPE outbreak internal review findings to be presented at a future meeting

Sam Peate asked if year to date graphical data on performance could be included in future reports so that trends could be visualised.

ACTION: YTD graphical data on performance to be included in future reports

Julie Beilby referred to the disappointing NLAG performance and the recurring theme around basic principles not being addressed and that clearly consequences to this were now overdue. In addition, the Risk Register only showed three high risks which did not seem accurate given NLaG's position. Wendy Millard replied that she would relook at this. Michela reassured Julie Beilby that the high risks were specifically referred to at Committee level and all risks were covered at the Risk & Compliance Group and IPC meeting. Hilda Gwilliams clarified that red-rated risks did need to be reviewed and was happy to support in this.

David Sulch indicated that despite the good amount of work ongoing, the improvements were yet to be visualised and CQC had reported on the lack of adherence to basic principles. Austin Smithies recognised that improvement may take some time to be seen but it was important to ensure the processes were correct in the meantime.

Jo Ledger clarified that a paper had been presented to the SLT meeting detailing the action to be taken for non-compliance of basic principles. In addition, with reference to the red ratings for NLaG, she considered this was partly due to process and expected to see an improvement going forward with all the changes beginning to take place.

Assurance was noted as limited due to insufficient progression.

Jo Ledger stressed that the external report should give the Committee more assurance but asked the Committee whether it was content the team was focussing on the right areas with engagement from Chiefs of Service. David Sulch was of the view that there was the correct focus, but the concern was how this instigated change in staff behaviour. Julie Beilby agreed that the issue was more around staff engagement. Austin Smithies considered the main area of non-compliance in staff was resident doctors; their shift pattern meant that they did not read Comms bulletins and questioned how best to engage with them. He suggested involving the clinical leads in senior leadership meetings such as the Mortality Improvement Group (MIG) and the Patient Safety & Learning Group (PSLG) and supporting involvement in the ward accreditation programme and Jo Ledger and Wendy Millard clarified other initiatives underway that would hopefully improve engagement rather than relying purely on Comms.

4.3.2 **Update on NHSE & UKHSA findings from recent outbreak review**

Wendy Millard advised that the paper was the result of a visit by NHSE and UKHSA following concerns over outbreaks which occurred at the time of extreme pressure and corridor care. Jo Ledger clarified that the ICB would be involved in the next round of winter planning and Sam Peate added that he had asked the Care Groups to review their winter planning processes in advance of the establishment of a working group and welcomed IPC team input.

4.4 **Learning from Harm including Never Events**

Hilda Gwilliams drew attention to the fact that the organisation was rated well in no and low harm and referred to the amount of work ongoing across different workstreams which had contributed to the improved position on Never Events. She acknowledged that there was a considerable number of historical cases still to be investigated but a new process had been implemented to improve the efficiency of investigation.

David Sulch asked about the current position on Martha's Rule. Austin Smithies responded in that the patient wellness questionnaire was in use across the organisation and there was a plan to use some of the NHSE money to use a chatbot to be able to manage calls. Staffing was being reviewed and a Comms campaign planned. It was recognised that this needed to be available to all patients, including non-English speaking and those with disabilities.

Julie Beilby was pleased to see reference to the Pause campaign and reiterated that staff were encouraged to speak up at the time a safety issue occurred. There was a sense that staff did not do this and instead raised it later with the Freedom to Speak Up (FTSU) Guardian, therefore she had asked that this be included in the FTSU policy. Training could also be developed to support staff in feeling confident to speak out and Hilda Gwilliams added that this was indeed being considered as part of the new focus.

David Sulch welcomed the Never Events Improvement Plan which would be complemented by the approval of the Safer Surgery Quality Priority.

Michelle Drinkell joined the meeting at 10.51am

Assurance was noted as limited until there was a more sustained position and a clear vision of the initiatives being effective.

Hilda Gwilliams anticipated that some clear improvement would be seen in the next three to six months, hopefully sufficient for the assurance level to improve.

4.5 **Putting Patients First**

- **Quality & Safety Accreditation**

Michelle Drinkell gave an overview of the new programme which, unlike previous accreditation programmes, centred around an improvement journey where staff could undertake self-directed learning with the support of the organisation through the Learning, Improvement & Safety Academy (LISA). It was a five-step approach which was detailed on the shared slide presentation. Hilda Gwilliams added that it should enable clear visibility on safety and quality standards across the organisation, highlighting high achievers as well as poor performers who would be supported through LISA, as well as highlighting where challenges originated.

Vicky Sharman advised colleagues that PPF had been well received by the ward managers as it was a more proactive approach.

Karen Harrison joined the meeting at 11.22am

Julie Beilby welcomed the report and reiterated that the Governors were very interested in this programme and were keen to be involved along with the Non-Executive Directors.

Jo Ledger thanked Michelle Drinkell and her team for their hard work in creating the programme in such a short period of time.

- **Corridor Care**

  David Sulch reminded colleagues that it was proposed by NHSE to eliminate corridor care by July 2026.

  Vicky Sharman updated that corridor care was a national patient safety priority and reminded colleagues that it was a regulatory safety and reputational risk and not just an operational issue. There was a plan to reduce the use of TES spaces by 25% each month up until July 2026. Austin Smithies questioned whether the improvement in flow was down to the Perfect Week initiative or whether it was related to other factors. Sam Peate considered it was a combination but anticipated that the Internal Professional Standards, the learning from Perfect Week and the support of NHSE colleagues would all support the endeavour to eliminate corridor care.

Yvonne McGrath joined the meeting at 11.25am

Julie Beilby was pleased to note the report but questioned whether the change chart related to HRI and the subsequent data related to both Trusts and Vicky Sharman replied that corridor care was active at HRI but the work to eliminate it was a group wide approach.

Julie Beilby also referred to Section 6 on Governance and pointed out that there was no reference to formal reporting to the Board through this Committee. Vicky Sharman agreed to amend the Terms of Reference (ToR).

ACTION: ToR in relation to the Corridor Care Reduction Programme to be amended to highlight that formal reporting to the Board was made through the Quality & Safety Committee

Assurance was noted as reasonable.

- **Review of Perfect Week**

  Julie Beilby referred to the No Criteria to Reside (NCTR) pathway 0 figures and asked what the challenges were in terms of discharging them. Hilda Gwilliams responded that there had been some improvement in numbers and there was an improved relationship with partners in terms of where patients would go on discharge but recognised that there was more work to do in terms of both Trusts. Vicky Sharman echoed this in that work was underway to have a more structured focus on these patients but added that there had been a coding issue which was hopefully now rectified.

There was a 10-minute break at 11.45am

Debbie Bray joined the meeting at 11.55am

The running order of the agenda was changed to enable discussion on Item 4.10

Safeguarding including MCA & DOLS

4.10 Karen Harrison reported that there had been some strong compliance with safeguarding training, but the challenge remained in that Level 3 was non-compliant across the Group, however support had been requested from medical, AHP and nursing and midwifery teams to encourage completion. There were improvements in the Children Looked After review health assessments on the South bank. The North bank had moved to a digital format in relation to MCA and DOLs and the maternity and children's safeguarding agendas were now realigned to a single operational group across the organisation. Issues were around workforce shortages across safeguarding and midwifery safeguarding roles, but some recruitment was underway and remodelling of the service in discussion. There was a continued reliance on security staff mainly on the North bank for patients with enhanced supervision needs but with changes to the existing model, there had been a reduction in the request for security staff assistance. Red Lines had been implemented, and a bi-weekly report was being provided to the Senior Leadership Team (SLT).

Julie Beilby welcomed the significant progress on recommendations from the Fuller inquiry but again noted that there was no reference to Lincolnshire County Council and Looked After Children and that this should be considered in future reports alongside North and North East Lincolnshire. She was also pleased to read the recent Comms article on an intervention and considered this was a great example of excellent teamwork.

Assurance was noted as reasonable.

The agenda reverted to normal running order

4.6 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, Incidents/MNSI)**

Yvonne McGrath updated colleagues that following the anonymous letter that had been received at the beginning of the year, she had completed 1:1s with thirteen

members of staff and some clear themes were emerging. She was actively working with Human Resources to design a suitable approach and would present this at a future meeting. Increases in staffing and ongoing work around flow were expected to enable some considerable improvement in performance. She was pleased to advise that following the receipt of some capital funds, the bereavement suite at HUTH had been reopened and there were plans for additional clinical space and improvement of the toilet facilities to be disability-friendly, as well as purchasing some reclining chairs which would improve the patient experience. She was also pleased to share that there was now a bereavement midwife available on both sites. The request for removing the Section 31 had been made and the outcome was awaited.

Linsay Cunningham and Stacey Kirby joined the meeting at 12.08pm

David Sulch asked whether staff were engaging more in their training and Yvonne McGrath responded to share that there was now a training clerk on both North and South sites and immediate escalations were made when a staff member did not engage as planned.

Yvonne McGrath offered to update on the next MIS at the April meeting but did share that there would be a greater emphasis on Board oversight and a multi-team approach.

ACTION: Yvonne McGrath to update on the forthcoming MIS at the April meeting

Julie Beilby asked that where there was evidence of an impact on health inequalities that this was referenced within the Health Inequality work under Linsay Cunningham's remit and gave the example of smoking cessation and Saving Babies Lives. Yvonne McGrath shared that plans were underway to launch a perinatal health inequality steering group planned for May 2026.

- **Section 31 submission**

This was referred to within the assurance paper.

Assurance was noted as reasonable.

4.7 **Deep Dive – Maternity Red Flags**

These were detailed within the assurance paper.

4.8.1 **Children & Young People Assurance**

Debbie Bray highlighted the paper and was pleased to share that the paediatric diabetes service in HUTH had made a significant change in their processes and were now compliant in their HBA1C levels. There had been sustained improvement with mandatory training, particularly for medical colleagues, and the challenges were being reviewed, particularly relating to rotational staff. There was still work to do in relation to Martha's Rule and there was to be some increased investment into paediatric emergency nursing on the South bank for ED, but there

had been an ask for the funding to be provided earlier than October 2026 to allow for the correct recruitment and placement of staff in readiness for winter. Jo Ledger offered to look at the phasing of funding provision outside of the meeting.

Hilda Gwiliams thanked Debbie Bray for her report but was concerned about the early recognition of a deteriorating child or young person so suggested working with Debbie Bray to relook at the training for medical staff. Debbie Bray responded in that the nurse educator post had been extended but there were also plans to recruit an additional educator as part of the Martha's Rule funding.

ACTION: Hilda Gwilliams and Debbie Bray to review the training profile to assist with early recognition of a deteriorating patient

Assurance was noted as limited due to the ongoing concerns around training.

4.8.2 **Children & Young People Board ToR**

David Sharif raised the point that there seemed to be an underlying indication within the draft document that this Committee was the management group for the Children & Young People (CYP) Board, when in fact it was the Committee's responsibility to receive assurance. He also suggested that rather than developing a Children & Young People strategy, an action plan was designed. Debbie Bray agreed with these points and would amend accordingly.

Julie Beilby raised involvement of Non-Executive Directors in the new Board, particularly when there was minimal capacity currently. Debbie Bray responded that whilst this was not a statutory requirement, it would be welcomed. David Sharif clarified that the current position around NED capacity was to be raised at future NED meetings.

4.9 **EQIA**

- **CIP schemes**

  Stacy Kirby highlighted that six-monthly reviews were now in place to ensure that mitigation was identified and sufficient for the level of risk and communications had been issued for the non-CIP EQIAs. She asked that for any service change or business cases that colleagues were aware of, that they ensured the EQIA process was followed.

  Hilda Gwilliams indicated that neither the Group Chief Nurse or Group Chief Medical Officer had signed any EQIAs, which was concerning considering the number of CIP schemes. Stacy Kirby confirmed she would review this within the team, but pointed out that there were two levels of EQIA; some go to the site panel and those that score over the retrospective scoring were submitted to Execs.

  ACTION: The EQIA team to provide assurance that the EQIAs are being given the appropriate level of oversight

  Julie Beilby welcomed the report as there had been a clear gap in the EQIA profile. There was a clear focus on CIP schemes but EQIAs needed to be

addressed more widely. The paper on patient experience discussed earlier in the meeting being brought to the Committee with an accompanying EQIA was a good example.

Linsay Cunningham was of the view that the non-CIP related EQIAs were not as well embedded as they should be.

David Sulch questioned the role of the Committee with EQIAs in terms of Governance and Hilda Gwilliams responded that the EQIA should be signed off by the Execs then be presented to the relevant Committee and as this did not appear to be happening, she welcomed a review on the level of oversight.

Tracy Means joined the meeting at 12.45pm

4.11 **Health Inequalities self-assessment update**

Linsay Cunningham shared a slide presentation, and this was well received by the Committee, who were asked to consider how this work could be progressed. Hilda Gwilliams noted it showed a lot of opportunity but questioned how this could be built into pathway reviews.

Julie Beilby considered whether there was a way of capturing data on this topic within every report and suggested having a section on the front sheet relating to contribution to population health. Linsay Cunningham pointed out that there was in fact a section on implications for health inequalities within the front sheet, but it was considered that it might be pertaining more to EQIAs. She also referred to the fact that again, there was no reference to Lincolnshire data within the report and Linsay Cunningham responded that it was indeed captured but had not been included in this paper.

Tony Curry queried whether the subject was receiving the correct amount of engagement and resource to be able to make a difference and Linsay Cunningham agreed that it was not receiving sufficient focus. Austin Smithies agreed and was of the view that it needed more leadership to be able to progress accordingly.

Julie Beilby pointed out that during the discussions on EQIA, there had been no reference to health inequalities so welcomed a deeper focus on this. She questioned where health inequalities would sit within the Committees and Rebecca Crashley responded that it had been agreed to sit with the Strategic Programmes & Partnerships CiC, which however had not been active for some time.

David Sulch reflected that it was important to consider health inequalities whilst reviewing quality and safety outcomes as there were clear gaps in care for the more disadvantaged population. It was also important to maintain Board focus on this emerging topic. Dr Pete Sedman agreed and was of the view that constitutional targets were aimed at people who were easiest to care for and this was at the expense of the more disadvantaged who struggled to access services.

Linsay Cunningham advised that a task and finish group would meet and look at the recommendations from the self-assessment exercise and the comments made at this meeting and offered to bring an update to this Committee in six months' time.

ACTION: Linsay Cunningham to present an update on Health Inequalities in six months' time

5. ANNUAL REPORTS

5.1 Group End of Life Annual Report 2025

Tracy Means highlighted the report, particularly around the concerns raised following the National Audit of Care at End of Life (NACEL) and National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) reports for the North bank which was an outlier in terms of individualised patient care plans, partly due to issues with IT and work on the new EPR system. There had also been a significant increase in referrals to all the palliative care teams, and it transpired that there had been no review of staffing establishments, including medics, resulting in an intention to look at how the team could work differently. There was also an issue with the North bank being an outlier for mandated training as there was none, unlike the South bank.

Tony Curry remained unsure of the key issues, other than staffing. Tracy Means added that patients were not being seen as timely as they should be, which was impacting on harm and complaints were being received from relatives. In relation to training, the South bank was fortunate to have the clinical educator positions, but funding had not been provided for these on the North bank. Tracy Means assured the Committee that the service would be reviewed on the North bank but there was no national tool available to assist with this.

Michela Littlewood referred to the CQC inspection, but Tracy Means clarified that this had only been to the South bank, not the North but it was agreed that learning could be shared across the organisation. Jo Ledger offered to work with Sam Peate in terms of the capacity and demand requirements of the service and where investment was needed, as well as the mandated training requirements on the North bank and the role of an end-of-life matron which was in place before the formation of the Group. Additionally, Jo Ledger was keen to review the governance arrangements for this service.

ACTION: Jo Ledger to review the End of Life service across the organisation alongside Sam Peate and Tracy Means

Hilda Gwilliams questioned where the audit findings were shared, along with the actions to enable improvement, to which Tracy Means replied that there was a palliative and end of life Governance meeting as well as an operational meeting where Care Groups were invited to attend and provide highlight reports, as it was their responsibility to action the service's recommendations. The information was also presented at the MIG as well as several other forums across the region.

Assurance was noted as limited.

6. HIGHLIGHT REPORTS

6.1 Patient Safety & Learning Group

Julie Beilby referred to the overdue national alert at HUTH regarding bed rails and questioned why this hadn't been closed after such a long time. Jo Ledger assured her that all actions had been taken and it remained with the asset team to update the register.

6.2 **Safeguarding**

This paper was noted.

6.3 **Maternity & Neonatal Assurance Group**

This paper was noted.

6.4 **Risk & Compliance**

This paper was noted.

7. ITEMS FOR INFORMATION

7.1 The following items for information were noted:

- Unplanned Care Board Minutes

  This paper was noted.

8. ANY OTHER URGENT BUSINESS

8.1 Any Other Urgent Business

There were no items of any other business raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other Board committees.

9.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Board in the Committees' highlight report:

- Ongoing improvements following the CQC Improvement Plan and reasonable assurance was given
- CPE outbreak now under control and stepped down with limited assurance due to ongoing issues with the estate on IPC
- Presentation received for the Putting Patients First accreditation programme which would be a multi-disciplinary approach
- Corridor care was now a national patient safety priority and reasonable assurance was provided
- Reasonable assurance was given to the Maternity & Neonatal Assurance paper, noting the request for removal of the Section 31 and compliance

around MIS, noting an NLaG issue regarding a doctor's training with an appeal having been raised
- Never Event numbers reduced but limited assurance given because of the current situation
- Additional assurance requested on patient restraint issues which had been referred by WEC, noting a new model being implemented and a further update to be provided at the next meeting
- Additional assurance requested on complaints and PALS, noting an external review of systems and processes to be undertaken, with a report to be presented in June 2026
- Additional assurance requested on EQIAs, in that any high-risk EQIAs to be reviewed comes under the QSC remit
- Health inequalities - resource and ownership is required to drive the agenda and meet priorities. An update to be provided in six months' time
- The recommended Quality Priorities were approved
- Group End of Life Report 2025 was received by the CiC with limited assurance
- CYP Board champion to be considered and discussed at a future NED meeting. CYP assurance paper received limited assurance

10. DATE AND TIME OF THE NEXT MEETING

10.1 **Date and Time of the next Quality & Safety CiC meeting:**

The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 30 April 2026 at 9.00am to 1.30pm via MS Teams.

The committee Chair thanked Tony Curry for his support and involvement in the Committee as he was stepping down from his role of Non-Executive Director for HUTH. The committee Chair closed the meeting at 1.26pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2025/2026

Name	Title	2025 / 2026											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y		Y	Y		Y	Y		
Tony Curry	Non-Executive Director (HUTH)	N	Y	Y	Y		Y	Y		Y	Y	Y	Y
Julie Beilby	Non-Executive Director (NLaG)	N	Y	Y	Y		Y	Y		Y	N	Y	Y
Dr Kate Wood	Group Chief Medical Officer	Y	D	Y	Y		D	Y		Y	N	D	D
Amanda Stanford	Group Chief Nurse	D	A				Y	Y					
Heather McNair	Interim Group Chief Nurse		Y	A	Y					Y		Y	D
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y		D	Y		Y	Y	Y	Y
Rebecca Crashley	Group Deputy Director of Assurance	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y
Yvonne McGrath	Group Director of Midwifery	N	N	Y	Y		Y	D		Y	Y	D	Y
Matt Powls	Interim Group Chief Delivery Officer							Y		Y	Y	Y	
Sam Peate	Group Chief Delivery Officer												Y
Sarah Tedford	Interim Group Chief Delivery Officer	A	A	A	Y		A						
Michela Littlewood	Associate Director of Quality Governance (HUTH)	Y	Y	Y	Y		N	Y		Y	Y	Y	Y
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y	Y		Y	Y		Y	N	Y	N
Kevin Allen	Governor Observor	N	D	Y	Y		Y	D		D	N	Y	N
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	N	N	Y	N		N	Y		N	N	N	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)113

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	14 May 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 12**
Executive Summary	This report highlights the reported financial position for the financial year ending 31 March 2026
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Presented to the Performance, Estates & Finance Committees-in-Common 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:

V2

NHS
Humber Health
Partnership

Finance Report Month 12
March – 2025/26

Finance Overview

In-month I&E Performance – page 3

(£0.2m)

The Group reported an in-month surplus of £4.0m for month 12, (£0.2m) adverse to plan.

Year to Date I&E Performance – page 3

(£36.5m)

The Group reported a year to date deficit of (£36.5m), (£36.5m) adverse to plan. This also includes £19.9m of non-recurrent balance sheet support.

YTD Cost Improvement Plan – page 4

(£35.2m)

The Group has delivered £94.8m in CIP against a £130.0m target, (£35.2m) behind target.

Underlying I&E – page 5

(£130.0m)

The Group's underlying position is estimated at a deficit of circa (£130.0m).

System Performance – page 6

(£96.7m)

The ICS reported a deficit of (£96.7m) for the year, (£96.7m) adverse to plan.

Capital Expenditure – page 7

£144.2m

The Group spent £144.2m on capital expenditure in line with plan.

Balance Sheet & Cash – pages 8 to 9

£73.1m

The Group's cash balance at the end of the year was £66.7m.

Elective Recovery Performance – page 10

(£5.1m)

The Group under-performed against ERF baselines by (£5.1m). No additional income or penalties have been enacted by the ICB.

Temporary Staffing – pages 11 to 14

£0.4m

The Group spent £66.9m on agency and bank for the year. This is £0.4m less than in 2024/25.

Financial Performance Summary

The Group ended the 2025/26 financial year with a deficit of (£36.5m), (£36.5m) 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	78.4	87.1	8.7	915.2	923.7	8.5	50.0	53.1	3.1	568.6	565.4	(3.2)	128.3	140.1	11.8	1,483.9	1,489.2	5.3
Other Income	7.7	41.6	33.9	89.0	125.8	36.9	6.4	37.0	30.6	75.2	100.5	25.3	14.1	78.6	64.5	164.2	226.4	62.2
Total Operating Income	**86.0**	**128.6**	**42.6**	**1,004.2**	**1,049.6**	**45.4**	**56.4**	**90.0**	**33.7**	**643.8**	**666.0**	**22.1**	**142.4**	**218.7**	**76.3**	**1,648.1**	**1,715.5**	**67.5**
Pay Costs																		
Clinical Pay	(39.1)	(43.5)	(4.4)	(474.9)	(493.8)	(18.9)	(27.9)	(30.1)	(2.2)	(336.5)	(344.2)	(7.8)	(67.0)	(73.6)	(6.6)	(811.4)	(838.0)	(26.6)
Other Pay	(8.2)	(43.1)	(35.0)	(100.3)	(135.0)	(34.7)	(6.9)	(31.2)	(24.2)	(87.7)	(110.2)	(22.5)	(15.1)	(74.3)	(59.2)	(188.0)	(245.1)	(57.1)
Total Pay Costs	**(47.2)**	**(86.7)**	**(39.4)**	**(575.2)**	**(628.7)**	**(53.5)**	**(34.9)**	**(61.2)**	**(26.4)**	**(424.1)**	**(454.4)**	**(30.3)**	**(82.1)**	**(147.9)**	**(65.8)**	**(999.3)**	**(1,083.1)**	**(83.8)**
Clinical Non Pay	(17.7)	(20.0)	(2.3)	(218.2)	(235.3)	(17.1)	(6.2)	(8.2)	(2.0)	(83.1)	(93.5)	(10.5)	(23.9)	(28.2)	(4.3)	(301.3)	(328.8)	(27.6)
Other Non Pay	(15.0)	(7.3)	7.7	(149.0)	(141.1)	7.8	(8.6)	(44.2)	(35.6)	(85.0)	(117.3)	(32.3)	(23.6)	(51.6)	(28.0)	(234.0)	(258.4)	(24.4)
Total Non Pay Costs	**(32.7)**	**(27.3)**	**5.4**	**(367.2)**	**(376.5)**	**(9.3)**	**(14.8)**	**(52.4)**	**(37.7)**	**(168.1)**	**(210.8)**	**(42.7)**	**(47.5)**	**(79.8)**	**(32.3)**	**(535.3)**	**(587.2)**	**(52.0)**
Total Operating Expenditure	**(80.0)**	**(114.0)**	**(34.0)**	**(942.4)**	**(1,005.2)**	**(62.8)**	**(49.7)**	**(113.7)**	**(64.0)**	**(592.2)**	**(665.2)**	**(73.0)**	**(129.6)**	**(227.7)**	**(98.0)**	**(1,534.6)**	**(1,670.4)**	**(135.8)**
EBITDA	**6.1**	**14.6**	**8.6**	**61.8**	**44.4**	**(17.4)**	**6.7**	**(23.6)**	**(30.3)**	**51.7**	**0.8**	**(50.9)**	**12.8**	**(9.0)**	**(21.8)**	**113.5**	**45.2**	**(68.3)**
Depreciation	(2.5)	(2.5)	0.0	(29.8)	(29.4)	0.4	(2.3)	(2.1)	0.2	(25.7)	(22.8)	3.0	(4.8)	(4.5)	0.3	(55.5)	(52.1)	3.4
Non Operating Items	(1.4)	(1.5)	(0.1)	(16.8)	(16.6)	0.2	(0.7)	(0.6)	0.1	(8.1)	(7.1)	0.9	(2.1)	(2.1)	(0.0)	(24.8)	(23.7)	1.1
Surplus/(Deficit)	**2.2**	**10.7**	**8.5**	**15.3**	**(1.6)**	**(16.9)**	**3.8**	**(26.3)**	**(30.1)**	**17.9**	**(29.1)**	**(47.0)**	**5.9**	**(15.6)**	**(21.5)**	**33.1**	**(30.7)**	**(63.8)**
NHSE Allowable Adjustments	(0.3)	(5.8)	(5.5)	(15.3)	(20.4)	(5.1)	(1.5)	25.4	26.9	(17.9)	14.6	32.5	(1.7)	19.6	21.3	(33.1)	(5.8)	27.3
Adjusted Surplus / (Deficit)	**1.9**	**4.9**	**3.0**	**(0.0)**	**(22.0)**	**(22.0)**	**2.3**	**(0.9)**	**(3.2)**	**(0.0)**	**(14.5)**	**(14.5)**	**4.2**	**4.0**	**(0.2)**	**(0.0)**	**(36.5)**	**(36.5)**

- **The Group reported a £4.0m surplus in month, (£0.2m) adverse to plan with a year to date deficit of (£36.5m), (£36.5m) adverse to its break-even plan. £19.9m of balance sheet has been released year-to-date to support the Groups financial position.**
- The Group delivered £94.8m in Cost Improvement Savings (CIP), (£35.2m) behind its £130.m target.
- The Group cash balance increased by £6.4m in month to £73.1m (£33.1m HUTH / £39.9m NLAG). This includes the Group's £12.2m additional external cash support application for March 2026.
- The Groups financial deficit of £36.5m was marginally better than the £36.6m forecast outturn change protocol of £36.6m.

See Appendix A on Page 16 to 17 for Detailed I&E Position

Financial Performance – CIP Delivery

The Group delivered £94.8m CIP for the year against a £130.0m target, (£35.2m) adverse.

		HUTH			NLAG			HHP		
		Year to Date			Year to Date			Year to Date		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute And Emergency Medicine	1,800	830	(969)	5,086	4,410	(676)	6,886	5,240	(1,646)
	Cancer Network	196	116	(80)	202	163	(39)	398	279	(119)
	Cardiovascular	1,491	2,180	689	490	632	142	1,981	2,812	832
	Chief Delivery Officer	38	39	1	37	138	101	75	176	102
	Community, Frailty & Therapy	1,324	1,034	(291)	2,620	2,550	(69)	3,944	3,584	(360)
	Digestive Diseases	848	312	(536)	2,750	3,291	541	3,598	3,603	5
	Family Services	3,066	2,193	(873)	3,132	3,077	(55)	6,197	5,270	(927)
	Head & Neck	1,765	2,061	297	1,098	1,200	102	2,863	3,261	398
	Major Trauma Network	100	99	(0)	5	1	(4)	105	100	(4)
	Neuroscience	1,710	1,170	(540)	462	429	(33)	2,172	1,599	(573)
	Pathology Network Group	588	434	(154)	2,347	2,294	(54)	2,936	2,728	(208)
	Patient Services	955	770	(184)	830	1,219	389	1,785	1,990	205
	Site Management & Discharge Teams	104	82	(22)	257	174	(82)	361	257	(104)
	Specialist Cancer And Support Services	7,626	6,897	(728)	2,481	2,809	328	10,107	9,707	(400)
	Specialist Medicine	1,985	1,262	(723)	1,041	1,261	220	3,026	2,523	(503)
	Specialist Surgery	1,694	1,653	(41)	1,140	1,090	(50)	2,834	2,743	(91)
	Theatres, Anaesthetics And Critical Care	3,071	3,462	391	1,845	1,483	(362)	4,915	4,945	30
Total Operations		**28,358**	**24,595**	**(3,763)**	**25,822**	**26,222**	**400**	**54,180**	**50,817**	**(3,363)**
Corporate	Chief Executive	52	56	4	46	31	(14)	98	88	(10)
	Chief Medical Officer	447	381	(66)	174	132	(42)	621	513	(108)
	Chief Nurse	442	639	198	388	679	292	829	1,319	489
	Director Of Assurance	11	0	(11)	46	12	(34)	57	12	(45)
	Director Of People	662	818	156	586	1,111	525	1,249	1,929	680
	Finance - E&F	3,555	4,709	1,154	2,428	1,647	(781)	5,983	6,356	373
	Finance - Finance	286	603	318	202	352	151	488	956	468
	Finance - Procurement	115	24	(91)	79	0	(79)	194	24	(170)
	Finance - S & P	371	485	114	237	490	253	609	975	367
	Strategy, Partnerships and Digital	510	543	33	607	879	273	1,117	1,423	306
Total Corporate		**6,451**	**8,259**	**1,808**	**4,792**	**5,334**	**543**	**11,243**	**13,593**	**2,351**
Total Allocated CIPCore Programme		**34,809**	**32,854**	**(1,955)**	**30,614**	**31,556**	**943**	**65,423**	**64,410**	**(1,012)**
Trustwide	Reserves	12,053	12,874	821	15,647	14,305	(1,342)	27,700	27,179	(521)
	Technical	630	671	41	466	466	0	1,096	1,137	41
	Unallocated	20,828	2,283	(18,545)	14,954	(195)	(15,148)	35,782	2,089	(33,693)
Total Technical & Unallocated		**33,511**	**15,828**	**(17,682)**	**31,066**	**14,576**	**(16,490)**	**64,577**	**30,404**	**(34,173)**
TOTAL		**68,320**	**48,682**	**(19,638)**	**61,680**	**46,132**	**(15,548)**	**130,000**	**94,815**	**(35,185)**

Underlying Position

The Group's underlying financial position is estimated at a deficit of (£130.0m)

Bridging from the forecast outturn deficit position for 2025-26 the below are the main drivers to the Groups underlying position:

1. The Group is in receipt of specific Non-Recurrent Income support totalling (£32.2m).
2. Non-Recurrent Deficit funding received in 2025/26 of (£21.8m).
3. The Group has historically relied on Non-Recurrent savings delivery to achieve its financial targets. This is forecast to be (£29.0m) within the current year's savings plan. The Group must look to convert non-recurrent savings schemes into recurrent schemes where possible.
4. Non-recurrent industrial action income support net of costs of (£2.9m)
5. The in year CIP schemes have a potential FYE of £11.3m if delivered in full in year.
6. The Groups has been heavily reliant on Non-recurrent technical support in year of (£18.8m)

£million	NLAG	HUTH	HHP
2025/26 - Surplus/(Deficit)	**(14.5)**	**(22.0)**	**(36.5)**
Non-recurrent Adjustments			
NR Additional Income Support	(5.5)	(26.6)	(32.2)
NR 25/26 Deficit Funding	(11.1)	(10.7)	(21.8)
NR Industrial Action	(1.3)	(1.6)	(2.9)
NR CIP (Forecast)	(15.4)	(13.7)	(29.0)
FYE 25/26 CIP	2.7	8.6	11.3
NR Flexibility	(5.8)	(13.0)	(18.8)
Underlying Deficit	**(51.0)**	**(79.0)**	**(130.0)**

System Financial Performance – Month 11, February 2026

The ICS reported a deficit of (£96.7m) for the year, (£96.7m) adverse to plan. The ICS position is (£3.3m) worse than forecast.

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Outturn Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	(7,094)	(7,094)	(0.1%)	-	(7,094)	(7,094)	(0.1%)
Harrogate And District NHS Foundation Trust	-	(23,757)	(23,757)	(5.9%)	-	(23,757)	(23,757)	(5.9%)
Hull University Teaching Hospitals NHS Trust	-	(22,017)	(22,017)	(2.2%)	-	(22,017)	(22,017)	(2.2%)
Humber Teaching NHS Foundation Trust	-	3,008	3,008	1.1%	-	3,008	3,008	1.1%
Northern Lincolnshire And Goole NHS Foundation Trust	-	(14,505)	(14,505)	(2.3%)	-	(14,505)	(14,505)	(2.3%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	-	(32,293)	(32,293)	(3.7%)	-	(32,293)	(32,293)	(3.7%)
ICS Total	-	(96,658)	(96,658)	(2.0%)	-	(96,658)	(96,658)	(2.0%)

Capital Expenditure

The Group spent its £144.3m Capital programme plan for the year.

£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	13.0	13.0	(3.8)	2.0	2.0	0.0	15.0	15.0	0.0
Day Surgery CHH	0.0	0.0	0.0	3.7	3.7	0.0	3.7	3.7	0.0
Theatres & IRT	0.0	0.0	0.0	1.1	1.1	0.0	1.1	1.1	0.0
Community Diagnostic Centres	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	6.8	6.8	0.0	6.6	6.6	0.0	13.3	13.3	0.0
NEEF 4	2.4	2.4	0.0	8.2	8.2	0.0	10.6	10.6	0.0
Decarbonisation Funding	5.8	5.8	0.0	0.0	0.0	0.0	5.8	5.8	0.0
Total Estates Major Schemes	**28.0**	**28.0**	**(3.8)**	**21.6**	**21.6**	**0.0**	**49.6**	**49.7**	**0.0**
Other Estates Schemes	0.1	0.0	(0.1)	0.0	0.0	0.0	0.1	0.0	(0.1)
IM&T Programme	3.7	3.7	(0.0)	2.7	2.7	0.0	6.3	6.3	(0.0)
EPR	7.0	7.0	0.0	6.6	6.6	0.0	13.5	13.5	0.0
Equipment Renewal	4.2	4.2	0.0	9.5	9.5	0.0	13.7	13.7	0.0
Facilities Maintenance	6.9	7.3	0.4	3.7	3.7	0.0	10.6	11.1	0.4
Other Capital Expenditure	20.8	20.3	(0.4)	29.6	29.6	0.0	50.4	49.9	(0.4)
Total Capital Programme	**70.6**	**70.6**	**(3.9)**	**73.7**	**73.7**	**0.0**	**144.3**	**144.3**	**0.0**
Funded By:									
Internally Generated	21.8	22.3	0.5	16.2	16.1	(0.0)	38.0	38.4	0.4
PDC Funded	28.3	28.3	0.0	41.3	41.3	0.0	69.7	69.7	0.0
Donated	19.5	19.5	0.0	3.0	3.0	0.0	22.5	22.5	0.0
IFRS16	1.0	0.5	(0.5)	13.1	13.1	0.0	14.1	13.7	(0.5)
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**70.6**	**70.6**	**0.0**	**73.7**	**73.6**	**(0.0)**	**144.3**	**144.2**	**(0.0)**

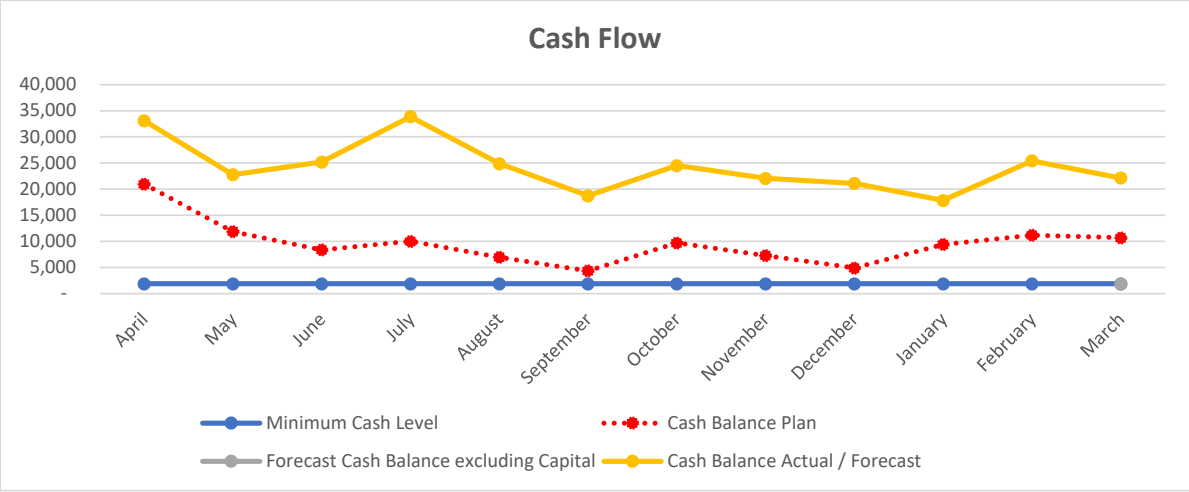
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 28-Feb-26	Actual 31-Mar-26	In month movement	Actual 28-Feb-26	Actual 31-Mar-26	In month movement	Actual 28-Feb-26	Actual 31-Mar-26	In month movement
Fixed Assets	300.4	312.8	12.5	492.5	546.4	53.9	792.8	859.2	66.4
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	5.1	4.9	(0.2)	20.3	20.4	0.0	25.4	25.2	(0.1)
Trade and Other Debtors	17.4	21.2	3.8	33.8	36.8	3.1	51.1	58.0	6.9
Cash	25.4	39.9	14.5	41.3	33.1	(8.1)	66.7	73.1	6.4
Total Current Assets	**47.9**	**66.0**	**18.1**	**95.3**	**90.3**	**(5.0)**	**143.2**	**156.3**	**13.1**
Current Liabilities									
Trade and Other Creditors	(47.3)	(84.9)	(37.6)	(72.8)	(98.9)	(26.0)	(120.1)	(183.7)	(63.6)
Accruals	(18.1)	(17.2)	0.9	(36.9)	(27.8)	9.0	(55.0)	(45.0)	10.0
Other Current Liabilities	(7.0)	(5.5)	1.6	(23.4)	(17.9)	5.4	(30.4)	(23.4)	7.0
Total Current Liabilities	**(72.5)**	**(107.5)**	**(35.1)**	**(133.1)**	**(144.6)**	**(11.5)**	**(205.6)**	**(252.2)**	**(46.6)**
Net Current Liabilities	**(24.6)**	**(41.5)**	**(16.9)**	**(37.8)**	**(54.3)**	**(16.6)**	**(62.4)**	**(95.9)**	**(33.5)**
Debtors Due > 1 Year	0.8	0.7	(0.1)	2.3	2.0	(0.3)	3.0	2.7	(0.3)
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	(3.8)	(3.1)	0.6	(6.7)	(6.0)	0.6
Finance Lease Obligations > 1 Year	(7.0)	(7.0)	0.0	(70.9)	(70.3)	0.5	(77.9)	(77.4)	0.5
Provisions - Non Current	(7.2)	(3.3)	3.8	(2.3)	(2.2)	0.2	(9.5)	(5.5)	4.0
Total Assets/(Liabilities)	**259.4**	**258.8**	**(0.7)**	**380.6**	**418.9**	**38.3**	**640.0**	**677.7**	**37.7**
TOTAL CAPITAL & RESERVES	**259.4**	**258.8**	**(0.7)**	**380.6**	**418.9**	**38.3**	**640.0**	**677.7**	**37.7**

Cash Flow

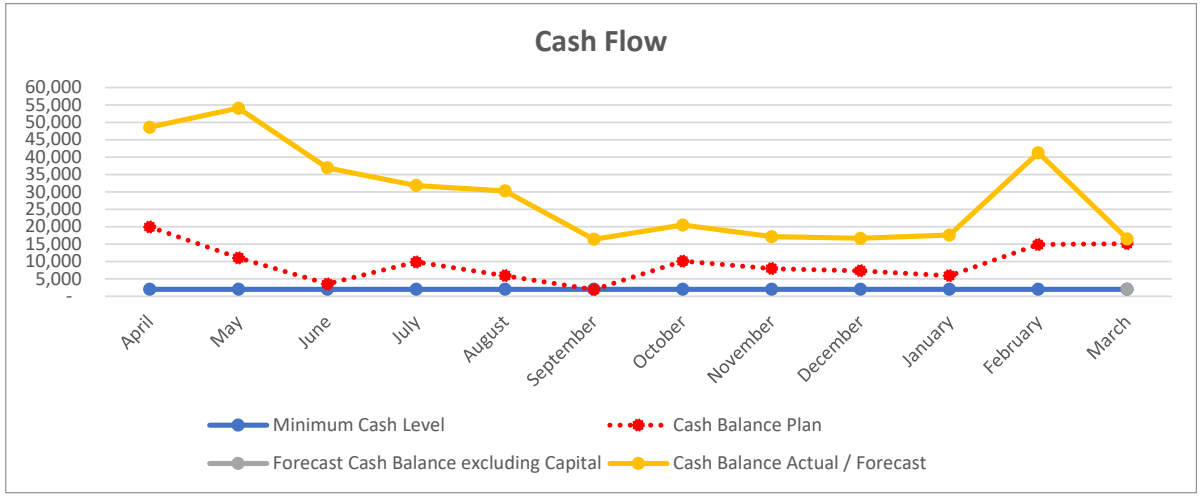
The Group's cash balance at the end of the year was £73.1m this includes £12.2m of additional external support.

NLAG



£000's	October	November	December	January	February	March
Minimum Cash Level	1,900	1,900	1,900	1,900	1,900	1,900
Cash Balance Plan	9,726	7,297	4,931	9,421	11,214	10,699
Forecast Cash Balance excluding Capital						1,900
Cash Balance Actual / Forecast	24,518	22,057	21,111	17,844	25,419	22,135

HUTH



£000's	October	November	December	January	February	March
Minimum Cash Level	2,000	2,000	2,000	2,000	2,000	2,000
Cash Balance Plan	10,089	7,921	7,321	5,904	14,845	15,110
Forecast Cash Balance excluding Capital						2,011
Cash Balance Actual / Forecast	20,461	17,125	16,656	17,595	41,259	16,492

Elective Recovery

The Group under-performed against its ERF baselines by (£5.1m). No additional income or penalties have been transacted by the ICB.

£000's	HUTH				NLAG				HHP Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	158,334	152,117	(6,217)	96%	72,803	74,811	2,008	103%	231,137	226,928	(4,209)	98%
External Contracts	2,832	2,491	(341)	88%	9,888	11,066	1,178	112%	12,720	13,557	837	107%
Specialist	45,142	42,909	(2,233)	95%	1,790	2,341	551	131%	46,932	45,250	(1,682)	96%
Sub Total ERF	**206,308**	**197,517**	**(8,791)**	**95.7%**	**84,481**	**88,218**	**3,736**	**104.4%**	**290,789**	**285,735**	**(5,055)**	**98.3%**
A&G	3,796	3,796	0	N/A	918	917	(1)	N/A	4,714	4,713	(1)	N/A
Total	**210,104**	**201,313**	**(8,791)**	**95.7%**	**85,400**	**89,135**	**3,735**	**104.4%**	**295,504**	**290,448**	**(5,056)**	**98.3%**

Temporary Staffing Summary

The Group has spent £66.9m on agency and bank in 2025/26. This is £0.4m less than in 2024/25 and remains below the NHSE Target of 3.2% of total pay expenditure at 2.4%.

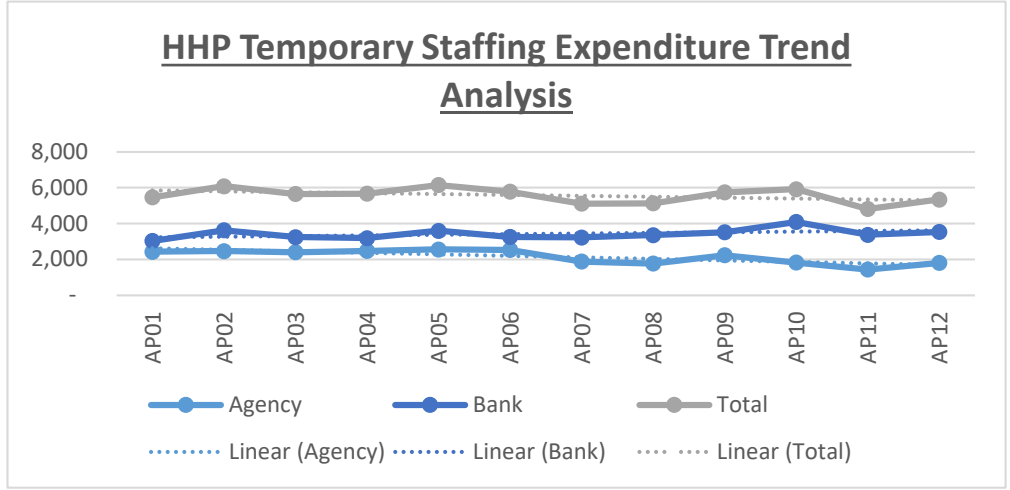
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Agency	Medical Staff	9,607	7,310	2,297	11,700	12,516	(816)	21,307	19,826	1,481
	Nursing Staff	398	1,599	(1,201)	3,126	2,566	560	3,524	4,165	(641)
	Scientific, Therapeutic & Technical Staff	397	191	206	1,317	1,534	(217)	1,714	1,725	(11)
	Admin & Clerical Staff	392	29	363	270	43	227	662	72	590
	Maintenance Staff	0	0	0	(1)		(1)	(1)	0	(1)
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	17	38	(21)	3	3	0	20	41	(21)
Agency Total		**10,811**	**9,166**	**1,645**	**16,415**	**16,662**	**(248)**	**27,225**	**25,828**	**1,397**
Bank	Medical Staff	4,176	4,550	(374)	11,464	11,344	120	15,640	15,894	(254)
	Nursing Staff	5,941	4,300	1,641	12,114	12,797	(683)	18,055	17,097	958
	Scientific, Therapeutic & Technical Staff	556	656	(100)	1,374	1,453	(79)	1,930	2,109	(179)
	Admin & Clerical Staff	41	811	(770)	2,144	1,971	173	2,185	2,782	(597)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	72	150	(77)	2,241	3,042	(802)	2,313	3,192	(879)
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**10,786**	**10,467**	**319**	**29,336**	**30,607**	**(1,271)**	**40,122**	**41,074**	**(952)**
Grand Total		**21,597**	**19,633**	**1,964**	**45,750**	**47,269**	**(1,519)**	**67,347**	**66,902**	**445**

Agency Spend as % Total Pay (3.2% is the NHSE Target)	1.5%	3.7%	2.4%

Temporary Staffing Summary – Directorate / Care Group

The Group has spent £66.9m on all agency and bank pay YTD. This is £0.4m less than in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	4,489	4,482	7	13,967	15,128	(1,161)	18,455	19,609	(1,154)
	Cancer Network	30	38	(7)	51	68	(17)	81	106	(25)
	Cardiovascular	678	656	22	537	537	(0)	1,215	1,192	22
	Chief Delivery Officer	0	0	0	0	0	(0)	0	0	(0)
	Community, Frailty & Therapy	2,589	2,783	(195)	3,623	3,636	(12)	6,212	6,419	(207)
	Digestive Diseases	1,103	726	377	2,129	2,946	(816)	3,232	3,671	(439)
	Family Services	1,889	1,323	566	5,006	5,148	(141)	6,895	6,471	425
	Head & Neck	1,115	1,177	(62)	2,106	2,018	88	3,221	3,196	25
	Major Trauma Network	58	77	(19)	0	0	0	58	77	(19)
	Neuroscience	1,226	625	602	1,415	1,445	(30)	2,641	2,069	572
	Pathology Network Group	31	6	25	1,153	917	236	1,184	924	261
	Patient Services	48	644	(596)	1,346	1,089	257	1,394	1,733	(339)
	Site Management & Discharge teams	204	415	(211)	353	326	27	557	741	(185)
	Specialist Cancer and Support Services	2,863	2,382	481	2,476	2,613	(137)	5,339	4,994	345
	Specialist Medicine	1,068	601	468	2,872	3,227	(355)	3,940	3,828	113
	Specialist Surgery	1,229	1,055	174	2,541	1,971	570	3,770	3,026	744
	Theatres, Anaesthetics and Critical Care	2,729	2,147	581	3,559	2,985	574	6,288	5,133	1,155
Total Operations		**21,349**	**19,136**	**2,213**	**43,134**	**44,053**	**(919)**	**64,483**	**63,189**	**1,294**
Corporate	Corporate Directorates	456	408	48	2,979	3,425	(446)	3,435	3,833	(398)
Total Corporate		**456**	**408**	**48**	**2,979**	**3,425**	**(446)**	**3,435**	**3,833**	**(398)**
Central Reserves & Technical	Central Technical	(213)	89	(302)	(363)	(246)	(116)	(576)	(158)	(418)
	Reserves	5	(0)	5	(0)	37	(37)	5	37	(32)
Total Central Income, Reserves & Technical		**(208)**	**89**	**(297)**	**(363)**	**(209)**	**(153)**	**(571)**	**(121)**	**(450)**
Surplus / (Deficit)		**21,597**	**19,633**	**1,964**	**45,750**	**47,269**	**(1,519)**	**67,347**	**66,902**	**445**

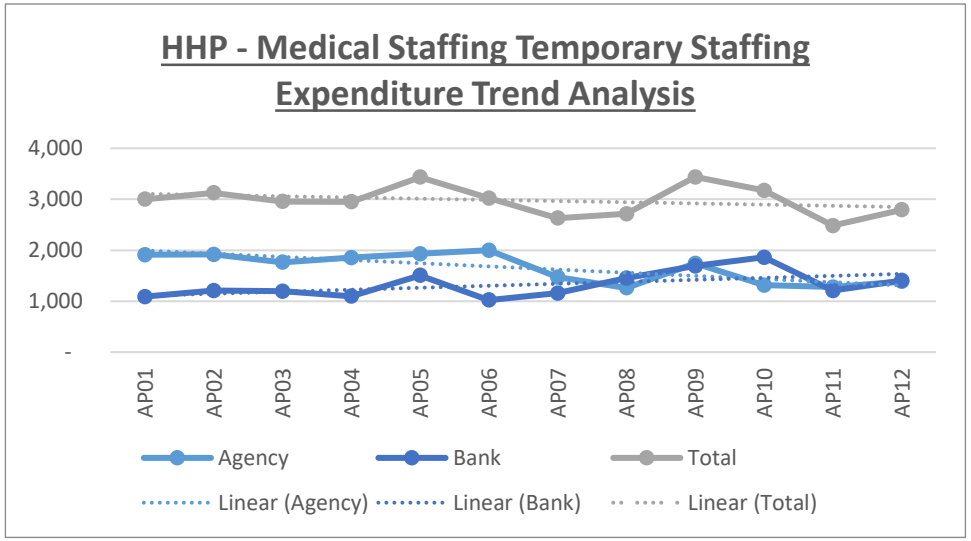


Type	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12
Agency	2,433	2,465	2,405	2,478	2,558	2,527	1,884	1,771	2,231	1,827	1,440	1,811
Bank	3,035	3,627	3,249	3,195	3,598	3,259	3,232	3,363	3,513	4,093	3,377	3,533
Total	**5,468**	**6,092**	**5,654**	**5,673**	**6,156**	**5,786**	**5,116**	**5,134**	**5,744**	**5,920**	**4,817**	**5,344**

Temporary Staffing Summary – Medical Staffing

The Group has spent £35.7m on Medical Staffing agency and bank pay, £1.2m less than in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	3,689	2,981	708	8,923	9,828	(905)	12,612	12,809	(197)
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	332	369	(38)	65	85	(21)	397	455	(58)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	1,111	1,296	(185)	1,419	1,477	(59)	2,530	2,773	(243)
	Digestive Diseases	432	218	214	922	1,678	(756)	1,355	1,896	(541)
	Family Services	1,392	821	571	1,945	2,291	(345)	3,337	3,111	226
	Head & Neck	1,049	1,091	(41)	1,729	1,469	260	2,779	2,560	219
	Major Trauma Network	41	23	18	0	0	0	41	23	18
	Neuroscience	806	389	417	641	712	(70)	1,448	1,101	347
	Pathology Network Group	1	0	1	563	372	191	564	372	192
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	46	39	7	0	0	0	46	39	7
	Specialist Cancer and Support Services	1,472	1,361	111	1,007	647	360	2,479	2,009	471
	Specialist Medicine	450	254	197	1,603	1,920	(318)	2,053	2,174	(121)
	Specialist Surgery	696	800	(105)	1,991	1,489	502	2,687	2,289	397
	Theatres, Anaesthetics and Critical Care	2,656	2,081	576	2,341	2,259	82	4,997	4,340	657
Total Operations		**14,174**	**11,723**	**2,451**	**23,150**	**24,227**	**(1,078)**	**37,323**	**35,950**	**1,373**
Corporate	Corporate Directorates	5	21	(17)		(0)	0	5	21	(17)
Total Corporate		**5**	**21**	**(17)**	**0**	**(0)**	**0**	**5**	**21**	**(17)**
Central Reserves & Technical	Central Technical	(400)	116	(516)	14	(367)	381	(386)	(251)	(135)
	Reserves	5	(0)	5	0	0	0	5	(0)	5
Total Central Income, Reserves & Technical		**(395)**	**116**	**(511)**	**14**	**(367)**	**381**	**(381)**	**(251)**	**(130)**
Surplus / (Deficit)		**13,783**	**11,860**	**1,923**	**23,164**	**23,860**	**(696)**	**36,946**	**35,720**	**1,227**

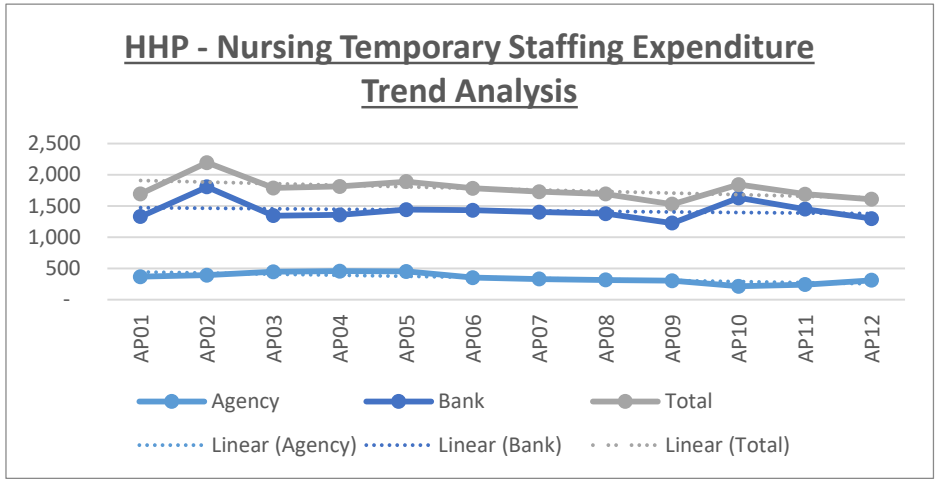


Type	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12
Agency	1,911	1,917	1,763	1,854	1,930	1,998	1,472	1,260	1,743	1,313	1,276	1,386
Bank	1,089	1,208	1,194	1,097	1,505	1,024	1,158	1,454	1,692	1,861	1,207	1,406
Total	**3,000**	**3,125**	**2,957**	**2,951**	**3,435**	**3,022**	**2,631**	**2,714**	**3,435**	**3,174**	**2,483**	**2,792**

Temporary Staffing Summary - Nursing

The Group has spent £21.3m on Nursing agency and bank pay This is £0.3m less than in 2024/25.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	797	1,501	(704)	4,814	5,107	(294)	5,610	6,608	(998)
	Cancer Network	0		0	9	0	9	9	0	9
	Cardiovascular	238	268	(30)	308	399	(91)	546	667	(121)
	Chief Delivery Officer	0		0	0	0	0	0	0	0
	Community, Frailty & Therapy	1,171	1,273	(102)	1,662	1,735	(74)	2,833	3,009	(176)
	Digestive Diseases	671	507	163	1,198	1,266	(69)	1,868	1,774	95
	Family Services	497	500	(3)	2,976	2,845	131	3,473	3,345	128
	Head & Neck	61	51	10	70	39	31	131	89	41
	Major Trauma Network	17	54	(37)	0	0	0	17	54	(37)
	Neuroscience	419	235	185	722	658	64	1,141	892	249
	Pathology Network Group	1		1	0	0	0	1	0	1
	Patient Services	13	5	8	250	61	189	263	66	197
	Site Management & Discharge teams	158	363	(206)	347	318	29	505	682	(177)
	Specialist Cancer and Support Services	802	476	326	206	240	(33)	1,009	716	293
	Specialist Medicine	617	346	271	1,236	1,284	(47)	1,853	1,630	223
	Specialist Surgery	533	254	279	528	482	46	1,061	736	325
	Theatres, Anaesthetics and Critical Care	73	67	6	1,085	638	447	1,158	705	453
Total Operations		**6,068**	**5,900**	**169**	**15,409**	**15,072**	**338**	**21,478**	**20,971**	**506**
Corporate	Corporate Directorates	16	35	(19)	95	110	(14)	111	145	(34)
Total Corporate		**16**	**35**	**(19)**	**95**	**110**	**(14)**	**111**	**145**	**(34)**
Central Reserves & Technical	Central Technical	254	(36)	290	(265)	144	(409)	(11)	108	(119)
	Reserves	0	0	0	0	37	(37)	0	37	(37)
Total Central Income, Reserves & Technical		**254**	**(36)**	**290**	**(265)**	**181**	**(446)**	**(11)**	**145**	**(156)**
Surplus / (Deficit)		**6,338**	**5,899**	**440**	**15,240**	**15,363**	**(123)**	**21,578**	**21,261**	**317**



Type	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12
Agency	366	391	444	456	450	352	328	313	303	213	240	308
Bank	1,330	1,806	1,345	1,358	1,442	1,433	1,402	1,378	1,225	1,630	1,450	1,299
Total	**1,696**	**2,196**	**1,789**	**1,814**	**1,892**	**1,785**	**1,730**	**1,691**	**1,528**	**1,843**	**1,690**	**1,607**

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	78.4	87.1	8.7	915.2	923.7	8.5	50.0	53.1	3.1	568.6	565.4	(3.2)	128.3	140.1	11.8	1,483.9	1,489.2	5.3
Other Income	7.7	41.6	33.9	89.0	125.8	36.9	6.4	37.0	30.6	75.2	100.5	25.3	14.1	78.6	64.5	164.2	226.4	62.2
Total Operating Income	**86.0**	**128.6**	**42.6**	**1,004.2**	**1,049.6**	**45.4**	**56.4**	**90.0**	**33.7**	**643.8**	**666.0**	**22.1**	**142.4**	**218.7**	**76.3**	**1,648.1**	**1,715.5**	**67.5**
Pay Costs																		
Medical Staff	(17.7)	(19.9)	(2.2)	(213.6)	(219.8)	(6.1)	(10.1)	(11.1)	(1.0)	(121.8)	(126.4)	(4.6)	(27.8)	(31.0)	(3.2)	(335.4)	(346.2)	(10.8)
Nursing Staff	(14.8)	(16.4)	(1.6)	(179.2)	(189.3)	(10.1)	(12.8)	(13.5)	(0.7)	(154.4)	(154.9)	(0.5)	(27.6)	(29.9)	(2.3)	(333.6)	(344.2)	(10.6)
Scientific Therapeutic & Technical Staff	(6.6)	(7.2)	(0.6)	(82.1)	(84.7)	(2.6)	(5.0)	(5.5)	(0.5)	(60.3)	(62.9)	(2.6)	(11.6)	(12.7)	(1.1)	(142.4)	(147.6)	(5.3)
Total Clincial Pay	**(39.1)**	**(43.5)**	**(4.4)**	**(474.9)**	**(493.8)**	**(18.9)**	**(27.9)**	**(30.1)**	**(2.2)**	**(336.5)**	**(344.2)**	**(7.8)**	**(67.0)**	**(73.6)**	**(6.6)**	**(811.4)**	**(838.0)**	**(26.6)**
Admin & Clerical Staff	(6.0)	(6.7)	(0.7)	(74.3)	(75.4)	(1.1)	(5.0)	(5.6)	(0.6)	(63.9)	(62.9)	1.0	(11.0)	(12.4)	(1.4)	(138.2)	(138.3)	(0.1)
Maintenance Staff	(0.3)	(0.3)	0.0	(3.9)	(3.7)	0.3	(0.2)	(0.2)	(0.0)	(2.1)	(2.0)	0.1	(0.5)	(0.5)	(0.0)	(6.0)	(5.7)	0.3
Support Staff	(1.7)	(1.6)	0.0	(19.9)	(19.3)	0.6	(1.6)	(1.7)	(0.0)	(19.7)	(19.8)	(0.1)	(3.3)	(3.3)	(0.0)	(39.6)	(39.1)	0.5
Other Staff	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.1
Apprentice Levy	(0.2)	(0.2)	(0.0)	(2.1)	(2.3)	(0.2)	(0.1)	(0.1)	0.0	(1.7)	(1.7)	0.0	(0.3)	(0.3)	(0.0)	(3.8)	(4.0)	(0.2)
Pensiosn Adjustment	0.0	(34.2)	(34.2)	0.0	(34.2)	(34.2)	0.0	(23.5)	(23.5)	0.0	(23.5)	(23.5)	0.0	(57.8)	(57.8)	0.0	(57.8)	(57.8)
Total Other Pay	**(8.2)**	**(43.1)**	**(35.0)**	**(100.3)**	**(135.0)**	**(34.7)**	**(6.9)**	**(31.2)**	**(24.2)**	**(87.7)**	**(110.2)**	**(22.5)**	**(15.1)**	**(74.3)**	**(59.2)**	**(188.0)**	**(245.1)**	**(57.1)**
Total Pay Costs	**(47.2)**	**(86.7)**	**(39.4)**	**(575.2)**	**(628.7)**	**(53.5)**	**(34.9)**	**(61.2)**	**(26.4)**	**(424.1)**	**(454.4)**	**(30.3)**	**(82.1)**	**(147.9)**	**(65.8)**	**(999.3)**	**(1,083.1)**	**(83.8)**
Drugs	(10.8)	(11.5)	(0.7)	(130.2)	(139.4)	(9.2)	(2.6)	(3.5)	(0.9)	(36.4)	(41.2)	(4.8)	(13.4)	(15.0)	(1.6)	(166.5)	(180.5)	(14.0)
Clinical Supplies & Services	(6.9)	(8.5)	(1.6)	(88.0)	(96.0)	(7.9)	(3.6)	(4.7)	(1.1)	(46.7)	(52.4)	(5.7)	(10.6)	(13.3)	(2.7)	(134.7)	(148.3)	(13.6)
Total Clinical Non Pay	**(17.7)**	**(20.0)**	**(2.3)**	**(218.2)**	**(235.3)**	**(17.1)**	**(6.2)**	**(8.2)**	**(2.0)**	**(83.1)**	**(93.5)**	**(10.5)**	**(23.9)**	**(28.2)**	**(4.3)**	**(301.3)**	**(328.8)**	**(27.6)**
General Supplies & Services	(2.0)	(1.9)	0.1	(23.2)	(23.0)	0.2	(0.5)	(0.7)	(0.2)	(6.2)	(8.5)	(2.2)	(2.5)	(2.6)	(0.1)	(29.4)	(31.5)	(2.1)
Establishment Expenses	(0.5)	(0.7)	(0.2)	(6.3)	(6.6)	(0.3)	(0.7)	(1.1)	(0.4)	(8.3)	(7.7)	0.6	(1.2)	(1.8)	(0.6)	(14.6)	(14.3)	0.3
Other Establishment Costs	(2.4)	(2.3)	0.2	(29.0)	(28.9)	0.2	(1.5)	(1.6)	(0.1)	(17.9)	(18.0)	(0.1)	(3.9)	(3.9)	0.0	(46.9)	(46.9)	0.1
Premises and Fixed Plant	(4.0)	(2.2)	1.8	(37.8)	(34.6)	3.2	(3.8)	(3.6)	0.2	(27.6)	(25.8)	1.8	(7.8)	(5.8)	2.0	(65.4)	(60.4)	5.0
Purchase of Healthcare Services	(5.4)	(5.0)	0.4	(45.1)	(45.3)	(0.2)	(1.7)	(1.6)	0.0	(20.1)	(17.3)	2.8	(7.1)	(6.6)	0.5	(65.2)	(62.6)	2.5
Miscellaneous Expenditure	(0.0)	0.3	0.3	(0.2)	(0.4)	(0.2)	(0.1)	(0.8)	(0.6)	(1.3)	(2.1)	(0.8)	(0.2)	(0.5)	(0.3)	(1.4)	(2.5)	(1.1)
Education Expenditure	(0.6)	(0.6)	0.0	(7.4)	(7.3)	0.1	(0.3)	(0.4)	(0.1)	(3.1)	(3.0)	0.1	(0.9)	(0.9)	(0.0)	(10.5)	(10.2)	0.3
Consultancy Expenditure	(0.0)	(0.6)	(0.6)	(0.0)	(0.7)	(0.7)	(0.0)	(1.2)	(1.2)	(0.4)	(1.6)	(1.2)	(0.0)	(1.8)	(1.8)	(0.4)	(2.4)	(1.9)
Fixed Assett Impairments / Revaluation	0.0	5.6	5.6	0.0	5.6	5.6	0.0	(33.2)	(33.2)	0.0	(33.2)	(33.2)	0.0	(27.6)	(27.6)	0.0	(27.6)	(27.6)
Total Other Non Pay	**(15.0)**	**(7.3)**	**7.7**	**(149.0)**	**(141.1)**	**7.8**	**(8.6)**	**(44.2)**	**(35.6)**	**(85.0)**	**(117.3)**	**(32.3)**	**(23.6)**	**(51.6)**	**(28.0)**	**(234.0)**	**(258.4)**	**(24.4)**
Total Non Pay Costs	**(32.7)**	**(27.3)**	**5.4**	**(367.2)**	**(376.5)**	**(9.3)**	**(14.8)**	**(52.4)**	**(37.7)**	**(168.1)**	**(210.8)**	**(42.7)**	**(47.5)**	**(79.8)**	**(32.3)**	**(535.3)**	**(587.2)**	**(52.0)**
Total Operating Expenditure	**(80.0)**	**(114.0)**	**(34.0)**	**(942.4)**	**(1,005.2)**	**(62.8)**	**(49.7)**	**(113.7)**	**(64.0)**	**(592.2)**	**(665.2)**	**(73.0)**	**(129.6)**	**(227.7)**	**(98.0)**	**(1,534.6)**	**(1,670.4)**	**(135.8)**
EBITDA	**6.1**	**14.6**	**8.6**	**61.8**	**44.4**	**(17.4)**	**6.7**	**(23.6)**	**(30.3)**	**51.7**	**0.8**	**(50.9)**	**12.8**	**(9.0)**	**(21.8)**	**113.5**	**45.2**	**(68.3)**
Depreciation	(2.5)	(2.5)	0.0	(29.8)	(29.4)	0.4	(2.3)	(2.1)	0.2	(25.7)	(22.8)	3.0	(4.8)	(4.5)	0.3	(55.5)	(52.1)	3.4
Non Operating Items	(1.4)	(1.5)	(0.1)	(16.8)	(16.6)	0.2	(0.7)	(0.6)	0.1	(8.1)	(7.1)	0.9	(2.1)	(2.1)	(0.0)	(24.8)	(23.7)	1.1
Surplus/(Deficit)	**2.2**	**10.7**	**8.5**	**15.3**	**(1.6)**	**(16.9)**	**3.8**	**(26.3)**	**(30.1)**	**17.9**	**(29.1)**	**(47.0)**	**5.9**	**(15.6)**	**(21.5)**	**33.1**	**(30.7)**	**(63.8)**
NHSE Allowable Adjustments	(0.3)	(5.8)	(5.5)	(15.3)	(20.4)	(5.1)	(1.5)	25.4	26.9	(17.9)	14.6	32.5	(1.7)	19.6	21.3	(33.1)	(5.8)	27.3
Adjusted Surplus / (Deficit)	**1.9**	**4.9**	**3.0**	**(0.0)**	**(22.0)**	**(22.0)**	**2.3**	**(0.9)**	**(3.2)**	**(0.0)**	**(14.5)**	**(14.5)**	**4.2**	**4.0**	**(0.2)**	**(0.0)**	**(36.5)**	**(36.5)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine	(3.4)	(3.8)	(0.5)	(40.8)	(44.7)	(3.8)	(5.7)	(5.9)	(0.1)	(68.6)	(70.2)	(1.5)	(9.1)	(9.7)	(0.6)	(109.5)	(114.8)	(5.3)
	Cancer Network	(0.4)	(0.4)	0.0	(5.3)	(5.3)	(0.0)	(0.3)	(0.2)	0.1	(3.2)	(3.0)	0.2	(0.7)	(0.6)	0.1	(8.5)	(8.3)	0.2
	Cardiovascular	(3.6)	(4.0)	(0.4)	(42.5)	(43.0)	(0.5)	(1.0)	(1.0)	(0.0)	(11.2)	(10.9)	0.3	(4.5)	(4.9)	(0.4)	(53.7)	(53.9)	(0.1)
	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(1.0)	(1.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.9)	(0.8)	0.2	(0.2)	(0.2)	(0.0)	(2.0)	(1.8)	0.2
	Community, Frailty & Therapy	(3.7)	(3.9)	(0.2)	(42.9)	(44.9)	(2.0)	(4.2)	(4.0)	0.1	(48.6)	(48.8)	(0.2)	(7.8)	(7.9)	(0.1)	(91.5)	(93.7)	(2.2)
	Digestive Diseases	(2.9)	(2.9)	(0.0)	(35.0)	(38.6)	(3.7)	(2.7)	(2.8)	(0.1)	(30.9)	(30.8)	0.1	(5.6)	(5.7)	(0.1)	(65.9)	(69.4)	(3.5)
	Family Services	(4.9)	(5.3)	(0.4)	(57.4)	(61.0)	(3.5)	(4.6)	(4.7)	(0.0)	(53.6)	(55.3)	(1.8)	(9.5)	(10.0)	(0.4)	(111.0)	(116.3)	(5.3)
	Head & Neck	(3.5)	(3.6)	(0.0)	(42.3)	(42.7)	(0.4)	(1.4)	(1.6)	(0.2)	(16.4)	(16.9)	(0.5)	(4.9)	(5.2)	(0.3)	(58.7)	(59.5)	(0.8)
	Major Trauma Network	(0.3)	(0.3)	0.0	(3.5)	(3.5)	0.0	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.1)	(0.3)	(0.3)	0.0	(3.7)	(3.7)	(0.0)
	Neuroscience	(2.7)	(2.8)	(0.1)	(28.1)	(30.3)	(2.1)	(0.8)	(0.9)	(0.0)	(10.0)	(10.6)	(0.6)	(3.6)	(3.7)	(0.1)	(38.1)	(40.9)	(2.8)
	Pathology Network Group	(2.0)	(1.6)	0.4	(23.8)	(25.0)	(1.2)	(2.4)	(2.5)	(0.1)	(25.8)	(25.2)	0.6	(4.4)	(4.1)	0.3	(49.6)	(50.2)	(0.6)
	Patient Services	(2.2)	(2.2)	(0.0)	(26.5)	(26.3)	0.2	(1.4)	(1.7)	(0.3)	(19.9)	(19.8)	0.1	(3.6)	(3.9)	(0.3)	(46.4)	(46.1)	0.3
	Site Management & Discharge teams	(0.3)	(0.3)	0.0	(3.3)	(3.8)	(0.5)	(0.4)	(0.4)	(0.0)	(4.3)	(4.4)	(0.1)	(0.7)	(0.7)	0.0	(7.6)	(8.2)	(0.6)
	Specialist Cancer and Support Services	(18.3)	(19.1)	(0.8)	(216.8)	(220.2)	(3.4)	(6.4)	(6.0)	0.4	(73.8)	(72.3)	1.5	(24.7)	(25.1)	(0.4)	(290.6)	(292.5)	(1.9)
	Specialist Medicine	(3.9)	(3.9)	0.0	(46.6)	(48.0)	(1.5)	(1.9)	(1.9)	0.0	(23.7)	(24.0)	(0.3)	(5.8)	(5.8)	0.0	(70.3)	(72.0)	(1.7)
	Specialist Surgery	(3.9)	(4.0)	(0.1)	(43.2)	(44.8)	(1.6)	(2.0)	(2.2)	(0.2)	(21.8)	(22.4)	(0.6)	(5.8)	(6.1)	(0.3)	(65.0)	(67.2)	(2.2)
	Theatres, Anaesthetics and Critical Care	(7.5)	(7.8)	(0.4)	(88.9)	(90.2)	(1.4)	(4.1)	(4.4)	(0.3)	(50.4)	(51.3)	(0.9)	(11.5)	(12.2)	(0.7)	(139.3)	(141.5)	(2.3)
Total Operations		**(63.5)**	**(66.1)**	**(2.5)**	**(748.0)**	**(773.3)**	**(25.3)**	**(39.3)**	**(40.1)**	**(0.8)**	**(463.4)**	**(466.8)**	**(3.4)**	**(102.8)**	**(106.2)**	**(3.3)**	**(1,211.4)**	**(1,240.1)**	**(28.7)**
Corporate	Chief Executive	(0.1)	(0.3)	(0.2)	(1.5)	(2.0)	(0.6)	(0.1)	(0.2)	(0.1)	(1.3)	(1.9)	(0.6)	(0.2)	(0.5)	(0.3)	(2.7)	(3.9)	(1.2)
	Chief Medical Officer	(0.5)	(0.6)	(0.2)	(5.4)	(5.3)	0.1	(0.6)	(0.6)	(0.0)	(7.9)	(7.8)	0.1	(1.1)	(1.3)	(0.2)	(13.3)	(13.1)	0.2
	Chief Nurse Office	(3.0)	(2.9)	0.1	(35.8)	(36.7)	(0.9)	(2.2)	(2.3)	(0.0)	(26.9)	(26.4)	0.5	(5.2)	(5.2)	0.0	(62.7)	(63.1)	(0.4)
	Director of Assurance	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.0)	(0.9)	(0.9)	(0.0)	(0.1)	(0.1)	(0.0)	(1.0)	(1.1)	(0.1)
	Director of People	(0.9)	(1.1)	(0.2)	(10.6)	(10.2)	0.5	(0.8)	(1.0)	(0.2)	(9.8)	(9.7)	0.1	(1.7)	(2.1)	(0.4)	(20.4)	(19.8)	0.6
	Director of Finance, Estates & Facilities	(7.0)	(6.4)	0.6	(77.7)	(73.4)	4.2	(4.2)	(5.1)	(0.9)	(50.4)	(53.1)	(2.7)	(11.2)	(11.5)	(0.3)	(128.1)	(126.5)	1.5
	Strategy and Partnerships	(1.9)	(2.2)	(0.2)	(11.7)	(11.8)	(0.0)	(1.7)	(1.9)	(0.2)	(9.8)	(9.4)	0.4	(3.7)	(4.1)	(0.4)	(21.6)	(21.2)	0.3
Total Corporate		**(13.4)**	**(13.6)**	**(0.2)**	**(142.9)**	**(139.7)**	**3.2**	**(9.8)**	**(11.2)**	**(1.5)**	**(107.0)**	**(109.1)**	**(2.2)**	**(23.2)**	**(24.8)**	**(1.6)**	**(249.9)**	**(248.8)**	**1.1**
Central Income, Reserves & Technical	Central Income	79.5	88.1	8.6	942.4	940.9	(1.5)	51.6	55.2	3.6	588.9	585.1	(3.8)	131.1	143.3	12.2	1,531.3	1,526.0	(5.3)
	Central Technical	(3.5)	1.6	5.1	(44.7)	(30.1)	14.6	(1.3)	(30.1)	(28.9)	(13.7)	(37.9)	(24.2)	(4.8)	(28.6)	(23.8)	(58.4)	(67.9)	(9.6)
	Reserves	3.1	0.6	(2.5)	8.5	0.5	(7.9)	2.5	0.0	(2.5)	13.0	(0.4)	(13.4)	5.6	0.7	(5.0)	21.5	0.1	(21.4)
Total Central Income, Reserves & Technical		**79.1**	**90.3**	**11.2**	**906.2**	**911.4**	**5.2**	**52.8**	**25.0**	**(27.8)**	**588.2**	**546.8**	**(41.4)**	**131.9**	**115.4**	**(16.6)**	**1,494.4**	**1,458.2**	**(36.2)**
Surplus / (Deficit)		**2.2**	**10.7**	**8.5**	**15.3**	**(1.6)**	**(16.9)**	**3.8**	**(26.3)**	**(30.1)**	**17.9**	**(29.1)**	**(47.0)**	**5.9**	**(15.6)**	**(21.5)**	**33.1**	**(30.7)**	**(63.8)**
Adjustments to adjusted financial performance		(0.3)	(5.8)	(5.5)	(15.3)	(20.4)	(5.1)	(1.5)	25.4	26.9	(17.9)	14.6	32.5	(1.7)	19.6	21.3	(33.1)	(5.8)	27.3
Adjusted financial performance Surplus / (Deficit)		**1.9**	**4.9**	**3.0**	**(0.0)**	**(22.0)**	**(22.0)**	**2.3**	**(0.9)**	**(3.2)**	**(0.0)**	**(14.5)**	**(14.5)**	**4.2**	**4.0**	**(0.2)**	**(0.0)**	**(36.5)**	**(36.5)**

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)114

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	14 May 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – January 2026 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 22 January 2026, approved at the ARG CiC meeting on 23 April 2026.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – January 2026
Prior Approval Process	ARG CiC meeting – 23 April 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:

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 22 January 2026 at 9.00am to 12.30pm via Microsoft Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

Jane Hawkard	Chair of ARG CiC (HUTH) - Non-Executive Director
Simon Parkes	Chair of ARG CiC (NLaG) - Non-Executive Director
Tony Curry	Non-Executive Director (HUTH)
Gill Ponder	Non-Executive Director (NLaG)
Julie Beilby	Non-Executive Director (NLaG)

In Attendance:

Emma Sayner	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Neil Thomas	Partner, KPMG – Group Internal Audit
Harriet Fisher	Senior Manager, KPMG – Group Internal Audit
James Collins	Forvis Mazars – External Audit HUTH
Brian Clerkin	Audit Partner, Sumer NI
Chipo-Grace Tete	Audit Manager, Sumer NI
Daryl Cheetham	Local Counter Fraud Specialist (LCFS)
Fran Moverley	Freedom to Speak Up Guardian (HUTH) (item 9.1)
Liz Houchin	Freedom to Speak Up Guardian (NLaG) (item 9.2)
Matt Overton	Group Operations Director (item 9.3)
Tracy Campbell	Director of Patient Safety and Quality Governance (item 9.5)
Mike Bateson	NLaG Governor Observer
Simon Elliott	Deputy Intensive Support Director, NHSE Observer
Stacey Howard	Workstream Lead NHSE, Observer
Laura Bibby	Workstream Lead NHSE, Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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

The meeting was recorded, and the recording will be deleted once the draft minutes are approved as correct.

1. Welcome and Apologies for Absence

Jane Hawkard, Audit, Risk and Governance Committees-in-Common (ARG CiC) Chair, welcomed colleagues to the meeting and introductions were made. Simon Parkes advised this would be his last ARG CiC meeting due to stepping down from his Non-Executive Director (NED) role at NLaG. Apologies for absence were received from Helen Wright, NED (HUTH) and Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest, and none were made.

3. To approve the minutes of the meetings held on 12 November 2025

3.1 Public Minutes – 12 November 2025

The public minutes were approved as a true and accurate record of the meeting.

3.2 Private Minutes – 12 November 2025

The private minutes were approved as a true and accurate record of the meeting.

4. Matters Arising and Review of ARG CiC Action Tracker

4.1 Public Action Tracker

The ARG CiC Chair invited members to raise any matters requiring discussion not captured on the agenda. The following items were discussed from the public action tracker:

- April 2025 - Item 11.2 – timescale amended to 31 March 2026.
- April 2025 - Item 11.3 – Humberside Police have confirmed that the Bad Apple fraud reporting system can be used on the HHP intranet site for both NLaG and HUTH. Action closed.
- July 2025 - Item 7.1 – Simon Parkes confirmed that he had exchanged correspondence with the Interim Group CEO around overdue Internal Audit management actions and the Interim Group CEO had advised that she wanted to manage them through Executive meetings initially in order to reduce the numbers.
- July 2025 - Item 7.2 (b) - on the agenda at item 4.3.
- November 2025 - Item 7.1 (a) - it was agreed that requests for a second extension to implementation dates on Internal Audit management actions would require the responsible officer to attend the ARG CiC to justify the request.
- November 2025 - Item 7.1 (b)– David Sharif updated that The Value Circle feedback had not yet been shared with the interim Group Chair or Interim Group CEO but was tabled for discussion at the February 2026 Trust Boards-in-Common meeting, and suggested adding to the agenda for the April 2026 ARG CiC meeting for discussion on the impact on the governance framework.

  ACTION: Sally Stevenson
- November 2025 - Item 8.1– Benchmarking data included in the LCFS Progress Report. Action closed.
- November 2025 - Item 9.3 (a) – David Sharif updated that this had been added as a future topic at the Trust Boards-in-Common Development sessions, and sessions were being arranged accordingly. Jane Hawkard asked that this action remain open for a further update.
- November 2025 - Item 9.3(b) and (c) – Simon Parkes to action these items before he leaves on 31.3.26.

  ACTION: Simon Parkes
- November 2025 - Item 9.6 (a) – on the agenda at item 4.5.
- November 2025 – Item 9.6 (b) – David Sharif advised topic added to development log for discussion with Interim Group Chair.
- November 2025 - Items 9.7 (a) and (b) – actions closed.

- November 2025 - Item 9.8– Simon Parkes to action before he leaves on 31.3.26.

Jane Hawkard added that the outstanding actions by Simon Parkes had previously been raised in ARG CiC Highlight Reports to the Trust Boards-in-Common and she had written directly to the interim Group CEO and initiated discussions at the Trust Boards-in-Common. However, Jane Hawkard asked that Simon Parkes also completes his actions in this regard and then updates Sally Stevenson once his actions were completed.

ACTION: Simon Parkes

4.2 Private Action Tracker

Refer to private minutes.

4.3 HUTH Inventory Management Update

Emma Sayner advised that a lot of work had been to be done on this and it had moved on significantly, highlighting there was quite a complex picture across the Group in terms of systems and processes in place relating to inventory management. It had been a joint effort with Andy Haywood, Group Chief Digital Officer, given that Emma Sayner is Director lead for Procurement and Andy Haywood, Director lead for the Scan4Safety element.

The Inventory Management Policy was now a Group wide policy, moving the Group forward in terms of the harmonisation piece, and the piece around the system strategy had been presented to the Executive team. There were various options on how to proceed, due to the level of systems fragmentation, but as there was currently no single system for procurement across the Group, it was agreed to proceed with the most pragmatic option of integrating Tagnos and Elcom, with a programme board to oversee this culminating in the production of a business case which considers the financial implications, but that any proposal would be contained within existing budgets.

There had also been significant work undertaken to ensure better grip and control on stock levels, particularly at HUTH. Some improvement had been noted, and it was hoped this would continue while the system alignment was underway.

Jane Hawkard asked about the timescales for this work and Emma Sayner responded that she hoped it would be the beginning of the next financial year when it would mobilise and move forward in earnest.

4.4 Governance Framework/Value Circle Findings

David Sharif reiterated that the Group were waiting for the results of The Value Circle work, and updated colleagues on the work undertaken relating to a risk stocktake by The Value Circle and was in the scope of the Board Assurance Framework (BAF). The Value Circle had identified several risks they felt were pertinent and also a number of risks either implied or perhaps missing from the BAF. As a result Board members had subsequently pulled together a list of the Top 20 risks which were due to be discussed at the Group Executive Risk and Assurance Committee (GERAC) meeting in January 2025, but the meeting had been postponed. However, David Sharif added that he had subsequently spoken

with The Value Circle to gain insight on their views on an outline proposal and there would be a discussion on how to progress this at the Trust Boards-in-Common, in terms of how the Group better reflects risks in the BAF. David Sharif informed the ARG CiC that he was preparing some materials and thoughts on how best to support the conversation at the Trust Boards-in-Common meeting. David Sharif acknowledged the work undertaken by the Interim Group Chief Nurse and her team in relation to the high scoring risks and the assignment of these to Executives. This would also be raised at the next GERAC meeting.

Jane Hawkard asked for an idea on the timescale for the update on the BAF as it had been brought back to the ARG CiC due to the Committees having no assurance. David Sharif advised it would be presented to the Trust Boards-in-Common in March 2026 (as a result of a new meeting cycle), having been discussed at GERAC during the first week of February 2026 and then potentially again at their March 2026 meeting for final approval ahead of the March 2026 Trust Boards-in-Common meeting. Executives would also have had the opportunity to review it ahead of the Trust Boards-in-Common meeting. Jane Hawkard asked that this item be added to the action log for the next meeting.

ACTION: Sally Stevenson

4.5 HHP Risk Management Strategy – Summary

Jane Hawkard reminded the ARG CiC they had asked for a summary document, but considered it was still very high level and didn't actually say what it needed staff to do as part of their risk management responsibilities.

David Sharif reflected on the work undertaken on the Risk Management Strategy and comments on the draft document had been forwarded to the Interim Group Chief Nurse and her team who had produced the one page summary, but reflected that a more staff orientated one-page user-friendly document was needed.

Gill Ponder clarified that the previous ARG CiC discussion was around risk management being an area that the Group needed to focus on and it was considered that a long strategy would not be referred to by staff, and an easy-read summary had been requested. Gill Ponder referred to slide two of the paper and the Strategic Programmes & Partnerships (SP&P) CiC not detailing an Executive lead unlike other CiCs, rather it showed herself and Helen Wright as co-Chairs of the CiC. Gill Ponder confirmed that Andy Haywood was the executive lead for the SP&P CiC, and considered there was a need to standardise some of the details on it. David Sharif agreed to amend this.

ACTION: David Sharif

Jane Hawkard asked that the summary document be revisited and brought back to the ARG CiC giving the information discussed and be clear on what staff need to do on a practical level to highlight risks and mitigating actions within the framework.

Action: Heather McNair/Tracey Campbell

5. NLaG External Audit (Sumer NI)

5.1 NLaG Audit Completion Certificate 2024/25

Brian Clerkin confirmed that the NLaG Audit Completion Certificate for 2024/25 had been issued to the Trust following confirmation from the National Audit Office (NAO) that they had completed their group audit of the Department of Health and Social Care (DHSC) and completion certificates could be issued. This confirms that the NLAG 2024/25 audit is now complete.

The NLAG ARG Committee noted the receipt of the completion certificate.

Post meeting note: The completion certificate was received by NLAG on 12.12.25 and circulated to NLAG ARG Committee NEDs via email on 17.12.25.

5.2 NLaG Audit Planning Report 2025/26

Brian Clerkin referred to the covering letter and advised that a separate planning letter had been issued to The Health Tree Foundation for the charity audit (which formed part of the consolidated financial statements of the Trust). Audit planning information requested before Christmas had all now been received. Materiality levels are the same as last year (2% of expenditure), although this will be reviewed again at the end of the year when they see outturn. Significant audit risks remain as last year, although the NAO have not yet issued their group instructions so there is the possibility these may change but there is no indication that they will at this stage. Brian Clerkin confirmed their interim work had commenced that week with the Finance team, a clearance meeting for the main year end audit had been diarised for 25.5.26 and their audit completion report would be submitted to the June 2026 ARG CiC meeting.

Brian Clerkin also notified colleagues that the NAO may request to review some sample audit files for work undertaken by the component auditors, following the implementation last year of a new auditing standard, ISA 600, in relation to group audits conducted by the NAO. NLAG were not sampled last year and it is not yet known who will be sampled this year, but if NLAG are selected then there will additional costs for the Trust associated with this extra work undertaken by the External Auditor. Brian Clerkin stated that he would advise NLAG if they had been selected as soon as it was known and any additional costs attached to the work.

Emma Sayner added that she had had discussions with the Interim Group CEO about what, if any, dialogue was needed with the External Auditors as a result of the stabilisation and oversight phase the Group are in, to ensure that Auditors were sighted on the implications on this, adding that she would liaise with the Auditors as necessary in due course. Emma Sayner also commented that she was anticipating the Remuneration Report would be quite involved this year because of the various changes in leadership and interim arrangements in place. Emma Sayner also advised that she had had conversations with other Trusts in a similar position with a view to having an aligned approach and ensure all data requests were submitted really early to the NHS Business Services Authority to ensure that the necessary information is obtained to populate the Remuneration Report which will be comprehensive.

6. HUTH External Audit (Forvis Mazars)

6.1 HUTH Progress Report

James Collins advised that the HUTH External Audit Completion Certificate for 2024/25 had also been issued to the Trust on 14.1.26 and therefore completed the HUTH 2024/25 audit.

Post meeting note: The completion certificate was received by HUTH on 14.1.26 and circulated to HUTH ARG Committee NEDs via email the same day.

James Collins informed the HUTH ARG Committee that following some internal staff changes within Forvis Mazars due to retirements, he would no longer be working on the HUTH audit and there would be a new Engagement Lead, Nicola Hallas, going forward, and introductory meetings would be arranged with the Trust before the April 2026 ARG CiC meeting. James Collins added that Nicola Hallas had NHS audit experience, already doing a number in the area. He would however still be supporting Nicola Hallas as necessary.

James Collins advised they would bring their Audit Strategy document to the April 2026 meeting, but was not anticipating any significant changes to last year, as already outlined by Brian Clerkin for the NLAG audit. James Collins was pleased to hear that the Trusts were aware of the additional attention needed to the Remuneration Report, as they would have an increased focus on it also, and offered to have a conversation with Emma Sayner to support with this through his experience elsewhere.

7. Group Internal Audit (KPMG)

7.1 Group Internal Audit Progress Report 2025/26 inc. Status of Management Actions

Neil Thomas outlined the headlines from the report and advised that good progress had been made against the delivery of the 2025/26 internal audit plan, with the final three audits scoped / field work scheduled and would be completed by the end of the financial year. Neil Thomas advised that a long list of ideas for the 2026/27 internal audit plan was contained in the papers, however it was not the final list as yet due to the cancellation of the GERAC meeting at which it was scheduled to be discussed further. Neil Thomas also advised that the new process of monitoring the implementation of management actions had been implemented but needed further embedding and work was ongoing in terms of indicating whether the action had or had not been completed and including the detail on future dates, but reported incrementally better engagement on this.

Harriet Fisher advised that ‘TBC’ was shown for the revised date against some overdue management actions on the report, but that since the report was produced they had received the actual revised dates through on email and could be updated accordingly and then tracked through to completion.

Jane Hawkard was disappointed to note there was still work to be done around the deadline dates, despite conversations with Executive leads by both KPMG and herself. Simon Parkes agreed that despite the current challenges and priorities within the organisation, it was very important this was improved, adding that the dates indicated were dates provided by management themselves and they needed to be realistic when setting them at the outset, including considering

whether they had the resource to deliver the action(s). Simon Parkes emphasised that considering the need to deliver the Improvement Plan, the ARG CiC had offered Executives and management the opportunity to come back to the Committees and advise that the actions were important but could not be done in the current context of what the Group was trying to do because they were focusing on other priority matters, or they were not important enough to take action on, but the offer to respond like that had not been taken up. Simon Parkes was of the view that this should continue to be encouraged through Emma Sayner, and that management should look again at their actions and set realistic implementation dates or say they are no longer going to be done.

David Sharif commented that there had been a number of discussions at GERAC emphasising exactly these points and stated that he and Emma Sayner would take this to GERAC for further discussion. David Sharif commented that maybe there was a need for more robust discussions by KPMG with those officers signing up to management actions at the point of finalising reports.

ACTION: David Sharif / Emma Sayner

Gill Ponder referred to the importance of accountability and consequences, with a need for a sense of importance attached to clearing actions. The auditors have identified weaknesses in Trust processes, and therefore the issues needed to be closed down. Gill Ponder agreed with Simon Parkes, that managers agreed the action dates, they did not have them imposed upon them and therefore they should deal with them in line with that date.

Julie Beilby agreed this was about accountability and noted that there had been various discussions about inviting people to the ARG CiC to discuss relevant issues that could be preventing actions being resolved. Julie Beilby cited a similar example at the Workforce, Education and Culture CiC, and considered it may now be appropriate to request attendance at the ARG CiC to understand the reasons as to why actions were not being closed, otherwise the same conversations would continue to keep taking place at future meetings. Emma Sayner considered that some of the challenge and frustration has been due to the reality of changing leadership and interim arrangements in significant areas, but anticipated that with substantive posts now in place and with continuity on expectations, improvements would be seen.

Harriet Fisher acknowledged KPMG's role in the process and stated that they do push back on obvious unrealistic implementation dates, but they could go further with more robust discussions in closing meetings by trying to help officers think through the steps to implementation a bit more, and would encourage her team to more conversations around this. Harriet Fisher also assured the ARG CiC that they do have conversations with officers when finalising reports as to how realistic actions are. Jane Hawkard welcomed a direct challenge from KPMG to management of asking if there were any actions being recommended that simply were not currently achievable or needed a much longer timescale, and if necessary, advise the ARG CiC of any actions that KPMG believe are important that management say that cannot achieve.

ACTION: Harriet Fisher, KPMG

Tony Curry noted that there seemed to be a need for an honest discussion between the teams around the action and whether it was realistic and what the

challenges were in preventing it being implemented e.g. resources, other priorities, change in circumstances, etc., adding that officers may sometimes say yes to an action initially but subsequently discover that it was not the best way to deal with the issue or subsequently decide to run with a higher degree of risk. An update on these types of discussion would bring assurance that the issue was being taken seriously even if the action was not being closed by the deadline agreed.

Simon Parkes emphasised his earlier point that staff needed to be encouraged to be honest and feel confident to speak out and say that the deadline date was unrealistic, explaining the reasons behind this, so that the ARG CiC could take forward appropriately. A culture of complete honesty was needed, and this was key to getting this process working effectively.

David Sharif suggested that when KPMG are speaking with the action owners to finalise reports, that they question 'how' they plan on completing the action not just when they expect to have completed it by. This could justify any possible requests for an extension if other areas needed to be involved and give a clear picture on why actions were being delayed.

ACTION: Harriet Fisher, KPMG

Jane Hawkard referred to the fourteen actions with an extension requested, and clarified that second extensions to deadline dates would not be agreed without an attendance at the ARG CiC by the relevant officer(s) to justify the request. Jane Hawkard suggested that for those requesting extensions they are written back to and asked to consider all relevant factors when setting the new deadline date and are also asked to consider whether it is still important. Emma Sayner agreed with this suggestion and suggested that Sally Stevenson lead on this. Jane Hawkard accepted this and suggested that Sally Stevenson also monitor the effectiveness of this process to see if it made a difference.

ACTION: Sally Stevenson

Jane Hawkard concluded that the position was improving but slowly.

Jane Hawkard asked Harriet Fisher if she could focus on the low priority actions in the latest reports, as it had previously been stated by KPMG that the number of such actions would be reduced to avoid officers having to spend time on low priority issues.

Harriet Fisher updated that there were five low priorities within the Core Financial Controls report and noted an inconsistency of approach across the Group but adding they were housekeeping issues rather than significant issues with controls. Jane Hawkard asked the question of whether it would make a difference if the actions were not completed. Emma Sayner commented that it was a mixed answer, stating that there was a need to sharpen up on on cash specifically and was of the view that there was some complacency around this, not just within the Group, and considering the current scrutiny and issues around the financial recovery agenda, it did need to have more focus. Emma Sayner stated she was less concerned about the accruals action as there was evidence of robust actions being in place. Jane Hawkard suggested therefore that more specific conversations were had before the report is finalised.
Simon Parkes acknowledged that Internal Auditors are bound to pick up what they do and can't just ignore it, and therefore they make recommendations to

management and management respond to those recommendations, including having the right to respond and say they will not proceed with those recommendations. Simon Parkes agreed that getting the cash right was needed, but stated that the Finance team should be focussed on the large issues of keeping costs down and improving productivity and the organisation be comfortable in admitting that it would not be following through with some recommendations currently and the reasons as to why. Emma Sayner agreed with this point and the need to focus energies and resources on financial recovery.

Gill Ponder agreed with Simon Parkes' comment but added that there was also the need to be focussed on ensuring patient safety and not prioritising finance above this.

Harriet Fisher moved to the next report and reported that there were three medium priorities within the Data Quality report with one low priority.

Regarding the third report, the CQC Action Plan report, Harriet Fisher was unsure why some actions were still open when the evidence was there to close them. Harriet Fisher added that it appeared to be due to embeddedness of them and evidence of this being sought, and stated that teams needed to gain confidence in closing actions and moving processes to 'business as usual' so that actions can be closed and focus can move elsewhere. Jane Hawkard responded to ask that David Sharif and Emma Sayner raise this at GERAC for specific discussion as she did not feel comfortable in doing that, as they wanted to make sure things are embedded, confirming what Harriet Fisher was saying i.e. there's more CQC actions open that there would be if a different view was taken. David Sharif stated that there had been a number of conversations around this i.e. the blue embeddedness seems to be more of a challenge than getting it to green. David Sharif added that it was a very helpful report in that respect and fell firmly into the remit of the Quality and Safety Cic, at which he was aware that similar conversations had taken place there.

Jane Hawkard asked for this particular point to be brought back to a future meeting once a referral to the Quality & Safety Committees-in-Common had been made and the discussion held there as to which CQC actions could be closed.

ACTION: Jane Hawkard

Jane Hawkard commented that the report overall had given significant assurance with minor improvements, so it was good assurance.

Matt Overton joined the meeting.

7.2 Internal Audit Plan Long List 2026/27

Harriet Fisher explained how the list had been developed and asked for ARG CiC views on choosing up to five risk-based reviews for the coming year from the prioritised list, in addition to the four core audits which are covered each year albeit with a different focus.

Harriet Fisher noted that there was a common theme around the management of change and advised that an initial discussion had been held with Emma Sayner

around the possibility of a larger audit on this. Harriet Fisher asked for the ARG CiC's views, including anything else not already listed.

Liz Houchin and Fran Moverley joined the meeting.

Julie Beilby was pleased to note that learning from patient harm and complaints was listed, adding that the organisation continued to have a poor turnround time for complaint responses and completion dates and considered it was missing out on opportunities to learn and improve patient services and patient safety.

Julie Beilby also referred to item six listed (Programme Management Office (PMO)) and questioned whether the audit would look at whether the organisation had an ability to encompass transformation as a whole or whether it was merely focussed on the PMO in relation to the Cost Improvement Programme (CIP). Harriet Fisher confirmed it was the first option, arising out of a conversation with the interim Group CEO and the plans to have a more strategic transformational PMO. Julie Beilby was pleased to hear this.

Gill Ponder supported an audit around transformation and change management as it was a weakness within the Group and transformational change was needed to drive the improvement agenda.

Gill Ponder was also pleased to see the inclusion of a review on the learning from patient safety and harm and asked whether this was an opportunity to include clinical governance in that piece of work as well, commenting that it was an area for scrutiny and suggestions on how it could be improved. It had been a constant concern of the Performance, Estates & Finance (PEF) CiC about the amount of money spent on temporary medical staffing and possible opportunities.

Gill Ponder also queried whether there was anything else that could be done to improve flow throughout the hospitals and within emergency care.

Gill Ponder also considered possibly looking at rostering and whether it was as effective as it could be and whether there were any opportunities for further cost savings.

Jane Hawkard suggested a review on the management of infection control, to which Harriet Fisher responded that it had now been added to the initial long list for 2027/28 and considering the amount of work that was ongoing in that area, it would be more appropriate to remain there. Jane Hawkard acknowledged this.

Jane Hawkard commented that the flow audit was a really important one to do, and queried whether the rostering and overtime review included the waiting list initiatives and ECP. Harriet Fisher confirmed it would.

David Sharif agreed with other comments on the priority areas, adding that in terms of waiting list management he would choose cancer over health inequalities, as cancer is clearly a priority area for the Group, but would want to ensure it was tightly scoped.

Jane Hawkard summarised that the ARG CiC were of the view that the right things were on the long list but five needed to be prioritised. A decision on the five would be made at GERAC and then a final list brought back to this Committee in

April 2026 for approval. Jane Hawkard thanked KPMG for the good papers and discussions and was pleased to note that the audits would all be done in the year.

ACTION: KPMG

8. Counter Fraud – Group

8.1 Group LCFS Progress Report

Emma Sayner highlighted the amount of work that had been undertaken on counter fraud and the addition of Daryl Cheetham to the team over the last few months had been very positive. Emma Sayner reported that the team met with her on a regular basis to review all cases and progress made. The paper was taken as read and Daryl Cheetham advised he was happy to answer any questions.

Gill Ponder referred to paragraph 4.5 of the report and reference to work carried out that transpired to be human error and asked for assurance that if human error was evidenced that any training requirements or new processes was being addressed to prevent a recurrence. Daryl Cheetham responded that if human error or technical weaknesses were present, the team would work to looking at ways to overcome this and would do a systems weakness report. Daryl Cheetham advised that he would speak with Sally Stevenson to ensure this specific event was followed up appropriately.

ACTION: Daryl Cheetham

Gill Ponder also referred to paragraph 5.2 on benchmarking, and noted this was being done against the national picture but questioned whether it would be better performed against comparable sized Trusts, although was not sure how easy this would be or if available. Daryl Cheetham responded that this would be included within the next report.

ACTION: Daryl Cheetham

Jane Hawkard acknowledged the comprehensive report but asked that the individual Trust metrics be noted as Groupwide going forward where the metrics were the same for both organisations (e.g. Facebook posts). Jane Hawkard was pleased to note very good progress being made and welcomed recent communications continuing to include case studies with prosecutions as a deterrent.

9. Management Reports for Assurance

9.1 Annual Review of HUTH Arrangements for Raising Concerns/Freedom to Speak Up

Fran Moverley reported that the number of cases being reported at HUTH was increasing and evidenced a well-utilised service. Fran Moverley advised that there were to be some changes nationally in that the National Guardian Office was being disbanded in June 2026 with responsibilities being moved into NHSE, but further details were awaited. The Freedom to Speak Up Guardian roles would remain until at least the end of March 2027.

Fran Moverley was pleased to advise that both Trusts had a mandated NHSE Speak Up Policy but there was now a draft awaiting ratification for a Group policy so that staff only have to look at one policy. A Group Strategy had also been

published within the last year. Fran Moverley shared that she had been working with internal education teams and Hull University to focus on students as early as possible in their careers as potential future members of staff . The Board had also repeated the self-reflection and planning tool as mandated every two to three years and the action plan was in place.

Jane Hawkard asked for the NLAG update to be done next before taking any questions on these two papers.

9.2 Annual Review of NLaG Arrangements for Raising Concerns/Freedom to Speak Up

Liz Houchin advised that in addition to the key points noted by Fran Moverley, NLaG was also seeing an increasing number of concerns being raised with an increase of 80 on the last year, and confirmed that all actions from the 2024 internal audit had been completed and signed off in the last year. Jane Hawkard invited questions.

Simon Parkes commented about the very regular discussions that took place around speaking up including looking at statistics, etc. and referred to various things that can go wrong in the NHS noting high profile cases at other Trusts which had been reported in the media recently involving significant compensation and legal costs. Simon Parkes questioned whether the freedom to speak up process was not working as effectively as it should when things go wrong and that Trusts are not getting it right, and asked whether in relation to the Boards reflections, it was really understood what does go wrong and why, and how the Group could be confident it would not find itself in that position of inadvertently doing similar things. Simon Parkes asked ‘how does the Group know it’s working’ and ‘how do we know that people feel safe to raise things’ and ‘how do we know that we are getting to the big issues’, adding that he wasn’t really assured that it was working as he didn’t know what he didn’t know. In response to Simon Parkes’ comments, Julie Beilby commented that it came down to the robustness of the whole suite of policies, comms, relationships, etc.

Julie Beilby referred to the focus on patient safety and advised that she had had discussions with both Fran Moverley and Liz Houchin on how to communicate the importance of speaking up as soon as possible for something that was happening in front of staff, and also ensuring this was detailed within the Group policy that was going through the ratification process.

Liz Houchin accepted Simon Parkes’ comment and acknowledged the difficulties with providing assurance around this but explained that with the increasing engagement of staff with the Guardians, it could be perceived as the creation of a speak up culture or that staff only feel comfortable in speaking to the Guardian as opposed to directly within their own team. Liz Houchin referred to the two things that stop people speaking up, namely fear and futility, and was also pleased to advise that cases of detriment for speaking up were very low both organisations and below the national average.

Fran Moverley added that not all speaking up came through the Guardians, some staff felt able to speak up in open and transparent cultures that exist within their own areas. Fran Moverley reflected on some of the cases she was dealing with and that staff did want to speak out, but acknowledged the fear held by some

about speaking out and the perception that they would suffer detriment. In response to Julie Beilby's comment about immediacy of reporting, Fran Moverley advised that at each induction session or presentation she undertook, she did always tell staff that if they had an immediate patient safety issue they should not wait to speak to the Guardians, but escalate it immediately through their normal escalation route.

Julie Beilby added that there are a number of routes that people can raise things, including at a senior level and had experience of being more comfortable that when things go wrong at the top of an organisation they are dealt with, even if via a different process. Julie Beilby therefore wanted to give assurance that there is very senior freedom to speak up reporting happening.

Tracy Campbell joined the meeting.

Simon Parkes recommended that this subject needed close attention within the organisation whilst improvement work was underway, to consistently check it was working across the Group in all areas. Simon Parkes added that the question is how do we know, and how do we get the dial to shift in terms of the levels of confidence in speaking up within the NHS and have the confidence that powerful leaders – clinical and managerial – are not suppressing important matters in their parts of the organisation. Simon Parkes concluded that he was reassured to an extent about what he had heard, but stated that the organisation cannot be complacent on this.

Jane Hawkard acknowledged the good freedom to speak up service within the Group and referred to the Golden Stars awards for Fran Moverley and Liz Houchin, noting also the continuing number of speaking up reports and the high visibility of the two teams and the assurance this gave.

Jane Hawkard asked if a Group report could be provided going forward. Liz Houchin advised that as two sovereign organisations they had been keeping reports separate, but Jane Hawkard asked that this be considered for future reports.

ACTION: Fran Moverley & Liz Houchin

Fran Moverley and Liz Houchin left the meeting.

9.3 Group EPRR Highlight Report

Matt Overton provided highlights from the report and briefed the ARG CiC on the new and emerging risks. More industrial action was anticipated for 2026 and with effect from 18 February 2026, the notice period for industrial action would be reducing from fourteen to ten calendar days as a result of new legislation. This would significantly reduce the planning time available for industrial action.

Jane Hawkard was pleased to note that a tabletop Hull Royal Infirmary (HRI) evacuation plan would take place on 4 February 2026 (Matt Overton advised this was now the 5th) with all Care Groups including corporate and support services involved based on a fire scenario.

There were also plans to have a digital and cyber tabletop exercise at some point but Jane Hawkard no date was shown for this, to which Matt Overton responded

that there were plans for a national tier one cyber exercise in April 2026 and once there was confirmation of this, plans would be confirmed to undertake a session locally.

Jane Hawkard thanked Matt Overton for the update and was pleased to note the really concise format of the report.

Matt Overton left the meeting. The meeting paused for a ten-minute break at 11am.

9.4 Group Board Assurance Framework

David Sharif clarified again that The Value Circle feedback was yet to be received and reflected in the BAF, and Heather McNair's team were undertaking work to support the BAF on the highest scoring risks and this would feature in the report from April 2026 if not before.

Tracy Campbell joined the meeting.

David Sharif updated colleagues that the People risk that was showing as out of date was now in date following a conversation with Simon Nearney, the Group Chief People Officer who had identified several additional controls to the People risk, specifically around the vacancy control panel, the establishment of the Clinical Policy Group and the impact from the Senior Leadership Team (SLT). The risk around the Executive team's instability / continuity was also discussed and the risk narrative had been updated since the paper was submitted but the score was unchanged. The Patient Access strategic risk was also updated following the change to the risk appetite to a more cautious one, therefore giving a greater distance to the desired tolerable risk score.

Gill Ponder offered some additional background to what David Sharif had just advised the ARG CiC of, and outlined that the patient access risk was previously phrased in a way about the risk of the organisation not becoming an outstanding organisation and there had been discussion on whether to focus on what the organisation should be delivering to patients as part of the constitutional standards. The wording was therefore changed and the risk appetite then became more cautious as the organisation should have low tolerance for not meeting constitutional standards.

Jane Hawkard commented that the Never Events were not mentioned within the report and the actions needed to be taken, and asked if the report was out of date. David Sharif reassured the ARG CiC that they were now included in the latest version of the report, having been identified as missing after the ARG CiC report was produced.

Jane Hawkard also added that there were several indications of reasonable and a significant assurance on the ward accreditation programme and questioned whether this was accurate considering the previous lack of significant assurance. David Sharif clarified that the significant assurance was around the delivery of the programme, but Jane Hawkard referred to a previous conversation at Board and asked for further assurance on this and David Sharif agreed with this and would provide further assurance.

ACTION: David Sharif

The ARG CiC accepted the report as assurance.

9.5 Group Risk Register

Tracy Campbell advised that she was attending to represent Heather McNair and outlined the report and asked for the Committees' thoughts on whether it gave sufficient detail on the mitigations of the higher risks and asked for a conversation with Jane Hawkard offline to discuss what it might look like in the future.

Tracy Campbell considered that really good progress had been made in how the organisation was managing risk, meeting with the Care Groups and getting reviews done, adding that progress had been made since the report was produced in areas such as training and advised that people were now accessing the new risk management training and evaluating it well in terms of understanding and confidence Tracy Campbell informed the ARG CiC that with circa 700 risks across the Group there were around 180 people who needed to go through the training, with 86 through the risk management training and 106 through the Ulysses training (with one single incident reporting system now in place). There was a clearer understanding of the difference between issues and risks, and the message was being reiterated that it was everybody's responsibility to manage risk.

Gill Ponder noted the update on reduced risks since the report was produced but was concerned that some high-level risks were able to become overdue and these needed some extra focus to ensure they were subject to regular review in order to gain assurance they were being appropriately mitigated.

Gill Ponder was also pleased to see a better understanding of the difference between risks and issues which would hopefully go some way to reducing the size of the risk register. It was important to continue to advise teams that it was not an opportunity to pass on responsibility and accountability. Tracy Campbell commented that there were some risks that had been on the register for an incredibly long time and needed a full review with more explicit details rather than just adjusting the existing narrative slightly. Gill Ponder stated that it was necessary to ensure that the risk register was not used as a place where people lodge things that they think they can abdicate responsibility for when funding isn't available for something, adding that it was still the managers responsibility to manage the risk. Tracey Campbell advised that they were having much more of these conversations and better engagement. Gill Ponder was pleased to hear this.

David Sharif spoke of the highest scoring risk on the register around ED flow and that it continued to be a really important topic, and wanted to reassure the ARG CiC that this was receiving appropriate scrutiny and challenge at the Executive meetings and other meetings across the organisation.

Jane Hawkard referred to the open risks with a score of 20+ on page four of the report and confirmed that these were well identified and triangulated with business cases coming forward and papers being discussed at appropriate committees. Jane Hawkard advised Tracy Campbell that it was a really good report and she would be happy to meet with her and discuss the risk register including more evidence of mitigation, check-ins with risk owners as to the efficacy of these, as well as reference to the confidence level of Executives.

ACTION: Tracy Campbell / Jane Hawkard

Jane Hawkard reflected that assurance remained low however it was moving in the right direction with more work to be done but was pleased to see it was receiving the appropriate focus.

Tracy Campbell left the meeting.

9.6 Charitable Funds Governance Arrangements Update – deferred from November 2025

Emma Sayner updated colleagues that there had been discussions with Jane Hawkard and Tony Curry on the potential for more joint working between the WISHH Charity that supported HUTH and The Health Tree Foundation that supported NLaG, but concluded that other than opportunities to learn and share good practice, there were no more substantive opportunities currently to work collaboratively. Emma Sayner advised that this was therefore closed down.

Jane Hawkard commented that there would be a proposal to bring to the Board after the meeting in February 2026 and asked for this to be put on the action tracker so that it wasn't lost sight in terms of the HUTH side and the governance arrangements in light of money now going to WISHH and the HUTH General Purposes charity closing. Jane Hawkard added that the next iteration of the HUTH governance arrangements was not yet clear and needed to be agreed by the HUTH Board, so wanted to keep it on the ARG CiC agenda.

ACTION: Sally Stevenson

It was noted that David Sharif was a Trustee of the WISHH Charity and Gill Ponder and Emma Sayner were Trustees of The Health Tree Foundation.

Policies for Review / Approval

10.1 Annual Review of Group Policy for Engagement of External Auditor for Non-Audit Work

10.

Emma Sayner advised of only minor adjustments to the existing policy. Gill Ponder questioned how effectiveness of the policy would be monitored as the NHS Audit Committee Handbook indicated this was a requirement of the ARG CiC, adding that she did not think there had been any non-audit services but if there had been how would the Committees monitor effectiveness of the policy in that situation. Jane Hawkard agreed that this needed to be very clear.

Brian Clerkin advised that in terms of external auditors' fees, this is detailed within their annual planning report along with any other fees. Jane Hawkard asked that the document be amended accordingly and the inserted paragraph relating to this be circulated to the ARG CiC for approval rather than wait until the April 2026 meeting. To be added to the action tracker.

ACTION: Emma Sayner / Sally Stevenson

11. ARG CiC Governance Items

11.1 Results of ARG CiC Annual Self-Assessment Exercise 2026

Jane Hawkard referred to the questions posed within the document for the ARG CiC to consider and referred to earlier discussions in the meeting that had addressed them, and invited any further comments on the self-assessment document.

Gill Ponder commented that as NHSE regional and national teams had been and observed the ARG CiC, as well as The Value Circle, she suggested that no changes be made until all feedback had been received and encompassed into the self-assessment document with no conflicting issues. That would allow the ARG CiC, and all other CiC's, to consider and agree changes to make them more effective.

Jane Hawkard stated that it was the ARG CiC's self-assessment and was therefore of the view that it could be approved now, but then bring the feedback from external parties to a future meeting and review anything that was possibly contradictory to the self-assessment.

ACTION: David Sharif

The ARG CiC approved the self-assessment for submission to the Boards-in-Common for information and Jane Hawkard thanked everyone involved for the work undertaken.

ACTION: Sally Stevenson

11.2 Annual Review of ARG CiC Terms of Reference – NLaG

The minor changes proposed were acknowledged and the document was approved for final ratification by the Boards-in-Common.

ACTION: Sally Stevenson

11.3 Annual Review of ARG CiC Terms of Reference – HUTH

The minor changes proposed were acknowledged and the document was approved.

ACTION: Sally Stevenson

11.4 Annual Review of ARG CiC Aligned Work Plan 2026/27

The minor changes proposed were acknowledged and approved.

David Sharif expressed his thanks to Sally Stevenson for her work on the ARG CiC governance documents in this section.

12. Highlight Reports and Action Logs from Board Sub-Committees-in-Common

12.1 Performance, Estates & Finance CiC
12.2 Strategic Programmes & Partnerships CiC
12.3 Quality & Safety CiC
12.4 Workforce, Education & Culture CiC
12.5 The Health Tree Foundation Committee – NLaG

The above highlight reports and action logs were received for information. There were no issues raised.

13. Private Agenda Items

Item 13.1 was minuted as a private agenda item.

14. Any Other Urgent Business

14.1 EPR Asset Accounting – Update January 2026

Emma Sayner thanked the Chair for allowing the paper to be added as urgent business for the ARG CiC and advised that the significant Electronic Patient Record (EPR) project had been some time in the making and expressed her thanks to Alison Drury within the Finance team and Neil Proudlove from the Digital team for the work undertaken. Emma Sayner advised colleagues that there was an update to the accounting treatment of the asset value due to a change in guidance around impairments (e.g. part of the staff implementation costs and non-pay costs), as set out in the paper.

Emma Sayner indicated that being one of the last organisations to onboard EPR had given the Group the opportunity to look at what other Trusts had done and the team would work with External Audit colleagues as the work progressed and was transacted in real time as the EPR goes live during late 2026/27.

Jane Hawkard stated that it sounded sensible, fair and proportionate but recognised that the guidance may change again.

The ARG CiC approved the paper.

15. Matters for Escalation to the Trust Boards-in-Common (Public/Private)

The following items of business were agreed to be highlighted to the public Trust Boards-in-Common:

- Group Internal Audit Progress Report – KPMG expect to finish all work on the 2025/26 IA plan by the end of the financial year. Overdue management actions remain a concern for the ARG CiC and additional specific oversight actions incorporated into the ARG CiC self-assessment exercise 2026.
- Group BAF – The Value Circle governance review yet to be received and incorporated into the BAF. Updates to risks undertaken since report to the ARG CiC produced.
- Group Risk Register – progress being made but assurance remained low at present. Actions being taken are the right ones.
- ARG CiC Self-Assessment Exercise 2026 – Approved for submission to the Boards-in-Common. Feedback from external observers will be duly considered and implemented as appropriate.
- ARG CiC Terms of Reference – Minor amendments agreed and to be presented to Boards-in-Common for final approval.

16. Matters to Highlight to other Trust Board CiCs

The following item of business was agreed to be highlighted to other CiCs:

- CQC Action Plan IA Report - The ARG CiC to request the Quality & Safety CiC review CQC outstanding actions and consider which ones could be closed.

Review of the Meeting

17.

Jane Hawkard noted that this was Simon Parkes last ARG CiC meeting before he left NLAG and, on behalf of the ARG CiC, thanked him for his excellent chairing of the meetings, and his valuable support and contributions and wished him well for the future.

Audit Services Items – Private

18.

Item 18.1 was minuted as a private agenda item.

DATE AND TIME OF THE NEXT MEETING

19.

The next meeting of the Audit, Risk and Governance Committees-in-Common will be held on Thursday 23 April 2026 at 9am to12.30pm via MS Teams.

The ARG CiC Chair closed the meeting at 12.17pm.

Schedule of Attendance at ARG CiC Meetings 2025/26

Member / Attendee	Apr-25	Jun25 Audited Accounts	Jul-25	Nov25	Jan-26	Total
Members - NLAG:						
Simon Parkes – NED / ARG CiC Chair	Y	Y	Y	Y	Y	5/5

Gill Ponder – NED	Y	N	Y	Y	Y	4/5
Julie Beilby – NED (from Jan 25)	Y	Y	Y	Y	Y	5/5
Members - HUTH:						
Jane Hawkard – NED / ARG CiC Chair	Y	Y	Y	N	Y	4/5
Tony Curry – NED	Y	N	Y	Y	Y	4/5
Helen Wright – NED (from Jun 24)	Y	Y	Y	Y	N	4/5
Regular Attendees:						
Emma Sayner – Group CFO (from Jan 25)	Y	Y	Y	N	Y	4/5
David Sharif – Group Director of Assurance	Y	Y	Y	Y	Y	5/5
Rebecca Thompson – Deputy Director of Assurance – HUTH	Y	N	N			1/3
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	N	4/5
Daryl Cheetham – Local Counter Fraud Specialist				Y	Y	2/2
External Audit - NLAG (Sumer NI)	Y	Y	Y	Y	Y	5/5
External Audit – HUTH (Forvis Mazars)	Y	Y	Y	Y	Y	5/5
Internal Audit - NLAG (Audit Yorkshire)	Y	Y				2/2
Internal Audit – HUTH – (RSM)	Y	Y				2/2
Internal Audit – Group (KPMG)	Y	Y	Y	Y	Y	5/5
Sue Meakin - Group DPO / IG Lead	Y	N[1]	Y	Y	Y	4/4
Mike Bateson - NLAG Governor Observer	Y	Y	Y	Y	Y	5/5
Ad-hoc Attendees:						
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y	-	-	-	2
HUTH Vice Chair (Murray MacDonald)	Y	-	-	-	-	1
Acting Group Chief Executive (Amanda Stanford)	Y	Y	-			2
Group Chief Strategy & Partnerships Officer (Ivan McConnell)	Y	-	-	-	-	1
Group Chair (Sean Lyons)	-	Y[2]	-			1
Ad-hoc Attendees continued….:						
Group Deputy Director of Communications (Adrian Beddow)	-	Y	-	-	-	1
Associate Director of Quality Governance (Richard Dickinson)	-	-	Y	-	-	1
Operations Director – Group Emergency Planning (Matt Overton)	-	-	Y	Y	Y	3
Group Head of Legal (Gerard Curran)	-	-	Y	-	-	1
Group Chief Technology Officer (Tony Deal)	-	-	Y	-	-	1

Group IT Security Manager (Manoj Konanki)	-	-	Y	-	-	1
Director of Procurement (Edd James)	-	-	-	Y	-	1
Freedom to Speak Up Guardian – HUTH (Fran Moverley)	-	-	-	-	Y	1
Freedom to Speak Up Guardian – NLAG (Liz Houchin)	-	-	-	-	Y	1
Director of Patient Safety and Quality Governance (Tracy Campbell)	-	-	-	-	Y	1
Ad-hoc Meeting Observers						
NHS England Observer (Jenny Sharp)	-	-	-	Y	-	1
The Value Circle Observer (Tony Bruce)	-	-	-	Y		1
NHS England Observers (Simon Elliott, Stacey Howard and Laura Bibby)	-	-	-	-	Y	1

Notes:
[1]Not required to attend, audited accounts meeting only
[2]Part meeting

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)115

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	14 May 2026
Director Lead	**Performance** Sam Peate, Group Chief Delivery Officer Emma Sayner, Group Chief Financial Officer **Quality & Safety** Jo Ledger, Deputy Chief Nurse Hilda Gwilliams, Group Chief Patient Safety Officer Dr Kate Wood, Group Chief Medical Officer **Workforce** Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing & Improvement
Contact Officer/Author	**Performance** Chris Fry, Associate Director, Performance & Insights Jackie Railton, Deputy Director, Planning & Performance Louise Topliss, Head of Performance **Quality & Safety** Richard Dickinson & Michela Littlewood, Associate Directors of Quality Governance **Workforce** Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing & Improvement
Title of the Report	Group Performance Report
Executive Summary	Executive Summary provided on each report
Background Information and/or Supporting Document(s) (if applicable)	The individual reports have been presented as follows: **Performance –** Performance, Estates & Finance Committees-in-Common – 5 May 2026 **Quality & Safety –** Quality & Safety Committees-in-Common – 30 April 2026 **Workforce –** Workforce, Education & Culture Committees-in-Common – 25 March 2026
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

TRUST BOARDS-IN-COMMON

ADVISE, ALERT and ASSURE Report

Agenda Item No: 4.3

Name of the Meeting		**Performance, Estates and Finance CiC**
Date of the Meeting		5th May 2026
Title of report		**Group Performance Report**
Director Lead		Sam Peate, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer / Author		Chris Fry, Associate Director, Performance & Insights Jackie Railton, Deputy Director, Planning and Performance Louise Topliss, Head of Performance
Requires (tick as appropriate)	Approval	
	Assurance	✓
	Discussion	
	Other	

PURPOSE OF REPORT

To provide the Executive Committee with an overview of current performance across elective, cancer, diagnostics and urgent care pathways, highlighting areas of non-compliance with national standards and associated delivery risks.

The report summarises emerging improvements, including reductions in long waits and early diagnostic recovery, while recognising that performance remains below required standards and recovery is fragile.

It seeks to support Executive oversight of the key system constraints impacting delivery—particularly diagnostic capacity, workforce and outpatient flow—and to ensure that recovery trajectories, mitigating actions and dependencies on non-recurrent measures are robust and sustainable.

The report also requests assurance that progress against recovery plans is sufficient to deliver sustained improvement and reduce risk over the short to medium term

To note that service level trajectories for 2026/27 have now been developed for RTT. Trajectories for DM01 and Cancer compliance will be completed in May 2026.

KEY POINTS

To **alert** Performance, Estates and Finance Committee to the following issue/s:

Elective RTT waits remain above the plan submitted at the start of 2025/26 but below the revised plan communicated to NHS England in January 2026:

- Total number of patients waiting beyond 52 weeks above 1% of total waiting list size. Total waiters > 52-week waiters - HUTH: 2,835; NLaG: 839
- 1 x 78-week and 1 x 104-week waiters at NLAG

Diagnostic 6-week performance remains materially non-compliant:

- HUTH: 33.8%, NLAG: 29.9% vs 95% standard

Cancer performance remains materially non-compliant, particularly:

- 62-day performance HUTH 51.6% and NLAG 63.3% vs 85% standard
- Persistent >104-day backlog (HUTH: 114; NLAG: 20)

UEC 4-hour performance (Type 1) remains below plan:

- HUTH 49.5% against a plan 70%.
- NLaG 54.6% against a plan of 64%.

UEC 12-hour performance remains below plan but in both HUTH and NLaG improving over the past 3 months.

- NLaG 14.1% against a target of 6.6%.
- HUTH 9.2% against a target of 7.1%.

UEC ambulance handover times remain below plan at NLaG;

- NLaG 31.4mins against 25

To **advise** Performance, Estates and Finance Committee on the following issue/s:

Improvements in RTT showing in:

- Total Waiting list size static at both HUTH and NLAG
- Reduction in 65-week and 52-week breaches across both HUTH and NLaG
- Improvement in RTT compliance

Diagnostics 6-week standards showing month-on-month improvement at both HUTH and NLaG

Capped theatre utilisation at HUTH and NLaG continue to show improvement towards the national standard of 85%

Faster diagnosis standard showing improvement for February on previous months in line with improvement initiatives with HUTH 74.6% and NLaG 69.9% Time to treatment in ED (Core Objective 1) showing signs of continued improvement at HUTH at 89 minutes Type 1 attendances for March 2026 are above plan for both HUTH and NLaG Non-elective admissions above plan YTD for both HUTH (4.2%) and NLaG (2.3%) Delivery of activity in CDC's at HUTH and NLAG showing an increasing trend albeit well below the annual plan set for 2025/26
To **assure** Performance, Estates and Finance Committee about the following issue/s: Non-admitted time in department (Core Objective 2) showing improvement on previous months. HUTH compliance at lowest level in more than 2 years. Ambulance handover compliance less than 60mins at HUTH remains in line with the agreed target

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

YYY is asked to:

DOCUMENT HISTORY

This document has / has not previously been considered in the Trust [at …]

Integrated Performance Report

MONTH 12: March 2026 Performance

February 2026 for Cancer data
Produced April 2026

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1. Executive Summary

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**March 2026*** **0** **0** **65** **2,812**	**March 2026*** **1** **1** **32** **820**	• 1 x 78w and 1 x 104w breaches at NLAG • Decrease in 65w breaches for NLAG (-6) and decrease at HUTH (-44) on previous month • Decrease in 52w breaches for NLAG (-53) and decrease at HUTH (-298) on previous month • Static total waiting list size at both HUTH and NLAG • * Provisional March position as NHSE have extended the validation period to 28.4.26
Diagnostic 6w Performance	**March 2026** **33.8%**	**March 2026** **29.9%**	• Improvement in performance for both HUTH and NLAG compared to previous month
Cancer 62-day Performance (all sources)	**February 2026** **51.6%**	**February 2026** **63.3%**	• Both Trusts are in Tier 1 for Cancer delivery, working with NE&Y Regional Office on recovery assurance • 62-day performance at HUTH deteriorated to 51.6% (-0.4%). • 62-day performance at NLaG improved to 63.3% (+1.2%) • Delays in the front of pathway (outpatient and diagnostics) driving increases in the total volume of patients waiting for Cancer assessment or treatment. The >104-day Urgent Suspected Cancer backlog remains a challenge at 20 in NLAG and 114 in HUTH.
ED: 4-hour standard (Type 1 & 3)	**March 2026** **64.0%** **Trust compliance inclusive of on-campus UTCs**	**March 2026** **71.6%** **Trust compliance inclusive of on-campus UTCs**	• HUTH A&E 4 Hour standard (all types) was 64% in March 2026 (plan 78%). Type 1 performance of 50.7% was below the 25/26 operating plan target of 69.8%. Type 3 performance (HRI UTC) was 94.6% against the 95% target. Type 1 attendances were above plan; Type 3 attendance volumes were below plan. • NLaG combined type 1 and 3 performance was 71.6% against a target of 78%. Type 1 performance = 54.9% (Target 63.9%) and Type 3 performance = 98.9% (Target 99%). Type 1 attendances were above plan; Type 3 attendances were below planned levels for March 2026.

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT - Patients waiting 18 weeks or less	Feb 26	-	54.58%			7
RTT 52 Week Breach	Feb 26	0	3,110			2
RTT 65 Week Breach	Feb 26	-	109			4
RTT 78 Week Breach	Feb 26	0	2			22
RTT 95th Percentile Admitted Waiting Time	Feb 26	18.0	64.9			7
RTT 95th Percentile Non-Admitted Waiting Time	Feb 26	18.0	55.4			12
RTT Admitted Treatment Within 18 Weeks	Feb 26	90.0%	53.4%			47
RTT Average (Median) Admitted Waiting Time	Feb 26	9.0	16.0			46
RTT Average (Median) Non-Admitted Waiting Time	Feb 26	5.0	9.4			67
RTT Average Wait for Incomplete	Feb 26	7.00	15.91			6
RTT Incomplete 92nd Percentile	Feb 26	-	44.7			6
RTT Incomplete Pathways With a DTA	Feb 26	25.0%	18.0%			35
RTT Non-Admitted Treatment Within 18 Weeks	Feb 26	95.0%	64.0%			48
RTT Total Clock Starts	Feb 26	-	18,393			86
RTT Total Clock Stops	Feb 26	-	18,819			91
RTT Total Incompletes	Feb 26	-	81,319			13

NLAG

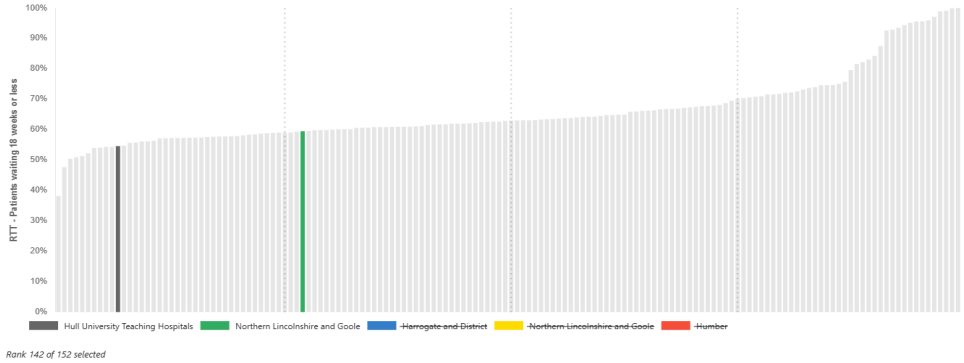
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT - Patients waiting 18 weeks or less	Feb 26	-	59.48%			27
RTT 52 Week Breach	Feb 26	0	873			33
RTT 65 Week Breach	Feb 26	-	38			16
RTT 78 Week Breach	Feb 26	0	2			22
RTT 95th Percentile Admitted Waiting Time	Feb 26	18.0	57.2			58
RTT 95th Percentile Non-Admitted Waiting Time	Feb 26	18.0	53.2			23
RTT Admitted Treatment Within 18 Weeks	Feb 26	90.0%	51.4%			38
RTT Average (Median) Admitted Waiting Time	Feb 26	9.0	17.2			37
RTT Average (Median) Non-Admitted Waiting Time	Feb 26	5.0	11.9			42
RTT Average Wait for Incomplete	Feb 26	7.00	13.81			36
RTT Incomplete 92nd Percentile	Feb 26	-	41.3			22
RTT Incomplete Pathways With a DTA	Feb 26	25.0%	15.3%			50
RTT Non-Admitted Treatment Within 18 Weeks	Feb 26	95.0%	59.4%			36
RTT Total Clock Starts	Feb 26	-	9,158			50
RTT Total Clock Stops	Feb 26	-	8,775			55
RTT Total Incompletes	Feb 26	-	39,443			48

2. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

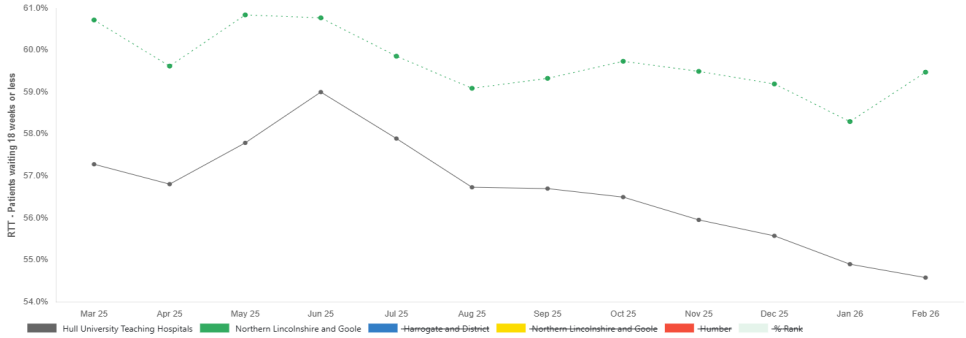
RTT – Incomplete Standard

Ranking Chart



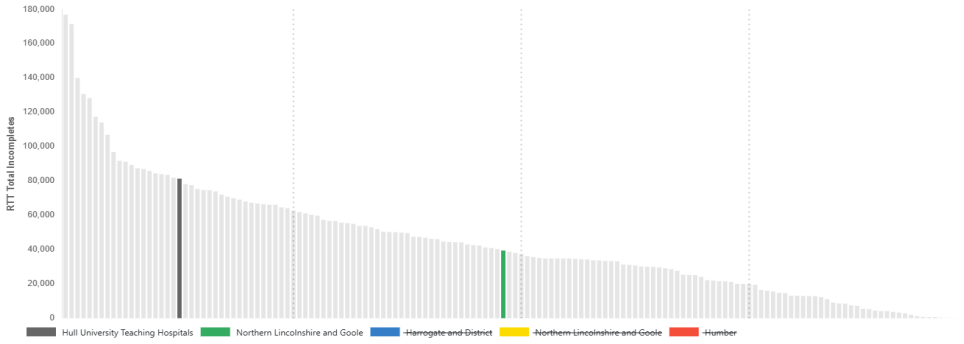
Rank 142 of 152 selected

Trend Chart



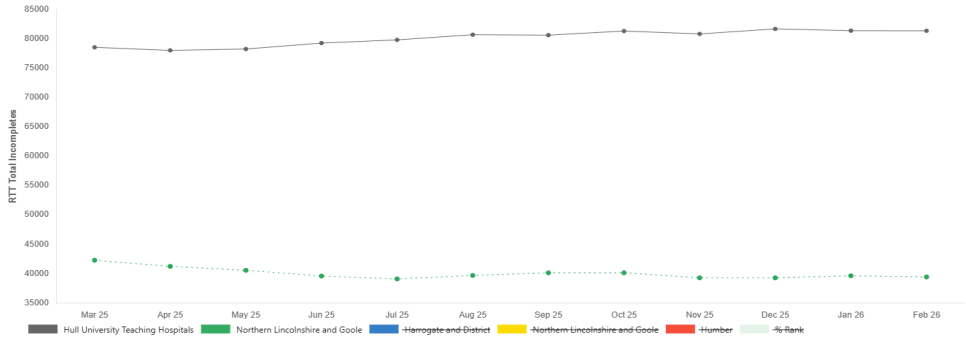
RTT – Total Waiting List Volume

Ranking Chart



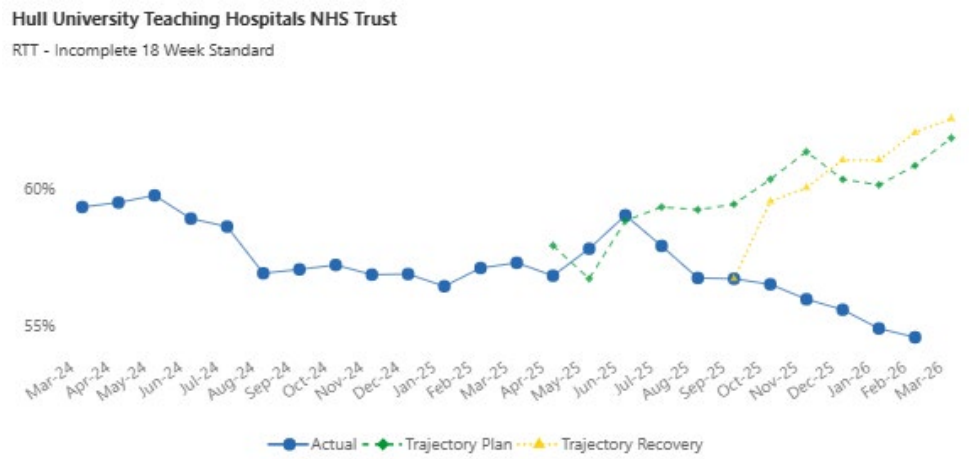
Rank 133 of 152 selected

Trend Chart



3. Referral to Treatment - HUTH

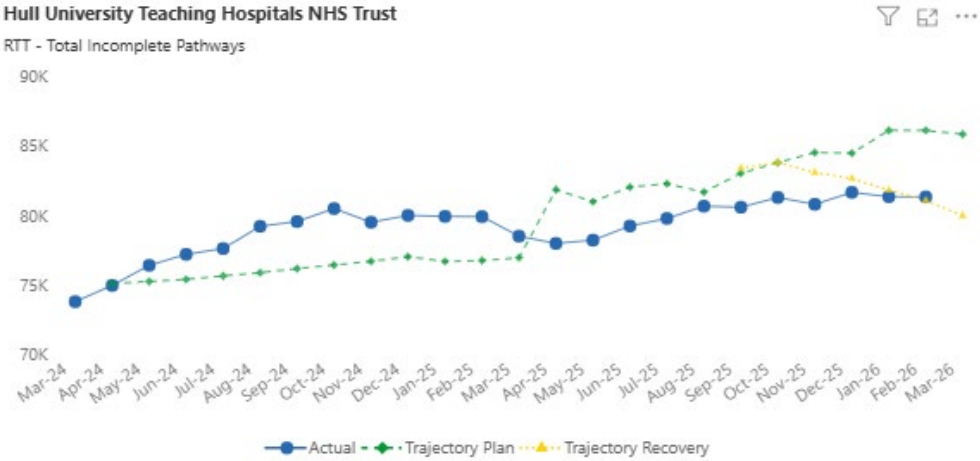
Compliance



Key Themes

- The total waiting list volume is showing linear growth to 81,076 but is below the trajectory due to enhanced in year validation volumes and waiting list initiatives in Q1.
- March RTT performance of 56.2% which is an improvement on the previous month and 2.3% below the recovery trajectory.
- Referrals are marginally up by 0.69 on last year, and below the 3% planning assumption.
- 57% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Dermatology, Ophthalmology, Neurology, Gynaecology and Plastic Surgery
- Average wait for incomplete pathway is 15 weeks but remains broadly stable.
- * Provisional March position as NHSE have extended the validation period to 28.4.26

Critical Enabler



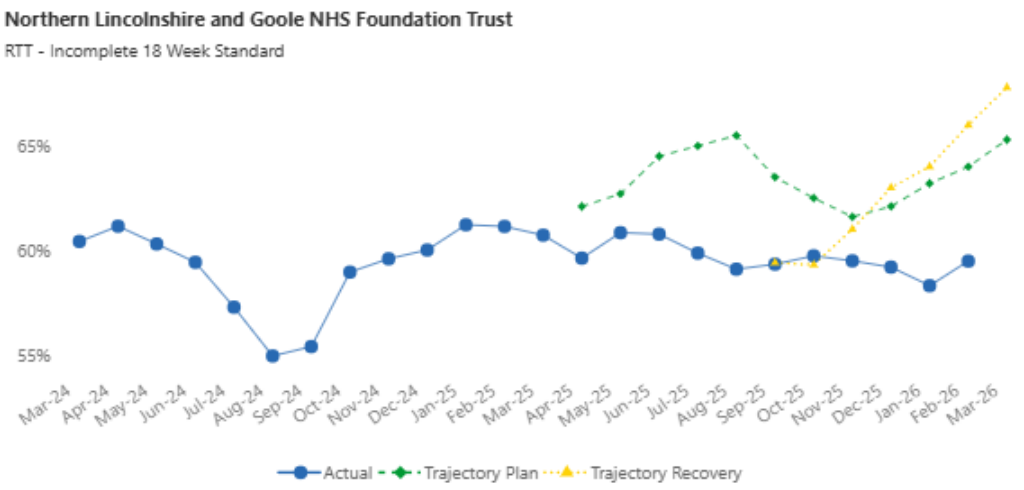
Actions

Critical actions being progressed through RTT Delivery Group:

- LUNA ROVA (automated validation) Deployment project enacted at both HUTH and NLAG, with the supplier indicating an early Q1 go-live due to some technical delays.
- Ongoing planning process to develop additional outpatient & day case/inpatient capacity in response to sustained demand increases.
- Ongoing Q4 validation Sprint with incentive payment of £33 per clock stop above baseline.
- Operational Improvement Plan developed to create enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

4. Referral to Treatment - NLAG

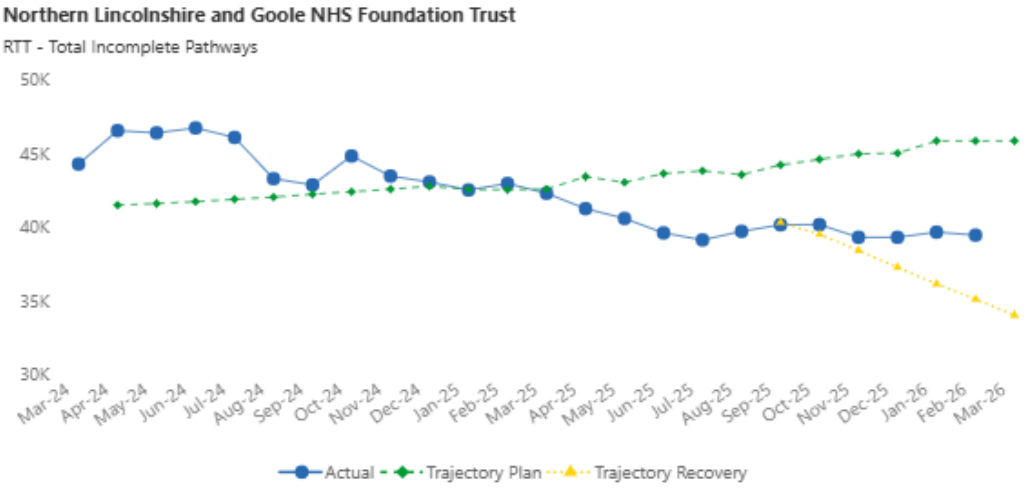
Compliance



Key Themes

- March performance of 61.4% which is a slight improvement but 6.4% below the recovery trajectory.
- The total waiting list volume is overall static a 39,653 but above the recovery trajectory by 5,655.
- * Provisional March position as NHSE have extended the validation period to 28.4.26

Critical Enabler



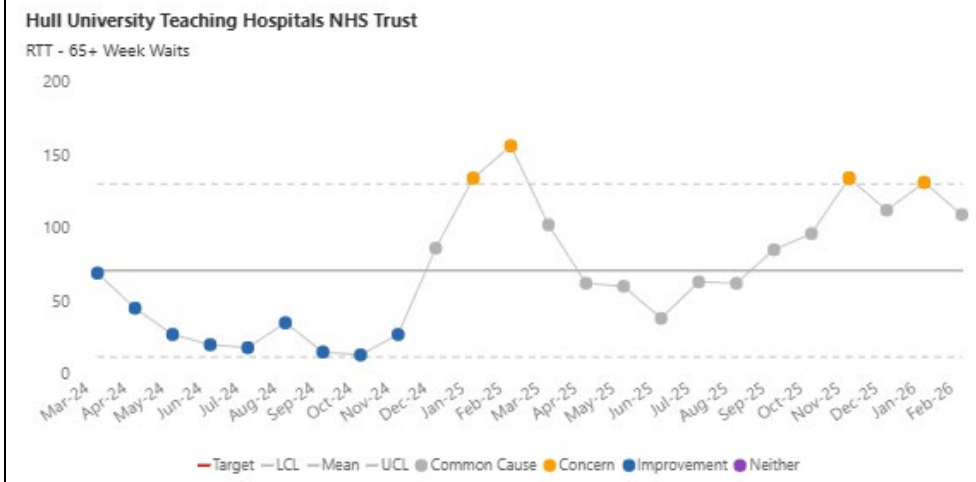
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Focused use of PIFU to increased outpatient discharge rates
- Continuation of the validation Sprint with incentive payment of £33 per clock stop above baseline.
- NLAG placed in Tier 1 for Elective Care in August 2025.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

5. Referral to Treatment – 65w Waits - HUTH

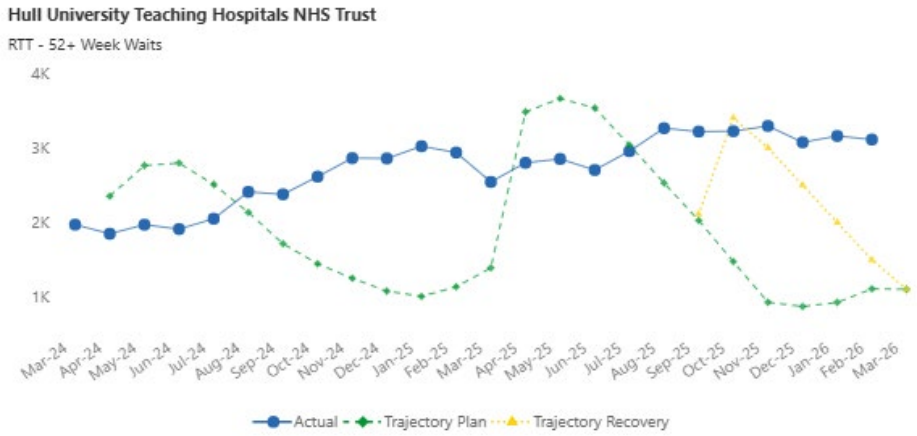
Compliance



Key Themes

- 65 patients exceeded 65 weeks at the end of March which is a decrease of 44 on the previous month
- 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
- 3.8% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year 2024. The 25/26 planning requirement is to achieve no more than 1% waiting over 52 weeks by March 26.
- * Provisional March position as NHSE have extended the validation period to 28.4.26

Critical Enabler



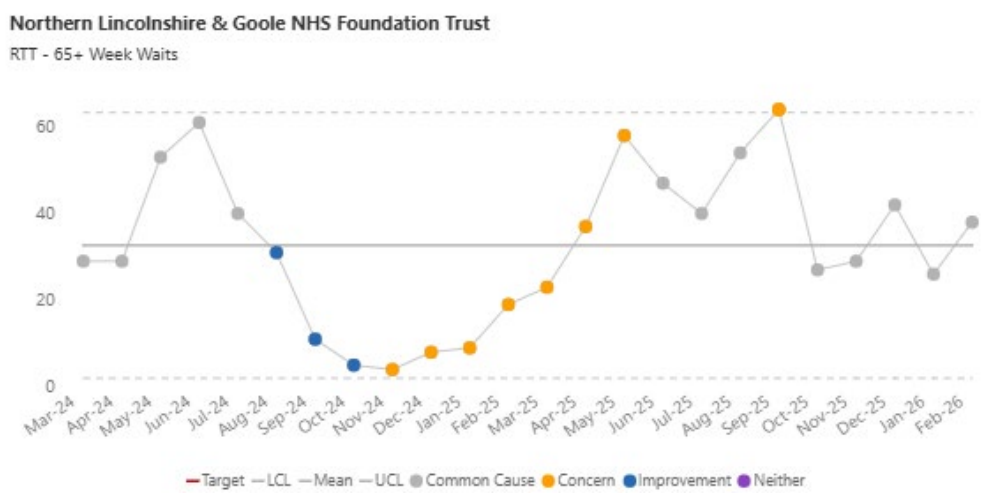
Actions

Critical actions being delivered through the RTT Delivery Group

- Additional insourced activity in place and ongoing engagement with system partners on mutual aid support
- Insourced capacity from Pioneer to deliver Dermatology first outpatient capacity commenced September 2025.
- Executive oversight and scrutiny of patients dated and/or risks to eliminate the number of >65-week waits
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.
- The use of the Independent Sector capacity to be mobilised from January 2026 for some specialties to reduce long wait backlog.

6. Referral to Treatment – 65w Waits - NLAG

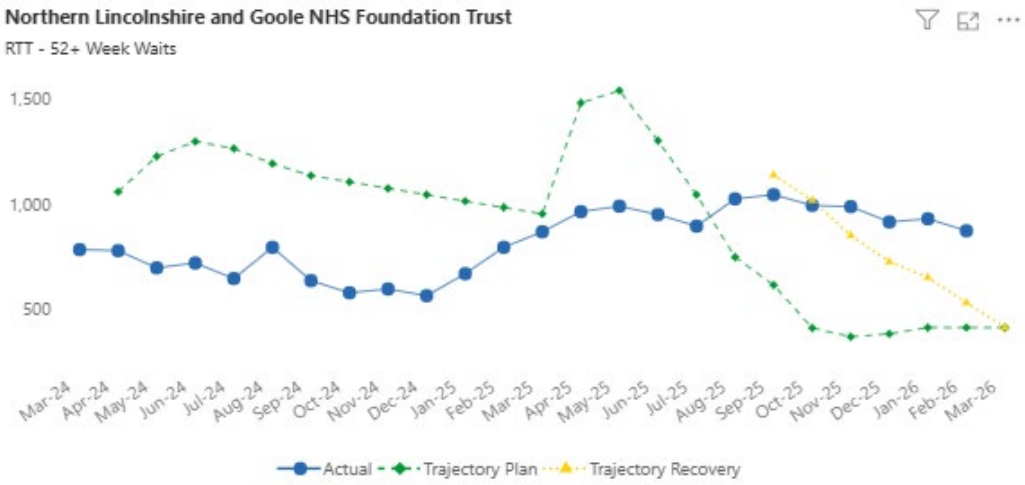
Compliance



Key Themes

- 32 breaches >65 weeks at the end of March which was a decrease of 5 on the previous month.
- There were also 1 x 78w breach and 1 x 104w breach in ENT
- 2.2% of the PTL is over 52 weeks which is an increase on the previous month.
- * Provisional March position as NHSE have extended the validation period to 28.4.26

Critical Enabler



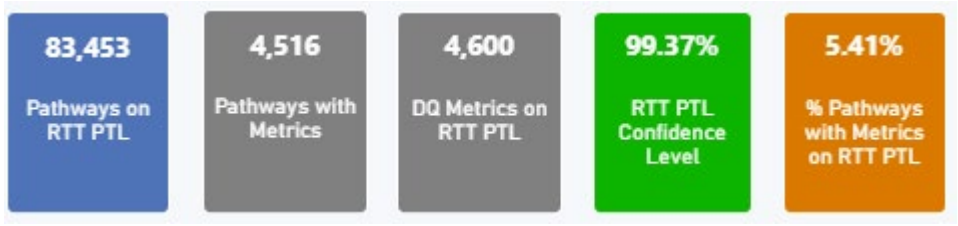
Actions

Critical actions being delivered through the RTT Delivery Group

- An insourcing contract for Paediatrics (ADHD commenced in October 2025 to clear the 65-week cohort. In tandem NHSE have issued new guidance which removes ADHD from RTT Acute Provider reporting and transfers to Community reporting.
- Focus on booking practice via earlier planning of admission dates to reduce unreasonable offers and subsequent patient choice breaches, as per the revised Group Access Policy.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

7. Referral to Treatment – Data Quality - HUTH

Compliance



Key Themes

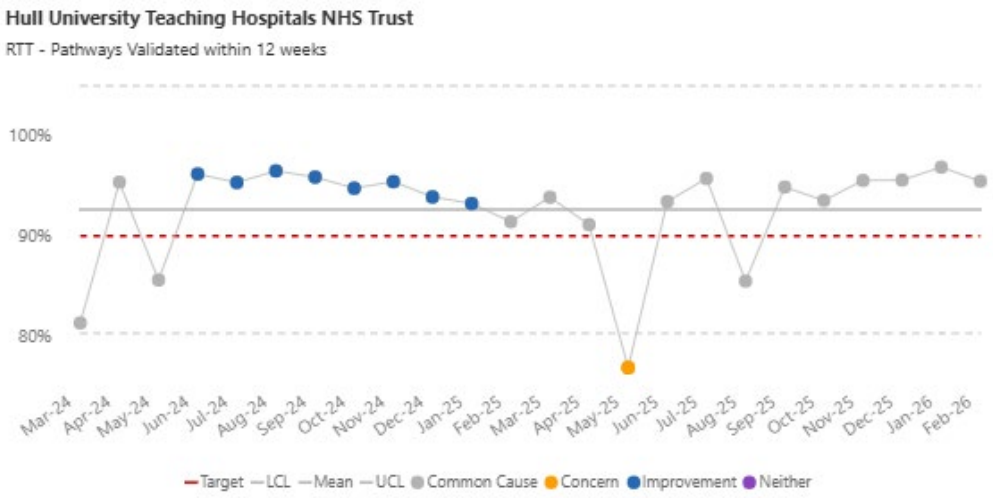
It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.3% confidence level for RTT PTL data quality.

95.5% pathways have been validated every 12 weeks.

The Q4 validation sprint is ongoing and is supported by over-time to existing staff.

Critical Enabler



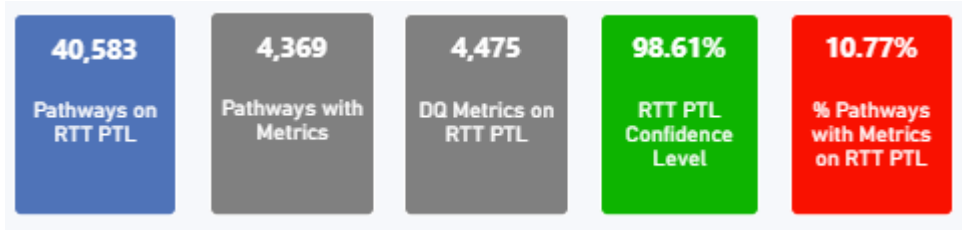
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment
- Deployment of LUNA ROVA
- The Q4 Validation Sprint is ongoing. Additional national income at £33 per clock of the baseline waiting list.

8. Referral to Treatment – Data Quality - NLAG

Compliance



Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a confidence rate to 98.6%.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks. Current performance is at 91.2%

The Q4 validation sprint is ongoing and is supported by over-time to existing staff from HUTH.

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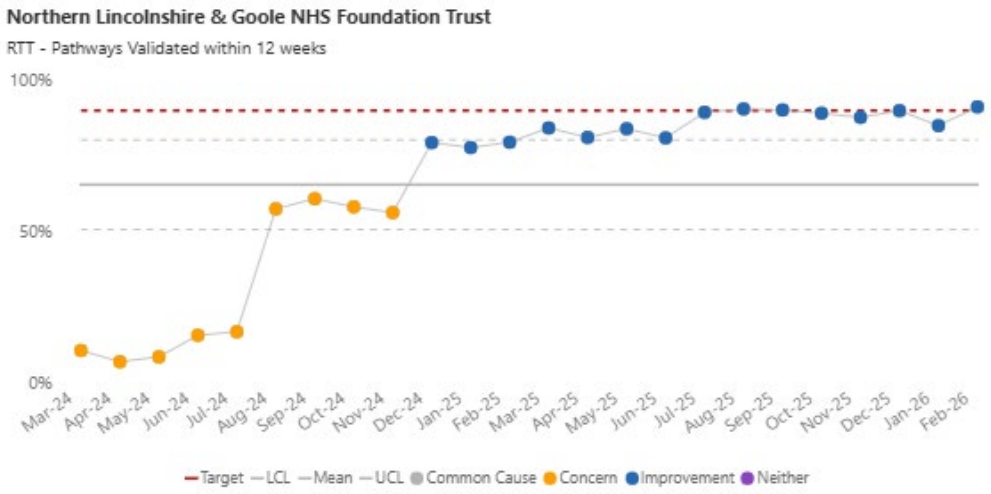
Critical Enabler

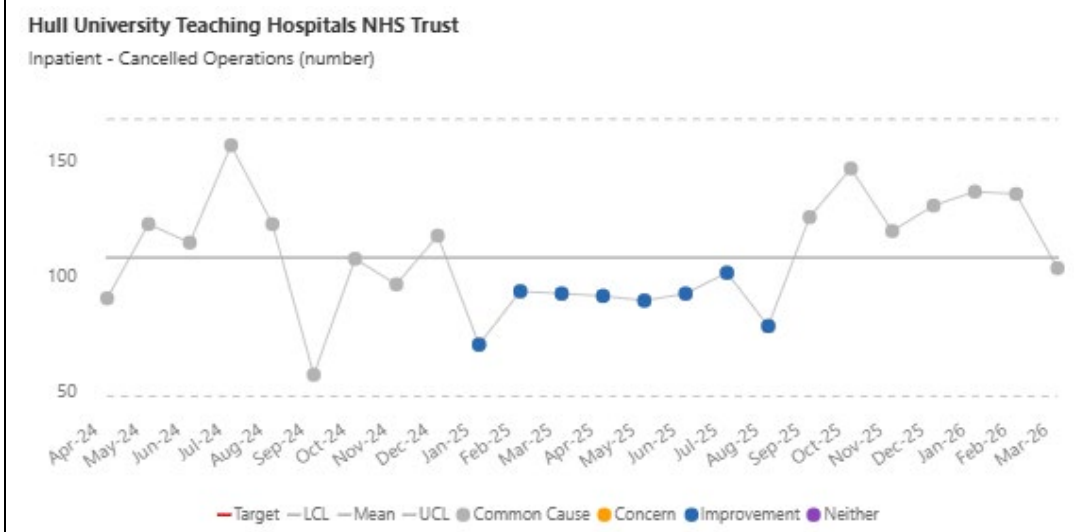


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments.
- Deployment of LUNA ROVA
- The Q4 Validation Sprint is ongoing. Additional national income at £33 per clock of the baseline waiting list.

9. Cancelled Operations - HUTH

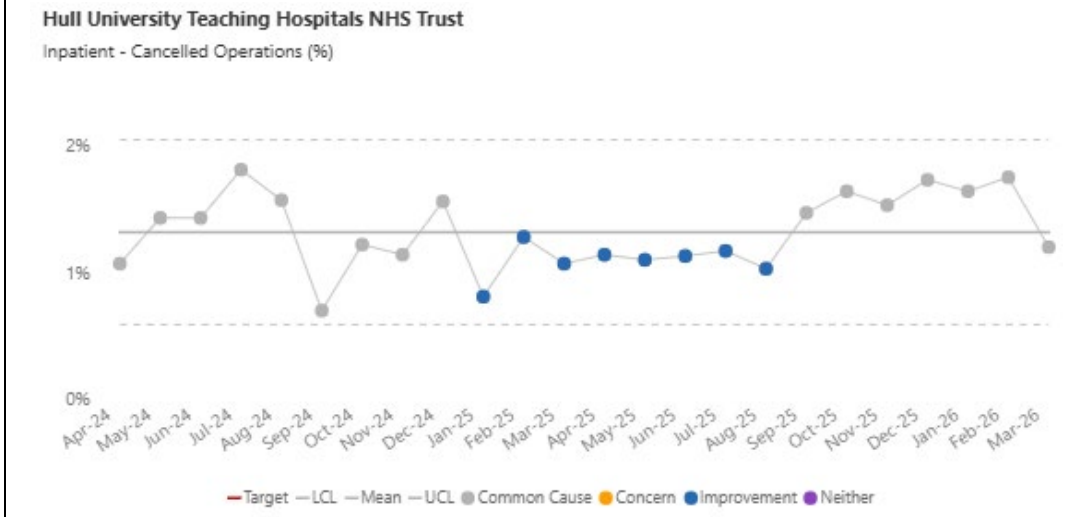
Compliance



Key Themes

- In March there were 103 cancelled operations on the day for non-clinical reasons equating to 1.2% of elective activity.
- The largest reasons were –
  - No Theatre Time – 41
  - No Beds (General and ICU) – 18
  - Surgeon unavailable – 17
  - Emergency Case - 8
- The main specialties incurring cancellations on the day were –
  - Gynaecology – 11
  - Trauma & Orthopaedics – 11
  - Urology – 11
  - Pain Management – 10
  - Upper GI Surgery – 10

Critical Enabler

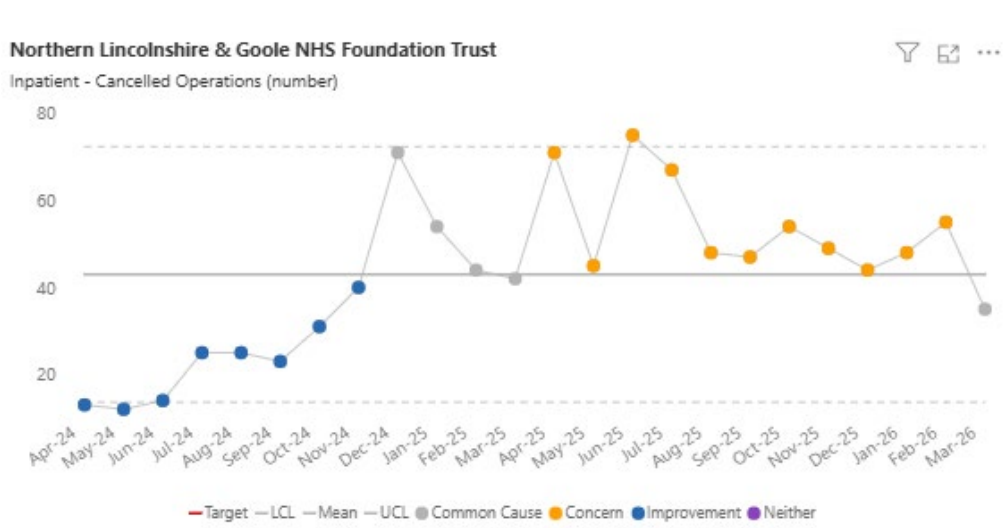


Actions

- Introduction of cancellation avoidance team (CAT) in day surgery commenced Feb 2026, planned roll out for in-patient April 2026
- Working with GIRFT to improve booking and scheduling and on the day flow
- Introduction of standby patient

10. Cancelled Operations - NLAG

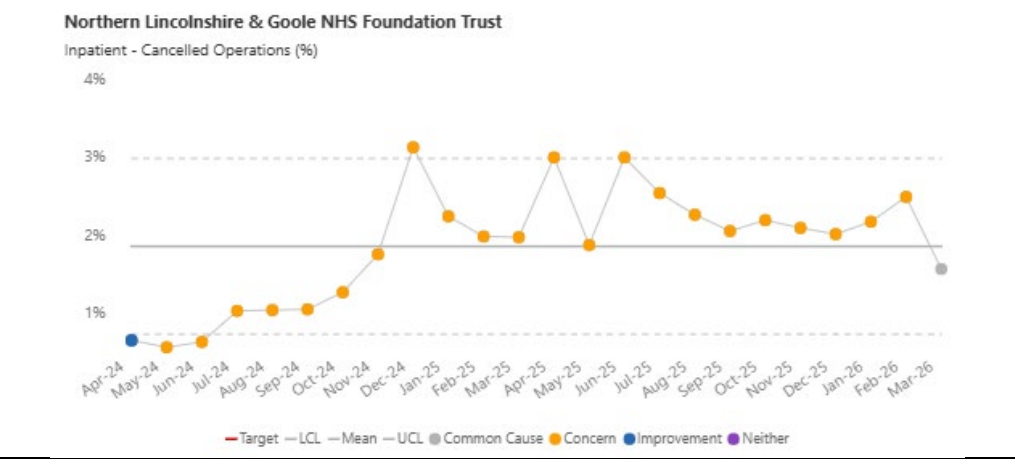
Compliance



Key Themes

- March cancellation volumes totalled 35 equating to 1.6% of elective activity
- The largest reasons were –
  - List overrun – 17
  - Surgery deferred – 6
  - Equipment failure – 4
- The main specialties incurring cancellations on the day were –
  - General Surgery – 8
  - T&O – 7
  - Gynaecology – 6
  - Urology – 6

Critical Enabler

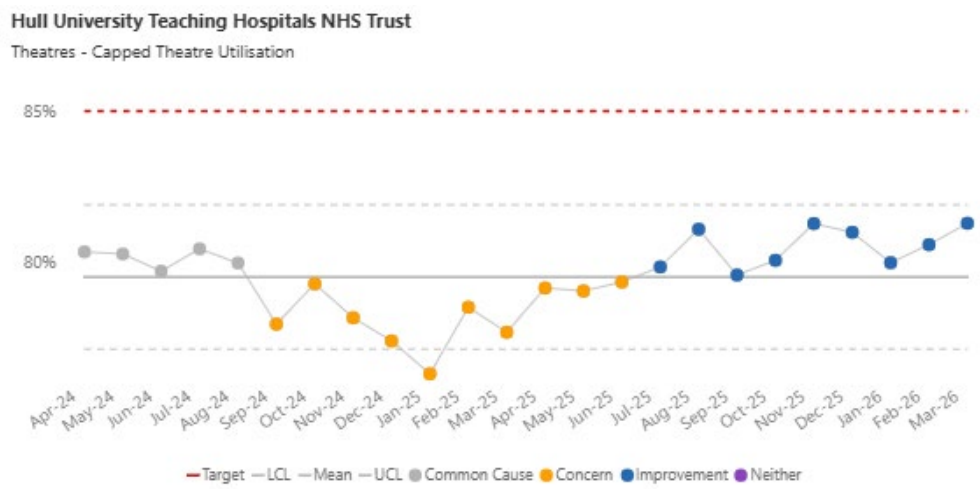


Actions

- Working with GIRFT to improve booking and scheduling and on the day flow
- Introduction of standby patient
- Planned change to reporting of QMCO from April 2026 to report from Lorenzo rather than WebV which will include additional procedures in Endoscopy, Cardiology and Minor procedures, previously not reported.

11. Capped Theatre Utilisation - HUTH

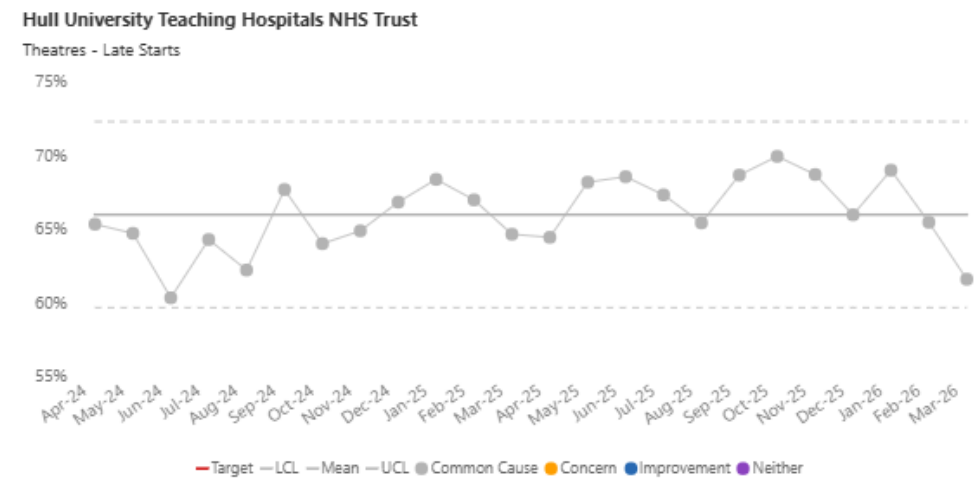
Compliance



Key Themes

- Internal reporting at 81.3% for capped theatre utilisation for March.
- Day Case capped theatre utilisation is at 77.8% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- There has been a slight decrease in late starts to 61.6% (methodology 0 minutes = late start)

Critical Enabler

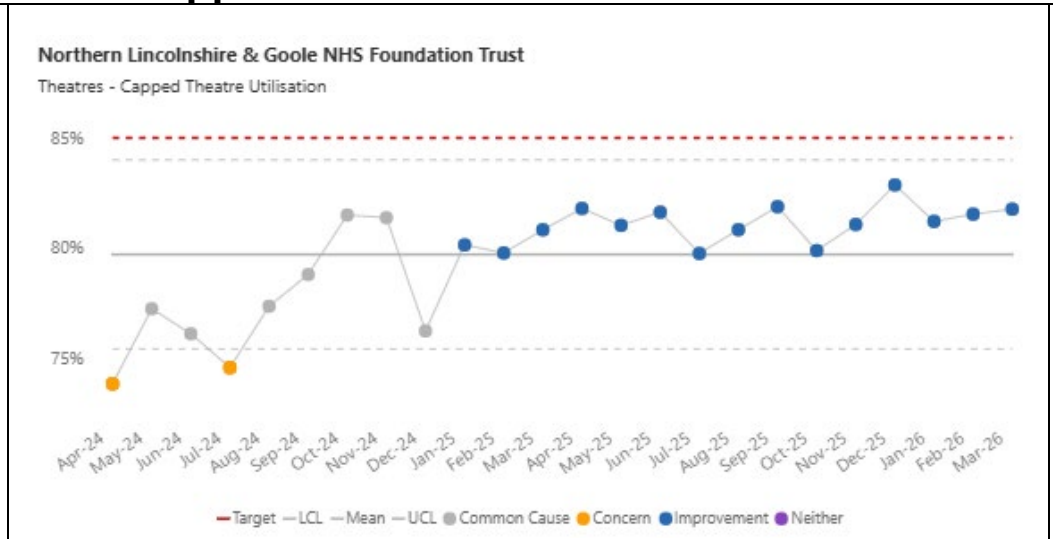


Actions

- Time in motion and real-time observations to support improved recording of day case touch points in ORMIS
- Working with GIRFT to improve on the day flow
- Working with specialties to increase booked utilisation and compliance with GIRFT booking recommendations
- Re-invigoration of golden patient protocol
- CMO communication to clinical body regarding theatre standards and expectations
- Re-invigoration of 6-4-2 process
- Review of theatre timetable to map against job plans and specialty demand and usage
- HHP Group Improvement Plan on-going with specific actions for theatre productivity and efficiency

12. Capped Theatre Utilisation - NLAG

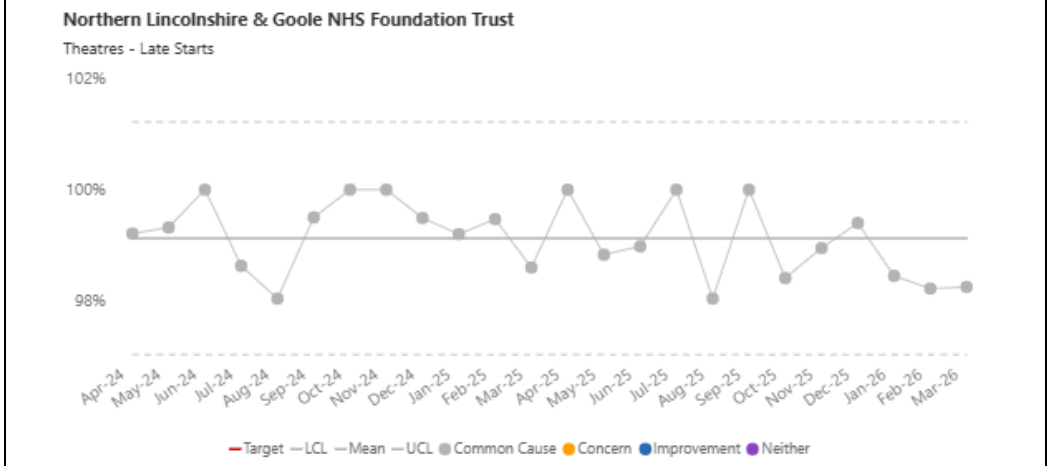
Compliance



Key Themes

- Internal reporting shows performance at 81.8%.
- Theatre late starts issue at NLAG with 98.3% of sessions starting late in March on the zero-minute measure.

Critical Enabler



Actions

- CMO communication to clinical body regarding theatre standards and expectations
- Working with GIRFT to improve on the day flow
- Working with specialties to increase booked utilisation and compliance with GIRFT booking recommendations
- Re-invigoration of golden patient protocol
- Working with information services regarding reporting and recording of admission type; mixed day case and inpatient lists impact on Model Hospital but deliver positive patient flow and throughput
- HHP Group Improvement Plan on-going with specific actions for theatre productivity and efficiency; detail provided in Elective Deep Dive paper

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Diagnostic activity levels - Audiology Assessments	Feb 26	-	1,054			83
Diagnostic activity levels - Barium Enema	Feb 26	-	56			82
Diagnostic activity levels - Colonoscopy	Feb 26	-	228			41
Diagnostic activity levels - CT	Feb 26	-	6,664			73
Diagnostic activity levels - Cystoscopy	Feb 26	-	400			88
Diagnostic activity levels - Dexa Scan	Feb 26	-	485			79
Diagnostic activity levels - Echocardiography	Feb 26	-	951			54
Diagnostic activity levels - Endoscopy	Feb 26	-	1,111			60
Diagnostic activity levels - Flexi Sigmoidoscopy	Feb 26	-	95			60
Diagnostic activity levels - Gastroscopy	Feb 26	-	388			62
Diagnostic activity levels - Imaging	Feb 26	-	15,083			69
Diagnostic activity levels - Non Obstetric Ultrasound	Feb 26	-	4,949			60
Diagnostic activity levels - Total	Feb 26	-	18,978			68
Diagnostic activity levels - Urodynamics	Feb 26	-	54			77
Diagnostics - 6 Week Standard	Feb 26	5.00%	35.93%			12
Diagnostics - 6 Week Standard - Audiology	Feb 26	5.00%	22.40%			42
Diagnostics - 6 Week Standard - Colonoscopy	Feb 26	5.00%	38.90%			21
Diagnostics - 6 Week Standard - Computed Tomography	Feb 26	5.00%	22.52%			7
Diagnostics - 6 Week Standard - Cystoscopy	Feb 26	5.00%	21.55%			42
Diagnostics - 6 Week Standard - DEXA Scan	Feb 26	5.00%	55.98%			5
Diagnostics - 6 Week Standard - Echocardiography	Feb 26	5.00%	70.15%			1
Diagnostics - 6 Week Standard - Gastroscopy	Feb 26	5.00%	36.49%			20
Diagnostics - 6 Week Standard - Magnetic Resonance Imaging	Feb 26	5.00%	22.91%			24
Diagnostics - 6 Week Standard - Neurophysiology	Feb 26	5.00%	26.06%			38
Diagnostics - 6 Week Standard - Non-obstetric Ultrasound	Feb 26	5.00%	20.28%			20
Diagnostics - 6 Week Standard - Urodynamics	Feb 26	5.00%	33.77%			43
Diagnostics - 6 Week Standard Reversed	Feb 26	95.00%	64.07%			12
DM01 Waiting <13 Weeks	Feb 26	100.00%	84.81%			11

NLAG

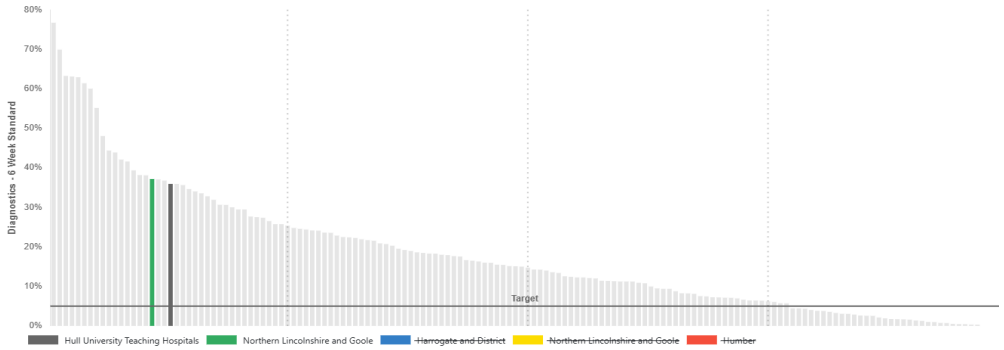
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Diagnostic activity levels - Audiology Assessments	Feb 26	-	541			53
Diagnostic activity levels - Barium Enema	Feb 26	-	161			98
Diagnostic activity levels - Colonoscopy	Feb 26	-	361			61
Diagnostic activity levels - CT	Feb 26	-	10,627			94
Diagnostic activity levels - Cystoscopy	Feb 26	-	372			84
Diagnostic activity levels - Dexa Scan	Feb 26	-	276			50
Diagnostic activity levels - Echocardiography	Feb 26	-	1,087			62
Diagnostic activity levels - Endoscopy	Feb 26	-	1,237			69
Diagnostic activity levels - Flexi Sigmoidoscopy	Feb 26	-	152			83
Diagnostic activity levels - Gastroscopy	Feb 26	-	352			57
Diagnostic activity levels - Imaging	Feb 26	-	22,081			90
Diagnostic activity levels - Non Obstetric Ultrasound	Feb 26	-	6,109			78
Diagnostic activity levels - Total	Feb 26	-	25,241			90
Diagnostic activity levels - Urodynamics	Feb 26	-	104			89
Diagnostics - 6 Week Standard	Feb 26	5.00%	37.17%			10
Diagnostics - 6 Week Standard - Audiology	Feb 26	5.00%	56.10%			19
Diagnostics - 6 Week Standard - Colonoscopy	Feb 26	5.00%	50.20%			10
Diagnostics - 6 Week Standard - Computed Tomography	Feb 26	5.00%	0.26%			78
Diagnostics - 6 Week Standard - Cystoscopy	Feb 26	5.00%	13.14%			53
Diagnostics - 6 Week Standard - DEXA Scan	Feb 26	5.00%	4.08%			31
Diagnostics - 6 Week Standard - Echocardiography	Feb 26	5.00%	6.95%			58
Diagnostics - 6 Week Standard - Gastroscopy	Feb 26	5.00%	46.41%			13
Diagnostics - 6 Week Standard - Magnetic Resonance Imaging	Feb 26	5.00%	43.73%			2
Diagnostics - 6 Week Standard - Neurophysiology	Feb 26	5.00%	29.73%			35
Diagnostics - 6 Week Standard - Non-obstetric Ultrasound	Feb 26	5.00%	41.09%			3
Diagnostics - 6 Week Standard Reversed	Feb 26	95.00%	62.83%			10
DM01 Waiting <13 Weeks	Feb 26	100.00%	87.36%			17

14. Pathway Benchmarking & Trend – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

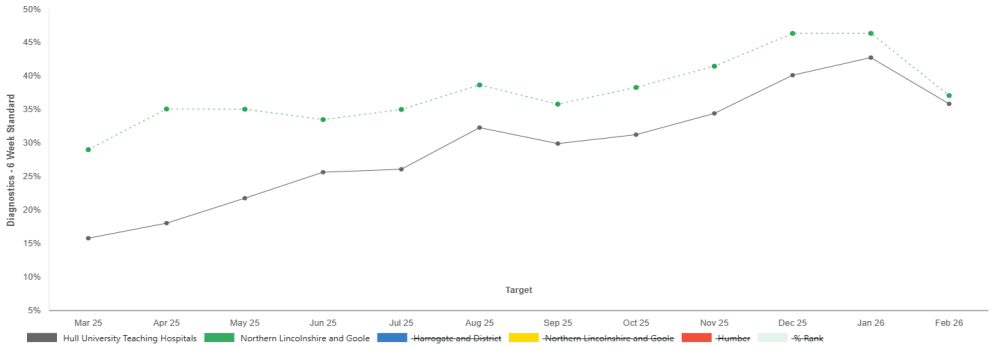
Diagnostics – 6 week Performance Standard

Ranking Chart



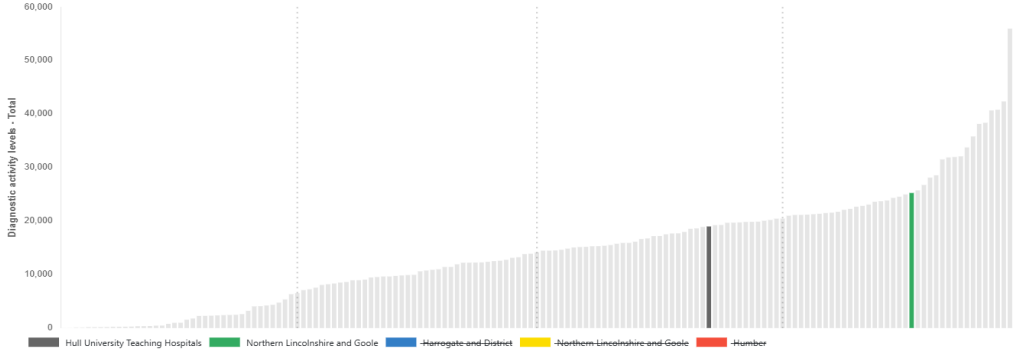
Rank 135 of 154 selected

Trend Chart



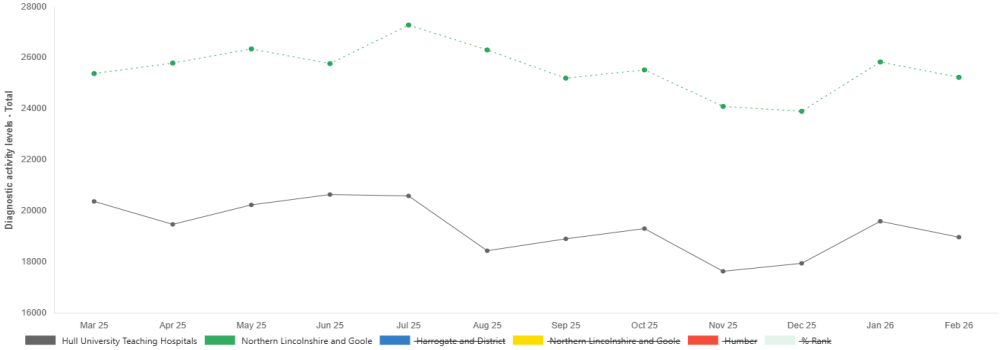
Diagnostics – Activity

Ranking Chart



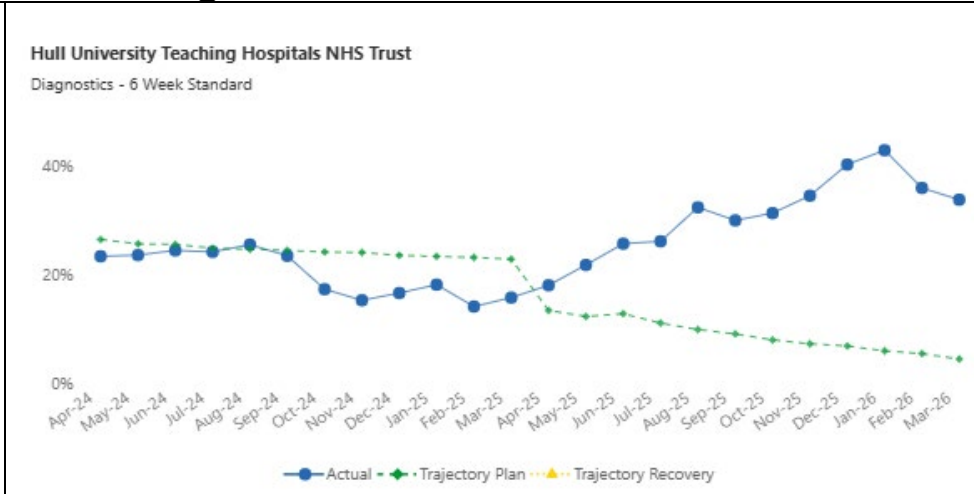
Rank 50 of 155 selected

Trend Chart



15. Diagnostic 6 Week Standard - HUTH

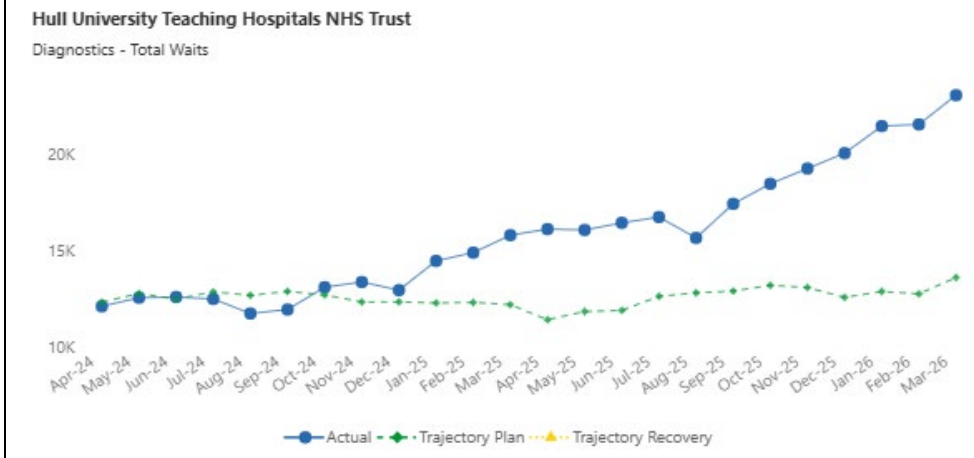
Compliance



Key Themes

- March showed an improvement in performance by - 2.1% at 33.8%.
- The most significant improvements were seen in Neurophysiology, Colonoscopy and CT.
- Continuing pressures are seen in Echo, DEXA, Sleep Studies, Urodynamics and Gastroscopy.
- Total waits show an increasing position on last month.

Critical Enabler



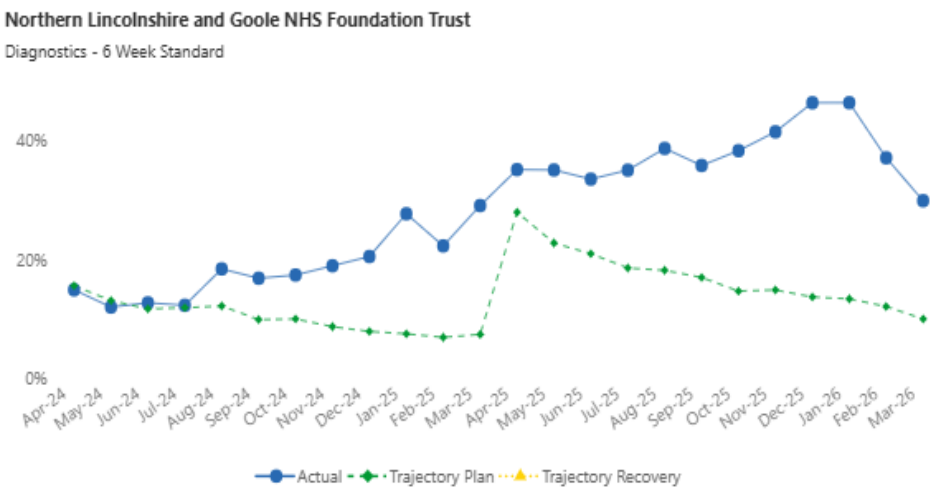
Actions

Critical actions being progressed through Diagnostic Delivery Group:

- IS and CDC capacity for Echo identified with Insourcing providers and HUTH CDC.
- Neurophysiology contract mobilisation commenced in October.
- CDC capacity for Sleep commenced in February.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

16. Diagnostic 6 Week Standard - NLAG

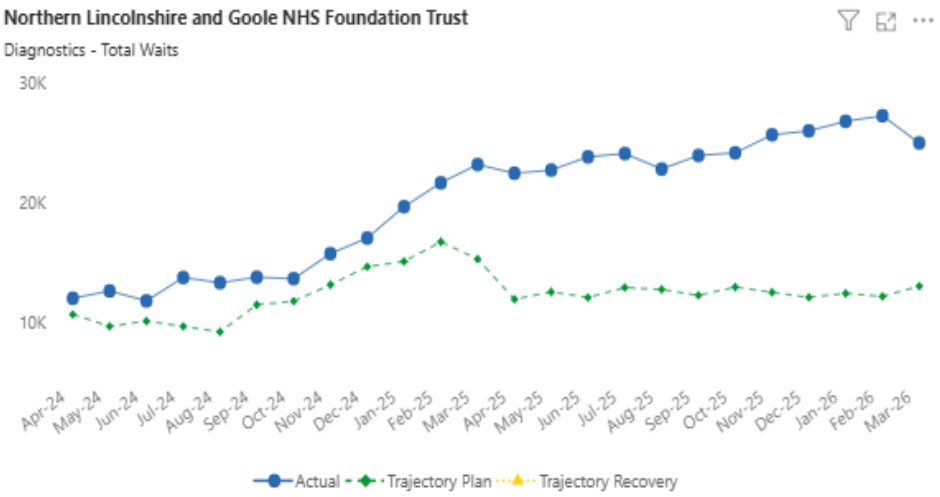
Compliance



Key Themes

- March performance showed a good improvement in performance by -7.22% at 29.9%.
- The most significant improvement was seen in NOUS (-21.2%) due to doubling of activity during March.
- Continuing pressures are seen in Audiology, Colonoscopy, Flexi, Gastroscopy, MRI and Neurophysiology.
- Total Waits show a decreasing position.

Critical Enabler



Actions

Critical actions being progressed through Diagnostic Delivery Group:

- Neurophysiology contract mobilisation commenced in October.
- Weekend waiting list initiatives for Stress Echo and develop sonographer-led service.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.
- Change in counting methodology in April 2026 to remove duplicate exams in Soliton which will affect activity and waiters for Radiology modalities.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 2 Week Wait	Feb 26	93.00%	57.08%			5
Cancer - 2 Week Wait Breast Symptomatic	Feb 26	93.0%	8.3%			13
Cancer - 31 Day All Stages	Feb 26	96.0%	76.2%			0
Cancer - 31 Day First Treatment	Feb 26	96.00%	77.38%			0
Cancer - 31 Day Subsequent Treatment	Feb 26	96.0%	75.1%			7
Cancer - 31 Day Subsequent Treatment - Drugs	Feb 26	96.0%	97.3%			14
Cancer - 31 Day Subsequent Treatment - Radiotherapy	Feb 26	96.0%	68.9%			9
Cancer - 62 Day Consultant Upgrade	Feb 26	85.0%	64.6%			4
Cancer - 62 Day Screening	Feb 26	90.0%	44.8%			25
Cancer - 62 Day Urgent Suspected	Feb 26	85.00%	44.51%			4
Cancer - Patients treated within 62 of referral	Feb 26	75.00%	51.64%			1
Cancer - Urgent referrals diagnosis within 4 weeks	Feb 26	80.0%	74.6%			16
Summary Hospital Mortality Indicator - Cancer of bronchus; lung	Nov 25	1.00	1.05			51

NLAG

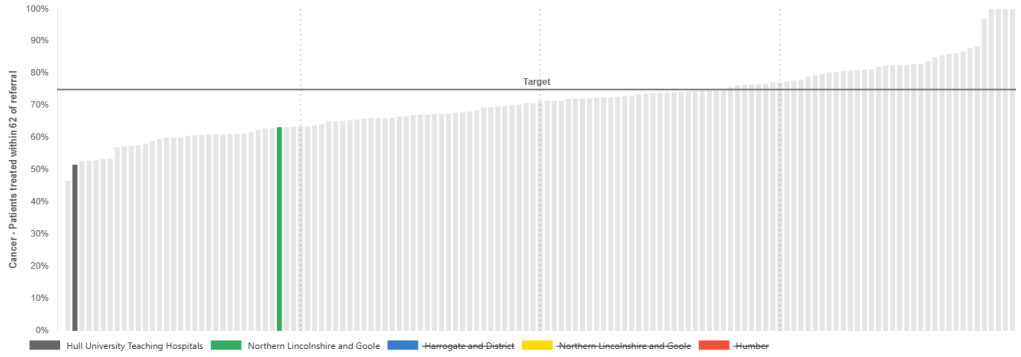
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 2 Week Wait	Feb 26	93.00%	82.57%			48
Cancer - 2 Week Wait Breast Symptomatic	Feb 26	93.0%	12.5%			16
Cancer - 31 Day All Stages	Feb 26	96.0%	96.0%			43
Cancer - 31 Day First Treatment	Feb 26	96.00%	95.83%			44
Cancer - 31 Day Subsequent Treatment	Feb 26	96.0%	96.2%			48
Cancer - 31 Day Subsequent Treatment - Drugs	Feb 26	96.0%	95.4%			6
Cancer - 31 Day Subsequent Treatment - Radiotherapy	Dec 25	96.0%	100.0%			100
Cancer - 62 Day Consultant Upgrade	Feb 26	85.0%	75.9%			25
Cancer - 62 Day Screening	Feb 26	90.0%	31.6%			16
Cancer - 62 Day Urgent Suspected	Feb 26	85.00%	58.45%			36
Cancer - Patients treated within 62 of referral	Feb 26	75.00%	63.27%			23
Cancer - Urgent referrals diagnosis within 4 weeks	Feb 26	80.0%	69.9%			7
Summary Hospital Mortality Indicator - Cancer of bronchus; lung	Nov 25	1.00	1.17			26

18. Pathway Benchmarking & Trending – Cancer Waiting Times

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

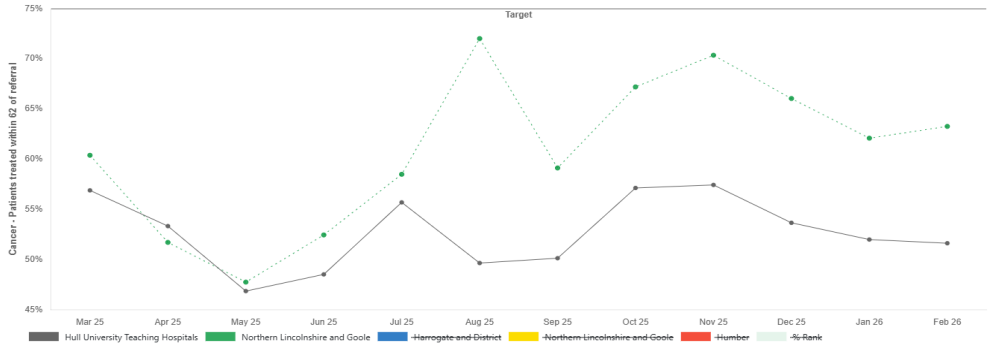
62 Day Performance

Ranking Chart



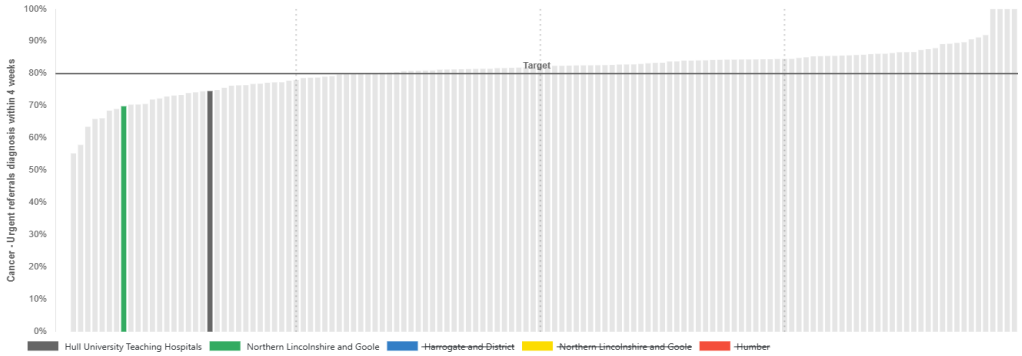
Rank 134 of 136 selected

Trending Chart



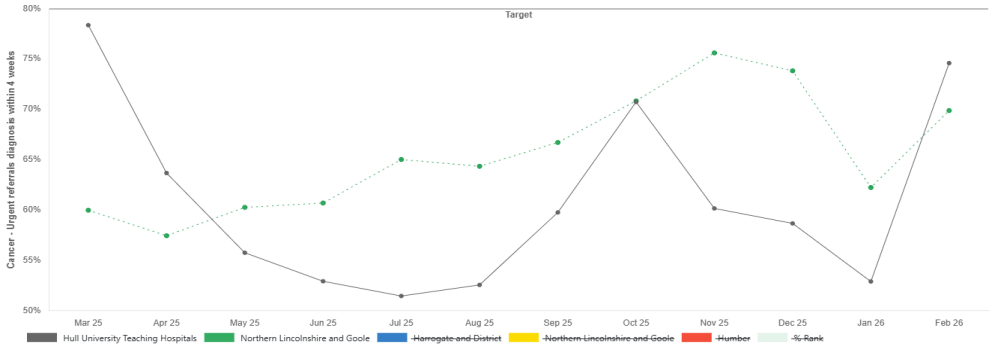
Faster Diagnosis Performance

Ranking Chart



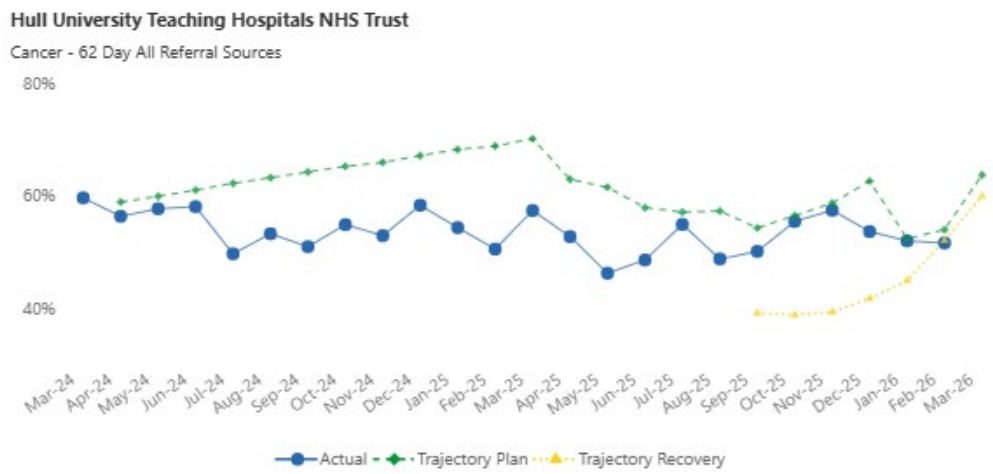
Rank 113 of 134 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

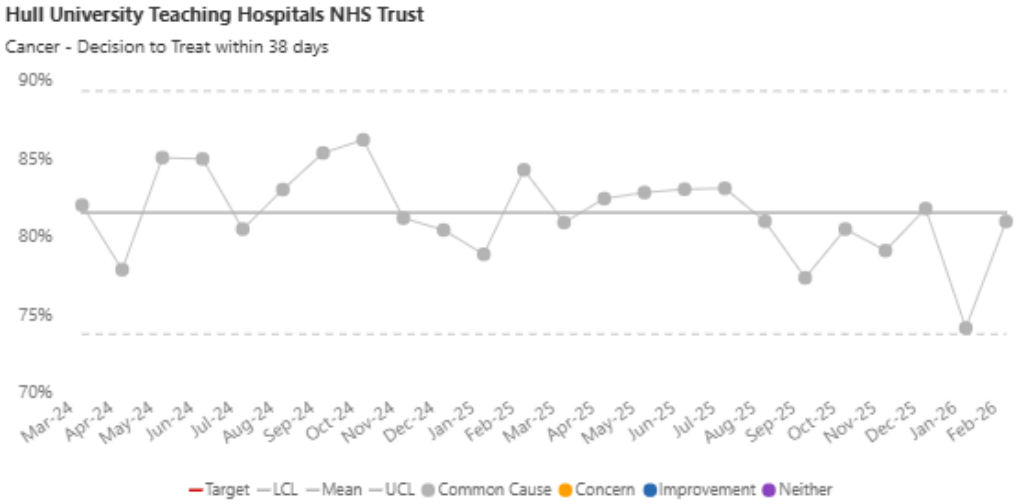
Compliance



Key Themes

- February performance of 51.6% shows a deterioration on the previous month but remains within normal variation.
- Waits for Radiotherapy is 10 plus weeks.
- Breast – 1st outpatient radiology capacity constraints
- Colorectal- Significant endoscopy capacity constraints, high Histopathology turnaround times (TAT), endoscopy equipment
- Gynaecology- Long Histopathology TAT, late IPTs and theatre capacity constraints; high levels of sickness
- Head and Neck- Surgical capacity constraints - thyroid
- Lung- Capacity in Radiotherapy and late IPTs
- Urology – Robotic surgery capacity constraints, loss of IS capacity
- Significant deterioration of first appointment within 2 weeks is impacting on 62 day and 28-day FDS delivery.

Critical Enabler

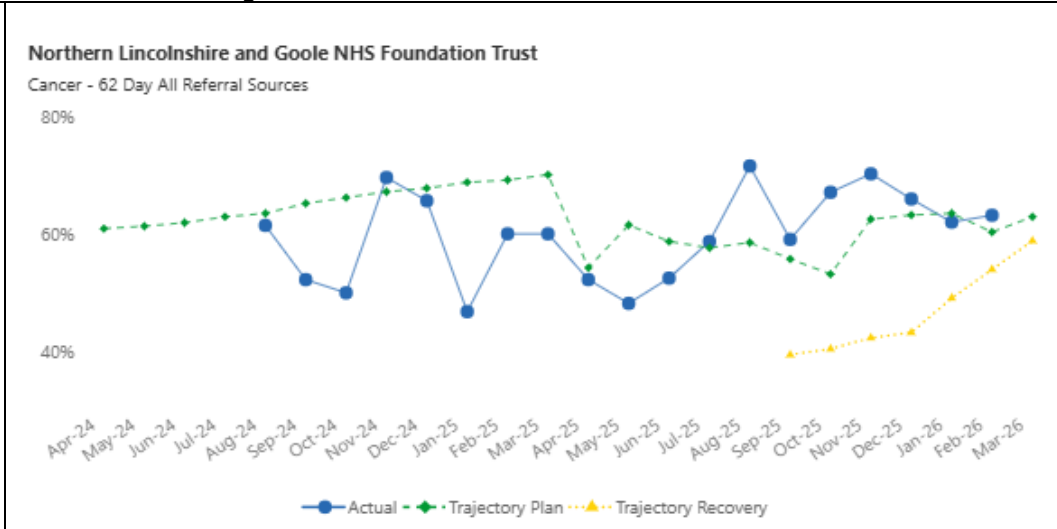


Actions

- Breast – Radiology recovery plan implemented. Additional weekend clinics and insourcing in place. Triple assessment insourcing continues.
- Histopathology SHYPS performance and improvement review progressing.
- Gynaecology –Workforce optimisation business case approved, phased implementation underway.
- Lung –Business Case for additional Thoracic Surgeon declined by executive team, productivity challenged. Case resubmitted. Radiotherapy business case implementation will impact performance only in 2028.
- Urology –Robotic theatre capacity remains a bottleneck.
- New fortnightly Service improvement and performance monitoring meetings in place
- Improvement trajectories in place for all tumour sites

20. 62 Day Cancer Performance - NLAG

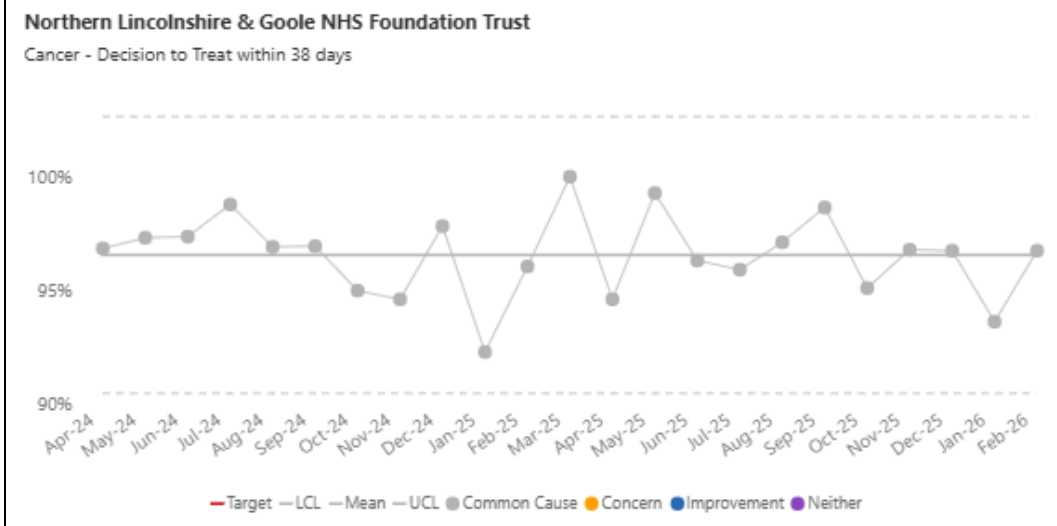
Compliance



Key Themes

- February performance of 63.3% shows a deterioration, although performance is above trajectory.
- Breast- Consultant vacancies, radiology capacity constraints, pathway delays
- Colorectal- Endoscopy capacity constraints, demand and capacity analysis progressing
- Gynaecology- Rightsizing business case being implemented. This will address the need for gynae oncology theatre requirements at NLAG. C&D work also to review hysteroscopy and USC capacity for 1st OPA
- Lung- clinical vacancies, Oncology capacity constraints
- Urology- Haematuria STT pathway introduced using CDC capacity. Will enable CT to be undertaken prior to cystoscopy, within the CDC. This will enable diagnosis to be given to patient at the time of the cystoscopy.

Critical Enabler

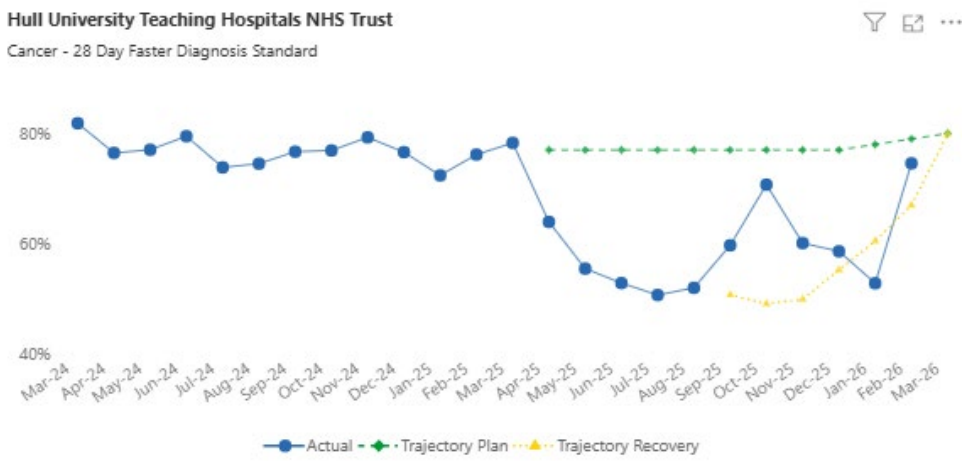


Actions

- Breast Radiology– Consultants x 1 WTE recruitment underway, with OD support. Radiology recovery plan in place, with additional weekend clinics and insourcing.
- Colorectal –Weekly monitoring of the PTL with navigators and trackers.
- Gynaecology – Capacity and demand work undertaken. Cancer Alliance funded WLIs in place to mitigate.
- Lung – Continuous advertisement for recruitment to 5 x WTE posts, locums in place
- Urology – Weekend theatres and in week additional theatre sessions in place funded by Cancer Alliance
- Improvement trajectories in place for all tumour sites.

21. 28 Day Faster Diagnosis Standard - HUTH

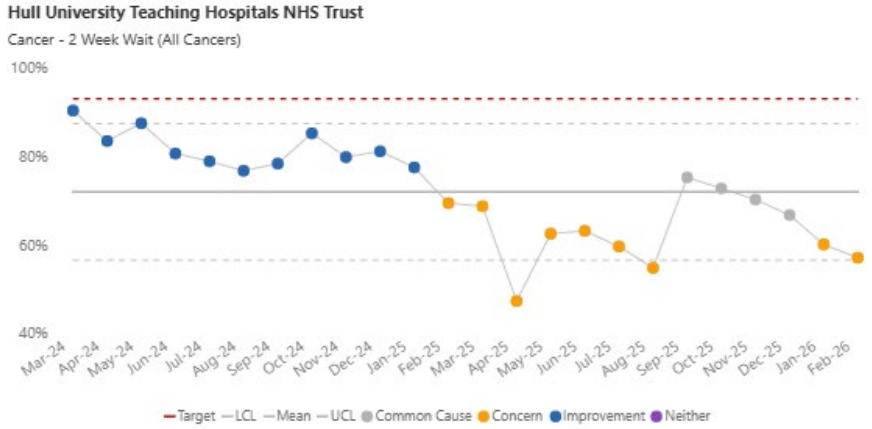
Compliance



Key Themes

- February performance 74.6%, is an improvement from the previous month and above the recovery trajectory.
- Histopathology turnaround times are significantly high approx. 17 days on average.
- Breast triple assessment clinics- significant delays due to radiologist capacity constraints
- Colorectal; loss of CNS through Alliance funding has reduced capacity for triage, bowel screening Endoscopy capacity shortfall for accredited endoscopists, CT Colon radiologist capacity with current waits up to 4 weeks
- Gynaecology; outpatient capacity and US capacity, diagnostic histology turnaround times up to 3 weeks
- Head & Neck; significant delays with first outpatient consultant capacity
- Skin; significant delays with first outpatient consultant capacity
- Urology: Development of One Stop Prostate Pathway.

Critical Enabler

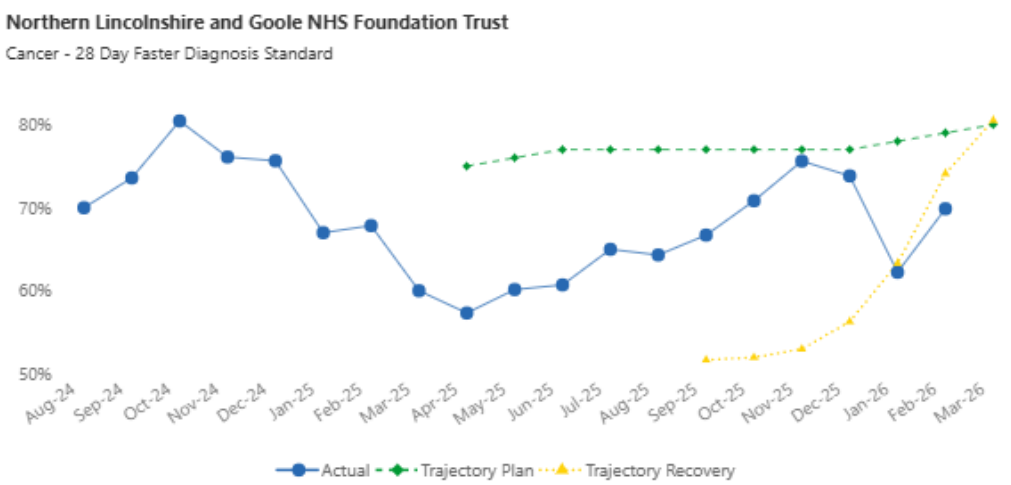


Actions

- Histopathology – Risk raised to Executive team to support
- Breast – Radiology recovery plan in place. Additional weekend clinics agreed and insourcing in place
- Lower GI – restructured endoscopic allocation to support focussed capacity for USC patients. Rightsizing business case development underway.
- Gynaecology – Sub Spec Gynae Oncology Consultant Business cases developed alongside wider Workforce Expansion Paper (unit leads and nursing)
- Head & Neck – Additional outpatient capacity to be done via WLIs and service working on plans to clear backlog
- Urology – rightsizing business case submitted
- Improvement trajectories in place for all tumour sites

22. 28 Day Faster Diagnosis Standard - NLAG

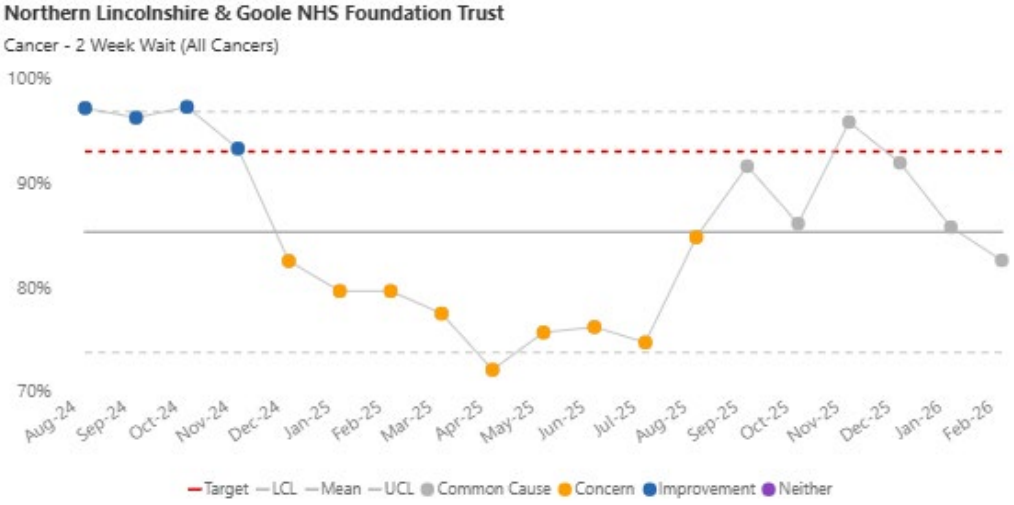
Compliance



Key Themes

- February performance 69.9%, which is an improvement on the previous month although 5% below the recovery trajectory.
- Breast- first outpatient capacity constraints, Radiology
- Colorectal- endoscopy core capacity constraints, screening continued delays due to patient choice
- Lung- Due to vacancies, locums in place to cover inpatient activity and allow the substantive consultants to focus on outpatient activity.
- Urology- increase in referrals and demand for prostate biopsies

Critical Enabler



Actions

- Breast radiology- recruitment to consultant vacancies underway, additional capacity for biopsies allocated
- Colorectal- Additional sessions for weekend theatres and STT capacity in place
- Gynaecology- Business case progressing to meet workforce constraints
- Head & Neck- Time out session with clinicians and managers arranged to streamline pathways
- Upper GI- extra contractual sessions maximised
- Lung- Direct to CT for suspected CXR, introduction of Cancer Physician of the week, introduction of OPD triage by CNS in place
- Urology- Utilising additional capacity with registrars where possible.
- Improvement trajectories in place for all tumour sites

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
ED - Attendances All Types	Mar 26	-	14,511			48
ED - Attendances managed within 4 hours	Mar 26	78.00%	64.02%			13
ED - Attendances managed within 4 hours (Type 1)	Mar 26	78.0%	50.7%			27
ED - Attendances managed within 4 hours (Type 2 or 3)	Mar 26	95.0%	94.6%			26
ED - Attendances over 12 hours in department	Mar 26	-	7.5%			61
ED - Attendances Type 1	Mar 26	-	10,114			46
ED - Attendances Type 3	Mar 26	-	4,397			47
ED - Conversion Rate	Mar 26	25.0%	27.7%			9
ED - DTA to Admission >12 Hours	Mar 26	0.0%	9.3%			42
ED - DTA to Admission >12 Hours#	Mar 26	0.0	375.0			36
ED - DTA to Admission >4 Hours	Mar 26	10.00%	35.56%			32
ED - Left Department Before Being Seen	Feb 26	5.00%	5.83%			32
ED - Reattendance Rate	Feb 26	5.0%	9.2%			47
ED - Time to Initial Assessment	Feb 26	15.0	14.0			24
ED - Time to Treatment	Feb 26	60.0	66.0			53
ED - Total Time in A&E	Feb 26	160.0	230.0			7
ED - Total Time in A&E (Admitted)	Feb 26	180.0	195.0			79
ED - Total Time in A&E (Non-Admitted)	Feb 26	140.0	236.0			2
Emergency Admissions Type 1	Mar 26	-	4,018			21
Emergency Admissions via A&E	Mar 26	-	4,018			23
Friends & Family A&E Score	Feb 26	85%	71%			12
Other Emergency Admissions	Mar 26	-	2,139			13
Total Emergency Admissions	Mar 26	-	6,157			15

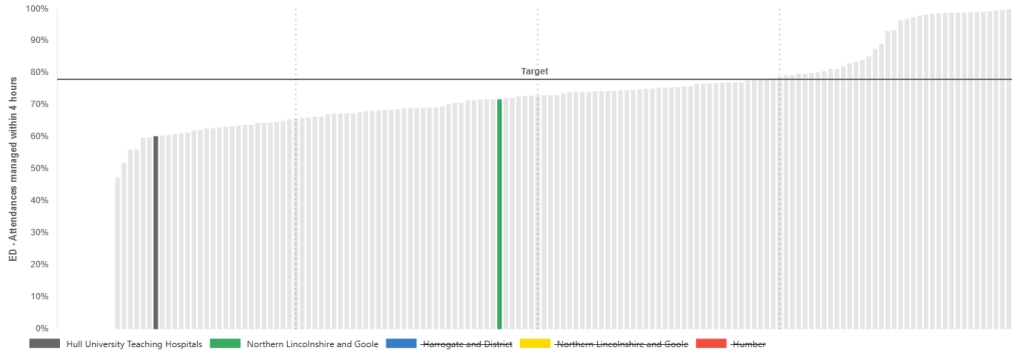
NLAG

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
ED - Attendances All Types	Mar 26	-	17,930			37
ED - Attendances managed within 4 hours	Mar 26	78.00%	72.23%			36
ED - Attendances managed within 4 hours (Type 1)	Mar 26	78.0%	54.9%			34
ED - Attendances managed within 4 hours (Type 2 or 3)	Mar 26	95.0%	98.9%			67
ED - Attendances over 12 hours in department	Mar 26	-	14.1%			16
ED - Attendances Type 1	Mar 26	-	10,855			42
ED - Attendances Type 3	Mar 26	-	7,075			32
ED - Conversion Rate	Mar 26	25.0%	32.1%			3
ED - DTA to Admission >12 Hours	Mar 26	0.0%	12.4%			32
ED - DTA to Admission >12 Hours#	Mar 26	0.0	715.0			14
ED - DTA to Admission >4 Hours	Mar 26	10.00%	25.15%			54
ED - Left Department Before Being Seen	Feb 26	5.00%	2.00%			87
ED - Reattendance Rate	Feb 26	5.0%	10.2%			25
ED - Time to Initial Assessment	Feb 26	15.0	24.0			4
ED - Time to Treatment	Feb 26	60.0	49.0			73
ED - Total Time in A&E	Feb 26	160.0	139.0			78
ED - Total Time in A&E (Admitted)	Feb 26	180.0	188.0			80
ED - Total Time in A&E (Non-Admitted)	Feb 26	140.0	131.0			73
Emergency Admissions Type 1	Mar 26	-	5,761			7
Emergency Admissions via A&E	Mar 26	-	5,761			7
Friends & Family A&E Score	Feb 26	85%	77%			39
Other Emergency Admissions	Mar 26	-	476			54
Total Emergency Admissions	Mar 26	-	6,237			14

24. Pathway Benchmarking & Trending – Unscheduled Care

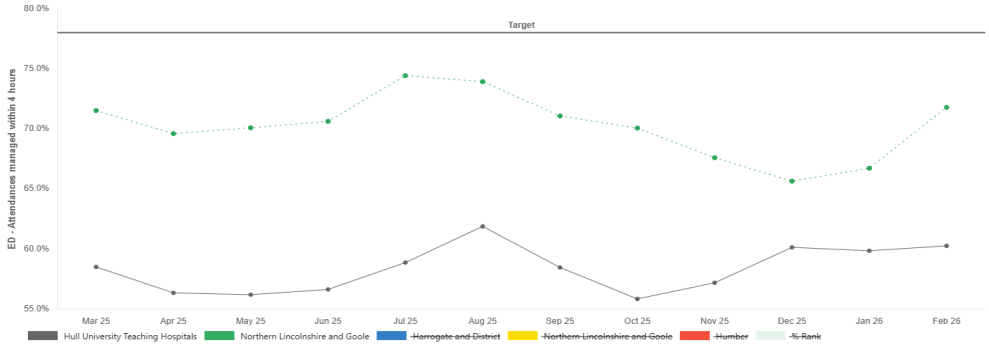
A&E - 4 Hour Performance

Ranking Chart



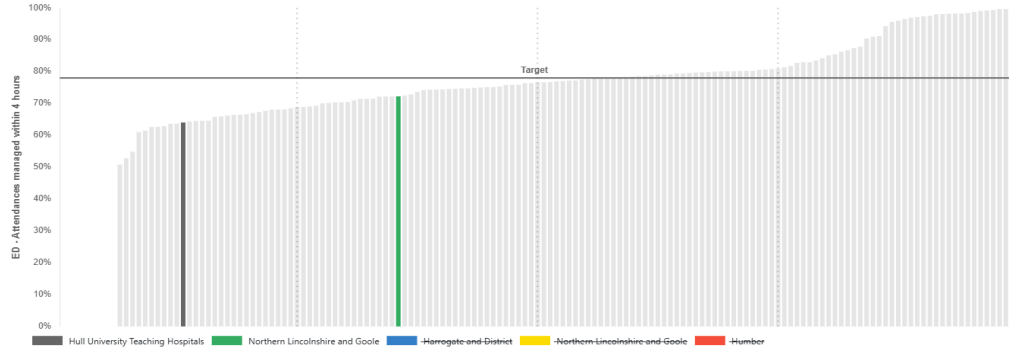
Rank 135 of 150 selected

Trending Chart



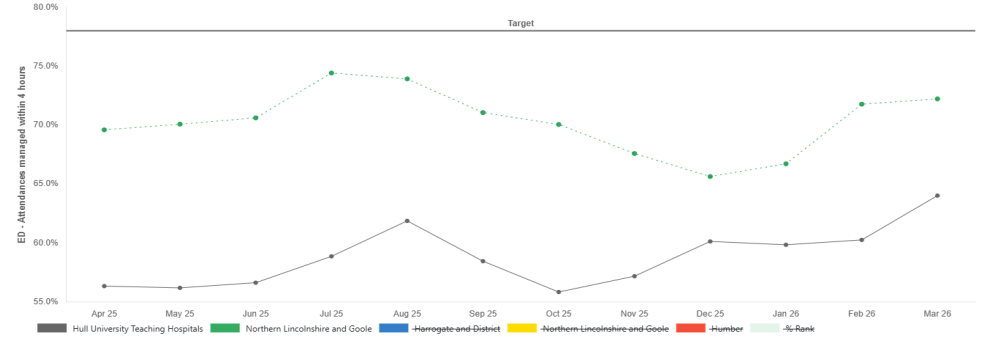
A&E – Attendances

Ranking Chart



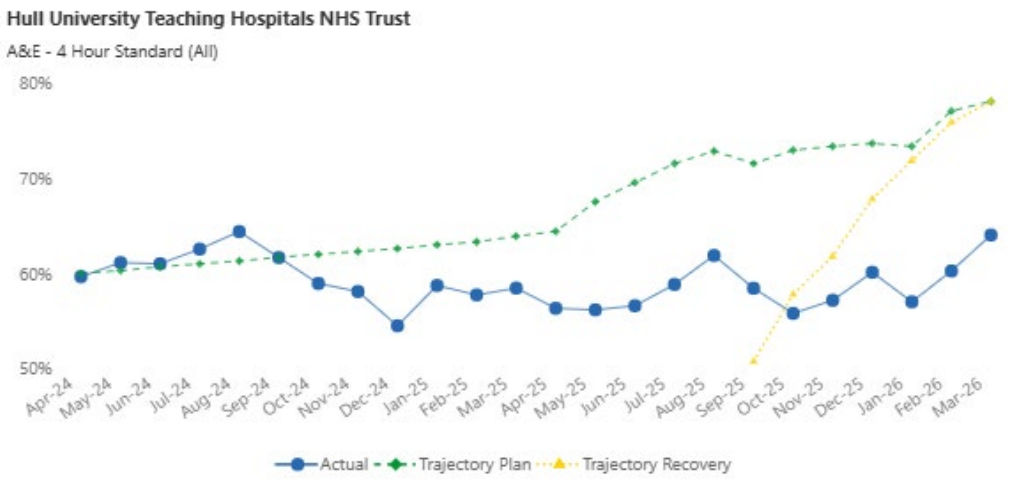
Rank 131 of 150 selected

Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

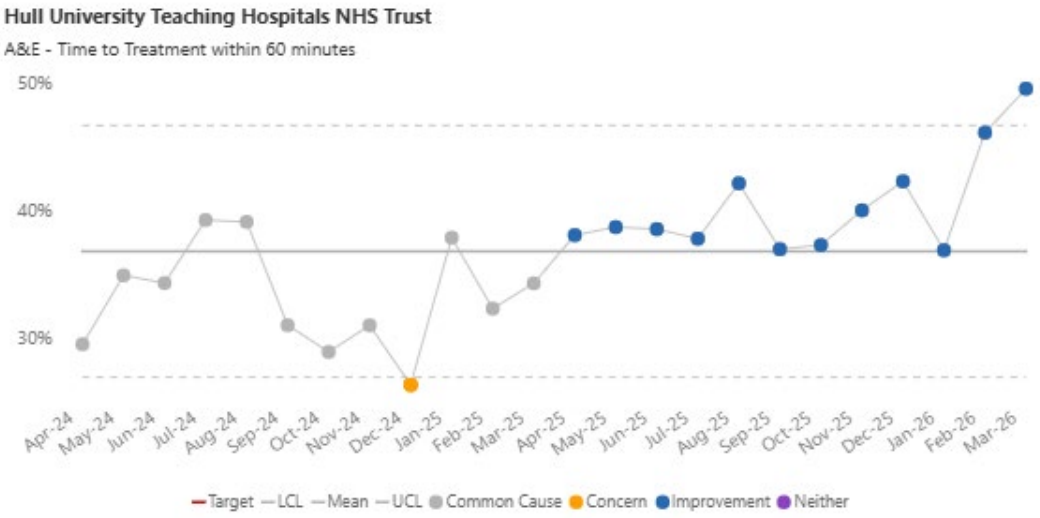
Compliance



Key Themes

- A&E 4 Hour standard (all types) remains challenged with performance of 64% in March 2026 behind the 25/26 Operating Plan (78%)
- Type 1 performance of 50.7% was below the 25/26 operating plan target of 69.8%. Attendances were above plan.
- Type 3 performance (HRI UTC) was 94.6% against the 95% target. Attendances at the UTC were below planned levels in March.
- The percentage of patients seen by a clinician within 60 minutes of arrival totalled 49.5%, an improvement on the previous month's position

Critical Enabler

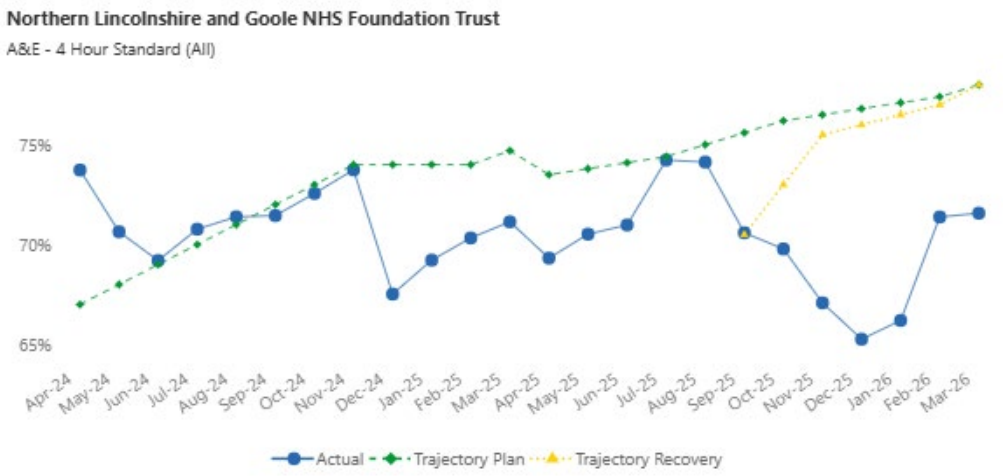


Actions

- Flow out of the department is a challenge, particularly if patients require side rooms. Close monitoring of 12 hours presented to Senior Leaders to increase awareness and ownership by Clinical Care Groups
- Work ongoing with Yorkshire Ambulance Service to develop a falls care home pathway to avoid ED attendance where appropriate
- Close monitoring of IPS to support delivery of performance targets.
- Business case under development for creation of an Extended Emergency Medicine Ambulatory Care (EEMAC) area.

26. Emergency Care Standards – 4 hour Performance - NLAG

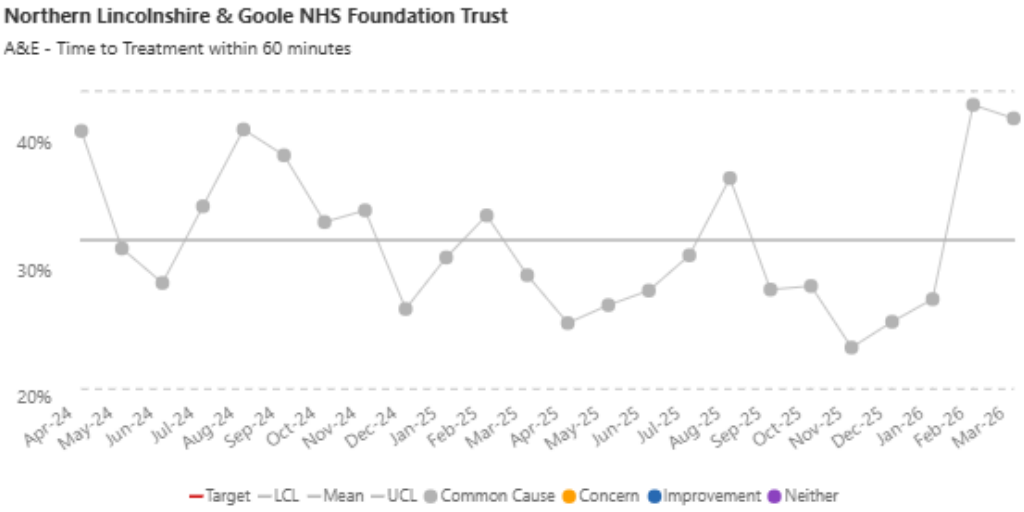
Compliance



Key Themes

- A&E 4 Hour standard (all types) performance was 71.6% in March 2026, which was behind the 25/26 Operating Plan (78%).
- Type 1 performance of 54.9% was below plan at 63.9%. Attendances were above plan.
- Type 3 performance of 98.9% which was in line with plan of 99%. Attendances were below plan
- Time to treatment within 60 minutes was 41.9% in March, a deterioration on the previous month

Critical Enabler



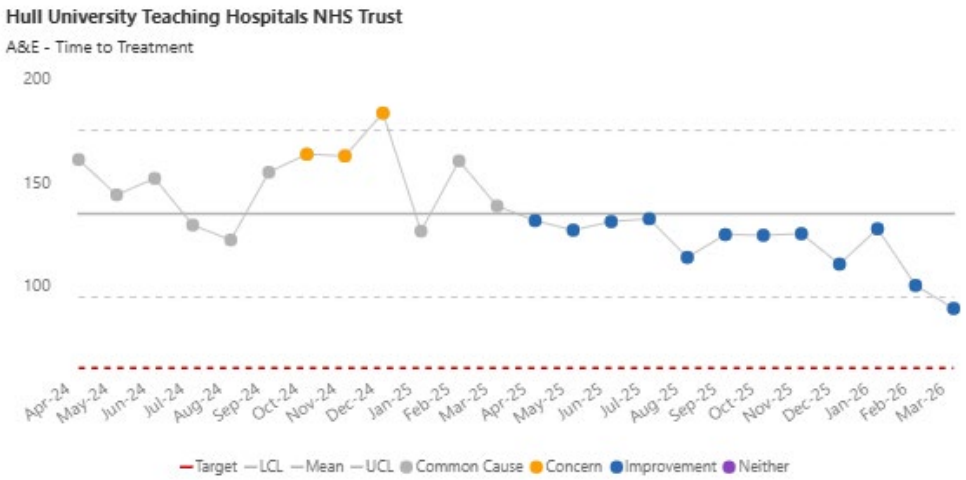
Actions

DPOW & SGH

- Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC
- Perfect Week Programme commenced at NLaG from 2nd March 2026.
- Streaming pathway improvements aligned to GIRFT principles finalised and will be launched in April 2026 to ensure UTC and SDEC treat the most appropriate patients to support flow and performance.

27. Core Objective 1 – Mean Time to Treatment

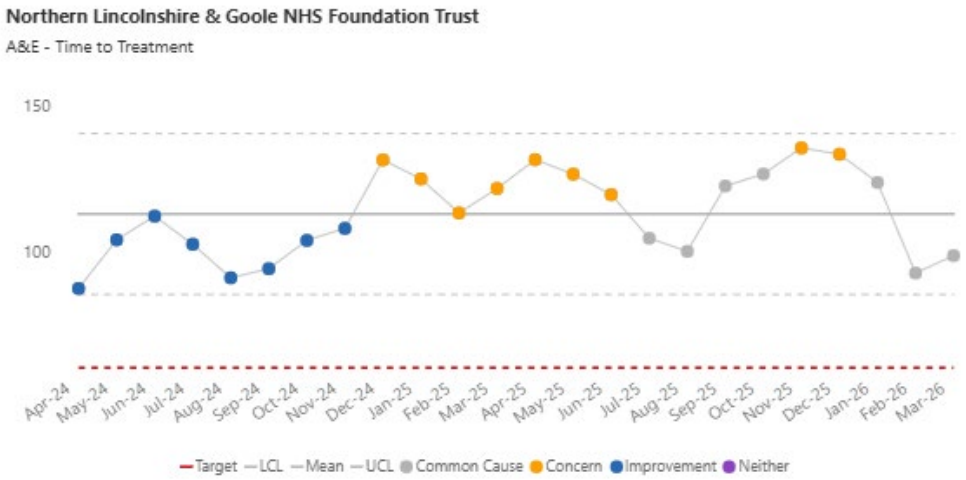
Compliance



Key Themes

- The Group established an operating target of 60 minutes for time to first clinician (time to treatment)
- HUTH performance in March was 89 minutes.
- NLaG performance was 98 minutes

Compliance

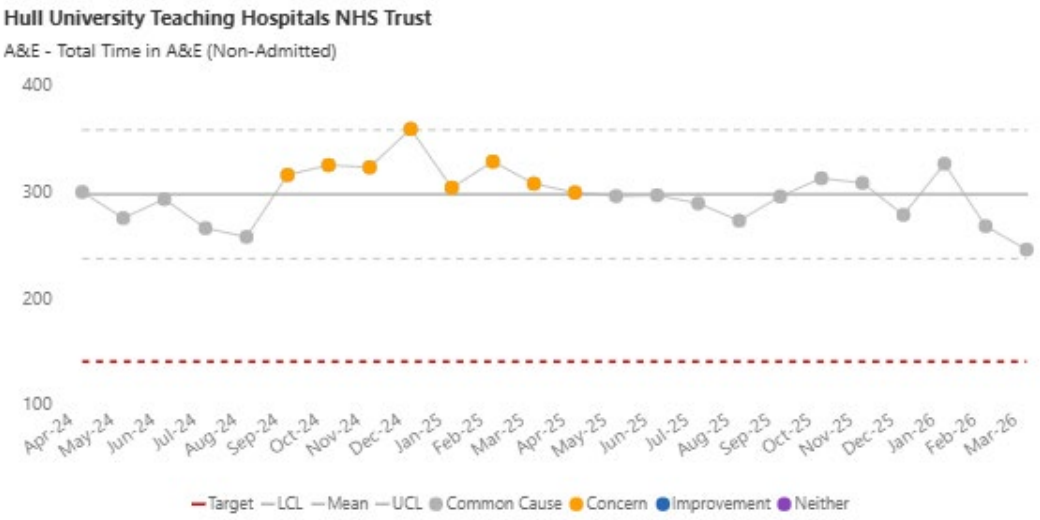


Actions

- Ongoing monitoring and focus on time first seen by doctor in department
- 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.
- Trial of new model in the ED ambulatory areas has resulted in improvement in 1st clinician seen time to support 4-hour performance. Model still under review for further improvement.

28. Core Objective 2 – Non-Admitted Total Time in Department

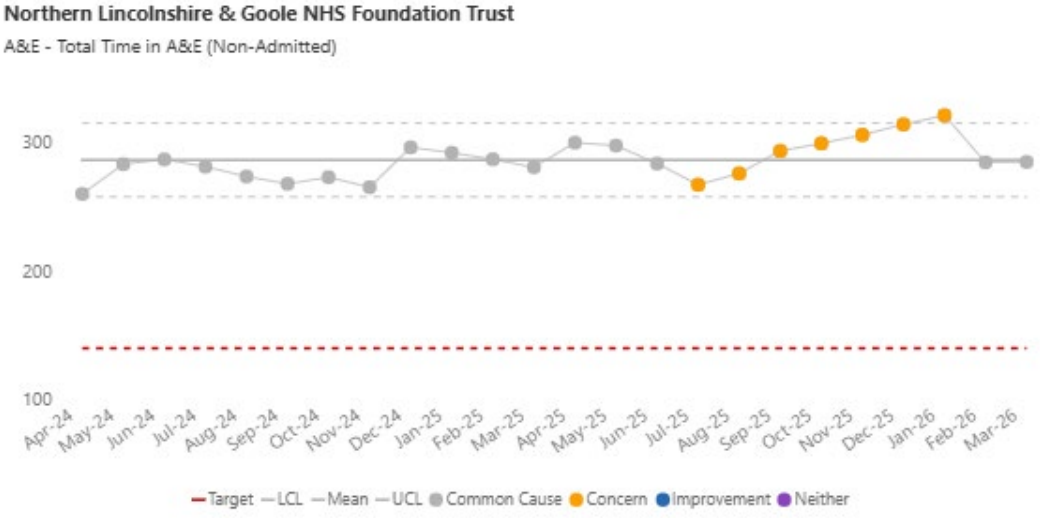
Compliance



Key Themes

- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED
- HUTH's performance improved in March was 245 minutes average
- NLaG has performed consistently in 265-300 mins range since late Spring 2024. March 2026 performance was 285 mins.

Compliance

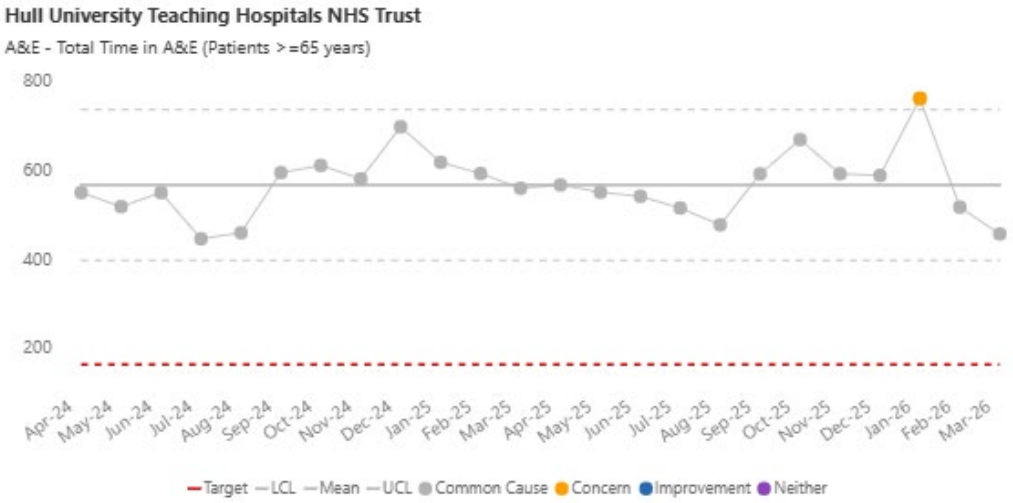


Actions

- Challenge remains with limited flow, and discharges compound this issue. Raised with clinical colleagues at SLT to agree way forward and ownership
- NLAG Trial of new model in the ED ambulatory areas has resulted in improvement in 1st clinician seen time to support 4-hour performance. Model still under review for further improvement.

29. Core Objective 3 – Total Time in Department (Patients >= 65 years)

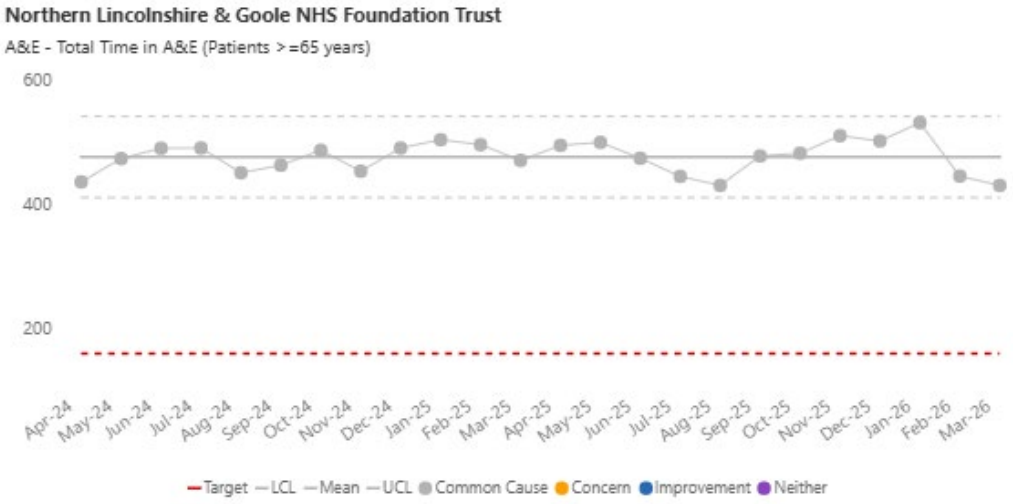
Compliance



Key Themes

- The Group established a target of 160 minutes for total time in the ED for patients aged 65 years and over
- The mean for HUTH was 455 minutes in March, an improvement on the previous month.
- NLaG's average time also saw an improvement on the previous month's position with March's average time in A&E at 431 minutes.

Compliance

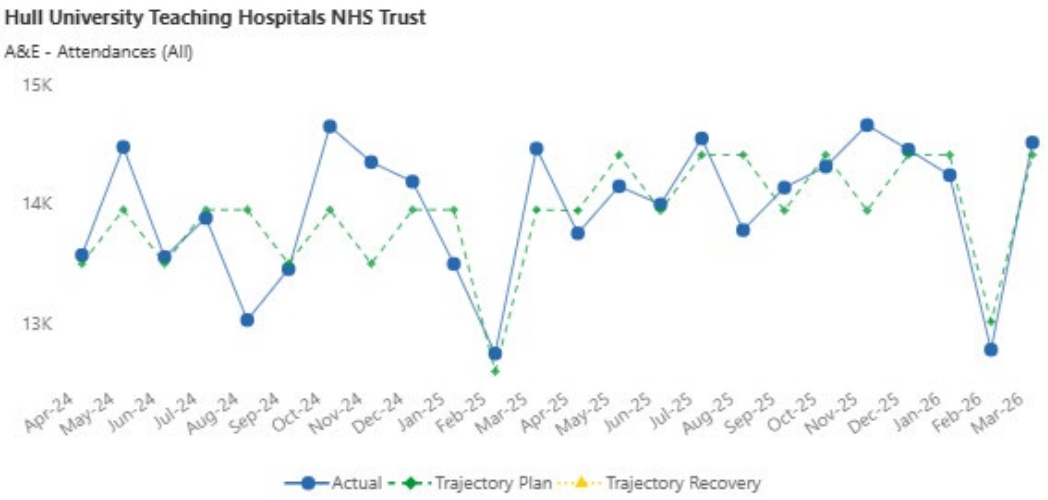


Action

- More movement out of ED in the morning due to continuous flow programme at HUTH
- Hourly monitoring of 12-hour position and reported to Director of the Day and visibility at Site Meetings for action
- Aim to move patients out of ED within 30 minutes as per Continuous Flow model utilising TES/escalation spaces
- Optimise SDEC and UTC – ensure effective streaming

30. A&E Attendances – All Types

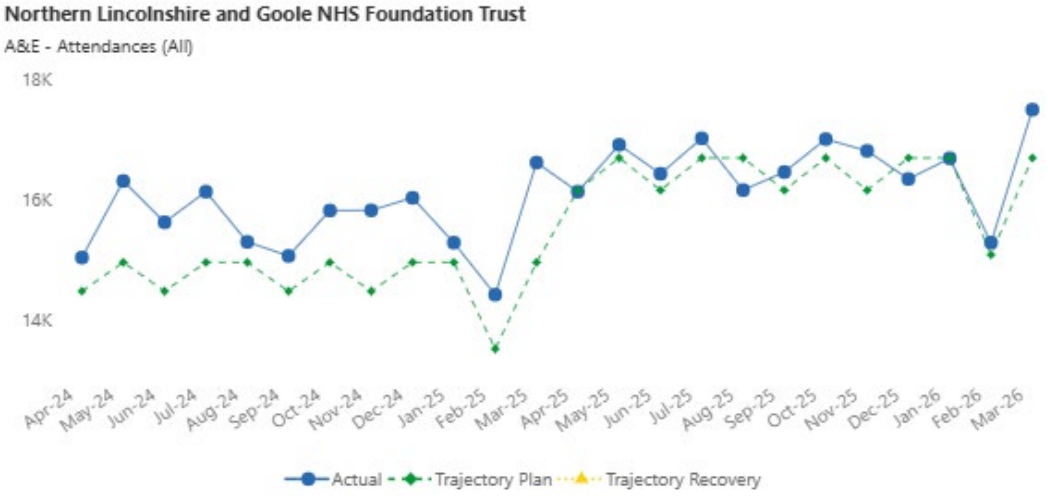
Compliance



Key Themes

- HUTH March 2026 – 14,511 total attendances comprising 10,114 Type 1 (above plan) and 4,397 Type 3 (below plan)
- NLaG March 2026 – 17,502 total attendances comprising 10.856 Type 1 (above plan) and 6,646 Type 3 (below plan)

Compliance

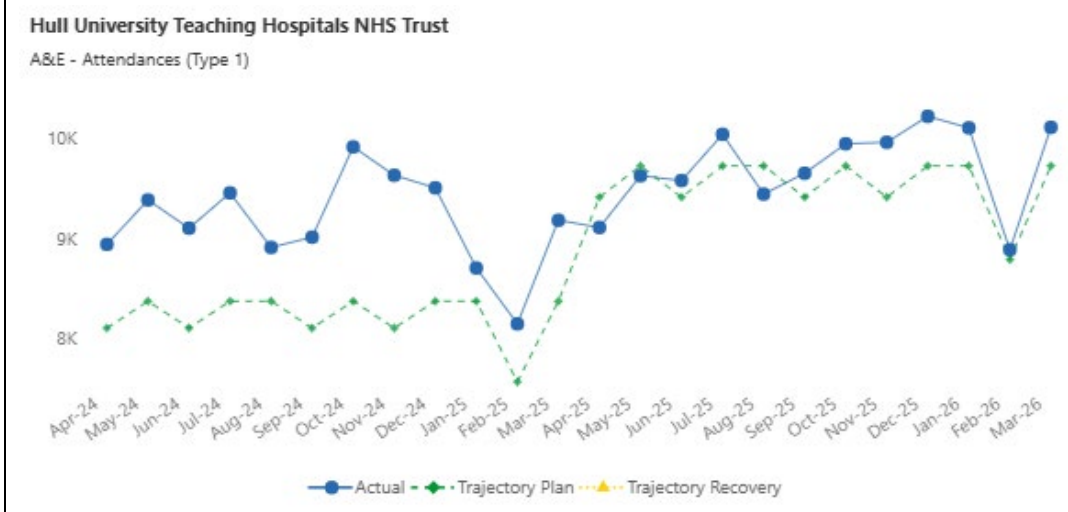


Actions

- Work taking place with system partners and Place to ensure pathways in place for community providers.
- Working with Yorkshire Ambulance Service on a Head Injury Pathway for Care Home patients.

31. A&E Attendances – Type 1 Attendances

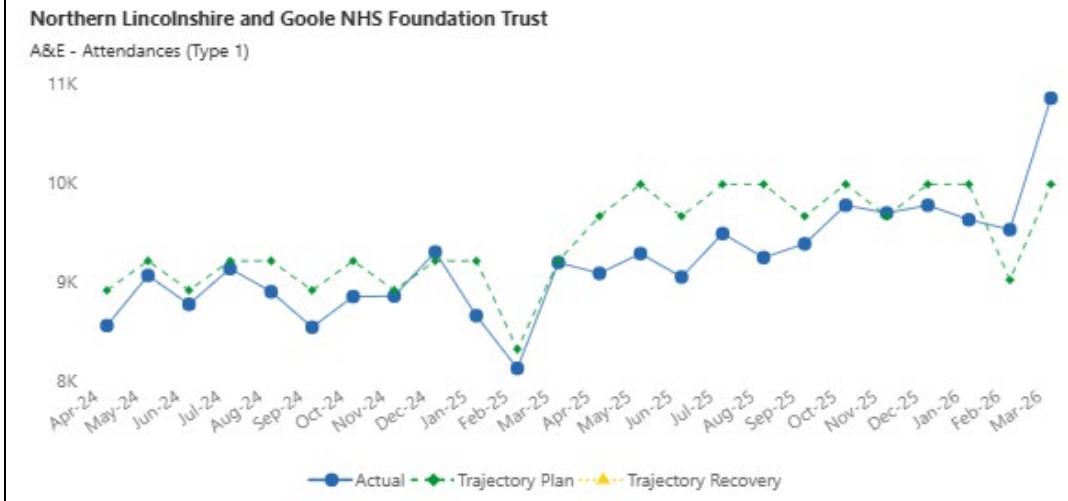
Compliance



Key Themes

- HUTH Type 1 attendances – March actuals were 10,114, above plan by 387.

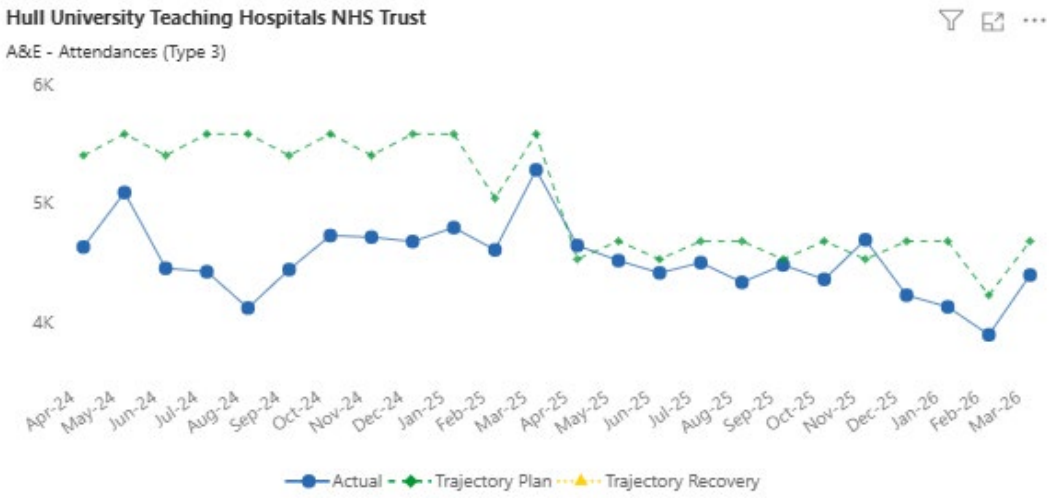
Compliance



- NLaG Type 1 attendances in March were 10,856 vs plan of 9,987 (869 above plan)

32. A&E Attendances – Type 3 Attendances

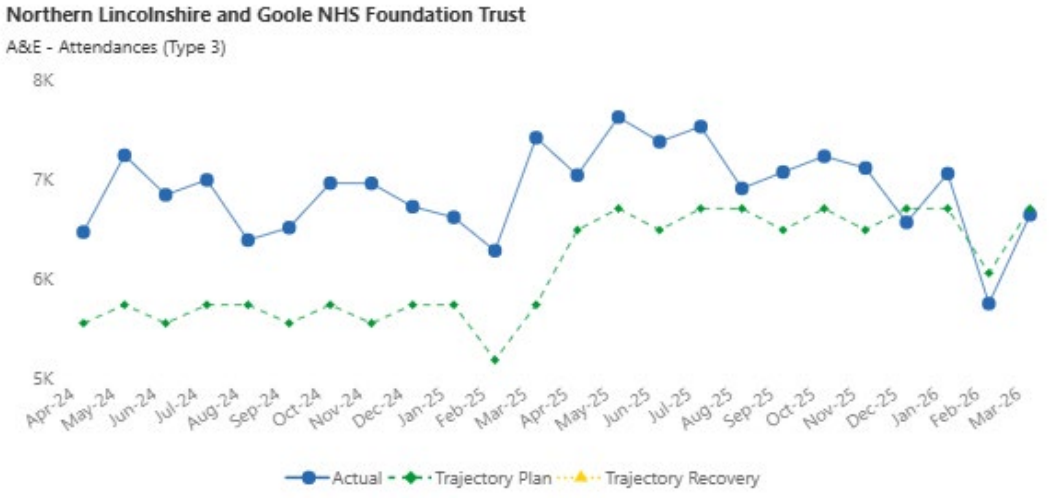
Compliance



Key Themes

- HUTH Type 3 attendances at HRI – 4,397 seen in March vs plan of 4,681 (284 below plan)

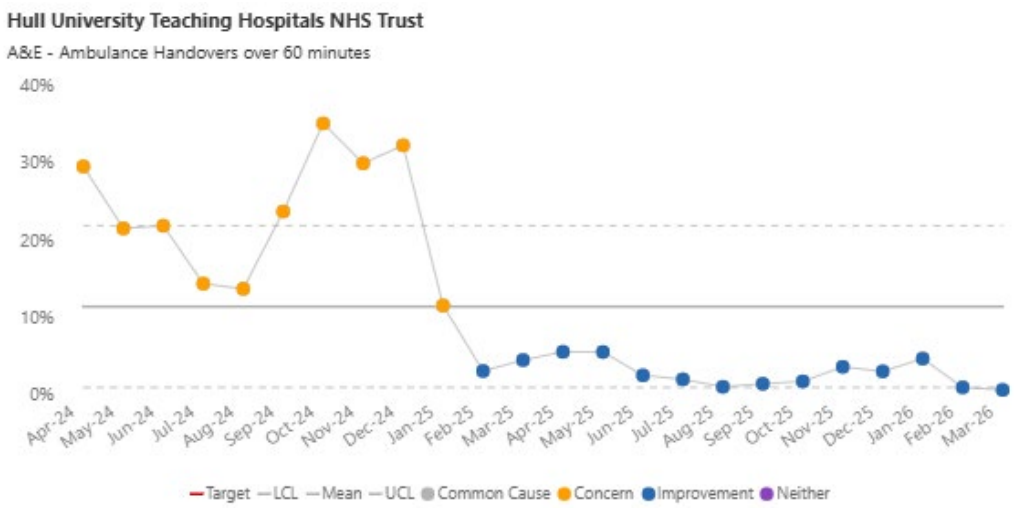
Compliance



- NLaG Type 3 attendances were 6,646 vs plan of 6,709 (63 below plan).

33. Ambulance Handovers >60 minutes - HUTH

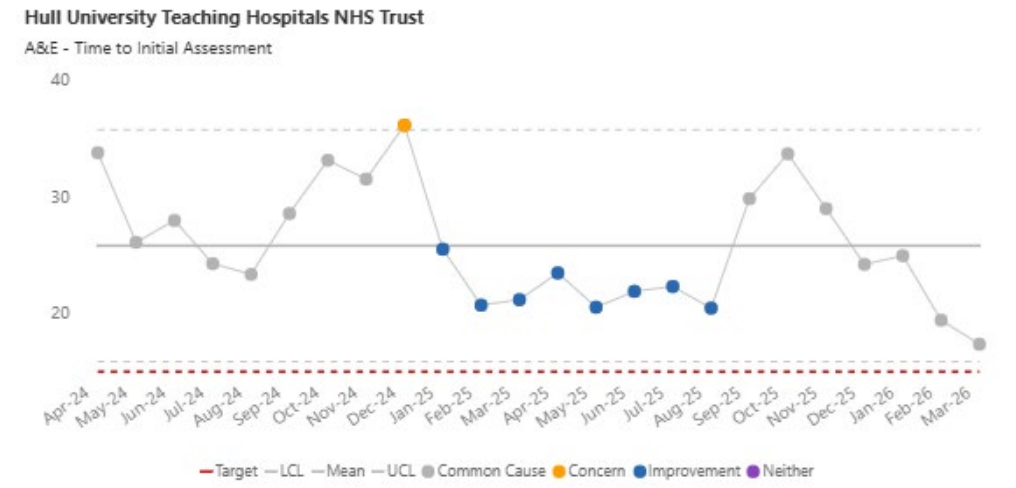
Compliance



Key Themes

- Significant sustained improvement on ambulance handover since the joint work with YAS in December 2024
- Average ambulance handover time in March 2026 was 19 minutes
- Total ambulance conveyances in March were 4,316
- Time to initial assessment 17 minutes

Critical Enabler

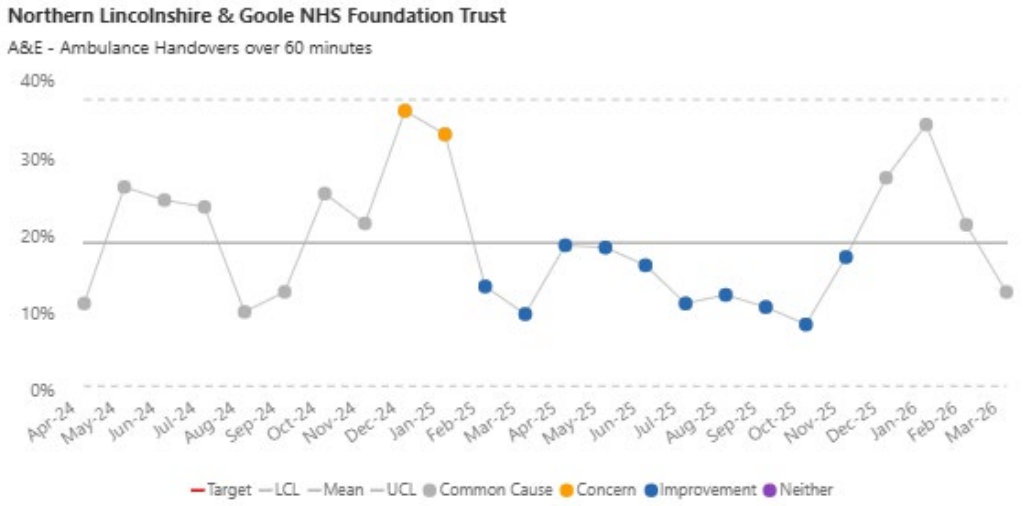


Actions

- Continue to review and monitor metrics to ensure improvement is sustained.
- Daily 2 hourly board round in ED to ensure all patients have a plan.
- Agree new pathways with YAS and EMAS for alternatives to ED. These pathways will be strengthened at HUTH when frailty capacity is increased.
- Continued audit of category 4 conveyances and alternate pathways, working with Place partners.

34. Ambulance Handovers >60 minutes - NLAG

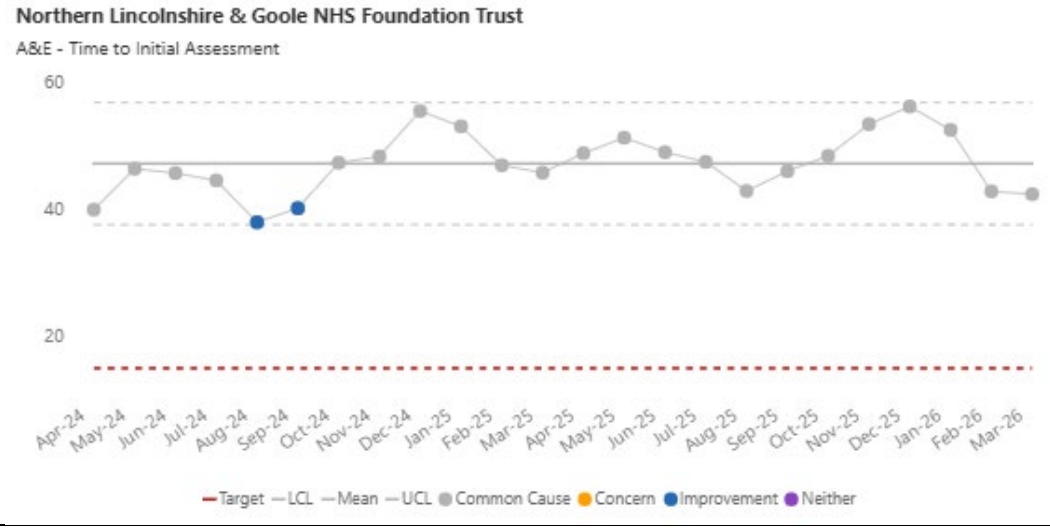
Compliance



Key Themes

- Performance in percentage of ambulance handovers >60 minutes had improved in March 2026 = 12.7%
- Time to initial assessment was 42 minutes against target of 15 minutes
- Average ambulance handover time in March was 32 minutes
- Total ambulance conveyances were 3,515.

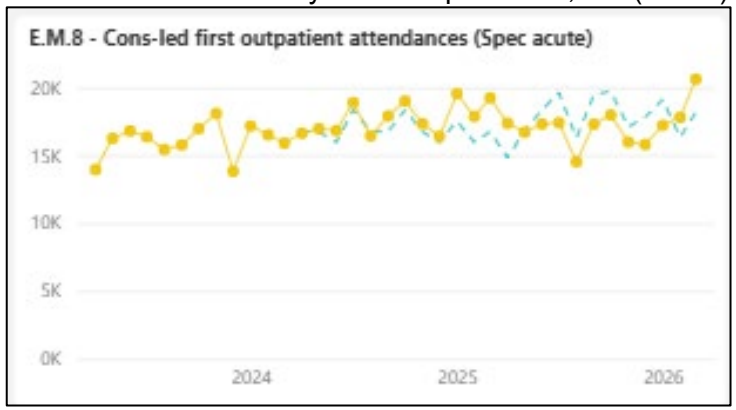
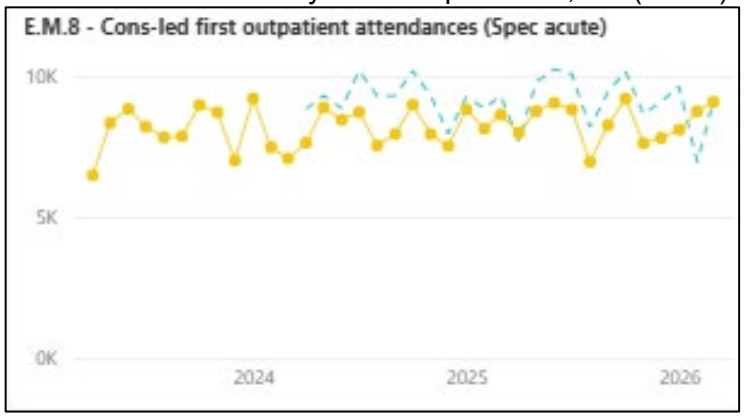
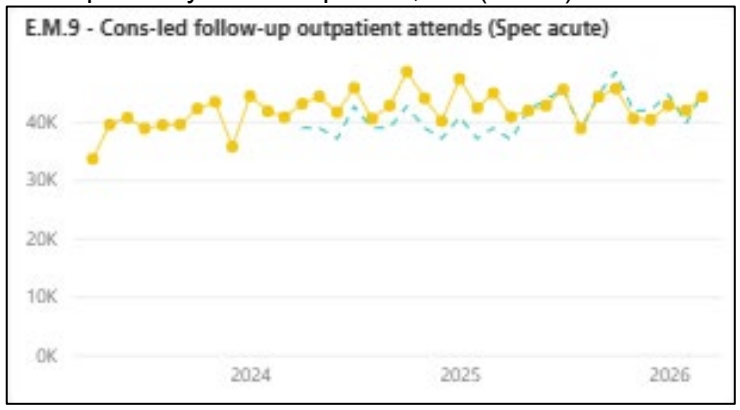
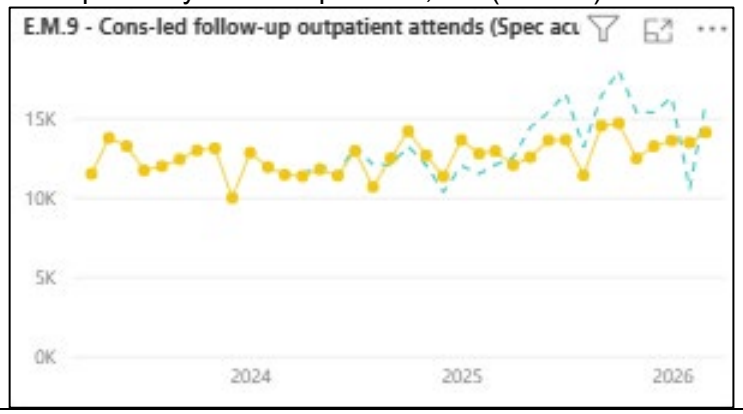
Critical Enabler



Actions

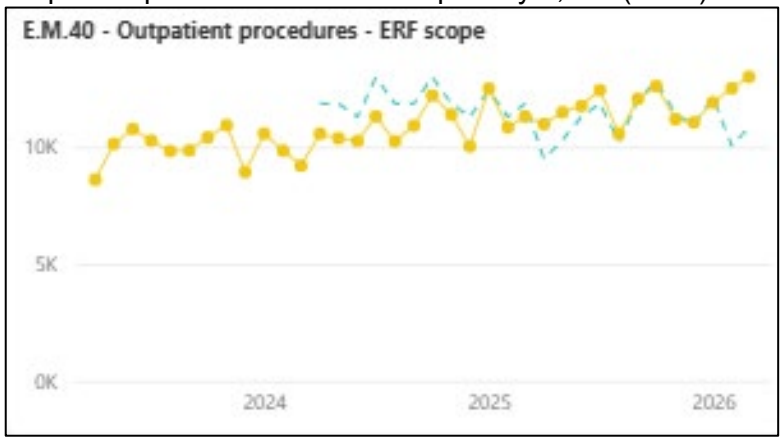
- Relaunched handover processes with ED and EMAS team commenced W/C 20/04/2026.
- Daily 2 hourly monitoring and escalation are in place to maintain ambulance performance.
- Discuss and agree new pathways with EMAS sharing lessons learnt from work undertaken with YAS.

35. Activity

HUTH (Month 12)	NLAG (Month 12)
New Outpatient Attendances vs Plan	**New Outpatient Attendances vs Plan**
YTD New consultant-led activity is below plan at -7,643 (-3.6%).	YTD New consultant-led activity is below plan at -8,634 (-7.9%).
	
Follow up Outpatient Attendances vs Plan	**Follow up Outpatient Attendances vs Plan**
YTD Follow up activity is below plan -3,628 (-0.7%)	YTD Follow up activity is below plan -20,706 (-11.5%).
	

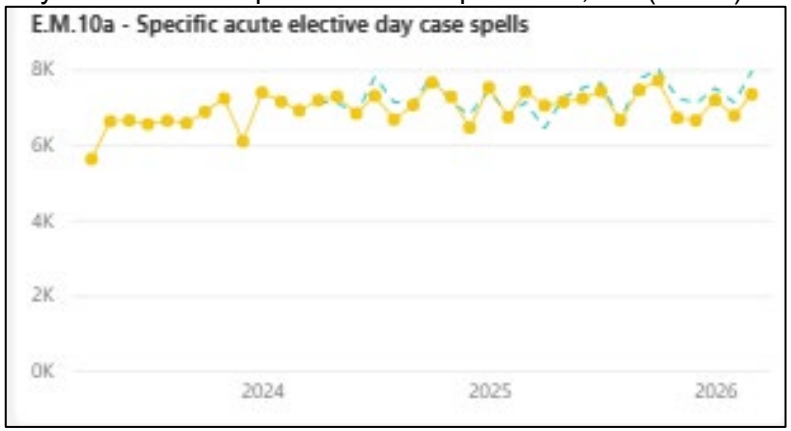
Outpatient Procedures vs Plan

YTD Outpatient procedures are above plan by 8,180 (6.1%).



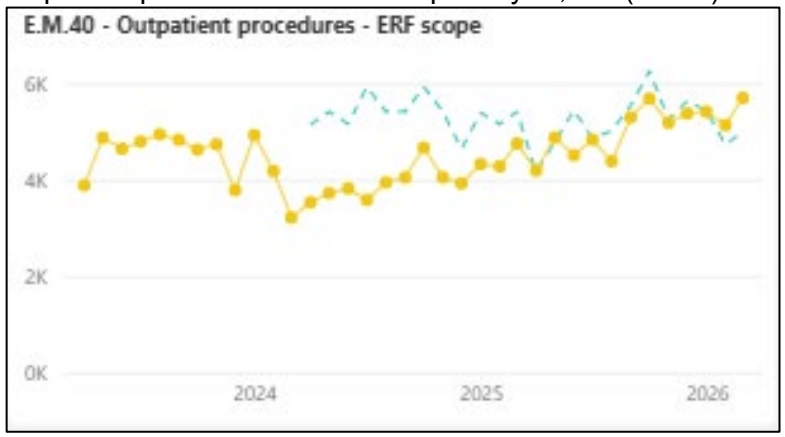
Day Case Admissions vs Plan

YTD Day case elective spells are below plan at -2,864 (-3.2%)



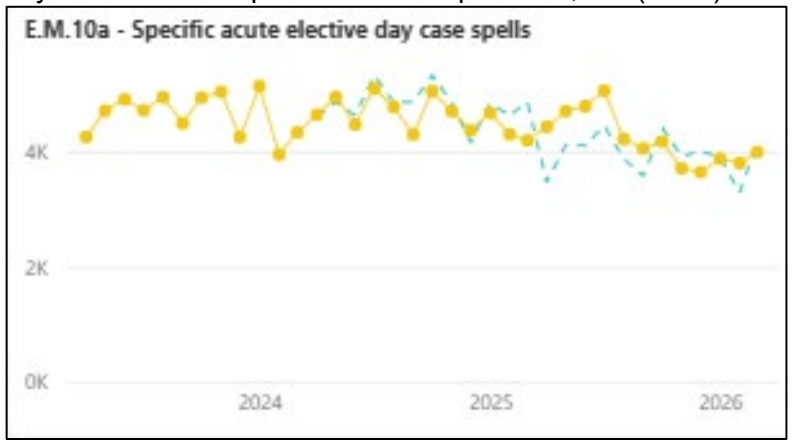
Outpatient Procedures vs Plan

YTD Outpatient procedures are below plan by -1,522 (-2.5%).



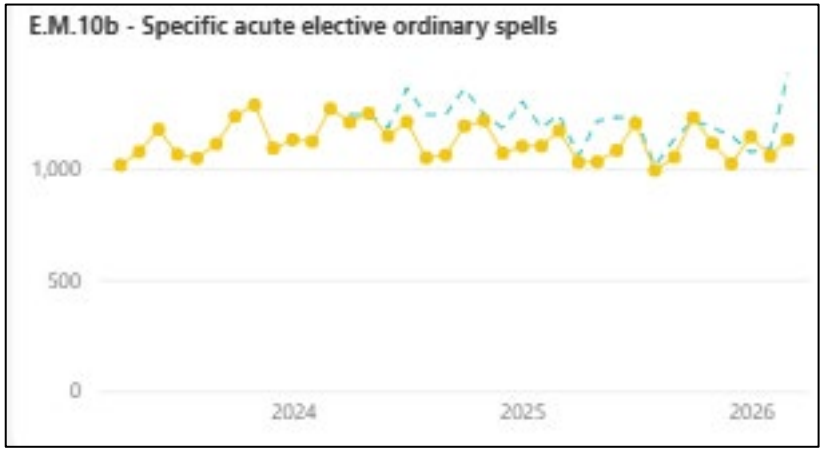
Day Case Admissions vs Plan

YTD Day case elective spells are above plan at 3,147 (6.7%)



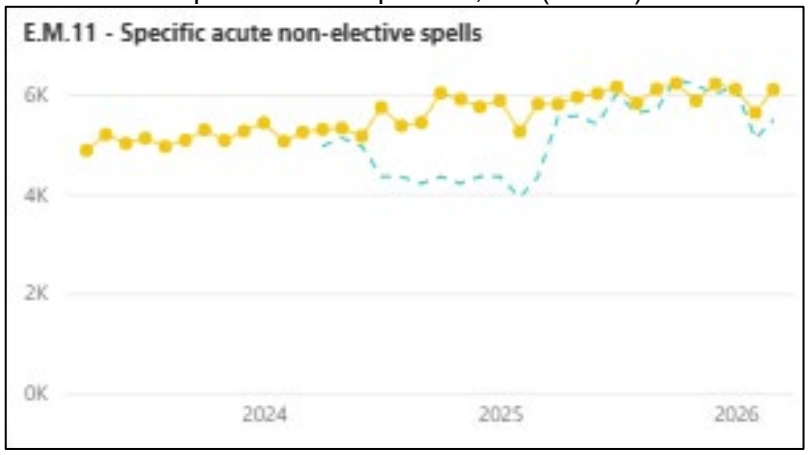
Elective Admissions vs Plan

YTD Inpatient spells are below plan at -932 (-6.6%)



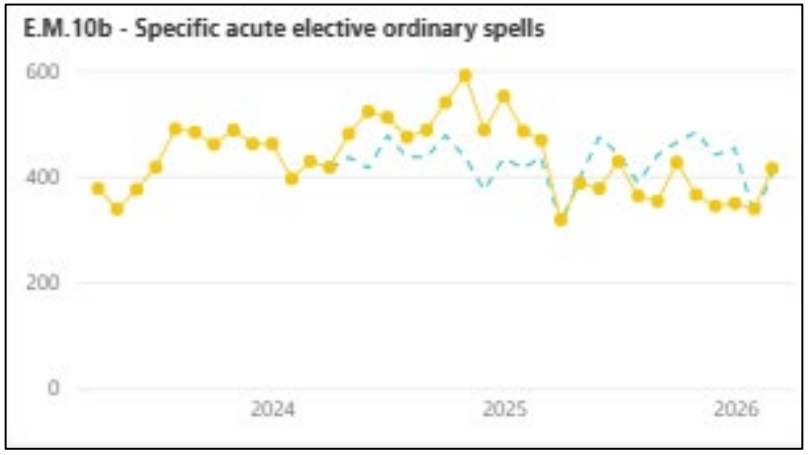
Non-Elective Admissions vs Plan

YTD non-elective spells are over plan +2,888 (+4.2%)



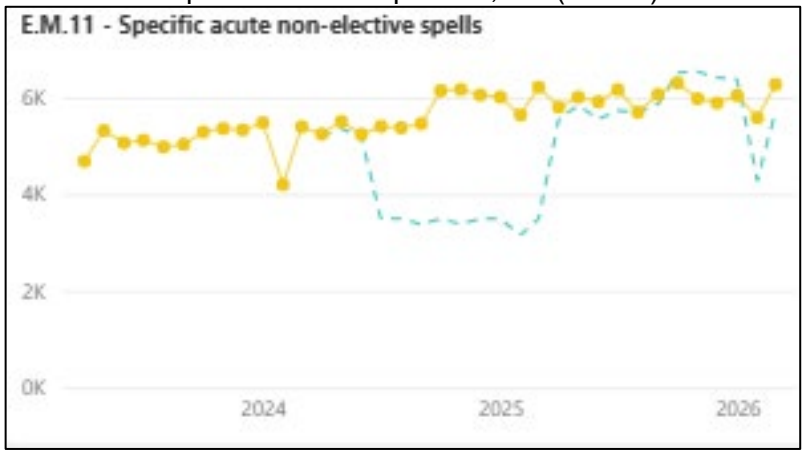
Elective Admissions vs Plan

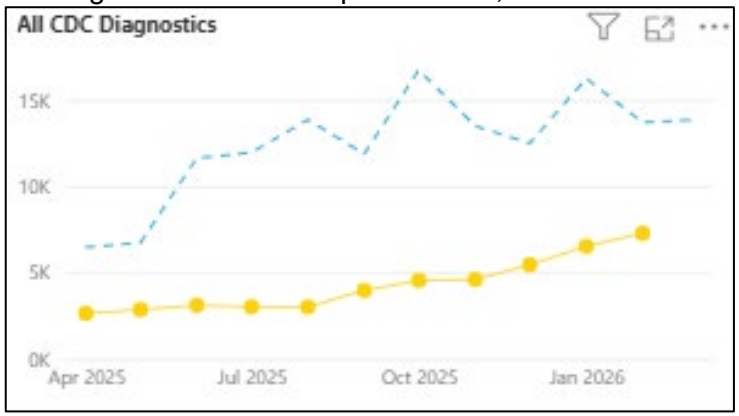
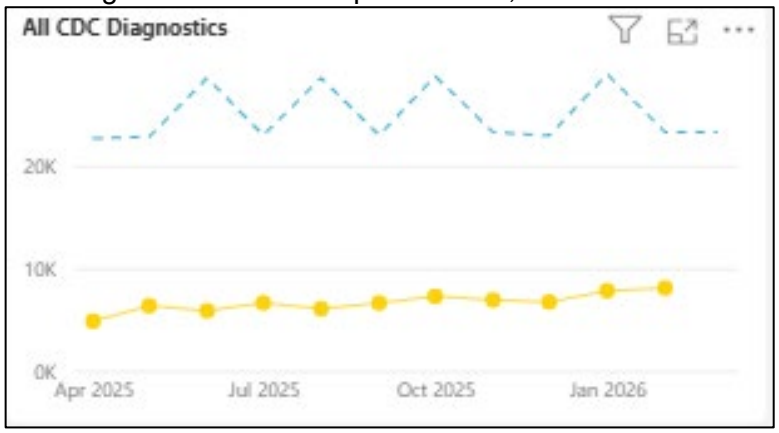
YTD Inpatient spells are below plan at -554 (-11.0%)



Non-Elective Admissions vs Plan

YTD non-elective spells are above plan +1,634 (+2.3%)



All CDC Diagnostics YTD CDC diagnostics are below plan at -102,098 	**All CDC Diagnostics** YTD CDC diagnostics are below plan at -226,147 

36. Financial Activity Summary - HUTH

HUTH 2025/26 Elective Recovery Activity M12

	Activity Plan	Activity Actual	Activity Variance	Price Plan (£)	Price Actual (£)	Price Variance (£)
Daycase	88,192	84,491	- 3,701	67,913,289	64,413,621	- 3,499,668
Elective	19,114	17,661	- 1,453	75,949,272	69,050,444	- 6,898,828
Outpatient New Attendance	200,277	198,474	- 1,803	40,442,651	39,722,481	- 720,171
Outpatient New Procedure	36,739	39,605	2,866	6,909,006	7,625,782	716,776
Outpatient Follow Up Procedure	115,091	122,383	7,292	12,549,334	13,130,478	581,144
	459,413	462,614	3,201	203,763,552	193,942,806	- 9,820,746

Data includes 2344 uncoded March spells priced at Average Tariff by Specialty

37. Financial Activity Summary - NLAG

NLAG 2025/26 Elective Recovery Activity M12

	Activity Plan	Activity Actual	Activity Variance	Price Plan (£)	Price Actual (£)	Price Variance (£)
Daycase	47,336	50,484	3,148	33,130,241	36,563,833	3,433,592
Elective	5,967	4,995	-972	23,179,901	21,097,515	-2,082,386
Outpatient New Attendance	77,632	76,718	-914	16,167,752	15,942,450	-225,302
Outpatient New Procedure	25,221	21,542	-3,679	5,160,489	4,217,946	-942,543
Outpatient Follow Up Procedure	40,876	49,351	8,475	5,451,194	8,657,247	3,206,053
	197,032	203,090	6,058	83,089,577	86,478,991	3,389,414

Data includes 1488 uncoded March spells priced at Average Tariff by Specialty

Some Intended Management fields had not been correctly filled in on NLAG Lorenzo, a DQ piece of work to backdate the completion is almost complete. This has meant a shift to Daycase for some spells that were previously classified as Elective. Prices remain the same.

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	30/04/2026
Director Lead	Jo Ledger, Interim Group Chief Nurse Dr Kate Wood, Group Chief Medical Officer Hilda Gwilliams, Group Chief Patient Safety 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 report since the last meeting, as we approach the latter part of April 2026. • 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, showing the majority of targets breached across the group. • Complaint response times are below the timescale response target. 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, with updated IPC data for this meeting.
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

Quality Performance Metrics

NHS
Humber Health
Partnership

March 2026

United By Compassion: Driving For Excellence

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 1.0231. This is lower than last month's value of 1.0183. • The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 100.1. • 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. • P. Aeruginosa rates are below trajectory for the end of the financial year. • There were no Never Events in March 2026 and there have been 8 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 1.0013. This is lower than last month's value of 1.0093. • There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 22 months, and at 88.4. 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 March 2026 with 6 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.
	• C.difficile rates, MRSA, E-coli, and Klebsiella bacteraemia are over the annual target.
	• 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.
		• C.difficile rates, MRSA, E-coli, Klebsiella and P Aeruginosa bacteraemia are over the annual target
		• The latest position at 14 hours from admission is below target.

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
Duty of Candour - Verbal apology	Sep-25	≥ 100.0%	60.4%		
Duty of Candour - Verbal apology within 10 working days	Sep-25	≥ 100.0%	54.1%		
Duty of Candour - Written apology	Sep-25	≥ 100.0%	100.0%		
Duty of Candour - Written apology within 10 working days	Sep-25	≥ 100.0%	100.0%		
Falls - Moderate and above (per 1,000 bed days)	Mar-26		0.11		
Falls - per 1,000 bed days	Mar-26		7.58		
Falls - Serious harm or death	Mar-26		3		
Falls - Serious harm or death (per 1,000 bed days)	Mar-26		0.08		
Falls - Total incidents	Mar-26		284		
Medication Incidents	Mar-26		115		
Medication Incidents - Moderate harm	Mar-26		1		
Medication Incidents - per 1,000 bed days	Mar-26		3.07		
Medication Incidents - Serious harm	Mar-26		0		
Patient Incidents	Mar-26		2,292		
Patient Safety Incidents - % Harmful	Mar-26		2.4%		
Patient Safety Incidents - Fatal	Mar-26		7		
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	Mar-26		462		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Mar-26		1.49		
Patient Safety Incidents - Moderate harm	Mar-26		44		
Patient Safety Incidents - No harm	Mar-26		1,774		
Patient Safety Incidents - Severe harm	Mar-26		5		
Pressure Ulcers - Category 1	Mar-26		12		
Pressure Ulcers - Category 2	Mar-26		49		
Pressure Ulcers - Category 3	Mar-26		1		
Pressure Ulcers - Category 4	Mar-26		0		
Pressure Ulcers - Device related	Mar-26		13		
Pressure Ulcers - Hospital acquired	Mar-26		129		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Mar-26		3.44		
Pressure Ulcers - Hospital acquired moderate and above (p...	Mar-26		0.37		
Pressure Ulcers - Suspected deep tissue injury	Mar-26		26		
Pressure Ulcers - Total community acquired	Sep-25		310		
Pressure Ulcers - Unstageable	Mar-26		13		
VTE Risk Assessment	Mar-26	≥ 95.0%	91.6%		
VTE Risk Assessment 14 Hour Standard	Feb-26	≥ 95.0%	90.7%		

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
Duty of Candour - Verbal apology	Mar-26	≥ 100.0%	87.0%		
Duty of Candour - Verbal apology within 10 working days	Mar-26	≥ 100.0%	78.3%		
Duty of Candour - Written apology	Mar-26	≥ 100.0%	78.3%		
Duty of Candour - Written apology within 10 working days	Mar-26	≥ 100.0%	60.9%		
Falls - Moderate and above (per 1,000 bed days)	Mar-26		0.00		
Falls - per 1,000 bed days	Mar-26		5.25		
Falls - Serious harm or death	Mar-26		0		
Falls - Serious harm or death (per 1,000 bed days)	Mar-26		0.00		
Falls - Total incidents	Mar-26		108		
Medication Incidents	Mar-26		76		
Medication Incidents - Moderate harm	Mar-26		0		
Medication Incidents - per 1,000 bed days	Mar-26		3.70		
Medication Incidents - Serious harm	Mar-26		0		
Patient Incidents	Mar-26		1,512		
Patient Safety Incidents - % Harmful	Mar-26		3.2%		
Patient Safety Incidents - Fatal	Mar-26		0		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Mar-26		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Mar-26		0		
Patient Safety Incidents - Low harm	Mar-26		479		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Mar-26		2.33		
Patient Safety Incidents - Moderate harm	Mar-26		48		
Patient Safety Incidents - No harm	Mar-26		985		
Patient Safety Incidents - Severe harm	Mar-26		0		
Pressure Ulcers - Category 1	Mar-26		15		
Pressure Ulcers - Category 2	Mar-26		111		
Pressure Ulcers - Category 3	Mar-26		6		
Pressure Ulcers - Category 4	Mar-26		2		
Pressure Ulcers - Device related	Mar-26		10		
Pressure Ulcers - Hospital acquired	Mar-26		231		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Mar-26		11.23		
Pressure Ulcers - Hospital acquired moderate and above (p...	Mar-26		1.56		
Pressure Ulcers - Suspected deep tissue injury	Mar-26		48		
Pressure Ulcers - Total community acquired	Mar-26		0		
Pressure Ulcers - Unstageable	Mar-26		22		
VTE Risk Assessment	Mar-26	≥ 95.0%	95.7%		
VTE Risk Assessment 14 Hour Standard	Feb-26	≥ 95.0%	93.2%		

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)	Mar-26		2.9%		
Mortality - HSMR	Dec-25	≤ 100.0	100.1		
Mortality - SHMI	Oct-25	≤ 1.0	1.018		
Mortality - Still Births (per 1,000 births)	Mar-26		7.874		

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)	Mar-26		1.9%		
Mortality - HSMR	Dec-25	≤ 100.0	88.4		
Mortality - SHMI	Oct-25	≤ 1.0	1.009		
Mortality - Still Births (per 1,000 births)	Mar-26		6.536		

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	Mar-26	≥ 85.0%	28.6%		
Complaints - 60 day compliance	Mar-26	≥ 85.0%	50.0%		
Complaints - Average response time	Mar-26	≤ 40	70		
Complaints - Received	Mar-26		26		
Complaints - Received (per 1,000 bed days)	Mar-26		0.69		
Complaints - Reopened	Mar-26		0		
Friends & Family - A&E Score	Feb-26	≥ 85.0%	70.8%		
Friends & Family - Antenatal Score	Feb-26	≥ 95.0%	81.8%		
Friends & Family - Birth Score	Feb-26	≥ 95.0%	100.0%		
Friends & Family - Inpatient Score	Feb-26	≥ 95.0%	97.1%		
Friends & Family - Outpatient Score	Feb-26	≥ 95.0%	97.1%		
Friends & Family - Postnatal Score	Feb-26	≥ 95.0%	66.7%		
PALS - Complaints	Mar-26	≤ 1	140		
PALS - Complaints compliance within 5 working days	Mar-26		41.1%		
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	Mar-26	≥ 85.0%	56.4%		
Complaints - 60 day compliance	Mar-26	≥ 85.0%	71.8%		
Complaints - Average response time	Mar-26	≤ 40	41		
Complaints - Received	Mar-26		43		
Complaints - Received (per 1,000 bed days)	Mar-26		2.09		
Complaints - Reopened	Mar-26		2		
Friends & Family - A&E Score	Feb-26	≥ 85.0%	76.8%		
Friends & Family - Antenatal Score	Feb-26	≥ 95.0%	96.3%		
Friends & Family - Birth Score	Feb-26	≥ 95.0%	100.0%		
Friends & Family - Community Score	Feb-26	≥ 95.0%	97.2%		
Friends & Family - Inpatient Score	Feb-26	≥ 95.0%	98.2%		
Friends & Family - Outpatient Score	Feb-26	≥ 95.0%	96.9%		
Friends & Family - Postnatal Community Score	Feb-26	≥ 95.0%	100.0%		
Friends & Family - Postnatal Score	Feb-26	≥ 95.0%	0.0%		
PALS - Complaints	Mar-26	≤ 1	233		
PALS - Complaints compliance within 5 working days	Mar-26		64.8%		

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	Mar-26		8.2		
CQC Safe Inspection Score	Mar-26		1.0		
Infections - C.Difficile	Feb-26		9		
Infections - C.Difficile (Cumulative)	Feb-26		97		
Infections - C.Difficile (per 1,000 bed days)	Feb-26		0.31		
Infections - E.Coli	Feb-26		16		
Infections - E.Coli (Cumulative)	Feb-26		200		
Infections - E.Coli (per 1,000 bed days)	Feb-26		0.56		
Infections - Klebsiella	Feb-26		3		
Infections - Klebsiella (Cumulative)	Feb-26		67		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Feb-26		0.10		
Infections - MRSA	Feb-26		0		
Infections - MRSA (Cumulative)	Feb-26		4		
Infections - MRSA (per 1,000 bed days)	Feb-26		0.00		
Infections - MSSA	Feb-26		11		
Infections - MSSA (Cumulative)	Feb-26		85		
Infections - MSSA (per 1,000 bed days)	Feb-26		0.38		
Infections - Pseudomonas aeruginosa	Feb-26		1		
Infections - Pseudomonas aeruginosa (Cumulative)	Feb-26		27		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Feb-26		0.03		

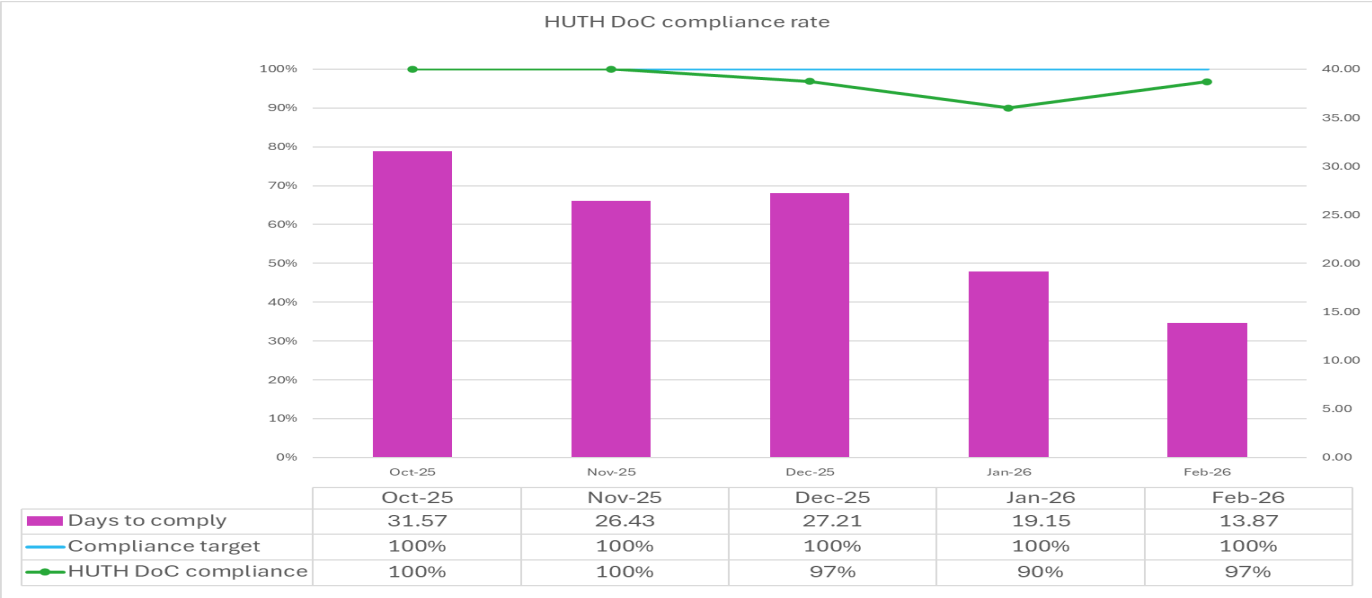
Northern Lincolnshire and Goole NHS Foundation Trust

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	Mar-26		8.1		
CQC Safe Inspection Score	Mar-26		2.0		
Infections - C.Difficile	Feb-26		3		
Infections - C.Difficile (Cumulative)	Feb-26		42		
Infections - C.Difficile (per 1,000 bed days)	Feb-26		0.16		
Infections - E.Coli	Feb-26		26		
Infections - E.Coli (Cumulative)	Feb-26		251		
Infections - E.Coli (per 1,000 bed days)	Feb-26		1.35		
Infections - Klebsiella	Feb-26		13		
Infections - Klebsiella (Cumulative)	Feb-26		113		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Feb-26		0.67		
Infections - MRSA	Feb-26		1		
Infections - MRSA (Cumulative)	Feb-26		5		
Infections - MRSA (per 1,000 bed days)	Feb-26		0.05		
Infections - MSSA	Feb-26		3		
Infections - MSSA (Cumulative)	Feb-26		73		
Infections - MSSA (per 1,000 bed days)	Feb-26		0.16		
Infections - Pseudomonas aeruginosa	Feb-26		2		
Infections - Pseudomonas aeruginosa (Cumulative)	Feb-26		33		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Feb-26		0.10		

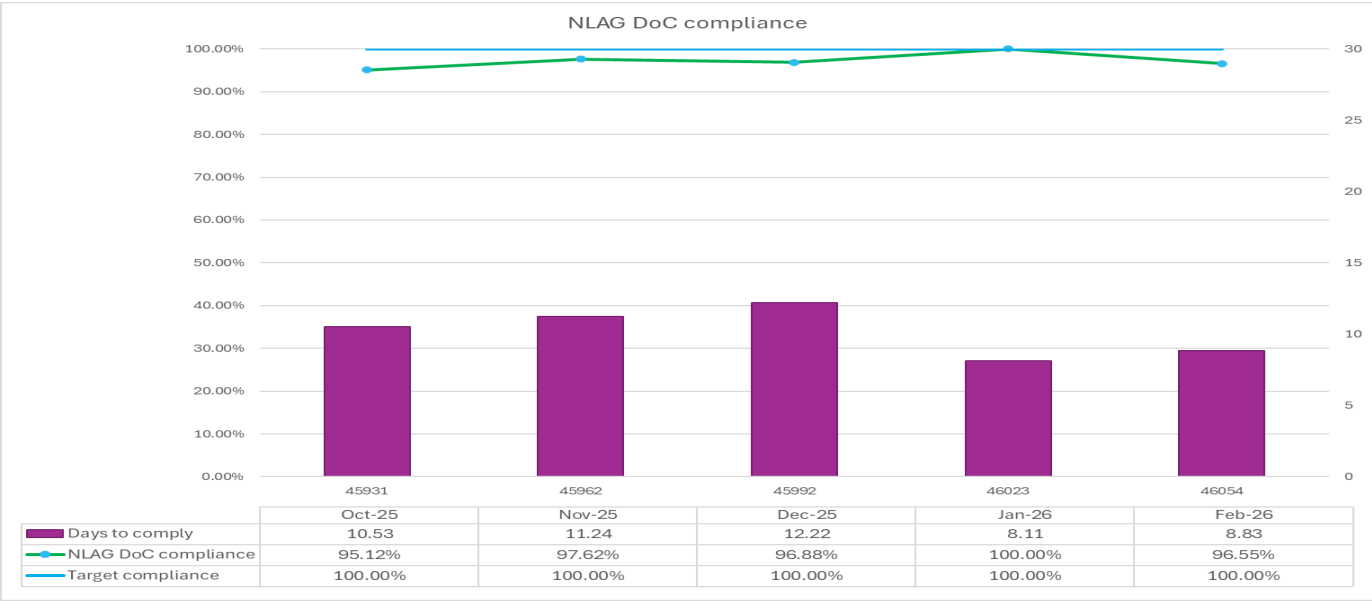
Duty of Candour

HUTH



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Days to comply	31.57	26.43	27.21	19.15	13.87
Compliance target	100%	100%	100%	100%	100%
HUTH DoC compliance	100%	100%	97%	90%	97%

NLAG



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Days to comply	10.53	11.24	12.22	8.11	8.83
NLAG DoC compliance	95.12%	97.62%	96.88%	100.00%	96.55%
Target compliance	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 >90% compliance across each month shown. March reported data is not included as has not all yet reached the 10 days target time.
- The target of 100% is shown, with additional data on the average number of days to comply with written DoC. This shows a reducing number, evidencing some improvement in timeliness from January onwards.

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 Safety and Governance Officer:
    - Commitment to clear historical backlog cases in March
    - Commitment to focus on 10 working day target for newly reported incidents
    - Commitment to clear all recent backlogs so that there is compliance to the target by the end of April 2026.
    - Sharing of good practice.
- Further training for teams that require support.to prompt act

NLAG

- The chart illustrates >95% compliance for written DoC across the months shown.
- There is a slight reduction in the average number of days taken to comply with written DoC since January 2026, which is now just below 10 days, with opportunity for further improvements.

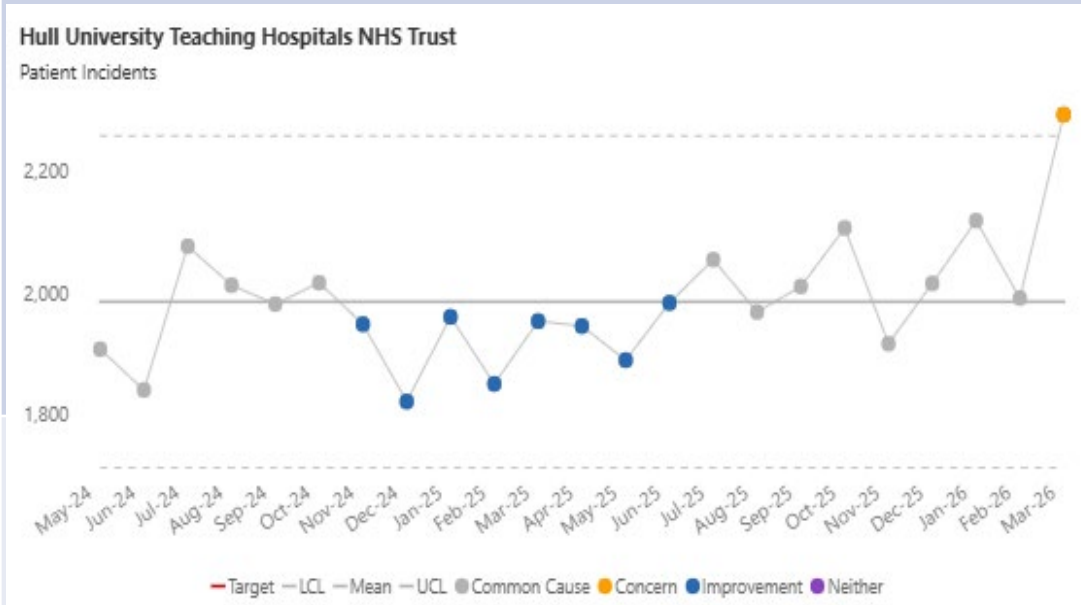
Never Events

HUTH	• There have been 8 Never Events in HUTH in the rolling 12 months up to the end of March 2026, with the last identified in February 2026 relating to a procedure in 2023 where a guidewire was retained.
NLAG	• There have been 6 Never Events in NLAG in the rolling 12 months up to the end of March 2026, with the last case identified in December 2025.

	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
	  • Feedback to staff
	  • TACC training sessions
	  • Simulation training

Patient Safety Incident (PSI) reporting

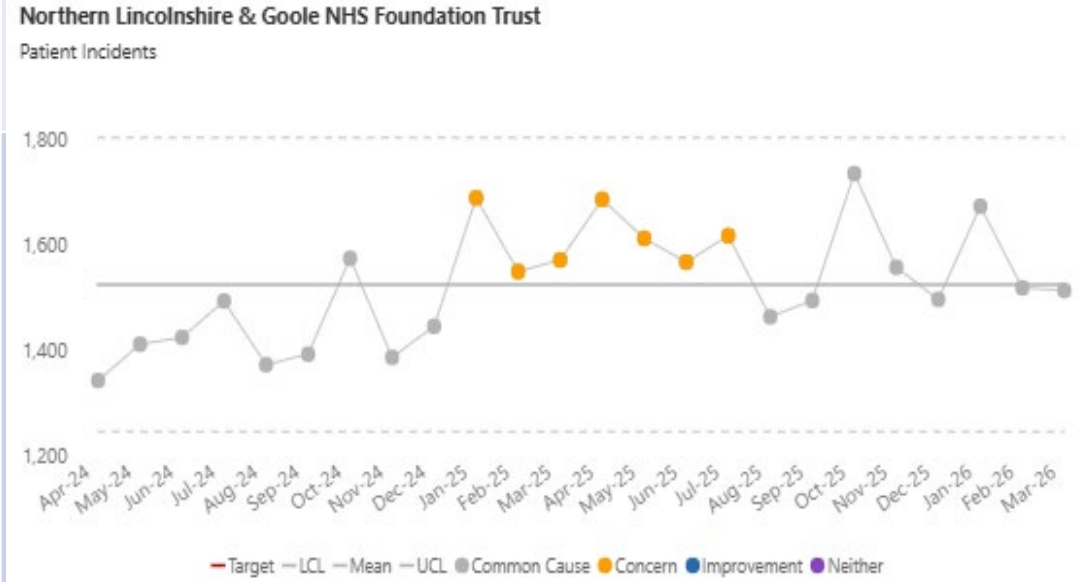
HUTH



Key themes

- There is a moderate increase in reporting for March. 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

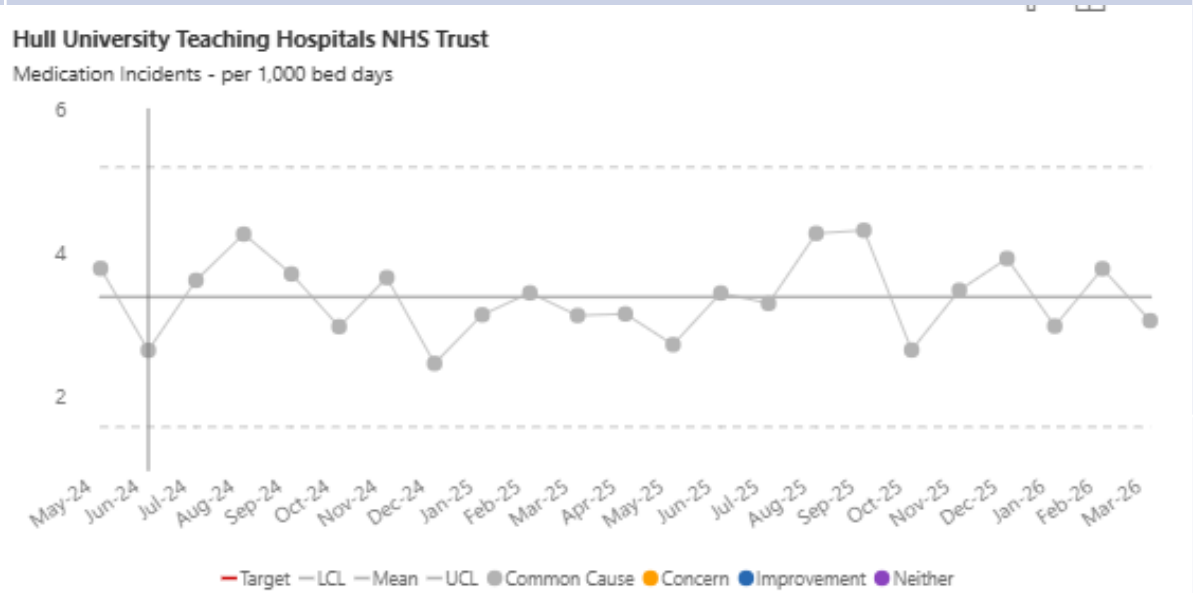
- Normal variation seen in this chart for the recent period.
- NLAG has Quartile 4 rates of Patient Safety Incident rates of reporting, with proportionally lower harm levels than the national data from LFPSE.
- Proportional rates of reporting harm show higher no harm and low harm reporting than the national 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

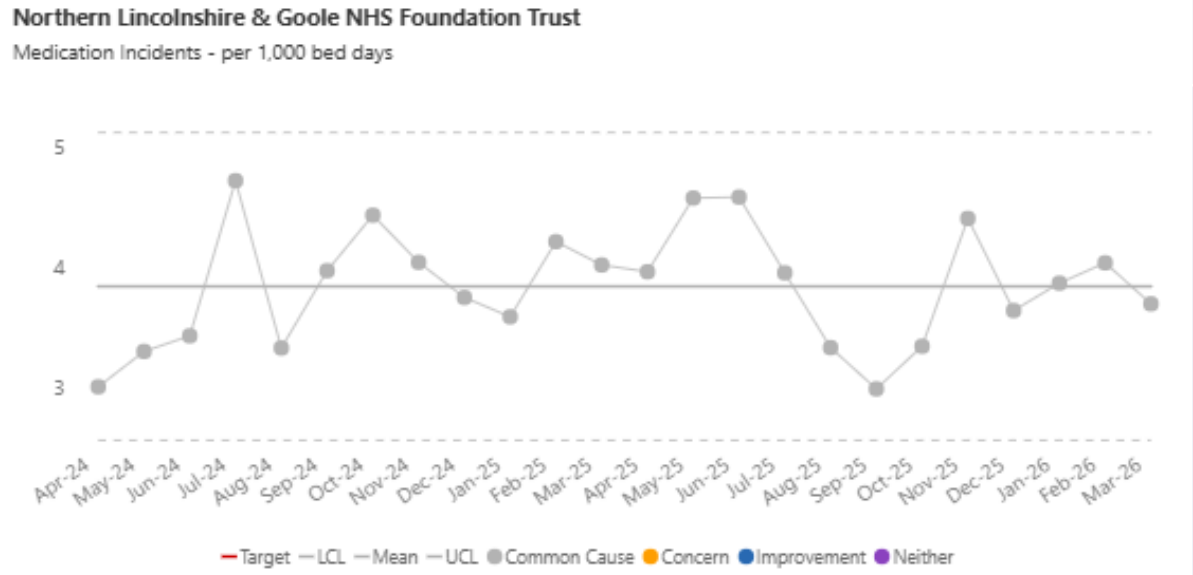
HUTH



Key themes

- Normal 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

- Normal 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 and sub-group, Operational Medicines Group, review of incidents and learning points. The Safer Medication Group reports to the Patient Safety Learning Group and Annual reporting to the Quality and Safety Committees-in-Common.

Improvement activities:

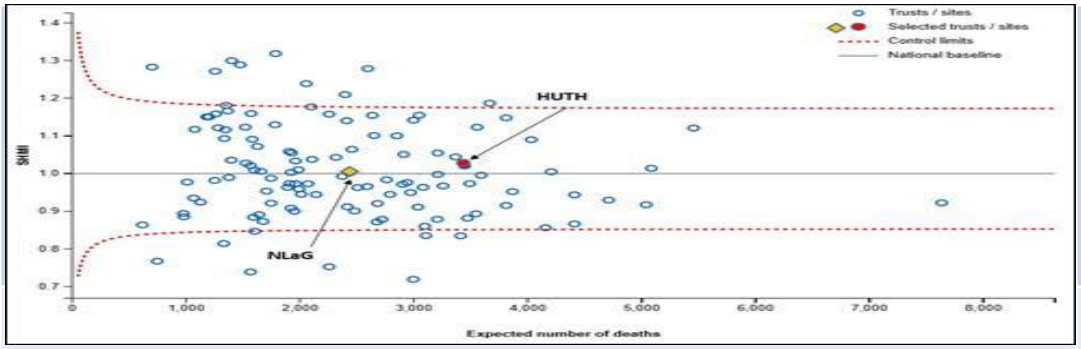
- Quality Priority workstreams on:
  - IV/Oral switch of antibiotics
  - Insulin Safety
  - Weight related doses.
  - Time Critical Medicines
- Safe practice with Insulin Syringe use communication issued in March 2026 linked to previous Never Event and review of initial control measures.

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 is 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. These steps should lead to compliance with the remaining two actions.
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. • NatPSA/2025/008/NHSPS - Risk associated with adult breathing circuits lacking a patent exhalation route. Due on 12 June 2026. **Completed Alerts:** • NatPSA/2026/003/DHSC – Shortage of Dinoprostone 3mg vaginal tablets and 1mg/2.5ml, 2mg/2.5ml vaginal gel. Due on 20 April 2026
NLAG	**Overdue:** • None to report.

Mortality - SHMI

Benchmark

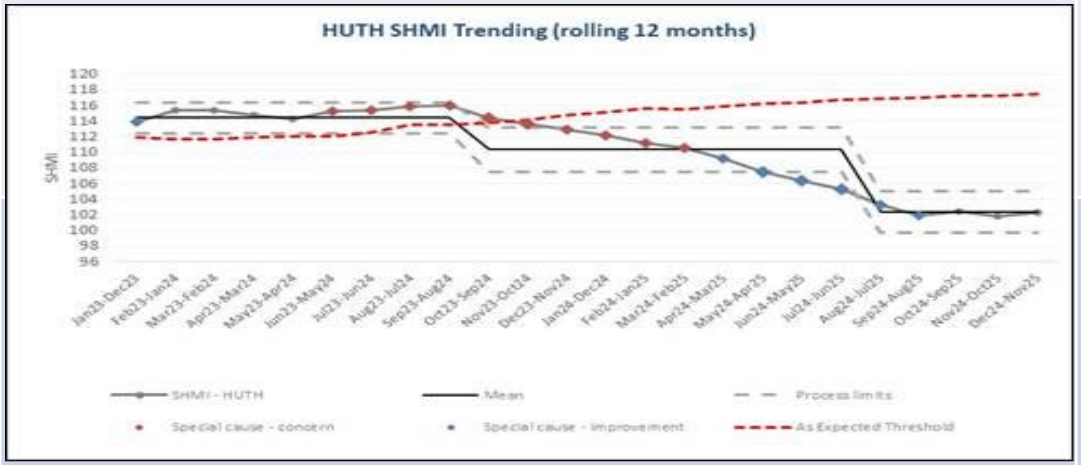


SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings..

The latest SHMI values for each site are:

- Castle Hill – 0.9722; 'as expected' (previously 0.9782 and 'as expected')
- Hull – 1.0452; 'as expected' (previously 1.0365 and 'as expected')
- Grimsby – 0.9480; 'as expected' (previously 0.9601 and 'as expected')
- Scunthorpe – 1.0621; 'as expected' (previously 1.0671 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 1.0231. This is lower than last month's value of 1.0183.

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 1.0013. This is lower than last month's value of 1.0093.

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

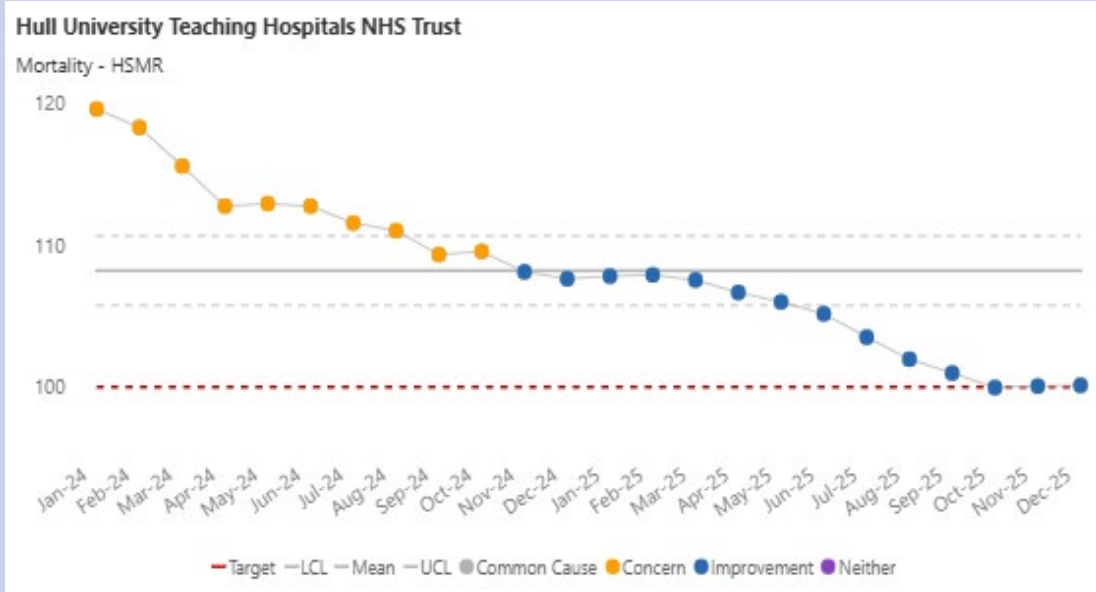
- Mortality Improvement Group (MIG) meets monthly and has a workplan to report on workstreams investigating and reviewing areas for improvement identified through analysis, to investigate causes of concern in the data and triangulated qualitative and quantitative sources.
- Care Groups report their mortality 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.

Mortality - HSMR

HUTH

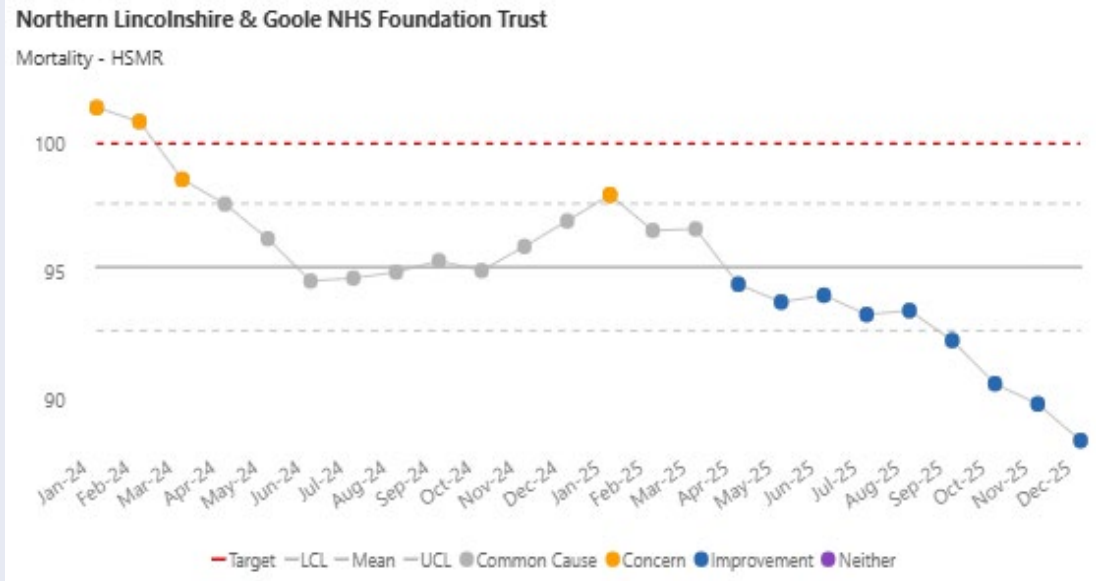


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 100.1.

NLAG



Key themes

There has been a statistically significant improvement with successive reduction in the HSMR over several months, now remains under 100 for 22 months, and at 88.4. This figure is the lowest level on record.

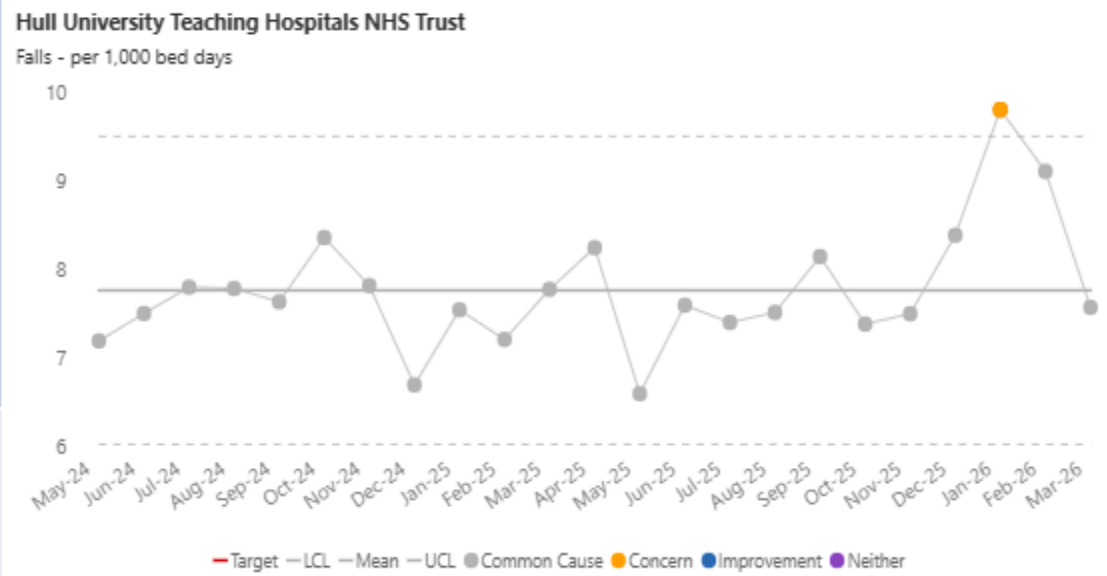
Actions are included in the same way for the SHMI description, and HSMR is used as part of the analysis of the mortality data, recognising a different methodology and risk adjustment is applied.

Controls, Oversight and Assurance

The same process are in place for MIG as set out in the SHMI section of this report.

Falls

HUTH

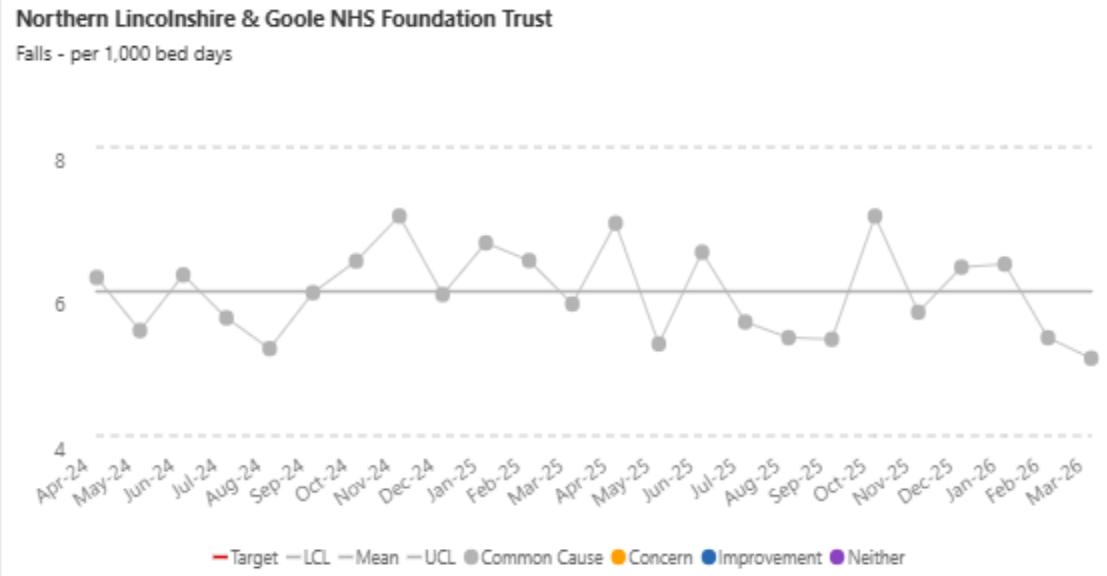


Key themes

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

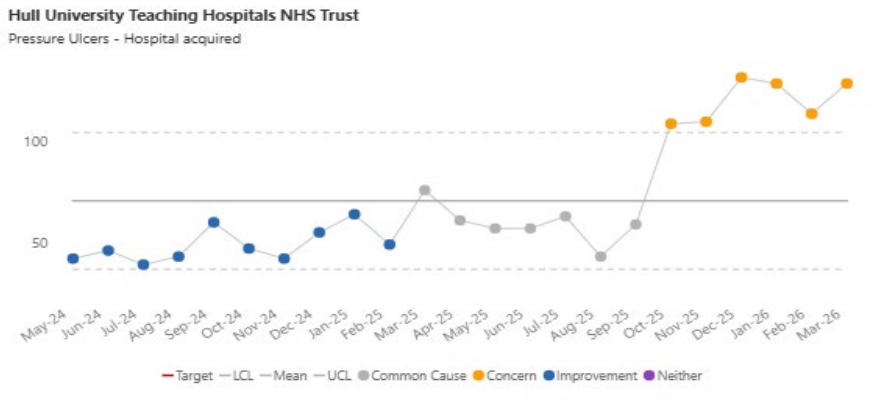
- Falls are reported as part of the daily safety huddle, flagging repeated fall patients, and significant injuries.
- Falls team review all repeated fall cases and potentially significant injuries
- All significant injuries following a fall are reviewed with a Swarm Huddle which is then reported to weekly 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

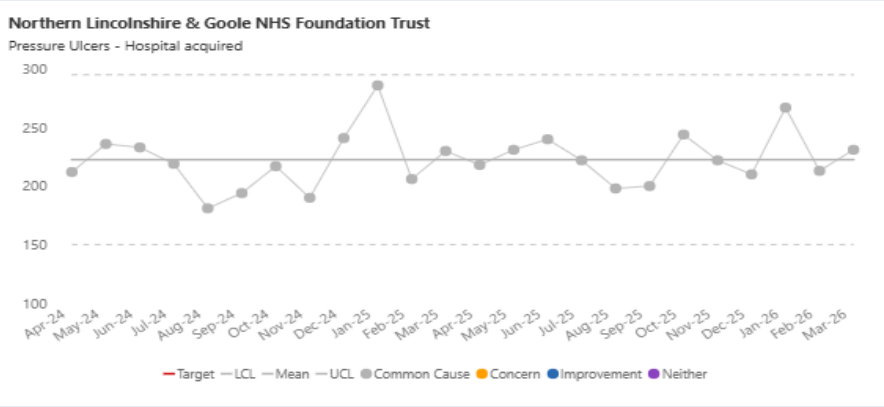
HUTH



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 NLAG BI report data is provided for Community which includes Category 2, 3 and 4 pressure ulcers and unstageable. Cat 1 cases are not included in the community bar chart.
- The Hospital Acquired data has been produced from incident data, excluding community locations.
- There is no per 1000 bed days data available for NLAG at this time as merges community and hospital data.
- BI updates are being worked through with Information team.

Controls, Oversight and Assurance

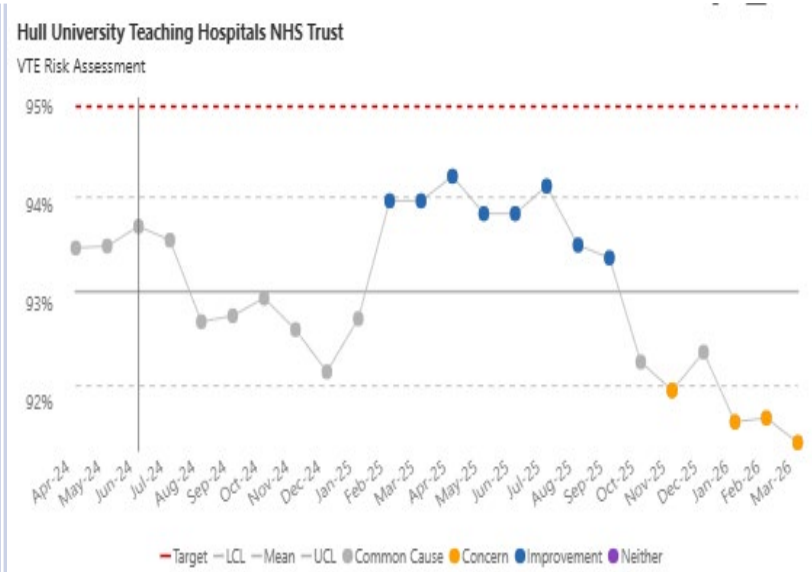
- Groupwide Pressure Ulcer Group has been established
- Weekly Pressure Ulcer Incident review process.

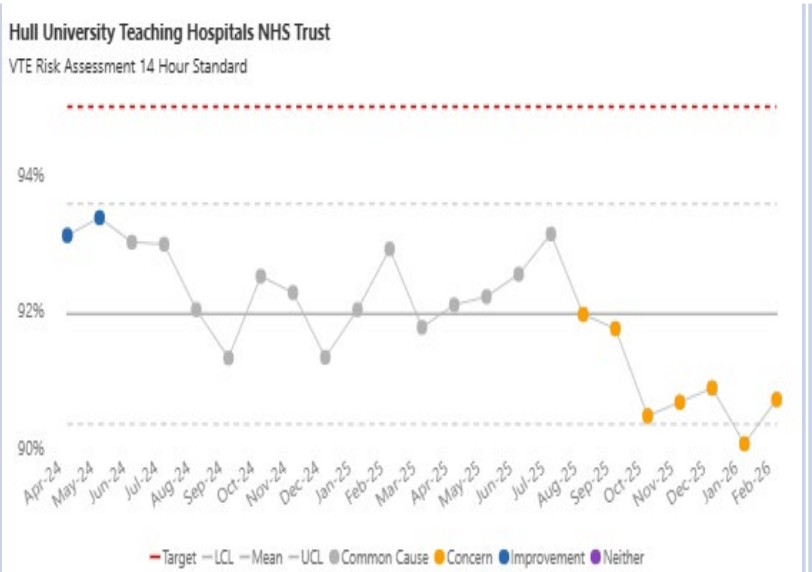
Actions being taken to improve across the Group:

- Group Chief Safety and Governance Officer, and Chief Nurse team have met with Nurse Directors to review the approach taken, with an improvement plan in place.
- Contributes to the metrics for measurement of patient deconditioning.

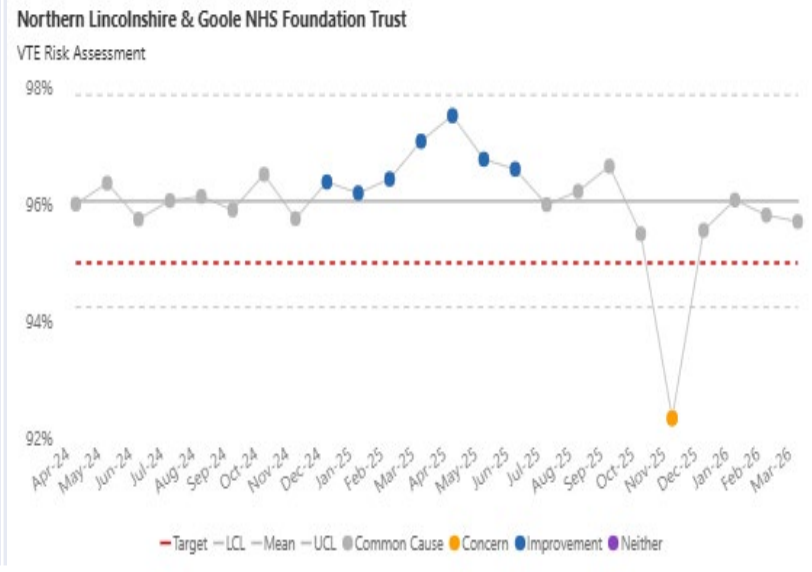
VTE Risk assessment rate

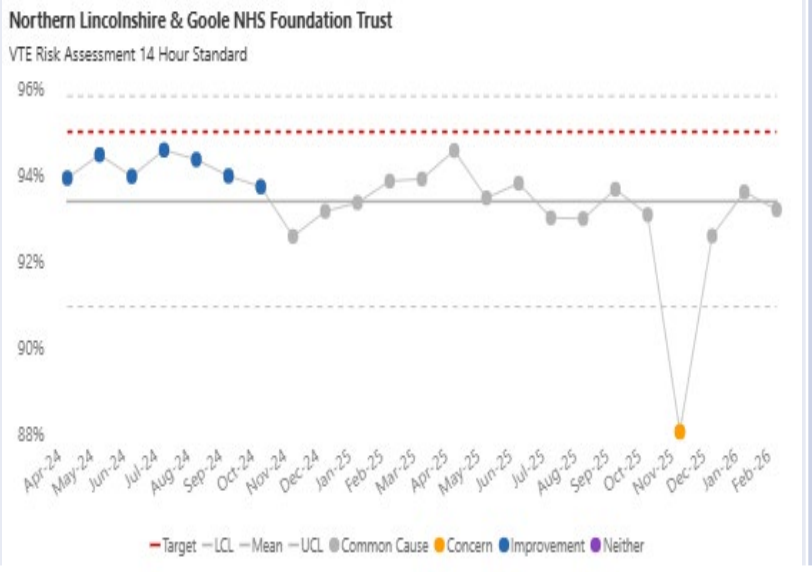
HUTH





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

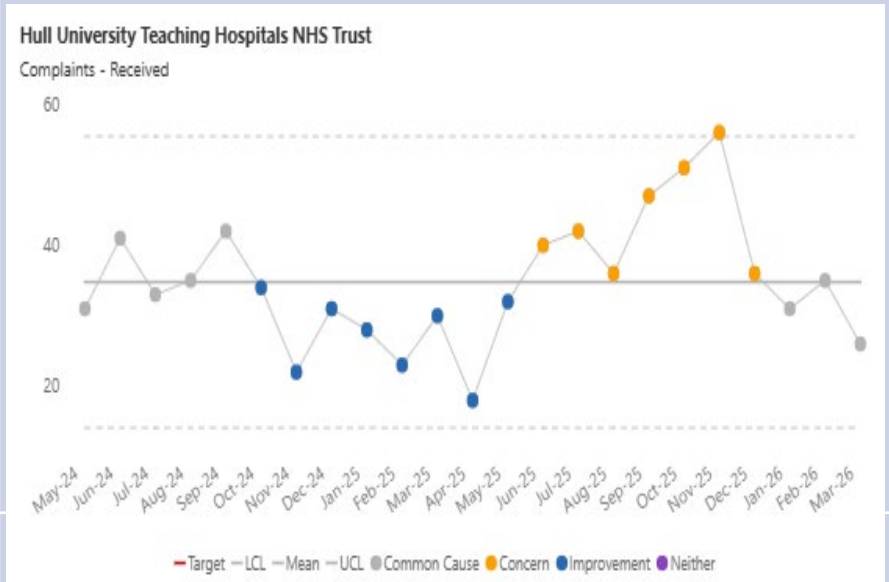
Rates of VTE harm are reviewed to determine if associated with risk assessment on admission with no evidence of harm being identified. On discharge and restarting treatment following surgery, there are some examples of harm identified through WLRP.

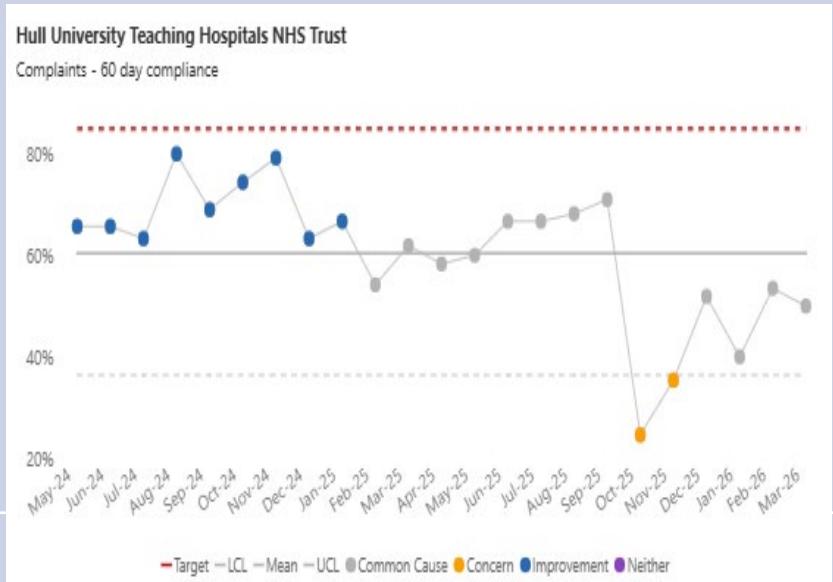
Actions being taken to improve:

- 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.

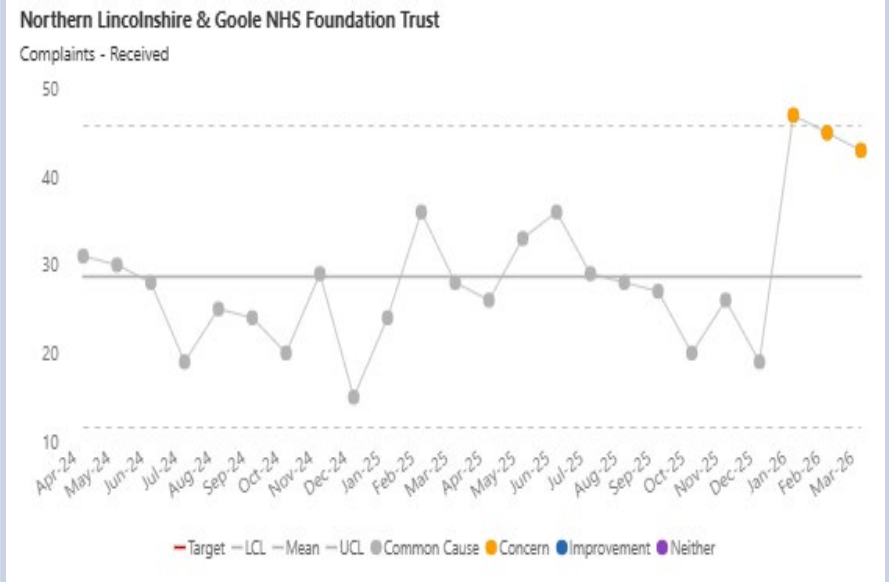
Patient Experience: Complaints – received and compliance with KPIs

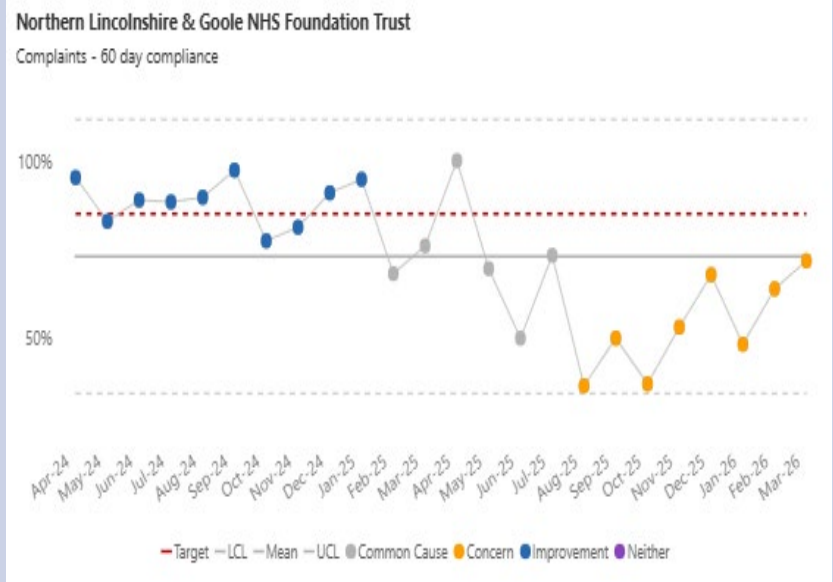
HUTH





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

Actions to improve:

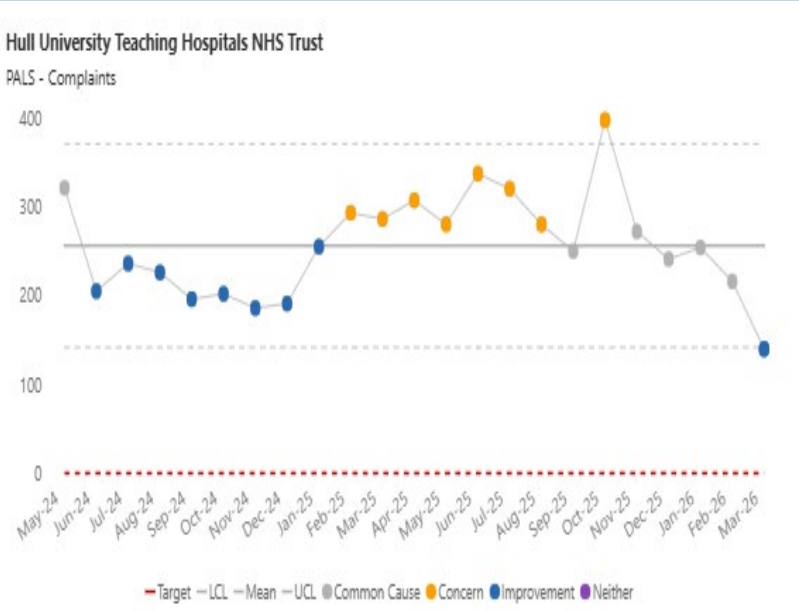
- A dedicated action plan focus being undertaken on
  - Patient Experience a user of service,
  - Operational process Complaints/ Pals
  - HR/Staffing
  - IT/Telephony
- Central team NLAG investigation and response model being introduced
- Reporting of Care Group performance
- Weekly meetings with Care 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

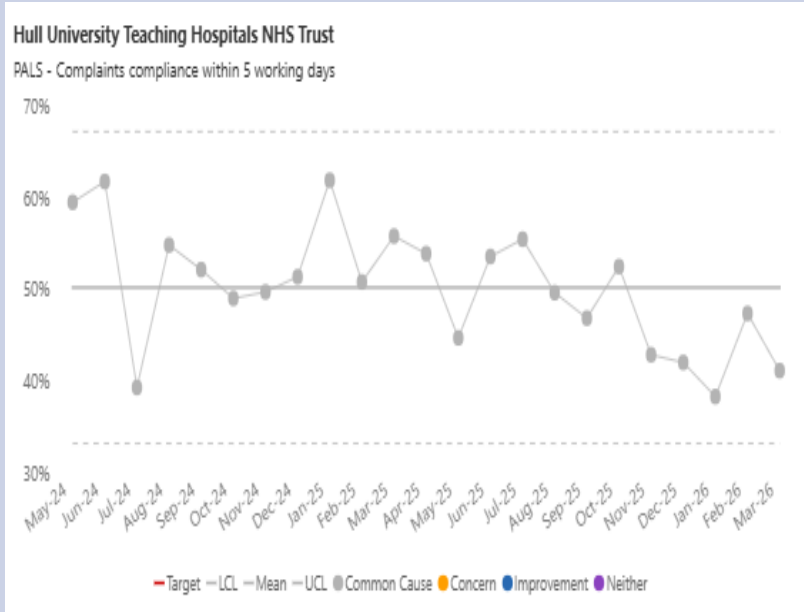
Key themes

- The rate of complaints has started to show a decrease during Q4 2026.
- Ongoing work, with processes is taking place to achieve 60-day KPI to support.
- Working with PALs is ongoing to prevent PALs escalation to complaints

PALS – received and response times

HUTH

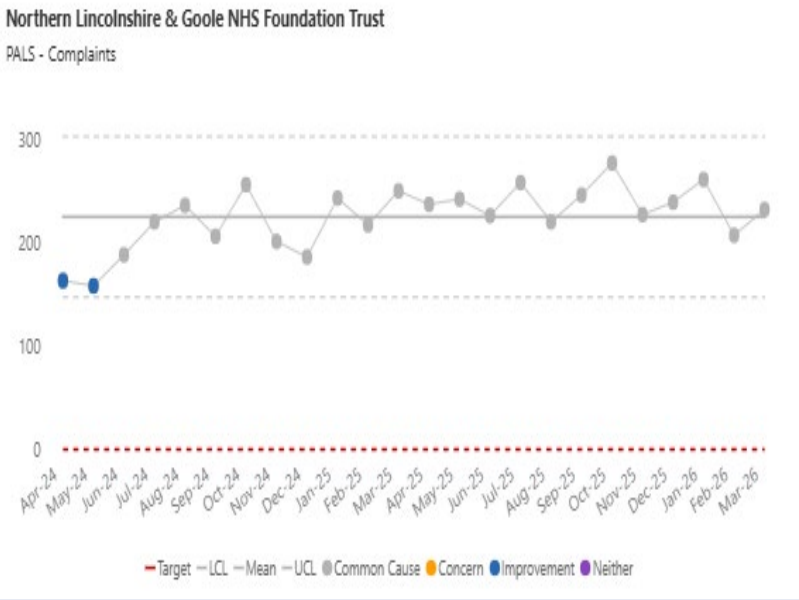


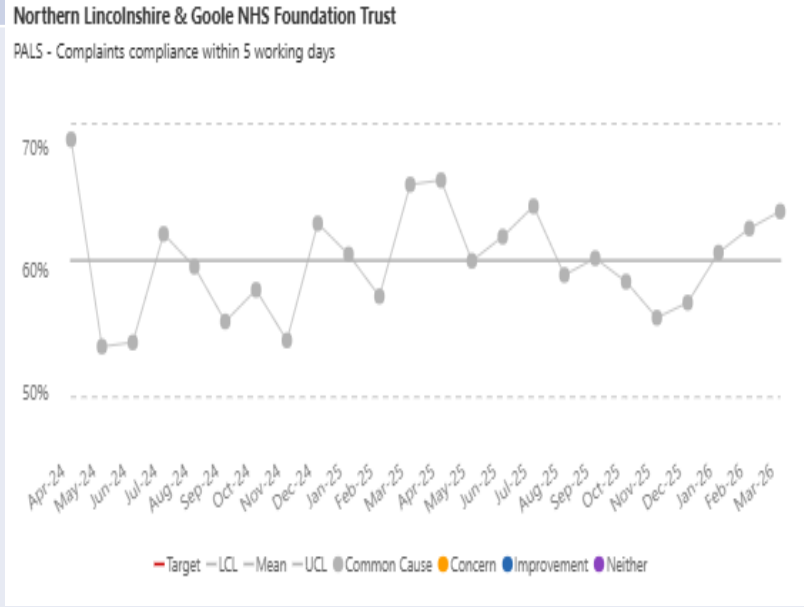


Key themes

- PALS received for HUTH is starting to decrease, this has remained relatively static returned to normal variation. NLAG PALs have remined consistent
- 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%. NLAG have returned to achieving 60%

NLAG



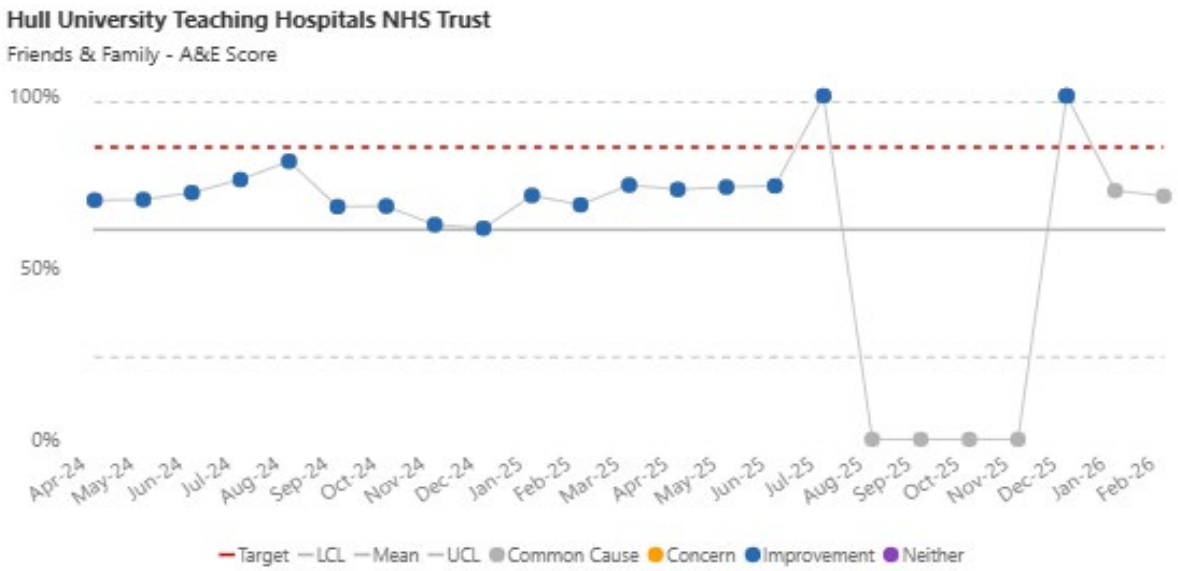


Key themes

- There are challenges in achieving the 5day response KPI, due to a number of factors,
  - Delay in IT / Telephony work expected date was 8/2025
  - Recruitment into posts and agreement via recruitment Panel
  - Aligning processes for PALs

Patient Experience – Friends and Family Test A&E

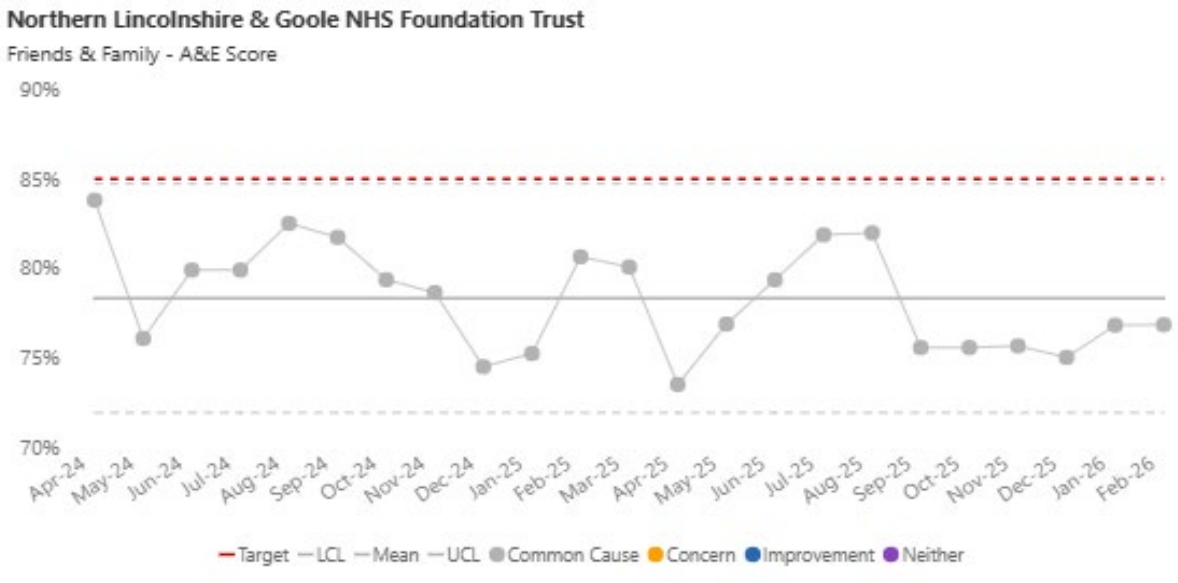
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- Business continuity plans have been confirmed to now be in place.
- 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. An electronic solution is being implemented.

NLAG



Key themes

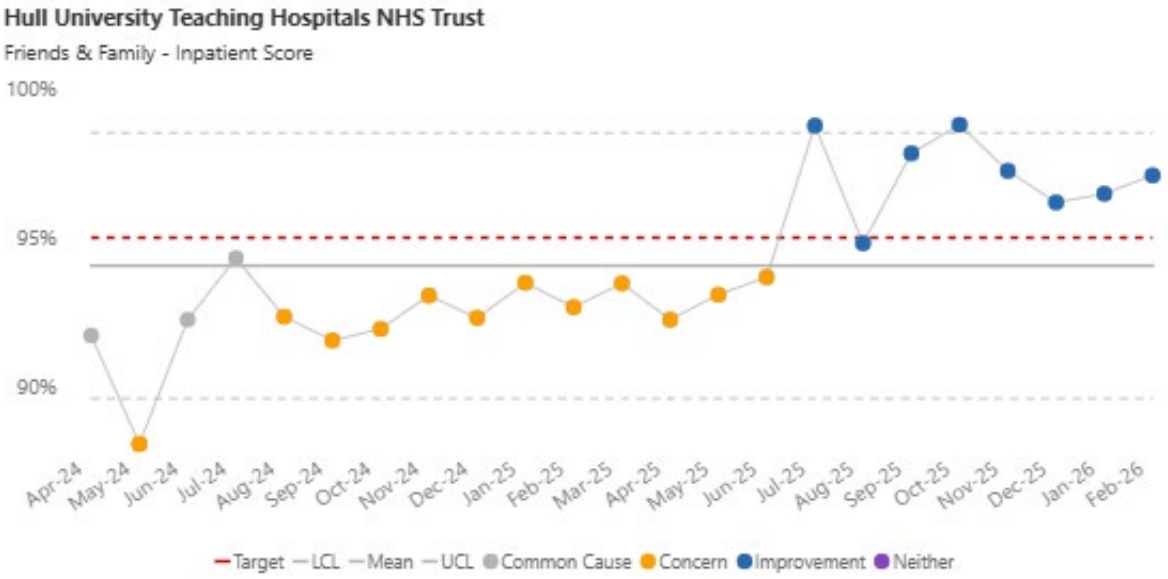
- Normal variation patterns observed for the recent period.
- Remains below the target.

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



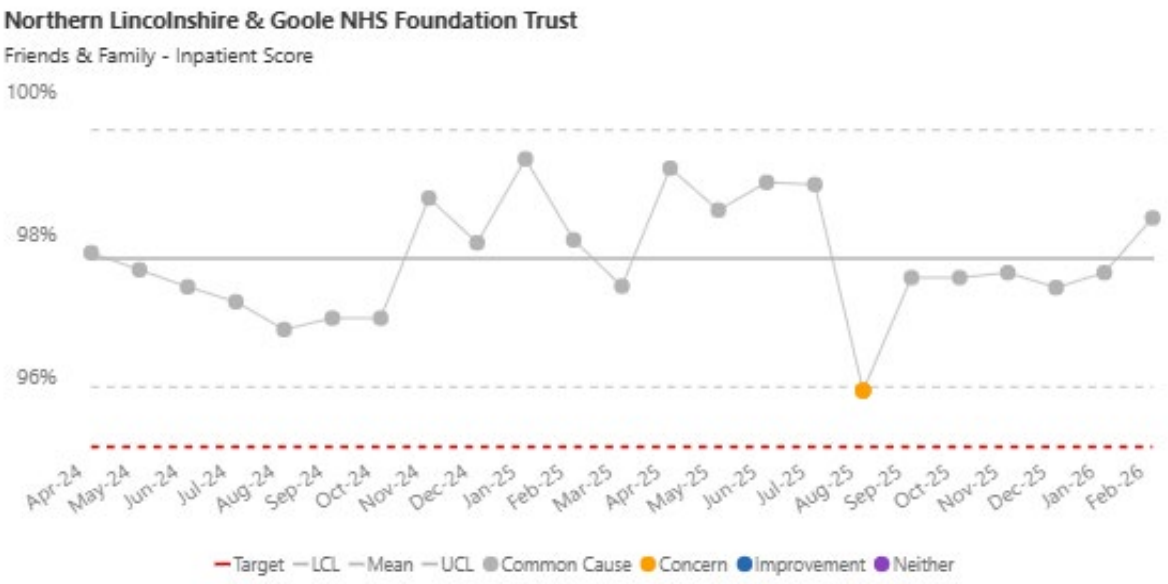
Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.
- A smaller number of forms were being undertaken, with a higher score, which is not directly comparable to the previous data.

Actions to improve:

- Negative responses are disseminated to care groups for learning which is a key focus of improvement across the themes of staff attitude, communication and environment.
- Care Group performance monitoring.

NLAG

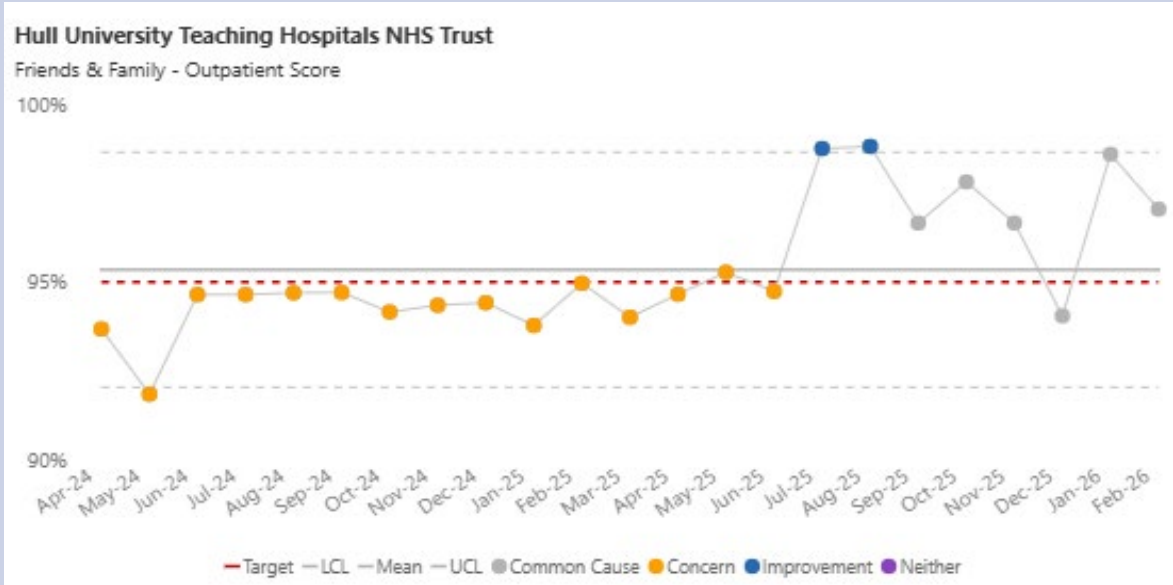


Key themes

- Consistency in achievement of the 95% target.

Patient Experience – Friends and Family Test Outpatient

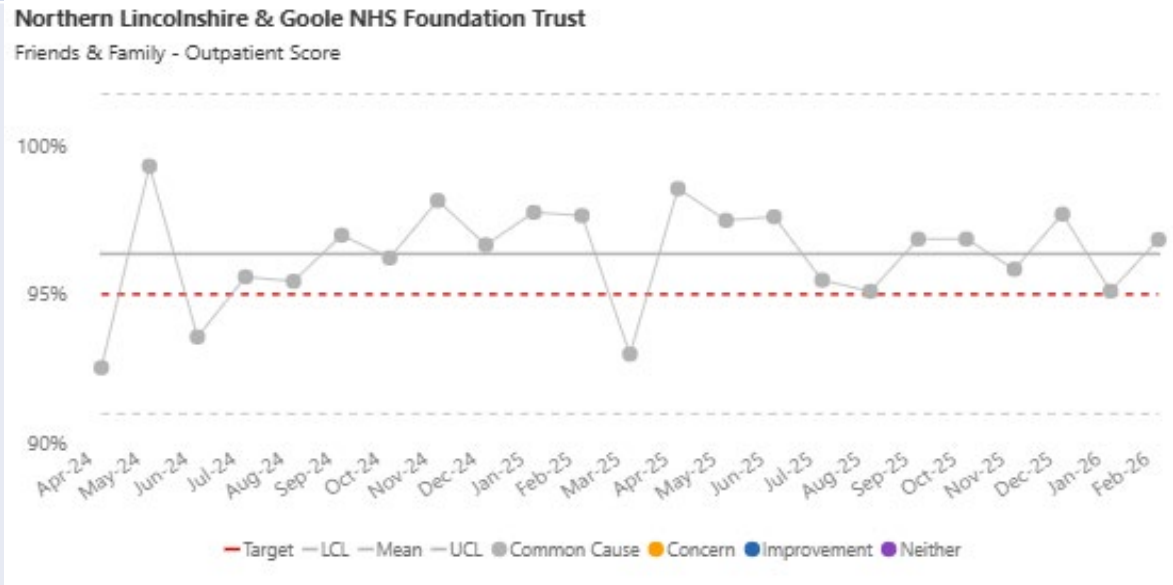
HUTH



Key themes

- A new system for collection of FFT for HUTH has been successfully implemented.

NLAG

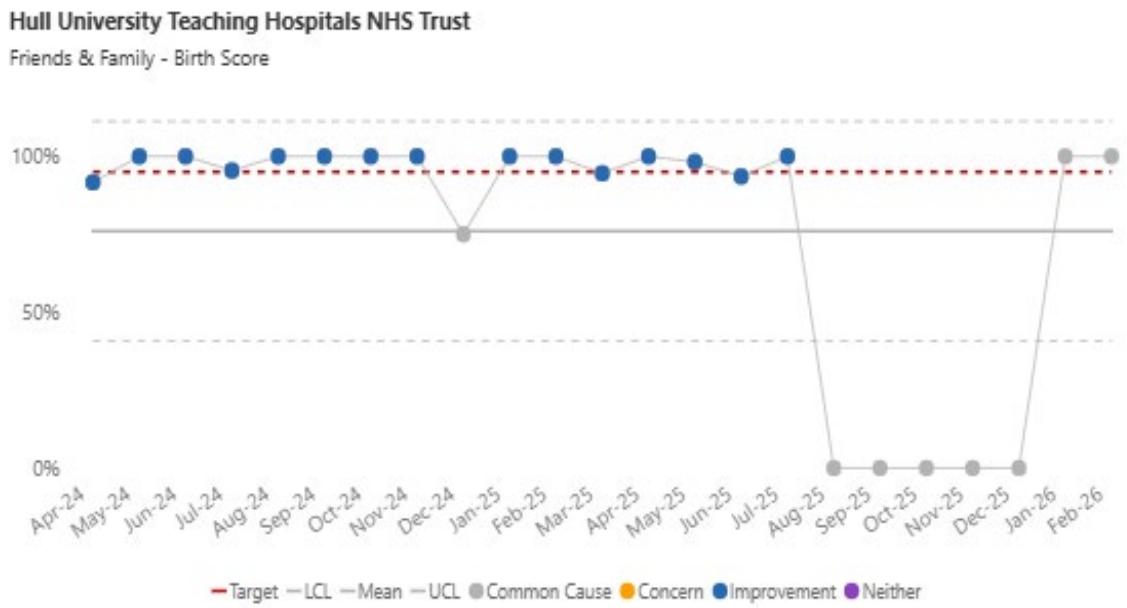


Key themes

- Previously sustained achievement over the target of 95%.

Patient Experience – Friends and Family Test Maternity (Birth)

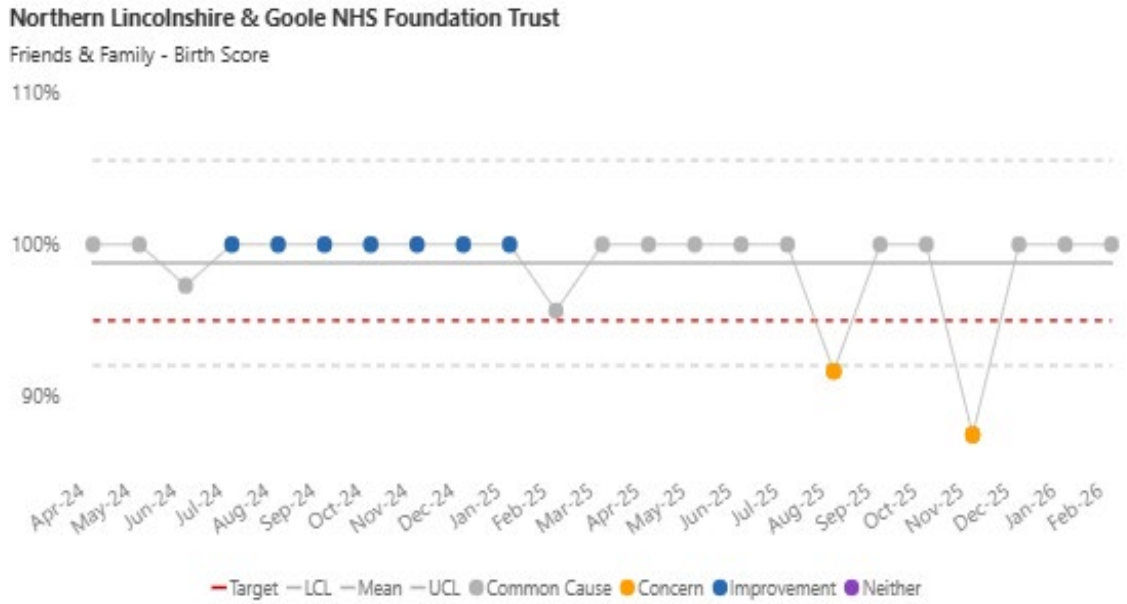
HUTH



Key themes

- Some positive results following a dip of performance in December 2024, with a rate of 100% in August.
- Recent results are due to a changes in the capture process.
- A new system for collection of FFT for HUTH has been successfully implemented.

NLAG

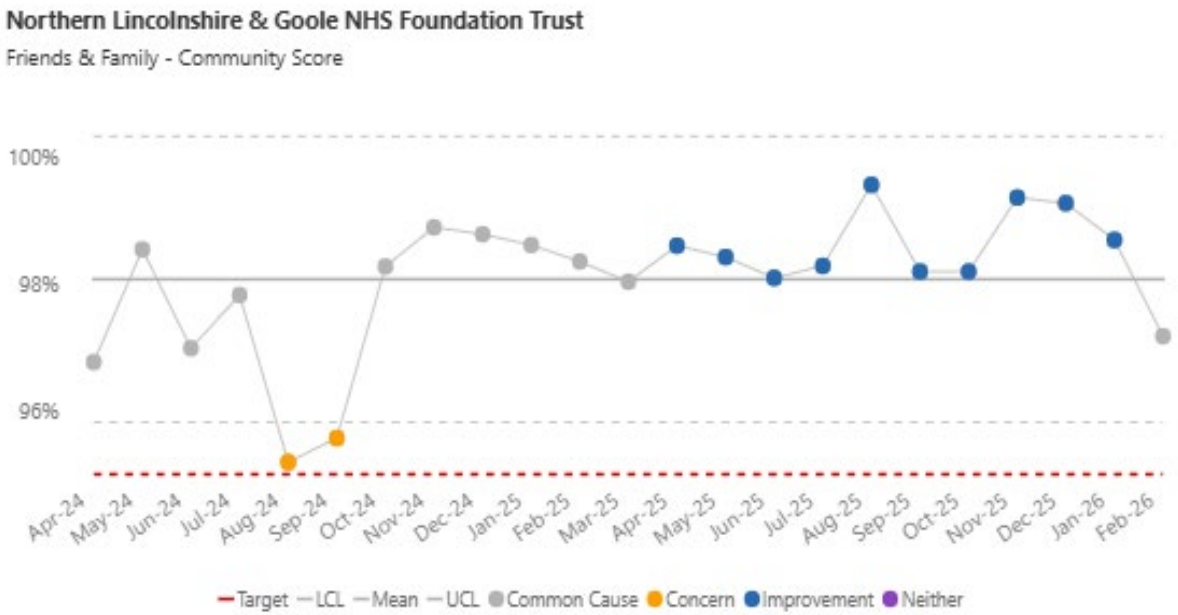


Key themes

- Sustained positive results are seen, remaining above the target and at 100% with the exception of February and August 2025..

Patient Experience – Friends and Family Test Community (NLAG only)

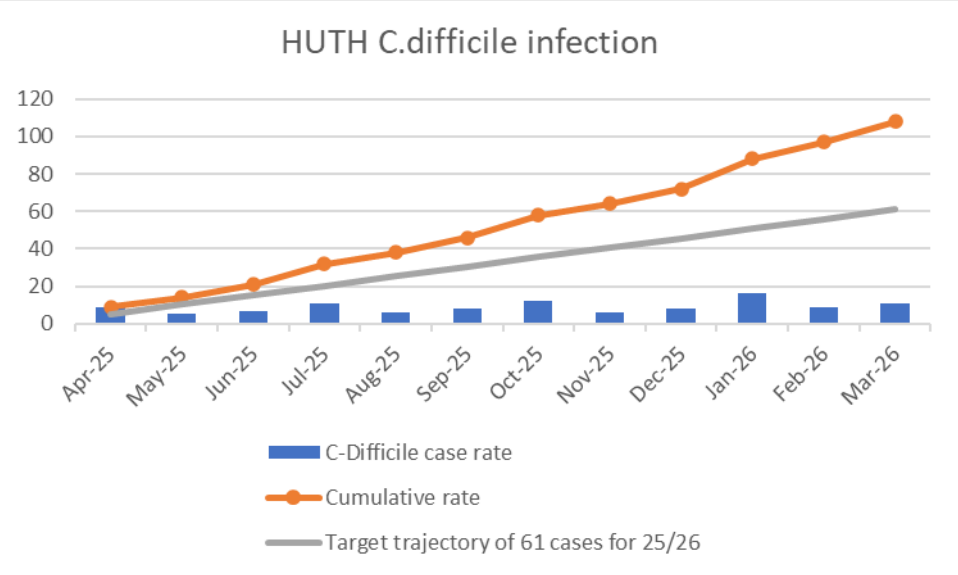
NLAG

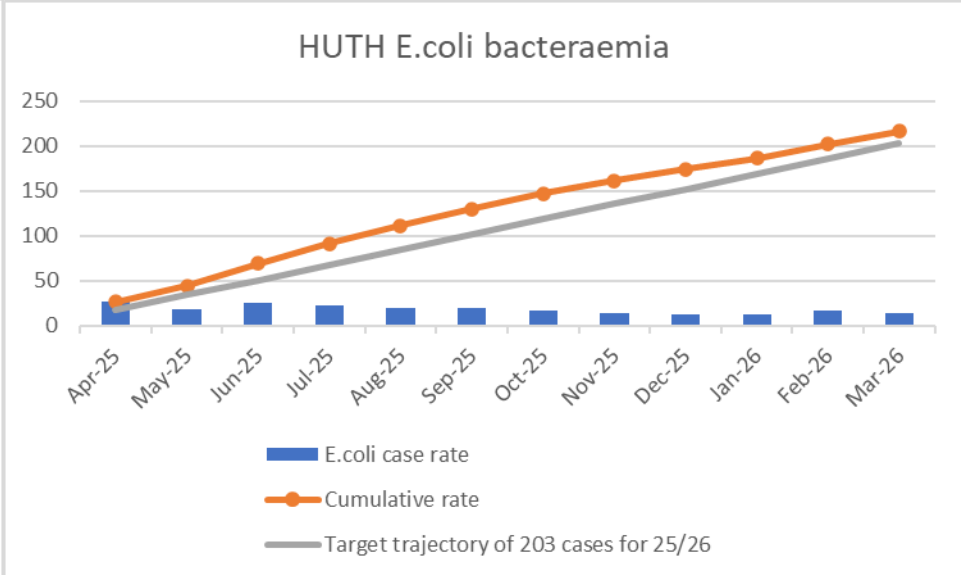


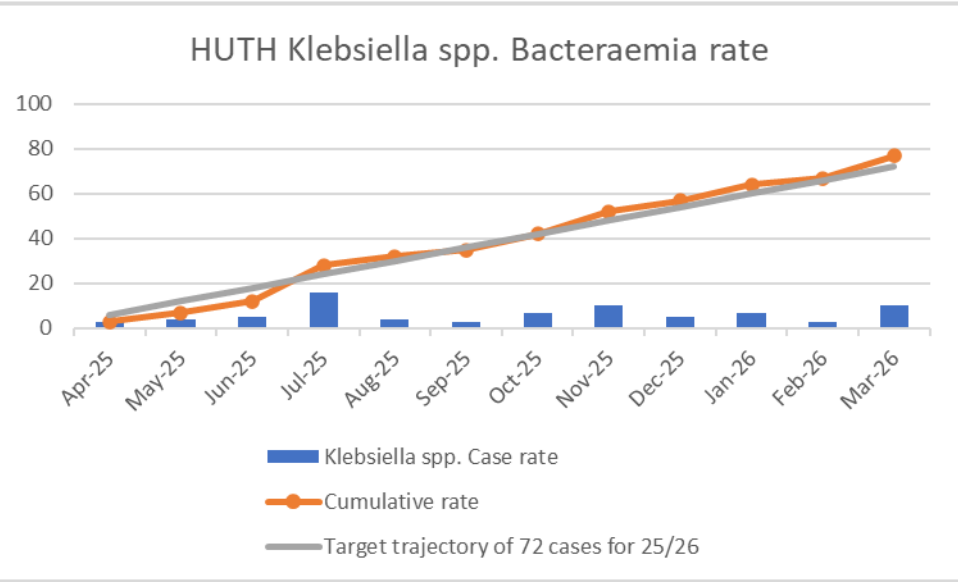
Key themes

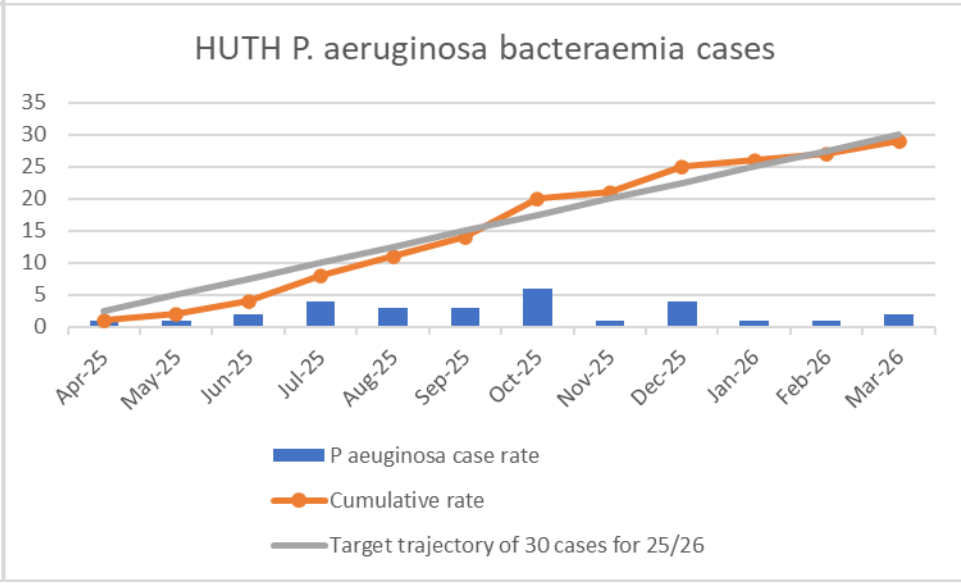
- Normal variation pattern is found and the Trust is consistently achieving the 95%.

Infection Control - HUTH









Alert organism	2025/26 Target	M12	YTD rate	Trajectory RAG
C. Difficile	61	9	108	
E. Coli	203	15	214	
P. Aeruginosa	30	2	29	
Klebsiella spp.	72	10	77	
MRSA bacteraemia	0	0	5	
MSSA bacteraemia	No target	12	93	NA

Key: Red – over annual target; Amber - over trajectory; Green – within trajectory

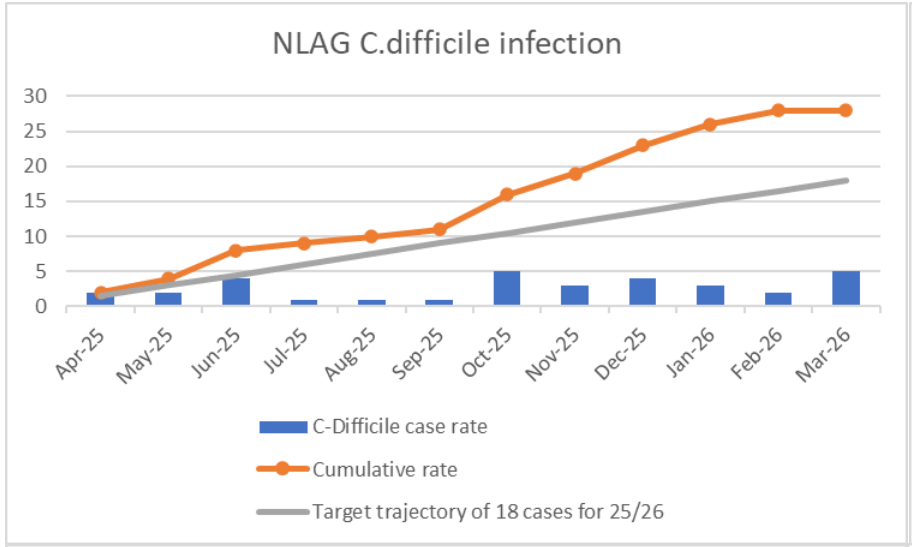
The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the March 2026 position.

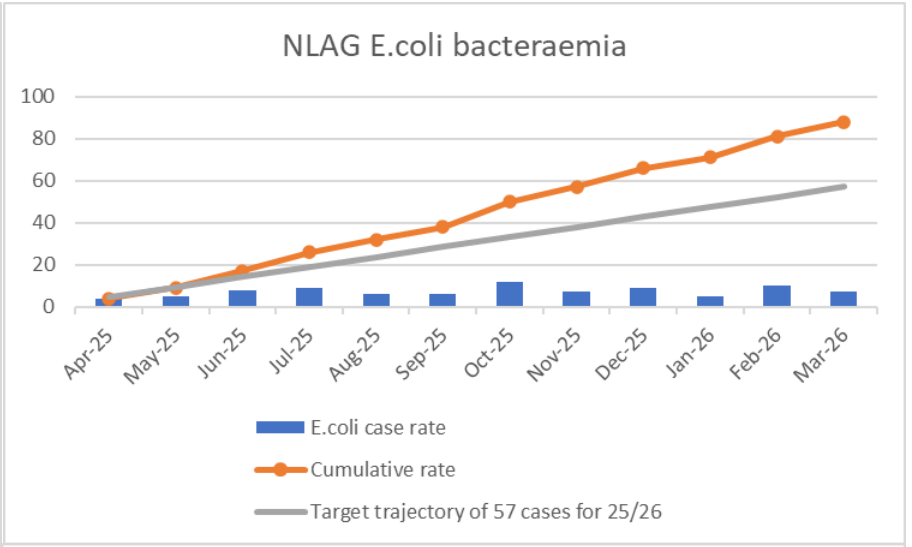
- C.difficile, Klebsiella, E-coli and MRSA rate are over the annual target.
- P Aeruginosa are within the target trajectory for the year.
- MSSA rates show normal variation (see charts on following pages)

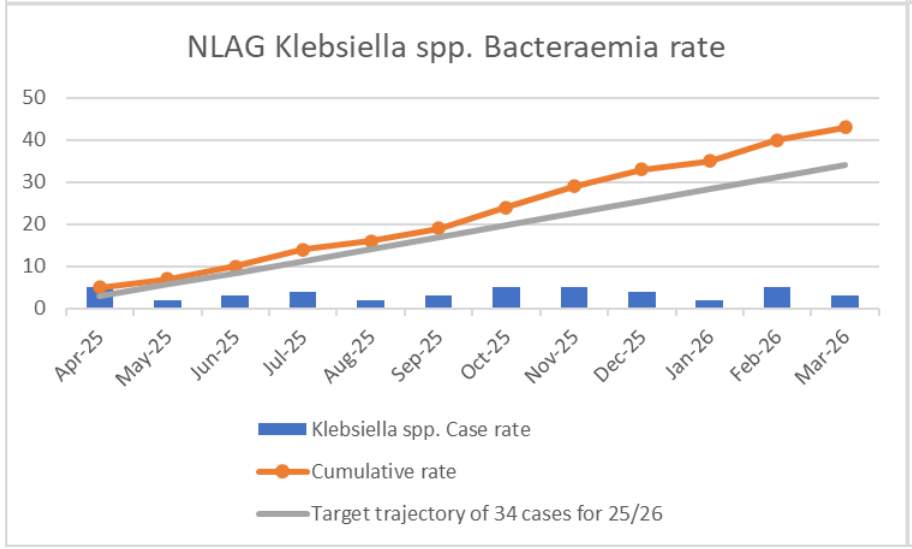
Improvement plans

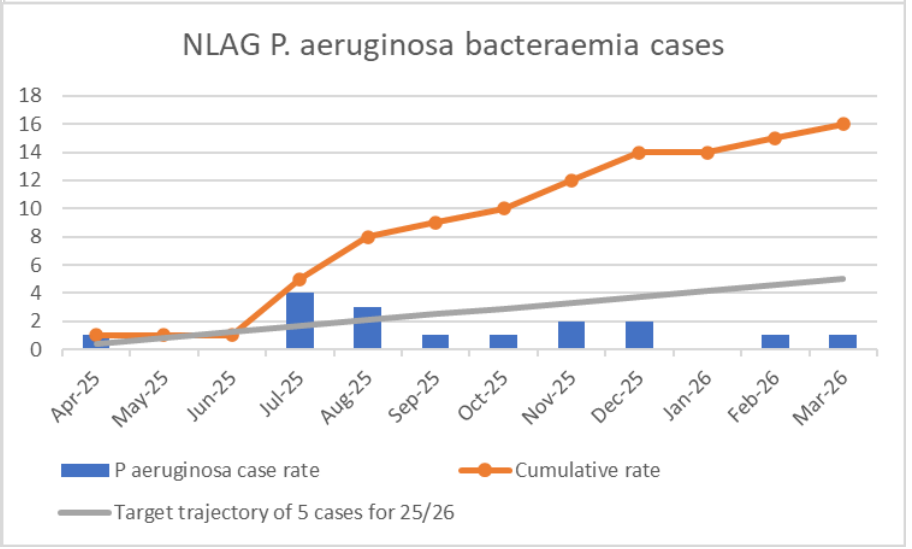
- The Quality Priorities for 2026/27 include the infection control KPI's that are part of the Safe section of the National Outcomes Framework.

Infection Control - NLAG









Alert organism	2025/26 Target	M 12	YTD rate	Trajectory RAG
C. Difficile	18	5	33	
E. Coli	57	7	88	
P. Aeruginosa	5	1	16	
Klebsiella spp.	34	3	43	
MRSA bacteraemia	0	0	4	
MSSA bacteraemia	No target	2	27	NA

Key: Red – over annual target; Amber - over trajectory; Green – within trajectory

The latest data is refreshed when validated and approved from 15th of the month.

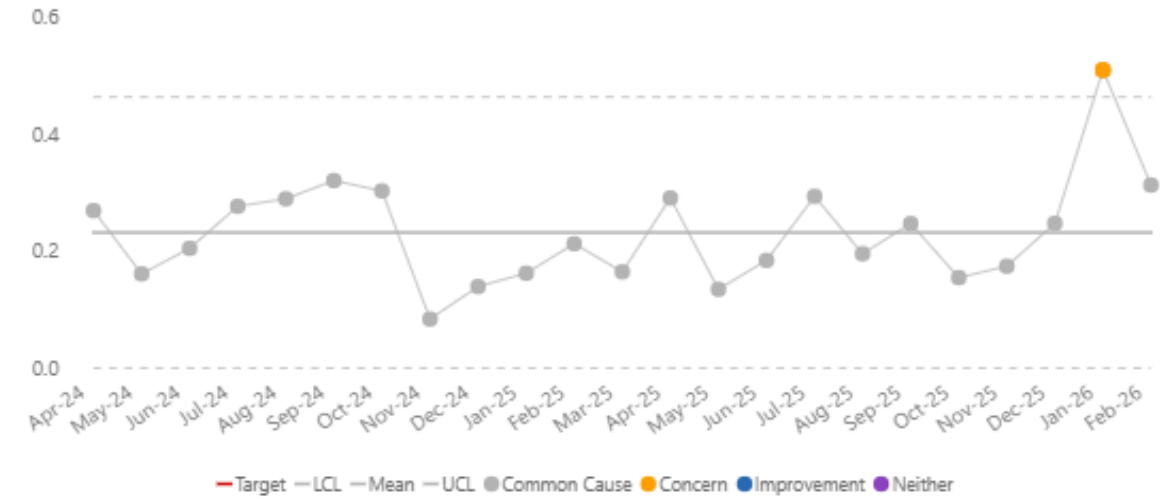
- C.difficile, E.coli, Klebsiella, MRSA and P.Aeruginosa are over trajectory, and over the annual target.
- MSSA rates remain within normal variation patterns

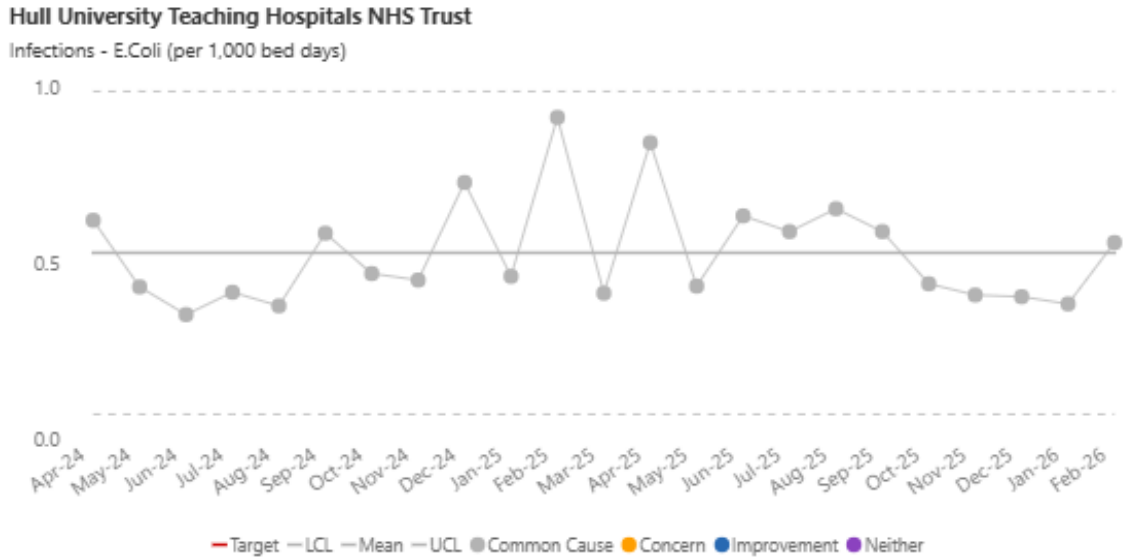
Improvement plans

- The Quality Priorities for 2026/27 include the infection control KPI's that are part of the Safe section of the National Outcomes Framework.

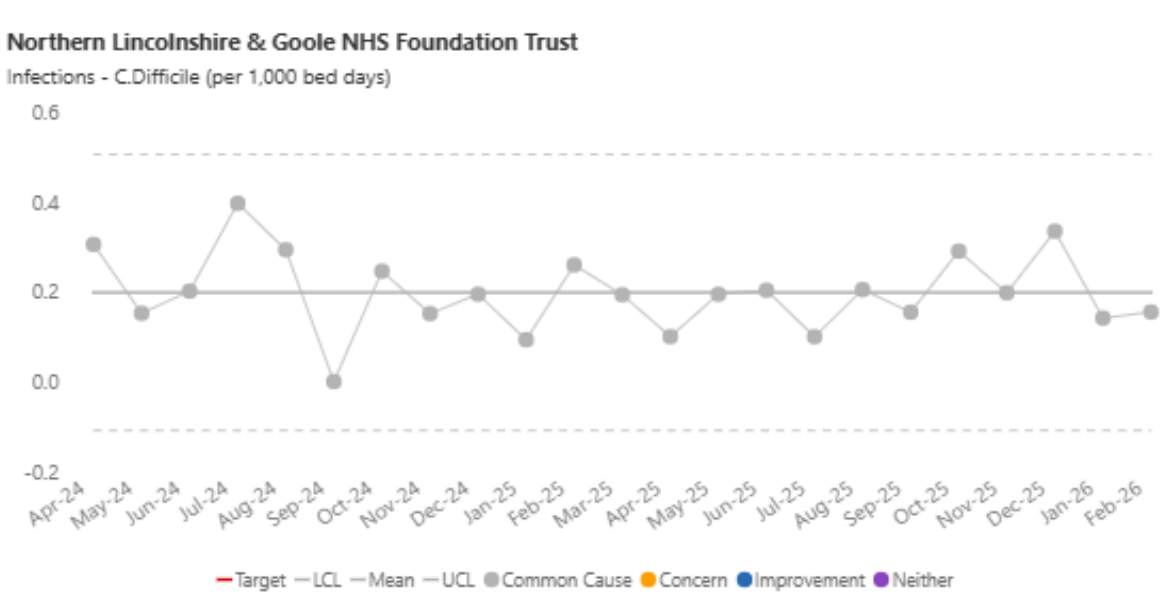
Infection control rates per 1000 bed days – C-difficile and E.Coli bateraemia

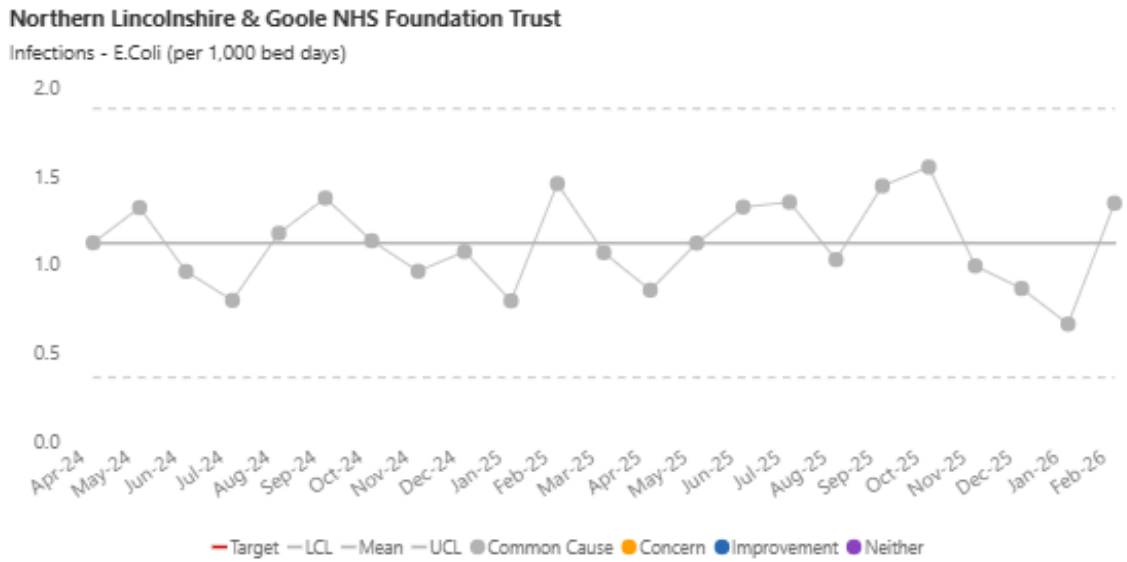
HUTH





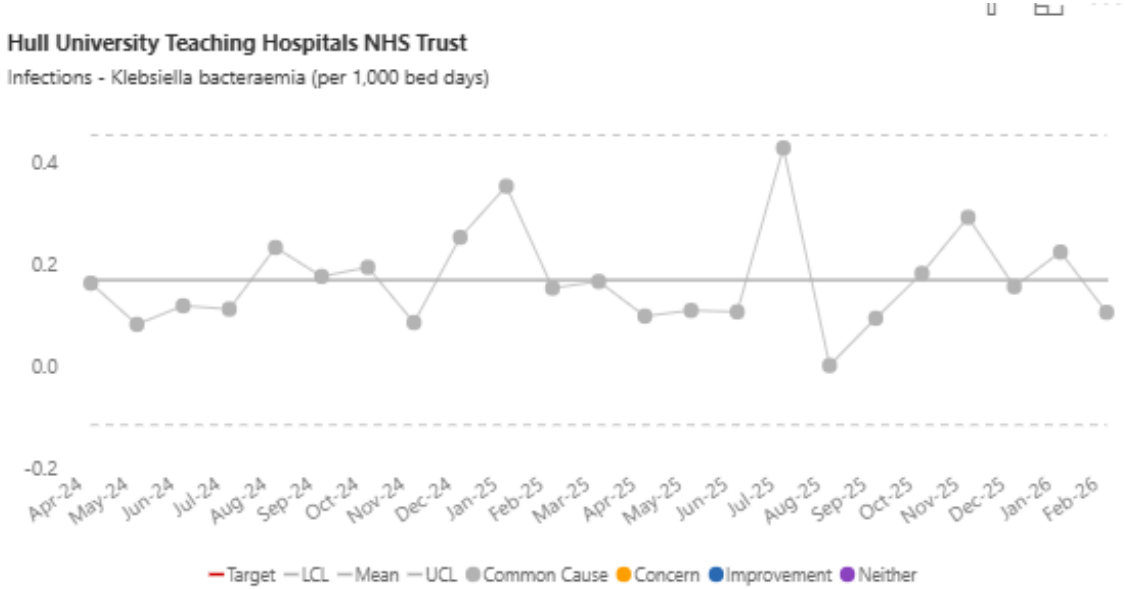
NLAG

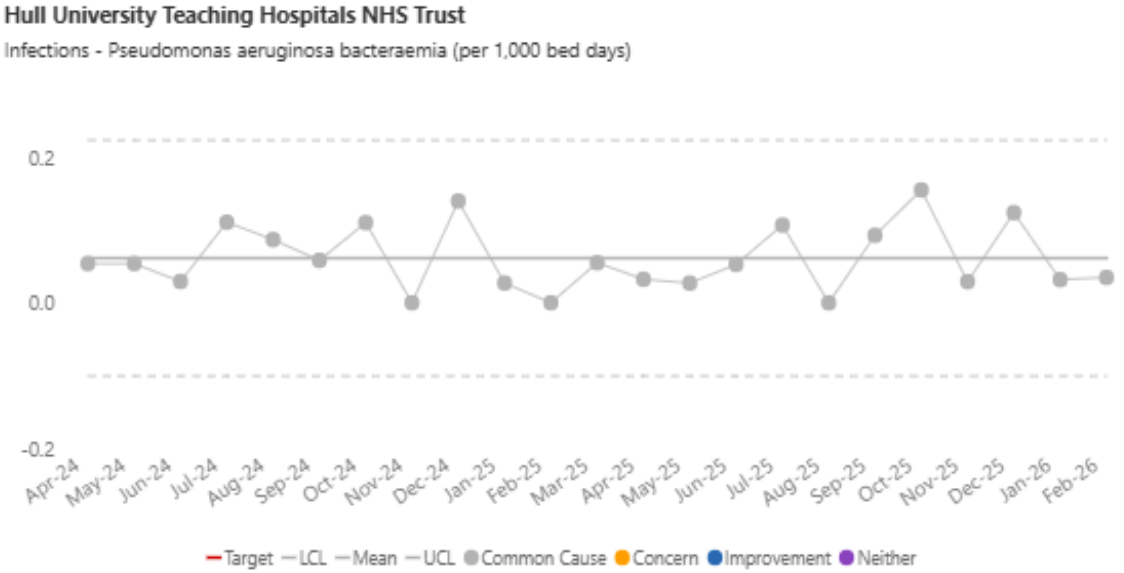




Infection control rates per 1000 bed days – Klebsiella and Pseudomonas aeruginosa bacteraemia

HUTH





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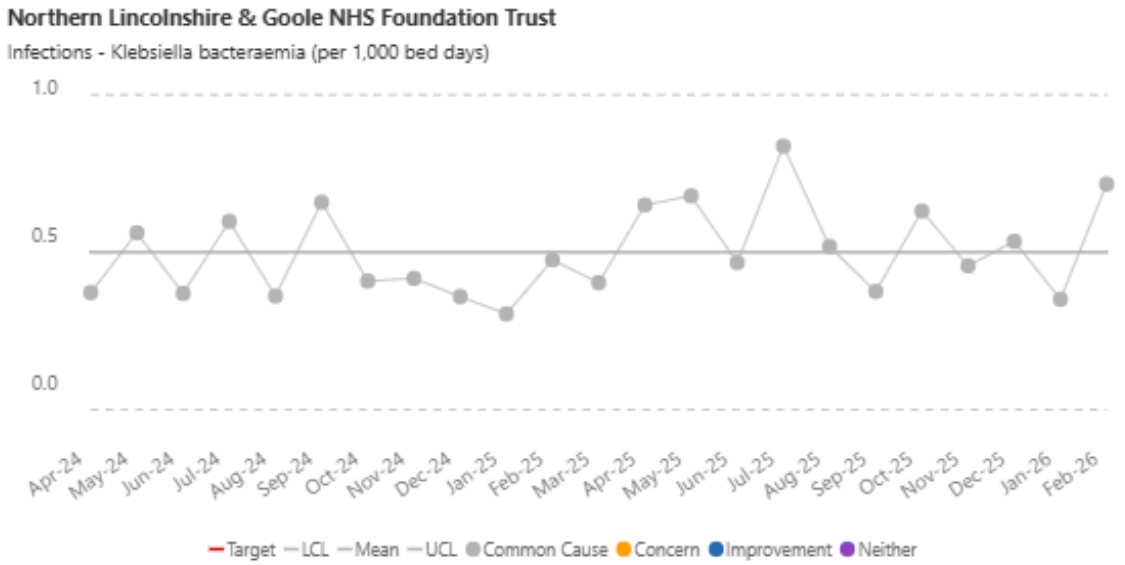
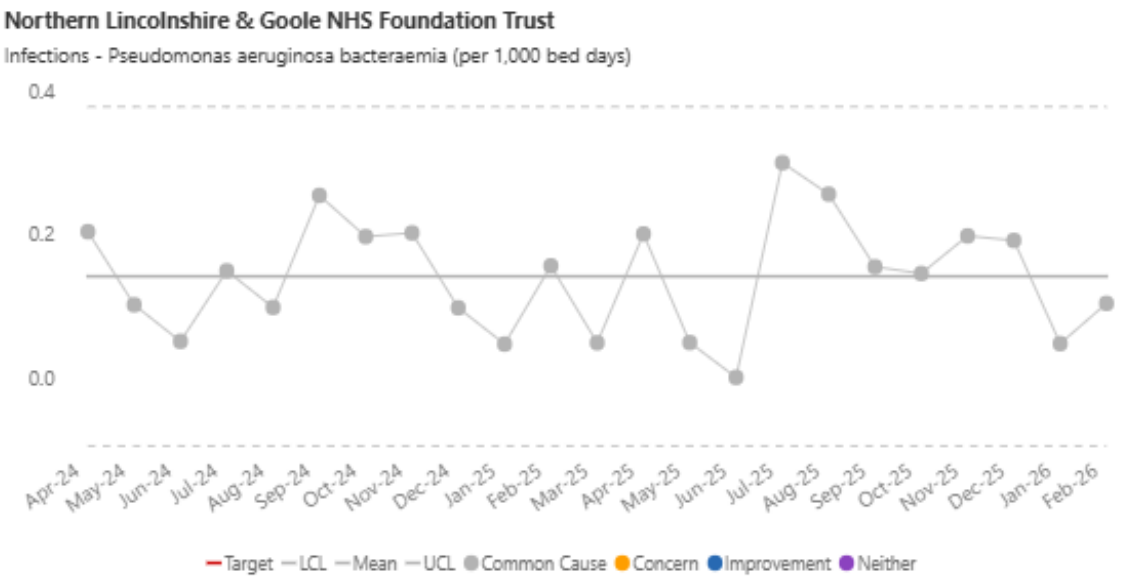


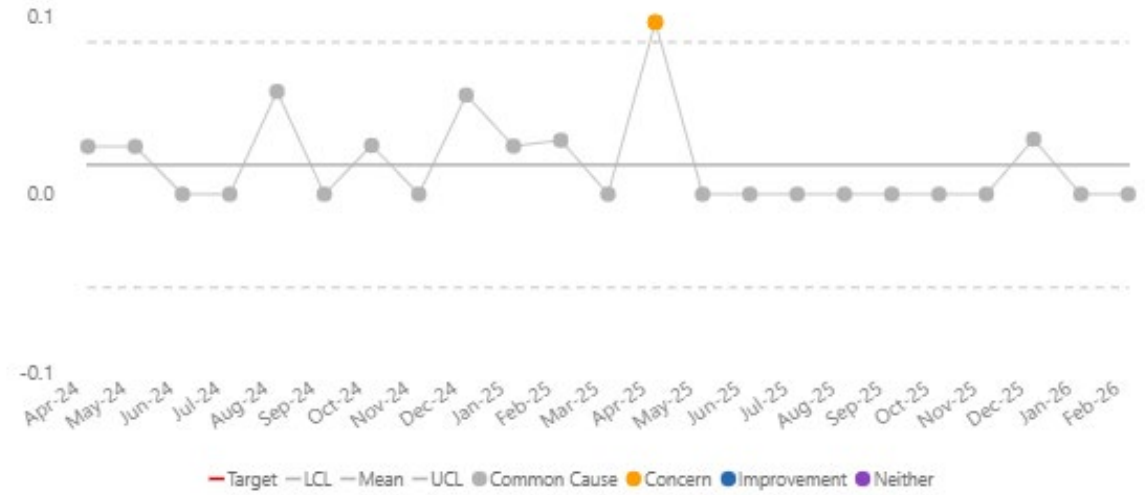


Infection control rates per 1000 bed days – MRSA and MSSA bateraemia

HUTH

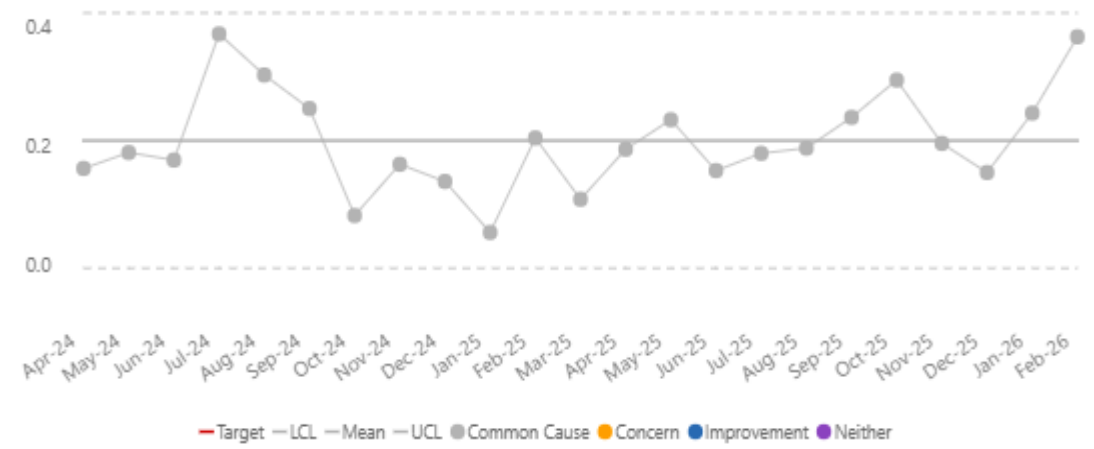
Hull University Teaching Hospitals NHS Trust

Infections - MRSA (per 1,000 bed days)



Hull University Teaching Hospitals NHS Trust

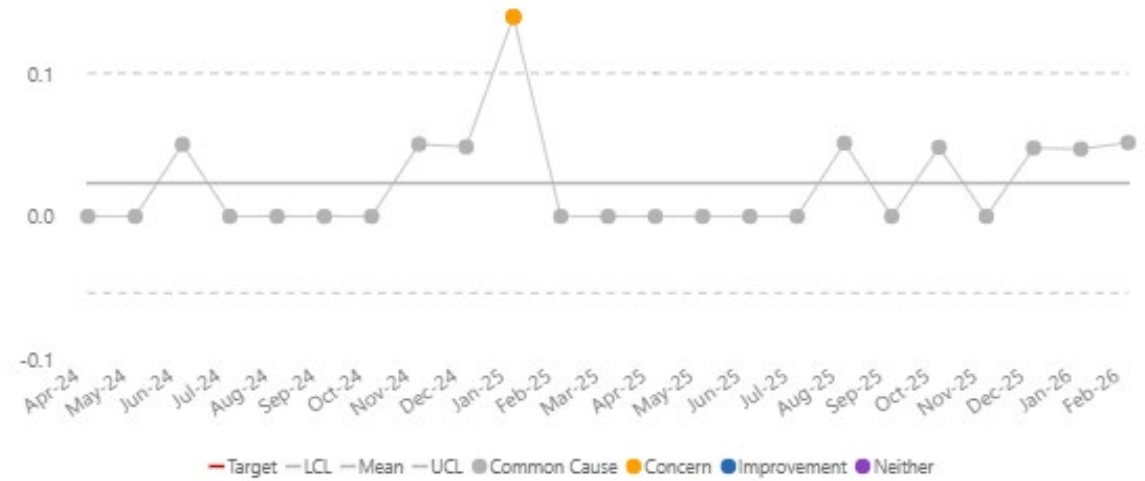
Infections - MSSA (per 1,000 bed days)



NLAG

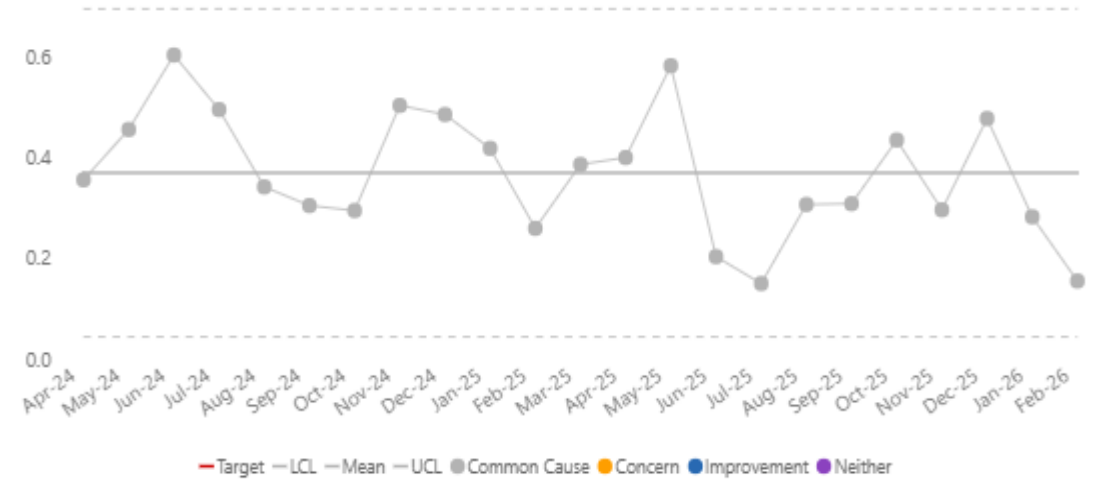
Northern Lincolnshire & Goole NHS Foundation Trust

Infections - MRSA (per 1,000 bed days)



Northern Lincolnshire & Goole NHS Foundation Trust

Infections - MSSA (per 1,000 bed days)



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.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: 4.1

Name of the Meeting	**Workforce, Education and Culture Committees-in-Common**
Date of the Meeting	Wednesday 25th March 2026
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing and Improvement
Title of the Report	**Workforce Integrated Performance Report**
Executive Summary	This report presents the Group Workforce position as part of monthly reporting cycles. **Key points to note:** • **Vacancies:** Overall rate 4.1% (↓0.3%). NLAG 6.1%, HUTH 2.6%. Consultant vacancies remain high at 16.7%, driving agency usage. Recruitment activity has increased, with 26 consultants in the pipeline. • **Nursing:** Vacancies stable at -48.8 WTE over established this is due to the impact of Newly Qualified Nurses commencing and this over established vacancy position is expected to be maintained in coming months and contribute towards reduced agency spend for this staff group. • **Agency Spend:** YTD spend £23,981.7K. Agency controls remain in place at a care group and executive level. • **Retention:** Turnover 6.8%, below 10% target (NLAG 7.8%, HUTH 6.1%). Highest in Additional Clinical Services, Admin & Clerical, and Estates. • **Sickness:** Absence 4.8% (target <4%), higher at NLAG (5.3%) than HUTH (4.4%). Stress and anxiety remain the main cause. • **Training & Appraisals:** Medical & Dental compliance remains lowest. Core compliance: HUTH 88.9% (↑1.6%), NLAG 86.9% (0%). Role specific: HUTH 81.9% (↓0.6%), NLAG 80.8% (↓2.6%) Appraisals at 79.9%, lowest in AHPs, Admin & Clerical, and Healthcare Scientists. • **Job Planning:** Completion improved to 92.6%
Background Information and/or Supporting Document(s) (if applicable)	The report is presented as part of normal monthly business
Prior Approval Process	NA
Financial implication(s)	Vacancy position is responsible for the majority of Agency spend and remains a priority

(if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No specific considerations within this report, however as part of future reporting EDI data sets will be made more available.
Recommended action(s) required	☐ Approval by CiC ☐ Endorse for approval by Trust Board(s) ☐ Other – please detail below: ✓ Assurance ☐ Information

NHS
Humber Health
Partnership

FEBRUARY 2026

Workforce Integrated Performance Report

People Directorate

nlg-tr.twworkforcedatareqs@nhs.net

Exception Repoert

Vacancy Rate

The Group's overall vacancy rate is 4.1%, representing a 0.2% reduction compared with the previous reporting period. Vacancy levels remain higher at NLAG (6.1%), while HUTH reports a lower rate of 2.6%.
When adjusted for bank and agency usage, the Group's overall vacancy factor is 0% (5.9 WTE). NLAG shows an adjusted vacancy of -58.8 WTE, driven primarily by bank utilisation within registered and unregistered nursing roles. The Medical and Dental vacancy rate is 4.2%, which remains within target. However, the consultant vacancy rate is 16.7% (including Specialists), reflecting recent establishment increases, although the staff in post position continues to improve. Agency usage is currently decreasing and remains at a comparable level to May 2025. The Medical and Dental vacancy position continues to be a key driver of agency expenditure, particularly within NLAG.

Overall staff appointed increased in the first two quarters of the current financial year across all staff groups, however quarter 3 showed signs of this slowing due to increased scrutiny and vacancy controls for non-clinical roles, and quarter 4 shows this trend continuing with appointments continuing to reduce. Recruitment to Consultant roles remains a priority, with 93 Consultants starting in the current financial year to date. There are 26 Consultants in the recruitment pipeline awaiting start. The Consultant vacancy position is also offset by Specialists in role, with 43 Specialists currently in post and 5 Specialists in the pipeline to further positively impact the Consultant vacancy position.
The most significant pressure for Consultant vacancies continues to be within Theatres, Anaesthetics and Critical Care, Specialist Cancer and Support Services, and Acute and Emergency Medicine. 10 of the 26 Consultants awaiting start and 2 of the 5 Specialists awaiting start are within these care groups.
Registered nurse vacancies have shown a significant reduction in vacancy position in month and now stands at -1.1%, equivalent to -48.8 WTE over establishment. This is due to the impact of Newly Qualified Nurses commencing and this over established vacancy position is expected to be maintained in coming months and contribute towards reduced agency spend for this staff group.
Allied Health Professional vacancies stand at 4.5% with the most significant pressure within Specialist Cancer and Support Services for Sonographers and Radiographers. The Care Group are receiving support in putting plans in place to address these issues.

Recruitment time to hire remains below KPI for both medical and general recruitment, alongside a reduction in activity as noted above this is also due to streamlining of processes. Time to shortlist at HUTH, particularly for medical staff, has seen a decrease of 10 days. A process has been put in place with the aim of reducing this further and to bring in line with target,

Workforce Utilisation and Retention Overview

The most recent validated data from February 26 shows agency usage at 142.4 WTE across the Group, with a decrease of 7WTE from the previous reporting period. This decrease amounts to a reduction of £485k when compared to the previous month. Year-to-date agency spend stands at £23,981.7K which is £6,218.3K behind target. - Agency controls remain in place at a care group and executive level.

Sickness absence continues to exceed the 4% target, with the Group reporting a rate of 4.8%. NLAG remains higher at 5.3%, compared to 4.4% at HUTH. The leading cause of absence is Anxiety, Stress, Depression, and other psychiatric illnesses, with the highest rates seen in the Nursing and Midwifery Registered and Additional Clinical Services staff groups, particularly within the Acute and Emergency Medicine, Community, Major Trauma, and Pathology Care Groups.

Staff retention remains below the Group target of 10%, with an overall rate of 6.8%—NLAG at 7.8% and HUTH at 6.1%. The highest turnover is observed in Additional Clinical Services, Admin and Clerical, and Estates and Ancillary roles. The primary reasons for staff leaving these groups are Voluntary Resignation - Relocation and Work Life Balance.

Performance Overview

Training Compliance for Medical and Dental staff for Mandatory and Role Specific continue to report the lowest compliance levels across all staff groups. At HUTH, Core Compliance is 88.9 (an increase of 1.6% from the previous report), while Role Specific Compliance is 81.9% (a decrease of 0.6%). At NLAG, Core Compliance is 86.9% (stayed the same), and Role Specific Compliance is 80.8% (an decrease of 2.6%).

The current **appraisal** completion rate for AFC staff stands at 79.9%. The lowest completion rates are observed within Additional Professional, Scientific and Technical roles, Admin and Clerical, Allied Health Professionals, and Healthcare Scientists.

HR Business Partners continue to work with Care Groups to improve compliance through KPI meetings
The current Job Planning completion rate across the Group is 92.6%, which remains below the 100% target. However, this represents a significant improvement from the previous reporting period, showing a 16.6% increase.

Workforce Position

This slide represents the Group workforce of Humber Health Partnership. It includes details related to Staff in Post, Headcount and Establishment

February 26 Workforce Position

Headcount 20,018
HUTH 11,251 - NLAG 8,767
↓
January 26 **20,425**
HUTH 11,774 NLAG 8,651
↑
December 25 **19,919**
HUTH 11,141 NLAG 8,778

Est WTE 16,576.9
HUTH 9,394.5 NLAG 7182.4
↑
January 26 **16,511.4**
HUTH 9392.3 NLAG 7119.1
↑
December 25 **16,401.7**
HUTH 9278.3 NLAG 7123.4

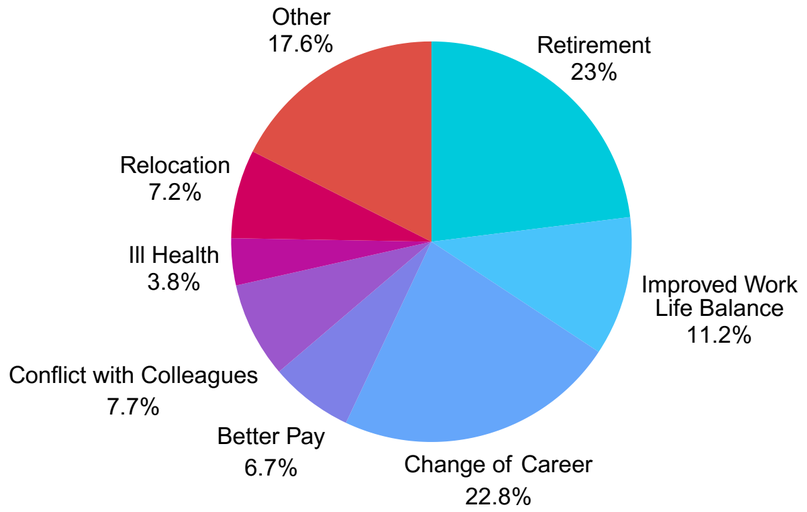
SIP WTE 15,890.0
HUTH 9147.0 NLAG 6743.0
↑
January 26 **15,798.2**
HUTH 9148.3 NLAG 6649.9
↑
December 25 **15,741.3**
HUTH 9060.7 NLAG 6680.6

Leavers WTE (12mAvg) 963.2
HUTH 494.9 NLAG 468.2
↓
January 26 **961.5**
HUTH 485.9 NLAG 475.5
↓
December 25 **977.3**
HUTH 503.7 NLAG 473.6

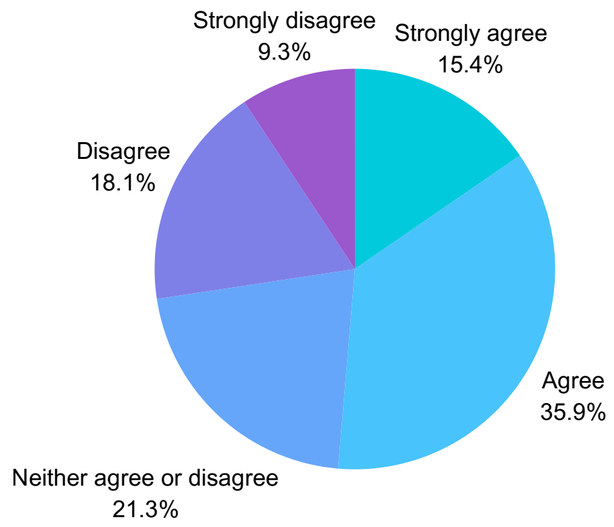
Starters WTE (12mAvg) 2091.0
HUTH 1382.5 NLAG 708.5
↑
January 26 **2022.6**
HUTH 1317.9 NLAG 704.8
↑
December 25 **1987.5**
HUTH 1269.3 NLAG 718.1

Exit Questionnaire Data (12 Months Roiling)

Reason For Leaving Insights



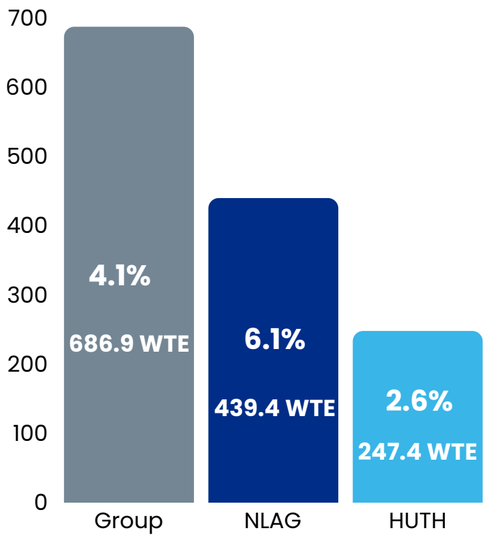
I looked forward to going to work



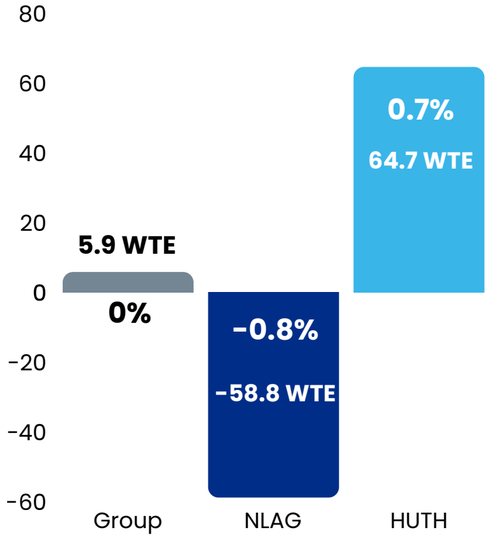
Vacancy and Recruitment Activity

The next two slides represents the vacancy and recruitment activity of Humber Health Partnership. It includes details related to specific staff groups and pipeline information.

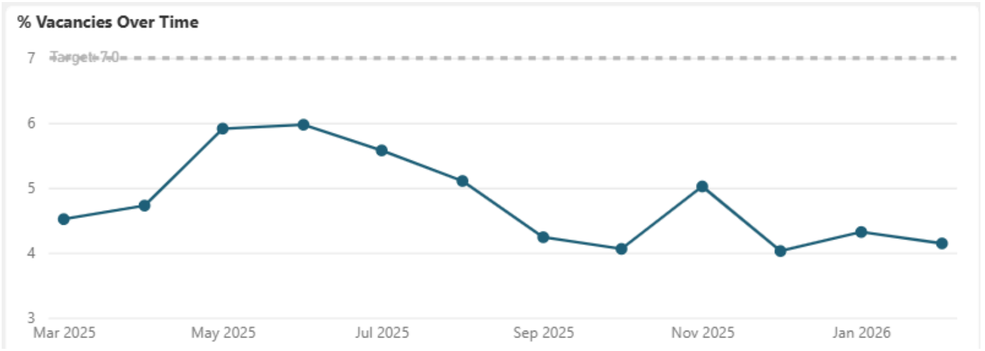
February 26 Group Overall Vacancy Position



Group Overall Adjusted Vacancy Position

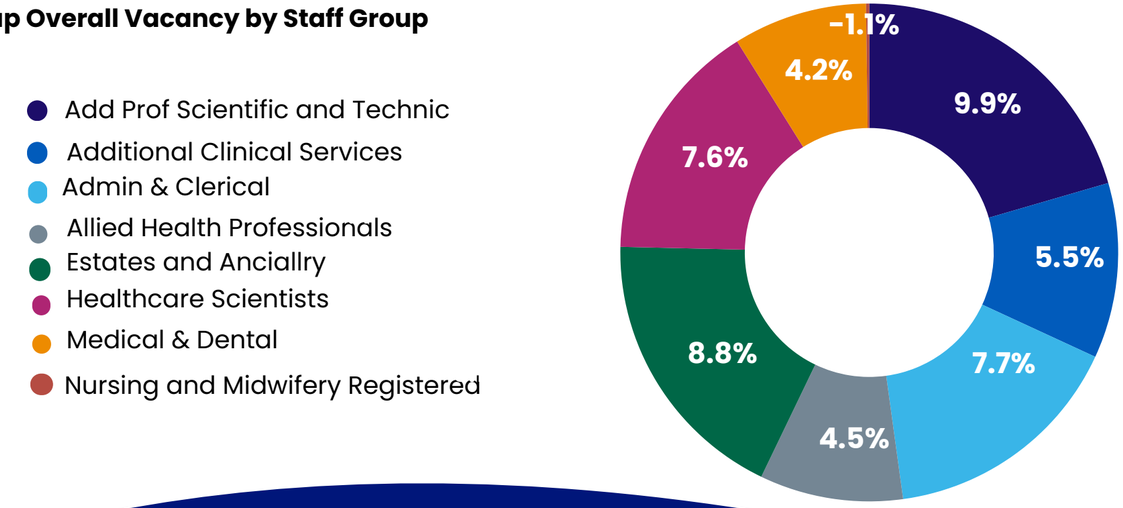


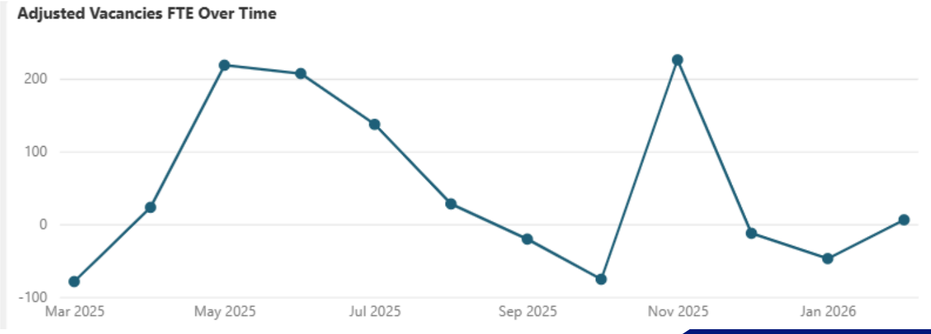
Group Overall Trend



Dec 25	Jan 26	Feb 26
4%	**4.3%**	**4.1%**

Group Overall Vacancy by Staff Group





Dec 25	Jan 26	Feb 26
-0.1%	**-0.3%**	**0%**

Vacancy and Recruitment Activity

Group Consultant Vacancy 3 Month Predictions

124.1 Predicted Vacancy WTE

Avg 12m Turnover 2.6%

26 Pipeline WTE

Vacancy WTE 148.8

Vacancy Rate **16.7%**

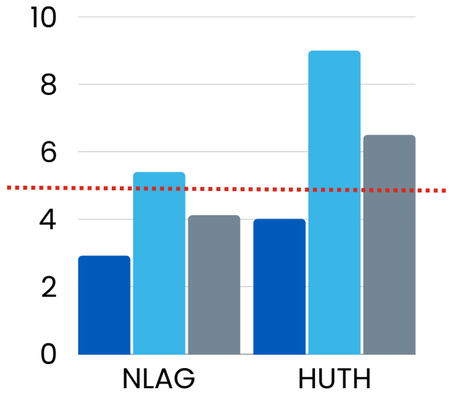
Predicted Vacancy Rate **13.9%**

Group Recruitment KPI Overview

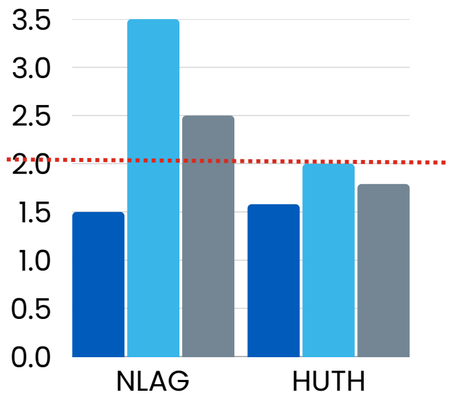
Recruitment KPI Overview	HUTH	NLAG	Total
Number of Active Vacancies	127	91	218
Number of Applications received	4500	3723	8223
Number of Conditional Offers Issued	150	84	234
Number of New Starters	91	125	216

Appointing Manager Metrics

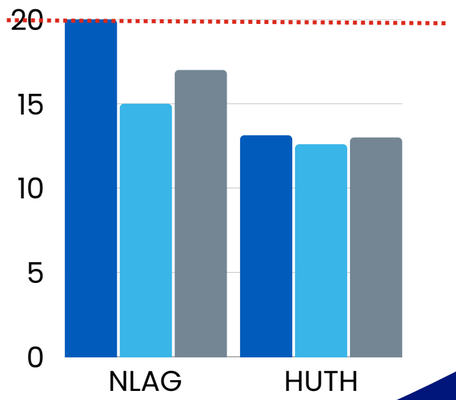
Time Taken to Shortlist (Target 5 Working Days)

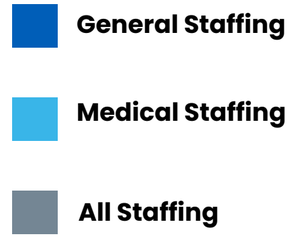


Time taken to provide interview outcome (Target 2 Working days)



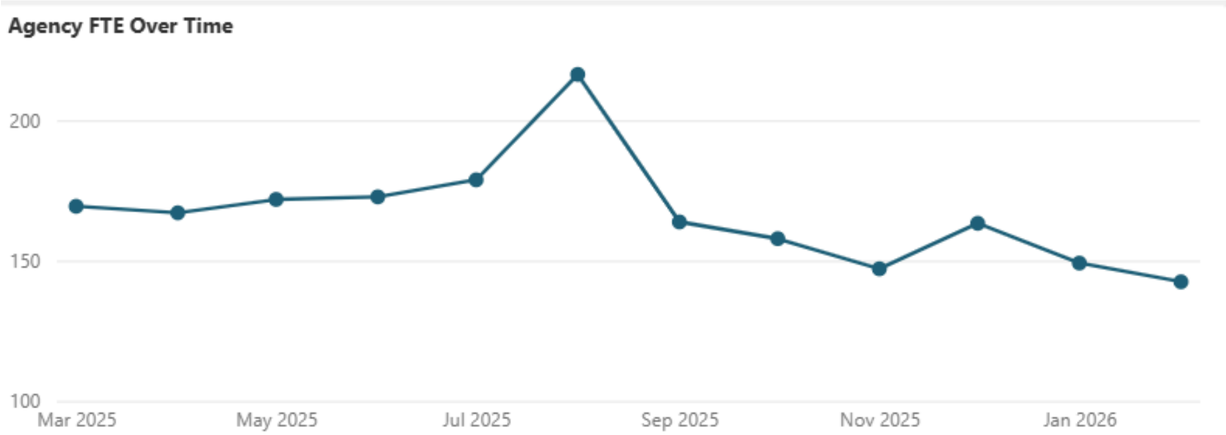
Time to Hire (Target 20 working days)

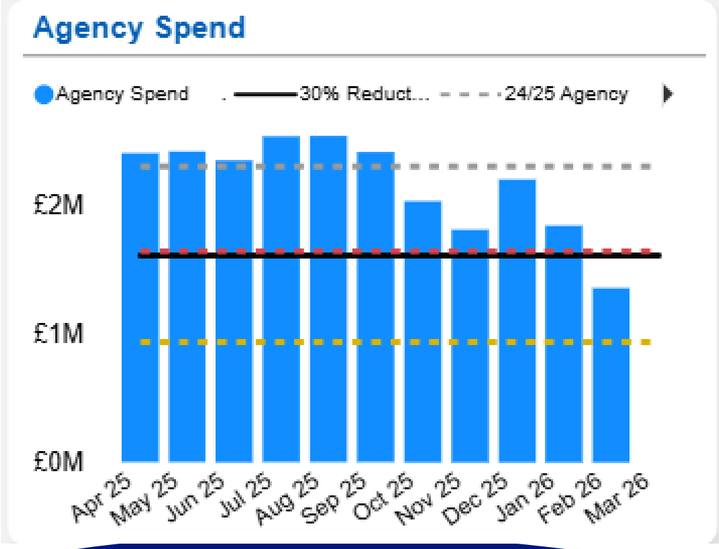




Agency

This slide represents the agency performance of Humber Health Partnership Group.





February Agency FTE Usage

Care Group	WTE
Acute and Emergency Medicine	59.3
Family Services	7.2
Specialist Medicine	5.7
Specialist Surgery	5.7
Specialist Cancer and Support Services	18.3
Digestive Diseases	16.4
Head and Neck	11.3
Community, Frailty and Therapy	6.6
Theatres, Anaesthetics and Critical Care	9.1
Neuroscience	5.3
Pathology Network Group	0
Site Management and Discharge Teams	0.6
Cardiovascular	1.4
Major Trauma	0
Cancer Network	0

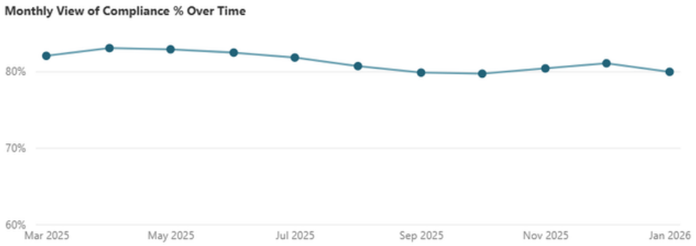
Agency target and opportunity by Staff Type

Staff Type	24/25 Agency	Prev YTD Agency	YTD Agency	YTD Change	Nat Median Opportunity	NHSE 30% Opportunity	30% Target Var, YTD
⊞ Medical	£21,680.1K	£19,788.2K	£18,359.4K	-7%	£21,362.9K	£6,504.0K	-£4,447.9K
⊞ Nursing	£3,520.9K	£3,153.0K	£3,877.0K	23%	£3,226.2K	£1,056.3K	-£1,617.8K
⊞ Allied Health Professional	£338.8K	£312.4K	£1,040.6K	233%	£270.0K	£101.6K	-£823.3K
⊞ Scientific + Technical	£1,417.1K	£1,295.6K	£604.4K	-53%	£1,350.4K	£425.1K	£304.8K
⊞ Admin + Clerical	£689.6K	£639.5K	£59.5K	-91%	£557.2K	£206.9K	£383.1K
⊞ Other Staff	£36.7K	£6.2K	£40.8K	557%	£36.1K	£11.0K	-£17.2K
⊞ Support Staff					£0.0K		
Total	£27,683.3K	£25,194.9K	£23,981.7K	-5%	£26,741.8K	£8,305.0K	-£6,218.3K

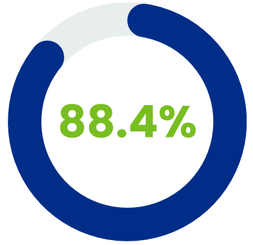
Training, Appraisals and Job Planning

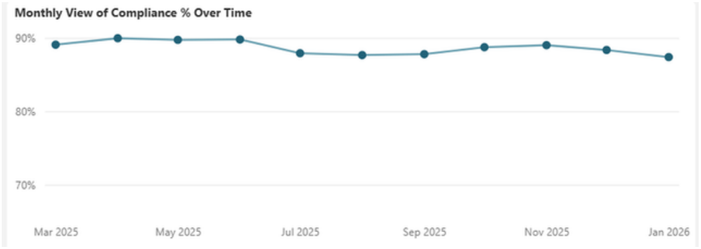
The next slide represents the performance activity Humber Health Partnership Group. It includes details related to appraisals, training and Job Planning.

Appraisals AfC

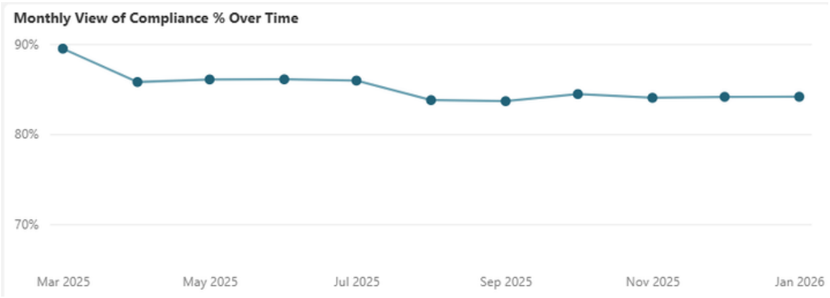


Core Mandatory Training

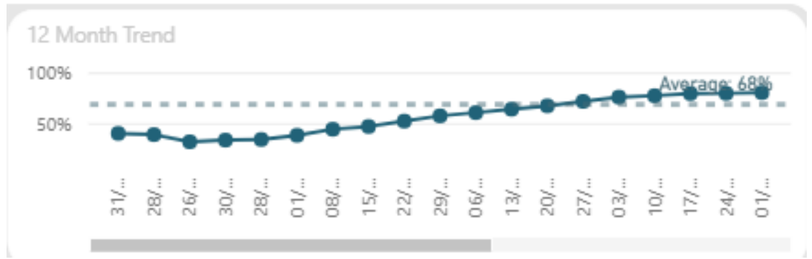




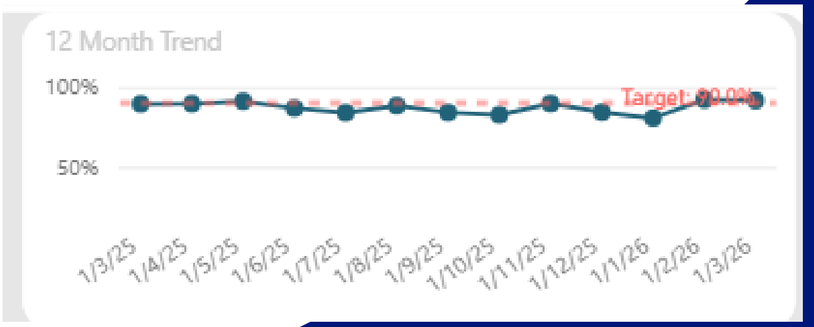
Role Specific Training



Job Planning



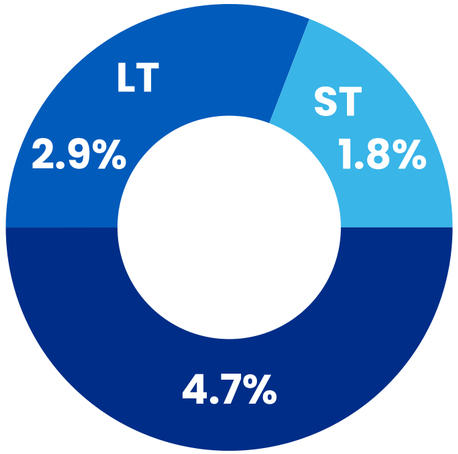
Appraisals Medical and Dental



Wellbeing and Retention

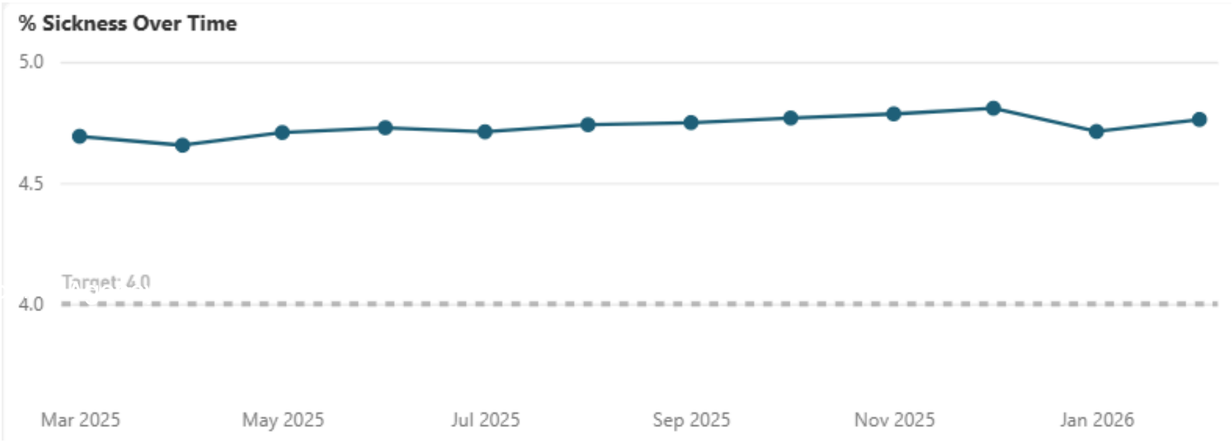
The next two slide represents the employee wellbeing and retention activity of Humber Health Partnership Group. It includes details related to Turnover, absence rates and retention.

Overall Sickness



Staff Group Summary

Staff Group	% Sickness	% ST	% LT	% Maternity	% Total Absence
Add Prof Scientific and Technic	3.6%	1.2%	2.4%	3.1%	6.7%
Additional Clinical Services	6.8%	2.5%	4.3%	2.4%	9.2%
Administrative and Clerical	4.1%	1.4%	2.7%	1.5%	5.6%
Allied Health Professionals	3.8%	1.7%	2.1%	3.2%	7.0%
Estates and Ancillary	5.8%	2.0%	3.8%	0.6%	6.4%
Healthcare Scientists	2.8%	1.3%	1.5%	1.9%	4.7%
Medical and Dental	2.1%	1.1%	1.0%	1.5%	3.7%
Nursing and Midwifery Registered	5.4%	2.1%	3.3%	3.8%	9.2%
Students	2.7%	1.0%	1.7%	0.5%	3.3%
Total	**4.7%**	**1.8%**	**2.9%**	**2.4%**	**7.2%**



Absence Reasons

Absence Reason	FTE Days Lost	Number of Episodes
S10 Anxiety/stress/depression/other psychiatric illnesses	605,675.76	27,622.00
S98 Other known causes - not elsewhere classified	356,757.53	46,806.00
S13 Cold, Cough, Flu - Influenza	279,605.41	92,009.00
S25 Gastrointestinal problems	259,042.26	78,996.00
S12 Other musculoskeletal problems	248,253.08	15,857.00
S28 Injury, fracture	181,426.54	9,153.00
S26 Genitourinary & gynaecological disorders	142,993.80	12,762.00
S30 Pregnancy related disorders	128,166.24	17,875.00
S11 Back Problems	124,810.01	12,074.00
S17 Benign and malignant tumours, cancers	92,849.12	1,451.00
S15 Chest & respiratory problems	72,849.55	13,218.00
S16 Headache / migraine	68,625.83	27,010.00
S21 Ear, nose, throat (ENT)	53,821.41	10,612.00
S19 Heart, cardiac & circulatory problems	53,291.52	3,571.00
S23 Eye problems	32,041.33	3,839.00
S29 Nervous system disorders	27,646.86	1,578.00
S31 Skin disorders	14,230.84	2,180.00
S99 Unknown causes / Not specified	13,839.86	689.00
S22 Dental and oral problems	13,361.46	4,513.00
S27 Infectious diseases	13,057.22	2,202.00
S18 Blood disorders	8,239.44	563.00
S24 Endocrine / glandular problems	7,834.93	885.00
S14 Asthma	3,363.02	694.00
S20 Burns, poisoning, frostbite, hypothermia	1,832.65	356.00
S32 Substance abuse	1,331.92	44.00
Total	**2,804,947.60**	**386,559.00**

Wellbeing and Retention

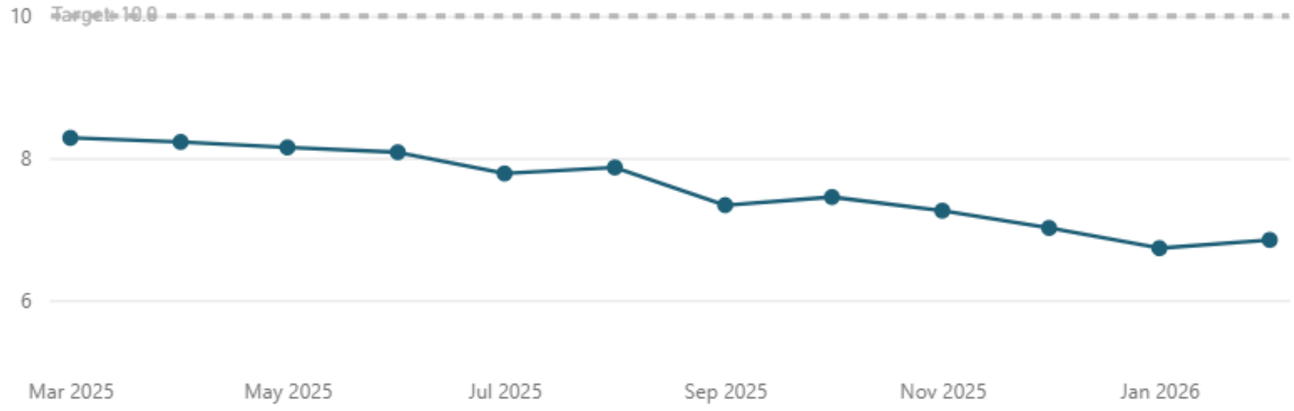
Overall Retention

Staff Group Summary

Staff Group	% Turnover	Leavers FTE (12m Avg)	Starters FTE (12m Avg)	First Year Termination FTE (12m Avg)	% First Year Termination
Add Prof Scientific and Technic	3.6%	10.3	16.2	1.0	9.8%
Additional Clinical Services	9.0%	239.2	417.2	64.3	26.9%
Administrative and Clerical	6.9%	198.2	289.5	45.6	23.0%
Allied Health Professionals	7.7%	95.7	87.4	14.7	15.3%
Estates and Ancillary	9.2%	100.1	111.4	22.1	22.1%
Healthcare Scientists	7.4%	28.0	39.3	2.0	7.1%
Medical and Dental	4.9%	43.7	937.5	6.0	13.7%
Nursing and Midwifery Registered	5.3%	247.9	180.6	18.8	7.6%
Students	0.0%	0.0	11.8	0.0	
Total	**6.8%**	**963.2**	**2091.0**	**174.5**	**18.1%**

Leavers does not include Fixed Term Contracts

% Turnover Over Time



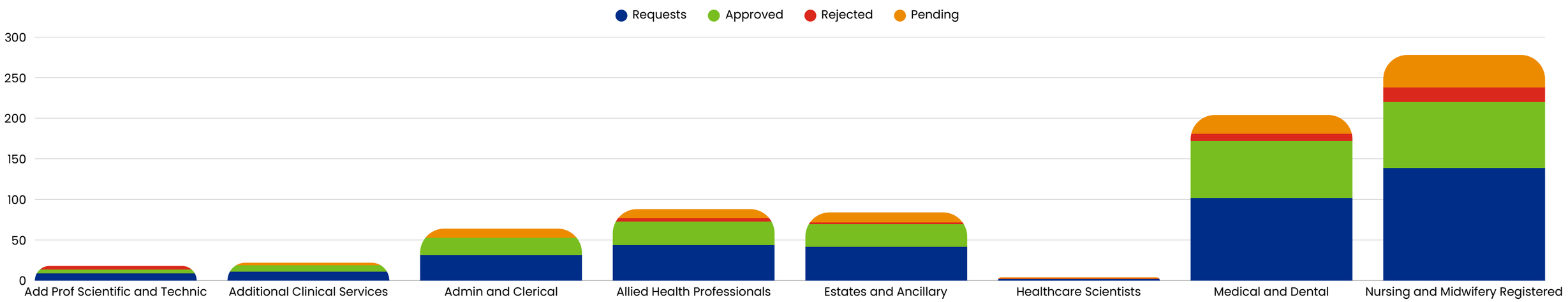
Leave Reasons

Leave Reasons - Selected Month	FTE
End of Fixed Term Contract	17.28
Voluntary Resignation - Relocation	15.88
Retirement Age	10.33
Voluntary Resignation - Work Life Balance	8.32
Voluntary Resignation - Other/Not Known	7.83
Voluntary Resignation - Health	4.45
Voluntary Resignation - Promotion	3.00
End of Fixed Term Contract - Completion of Training Scheme	2.00
Dismissal - Statutory Reason	1.56
Dismissal - Capability	1.00
Voluntary Early Retirement - with Actuarial Reduction	1.00
Voluntary Resignation - Lack of Opportunities	1.00
Voluntary Resignation - Pay and Reward Related	1.00
Voluntary Resignation - To undertake further education or training	1.00
Pregnancy	0.80
Retirement - Ill Health	0.64
Voluntary Resignation - Child Dependants	0.61
Dismissal - Some Other Substantial Reason	0.59
Death in Service	0.51
Voluntary Resignation - Incompatible Working Relationships	0.48
Has Not Worked	0.40
Total	**79.68**

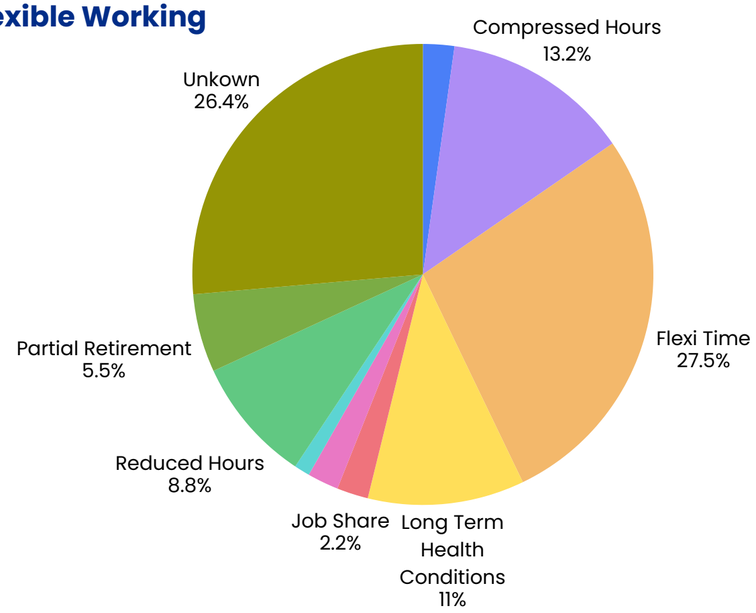
Wellbeing and Retention

This slide presents analysis of flexible working requests since the implementation of the new Group platform in November 2025, highlighting trends in requests and outcomes across staff groups.

Flexible Working Requests by Staff Group



Types of Flexible Working



Flexible Working Requests Overview

	Requests	Approved	Declined	Pending
Nov	9	7	1	1
Dec	53	36	9	8
Jan	132	94	24	14
Feb	137	91	8	38

Support & Further Information

For a more detailed view of workforce insights, Care Groups can access the HR Workforce Power BI Dashboard, which provides live data on:

- Establishment and vacancy position
- Temporary staffing usage (bank and agency)
- Turnover, sickness absence, and retention trends
- Workforce demographics and age profiles

HR Workforce Reports - Power BI Report Server

The dashboard allows you to explore data at both Trust and Care Group level, supporting ongoing monitoring and planning.

If you require any additional support with workforce data, or need help interpreting the information provided in this pack, please contact the Workforce Intelligence & Systems Team at:

GET IN TOUCH

nlg-tr.twworkforcedatareqs@nhs.net

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)116

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	14 May 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 - V19

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 **Boardroom, DPOW**	07.07.26 **Boardroom, HRI**	04.08.26 **Nightingale, SGH**	01.09.26 **Boardroom, CHH**	29.09.26 **(please note falls in September) Boardroom, DPOW**	03.11.26 **Nightingale, SGH**	01.12.26 **Boardroom, HRI**
Strategic Programmes & Partnerships (Thursdays - 9.00 am - 12.00 pm with exceptions as stated)						30.06.26 **Virtual Meeting**			17.09.26 **Boardroom, DPOW**			15.12.26 (Tuesday - 1.30 pm - 4.30 pm) **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		26.02.26 **Virtual Meeting** (1.00 pm - 4.00 pm)	26.03.26 **Virtual Meeting**	30.04.26 **Virtual Meeting**	28.05.26 **Boardroom, DPOW**	25.06.26 **Boardroom, HRI**	23.07.26 **Nightingale, SGH**		24.09.26 **Boardroom, HRI**	29.10.26 **Boardroom, DPOW**	26.11.26 **Nightingale, SGH**	17.12.26 **TBC, Goole**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)					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 **Boardroom, CHH**	26.08.26 **Boardroom, HRI**	23.09.26 **Nightingale, SGH**	28.10.26 **Boardroom, CHH**	25.11.26 **Boardroom, HRI**	16.12.26 **Boardroom, DPOW**
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26 **Virtual Meeting**			23.04.26 (subject to NHSE Submission Deadline **Virtual Meeting**		18.06.26 HUTH & NLaG **Annual Accounts** 1.30 pm - 4.30 pm **Nightingale, SGH**	30.07.26 **Boardroom, DPOW**				11.11.26 (Wednesday) **Boardroom, HRI**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26 **Boardroom, DPOW**			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			20.11.26	
Executive Team Meetings												
Group Cabinet Meeting	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)						

Hull University Teaching Hospitals NHS Trust

Trust Boards-in-Common – Front Sheet

Northern Lincolnshire and Goole NHS Foundation Trust

Meeting name	Trust Boards-in-Common
Meeting date	14 May 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

NHS
Humber Health
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

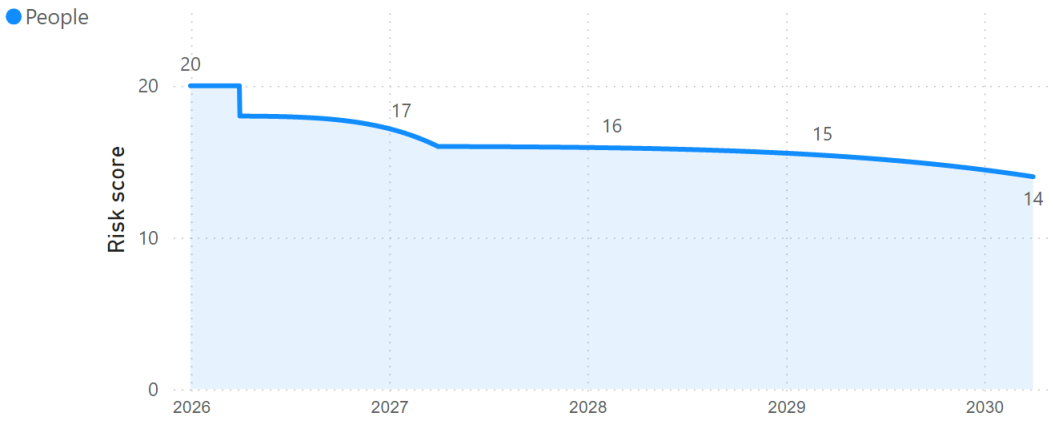
1. People

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:

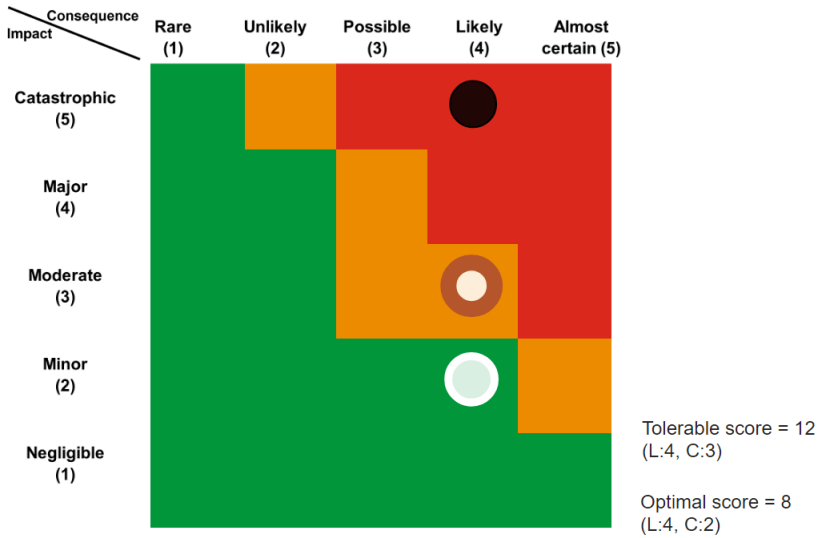
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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

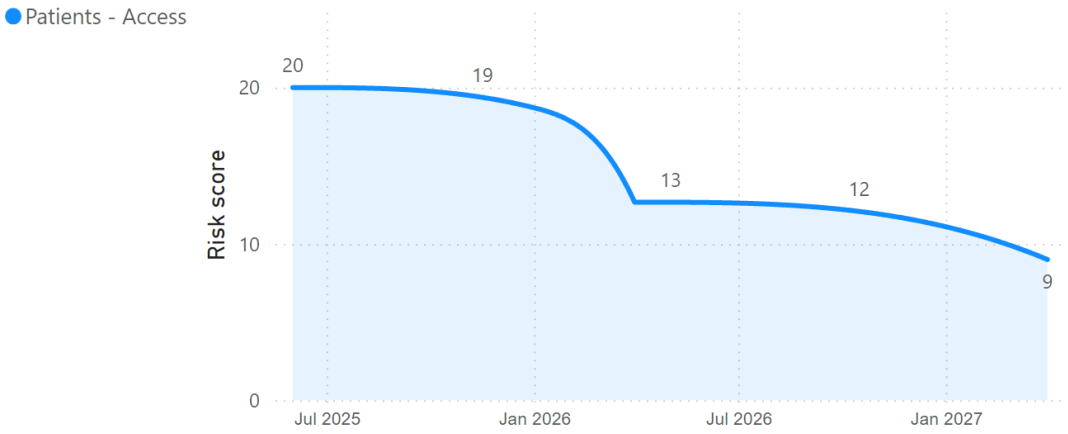
2. Patients - Access

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:

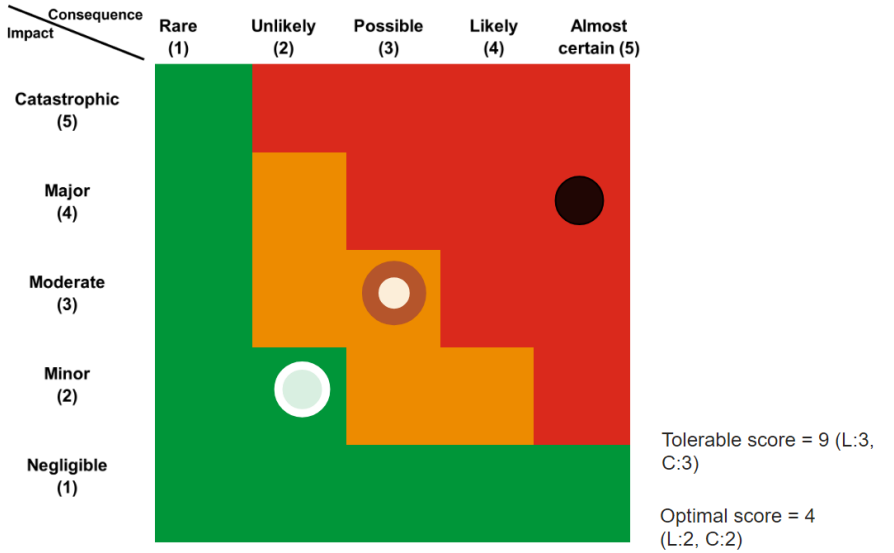
We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.

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

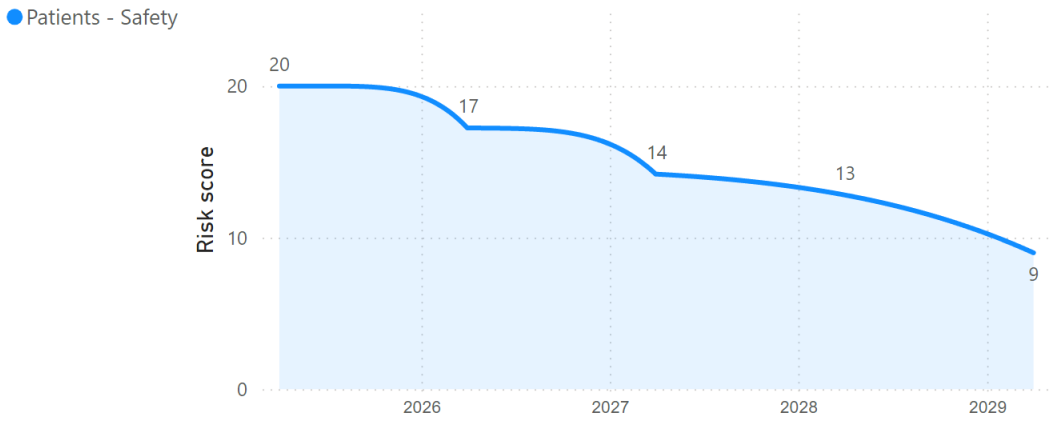
3. Patients - Safety

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:

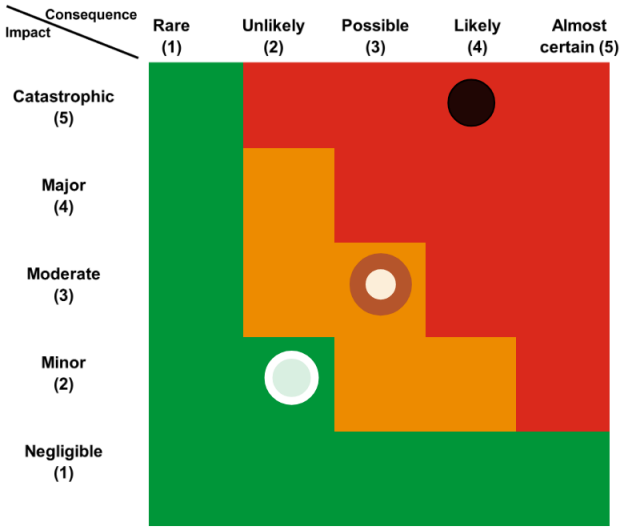
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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

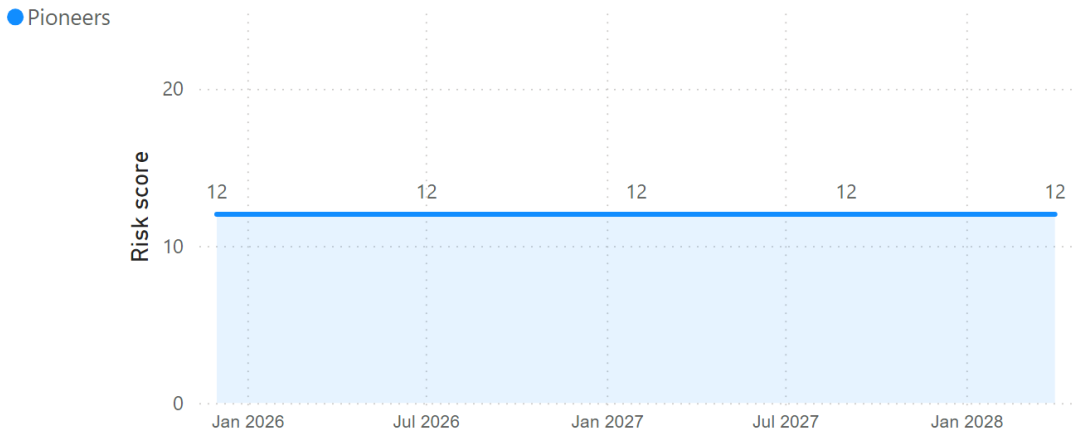
4. Pioneers

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:

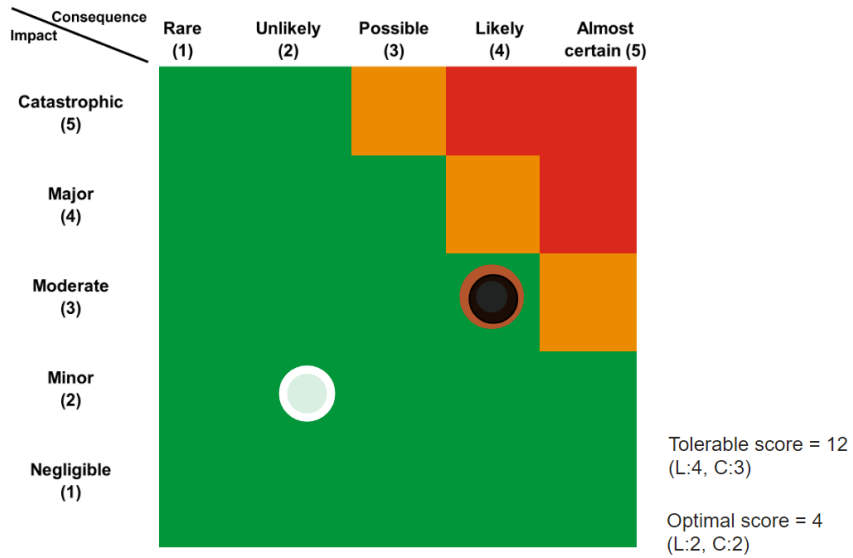
We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit 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

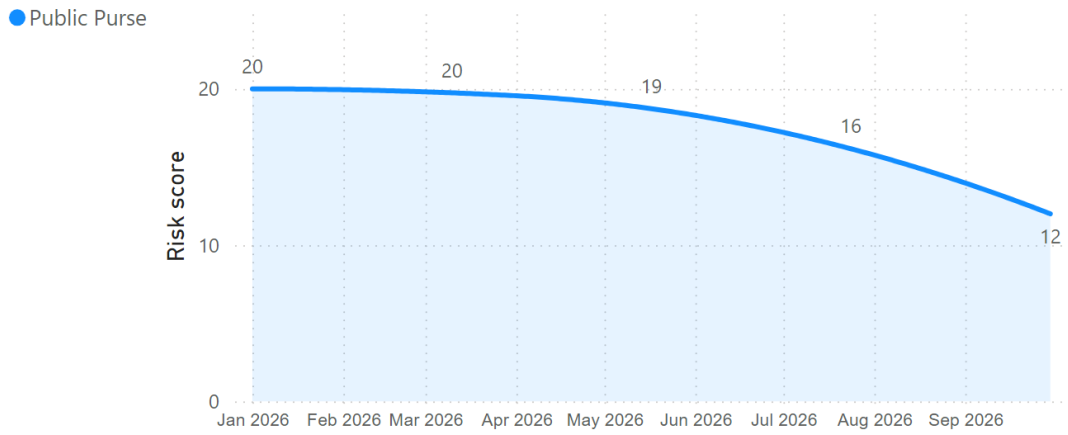
5. Public Purse

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:

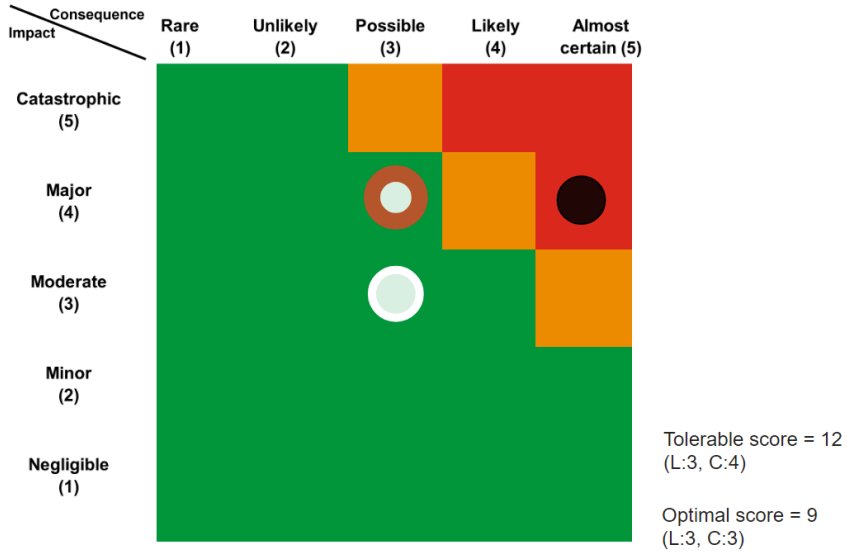
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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

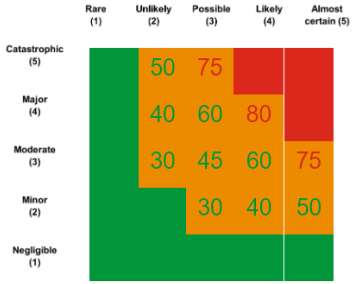
NHS Humber Health Partnership

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.

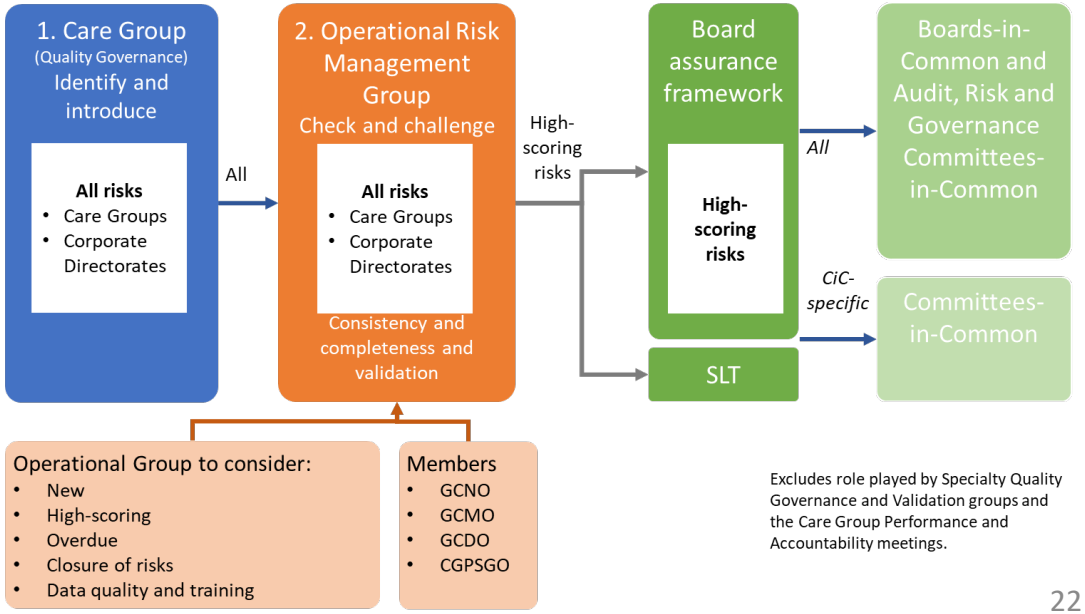
Intensive recovery programme

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)126

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	14 May 2026
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Alison Hurley, Deputy Director of Assurance
Title of Report	**Trust Constitution**
Executive Summary	The Trust Board (NLaG) is asked to approve amendments to the Trust Constitution. Capsticks LLP have reviewed the proposed amendments and recommended approval to the Trust Board and Council of Governors. The amendments for approval are as follows: • Section 11.6 and 11.7 (page 8) – further detail added to the need to maintain a reserved list from the latest elections for co-opting Governors if required • Section 23.1. and 23.2 (page 12) – further details regarding Non-Executive Director appointments added • Annex 1 (page 28) - Council ward information updated to reflect current ward names and Rest of England constituency added • Section 2.6 (page 33) - total number of Governors amended to 26 (from 25) • Section 4.4.1 (page 101) - potential annual re-appointment of a Non-Executive Director after the maximum nine years' service clarified • Various - minor corrections, refinements and job title changes throughout the document. The Trust Constitution is attached and details the amendments via track-changes for ease of reference.
Background Information and/or Supporting Document(s) (if applicable)	NHS Foundation Trust: Model Core Constitution
Prior Approval Process	Capsticks LLP Council of Governors (6 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 ☐ Assurance	☐ Information ☐ Other – please detail below:

V2

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

TRUST CONSTITUTION

Reference:	DCM001
Version:	8.0
This version issued:	dd/mm/26
Result of last review:	Major changes
Date approved by owner (if applicable):	N/A
Date approved:	dd/mm/2026 and dd/mm/2026
Approving body:	Trust Board / Council of Governors
Date for review:	April 2029
Owner:	Alan Downey, Group Chair / Lyn Simpson, Group Chief Executive
Document type:	Miscellaneous
Number of pages:	123 (including front sheet)
Author / Contact:	David Sharif, Group Director of Assurance

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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1. Name

1.1 The name of the foundation Trust is Northern Lincolnshire and Goole NHS Foundation Trust (“the Trust”).

2. Principal Purpose

2.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England (the "Principal Purpose").

2.2. The Trust does not fulfil its Principal Purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3. The Trust may provide goods and services for any purposes related to:

2.3.1. The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

2.3.2. The promotion and protection of public health.

2.4. Subject to the requirements of paragraph 40.2, the Trust may also carry on activities other than those mentioned in paragraph 2.3 for the purpose of making additional income available in order to better carry on its Principal Purpose.

3. Powers

3.1. The powers of the Trust are set out in the 2006 Act, and within the Health and Care Act 2022, subject to any restrictions in its Licence.

3.2. All the powers of the Trust shall be exercised by the Trust Board on behalf of the Trust.

3.3. Any of these powers may be delegated to a committee of directors or to an executive director.

4. Membership and Constituencies

4.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1.1 a public constituency and

4.1.2 a staff constituency.

5. Application for Membership

5.1. An individual who is eligible to become a member of the Trust may do so on application to the Trust.

5.2. Applications for membership shall be dealt with by the Trust in accordance with the provisions of Annex 8.

6. Public Constituency

6.1. An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

6.2. Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the public constituency.

6.3. The minimum number of members in each area specified as an area for a public constituency is specified in Annex 1.

7. Staff Constituency

7.1. An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided that:

7.1.1. he or she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve months; or

7.1.2. he or she has been continuously employed by the Trust under a contract of employment for at least twelve months.

7.2. Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised those functions continuously for a period of at least twelve months.

7.3. Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the staff constituency.

7.4. The minimum number of members in the staff constituency is specified in Annex 2.

7.5. An individual who is:

7.5.1. eligible to become a member of the staff constituency, and

7.5.2. invited by the Trust to become a member of the staff constituency, shall become a member of the Trust without an application being made, unless they inform the Trust that they do not wish to do so, in accordance with the process more fully set out in Annex 8.

8. Restriction on Membership

8.1. An individual who is a member of a constituency may not while membership of that constituency continues, be a member of any other constituency.

8.2. An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of any constituency other than the staff constituency.

8.3. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8.

9. Annual Members' Meeting

9.1. The Trust shall hold an annual members' meeting which shall be open to members of the public. Further provisions about the annual members meeting are set out Annex 6.

10. Council of Governors – Composition

10.1. The Trust shall have a Council of Governors, which shall comprise both elected and appointed governors.

10.2. The composition of the Council of Governors is specified in Annex 3.

10.3. The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency. The number of governors to be elected by each constituency is specified in Annex 3.

11. Council of Governors – Election of Governors

11.1. Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

11.2. Staff members must liaise with the Trust Secretary and then consult their Line Manager prior to nominating themselves as a Staff Governor. [Note: this is to ensure that staff members have discussed the Governor role commitments with their Line Manager.]

11.3. The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

11.4. A variation of the Model Rules by the Department of Health and Social Care shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

11.5. An election, if contested, shall be by secret ballot.

11.6. In the event that a vacancy is not filled by election, or a vacancy arises, the Council of Governors, by agreement at a meeting, may co-opt to that vacancy from a reserved list (as paragraph 11.7) until the next Governor elections, but the co-optee must be from the same constituency as the vacancy.

11.7. A reserved list from the most recent Governor elections will be maintained to allow succession planning and for use as co-optees until the next election process.

12. Council of Governors – Tenure

12.1. Subject to the transitional provisions, governors, both elected and nominated, shall hold office for three years and will be eligible for re-election or re-appointment as applicable at the end of that period.

12.2. A Governor may hold office for no more than three consecutive terms of three years, unless approved by the Council of Governors. An elected Governor may not immediately stand for election again on completion of the maximum term of nine years.

12.3. Should a governor's term of office end before the annual governor election process, the term of office may be extended by the Chair or Trust Secretary.

12.4. An elected governor shall cease to hold office if they cease to be a member of the constituency by which they were elected.

12.5. An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship and / or terminates the appointment.

13. Council of Governors – Disqualification and Removal

13.1. The following may not become or continue as a member of the Council of Governors:

13.1.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2. a person who has made a composition or arrangement with, or granted a Trust deed for, creditors and has not been discharged in respect of it;

13.1.3. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed.

13.2. Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14. Termination of office and Removal of Governors

14.1. A governor shall immediately cease to hold office if:

14.1.1. They resign by notice in writing to the Trust Secretary.

14.1.2. They fail to attend half of the council meetings in any financial year, unless the other governors are satisfied that:

- the absences were due to a reasonable cause and
- they will start attending council meetings within such a period as the governors consider reasonable.

14.2. In the case of an elected governor, they cease to be a member of the constituency by whom they were elected.

14.3. In the case of an appointed governor, the appointing organisation withdraws its sponsorship or terminates the appointment.

14.4. Without good reason the governor has failed to undertake any training required by the Council of Governors and / or fails to engage with the development review process for governors as agreed by the Council of Governors.

14.5. They have failed to sign and deliver to the Chair a statement in the form required by the Council of Governors confirming acceptance of the code of conduct and / or complete the Disclosure and Barring Service process within the specified time period.

14.6. They refuse to sign a declaration, in the form specified by the Council of Governors, that they are a member of one of the public constituencies or one of the classes of staff constituency as the case might be and are not prevented from being a member of the Council of Governors.

14.7. Any of the exclusion criteria listed in Annex 5 become applicable.

14.8. They are removed from the Council of Governors by a resolution, approved by a two-thirds majority of the remaining governors, that:

14.8.1. they have committed a serious breach of the code of conduct;

14.8.2. they have acted in a manner detrimental to the interests of the Trust,

14.8.3. the Council of Governors considers that it is not in the best interests of the Trust for that person to continue as governor.

14.9. Where there is any disagreement as to whether the proposal for removal of a governor is justified, an independent assessor agreeable to both parties shall be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

15. Council of Governors – Duties of Governors

15.1. The general duties of the Council of Governors are:

15.1.1. to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board;

15.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public within the Trust constituencies and wider integrated health and care system area; and

15.1.3. to assist with collaborative place-based system working.

15.2. The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

15.3. While the business of the Council of Governors is primarily conducted through or with the support of digital platforms, the Trust commits to provide full support to Governors (and candidates to be Governors) who feel unable to use digital platforms to engage in the business of the Council of Governors.

16. Council of Governors – Meetings of Governors

16.1. The Chair or, in the absence of the Chair, the Vice Chair or, in the absence of the Vice Chair, any other Non-Executive Director, shall preside at meetings of the Council of Governors.

16.2. Meetings of the Council of Governors shall be open to members of the public except as provided for in Annex 6.

16.3. For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

17. Council of Governors – Standing Orders

17.1. The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are provided for, are attached at Annex 6.

18. Council of Governors – Referral to the Panel for Advising Governors

18.1. The Panel is both independent and national and is appointed by NHSE. Its role is to answer questions raised by the governors of an NHS foundation Trust about whether the Trust has failed or is failing to act in accordance with:

18.1.1. its own Constitution; or

18.1.2. Chapter 5 of the NHS Act 2006.

18.2. A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral. Evidence of the vote will need to be provided to the Panel before it can consider a question from governors. The Panel's remit is to support governors in fulfilling their role in representing the interests of their members and the public. Best interests are served by governors seeking to resolve any questions or issues with their Trust chair and other Non-Executive Directors before posing a question to the Panel. However, the Panel is available as a free resource in the event of continued uncertainty.

19. Council of Governors – Conflicts of Interest of Governors

19.1. If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he or she becomes aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. Council of Governors – Expenses

20.1. The Trust shall pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

21. Trust Board – Composition

21.1. The Trust Board which shall comprise both Executive and Non-Executive Directors:

21.1.1. a Non-Executive Chair;

21.1.2. five other Non-Executive Directors; and

21.1.3. five Executive Directors.

21.2. One of the Executive Directors shall be the Chief Executive.

21.3. The Chief Executive shall be the accounting officer.

21.4. One of the Executive Directors shall be the Chief Financial Officer.

21.5. One of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984 (amendment order 2005)).

21.6. One of the Executive Directors shall be a registered nurse or a registered midwife.

22. Trust Board – General Duty

22.1. The general duty of the Trust Board and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

23. Trust Board – Qualification for Appointment as a Non-Executive Director (including the Chair)

23.1. A person may be appointed as a Non-Executive Director only if:

23.1.1. they are a member of a public constituency, or

23.1.2. they can demonstrate close personal or professional links with one or more of the public constituencies, or

23.1.3. they serve as a Non-Executive Director with another NHS body with which the Trust has entered into a Memorandum of Understanding, or

23.1.4. where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

23.1.5. they are not disqualified by virtue of paragraph 27 below.

24. Trust Board – Appointment and Removal of Chair and other Non-Executive Directors

24.1. The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

24.2. The Council of Governors shall appoint a Chair who is independent. This provision shall exclude anyone who:

- is a former Chief Executive of the Trust.
- has been an employee of the NHS foundation Trust within the last five years.
- has, or has had within the last three years, a material business relationship with the NHS foundation Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation Trust.
- has received or receives additional remuneration from the NHS foundation Trust apart from a director's fee, participates in the NHS foundation Trust's performance-related pay scheme, or is a member of the NHS foundation Trust's pension scheme;
- has close family ties with any of the NHS foundation Trust's advisers, directors or senior employees;
- holds cross directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board for more than nine years from the date of his or her first appointment;
- is an appointed representative of the NHS foundation Trust's university medical or dental school.

[These criteria shall apply only on appointment, thereafter the test of independence is not appropriate in relation to the Chair.]

24.3. Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

24.4. Subject to a Memorandum of Understanding, a Non-Executive Director from another NHS body, may undertake the role of Non-Executive Director at the Trust.

25. Trust Board – Appointment of Vice Chair

25.1. The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as Vice Chair.

25.2. The Vice Chair may undertake the role of Vice Chair or equivalent, in accordance with a Memorandum of Understanding with another NHS body.

26. Trust Board – Appointment and Removal of the Chief Executive and other Executive Directors

26.1. The Non-Executive Directors shall appoint or remove the Chief Executive.

26.2. The appointment of the Chief Executive shall require the approval of the Council of Governors. This shall be a subject of the first general meeting after the selection process and prior to the appointment being made.

26.3. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other executive directors.

27. Trust Board – Disqualification

27.1. The following shall not become or continue as a member of the Trust Board:

27.1.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

27.1.2. a person who has made a composition or arrangement with, or granted a Trust deed for, creditors and has not been discharged in respect of it;

27.1.3. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed;

27.1.4. a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, or/

27.1.5. a person who falls within the additional grounds for disqualification set out at Annex 8.

28. Trust Board – Meetings

28.1. Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

28.2. Before holding a meeting, the Trust Board must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Trust Board must send a copy of the minutes of the meeting to the Council of Governors.

28.3. The Chair (or Vice Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public such as to ensure that business shall be conducted without interruption and disruption.

28.4. There may be times and reasons why the Trust Board meetings are held 'virtually online' and not in person. The Chair (or Vice Chair) will decide these times in consultation with the Chief Executive.

29. Trust Board of Directors – Standing Orders

29.1. The standing orders for the practice and procedure of the Trust Board, as may be varied from time to time, are attached at Annex 7.

30. Trust Board – Liability of Directors

30.1. The Trust shall indemnify Non-Executive Directors in respect of any personal civil liability they incur as a result of carrying out their duties, provided that they have acted honestly, in good faith and without recklessness.

30.2. The Trust shall indemnify executive directors in respect of any personal civil liability they incur as a result of carrying out their duties, provided that they have acted honestly, in good faith, without recklessness and within the remit of their contractual duties as set out by the Trust.

31. Trust Board – Conflicts of Interest of Directors

31.1. The duties that a director of the Trust has by virtue of being a director include in particular:

31.1.1. a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

31.1.2. a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

31.2. The duty referred to in sub-paragraph 33.1.1 is not infringed if:

31.2.1. the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

31.2.2. the matter has been authorised in accordance with the Constitution.

31.3. The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4. In sub-paragraph 33.1.2, "third party" means a person other than:

31.4.1. the Trust; or

31.4.2. a person acting on its behalf.

31.5. If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

31.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

31.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

31.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

31.9. A director need not declare an interest:

31.9.1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

31.9.2. if, or to the extent that, the Trust Board are already aware of it;

31.9.3. if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:

- by a meeting of the Trust Board; or
- by a committee of the directors appointed for the purpose under the Constitution.

32. Trust Board of Directors – Remuneration and Terms of Office

32.1. The Council of Governors at a general meeting of the Council of Governors, following a recommendation by the Appointments & Remuneration Committee for Non-Executive Directors (including Chair, Vice Chair and Senior Independent Director), shall decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chair and the other Non-Executive Directors.

32.2. The Trust shall establish a committee of Non-Executive Directors (the 'Remuneration and Terms of Service Committee') to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

33. Committees in Common and Pooled Funds

33.1. The Trust may form Committees in Common, with two or more providers, to make joint arrangements and pool funds. [Note: Providers means: Trusts, Foundation Trusts, NHSE, Integrated Care Boards and Local Authorities].

34. Registers

34.1. The Trust shall have:

34.1.1. a register of members showing, in respect of each member, the constituency to which they belong;

34.1.2. a register of members of the Council of Governors;

34.1.3. a register of interests of governors;

34.1.4. a register of directors; and

34.1.5. a register of interests of the directors.

34.2. The process of admission to and removal from the register shall be as set out in Annex 8.

35. Registers – Inspection and Copies

35.1. The Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

35.2. The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

35.3. So far as the registers are required to be made available:

35.3.1. they are to be available for inspection free of charge at all reasonable times; and

35.3.2. a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

35.4. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36. Documents Available for Public Inspection

36.1. The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

36.1.1. a copy of the current Constitution:

36.1.2. a copy of the latest annual accounts and of any report of the auditor on them; and

36.1.3. a copy of the latest annual report and quality account;

36.1.4. a copy of the latest Care Quality Commission report and ratings. The Care Quality Commission report will also be available / published on the Care Quality Commission website.

36.2. The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

36.2.1. a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

36.2.2. a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;

36.2.3. a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act;

36.2.4. a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

36.2.5. a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

36.2.6. a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHSE's decision), 65KB (Secretary of State's response to NHSE's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

36.2.7. a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

36.2.8. a copy of any final report published under section 65I (administrator's final report);

36.2.9. a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

36.2.10. a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

36.3. Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.4. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Appointing & Removing the NHS Foundation Trust's External Auditor

37.1. The Trust shall have an external auditor.

37.2. The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

37.3. When appointing or removing the external auditor, governors must consider the criteria set out in the 'National Audit Office – Code of Audit Practice. In all matters regarding the appointment, re-appointment, removal, remuneration and terms of engagement of the external auditor, and in discharging its responsibilities in this regard as referred to above, the Council of Governors will be advised by the audit committee.

37.4. Should the Council of Governors not accept the recommendation of the audit committee then the Trust Board shall ensure that the annual report both includes a statement from the audit committee explaining the recommendation and also sets out the reasons why the Council of Governors has taken a different position.

37.5. Should the Council of Governors remove the auditor contrary to the advice of the audit committee then the Chair will advise NHSE in writing of the reasons behind the decision.

38. Audit, Risk and Governance Committee

38.1. The Trust shall establish a committee of Non-Executive Directors as an audit, risk and governance committee to perform such monitoring, reviewing and other functions as are appropriate.

38.2. The Council of Governors may appoint up to one governor (and one governor deputy to cover in their absence) as **observers**.

39. Accounts

39.1. The Trust shall keep proper accounts and proper records in relation to the accounts.

39.2. NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

39.3. The accounts shall be audited by the Trust's auditor.

39.4. The Trust shall prepare in respect of each financial year annual accounts in such form as NHSE may, with the approval of the Secretary of State, direct.

39.5. The functions of the Trust with respect to the preparation of the annual accounts shall as set out in paragraph 25 of schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

40. Annual Report, Forward (Operational) Plans and non-NHS Work

40.1. The Trust shall prepare an annual report and send it to NHSE.

40.2. The Trust shall give information as to its forward (operational) planning in respect of each financial year to NHSE.

40.3. The document containing the information with respect to forward (operational) planning (referred to in paragraph 40.2 above) shall be prepared by the directors.

40.4. In preparing the said document with respect to forward (operational) planning, the directors shall have regard to the views of the Council of Governors.

40.5. Each forward (operational) plan must include information about:

40.5.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

40.5.2. the income it expects to receive from doing so.

40.6. Where a forward (operational) plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must:

40.6.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

40.6.2. notify the directors of the Trust of its determination.

40.7. A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

41. Presentation of the Annual Accounts and Reports to the Governors and Members

41.1. The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

41.1.1. the annual accounts;

41.1.2. any report of the auditor on them; and

41.1.3. the annual report.

41.2. The documents shall also be presented to the members of the Trust at the annual members' meeting by at least one member of the Trust Board of Directors in attendance.

41.3. The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 41.1 with the annual members' meeting.

42. Resolution of Disputes

42.1. Should a disagreement arise between the Trust Board of Directors and the Council of Governors, such as would impair the decision making process or the successful operation of the Trust, then the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute.

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

43. Instruments

43.1. The Trust shall have a seal.

43.2. The seal shall not be affixed except under the authority of the Trust Board of Directors and as delegated to the Trust Secretary.

44. Amendment of the Constitution

44.1. The Trust may make amendments of its Constitution only if:

44.1.1. More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2. More than half of the members of the Trust Board of Directors of the Trust voting approve the amendments.

44.2. Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3. Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1. At least one member of the Council of Governors must attend the next annual members' meeting and present the amendment; and

44.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4. If more than half of the members voting approve the amendment, the amendment will continue to have effect; otherwise, it will cease to have effect and the Trust must take such steps as are necessary as a result.

44.5. Amendments by the Trust of its Constitution are to be notified to NHSE. For the avoidance of doubt, NHSE's function do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Significant Transactions

45.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors – not just half the number that attends the meeting at which the decision is taken.

45.2. The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve of the Trust entering into the transaction.

45.3. "Significant Transaction" means:

45.3.1. the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

45.3.2. the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

45.3.3. a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's gross assets before the transaction.

45.4. For the purpose of this paragraph:

45.4.1. "gross assets" means the total of fixed assets and current assets;

45.4.2. in assessing the value of any contingent liability for the purposes of sub-paragraph 45.3.3, the directors:

- must have regard to all circumstances that the directors know, or ought to know, affect, or may affect, the value of the contingent liability; and
- may rely on estimates of the contingent liability that are reasonable in the circumstances; and
- may take account of the likelihood of the contingency occurring.

45.5. Where the Trust is considering organisational transactions (mergers and acquisitions, transfer and dissolutions) or non-organisational transactions (significant capital investments, joint ventures and private finance initiatives), early engagement with NHSE is required. This process aims to reduce costs and allow Trusts to identify issues prior to committing significant resources to a particular transaction. Further guidance on the process for Trusts to follow when considering such transactions is outlined in the NHSE, Assuring and supporting complex change, Statutory transactions, including mergers and acquisitions, October 2022.

45.6. Where the Trust is undertaking significant transactions / proposals, a report should be presented to the Council of Governors.

46. Interpretation and definitions

46.1. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.

46.2. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

46.3. References in this Constitution to legislation include all amendments, replacements or re-enactments made in references to paragraph numbers or references to paragraphs of this Constitution unless the context provides otherwise.

46.4. References to legislation include all regulations and statutory guidance.

46.5. Headings are for ease of reference only and are not to affect interpretation.

46.6. If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein then the provisions of this Constitution shall prevail unless the law requires otherwise.

46.7. References to this paragraph are to paragraphs in this Constitution.

46.8. All Annexes referred to in this Constitution form part of it.

46.9. In this Constitution:

"accounting officer"	is the person who from time to time discharges the functions specified in paragraph 25(5) in Schedule 7 to the 2006 Act
"annual members' meeting"	means the annual meeting of all the members
"appointed governors"	means the local authority governors and the partnership organisation governors
"authorisation"	means the authorisation for the Trust to become an NHS foundation Trust given by Monitor at that time* [*Monitor became part of NHS Improvement as of 1 April 2016] [*NHS Improvement became part of NHS England as of 1 July 2022]
"Trust Board of Directors"	means the Trust Board of Directors of the Trust as constituted in accordance with this Constitution and referred to in paragraph 21
"Group **Chair**"	means the Group Chair of the Trust and Group as appointed in accordance with the Constitution
"Chief Executive"	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with paragraph 27

"constituencies"	means the public constituencies and the staff constituency of the Trust
"Constitution"	means this constitution of the Trust
"Council of Governors"	means the Council of Governors of the Trust as constituted in accordance with this Constitution
"deputy lead governor"	means the deputy of the lead governor
"director"	means a director on the Trust Board of Directors
"elected governors"	means the public and staff governors respectively
"election rules"	means the election rules set out in Annex 4 and which are to be used in connection with the election of the elected governors
"executive director"	means an executive director of the Trust
"financial year"	means-: (a) the period beginning with the date on which the Trust is authorised and ending with the next 31st March; and (b) each successive period of twelve months beginning with 1st April
"governor"	means a governor on the Council of Governors and being either an elected governor or an appointed governor
"group"	refers to the partnership established with Hull University Teaching Hospitals NHS Trust under a Memorandum of Understanding
"integrated care board"	means a statutory NHS organisation with responsibility for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area
"integrated care system"	means the partnership between NHS organisations, local councils and others, who take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve

“lead governor”	means the main governor contact in a few specific circumstances in which NHSE may need to contact the council of governors or the other way round (further details on this role are provided within the Standing Orders of the Council of Governors at Annex 6, 1.9)
"Licence"	means the Trust's licence granted by NHSE at the time under the 2012 Act
“member"	means a member of the Trust as determined in accordance with this Constitution
“members’ meetings”	means a meeting of the members
“membership”	means membership of the Trust through being a member of one of the constituencies
“model election rules”	means the model form rules for the conduct of elections published from time to time by the Department of Health and Social Care and as currently set out in Annex 4
“NHSE”	means the regulator for the purposes of the 2006 Act
“Non-Executive Directors”	means a Non-Executive Director of the Trust
“partnership organisation governor”	means a member of the Council of Governors appointed by a partnership organisation referred to in Annex 3
“partnership organisations”	means organisations designated as partnership organisations for the purposes of this Constitution and referred to in Annex 3
“public constituencies”	means that part of the Trust’s membership consisting of members from the area of the public constituency as described in Annex 1
“public governor”	means a member of the Council of Governors elected by the members of a public constituency
“qualifying local authorities”	means those Councils referred to in Annex 3 all of which are Councils for an area which includes the whole or part of the area of the Trust
“qualifying local authority governors”	means a member of the Council of Governors appointed by qualifying local authorities and referred to in Annex 3

"Trust Secretary"	means the Trust Secretary [this role is undertaken within NLAG by the Group Director of Assurance] of the Trust or any other person appointed to perform the duties of a 'company secretary'
"senior independent director"	means the Non-Executive Director appointed as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate
"staff constituency"	means that part of the Trust's membership consisting of staff of the Trust and other persons as described in paragraph 7
"staff governor"	means a member of the Council of Governors elected by the staff constituency
"the 2006 Act"	means the National Health Service Act 2006
"the 2022 Act"	means the Health and Care Act 2022
"the Trust"	means the Northern Lincolnshire and Goole NHS Foundation Trust
"transitional provisions"	means those provisions relating to the terms of office of the initial governors as set out in Annex 3
"Vice Chair"	means the Vice Chair of the Trust

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of the Public Constituency	Area of the public constituency by Electoral Wards	Minimum number of members	Number of Governors to be elected
North Lincolnshire	The Wards of: Ashby Central; Ashby Lakeside; Axholme Central; Axholme North; Axholme South; Barton; Bottesford; Brigg & Wolds; Broughton & Scawby; Brumby; Burringham & Gunness; Burton upon Stather & Winterton; Crosby & Park; Ferry; Frodingham; Kingsway with Lincoln Gardens; Messingham; Ridge; Town.	500	5
North East Lincolnshire	The Wards of: Croft Baker; East Marsh; Freshney; Haverstoe; Heneage; Humberston & New Waltham; Immingham; Park; Scartho; Sidney Sussex; South; Waltham; West Marsh; Wolds; Yarborough.	500	5
Goole & Howdenshire	The Wards of Goole North; Goole South; Howden; Howdenshire; Snaith, Airmyn & Rawcliffe and Marshlands.	200	3

East & West Lindsey	The Wards of: BinBrook; Fulstow; Grimoldby; Holme; Holton Le Clay and North Thoresby; Legbourne; Louth North Holme; Louth Priory and St James; Louth St Margaret's; Louth St Mary's, Louth St Michael's; Louth Trinity; Mablethorpe; Marshchapel and Somercotes;;; Sutton on Sea; Tetney; Withern and Theddlethorpe. Caistor and Yarborough; Gainsborough East; Gainsborough North; Gainsborough South West; Hemswell; Kelsey Wold; Scotter and Blyton;Waddingham and Spital; Wold View.	200	3
Rest of England	The rest of England excluding the areas above	10	0

ANNEX 2 – THE STAFF CONSTITUENCY

There are no classes within the staff constituency. The minimum number of members in the staff constituency is 150.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1. Introduction

1.1 The Council of Governors shall comprise governors who are:

1.1.1 elected by the respective constituencies in accordance with the provisions of this constitution; and

1.1.2 appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of governors who are elected by members of the Trust other than those who are members of the staff constituency.

2. Bodies entitled to appoint a member of the Council of Governors

2.1 The following bodies in this paragraph 2 shall be entitled to appoint a governor or governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Qualifying Local Authorities

There are four qualifying local authorities covering the areas specified within the Trust's Constitution as a public constituency, as follows:

- East Riding of Yorkshire
- Lincolnshire
- North East Lincolnshire
- North Lincolnshire

2.3 There will be four local authority seats on the Council of Governors for the four qualifying local authorities.

2.4 A governor appointed under paragraph 2.3 above shall then serve on the Council of Governors for the period stipulated in the Constitution.

2.5 Partnership Organisations

2.5.1 Place Health and Care Partnerships (North Lincolnshire and North East Lincolnshire)

2.5.1.1 Place Health and Care Partnerships for North Lincolnshire and North East Lincolnshire shall be entitled to appoint one governor each in accordance with a process of appointment agreed by them with the Trust. The absence of any such agreed process of appointment shall not preclude the said Place Partnerships from appointing their governors provided the appointment is duly made in accordance with the Place Partnerships' own internal processes.

2.5.1.2 If a Place Partnership named in paragraph 2.5.1.1 above declines or fails to appoint a governor within three months of being requested to do so by the Trust, the Trust shall in its absolute discretion be entitled to invite any of those other Place Partnerships to whom it provides goods and services to appoint a governor in substitution for the Place Partnerships detailed which has failed or declined to do so.

2.5.1.3 If the invitation referred to in paragraph 2.5.1.1 above is accepted by a member or officer of either Place Partnership, they shall be appointed as governor. Any Place Partnership appointment that has previously failed, shall cease to be entitled to do so. The Trust shall give notice of that invitation to NHS England.

2.5.1.4 Subject to paragraph 2.5.1.5 below, if the invitation is not accepted within a reasonable period or such period as may have been specified in the invitation, the Trust shall invite any other such Place Partnership to appoint a governor until the invitation, is accepted and a governor is appointed.

2.5.1.5 Any governor appointed under paragraphs 2.5.1.3 and 2.5.1.4 above shall serve on the Council of Governors for the period stipulated in the constitution. At the end of that period the Trust shall in its absolute discretion decide whether to permit that which had first failed or declined to appoint a governor to do so for the next period of office or to invite the Place Partnership which had appointed a governor in substitution to do so.

2.5.2 Notwithstanding the foregoing provisions of this paragraph, the Trust shall in its absolute discretion be entitled to:

2.5.2.1 give not less than six months' notice to the Place Partnership referred to in paragraphs 2.5.1.1 above (or any substituted Place Partnership appointed under paragraphs 2.5.1.2 and 2.5.1.4 above) terminating their right to appoint a governor and upon the expiration of that notice period or such other date as the Trust and the relevant Place Partnership may agree that Place Partnership right to appoint a governor shall be terminated and the period of office of the governor appointed by that Place Partnership shall also come to an end on that date; and

2.5.2.2 appoint another Place Partnership for which the Trust provides goods and services to replace that Place Partnership to which notice has been given under paragraph 2.5.3 above save that these provisions shall at all times be operated so as to ensure that the number of Place Partnership entitled to appoint a governor remains as provided for in paragraph 2.5.1.1 and 2.5.1.2 above.

2.6 The Composition of the Council of Governors

The composition of the Council of Governors shall be as set out in Table 1 below

Table 1:

	Electing/Appointing Body	Number of Governors
1.	**Public Constituency Governors**	
1.1	North East Lincolnshire Constituency	5
1.2	North Lincolnshire Constituency	5
1.3	East and West Lindsey Constituency	3
1.4	Goole & Howdenshire Constituency	3
2.	**Staff Governors**	4
3.	**Partnership Organisations**	
3.1	North East Lincolnshire Health and Care Partnership	1
3.2	North Lincolnshire Health and Care Partnership	1
4.	**Qualifying Local Authority Governors**	
4.1	East Riding of Yorkshire	1
4.2	Lincolnshire	1
4.3	North East Lincolnshire	1
4.4	North Lincolnshire	1
	Total number of governors	**26**

ANNEX 4 – THE MODEL RULES FOR ELECTIONS

(Paragraph 11 of the Trust Constitution refers)

Part 1 – Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5 – Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers
30. Lost voting information
31. Issue of replacement voting information
32. Declaration of identity for replacement ballot information
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Part 1 – Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"corporation" means the public benefit corporation subject to this Constitution;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"the regulator" means the Independent Regulator for NHS foundation trusts; and "the 2006 Act" means the National Health Service Act 2006;

"e-voting" means voting using the internet;

"internet voting system" means such computer hardware and software, data, other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"method of polling" means voting either by post or internet;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or,
(c) a day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 – Stages Common to Contested and Uncontested Elections

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;
(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;
(d) the details of any nomination committee that has been established by the corporation;
(e) the address and times at which nomination papers may be obtained;
(f) the address for return of nomination papers and the date and time by which they must be received by the returning officer;
(g) the date and time by which any notice of withdrawal must be received by the returning officer;
(g) the contact details of the returning officer; and,
(h) the date and time of the close of the poll in the event of a contest,

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination paper, and;
(b) is to prepare a nomination paper for signature at the request of any member of the corporation;

but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination paper must state the candidate's:

(a) full name;
(b) contact address in full; and,
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination paper must state:

(a) any financial interest that the candidate has in the corporation; and,
(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,
(b) for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;
(d) that the paper does not include a declaration of eligibility as required by rule 12; or,
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the public free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.
(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.
(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling;
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and,
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituencies)

21.1 In respect of an election for a public constituency a declaration of identity must be issued with all ballot information.

21.2 The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot information was addressed;
(b) that the voter has not marked or returned any other voting paper in the election; and,
(c) for a member of the public constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

21.3 The declaration of identity is to include space for:

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and,
(d) the date that the declaration was made by the voter.

21.4 The voter must be required to return the declaration of identity together with the ballot information, or complete the electronic declaration prior to voting electronically.

21.5 The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, or if it is not completed prior to electronic voting, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

22.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19.3;
(f) the address for return of the ballot papers, and the date and time of the close of the poll;
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located;
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located;
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located;
(j) the address and final dates for applications for replacement voting information; and,
(k) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information to each member of the corporation named in the list of eligible voters:

(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 22 able to cast their vote by post:
(i) a ballot paper and ballot paper envelope;
(ii) a declaration of identity (if required);
(iii) information about each candidate standing for election, pursuant to rule 68 of these rules; and,
(iv) a covering envelope.

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
(i) instructions on how to vote;
(ii) the eligible voter's voter ID number;
(iii) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate;
(iv) contact details of the returning officer.

24.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and,
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed declaration of identity if required; and,
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The provision of the polling website and internet voting system will:

(a) require a voter, to be permitted to vote, to enter his voter ID number;
(b) specify:
  (i) the name of the corporation;
  (ii) the constituency, or class within a constituency, for which the election is being held;
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency;
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
  (v) instructions on how to vote.
(c) prevent a voter voting for more candidates than they are entitled to at the election;
(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of:
  (i) the voter ID number used by the voter;
  (ii) the candidate or candidates for whom he has voted; and,
  (iii) the date and time of his vote;
(e) if their vote has been cast and recorded, provide the voter with confirmation;
(f) prevent any voter voting after the close of poll.

26.5 The provision of a telephone voting facility and telephone voting system, will:

(a) require a voter to be permitted to vote, to enter his voter ID number;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

26.6 The provision of a text message voting facility and text messaging voting system, will:

(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless:

(a) satisfied as to the voter's identity; or,
(b) the declaration of identity, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter and confirmation of the voter's identity;
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and,
(c) the details of the unique identifier of the replacement ballot paper.

30. Lost voting information

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information for lost voting information unless they:

(a) are satisfied as to the voter's identity;
(b) have no reason to doubt that the voter did not receive the original voting information;
(c) has ensured that the declaration of identity if required has not been returned.

30.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):

(a) the name of the voter;
(b) the details of the unique identifier of the replacement ballot paper; and,
(c) if applicable, the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and,
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

32. Declaration of identity for replacement voting information (public constituencies)

32.1 In respect of an election for a public constituency a declaration of identity must be issued with all replacement ballot information.

32.2 The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot information other than the ballot information being returned or completed with the declaration; and,
(b) of the particulars of that member's qualification to vote as a member of the public constituency, or class within a constituency, for which the election is being held.

32.3 The declaration of identity is to include space for:

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and,
(d) the date that the declaration was made by the voter.

32.4 The voter must be required to return or electronically complete the declaration of identity together with the ballot paper.

32.5 The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, or electronically completed prior to e-voting, the replacement ballot information may be declared invalid.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter must enter their voter ID number.

33.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with Part Five of these rules, for whom they wish to vote.

34.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives a:

(a) covering envelope; or,
(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any ballot paper covering envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or,
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they should:

(a) put the declaration of identity if required in a separate packet; and,
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they should:

(a) mark the ballot paper “disqualified”;
(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper;
(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and,
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

38. De-duplication of votes

38.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

38.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:

(a) only accept as duly returned the first vote received that contained the duplicated voter ID number;

(b) mark as "disqualified" all other votes containing the duplicated voter ID number

38.3 Where a ballot paper is "disqualified" under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) record the unique identifier and voter id number on the ballot paper in a list (the "list of disqualified documents"); and

(c) place the ballot paper in a separate packet.

38.4 Where an internet, telephone or text voting record is "disqualified" under this rule the returning officer shall:

(a) mark the record as "disqualified",

(b) record the voter ID number on the record in a list (the "list of disqualified documents".

(c) disregard the record when counting the votes in accordance with these Rules.

39. Declaration of identity but no ballot paper (public constituency) – Where the returning officer receives a declaration of identity if required but no ballot paper:

(a) mark the declaration of identity "disqualified";
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity has been received from the voter without a ballot paper; and,
(c) place the declaration of identity in a separate packet.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;
(b) the declarations of identity if required;
(c) the list of spoilt ballots;
(d) the list of lost ballots;
(e) the list of eligible voters;
(e) the list of tendered ballots; and,
(f) complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage.

Part 6 – Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

41. Single Transferable Vote (STV) - Interpretation of Part 6

In part 6 of these rules:

"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record;

"continuing candidate" means any candidate not deemed to be elected, and not excluded;

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;

"mark" means a figure, an identifiable written word, or a mark such as "X";

"non-transferable vote" means a ballot:

(a) on which no second or subsequent preference is recorded for a continuing candidate; or,

(b) which is excluded by the returning officer under rule 49 - STV below;

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference;
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and,
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;

"quota" means the number calculated in accordance with rule 46 - STV below;

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus;

"stage of the count" means:

(a) the determination of the first preference vote of each candidate;
(b) the transfer of a surplus of a candidate deemed to be elected; or,
(c) the exclusion of one or more candidates at any given time;

"transferable vote" means a ballot on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;

"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred; and,

"transfer value" means the value of a transferred vote calculated in accordance with rules 47.4 - STV or 47.7 - STV below

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

43. The count

43.1 The returning officer is to:

(a) count and record the number of votes that have been returned; and,
(b) count the votes according to the provisions in this Part of the rules.

43.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. STV - Rejected ballot papers

44.1 STV - Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or,
(d) which is unmarked or rejected because of uncertainty;

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.2 STV – The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

44.3 STV - The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 - STV

44. First Past the Post (FPP) - Rejected ballot papers

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which votes are given for more candidates than the voter is entitled to vote;
(b) on which anything is written or marked by which the voter can be identified except the unique identifier; or,

(c) which is unmarked or rejected because of uncertainty;

shall, subject to rules 44.2- FPP and 44.3 - FPP, be rejected and not counted.

44.2 FPP - Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.3 FPP - A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place;
(b) otherwise than by means of a clear mark;
(c) by more than one mark;

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

44.4 FPP - The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted; and
(b) in the case of a ballot paper on which any vote is counted under rules 44.2 - FPP and 44.3 - FPP, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 FPP - The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to;
(c) writing or mark by which voter could be identified; and,
(d) unmarked or rejected because of uncertainty;

and, where applicable, each heading must record the number of ballot papers rejected in part.

45. STV - First stage

45.1 STV - The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

45.2 STV - The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

45.3 STV - The returning officer is to also ascertain and record the number of valid ballots.

46. STV - The quota

46.1 STV - The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

46.2 STV - The result, increased by one, of the division under rule 46.1 - STV (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

46.3 STV - At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 - STV to 47.3 - STV has been complied with.

47. STV - Transfer of votes

47.1 STV - Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballots for any continuing candidate; or,
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 STV - The returning officer is to count the number of ballots in each parcel referred to in rule.

47.3 STV - The returning officer is, in accordance with this rule and rule 48 - STV, to transfer each sub-parcel of ballots referred to in rule 47.1(a) - STV to the candidate for whom the next available preference is given on those papers.

47.4 STV - The vote on each ballot transferred under rule 47.3 - STV shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and,
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 STV - Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballots for any continuing candidate; or,
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 STV - The returning officer is, in accordance with this rule and rule 48 - STV, to transfer each sub-parcel of ballots referred to in rule 47.5(a) - STV to the candidate for whom the next available preference is given on those ballots.

47.7 STV - The vote on each ballot transferred under rule 47.6 - STV shall be at:

(a) a transfer value calculated as set out in rule 47.4(b) - STV; or,
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

47.8 STV - Each transfer of a surplus constitutes a stage in the count.

47.9 STV - Subject to rule 47.10 - STV, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 STV - Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are**:**

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or,
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

47.11 STV - This rule does not apply at an election where there is only one vacancy.

48. STV - Supplementary provisions on transfer

48.1 STV - If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and,
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

48.2 STV - The returning officer shall, on each transfer of transferable ballots under rule 47 - STV:

(a) record the total value of the votes transferred to each candidate;
(b) add that value to the previous total of votes recorded for each candidate and record the new total;
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and,
(d) compare**:**
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with,
    (ii) the recorded total of valid first preference votes.

48.3 STV - All ballots transferred under rule 47 - STV or 48 - STV shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

48.4 STV - Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule 47 - STV or 48 - STV for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. STV - Exclusion of candidates

49.1 STV - If:

(a) all transferable ballots which under the provisions of rule 47 – STV (including that rule as applied by rule 49.11 - STV and this rule are required to be transferred, have been transferred; and,
(b) subject to rule 50 - STV, one or more vacancies remain to be filled;

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 - STV applies, the candidates with the then lowest votes).

49.2 STV - The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule 49.1 - STV into two sub-parcels so that they are grouped as:

(a) ballots on which a next available preference is given; and,
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 STV - The returning officer shall, in accordance with this rule and rule 48 - STV, transfer each sub-parcel of ballots referred to in rule 49.2 - STV to the candidate for whom the next available preference is given on those ballots.

49.4 STV - The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

49.5 STV - If, subject to rule 50 - STV, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule 49.1 - STV into sub- parcels according to their transfer value.

49.6 STV - The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

49.7 STV - The vote on each transferable ballot transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

49.8 STV - Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 STV - After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

49.10 STV - The returning officer shall after each stage of the count completed under this rule:

(a) record:
  (i) the total value of votes; or,
  (ii) the total transfer value of votes transferred to each candidate;
(b) add that total to the previous total of votes recorded for each candidate and record the new total;
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and,
(d) compare:

  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with,
  (ii) the recorded total of valid first preference votes.

49.11 STV - If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 - STV 47.10 - STV and rule 48 - STV.

49.12 STV - Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

49.13 STV - If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest**:**

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and,
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. STV - Filling of last vacancies

50.1 STV - Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

50.2 STV - Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

50.3 STV - Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. STV - Order of election of candidates

51.1 STV - The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10 - STV.

51.2 STV - A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

51.3 STV - Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

51.4 STV - Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

51. FPP - Equality of votes

51.1 FPP - Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

52. STV - Declaration of result for contested elections

52.1 STV - In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;
(b) give notice of the name of each candidate who they have declared elected:

(i) where the election is held under a proposed Constitution pursuant to powers conferred on the Northern Lincolnshire and Goole Foundation NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust; or,
(ii) in any other case, to the Chair of the corporation; and,

(c) give public notice of the name of each candidate who they have declared elected.

52.2 STV - The returning officer is to make**:**

(a) the number of first preference votes for each candidate whether elected or not;
(b) any transfer of votes;
(b) the total number of votes for each candidate at each stage of the count at which such transfer took place;
(d) the order in which the successful candidates were elected; and,
(e) the number of rejected ballot papers under each of the headings in rule STV- 44.1,
available on request.

52. FPP - Declaration of result for contested elections

52.1 FPP - In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected;

(b) give notice of the name of each candidate who they have declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the Northern Lincolnshire and Goole Foundation NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and,

(b) give public notice of the name of each candidate whom they have declared elected.

52.2 FPP - The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not); and,
(b) the number of rejected ballot papers under each of the headings in rule 44.5 - FPP, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;
(b) give notice of the name of each candidate who they have declared elected to the Chair of the corporation; and,
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 – Disposal of documents

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;
(b) the ballot papers endorsed with “rejected in part”;
(c) the rejected ballot papers;
(d) papers; and,
(e) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;
(b) the list of spoilt ballot papers;
(c) the list of lost ballots;
(d) the list of eligible voters;
(e) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage; and,
(f) the list of tendered ballot papers.

54.3 The returning officer must endorse on each packet a description of**:**

(a) its contents;
(b) the date of the publication of notice of the election;
(c) the name of the corporation to which the election relates; and,
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 54, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll; or,
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or,
(c) any applications for replacement voter information is made too late to enable new ballot papers to be issued.

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;
(b) any disqualified documents, or the list of disqualified documents;
(c) any counted ballot papers;
(d) any declarations of identity;
(e) the list of eligible voters; or,
(f) the complete electronic copies of records referred to in rule 26 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

58.2 A person may apply to the Regulator to inspect any of the documents listed in rule 58.1, and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;
(b) time;
(c) place and mode of inspection;
(d) production or opening, and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1:

(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that their vote was given; and,
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

59. STV - Countermand or abandonment of poll on death of candidate

59.1 STV - If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and,

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballots which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and,

(ii) ballots which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 STV - The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 54.1(a).

59. FPP - Countermand or abandonment of poll on death of candidate

59.1 FPP - If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class; and,
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

59.2 FPP - Where a new election is ordered under rule 59.1 - FPP, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

59.3 FPP - Where a poll is abandoned under rule 59.1(a) - FPP, rules 59.4 - FPP to 59.7 - FPP are to apply.

59.4 FPP - The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 37 and 38, and is to make up separate sealed packets in accordance with rule 39.

59.5 FPP - The returning officer is to:

(a) count and record the number of ballot papers that have been received; and,
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers;
(c) seal up the electronic copies of records that have been received referred to in rule 26 held in a device suitable for the purpose of storage.

59.6 FPP - The returning officer is to endorse on each packet a description of:

(a) its contents;
(b) the date of the publication of notice of the election;
(c) the name of the corporation to which the election relates; and,
(d) the constituency, or class within a constituency, to which the election relates.

59.7 FPP - Once the documents relating to the poll have been sealed up and endorsed pursuant to rules 59.4 - FPP to 59.6 - FPP, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

Part 10 – Election expenses and publicity

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to

(a) personal expenses;
(b) travelling expenses, and expenses incurred while living away from home; and,
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or their family any money or property (whether a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates; and,
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be**:**

(a) objective, balanced and fair;
(b) equivalent in size and content for all candidates;
(c) compiled and distributed in consultation with all of the candidates standing for election; and,
(d) must not seek to promote or procure the election of a specific candidate or candidates, the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words;
(b) a photograph of the candidate;
(c) an optional video statement may also be submitted.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or,
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and,
(b) be in such a form as the Regulator may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

66.8 The determination by the person or persons nominated in accordance with rule 64.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

66.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

67. Secrecy

67.1 The following persons:

(a) the returning officer;
(b) the returning officer's staff, must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted;
(ii) the unique identifier on any ballot paper;
(iii) the voter ID number allocated to any voter;
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in**:**

(a) the delivery of the documents in rule 24; or,
(b) the return of the ballot papers and declarations of identity;

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section 13)

1.1 A Governor:

1.1.1 shall cease to hold office if:

(a) they cease to be a Member of a Trust constituency or, in the case of an Appointed Governor, if the body which appointed them withdraws its appointment at any time;

(b) their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or are otherwise ineligible to hold office as a Governor; or

1.1.2 they resign by notice in writing to the Trust.

1.2 Notwithstanding the provisions of paragraph 1.1.1(a) above, a Public Governor elected by a Public Constituency who ceases to be eligible to be a Member of that Public Constituency but who is eligible to be and forthwith becomes a Member of another Public Constituency shall not by virtue of paragraph 1.1.1(a) above cease to hold office but shall continue in office as Public Governor for the Constituency which elected them for the remainder of the term for which he was elected.

2. Council of Governors: Nomination of, Disqualification and Removal

2.1 In addition to those provisions in Section 13 of the Constitution, the following persons shall not become or continue to be eligible as a member of the Council of Governors:

2.1.1 anyone who is a director or chair of the Trust or a governor of another healthcare Trust or equivalent NHS funded provider.

2.1.2 persons defined as a vexatious complainant or litigant, as determined by the Trust Chair, Chief Executive and Trust Secretary (two out of the three have to agree).

2.1.3 staff and appointed governors with current disciplinary action, ongoing investigations, or who have a disciplinary sanction still in force will not be permitted to be elected, or if already elected carry out the role of a governor.

2.1.4 members who have been dismissed otherwise than by reason of redundancy or ill health from any paid employment with a health service body.

2.1.5 whilst the Trust will not automatically reject nominations for potential governors based on previous adverse employment / relationships issues with the Trust or other organisations, it does reserve the right to reject / not support applications if it believes that such an appointment would not support the Trust's culture or values. This decision will be made by Trust Chair, Chief Executive and Trust Secretary (two out of the three have to agree). Each case will be considered on a case by case basis.

2.1.6 persons whose name appears or is added to the Sex Offenders Register, of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and / or the Children and Young Person's Act 1933 and updated in 2008.

2.1.7 a person whose tenure of office as the Chair, governor or director of a health service body has been terminated on the grounds that the appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

2.1.8 anyone who is suffering from a mental disorder and is either admitted to hospital in pursuance of an application for admission for treatment under the Mental Health Act 1983 or is subject to an order made by a court having jurisdiction in matters concerning mental disorder for detention or for the appointment of a receiver; and is, therefore, incapable by reason of mental disorder of carrying out the duties of a governor.

2.1.9 has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or nonpecuniary interest and they are judged to have acted so by a majority of not less than 75% of the Council of Governors at a meeting;

2.1.10 NHSE has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or NHSE has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

2.1.11 has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

2.1.12 their term of office is terminated pursuant to paragraph 3 below;

2.1.13 is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six months;

2.1.14 the relevant organisation which they represents ceases to exist;

2.1.15 is a member of the UK Parliament;

2.1.16 is a Director of the Trust.

2.2 Where a person has been elected or appointed to be a Governor and they become disqualified from that appointment they shall notify the Trust Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered them disqualified.

2.3 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare them disqualified and shall give them notice in writing to that effect as soon as practicable.

2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Governor and their name shall be removed from the Register of Governors.

2.5 If a complaint is received against a member of the Council of Governors, it shall be referred to the Chair who will address the complaint appropriately based on a case by case basis in liaison with the Trust Secretary and/or Director of People as necessary.

2.5.1 the Chair upon receipt of the complaint may carry out an investigation and may suspend the Governor from duties. If the outcome of the investigation is to terminate the Governor, the process is set out under paragraph 3. [Note: the investigation will be determined on a case by case basis].

3. Council of Governors: Termination of Office

3.1 A governor shall immediately cease to hold office if:

3.1.1 they resign by notice in writing to the Trust Secretary;

3.1.2 they fail to attend half of the council meetings in any financial year, unless the other governors are satisfied that:

(a) the absences were due to a reasonable cause and

(b) they will start attending council meetings within such a period as the governors consider reasonable.

3.1.3 in the case of an elected governor, they cease to be a member of the constituency by whom they were elected.

3.1.4 in the case of an appointed governor, the appointing organisation withdraws its sponsorship or terminates the appointment.

3.1.5 without good reason the governor has failed to undertake any training required by the Council of Governors and/or fails to engage with the development review process for governors as agreed by the Council of Governors.

3.1.6 they have failed to sign and deliver to the Chair a statement in the form required by the Council of Governors confirming acceptance of the code of conduct and/or complete the Disclosure and Barring Service process within the specified time period.

3.1.7 they refuse to sign a declaration, in the form specified by the Council of Governors, that they are a member of one of the public constituencies or one of the classes of staff constituency as the case might be and are not prevented from being a member of the Council of Governors.

3.1.8 they are removed from the Council of Governors by a resolution, approved by a two-thirds majority of the remaining governors, that:

(a) they have committed a serious breach of the code of conduct;

(b) he or she has acted in a manner detrimental to the interests of the Trust,

(c) the Council of Governors considers that it is not in the best interests of the Trust for that person to continue as governor.

3.1.9 where there is any disagreement as to whether the proposal for removal of a governor is justified, an independent assessor agreeable to both parties shall be requested to consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

3.1.10 upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

3.1.11 the Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating his tenure of office, except in the case of 3.1.8a above.

3.1.12 a Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of three years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later except by resolution carried by a majority of the Council of Governors present and voting at a general meeting. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.

3.1.13 where a Governor's membership of the Council of Governors ceases for one of the reasons set out in paragraph 2 or paragraph 3, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.2 below and, in the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

4. Council of Governors: Vacancies – Elected Governors

4.1 In the event of an appointed stakeholder governor not serving out their full term of office the Council of Governors shall require the organisation concerned to appoint a replacement at the earliest opportunity.

4.2 In the event of an elected governor not serving out their full term of office the Chair may, where the unexpired term is less than twelve months, choose to leave the seat vacant until the next scheduled election unless the vacancy is in a public constituency and the vacancy means that the governors elected by the public constituencies no longer constitute more than half the members of the Council of Governors. In that event and in all other cases save as provided for in this paragraph the Chair shall be at liberty either:

4.2.1 to call an election within three months to fill the seat for the remainder of that term of office, or

4.2.2 to invite the next highest polling candidate for that seat at the most recent election to fill the seat and be co-opted onto the Council of Governors until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office. At the annual election, it shall be the last candidate elected to the constituency involved who will serve the unexpired period of the term of office for that constituency.

5. Council of Governors: Role

5.1 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

5.2 Subject to the requirement specified in paragraph 5.1 above, each Governor shall exercise their own skill and judgement in their conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring as appropriate the perspective of the constituency or organisation by which s/he was elected or appointed, as the case may be. Public governors are expected to represent all members and the public, and not to promote a single issue or cause.

5.3 Subject to the further provisions of this Constitution and without in any way derogating from them, the Council of Governors shall;

5.3.1 hold the Non-Executive Directors to account in assisting the Trust Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and

5.3.2 observe the activities of the Trust with the view to ensuring that they are being conducted in a manner consistent with this Constitution.

6. Council of Governors: Meetings

6.1 The Council of Governors shall hold not less than four general meetings each financial year. However, in extremis (see paragraph 16 of the Trust Constitution), the Chair may decide to suspend Council of Governors' meetings.

6.2 The Council of Governors may appoint committees or sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

7. Council of Governors: Declarations

7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of their qualification to vote as a Member and that they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

7.2 The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme.

8. Council of Governors: Lead Governor

8.1 No person may serve as the Lead Governor for more than a total of six years.

8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if they cease to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

8.3 Further provisions can be found in the Council of Governors Standing Orders.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. General Overview and Introduction to the Council of Governors

1.1 The Council of Governors shall be constituted in accordance with the requirements of the constitution.

1.2 Provisions concerning the nomination and election to the Council of Governors are set out in the Constitution and the election rules. A member may not be nominated as a candidate for election to the Council of Governors unless he or she conforms to the requirements set out in the Constitution.

1.3 Governors shall comply with the code of conduct set out in Standing Order 4.

1.4 A member of the Council of Governors shall be disqualified from taking up office, or if in office shall vacate the office, in the circumstances set out in the Constitution. A governor shall cease to hold office when required to do so by the Council of Governors.

1.5 In accordance with the Constitution the Chair will chair the Council of Governors.

1.6 Standing Orders, including those concerning agenda, quorum, voting and the taking of minutes at Council of Governors meetings are set out in Standing Order 2 and in the Constitution.

1.7 Members of the Council of Governors shall not be remunerated but may receive expenses e.g. travel expenses in accordance with the relevant Trust polices and guidance.

1.8 Functions and Responsibilities of the Council of Governors

1.8.1 The function of the Council of Governors is to exercise the rights set out in the Constitution and the powers (if any) delegated from time to time by the Trust Board and to act in accordance with these procedures. The Council's roles and responsibilities are set out in Standing Order 3 and the trust shall provide sufficient resources to enable the Council of Governors to discharge its responsibilities.

1.9 Lead Governor

1.9.1 The Council of Governors shall select a public governor to undertake the role of Lead Governor of the Northern Lincolnshire and Goole NHS Foundation Trust. The Lead Governor shall be chosen by the Council of Governors, which will also approve the process for the appointment.

1.9.1 The process for the selection and appointment of the Lead Governor shall be as follows:

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

- At least one calendar month before the date of the meeting of the Council of Governors, the Trust Secretary shall contact all Governors by e-mail inviting nominations together with a short election statement in support of their nomination.

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

- Once elected, the shadow Lead Governor's terms as Lead Governor shall commence upon the expiry of the incumbent Lead Governor's term of office.

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

- the end of that Governor's current term of office whichever is the sooner; or

- they resign the position of Lead Governor by giving notice to the Chair in writing; or

- they are removed from the position of Lead Governor by a resolution passed by a two thirds majority of the remaining governors at a general meeting of the Council of Governors;

- with the option of re-election after that period if that governor is re-elected on to the Council of Governors. Continuation in the role will not be automatic on re-election to the Council.

1.9.3 The Trust Secretary shall be responsible for notifying NHSE of a change of Lead Governor.

1.9.4 The responsibilities of the Lead Governor shall be:

- To lead the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another one of the Non-Executive Directors to lead (e.g. chairing a meeting to discuss the appointment of a new chair) and to act as the point of contact with the independent panel referred to in the Trust Constitution Section 18, where a question is referred to that panel in accordance with that paragraph;
- To chair the Membership and Public Engagement & Assurance Group and Appointments and Remuneration Committee;
- On behalf of the Council of Governors, to attend monthly meetings with the Chair and the Trust Secretary;
- On behalf of the Council of Governors, to raise issues for discussion at the Trust Board;
- To assist the Chair in facilitating the flow of information between the Trust Board and the Council of Governors.
- To work with the Trust Chair to draft the Council of Governors commentary for inclusion in the Quality Report.

1.9.5 Further details on the role of the Lead Governor including the role criteria and desirable personal qualities can be found in the Trust document 'Criteria & Process for the Appointment of a Lead Governor".

1.10 Appointment of Deputy Lead Governor

1.10.1 The process for the appointment of the Deputy Lead Governor shall follow the rules outlined in Section 1.9.2.

1.10.2 The responsibilities of the Deputy Lead Governor are in line with the Lead Governor role.

1.11 Trust Secretary

1.11.1 The functions of Trust Secretary; most particularly monitoring of the trust's compliance with the law, Standing Orders and the regulatory framework, are a corporate responsibility shared by the directors but with the lead role being assumed by the Trust Secretary. The Trust Secretary has a significant role to play in the administration of corporate governance. In accordance with the Trust Board Standing Orders at Annex 7 the Chief Executive and the Chief Financial Officer have responsibility for advising the Chair on the interpretation of Standing Orders and the Standing Financial Instructions. The specific duties and responsibilities of the Trust Secretary are outlined below.

1.11.2 Acts as 'Company Secretary' to the Council of Governors and Trust Board of Directors:

- ensuring good information flows within the Trust Board and its committees and between senior management, Non-Executive Directors and the governors;
- ensuring that meetings of the Trust Board, Council of Governors and committees thereof run efficiently and effectively, that they are properly recorded and that Directors and Governors receive appropriate support and timely information;
- ensure that board procedures of both the Trust Board and the Council of Governors are complied with;
- advise the Trust Board and the Council of Governors (through the chairperson) on all corporate governance matters;
- in conjunction with Executive and Non-Executive Directors, ensure that the Trust complies with all relevant legislation and the Terms of its Provider Licence';
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development;
- in conjunction with the Chair and Lead Governor ensuring the ongoing development of the Council of Governors;
- responsible for the management of the membership office;
- as / if required, provide a source of advice and support independent of the Executive on any matters of concern relating to the governance of the organisation.

1.11.3 All directors and governors have access to the advice and services of the Trust Secretary. Both the appointment and removal of the Trust Secretary is a matter for the Chief Executive and Chair jointly.

1.12 Disputes

1.12.1 The Chair shall, in the first instance, arbitrate in any dispute concerning the interpretation of or arising out of these procedures. The Chair shall enforce any code of conduct approved by the Trust Board. Any unresolved dispute shall be determined in accordance with the Constitution as if references to any dispute in relation to the Constitution include any dispute in relation to these procedures.

1.13 Validity of Procedures

1.13.1 The procedures set out in this document are made in accordance with the Constitution. They shall only be altered on a recommendation of the Council of Governors and with the approval of the Trust Board. Changes to these procedures shall not be recommended that would make them inconsistent with the Constitution or the 2006 Act. Where there is any inconsistency between these procedures and the Constitution, the Constitution shall prevail.

2 Standing Orders for Council of Governors Meetings

2.1 Calling Meetings

2.1.1 The Council of Governors is to meet at least three times in each financial year (excluding the annual members meeting) at such times and places as the Council of Governors may determine.

2.1.2 Meetings of the Council of Governors may be called by the Chair, or by six governors including not less than three public governors who give written notice to the Chair specifying the business to be carried out.

2.2 Admission of the Public

All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

2.3 Notice of Meetings

2.3.1 Save in the case of emergencies or the need to conduct urgent business, the Chair's office will give at least 14 days written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will also be published on the trust's website.

2.3.2 After the receipt of a request to call a meeting the Chair's office shall send written notice to all governors, specifying the business to be carried out, as soon as possible after the receipt of such a request. The Chair shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Chair fails to call such a meeting then four governors may call such a meeting.

2.3.3 The notice of the meeting shall be delivered to every governor by email so as to be available to the governor at least five clear days before the meeting.

2.3.4 In the case of a meeting called by the governors in default of the Chair, those governors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

2.3.5 Failure to serve such a notice on more than 25 governors will invalidate the meeting.

2.4 Setting the Agenda

2.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

2.4.2 In accordance with the Constitution every agenda for meetings of the Council of Governors will draw to the attention of the elected governors the declaration governors are required to make in Standing Order 5 stating that they are qualified to vote as a member of the trust and that they are not prevented from being a member of the Council of Governors An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the meeting of the Council of Governors.

2.4.3 Any governor wishing to submit an agenda item must notify the Trust Secretary in writing at least ten clear working days prior to the meeting at which it is to be considered. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Group Chair.

2.5 Chair of the Meeting

2.5.1 The Group Chair or, in the absence of the Group Chair, the Vice Chair or, in the absence of the Vice Chair, one of the other Non-Executive Directors is to preside at meetings of the Council of Governors.

2.5.2 If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed then the governors present will choose one of their number to chair that part of the meeting.

2.5.3 If a vote concerns matters relating to the Chair and / or Non-Executive Directors, neither the Chair nor any other Non-Executive Director should preside over the meeting. In this instance, the governors present will choose **one of their number to chair the meeting and to have the casting vote.**

2.6 Annual Members Meeting

2.6.1 The trust will publicise and hold an annual members meeting in accordance with the Constitution.

2.6.2 The following documents shall be presented to the members of the trust at the annual members' meeting by at least one member of the Trust Board:

(a) the annual accounts;

(b) any report of the auditor on the annual accounts; and

(c) the annual report.

2.6.3 The trust may combine a meeting of the Council of Governors convened for the purposes of being presented with the documents in sub-paragraph 2.6.2 with the annual members' meeting.

2.6.4 Members (Executive or suitable Deputy, Non-Executive Directors and Associate Non-Executive Directors) of the Trust Board shall attend the Annual Members' Meeting unless agreed in advance with the Trust Chair.

2.7 Motions

2.7.1 Motions may only be submitted by a governor and must be received by the Chair's office in writing at least one week prior to the meeting at which they are to be considered.

2.7.2 Emergency motions may only be submitted by a governor and must be received by the Chair before the commencement of the meeting. Acceptance of such motions for inclusion on the agenda will be at the discretion of the Chair.

2.7.3 Any other business should be notified to the Chair at the commencement of the meeting. Acceptance of such items of business for inclusion on the agenda will be at the discretion of the Chair.

2.7.4 Notice of a motion to rescind a previous minute must be received by the Chair's office at least 21 days before the meeting and must be signed by a majority of members. Such a motion should not be taken until at least 30 minutes after the start of the meeting.

2.7.5 An amendment that does not directly negate a resolution may be moved by any member. No further amendments may be moved until the first amendment is disposed of. If an amendment is passed it shall become part of the substantive motion and subject to further amendment.

2.7.6 The mover of a motion under Standing Order 2.7.1 or 2.7.2 above shall have a maximum of five minutes to move and three minutes to reply. Once a motion has been moved no member shall speak more than once or for more than three minutes.

2.8 Chair's Ruling

2.8.1 Statements of governors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2.9 Voting

2.9.1 An elected governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, a declaration has been made in the form specified by the Council of Governors of particulars of their qualification to vote as a member of the trust, and that they are not prevented from being a member of the Council of Governors. An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected governors.

2.9.2 Subject to the Constitution, questions arising at a meeting shall be determined by a majority of the votes of the governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

2.9.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

2.9.4 In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

2.9.5 No resolution of the Council of Governors shall be passed if the public governors present unanimously oppose it.

2.10 Attendance

2.10.1 Governors who are unable to attend the Council of Governors meeting should advise the Chair's office in advance of the meeting so that their apologies may be submitted.

2.10.2 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

2.10.3 The Council of Governors may invite the Chief Executive or any other member or members of the Trust Board, or a representative of the trust's auditors or other advisors to attend a meeting of the Council of Governors.

2.10.4 The Council of Governors may require one or more directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance).

2.11 Minutes

2.11.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting. The person presiding at it will sign them.

2.11.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.11.3 Minutes shall be circulated in accordance with the governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

2.12 Record of Attendance

2.12.1 The names of the governors present at the meeting shall be recorded in the minutes.

2.13 Suspension of Standing Orders

2.13.1 Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors members are present, and that a majority of those present vote in favour of suspension.

2.13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

2.13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the governors.

2.13.4 No formal business may be transacted while Standing Orders are suspended.

2.14 Variation and Amendment of Standing Orders

2.14.1 These Standing Orders shall be amended only if the requirements provided for in the Constitution for variation of the Constitution have been met and if:

(a) a majority of the governors voting at a quorate meeting of the Council of Governors agrees to the amendment;

(b) the amendment has been authorised by a majority of directors voting at a quorate meeting of the Trust Board;

(c) the variation proposed does not contravene a statutory provision.

Any amendments to these Standing Orders shall be reported to NHSE.

2.14.2 Where an amendment is made in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust) at least one member of the Council of Governors must attend the next annual members' meeting and present the amendment and the trust must give the members an opportunity to vote on whether they approve the amendment.

2.14.3 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

2.15 Quorum

2.15.1 Nine governors including not less than five public governors shall form a quorum.

2.15.2 Any governor who has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.15.3 In accordance with the Constitution, if at any meeting there is no quorum within an appropriate period of time (to be determined by the Chair of the meeting) from the start of the meeting it shall stand adjourned for six clear days and written notice of the date, place and time of the adjourned meeting shall be given to all governors. Upon reconvening, those present shall constitute a quorum.

2.16 Appointment of Committees

2.16.1 The Council of Governors may establish such committees as it requires to conduct its business. Membership of these committees shall be open to all governors.

2.16.2 Each committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the council) as the Council of Governors shall decide. Such terms of reference shall be read in conjunction with these Standing Orders.

2.16.3 As and when vacancies arise on each committee, governors shall be invited to express an interest in standing for appointment. Where elections are required, they shall be held at the first meeting of the Council of Governors after the vacancy has arisen. Governor members will be elected by the Council of Governors until the end of their term of office as a governor although will be entitled to express an interest in standing for re-appointment if they are re-elected as a governor.

3 Governors – Roles and Responsibilities

3.1 In addition to those duties specified in the constitution, it is the role of the Council of Governors and of each governor:

3.1.1 To act at all times in the best interests of the Trust.

3.1.2 To represent the interests of the membership and partner organisations.

3.1.3 To feedback information about the trust to the membership and partner organisations.

3.1.4 To use their best endeavours to ensure Northern Lincolnshire and Goole NHS Foundation Trust remains a leading acute trust.

3.1.5 To ensure the Council of Governor meetings are held in accordance with policy and Standing Orders.

3.1.6 To comply with and implement the code of conduct for the Council of Governors as set out in Standing Order 4.

3.2 To be consulted on and make recommendations to the Trust Board on the development of the membership strategy.

3.3 To respond as appropriate when consulted by the Trust Board in accordance with the Constitution.

3.4 To undertake such functions as the Trust Board shall from time to time request.

3.5 To consider the annual accounts, any report of the auditor on them and the annual report.

3.6 To set up committees and working groups; for example, membership strategy, assurance, quality.

3.7 To attend regular Council of Governor meetings.

3.8 To attend the annual members meeting.

3.9 The specific duties of governors are:

3.9.1 amending the constitution;

3.9.2 approving the appointment of the Chief Executive;

3.9.3 appointing and removing the Chair and other Non-Executive Directors;

3.9.4 appointing and removing the NHS foundation trust's external auditor;

3.9.5 receiving the NHS foundation trust's annual accounts and annual report;

3.9.6 receiving the Trust's forward (operational) plan;

3.9.7 taking decisions on 'significant transactions';

3.9.8 taking decisions on non-NHS income.

4 Code of Conduct for the Council of Governors and the Nolan Principles

4.1 Introduction

4.1.1 This code seeks to outline appropriate conduct for governors, and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied. However, a code is considered an essential guide for governors, particularly those who are newly elected.

4.1.2 The code seeks to expand on or complement the Constitution. Copies will be made available for the information of all governors and for those considering seeking election to the trust's Council of Governors.

4.1.3 Members seeking election to the Council of Governors should sign a declaration to confirm that they will comply with the code in all respects and that, in particular, they support the Trust's objectives.

4.2 Qualifications for Office

4.2.1 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Chair should be advised of any changes in circumstances, which disqualify the governor from continuing in office. An example of this would be a public governor becoming an employee of the trust.

4.3 Code of Conduct Role and Functions

4.3.1 In addition to their duties set out in the Constitution, and specifically in relation to matters of conduct, governors should:

4.3.1.1 adhere to the Trust's rules and policies and support its objectives, in particular those of retaining foundation status and developing a successful organisation;

4.3.1.2 act in the best interests of the Trust at all times;

4.3.1.3 contribute to the workings of the Council of Governors in order for it to fulfil its role and functions as defined in the Constitution;

4.3.1.4 recognise that their role is a collective one. They exercise collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a governor has no more rights and privileges than any other member;

4.3.1.5 note that the functions allotted to the Council of Governors are not of a managerial nature.

4.4 Confidentiality

4.4.1 All governors are required to respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors.

4.5 Conflict of Interests

4.5.1 Governors should act with the utmost integrity and objectivity and in the best interests of the trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

- shall not vote on any such matters;
- shall not be present except with the permission of the Council of Governors in any discussion of the matter.

4.5.2 If in any doubt the governor should seek advice from the Chair and / or Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

4.5.3 Any governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining governors.

4.5.4 The Register of Governors Interests will feature as a standing item on the agenda of each meeting of the Council of Governors.

4.6 Council of Governors Meetings

4.6.1 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Chair's office in advance of the meeting stating the reason for non-attendance. The reason for non-attendance will be recorded in the minutes of the meeting.

4.6.2 In accordance with the Constitution, absence from the Council of Governor meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. If a governor fails to attend half of the meetings of the Council of Governors in any financial year his or her tenure of office is to be immediately terminated unless the other governors are satisfied that the absence was due to a reasonable cause and he or she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.6.3 Governors are expected to attend for the duration of the meeting.

4.7 Personal Conduct

4.7.1 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

4.7.1.1 adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected members;

4.7.1.2 be mindful of conduct which could be deemed to be unfair or discriminatory;

4.7.1.3 treat the Trust's executives and other employees with respect and in accordance with the Trust's policy in this respect;

4.7.1.4 recognise that the Council of Governors and management have a common purpose, i.e. the success of the Trust and adopt a team approach;

4.7.1.5 conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for governors to be ambassadors for the trust.

4.8 Accountability

4.8.1 Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events, which provide opportunities to interface with their electorate in order to understand their views.

4.9 Induction and Development

4.9.1 Training is essential for governors, in respect of the effective performance of their current role. Governors are required to adhere to the Trust's policy in all respects.

4.10 Visits to Trust Premises

4.10.1 Where governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Membership Office to make the necessary arrangements.

4.11 Non-Compliance with the Code of Conduct

4.11.1 Non-compliance with the code may result in action being taken as follows:

- Where misconduct takes place, the Chair shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.

- Where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to lay a formal charge of misconduct:

- notifying the governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the Trust, and inviting and considering their response within a defined timescale.

- inviting the governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;

- deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust;

- imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the member's future conduct and consequences, non-payment of expenses to the removal of the governor from office.

4.11.2 A governor may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining governors present and voting at a general meeting of the Council of Governors.

4.11.3 This code of conduct does not limit or invalidate the right of the governor or the trust to act under the Constitution.

4.12 Nolan Principles – the seven principles of public life

4.12.1 Governors should act in accordance with the Nolan Principles, namely:

Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example.

5 Declarations of Interests and Register of Interests

5.1 Declarations

5.1.1 In accordance with the Constitution and the 2006 Act and in recognition of the codes of conduct and accountability issued by the Department of Health and Social Care the trust is required to maintain a register of interests of governors. The governors must declare any relevant and material interest, whether direct or indirect, in any contract, proposed contract or other matter which is under consideration by the Council of Governors.

5.1.2 Interests, which should be regarded as 'relevant and material' are:

- Directorships, including non-executive Directorships held in private companies or PLCs (with the exception of those of dormant companies) likely or possibly seeking to do business with the NHS.
- Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- Majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary organisation in the field of health or social care.
- Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
- Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the trust, including but not limited to, lenders or banks.

5.1.3 The Trust will interpret the phrase 'relevant and material' in accordance with guidance issued from time to time by the Independent Regulator.

5.1.4 If governors have any doubt about the relevance of an interest, this should be discussed with the Chair.

5.1.5 The exceptions, which shall not be treated as material interests are as follows:

- shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.
- an employment contract held by staff governors.
- an employment contract with the Humber and North Yorkshire Integrated Care Board or an organisation in membership of a Place Health and Care Partnership held by a Place Partnership governor.
- an employment contract with a local authority held by a local authority governor.
- an employment contract with a partnership organisation held by a partnership governor.

5.2 Register of Interests

5.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests, which governors have declared.

5.2.2 These details will be kept up to date and governors must disclose any relevant and material interest as soon as they are aware of it.

5.2.3 The register will be available for inspection by members of the public free of charge.

5.3 Disclosure

5.3.1 Any governor who has a material interest as defined above shall declare such interest to the Council of Governors and:

- shall not be present except with the permission of the Council of Governors in any discussion with relevance to the interest;
- shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE TRUST BOARD

1 Introduction

1.1. The Northern Lincolnshire and Goole NHS Foundation Trust (the Trust) is a public benefit corporation authorised by the Independent Regulator of NHS foundation Trusts under the National Health Service Act 2006.

1.2. The principal purpose of the Trust is set out in the 2012 and 2022 Act, and the Trust Constitution.

1.3. The Trust is required to adopt Standing Orders for the regulation of its proceedings and business.

1.4. The powers of the Trust are set out in section 3 of the Trust Constitution.

1.5. The Trust has specific powers to contract in its own name and to act as a corporate Trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to NHSE. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

2 Delegation of Powers

2.1 The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

2.2 Under the Standing Orders 7.2 relating to the Arrangements for the Exercise of Functions the Trust Board may exercise its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 8 or by an Executive Director, in each case subject to such restrictions and conditions as the Trust Board thinks fit or as NHSE may direct.

2.3 Delegated powers are covered in the Scheme of Delegation, which has effect as if incorporated into the Standing Orders.

3 Interpretation and Scope

3.1 Interpretation

3.1.1 Save as permitted by law, and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders on which they shall be advised by the Chief Executive and in the case of Standing Financial Instructions by the Chief Financial Officer.

3.1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"Accounting Officer" shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Northern Lincolnshire and Goole NHS Foundation Trust.

"Board" shall mean the Chair, Non-Executive Directors, and the Executive Directors.

"Budget" shall mean a resource, expressed in financial terms, proposed by the board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Chair" is the person appointed by the Council of Governors to lead the board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" shall mean the chief executive officer of the Trust.

"Chief Financial Officer" shall mean the chief financial officer of the Trust.

"Committee" shall mean a committee appointed by the Trust.

"Committee Members" shall be persons formally appointed by the Trust to sit on or to chair specific committees.

"Director" shall mean a person appointed as a director in accordance with the Constitution and includes the Chair.

"Funds Held On Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept. Such funds may or may not be charitable.

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Non-Executive Director" means a director, including the Chair, who does not hold an executive office of the Trust.

"Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Officer" means an employee of the Trust.

"Senior Independent Director" means the Non-Executive Director appointed as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate.

"Vice Chair" means the Non-Executive Director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason

3.2 Scope

3.2.1 All business shall be conducted using these Standing Orders in the name of the Trust.

3.2.2 All funds received in Trust shall be in the name of the Trust as corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.2.3 The Trust has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the "Reservation of Powers to the Board" and have effect as if incorporated into the standing orders.

4 Appointment to the Board

4.1 Composition of the Trust Board

4.1.1 In accordance with the NHS 2006 Act and the Trust Constitution the composition of the board of the Trust shall comprise a Chair, five Non-Executive Directors, and five Executive Directors including the Chief Executive, Chief Financial Officer, a registered medical practitioner and a registered nurse or midwife.

4.1.2 The Trust, on occasion, may seek to appoint Associate Non-Executive Directors to address specific identified skills gaps or allow succession planning. Associate Non-Executive Directors are non-voting members of the Trust Board.

4.2 Appointment of the Chair and Non-Executive Directors

4.2.1 The Trust has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in the "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

4.2.2 In accordance with the Trust Constitution, the appointment and removal of the Chair and the other Non-Executive Directors is the prerogative of the Council of Governors. Where a Non-Executive Director vacancy arises, the Appointment & Remuneration Committee, on behalf of the Council of Governors, with the Joint Chair and / or Vice Chair, will assess and seek opinion from the Trust Board on the skills and experience required.

4.2.3 For the appointment of a Chair the Trust shall appoint a nominations panel (of the Appointments & Remuneration Committee for Non-Executive Directors) which will include the Senior Independent Director (or another Non-Executive Director in the case of a conflict of interests) and at least three governors to interview applicants and make a recommendation to the Council of Governors.

4.2.4 In the case of other Non-Executive Directors, the Trust shall appoint a nominations panel which will include the Chair, and at least three governors to interview applicants and to make a recommendation to the Council of Governors.

4.3 Appointment of an Associate Non-Executive Director

4.3.1 In accordance with the Trust Constitution, the appointment and removal of an Associate Non-Executive Director is the prerogative of the Council of Governors. Where an Associate Non-Executive Director vacancy arises, the Appointment & Remuneration Committee, on behalf of the Council of Governors, with the Joint Chair and / or Vice Chair, will assess and seek opinion from the Trust Board on the skills and experience required.

4.3.2 For the appointment of an Associate Non-Executive Director the Trust shall appoint a nominations panel (of the Appointments & Remuneration Committee for Non-Executive Directors) which will include the Senior Independent Director (or another Non-Executive Director in the case of a conflict of interests) and at least three governors to interview applicants and make a recommendation to the Council of Governors.

4.4

4.4Terms of Office of the Chair and Non-Executive Directors4.4.1Unless the Council of Governors decides otherwise from time to time the Chair and the Non-Executive Directors are to be appointed for a term of three years and will be eligible for reappointment for two further terms of three years. Any proposed term beyond nine years (e.g. three three-year terms) for a Non-Executive Director shall be subject to annual re-appointment, rigorous review, and shall take into account the need for progressive refreshing of the board.

4.5Terms of Office of an Associate Non-Executive Director

4.5.1Unless the Council of Governors decides otherwise from time to time Associate Non-Executive Directors are to be appointed for a term of one year and may be eligible for reappointment for an additional two, one-year terms.

4.5.2Associate Non-Executive Directors are a non-voting members of the Trust Board.

4.6Performance Appraisal of the Group Chair

4.6.1`The Non-Executive Directors shall meet without the Group Chair at least annually to evaluate the Group Chair's performance as part of a process of appraisal which has been agreed with the Council of Governors.

4.7Appointment of Vice Chair

4.7.1`For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Group Chair, the Council of Governors will appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of the term as Non-Executive Director of the Trust, as it may specify on making the appointment. If the Group Chair is unable to discharge the office of Group Chair of the Trust/Group, the Vice Chair shall be Acting Chair of the Trust.

4.7.2Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Group Chair and the Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair.

4.8**Powers of Vice Chair**

4.8.1Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice Chair.

4.9Appointment of Senior Independent Director

4.9.1The NHS Foundation Trust Code of Governance recommends that the Board of Directors should appoint a Non-Executive Director as the Senior Independent Director as an alternative point of contact for governors and directors when they have concerns that have not been resolved through the normal channels of Chair, Chief Executive, Chief Financial Officer or Trust Secretary or for which such contact is inappropriate.

4.9.2The criteria and process for the appointment of a Senior Independent Director is set out in Appendix A of the Terms of Reference and Membership of the Appointments & Remuneration Committee for Non-Executive Directors.

4.10Executive Directors – Additional Appointments

4.10.1 With the approval of the Trust Board, a Group Executive Director may accept not more than one appointment as a Non-Executive Director of another NHS foundation Trust or an organisation of comparable size and complexity.

4.10.2 An Executive Director may not accept an appointment as Chair of another NHS Foundation Trust or an organisation of comparable size and complexity, except in the case of a Trust which is the subject of a Memorandum of Understanding.

5 Executive Directors – Joint Appointments

5.1 The Trust recognises that as partnership and collaborative working is further developed with partners, opportunities may arise to introduce joint executive roles. Such opportunities are managed in accordance with section 7 ('Joint Roles with Other Trusts') of the 'Principles Framework for Determining the Remuneration & Terms of Service for the Chief Executive and Executive Directors' document (managed by the Remuneration and Terms of Service Committee).

6 Practice and Procedure of Meetings

6.0.1 All business meetings of the Trust Board shall be conducted in the name of the Trust.

6.1 Annual Members' Meeting

6.1.1 In accordance with the Trust Constitution the Trust will hold a members meeting (the "annual members' meeting") within nine months of the end of the financial year.

6.2 Calling Meetings / Extraordinary Meetings

6.2.1 The Chair may call a meeting of the Trust Board at any time. The Chair shall send a written notice to all directors as soon as possible after the receipt of such a request. The Chief Executive or four directors may request the Chair to call a meeting giving written notice of the business to be carried out. If the Chair fails to call such a meeting then the Chief Executive, or four directors, whichever is the case, may forthwith call a meeting.

6.2.2 The ordinary meetings of the Trust Board shall, unless otherwise be determined, be held on a nominated day each month or at such other times as the board may determine and at such places as the board may determine.

6.2.3 Meetings of the Trust Board shall be open to the public, unless and to the extent that the Trust Board has resolved that members of the public should be excluded from a meeting due to special reasons.

6.2.4 The Chair (Vice Chair in the absence of the Chair) shall give such directions as the Chair thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust Board's business shall be conducted without interruption and disruption.

6.2.5 Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make an oral report of proceedings as they take place without the prior agreement of the Trust Board.

6.3 Notice of Meetings

6.3.1 Save in the case of emergencies or the need to conduct urgent business, the Chairman’s office shall give to all directors at least fourteen days written notice of the date and place of every meeting of the Trust Board.

6.3.2 Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to every director at least three clear days before the meeting.

6.3.3 Lack of service of the notice on any director shall not affect the validity of a meeting.

6.3.4 In the case of a meeting called by directors or the Chair, in default of the Chief Executive, the notice shall be signed by those directors or the Chair and no business shall be transacted at the meeting other than that specified in the notice.

6.3.5 Failure to serve such a notice on more than two directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

6.4 Notice of Agenda Items

6.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust Board and shall be addressed prior to any other business being conducted, which will have effect as though incorporated into the Standing Orders.

6.4.2 A director wishing to propose an agenda item or motion should send written notice eight clear days before the meeting to the Chair who shall insert the item or motion in the agenda for the meeting. Requests made less than eight days before a meeting may be included on the agenda at the discretion of the Chair.

6.4.3 Notwithstanding the intent of the previous paragraph urgent business may be raised at a meeting of the board provided the director wishing to raise such business has given notice to the Chair not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting. In either case, the Chair (or in their absence the Vice Chair) shall determine in consultation with the Chief Executive, the urgency of the proposed business and whether it should be discussed, deferred to the next meeting, or dealt with by the Chief Executive.

6.4.4 Before holding a meeting, the Trust Board shall send a copy of the agenda to the Council of Governors.

6.5 Chair of Meeting

6.5.1 At any meeting of the Trust Board, the Chair, if present, shall preside.

6.5.2 If the Chair is absent from the meeting the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent such Non-Executive Directors as the directors' present shall choose shall preside.

6.5.3 If the Chair is absent from the meeting temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Directors as the directors' present shall choose shall preside.

6.6 Motions

6.6.1 A director of the Trust wishing to propose an agenda item, or move or amend a motion shall send a written notice thereof at least eight clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to Standing Order 6.5.

6.6.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

6.6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director(s) who gives it and also the signature of four other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Group Chair to propose a motion to the same effect within six months.

6.6.4 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

6.6.4.1 An amendment to the motion.

6.6.4.2 The adjournment of the discussion or the meeting.

6.6.4.3 That the meeting proceed to the next business. (*)

6.6.4.4 The appointment of an ad hoc committee to deal with a specific item of business.

6.6.4.5 That the motion be now put to a vote. (*)

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate and who is eligible to vote.

6.6.5 No amendment to the motion shall be admitted if, in the opinion of the chairman of the meeting, the amendment negates the substance of the motion.

6.6.6 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

6.7 Group Chair's Ruling

6.7.1 Statements of directors made at meetings of the board shall be relevant to the matter under discussion at the material time. The decision of the Group Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, shall be final. In this interpretation they shall be advised by the

Executive and in the case of Standing Financial Instructions by the Chief Financial Officer.

6.8 Voting

6.8.1 Every question at a meeting can be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

6.8.2 All questions put to the vote shall, at the discretion of the Group Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

6.8.3 If at least one-third of the directors' present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

6.8.4 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

6.8.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

6.8.6 Any director or member of a committee of the directors may participate in a meeting of the Trust Board or such committee by means of a conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

6.8.7 A resolution in writing signed by all of the directors entitled to receive notice of a meeting of the Trust Board shall be as valid and effectual as if it had been passed at a meeting of the board of directors duly convened and held and may consist of several documents in the like form each signed by one or more directors.

6.8.8 A resolution in electronic form sent to all of the directors entitled to receive notice of a meeting of the board of directors by electronic communication (for the purposes of this provision "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa) (a) by means of an electronic communications network; or (b) by other means but while in an electronic form) to the electronic addresses notified to the Trust by each of the directors, shall be as valid and effectual as if it had been passed at a meeting of the Trust Board duly convened and held provided that each and every director entitled to receive a notice of a meeting of the Trust Board responds by electronic communication to the electronic address from which the resolution in electronic form was transmitted from, confirming their acceptance of the resolution.

6.8.9 An acting director who has been appointed formally by the appropriate appointments committee in accordance with the Constitution to carry out a vacant director's duties during a period of temporary incapacity, shall be entitled to exercise the voting rights of the director.

6.8.10 An officer attending the board to represent an executive director during a period of incapacity or temporary absence without being formally appointed to the board may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

6.9 Minutes

6.9.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

6.9.2 The names of the directors' present at the meeting shall be recorded in the minutes. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.9.3 It is the responsibility of each individual director to ensure that, where they have concerns which cannot be resolved about the running of the foundation Trust or a proposed action, those concerns are recorded in the board minutes.

6.9.4 Minutes shall be circulated in accordance with directors' wishes.

6.9.5 A copy of the minutes shall be provided by the Trust Board to the Council of Governors as soon as practicable after the meeting to which they relate.

6.10 Quorum

6.10.1 No business shall be transacted at a meeting of the Trust Board unless at least six of the directors are present including not less than three executive directors (one of whom must be the Chief Executive or Chief Financial Officer) and three Non-Executive Directors.

6.10.2 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

6.10.3 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 10 and 11) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least three executive directors to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the board considers the recommendations of the Remuneration and Terms of Service Committee).

6.10.4 Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

6.11 Personal Conduct (part of Standards of Business Conduct Policy section)

6.11.1 Directors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

- adhere to good practice in respect of the conduct of meetings and respect the views of their colleagues;
- be mindful of conduct which could be deemed to be unfair or discriminatory;
- treat the Trust's Council of Governors and Trust employees with respect and in accordance with the Trust's policy;
- recognise that the Trust Board and the Council of Governors have a common purpose, i.e. the success of the Trust, and adopt a team approach;
- conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for directors to be ambassadors for the Trust.

7 Suspension of Standing Orders

7.1 Except where this would contravene any statutory provision, Standing Orders may be suspended at any meeting, provided that:

7.1.1 at least two thirds of the board are present including one executive director and one Non-Executive Director,

7.1.2 a majority of those present vote in favour of a suspension;

7.1.3 the variation proposed does not contravene any statutory provision or direction made by NHSE.

7.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

7.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and should be available to the directors.

7.4 No formal business shall be transacted while Standing Orders are suspended.

7.5 The Audit, Risk and Governance Committee shall review every decision to suspend Standing Orders.

8 Reservation of Powers and Delegation of Functions

8.1 Reservation of Powers

8.1.1 The Trust has resolved that certain powers and decisions may only be exercised by the Board in formal session, held in accordance with Standing Order 6. These powers and decisions are set out in the "Reservation of Powers to the Board and Delegation of Powers" and have effect as if incorporated into the Standing Orders.

8.2 Arrangements for the Exercise of Functions by Delegation

8.2.1 The Trust Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 9.5 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the board thinks fit.

8.3 Emergency Powers

8.3.1 The powers which the Trust Board has retained to itself within these Standing Order 8.1 may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors.

8.3.2 The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the board for ratification.

8.4 Delegation to Committees

8.4.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by executive committees or assurance sub-committees of the Trust Board, which it has formally constituted.

8.4.2 The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Trust Board.

8.5 Delegation to Officers

8.5.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a committee or committee of the Trust Board shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

8.5.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered for approval by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered for approval by the Trust Board as indicated above.

8.5.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the board of the Chief Financial Officer or other executive director to provide information and advise the Trust Board in accordance with any statutory requirements or the requirements of the Independent Regulator.

8.5.4 The arrangements made by the Trust Board as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

9 Committees

9.1 Appointment of Committees and Sub-Committees

9.1.1 Subject to Standing Order 8.4 and such directions as may be given by the Constitution, the Trust may appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

9.1.2 A committee appointed under Standing Order 8.4 may, subject to such directions as may be given by the Trust, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

9.1.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration agreed by the Trust Board to meetings of any committees or sub-committee established by the Trust.

9.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the board), as the board shall decide.

9.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the board.

9.1.6 The Board Committees will be made up of Non-Executive Directors and Executive Directors as core members and other staff as deemed appropriate being 'in attendance'. Except the Audit, Risk and Governance Committee and Remuneration and Terms of Service Committee must only have Non-Executive Directors as core members.

9.1.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the independent regulator, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with applicable statute and regulations and with guidance issued by the independent regulator.

9.1.8 The following committees shall be established:

(a) Audit Committee
The Trust Board shall establish an Audit Committee to be known as the Audit, Risk and Governance Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into these Standing Orders.

(b) Remuneration Committee
The board shall establish a Remuneration Committee, to be known as the Remuneration Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(c) Charitable Funds Committee
The Trust Board shall establish a Charitable Funds Committee which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(d) Finance Committee
The Trust Board shall establish a Finance Committee to be known as the Finance, Estates & Performance Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into these Standing Orders.

(e) Quality & Safety Committee
The Trust Board shall establish a Quality & Safety Committee to be known as the Group Quality and Safety Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(f) Workforce Committee

The Trust Board shall establish a Workforce Committee to be known as the Group Workforce, Education and Culture Committees-in-Common which shall meet at least quarterly and be answerable to, and report to, the Trust Boards-in-Common. The terms of reference of the Committee have effect as if incorporated into the Standing Orders.

(g) Committees In Common

The Trust Board shall establish any other joint permanent or ad-hoc committee in common as may be required. It is not necessarily a requirement that these other committees report directly to the Trust Board, but in all cases the reporting arrangements will be defined in their terms of reference.

(h) Other Committees

The Trust Board shall establish any other permanent or ad-hoc committees as may be required. It is not necessarily a requirement that these other committees report directly to the Trust Board, but in all cases the reporting arrangements will be defined in their terms of reference.

9.2 Confidentiality

9.2.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the board or shall otherwise have concluded on that matter.

9.2.2 A director of the Trust or a member of a committee shall not disclose any matter reported to the board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the board or committee shall resolve that it is confidential.

10 Declaration of Interests and Register of Interests

10.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

10.2 Pursuant to Section 152 of the 2012 Act, Directors have a duty:

10.2.1 to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

10.2.2 not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

Declarations of Interests

10.3.1 Trust Board directors are required to declare relevant and material interests. Any directors appointed subsequently should do so on appointment.

10.3.2 Interests which should be regarded as "relevant and material" are:

10.3.2.1 Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies) likely or possibly seeking to do business with the NHS.

10.3.2.2 Ownership, part-ownership or directorates of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

10.3.2.3 Majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS;

10.3.2.4 A position of authority in a charity or voluntary organisation in the field of health and social care;

10.3.2.5 Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

10.3.2.6 Any connection with an organisation, entity or company considering entering into a financial arrangement with the Trust, including, but not limited to, lenders or banks.

10.3.3 If Trust Board directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

10.3.4 At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next Trust Board meeting following the change occurring.

10.3.5 Trust Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

10.3.6 During the course of a Trust Board meeting, if a conflict of interest is established, the board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

10.3.7 There is no requirement for the interests of board directors' spouses or partners to be declared. (Note, however, that Standing Order 11 requires that the interest of directors' spouses, if living together, in contracts should be declared).

10.3.8 It is the obligation of the director to inform the Trust Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The secretary will amend the register upon receipt within three working days.

10.4 Authorisation of Conflict of Interest

10.4.1 Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (in contravention of the duty outlined at Standing Order 10), this may be authorised if a majority of directors vote in favour of authorisation.

10.4.2 If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

10.4.3 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Trust Board, the director in question will be deemed to be in breach of the statutory duty.

10.5 Register of Interests

10.5.1 In accordance with the Constitution the Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive board directors.

10.5.2 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated and reviewed by the Trust Board.

10.5.3 The register will be available to the public and the Chair will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

11 Exclusion of Directors from Proceedings on Account of Pecuniary Interest

11.1 Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

11.2 The Trust shall exclude a director from a meeting of the Trust while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

11.3 For the purpose of this Standing Order, any remuneration, compensation or allowances payable to a director by virtue of paragraph 9 of Schedule 2 to the NHS & Community Care Act 1990, relating to payments of travelling expenses and other allowances as determined by the Secretary of State with the approval of the Treasury, shall not be treated as a pecuniary interest.

11.4 For the purpose of this Standing Order the Chair or a director shall be treated, subject to Standing Order 11.2, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

11.4.1 they, or their nominee, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

11.4.2 they are a partner of, or in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of persons living together as partners the interest of one or other shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

11.5 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

11.5.1 of their membership of a company or other body, if the director has no beneficial interest in any securities of that company or other body;

11.5.2 of an interest in any company, body or person with which the director is connected as mentioned in Standing Order 11.2 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

11.6 Where a director:

11.6.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

11.6.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

11.6.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which the director has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

11.6.4 This Standing Order shall not prohibit the director from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

11.7 Standing Order 11 applies to a committee or sub-committee of the Trust as it applies to the Trust and applies to any member of any such committee or sub-committee (whether or not they is also a director of the Trust) as it applies to a director of the Trust.

12 Standards of Business Conduct

12.1 Policy

12.1.1 Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times.

12.1.2 Staff must comply with the Trust's guidance contained in `Standards of Business Conduct Policy. The following provisions should be read in conjunction with that document.

12.2 Interest of Officers in Contracts

12.2.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which they have any pecuniary interest, not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

12.2.2 An officer or employee must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. A register of declared interests shall be kept and maintained by means of an annual review.

12.3 Canvassing of, and Recommendations by Directors in Relation to Appointments

12.3.1 Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

12.3.2 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment. This does not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust for reference purposes.

12.3.3 Informal discussions which take place with potential candidates outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

12.4 Relatives of Directors of Officers

12.4.1 Candidates for any staff appointment shall, when making application, be required to disclose in writing whether they have a close relationship or are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

12.4.2 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

12.4.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

12.4.4 Where the relationship of an officer or another director to a director of the Trust is disclosed, Standing Order 11.2 shall apply.

12.4.5 All managers must comply with the Trust's Standards of Business Conduct Policy.

13 Tendering and Contracting Procedures

Details relating to Tendering and Contracting Procedures can be found in the **Standing Financial Instructions document reference DCM076.**

14 Miscellaneous

14.1 Standing Orders to be Given to Directors and Officers

14.1.1 It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.

14.1.2 Updated copies shall be available to all staff via the Trust intranet.

14.1.3 New officers designated by the Chief Executive shall be informed in writing of the location and means of accessing Standing Orders.

14.2 Trust Policies

14.2.1 All Trust policies will be prepared, consulted upon and assessed for equality impact in accordance with the Trust document control policy and supporting procedures.

14.2.2 Draft policies presented to the board or the Trust Executive Team for approval must be accompanied by evidence of compliance with the proper procedures for consultation and equality impact assessment.

14.3 Documents Having the Standing of Standing Orders

14.3.1 Standing Financial Instructions, Reservation of Powers to the Trust Board and Delegation of Powers including the Trust's Devolution Policy, shall have the effect as if incorporated into Standing Orders.

14.4 Signature of Documents

14.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the board shall have given the necessary authority to some other person for the purpose of such proceedings.

14.4.2 The Chief Executive or nominated officers shall be authorised, by resolution of the board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the board or committee or sub-committee to which the board has delegated appropriate authority.

14.5 Seal and Sealing of Documents

14.5.1 Custody of Seal

14.5.2 The Common Seal of the Trust shall be kept securely by the Trust Secretary as delegated by the Chief Executive. The seal will only be affixed to a document in accordance with these Standing Orders.

14.5.3 Sealing of Documents

14.5.3.1 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the board in accordance with these Standing Orders. The seal of the Trust must be used in order to execute a deed, when required to do so by law, normally the conveyancing of land.

14.5.3.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer and authorised and countersigned by the Chief Executive (or an officer nominated by the Chief Executive who shall not be within the originating directorate).

14.5.4 Register of Sealing

14.5.4.1 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.

14.5.4.2 A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

14.6 Review of Standing Orders

14.6.1 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

14.7 Variation of Standing Orders

14.7.1 These Standing Orders shall be amended only if: the requirements provided for in the Constitution for variation of the Constitution have been met and if:

14.7.2 a notice of motion under Standing Order 6.7 has been given; and

14.7.3 no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and

14.7.4 at least two-thirds of the directors are present; and

14.7.5 the variation proposed does not contravene a statutory provision; and

14.7.6 the proposed amendment has been reported to NHSE.

ANNEX 8 – FURTHER PROVISIONS

1. Application for Membership

1.1 An individual may become a member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a member of a staff class of the staff constituency in accordance with paragraph 7.5 of the Trust Constitution.

1.2 Where an individual wishes to apply to become a member of the Trust, the following procedure shall apply:

1.2.1 the Trust shall upon request supply the individual with a form of application for membership in a form determined by the Trust;

1.2.2 upon receipt of the said form of application duly completed or upon application in person or via the telephone, the Trust will complete the actions described in paragraph 1.2.3;

1.2.3 unless the applicant is ineligible for membership or is disqualified from membership, the Trust shall cause their name to be entered forthwith on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

1.2.4 upon the applicant's name being entered on the Trust's Register of Members the individual shall thereupon become a member;

1.2.5 the information to be included in the Trust's Register of Members shall include the following details relating to that member:

- full name and title;
- the constituency of which they are a member.

1.3 Where an individual is to be invited by the Trust to become a member, the following procedure shall apply:

1.3.1 the Trust shall take all reasonable steps to satisfy itself that the individual is eligible to become a member of the staff constituency before issuing an invitation to become a member of the Trust and that it has all the information needed to administer that person's membership, as may be defined by the Trust from time to time;

1.3.2 the Trust having so satisfied itself, it shall thereupon invite that individual to become a member pursuant to paragraph 7.5 of the Constitution and if necessary shall request the individual to provide such further information, if any, as it may need to administer his or her membership;

1.3.3 unless the individual has within 14 days of the date upon which the Trust dispatches its invitation to him or her to become a member advised the Trust that they do not wish to become a member, the Trust shall thereupon enter that individual's name on the Register of Members and they shall thereupon become a member provided that the Trust has been provided with the information, if any, requested pursuant to paragraph 1.3.2 above to enable it to administer the membership;

1.3.4 if the individual has failed to provide the information requested by the Trust within 14 days of being invited by the Trust to provide it in accordance with paragraph 1.3.2 above, the Trust shall give notice in writing to the applicant that the information has not been provided and that unless and until the information is provided that individual's name shall not be entered on the Register of Members.

1.4 No individual who is ineligible or disqualified from membership shall be entered or remain on the Register of Members.

1.5 For the avoidance of doubt, an individual shall become a member on the date upon which their name is entered on the Trust's Register of Members and shall cease to be a member upon the date on which their name is removed from the Register of Members as provided for in this Constitution.

2. Additional Grounds for Eligibility or Disqualification of Members

2.1 In addition to satisfying those grounds of eligibility otherwise provided for in the Constitution, the Trust reserves the right to exclude persons from membership of the Trust if they are:

- Persons under 16 years of age.
- Vexatious complainants, as defined by the Trust Policy and Procedure for the Management of Feedback from Complaints, Concerns, Comments and Compliments (DCP071) from time to time.
- Former members of the staff of the Trust who were dismissed due to misconduct in the course of their employment.
- Patients of the Trust who have been excluded from treatment by the Trust in accordance with the Trust's policy from time to time for the management of violent and aggressive behaviour towards Trust staff.
- Persons who, within the preceding five years, have committed an act of violence against any of the Trust's employees or registered volunteers in association with their employment, as defined in the Trust's policy from time to time for the management of violent and aggressive behaviour, or who have wilfully damaged Trust property or facilities.

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Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common

Agenda Item No: BIC(26)128

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	14 May 2026
Director Lead	Lyn Simpson, Interim Group Chief Executive
Contact Officer / Author	Lyn Simpson, Interim Group Chief Executive
Title of Report	**Draft Strategic Objectives 2026/27**
Executive Summary	This paper sets out a proposed set of six strategic objectives for 2026/27 for approval by the Boards-in-Common. The objectives are designed to provide a clear, focused framework to guide delivery over the next 12–24 months, aligning operational recovery with longer-term transformation. They reflect the Group's current context, including the need to stabilise services, improve operational performance, strengthen clinical leadership, and build a sustainable model of care supported by digital, research and continuous improvement. They align with national NHS objectives, the organisation's current position within the National Oversight Framework (NOF), and the requirements of the Intensive Recovery Programme (IRP), while supporting longer-term transformation. The objectives are deliberately concise and outcome-focused. They are intended to: • Provide clarity of organisational priorities • Align leadership and teams around a shared direction • Support delivery against regulatory and performance expectations • Enable consistent communication with colleagues, partners and stakeholders

	The six proposed strategic objectives are: 1. Stabilise services and deliver care 2. Improve flow and restore operational performance 3. Embed clinically led leadership and decision-making 4. Build a culture of continuous improvement 5. Deliver sustainable, integrated care 6. Accelerate digitally enabled care
Background Information and/or Supporting Document(s) (if applicable)	The Group has faced longstanding and well-documented challenges, including variability in clinical quality and operational performance, and a structural financial deficit. These challenges have impacted the organisation's ability to consistently deliver against national standards and have required a renewed focus on stability, performance and organisational grip. In response, the Group has developed and is now delivering a clinically led Improvement Plan to stabilise services, improve performance and provide a clear and credible trajectory towards sustainable, high-quality care. These strategic objectives are intended to build directly on that Improvement Plan, providing a clear and consistent framework to guide delivery. The objectives have been developed drawing on: • The Group's Improvement Plan and NOF requirements • Current operational and recovery priorities • Feedback from clinical and operational leaders • The need to ensure the operating model continues to evolve to support effective clinical delivery They are designed to strike a balance between: • Immediate priorities (stabilisation, performance and safety) • Medium-term transformation (integration, sustainability and digital) • Cultural enablers (leadership, improvement capability and engagement)
Prior Approval Process	The objectives have been developed following executive discussion and prior engagement with senior clinical and operational leaders in the Improvement Plan's development.

Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The objectives support the delivery of equitable, high-quality care and improved access across all communities. Emphasis will be placed, through delivery plans, on reducing health inequalities, improving access to services, and ensuring inclusive engagement with colleagues and patients.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

TRUST BOARD OF DIRECTORS
14 May 2026

Draft strategic objectives 2026/27

1. Stabilise services and deliver care
Stabilise services and consistently meet safety, quality and regulatory standards across all areas, ensuring patients receive safe, high-quality care at all times.

2. Improve flow and restore operational performance
Improve patient flow, discharge and access by reducing delays and optimising urgent, elective and community pathways, restoring performance against key standards.

3. Embed clinically led leadership and decision-making
Strengthen clinical leadership at all levels, with the Clinical Policy Group guiding priorities, investment and service change, alongside clear, accountable site-level leadership enabling timely, effective decision-making aligned to service and population needs.

4. Build a culture of continuous improvement
Develop a culture of continuous improvement and engagement through the Learning, Improvement and Safety Academy (LISA), supporting surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support colleagues to ensure the delivery of safe, timely and coordinated care.

5. Deliver sustainable, integrated care
Deliver a rolling programme of clinically led specialty reviews, integrating care across pathways and ensuring services are clinically effective, underpinned by world-class research and education, operationally efficient and financially sustainable.

6. Accelerate digitally enabled care
Successfully implement the Group's electronic patient record system and expand digitally enabled care, equipping colleagues with the tools to deliver safe, timely and coordinated care, and improving access and experience for patients.

Next steps

Subject to Board approval, the strategic objectives will inform director and senior leader objectives and provide a clear framework for organisational focus. Progress will be reported through existing governance arrangements.