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 Friday, 9 October 2026 at 10.00 am to 1.00 pm
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** 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	Verbal	Assurance	**10:30**
1.6	**Minutes of the Meeting held on Thursday, 9 September 2026** Alan Downey, Group Chair	BIC(26)232 Attached	Approval	
1.7	**Matters Arising** Alan Downey, Group Chair	Verbal	Assurance	
1.8	**Action Tracker** - **Public** Alan Downey, Group Chair	BIC(26)233 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Group Chair's Briefing** Alan Downey, Group Chair	BIC(26)234 Attached	Assurance	**10:35**
2.2	**Group Chief Executive's Briefing** Lyn Simpson, Group Chief Executive	BIC(26)235 Attached	Assurance	**10:45**
2.3	**Integrated Improvement Plan (IIP) (including update on CQC Section 29A Actions & Financial Recovery Plan)** Lyn Simpson, Group Chief Executive & Ben Smith, NHS England	BIC(26)237 Attached	Assurance	**10:55**
2.4	**National Reports and Guidance** Lyn Simpson, Group Chief Executive	BIC(26)238 Attached	Assurance	**11:15**
3.	**PATIENT SAFETY UPDATE**			
3.1	**Monthly Patient Safety Update (including Assurance Committee update)** Mr Peter Sedman, Deputy Medical Officer, Hilda Gwilliams, Group Chief Patient Safety Officer & Jo Ledger, Deputy Chief Nurse	BIC(26)239 Attached	Assurance	**11:20**
3.2	**Maternity 10 Point Plan** Jo Ledger, Deputy Chief Nurse	BIC(26)241	Assurance	**11:30**

3.3	**Briefing on Thirlwall Report & Recommendations** Hilda Gwilliams, Group Chief Patient Safety Officer & Jo Ledger, Group Chief Nurse	BIC(26)242 Attached	Assurance	**11:40**
4.	**STRATEGIC PROGRESS**			
4.1	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Sam Peate, Group Chief Delivery Officer	BIC(26)243 Attached	Assurance	**11:50**
4.2	**People - Assurance Committee Update** Julie Beilby, NED Committee Chair	BIC(26)244 Attached	Assurance	**12:05**
4.2.1	**Freedom to Speak Up Guardian Report – Quarter One – NLaG & HUTH** Liz Houchin & Fran Moverley, Freedom to Speak Up Guardians	BIC(26)245 Attached	Assurance	**12:15**
4.3	**Workforce Disability Equality Standard (WDES)** Helen Marks, Group Chief People Officer	BIC(26)246 Attached	Approval	**12:25**
4.4	**Workforce Race Equality Standard (WRES)** Helen Marks, Group Chief People Officer	BIC(26)247 Attached	Approval	**12:30**
4.5	**NHS Equality Delivery System (EDS) – Six Monthly Update** Lucy Vere, Director of Learning & Organisational Development	BIC(26)248 Attached	Assurance	**12:35**
5.	**OTHER ITEMS FOR ASSURANCE**			
5.1	None			
6.	**OTHER ITEMS FOR APPROVAL**			
6.1	**Linen & Laundry Contract Award** Emma Sayner, Group Chief Financial Officer	BIC(26)250 Attached	Approval	**12:45**
6.2	**Trust Constitution** Keith Haynes, Interim Board Secretary	BIC(26)252 Attached	Approval	**12:50**
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		**12:55**
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, 12 November 2026**			

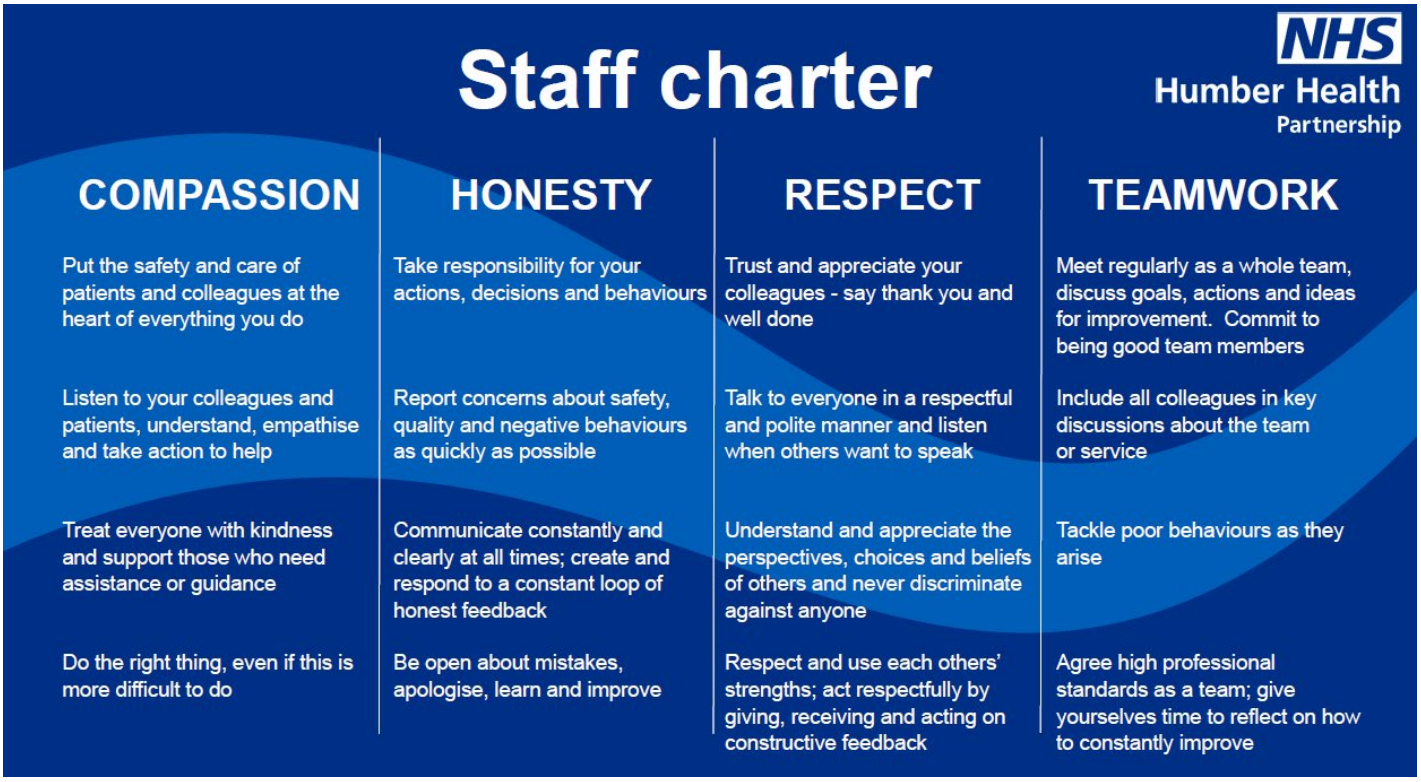
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

7.	ITEMS FOR INFORMATION / SUPPORTING PAPERS	
7.1	**Quality & Safety Committees-in-Common**	
7.1.1	**Quality & Safety Committees-in-Common Minutes – July 2026** Dr David Sulch, Non-Executive Director Committee Chair	BIC(26)253 Attached
7.1.2	**Infection Control Annual Report** Jo Ledger, Deputy Chief Nurse	BIC(26)254 Attached
7.2	**Performance, Estates & Finance Committees-in-Common**	
7.2.1	**Performance, Estates & Finance Committees-in-Common Minutes – September 2026** Murray Macdonald, NED Committee Chair	BIC(26)255 Attached
7.2.2	**Finance Report – Month 5** Emma Sayner, Group Chief Financial Officer	BIC(26)256 Attached
7.2.3	**Fire Annual Report & Work Plan** Tom Myers, Group Director of Estates & Facilities	BIC(26)257 Attached
7.2.4	**Group Annual Security Report** Tom Myers, Group Director of Estates & Facilities	BIC(26)258 Attached
7.3	**Workforce, Education & Culture Committees-in-Common**	
7.3.1	**Workforce, Education & Culture Committees-in-Common Minutes – May & July 2026** Julie Beilby, Non-Executive Director Committee Chair	BIC(26)259 Attached
7.4	**Audit, Risk & Governance Committees-in-Common**	
7.4.1	None	
7.5	**Other**	
7.5.1	**Trust Boards & Committees Meeting Cycle – 2026** Keith Haynes, Interim Board Secretary	BIC(26)263 Attached
7.5.2	**Documents Signed Under Seal** Keith Haynes, Interim Board Secretary	BIC(26)264 Attached
7.5.3	**Provider Capability Assessment 2026** Keith Haynes, Interim Board Secretary	BIC(26)272 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.



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DRAFT
TRUST BOARDS-IN-COMMON MEETING IN PUBLIC
Minutes of the meeting held on Thursday, 10 September 2026 at 2.00 pm
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Mr Sakkaf Ahmed Aftab	Staff Governor (attended virtually)
Angela Brocklebank	Member of the public
Marian Davison	Public Governor (attending virtually)
Dean Gillon	Member of the public (attended virtually)
Hilda Gwilliams	Group Chief Patient Safety Officer
Dietmar Harteveld	Public Governor (attending virtually)
Keith Haynes	Interim Board Secretary
Brent Huntington	Public Governor
Rachel Johnson	Communications (attended virtually)
Wendy Lawtey	Public Governor (attending virtually)
Yvonne McGrath	Group Director of Midwifery (for item 3.2.2 & 3.2.3)
Helen Marks	Group Chief People Officer
John Palmer	Trust Member
Dr Alastair Pickering	Interim Group Chief Digital Officer
Ian Reekie	Lead Governor (attended virtually)
Mr Sandeep Saxena	Governor & Member of Staff (attending virtually)
Leslie Saunders	Trust Member
Penelope Sellers	Member of Staff, NHSE Fellow
Annemarie Tasker	Member of the public (attended virtually)
Zoe Tidman	Member of the public (attended virtually)
Mr Gorajala Vijay	Governor & Member of Staff (attending virtually)
Kevin Woolas	Trust Member
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 2.00 pm. He advised that Lyn Simpson would be late joining the meeting due to a stakeholder session that she was required to attend.

Apologies for absence were received from

Professor John Craig Non-Executive Director (HUTH)

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 Questions from the Public and Governors

Alan Downey advised that no formal questions had been received from the public and governors prior to the meeting.

Brent Huntington advised that he had a question to raise that related to an issue he had only become aware of that week. He advised that this related to infection prevention and control (IPC) and that the Care Quality Commission (CQC) had reported that the organisation was an outlier for this. His query related to the fact that permission had to be requested through human resources to put in place a Non-comformance Report (NCR) for those staff not complying with IPC. He queried why human resources had to be asked for approval of this.

Jo Ledger advised that this was due to several issues around why staff had not been complying, she agreed to speak with Brent Huntington outside of the meeting.

Post Meeting Note:
Jo Ledger discussed the point raised with Brent Huntington after the meeting was held.

1.4 Declarations of Interest

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

1.5 To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 9 July 2026 – BIC(26)188

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

1.6 **Matters Arising**

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

1.7 **Action Tracker – Public – BIC(26)189**

Alan Downey referred to the action tracker and noted that a number of actions were scheduled for discussion at the current meeting and were included within the agenda. It was further noted that updates on the remaining actions would be provided at the October 2026 meeting.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Chair's Report – BIC(26)195**

Alan Downey referred to the report and asked that it be taken as read.

It was reported that both Trusts continued to face a number of performance challenges, although early signs of improvement were now being seen.

In relation to patient safety, Alan Downey noted that, despite the progress made in reducing the number of 'Never Events', two such incidents had recently been reported. He also highlighted improvements in reducing corridor care and expressed his appreciation to executive colleagues and staff across both Trusts for their contribution to the progress achieved.

Alan Downey advised that both Trusts had received Section 29A notices following the recent CQC Well-Led inspections. He noted that teams across the organisation continued to work closely to address the requirements of the notices and ensure compliance.

Board members were advised of recent appointments to the Boards, comprising one Non-Executive Director (NED) and two Associate Non-Executive Directors. Approval had been received from the NLaG Council of Governors (CoG), with approval from NHS England (NHSE) still awaited. Further details, including commencement dates, would be shared in due course.

Alan Downey reported that he had recently visited the NLaG Community and Therapy teams, during which he met with patients receiving care in their own homes. He noted that the visit demonstrated the benefits of supporting patients to remain at home wherever possible. He also advised that he had visited the Hull Community Diagnostic Centre (CDC), where he had been encouraged by the positive culture and strong local leadership evident within the service.
At this point the sequence of the agenda changed.

3. PATIENT SAFETY UPDATE

3.1 **Monthly Patient Safety Update (including Assurance Committee Update) – BIC(26)190**

Hilda Gwilliams referred to the report and asked that it be taken as read.

She advised that the organisation maintained a strong reporting culture in relation to incidents, which supported the identification, learning and dissemination of lessons across the Trusts.

In relation to IPC, complaints and the Patient Advice and Liaison Service (PALS), it was acknowledged that the organisation remained on a continuous improvement journey, with further work underway to enhance performance and patient experience.

Jo Ledger reported that a number of IPC workstreams were in place and had contributed to modest improvements in performance. She advised that this work continued to progress, with staff compliance being regularly monitored and assessed. Any instances of non-compliance would be managed in accordance with the organisation's conduct processes.

Mr Peter Sedman referred to the Summary Hospital-level Mortality Indicator (SHMI) information contained within the report.

3.2 **Maternity Oversight:**

3.2.1 **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(26)192**

Dr David Sulch referred to the update within the report regarding the Local Maternity and Neonatal System (LMNS), noting that the service had ceased at the end of July 2026. He expressed concern that the loss of the service would remove a source of support that had previously been valued and beneficial to the organisation.

Dr David Sulch requested that delegated authority be granted to the Quality & Safety Committees-in-Common to approve and submit the 10-point plan by 25 September 2026, noting that no meeting of the Trust Boards-in-Common was scheduled to take place before the submission deadline.

The Trust Boards-in-Common approved delegated authority to the Quality & Safety Committees-in-Common.

3.2.2 **Maternity & Neonatal Assurance Reports – NLaG & HUTH (including Maternity Incentive Scheme (MIS) Year 8 & Perinatal Mortality Review Tool (PMRT) Quarterly Report) – BIC(26)193**

Yvonne McGrath referred to the report and advised that the Maternity Incentive Scheme (MIS) Standards had been revised for 2026/27, with the number of standards reducing from ten to six.

It was further reported that elements of the assurance process previously provided through the Integrated Care Board (ICB) and the Local Maternity and Neonatal System (LMNS) would now transfer to Trust governance arrangements. As a result, responsibility for oversight and assurance against the MIS Standards would rest with the Trust Boards.

Board members were advised that HUTH had reported two Maternity Outcomes Signal System (MOSS) alerts. Both alerts had been responded to within the required timescales, and associated action plans were being progressed.

Yvonne McGrath drew the Boards' attention to the consultant attendance audit set out at Appendix A. It was noted that compliance with the required standard had been achieved, with consultant attendance reported at 80%.

Yvonne McGrath further advised that the first training checkpoint had been scheduled for 31 July 2026 and confirmed that this milestone had been successfully met.

Yvonne McGrath advised that responsibility for the oversight and sign-off of the Saving Babies' Lives Care Bundle now rested with the Trust Boards-in-Common, and that further information was provided within the report. She highlighted concerns at HUTH regarding compliance with the smoking cessation element of the programme. Performance remained below the required target, with challenges arising from women not setting formal quit dates. It was noted that this was a wider regional issue and not unique to HUTH.

In relation to scan capacity for reduced fetal movements, Yvonne McGrath reported that significant improvement work was underway, supported by Grant Thornton. Board members were advised that pre-term birth rates remained high at both NLaG and HUTH, with compliance levels continuing to fluctuate. It was explained that, while mothers were generally receiving the first dose of steroids, the second dose was not always able to be administered before delivery. Current compliance was reported as 90% at HUTH and 86% at NLaG. Yvonne McGrath advised that additional sonographers had been trained to increase capacity and support improvements in performance going forward.

It was reported that an additional area of risk for NLaG related to the delivery of diabetes services at Diana, Princess of Wales Hospital (DPoWH). Women with pre-existing diabetes and those with gestational diabetes were being managed through separate clinics. Yvonne McGrath asked the Boards to consider whether they were assured that appropriate arrangements were in place, noting that responsibility for this assurance now rested with the Trust Boards.

In relation to Safety Action C, Yvonne McGrath advised that Perinatal Mortality Review Tool (PMRT) reports had been shared and included details of all deaths, together with information on the timeliness of reporting, the outcomes of reviews undertaken and any associated action plans.

It was further reported that parent feedback was routinely sought to inform the review process. Families were provided with copies of the review reports, and the Boards received oversight of the findings, including any identified gaps, learning points and areas requiring further improvement.

In relation to the Thematic Analysis, Yvonne McGrath advised that reports were presented to the Boards on a quarterly basis. She noted that Board scrutiny, together with any actions arising, was clearly documented. The reports provided assurance regarding learning and improvement activity across all required sources, including summaries of key themes, actions taken and evidence of progress.

Referring to the Assurance Report, Yvonne McGrath advised that significant challenges had been identified in relation to caesarean section capacity. She reported that interim mitigations were in place to manage the current position; however, it was anticipated that these pressures could increase further given the rising demand for caesarean sections.

In relation to the Maternity and Neonatal Voices Partnership (MNVP) function, Yvonne McGrath advised that funding had been received from the ICB to support the service. A meeting was scheduled for the following week to consider interim arrangements to sustain the function through to April 2027. It was also reported that Patient Engagement Leaders had now been appointed and would provide additional support to this work.

Yvonne McGrath advised that the induction of labour pathway continued to present challenges. She reported that ongoing discussions were being held with staff and that risk assessments were being undertaken in relation to concerns that had been identified.

Yvonne McGrath was pleased to report that three midwifery apprentices had recently commenced in post. It was noted that all three individuals had previously been employed within the organisation as Maternity and Neonatal Support Workers (MNSWs).

Alan Downey referred to the increase in caesarean section rates and queried whether this reflected a national trend. Yvonne McGrath confirmed that caesarean section rates were increasing nationally and advised that the issue was not unique to the organisation.

Yvonne McGrath referred to the report and advised that it included a series of performance dashboards accompanied by narrative commentary to provide context and support the interpretation of the data.

Yvonne McGrath referred to the report and highlighted the key themes and emerging trends. She advised that the organisation had no outstanding CQC actions, providing assurance regarding compliance and regulatory oversight.
In relation to staffing fill rates, Yvonne McGrath acknowledged that challenges remained in a number of areas and that work continued to improve workforce capacity and resilience.

Jane Hawkard referred to the reported delays between admission and induction of labour, noting that the figures appeared high. Yvonne McGrath advised that issues had been identified in relation to the collection and recording of the data. Following further review, it had been confirmed that the reported delays did not accurately reflect operational performance.

At this point Lyn Simpson joined the meeting.

Jane Hawkard referred to the fill rates within the report and requested that they were rag rated.

Action: **Yvonne McGrath to provide the rag rating detail within the report for the fill rates.**

Jo Ledger advised that further work was being undertaken to strengthen neonatal staffing arrangements, including a review of staffing rosters to ensure workforce requirements could be met safely and sustainably.

Hilda Gwilliams acknowledged the positive progress made in response to the CQC Section 31 notice and welcomed the continued improvement journey within maternity services. She also noted the recent appointment of midwifery apprentices and the contribution this would make to the workforce. Referring to the patient feedback highlighted within the report, she queried whether any additional support was required.

In response, Yvonne McGrath advised that the feedback primarily related to delays in outpatient clinics. She reported that the team was reviewing capacity and demand within the service to better understand and address the issues raised by patients.

Alan Downey acknowledged the progress that had been made and noted that there were no outstanding actions requiring Board attention.

Dr David Sulch advised that, whilst the Quality & Safety Committees-in-Common had received assurance in a number of areas, some concerns remained. In particular, he highlighted ongoing challenges relating to ultrasound capacity and the continued increase in caesarean section rates.

Jo Ledger acknowledged these concerns and agreed to discuss the issues further with Yvonne McGrath and Dr David Sulch outside of the meeting.

Action: Discussion to be held with Jo Ledger, Yvonne McGrath and Dr David Sulch outside of the meeting the concerns raised in respect of ultrasounds and the increase in Caesarean sections

3.2.3 **Ockenden Independent Review – Nottingham – BIC(26)194**

Yvonne McGrath referred to the report and provided an update on the recent reviews that had been undertaken. She advised that a high-level self-assessment would be presented to the Quality & Safety Committees-in-Common at its September 2026 meeting.

Yvonne McGrath also highlighted issues arising from the Nottingham Review and outlined the actions required in response. She noted that further national guidance and requirements were expected in December 2026, which would require review and consideration by the organisation.

Drawing the Boards' attention to maternal deaths occurring during the postnatal period, Yvonne McGrath advised that two dedicated review groups had been established to strengthen oversight and learning in this area. She reported that good progress was being made, although the work was expected to take some time to complete.

It was further noted that there was a requirement to undertake a retrospective review of cases from 2015 onwards, including consideration of incidents that may not previously have been reported, in order to identify any additional learning and provide assurance regarding historical practice.

Yvonne McGrath referred to the report and advised that implementation of the recommendations arising from the Ockenden/Amos review remained underway. She noted that eight recommendations required action, some of which were the responsibility of ICBs and national bodies. She further advised that implementation of the Maternity and Neonatal Services Framework would be a longer-term programme of work.

In relation to addressing health inequalities, Yvonne McGrath reported that a gap analysis was being undertaken to identify areas for improvement and to support the development of actions in response to the issues identified.

Jane Hawkard queried whether the cessation of the LMNS function was a national decision or specific to the local system. Yvonne McGrath advised that arrangements varied across the country. She noted that a Maternity Commissioner role was due to be advertised; however, there would no longer be an assurance function within the ICB, as this responsibility would sit with the regional team. She added that the regional team would also undertake annual assurance visits.
Jane Hawkard sought assurance regarding how service user feedback would be captured and reflected in future. Yvonne McGrath advised that arrangements for obtaining and incorporating feedback would remain in place and that the future model for the organisation was currently being developed and considered.

Alan Downey thanked Yvonne McGrath for the papers shared.

At this point the meeting then returned to the scheduled order of business.

2.2 **Group Chief Executive's Briefing – BIC(26)196**

Lyn Simpson referred to the report and highlighted a number of positive achievements across the organisation. She noted the success of the robotic surgery programme at Castle Hill Hospital and recognised the contribution of the multidisciplinary teams whose efforts had supported this achievement.

Lyn Simpson also drew attention to other positive developments outlined in the report, including the opening of dementia-friendly facilities at Scunthorpe General Hospital (SGH), which would enhance the experience and environment for patients living with dementia.

Board members were advised that the annual staff flu vaccination programme would shortly commence. Lyn Simpson emphasised the importance of promoting key messages to staff to encourage uptake of the vaccination programme and help protect both staff and patients during the winter period.

Lyn Simpson drew the Boards' attention to the performance dashboard included within the report and highlighted the key areas of focus contained within it.

Sam Peate advised that the National Oversight Framework (NOF) ratings had been published on the day of the meeting. He reported that both Trusts were rated at position 128, with HUTH improving from position 134. NLaG had experienced a decline in its position; however, the underlying metric-level detail was not yet available for review.

Sam Peate highlighted a number of positive performance improvements, noting in particular that HUTH had achieved the greatest improvement nationally against the 12-hour emergency care standard.

Dr David Sulch referred to the newly opened dementia-friendly ward and sought assurance that appropriate staffing arrangements were in place to support the service.

In response, Lyn Simpson acknowledged that workforce capacity would present some challenges but advised that close work would continue with the relevant teams to ensure the ward was staffed appropriately and safely.

2.3 **National Reports and Guidance - BIC(26)197**

Lyn Simpson referred to the report and asked that it be taken as read.

2.4 **Carnall Farrar Report – BIC(26)230**

Lyn Simpson referred to the report and advised that the Group had originally been established to provide greater focus on addressing fragile services and workforce challenges across both Trusts. She acknowledged, however, that the Group model had not delivered the level of improvement seen in some other organisations nationally and that overall performance across the partnership had deteriorated during this period.

As a result, NHS England had commissioned an independent review, which was undertaken over a 12-week period. Lyn Simpson advised that the review team had gathered and analysed a comprehensive range of evidence and benchmarked performance against relevant metrics to determine the most appropriate arrangements to support the future success of both Trusts.

Lyn Simpson emphasised that the review had focused on securing the best possible outcomes for patients across the local health system. She further noted that the review had been conducted in a professional and collaborative manner, with the review team engaging extensively with colleagues across the organisation throughout the process.

The Carnall Farrar review set out a number of preferred options for the future organisational arrangements, which had been considered by the Boards.

Alan Downey advised that the Boards had expressed a preference for the eventual dissolution of the Humber Health Partnership (HHP), recognising that this would be a complex process requiring a significant period of transition. He noted that this would involve the appointment of separate Chairs, Chief Executives, Non-Executive Directors and Executive leadership teams for each Trust.

It was emphasised that, notwithstanding any future organisational separation, both Trusts would continue to work collaboratively in the interests of patients. Alan Downey noted that a number of services would continue to require joint working and shared arrangements. He further advised that dissolution of the HHP would not represent a return to previous ways of working, and that maintaining strong collaboration between the two organisations would remain essential.

Lyn Simpson emphasised that any future dissolution of HHP would not represent a return to arrangements that existed prior to the partnership. She noted that there remained a clear need for both Trusts to continue working collaboratively and to build on the benefits and shared approaches developed through the partnership. It was acknowledged that commissioners would also have a role in supporting future arrangements and that lessons had been learned from the partnership model.

Lyn Simpson advised that, following the Boards' decision in principle, a significant programme of work would now be required to progress towards organisational separation. She explained that a detailed transition plan had not yet been developed, as this would form the next phase of the programme. Engagement would be undertaken with patients, staff and other stakeholders to ensure the process was managed effectively and positively. Whilst no formal timeline had yet been agreed, it was acknowledged that progress would need to be made at pace to deliver the required changes.

Jane Hawkard noted that the proposed organisational separation would not, in itself, resolve the significant financial challenges facing either Trust. She highlighted that delivery of the Cost Improvement Programme (CIP) would remain a key challenge and emphasised the importance of ensuring sufficient protected Executive capacity to support its delivery.

Referring to the dashboard presented within the Chief Executive's Report, Jane Hawkard acknowledged that it demonstrated a number of positive developments across both Trusts and provided evidence of progress being made in several areas.

Alan Downey acknowledged the points raised and agreed that significant challenges remained. He advised, however, that the Boards' decision provided greater clarity regarding the future direction of the organisations and would enable focused action to be taken to address those challenges as the Trusts progressed with the agreed approach.

Julie Beilby advised that extensive discussion had taken place regarding the preferred option and the decision reached by the Boards. She noted that the decision provided an opportunity for both Trusts to move forward positively and focus on the next phase of development. She further advised that further Board discussions would be required once a detailed implementation plan had been developed.

Alan Downey advised that arrangements had been put in place to communicate the decision to key stakeholders, with engagement sessions held on the day of the meeting with local authority representatives and staff. He added that staff network groups would continue to be regularly briefed and updated as work progressed to ensure ongoing engagement and communication throughout the implementation period.

Murray Macdonald agreed with the points that had been made and noted that the proposed arrangements would provide both Trusts with an opportunity to strengthen their focus on the needs of their respective communities. He acknowledged, however, that significant challenges remained for both organisations and would need to be addressed as part of the transition process. He added that he looked forward to considering the detailed implementation plan as work progressed.

Dr David Sulch highlighted the need for both Trusts to recognise and proactively manage the risks associated with an ageing consultant workforce. He noted that this was of particular importance in vulnerable and hard-to-staff service areas, where workforce sustainability would require careful planning and mitigation.

Alan Downey noted that the paper was not for approval / ratification as stated on the agenda as this decision had been made in the private Trust Boards-in-Common meeting held earlier that day.

4. STRATEGIC PROGRESS

4.1 Public Purse (including Assurance Committee Update) – BIC(26)198

Emma Sayner referred to the report and advised that the 2026/27 financial plan remained non-compliant; however, she noted that there had been some improvement in the underlying run rate during the month.

Board members were advised that NLaG had delivered performance in line with plan for Month 4, while HUTH had achieved a reduction in expenditure during the same period. Emma Sayner highlighted a number of additional key points within the report and provided an overview of the current financial position. There was a specific discussion on how challenging the cash position is given the deficit position. Board members noted the approval for the revenue cash support application for HUTH & NLAG that was made at the most recent Performance, Estates & Finance Committees-in-Common.

It was reported that significant work continued across both Trusts to support financial recovery, with a focus on improving financial performance and delivering the required recovery plans.

As Chair of the Performance, Estates & Finance Committees-in-Common, Murray Macdonald advised that three areas of concern had been highlighted within the report.

The first related to the need for continued organisational focus on the Electronic Patient Record (EPR) programme. Murray Macdonald queried whether further consideration should be given to the future delivery of the programme in light of the Boards' decision to pursue the dissolution of the Humber Health Partnership. The second concern related to increasing digital costs, which were creating significant financial pressures for the organisation.

The third issue concerned the governance and oversight of digital services. Murray Macdonald noted that responsibility for cyber security currently sat with the Audit, Risk & Governance Committees-in-Common, whilst responsibility for the wider digital agenda sat with the Performance, Estates & Finance Committees-in-Common. He queried whether the current governance arrangements remained appropriate and whether further consideration should be given to the allocation of responsibilities.

Following discussion, it was agreed that Keith Haynes would review the matter and provide a further update.

Action: **Keith Haynes to provide an update on whether digital business should be with one Committee-in-Common or if this should remain separated across the two**

4.2 Patients – Performance (including Assurance Committee Update) – BIC(26)199

Sam Peate referred to the report and advised that a number of improvements had been achieved during the first few months of the financial year. He reported that work with system partners continued to progress positively, with tangible improvements having been seen in this area in recent months.

Board members were advised that performance against the 12-hour standard had been discussed at the recent Senior Leadership Team (SLT) meeting. Sam Peate noted that teams were committed to implementing further changes to support sustained improvement in performance.

In relation to cancer performance, Sam Peate reported that both Trusts were performing ahead of plan against the 62-day referral-to-treatment standard. He advised that a Cancer Turnaround Transformation Lead had recently joined the organisation and had already identified a number of opportunities to further improve pathways and performance.

In respect of diagnostic performance this remained static between the organisations. Further information in respect of the Community Diagnostic Centre (CDC) detail would be shared with Board colleagues following the meeting.

Post Meeting Note:
Information shared with Board members following the meeting.

Sam Peate advised that the principal area of concern remained performance against the Referral to Treatment (RTT) long-wait standards. He reported, however, that both Trusts had performed ahead of plan from an overall performance perspective at the end of July 2026. Sam Peate highlighted a number of additional areas of performance improvement and challenge as set out within the report.

Jane Hawkard thanked operational colleagues for their continued efforts and acknowledged the improvements that had been achieved in performance across a number of areas.

As Chair of the Performance, Estates & Finance Committees-in-Common, Murray Macdonald advised that the Committees had welcomed the introduction of the new Integrated Performance Report (IPR). He noted that members had found the report helpful and informative, whilst recognising that there remained opportunities to further develop and refine the summary page to enhance oversight and reporting.

Murray Macdonald advised that, from a quality governance perspective, Committee members had found it challenging to obtain sufficient assurance from the information currently presented within the Integrated Performance Report (IPR). He noted that members did not have access to the detailed papers considered by the Quality & Safety Committees-in-Common, which limited their ability to fully understand the basis of the assurance being provided. It was therefore considered that additional information or enhanced reporting may be required within the IPR.

Murray Macdonald noted that Sam Peate had acknowledged this point and would consider how the report could be further developed.

Dr David Sulch queried whether performance in relation to diagnostic reporting turnaround times was routinely monitored.

In response, Sam Peate confirmed that reporting turnaround times were monitored. He explained that oversight of this performance was undertaken through Care Group performance meetings rather than through the Committees-in-Common structure.

4.3 People (only Assurance Committee Update) – BIC(26)200

Julie Beilby referred to the report and advised this only included a report from the Workforce, Education & Culture Committees-in-Common as Helen Marks was currently reviewing the report that would be shared with Board members.

She explained that there had been considerable work undertaken and that progress was being made. She added that the Revalidation Report had been reviewed at the meeting, and it had been noted that it was in a more improved position than the previous year.

5. OTHER ITEMS FOR ASSURANCE

5.1 Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report - BIC(26)202

Jane Hawkard referred to the report and advised that the Audit, Risk & Governance Committees-in-Common had approved an amendment to the Internal Audit Plan. This involved the removal of the Cost Improvement Programme (CIP) review and the inclusion of an audit relating to Emergency Preparedness, Resilience and Response (EPRR). She noted that extensive work on the CIP was already being undertaken in conjunction with Grant Thornton.

Jane Hawkard further reported that the Committees had received an update on the internal audit of mortuary services. A number of concerns had been identified within the audit findings, and it was agreed that these would be triangulated through the Quality & Safety Committees-in-Common to provide additional assurance.
It was noted that actions arising from the audit had been developed, and it was anticipated that the majority of these would be completed and reported back to the Committees at their next meeting.

Jane Hawkard referred to the work being undertaken by Value Circle and advised that a review of progress against the recommendations had been requested for consideration at the next meeting of the Audit, Risk & Governance Committees-in-Common. She noted that particular attention would be given to the development and current maturity of the Board Assurance Framework (BAF).

Jane Hawkard further noted that, notwithstanding the proposed organisational separation, the outputs and learning arising from the Value Circle work would remain relevant to both Trusts and could continue to be utilised to strengthen governance and assurance arrangements across the organisations.

6. OTHER ITEMS FOR APPROVAL

6.1 Modern Slavery Statement – BIC(26)203

Helen Marks referred to the report and advised this had been approved at the Workforce, Education & Culture Committees-in-Common, this was an annual requirement of the organisation.

Julie Beilby thanked the teams for the work that had been undertaken with this.

The Trust Boards-in-Common approved the Modern Slavery Statement.

6.2 Group Charities – NLaG & HUTH – BIC(26)204

Alan Downey referred to the report and advised that it had been presented to the Boards to provide greater clarity regarding the governance arrangements and oversight of the Trusts' charitable funds. He noted that there had previously been limited visibility and understanding of the governance structures in place for the charities.

Alan Downey expressed his thanks to Neil Gammon for his role as Chair of the Health Tree Foundation Trustees' Committee and recognised his ongoing contribution to the charity's work.

It was proposed that Neil Gammon be invited to attend the Trust Boards-in-Common twice each year to provide updates on the activities, achievements and priorities of the Health Tree Foundation. Alan Downey further advised that Emma Sayner, Peter Sedman and Murray Macdonald would also become members of the Trustees' Committee.

Alan Downey added that he would like to invite Jamie Lewis to a future meeting of the Trust Boards-in-Common to provide Board members with further insight into the work of the Health Tree Foundation and the impact of charitable funding across the organisation.

The Trust Boards-in-Common members were happy to approve the recommendations for the Health Tree Foundation Committee.

In relation to HUTH, Alan Downey advised that the Charitable Funds Committee had been disestablished; however, the WISHH Charity continued to operate in support of the Trust. He noted that WISHH was an independent charity with its own governance arrangements and expressed his thanks to the Trustees for their continued commitment and contribution.

Alan Downey advised that two Board members could be nominated to become members of the WISHH Committee. He reported that Jane Hawkard had agreed to undertake one of these roles. The second appointment would be confirmed at a later date, as consideration was being given to identifying a Board member with an appropriate clinical background.

Alan Downey further advised that he would like to invite the Chair and Chief Executive of WISHH to attend a future meeting of the Trust Boards-in-Common to provide Board members with an overview of the Charity's work and its contribution

to enhancing services and patient care across the Trust.

The Trust Boards-in-Common agreed to stand down the Charitable Funds Committee.

The Trust Boards-in-Common approved the Group Charities Report recommendations.

6.3 **Winter Plan – BIC(26)229**

Sam Peate referred to the report and advised this had been shared with the Performance, Estates & Finance Committees-in-Common.

It was reported that there would be further updates made prior to the final submission. It was explained that discussions in respect of the Winter Plan had also been held with the Unplanned Care Board and SLT forum.

Sam Peate advised the report shared a number of key highlights.

Sam Peate asked the Boards to note the progress made on the plan at this time and also note the actions required at this time.

Julie Beilby referred to the Multi-Agency Discharge Event (MADE) session and asked that North Lincolnshire was considered as part of this. Sam Peate advised that North Lincolnshire would be included in the events.

6.4 **Medical Appraisal & Revalidation Annual Report – NLaG & HUTH – BIC(26)210**

Mr Peter Sedman referred to the report and advised this had been approved at the Workforce, Education & Culture Committees-in-Common.

Alan Downey wanted to thank the teams for undertaking this piece of work.

The Trust Boards-in-Common approved the Medical Appraisal & Revalidation Annual Report for NLaG and HUTH.

7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

7.1 **Items for Information / Supporting Papers**

The following items for information were shared.

- Quality & Safety CiC Minutes – June 2026
- Medicines Management Annual Report
- Organ Donation Annual Report
- Performance, Estates & Finance CiC Minutes – March, May, June and July 2026
- Finance Report – Month 4
- Workforce, Education & Culture CiC Minutes – May 2026
- Audit, Risk & Governance CiC Minutes – June 2026
- Health Tree Foundation Trustees Committee Highlight Report
- Group Performance Report – NLaG & HUTH

- Trust Boards & Committees Meeting Cycle – 2026
- Council of Governors (CoG) and Trust Board Engagement Policy

8. ANY OTHER URGENT BUSINESS

Alan Downey sought any other urgent business items.

Alan Downey advised that he had invited expressions of interest from the Non-Executive Directors for the role of Senior Independent Director (SID). He reported that Dr David Sulch had expressed an interest in undertaking the role.

Alan Downey sought the approval of the Boards for the appointment of Dr David Sulch as SID.

The Trust Boards-in-Common approved the SID appointment.

Alan Downey wanted to thank Lyn Simpson for the work she had supported in respect of the operational model for the two Trusts.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

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

10. DATE AND TIME OF THE NEXT MEETING

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

Thursday, 8 October 2026 at 10.00 am in the Boardroom, Hull Royal Infirmary.

The meeting closed at 4.00 pm.

Cumulative Record of Board Director's Attendance 2026/27

Name	Possible	Actual	Name	Possible	Actual
Alan Downey	5	4	Murray Macdonald	5	5
Lyn Simpson	5	5	Helen Marks	1	1
Julie Beilby	5		Sam Peate	5	5
Paul Bunyan	4	4	Alastair Pickering	5	5
John Craig	2	1	Emma Sayner	5	5
Hilda Gwilliams	5	5	Peter Sedman	5	5
Keith Haynes	2	2	David Sharif	4	2
Jane Hawkard	5	5	David Sulch	5	4
Jo Ledger	5	4	Kate Wood	4	0

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BIC(26)233

BOARDS-IN-COMMON - PUBLIC
ACTION TRACKER - PUBLIC

2026 / 27

ACTION TRACKER - CURRENT ACTIONS - 9 OCTOBER 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									
5.1	12.02.26	Nursing Establishment Paper - risk register score to be reviewed		Jo Ledger to review risk register score for staffing due to investment being approved	Jo Ledger	October 2026	To be reviewed in October once new recruits have commenced employment with organisation		
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	November 2026	Paper to be shared at the November 2026 meeting.		
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	Emma Sayner	October 2026	Updates have been incorporated into the planning timetable for 2026/27		
1.3	14.05.26	Patient Story - safeguarding capacity update		Report on safeguarding capacity to be shared with the Trust Boards-in-Common by Jo Ledger once the review had been undertaken	Jo Ledger	November 2026	Full service review being undertaken by Tracy Campell, Site Nursing Director and will be shared with Trust Board in November 2026.		
3.1	14.05.26	Monthly Patient Safety Update - More detailed information to be added to front sheets		communicate to report authors details to be included on front sheets including prior approval	TBC	November 2026	Update to be provided at October 2026 meeting. Progressed through Governance workstream and Board Goverance Manual.		
3.1	14.05.26	Monthly Patient Safety Update - Complex Cases Presentation		Complex cases presentation to be shared with Board members	Hilda Gwilliams / Wendy Page	November 2026	Update to be provided at November 2026 meeting		
4.2	14.05.26	Public Purse - Finance Strategy - milestones		Emma Sayner to share milestones relating to the Finance Strategy with the Performance, Estates & Finance Committees-in-Common	Emma Sayner	September 2026	Update to be provided to PEF in September 2026.		
4.2	14.05.26	Public Purse - Triple A Report		Further discussion to take place regarding how the Triple A report highlights concerns requiring escalation to the Boards	Keith Haynes	November 2026	Update to be provided at November 2026 meeting. Progressed through Governance workstream and Board Goverance Manual.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care Session in respect of changes and the impact of this		Session to be held with the Boards on changes made in respect of corridor care and how this had positively impacted patients and staff	Jo Ledger	October 2026	The team are developing a point prevalence survey to support this; Jo Ledger to provide an update at the meeting.		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Birth Rate Plus		Birth rate plus target dates to be added to the report to highlight progress being made	Yvonne McGrath	September 2026	Recruitment to BR+ is overall on track with just a few specialist roles outstanding mainly due to JDS		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - update on progress following investment		Summary of successes within Maternity Service and progress made following the recent investment to include any current concerns that needed to be highlighted within the current reporting	Yvonne McGrath	September 2026	Once our Newly Qualified Midwives (NQMs) start we will be fully recruited on all sites and we have just received confirmation of a successful bid for the funding to supporting Early Career Midwives (ECM).		
6.2	11.06.26	NHS Equality Delivery System (EDS) Submission		Session to be scheduled for the EDS mid-point submission during the year	Lucy Vere	October 2026	Session scheduled for October 2026 meeting.		
2.2	09.07.26	Group Chief Executive's Briefing - Communication options to be shared with Public		Myles Howell to review further options for communication in addition to those being shared on social media	Myles Howell	September 2026	Update to be provided at the September 2026 meeting.		
3.1	09.07.26	Monthly Patient Safety Update (including Assurance Committee Update) - Patient Experience Model Update		NLaG Governors to be considered as part of the engagement work in respect of the patient experience model	Hilda Gwilliams / Jo Ledger	October 2026	Governors have been included as part of this, One Governor attends the Steering Group and the Council of Governors are updated on a quarterly basis.		
3.2.2	10.09.26	Maternity & Neonatal Assurance Reports - NLaG & HUTH (including MIS Year 7, PMRT) - Rag Rating Detail		Yvonne McGrath to provide the rag rating detail within the report for the fill rates	Yvonne McGrath	October 2026			
3.2.2	10.09.26	Maternity & Neonatal Assurance Reports - NLaG & HUTH (including MIS Year 7, PMRT) - Ultrasound and C-Sections		Discussion to be held with Jo Ledger, Yvonne McGrath and Dr David Sulch outside of the meeting the concerns raised in respect of ultrasounds and the increase in Caesarean sections	Jo Ledger, Yvonne McGrath & David Sulch	October 2026	Ultrasound capacity work ongoing.		
4.1	10.09.26	Public Purse (including Assurance Committee Update)		Keith Haynes to provide an update on whether digital business should be with one Committee-in-Common or if this should remain separated across the two	Keith Haynes	October 2026	Capcity and demand study for ultrasound is being completed by Grant Thornton		

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	09.04.26	Questions from the Public & Governors - Response to be provided to questions asked		Updated response to question following meeting between Sam Peate and John Palmer to be provided at May 2026 meeting	David Sharif / Sam Peate	May 2026	Sam Peate met with John Palmer on the 15 April 2026		
1.4	09.04.26	Questions from the Public & Governors - Sam Peate to meet with John Palmer to discuss points raised		Sam Peate to arrange to meet with John Palmer	Sam Peate	April 2026	Sam Peate met with John Palmer on the 15 April 2026		
2.2	09.04.26	Group Chief Executive's Briefing - Board Development Session		Board Development Session on 247 staffing provision to include holiday periods and weekend cover	Paul Bunyan	May 2026	Item added to Board Development Sessions - date to be agreed		
2.3	09.04.26	National Reports & Guidance - Lead added to report for initiatives		Lead to be added to report to highlight who was overseeing initiatives	Lyn Simpson	May 2026	Update to be provided at May 2026 meeting		Sharepoint system introduced for all correspondence to be added to including lead executive, reports to continue being shared with the Boards
3.1	09.04.26	Monthly Patient Safety Update -Further detail included within report		Infection control and corridor care to be included within future patient safety reporting	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Report now included in Patient Safety Report, to then be included in IPR future report.
5.1	09.04.26	Briefing on Ward Accreditation Programme - Indicators to be added		Appendix of indicators to be included within future reports	Hilda Gwilliams / Jo Ledger	May 2026	Update to be provided at May 2026 meeting		Information included in future reports
5.1	09.04.26	Briefing on Ward Accreditation Programme - Session with 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.		
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.		
5.1	12.02.26	Nursing Establishment Paper - how investment would be managed on staffing		Executive report to be shared at the Workforce, Education & Culture Committees-in-Common on how the staffing investment would be managed in respect of reducing bank and agency staffing in areas where investment had been made	Executives (Jo Ledger)	June 2026	Paper presented to Workforce, Education & Culture Committees-in-Common in May 2026.		
5.3	09.04.26	The Value Circle Report		Value Circle Priorities to be clarified	David Sharif	June 2026	Item discussed at the May 2026 meeting, Value Circle to undertake a further session with the Boards in June 2026		
4.1	14.05.26	Monthly Patient Survey Results - Review other organisations in same tiering		Paul Bunyan to review staff survey results from comparator organisations within the same tier and report findings to the Boards	Paul Bunyan	June 2026	Data for the NOF 5 trusts has been isolated and benchmarked against the national average as well as the trusts in the NEY region. Information shared with Board members.		
7.1	14.05.26	Items for Information - CiC to move to virtual meetings		Committees-in-Common Meetings to be held virtually, amended diary invites to be circulated	David Sharif	June 2026	Administrators for the CiC updated meeting invites to virtual meetings		
4.1	12.03.26	Public Purse - model hospital data shared at PEF CiC		Model Hospital data to be included within reports to the Performance, Estates & Finance Committees-in-Common for oversight	Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
1.4	09.04.26	Questions from the Public & Governors - review of administrative function to be undertaken		Performance, Estates & Finance Committees-in-Common to review administrative functions to provide assurance to the Trust Boards-in-Common	NED Chair, TBC / Sam Peate	July 2026	Item to be discussed at the PEF CiC in June 2026; item on agenda for sharing		
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	Dates were provided to the NEDs in June 2026		
6.1	09.04.26	Quality Priorities - insulin safe practice		Jo Ledger to review current position for insulin safe practice and incorporate into the Quality Priorities	Jo Ledger	June 2026	Reported that there has been a 20% reduction of incidents causing harm from insulin prescribing and medication errors.		
3.1	14.05.26	Monthly Patient Safety Update - PALS Concerns Update		Jo Ledger to provide an update on the success of the amnesty process for PALS concerns	Jo Ledger	June 2026	294 PALS concerns had been reviewed and that 237 of those had been closed following review. The process was to be reviewed for PALS concerns including additional capacity to continue sustainable change and improvements.		
5.1	14.05.26	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report - Review of policies and procedures		Hilda Gwilliams and David Sharif to review policies and procedures that were outstanding to ensure they did not relate to patient safety	Hilda Gwilliams & David Sharif	July 2026	Review of overdue policy documents completed by Sarah McDougall, email sent to relevant SRO (Executive or Chief of Staff) including key information. Oversight and assurance to be tracked in GERAC.		
7.1	14.05.26	Items for Information - WEC CiC frequency		Further discussion required as to whether the Workforce, Education & Cultures Committees-in-Common continues to be held on a bi-monthly basis	David Sharif	July 2026	It has been agreed the WEC CiC would move to bi-monthly sequencing		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Corridor Care query		Jo Ledger to review whether the zero target for corridor care was in respect of all areas or if this excluded ED	Jo Ledger	July 2026	Corridor care reduction programme includes all areas where care is carried out in non -designated clinical space. This includes Emergency Departments. There are two reporting metrics one for ED and one is for G&A beds which excludes ED. The ED data runs midnight to midnight and is the number in total of individual patients who exceed a 45 minute corridor care time in this attendance episode. The G&A bed data return is a snapshot of occupied corridor care spaces at 8am in the morning . This should read as 0 from July as there are no chairs in use in our corridors in our wards or assessment units. HHP Corridor Care slides circulated to Board members 7 July 2026.		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - TES achievement to be included within report for each hospital		Jo Ledger to provide details in reference to each hospital and the TES achievement against each within the report in the future	Jo Ledger	July 2026	Updated presentation circulated to NEDS including the trajectory and actual achievement of reduction against trajectory for end of June		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - IQIG Reporting		Agreement of IQIG report to be shared with Board members until IPR had been updated	Sam Peate / Emma Sayner	July 2026	IQIG papers shared with Board Members.		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - Harm Reviews being undertaken		Sam Peate to review whether harm reviews were being undertaken in relation to patients that were delayed for diagnostic testing	Sam Peate	July 2026	Any patients who have delay to treatment in line with the clinical harm process will be reviewed on completion of their Cancer or RTT pathway and any issues relating to delayed diagnostics would be picked up in these reviews. There is not a standalone process for diagnostics as all picked up via this route		
4.2	11.06.26	People (including Assurance Committee Update - IQIG Information - workforce		Paul Bunyan to circulate slides in respect of workforce from the IQIG meeting	Paul Bunyan	July 2026	Slides shared with Board members on 30 June 2026 and due to be presented to NHSE regional team on 3 July 2026.		
4.2	11.06.26	People (including Assurance Committee Update) - Lead CiC for CIP		Further consideration required in respect of which Committee-in-Common would be the lead for triagulation of performance, workforce and finance in respect of CIP	Emma Sayner	July 2026	Recommend PEF undertakes this role on triangulation.		
1.3	11.06.26	Patient Story - Library of patient stories		Hilda Gwilliams to review a process for a library of patient stories for reference	Hilda Gwilliams	July 2026	Electronic library developed in Bridget.		
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	September 2026	New IPR in place shared at September 2026 Trust Board meeting		
1.3	11.06.26	Patient Story - Sharing of Stories with staff		Myles Howell to work with the patient experience team to improve the sharing of patient stories with staff through communications	Myles Howell	July 2026	Library of patient stories now shared on Bridget, stories also to be shared more widely through the Learning Improvement Safety Academy (LISA)		
3.1	11.06.26	Monthly Patient Safety Update (including Assurance Committee Update) - Sepsis Six		Mr Peter Sedman to circulate Sepsis Six documentation to Board members	Peter Sedman	July 2026	Information has been shared with Board members.		
3.1.2	11.06.26	Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH - Ultrasound capacity		Jo Ledger to provide update on concerns raised in respect of Ultrasound within future reporting	Jo Ledger	September 2026	Meeting held with Grant Thornton project scope agreed and reported through MNAG and Quality CIC.		
4.1	11.06.26	Patient – Performance (including Assurance Committee Update) - CDC Activity		Sam Peate to provide information in respect of the CDC activity currently being used and how this was impacting on organisational activity	Sam Peate	September 2026	Information provided by email to Board members on 14.09.26		
4.2.1	11.06.26	Freedom to Speak Up (FTSU) Guardian Report – Quarter Four & Annual Report		Jo Ledger to provide information to the FTSUGs on the EQIA	Jo Ledger	July 2026	Information shared with the FTSUGs with a meeting arranged to discuss.		
1.6	09.07.26	Fit & Proper Persons Test: Annual Declaration		Keith Haynes to confirm required details within the report and ensure this was updated	Keith Haynes	September 2026	The TBC register of interests entry has now been completed and register updated.		
5.1	09.07.26	Audit, Risk & Governance CiC Highlight / Escalation - Issues raised during meeting - further discussion		Board members to address how issues raised would be addressed, further discussion to be held in private	Murray Macdonald	September 2026	It was agreed to bring forward the November 2026 meeting to October 2026.		

KEY	
Green	Completed

NHS
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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)234

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9 October 2026**
Director Lead	Alan Downey, Group Chair
Contact Officer / Author	Alan Downey, Group Chair
Title of Report	Group Chair's Report
Executive Summary	Report on Policy, Regulation and wider activities
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Group Chair's Update

Performance

In my last update I listed some of the positive results from the improvement initiatives launched in recent months. These included improved Care Quality Commission (CQC) ratings for several services, a reduction in the number of Never Events and improvements against constitutional standards in a number of areas. It is clear, however, that there is no room for complacency. As we enter a transitional period, pending dissolution of Humber Health Partnership (HHP), it is essential that we retain our focus on an improvement journey that is beginning to bear fruit.

It is particularly important that we make the changes required by the CQC in the two Section 29A notices they served after their recent well-led inspection. They will be returning in only a few months' time, and we must be able to show that we have made demonstrable improvements in our governance systems, our approach to risk management, the way we embed learning from incidents and complaints, and our approach to infection prevention and control.

We recently had our mid-year review with the regional team from NHS England (NHSE) and the Hull & North Yorkshire Integrated Care Board (ICB). They continue to expect that we will make progress across the board, from patient safety to corporate governance, and from deficit reduction to waiting times. This is a huge ask at a time when we are preparing for a major organisational change, but I have to acknowledge the level and value of the support we are receiving from the NHSE national and regional teams.

Partnerships

We know that partnerships are key to improving performance, and we have been aiming to improve our communication and style of working with our partners. With that in mind, immediately after the decision to dissolve HHP, we held a series of briefing sessions with partners including MPs, local authority chief executives and colleagues in primary care. The news about the intention to dissolve HHP was generally well received. Several of our partners stressed the need for us to move at pace, which is a message we have taken on board.

Governance

It is less than a month since we took the momentous decision to dissolve HHP and restore the autonomy and sovereignty of the two trusts, HUTH and NLaG. In the run-up to the decision, many voices were heard, some in favour of separation and some against. It was inevitable that some colleagues would be disappointed by the decision, but I know that it was taken diligently and only after thorough consideration of the evidence. My impression is that it has been welcomed by a majority of staff members, on both sides of the Humber.

A number of factors were weighed up, of which the most important were the interests of our patients and the communities we serve. Perhaps the most decisive consideration was the scale of the challenge we have faced in trying to co-ordinate services across such a large geographical area, across communities with rather different needs, and across two trusts with significantly different service profiles, as well as different histories and organisational cultures. I am confident that the new approach – two independent trusts working closely together – will put us in a better position to tackle the deep-seated

performance issues we have been wrestling with as group.

As noted above, some of our external partners have been urging us to move quickly and to make the transitional period as short as possible. We have heard the same thing from colleagues across both trusts. We must, of course, make sure that we get it right: speed is not the only consideration. I am, however, delighted that we have been able to move very quickly to appoint an interim Chair and interim Chief Executive for NLaG. These appointments are crucial, because they give the south bank of the Humber a clear and authoritative “voice” in all the decisions about how we separate the two trusts. I have got to know Murray Macdonald well over the last six months, and I know he will do a first-rate job as interim NLaG Chair. I am just getting to know Therese Patten, but it is already clear that she is an ideal choice for the task ahead, bringing not only highly relevant experience and sound judgement, but also a calm determination to make NLaG a great place to work and to receive care.

Colleagues

Lyn Simpson and I have held the first two of a series of roadshows, focusing on the transition to the new arrangements. We are keen to listen to views and concerns from colleagues in all disciplines and at all levels, and we will continue to listen and consult as we plan the steps that will lead towards the dissolution of HHP. The first two roadshows were on the north bank (in Castle Hill and Hull Royal Infirmary (HRI)), as we were waiting for the appointment of Therese and Murray before moving on to south bank locations.

A couple of themes have emerged loud and clear from the first two roadshows. There is clearly a great deal of concern about the current recruitment pause and the impact this is having on the day-to-day lives of staff, on their morale, and on their ability to provide safe and effective care. We have processes in place to override the recruitment pause in specific cases, where there is a risk to patient safety. However, we are hearing a general concern that the pause is having a widespread negative impact. We will look again at our approach, in the light of that concern, aiming as always to balance the needs of patients and staff with our responsibility to live within our means.

The second theme is a request that we should take account, as far as we possibly can, of the views of staff at all levels, including the more junior. It would be impossible to consult in a timely fashion with every member of staff in a group of our size, but we will look for ways of ensuring that we hear the voices of colleagues working on the front line. One way of doing that is to ensure that our trade unions are represented on the transition delivery board.

Patients

The last month has been taken up, almost exclusively, with discussions about the decision to restore the independence of the two trusts and to plan the separation. I regret that I have not therefore had the opportunity to chat to patients as much as I would have liked. However, thinking back over my conversations with patients since I joined in the spring, I would say that patients and their families are generally both impressed and grateful for the care they receive, with many examples of outstanding care, and only a few (but an important few) where care was below the standard our patients expect and deserve. I can say, however, that most of the patients I talk to express frustration about some aspect of their interaction with our trusts, often relating to poor or confusing communication, or to delays and cancellations. We know that these aspects of the patient experience matter a

great deal, even if the clinical care is of a high standard when it is received. Separating into two more manageable trusts will give us an opportunity to make progress in these areas, which are often as frustrating for staff members as they are for patients.

Alan Downey
Group Chair

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Trust Boards-in-Common - Public

Agenda Item No: BIC(26)235

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2026
Director Lead	Lyn Simpson, Group and HUTH Chief Executive
Contact Officer / Author	Lyn Simpson, Group and HUTH Chief Executive
Title of Report	**Group Chief Executive update**
Executive Summary	This report provides the Boards with an update on key developments since the previous meeting, including the latest National Oversight Framework (NOF) position, national and ministerial engagement, staff engagement, quality and safety, clinical innovation, research and patient experience. Separate reports on the transition programme, financial recovery and Integrated Improvement Plan are presented elsewhere on the agenda. The Boards are asked to note the update.
Background Information and/or Supporting Document(s) (if applicable)	This report provides a general update from the Group Chief Executive on organisational developments since the previous Board meeting. Reporting on the transition programme, Integrated Improvement Plan, financial recovery and other substantive programmes is provided elsewhere on the agenda.
Prior Approval Process	This is an update report for information.
Financial Implication(s) (if applicable)	There are no specific financial implications arising directly from this report. Any financial implications relating to individual programmes or initiatives are considered through the relevant governance and approval processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	There are no specific new equality, diversity or health inequality implications arising directly from this report. Relevant implications are considered through the appropriate governance arrangements for individual programmes and initiatives.
Recommended action(s) required	☐ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

Trust Boards-in-Common – Public

GROUP CHIEF EXECUTIVE UPDATE

1. National Oversight Framework

The latest National Oversight Framework (NOF) data for Quarter 1 of 2026/27 was published during September 2026.

Hull University Teaching Hospitals NHS Trust (HUTH) has moved from 134 to 128 in the national provider rankings, while Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) remained at position 128.

There were encouraging signs of improvement in a number of areas, reflecting the work being undertaken by colleagues to reduce waiting times, improve access and strengthen quality and safety. At the same time, the position underlines the continuing need for sustained focus on improvement and performance.

The organisational review considered the different circumstances, populations and local systems served by the two Trusts, and the Boards' decision on 10 September 2026 provided the basis for increasingly local Trust-level accountability and clinically led improvement.

Detailed performance and improvement reporting continued through the Integrated Improvement Plan (IIP) and associated Board reporting arrangements.

2. Visit by NHS England Chief Executive

NHS England Chief Executive, Sir James Mackey visited HUTH on 10 September 2026.

He met with members of the Board and visited the Neonatal Intensive Care Unit and the Fatima Allam Birth Centre at HUTH's Women and Children's Hospital, accompanied by Director of Midwifery, Yvonne McGrath and Head of Midwifery, Tess Dunning.

The visit provided an opportunity to discuss the relationship between population health, health literacy and wider determinants of health and the way maternity services were designed and delivered for local communities.

The team was also able to share some of the improvements being achieved within maternity services, including increased breastfeeding rates and work with partners to strengthen engagement during pregnancy, reduce missed appointments and support healthier choices.

This was a valuable opportunity to demonstrate the progress being made by maternity colleagues following the removal of the previous Care Quality Commission (CQC) Section 31 notice and to highlight the importance of sustained attention to quality, safety and patient experience.

3. Ministerial visit to Castle Hill Hospital

The Group Chair and Chief Executive (CE) welcomed Dame Diana Johnson MP, Minister for Health and Social Care, to Castle Hill Hospital on 23 September 2026.

The visit provided an opportunity to discuss the improvement work underway and to showcase the contribution being made by colleagues to patient care.

The Minister visited the Queen's Centre and Day Surgery Centre and met colleagues working across the services.

Dame Diana recognised the progress reflected in the latest national performance information and asked that her thanks be passed to colleagues.

4. Local Authority and wider partnership engagement

On 21 September 2026, the Group Chair and CE attended the North Lincolnshire Health and Wellbeing Board, which brings together the Council, NHS and wider system partners. We provided an update on the improvement work underway across the Trusts, including progress against recent CQC inspections, and the Boards' decision to move towards separate governance for HUTH and NLaG.

On 30 September 2026, the Group CE met with representatives of Hull City Council and East Riding of Yorkshire Council to discuss how we could work more closely together following the decision to establish two separate Trusts.

The discussion focused on maintaining strong relationships through the transition and on the opportunities for HUTH to work more closely with its principal North Bank Local Authority partners.

The Group Chair and CE were also meeting with the wider local authority and partner group to consider how connections and collaboration could be maintained and strengthened as the new arrangements develop.

Local government is being directly involved in the transition programme, including through representation on the Programme Delivery Group. As the transition progressed, our new NLaG CE colleague, Therese Patten, would lead the developing relationship with South Bank Local Authorities, while HUTH's CE would continue to strengthen its relationships with Hull, East Riding and other North Bank partners.

On 29 September 2026, the Group CE attended the Anchor Institution meeting, convened by the University of Hull. A discussion took place around how the area's major Anchor Institutions could support the Mayoral Combined Authority.

A further meeting with Local Authority CEs was planned for 30 October, with the intention of establishing a regular rhythm of engagement and identifying opportunities for practical collaboration between the NHS and Local Government.

5. Staff engagement

The Group CE continued to regularly engage with staff networks, including most recently colleagues from the Equality, Diversity and Inclusion Group, discussing the transition and the issues members would like to see reflected as the programme developed. The discussion highlighted the importance of continuing to involve colleagues throughout the transition, maintaining a focus on staff wellbeing and development, and providing clarity around leadership and allyship.

Members also emphasised the value of our staff networks and the benefits of them continuing to work across both organisations where appropriate.

The Group Chair and CE also held two all-staff engagement sessions on the transition, at Castle Hill Hospital and HUTH. These provided an opportunity to update colleagues on the

transition process, respond to questions and hear directly from colleagues about the issues that were important to them as the new arrangements developed.

6. Transition organisational development

Work was underway to develop the organisational development (OD) approach to support the transition to both Trusts' new organisational arrangements. Each Trust would develop an OD programme that reflected its own organisational context and priorities, while maintaining opportunities for collaboration.

The approach would support shared learning and effective working relationships across both organisations, alongside the development of the leadership, culture and organisational arrangements required to support the transition and longer-term improvement.

7. 5,000 robotic surgery procedures

Dame Diana's visit coincided with an important milestone at Castle Hill Hospital: the completion of the 5,000th robotic surgical procedure.

Robotic surgery was introduced in HUTH in 2015, initially for urology procedures, and had subsequently expanded across six specialties, including gynaecological oncology, thoracic, colorectal, upper gastrointestinal, and head and neck surgery.

Colleagues marked the milestone with an event at the Allam Digestive Centre involving clinical teams, demonstrations and opportunities to see the technology in use.

Robotic surgery was able to support greater surgical precision and, for appropriate patients, shorter hospital stays and faster recovery.

8. Research and innovation

Professor Simon Hart and colleagues at Castle Hill Hospital had recruited the first European participant to the ARGiNAUT study, which is exploring the care of patients with Idiopathic Pulmonary Fibrosis.

This was a significant achievement for the team and reflected the expertise and work required to assess, establish and open complex research studies effectively.

Providing local patients with opportunities to participate in research was an important part of HUTH's role as a teaching and research organisation and strengthened our contribution to the wider NHS research and life sciences agenda.

9. Infection prevention and sepsis improvement

Clinical educator Molly Bates and colleagues were currently leading work to strengthen infection prevention and control practice within emergency departments (ED) on the South Bank.

Most recently, this included a six-week sepsis improvement project supporting ED teams to recognise sepsis earlier, improve consistency in screening and documentation and ensure patients received timely treatment.

10. Community Diagnostic Centre first anniversary

Hull's Community Diagnostic Centre (the Centre) marked its first anniversary since opening to patients.

During its first year, the Centre delivered more than 50,000 imaging appointments and now provided an expanding range of diagnostic tests.

The Centre was helping to provide patients with more convenient and timely access to diagnostics while also enabling hospital-based diagnostic capacity to be focused on patients requiring acute and specialist care.

Its first year demonstrated the potential of providing more diagnostic services away from the traditional acute hospital setting and the benefits which could be achieved through teams and services working together.

11. Child Development Centre sensory garden

At Diana, Princess of Wales Hospital, the Group CE was pleased to attend the opening of the new sensory garden at the Child Development Centre.

The garden provided an additional space for children and families attending outpatient appointments and had been made possible through significant fundraising and community support.

Colleagues had contributed through a range of fundraising activities, alongside support from local businesses and the Health Tree Foundation.

The project was an example of how charitable and community support could enhance the experience of patients and families alongside the clinical care provided by our teams.

12. NHS Staff Survey

The national NHS Staff Survey opened on 1 October 2026. The survey provided an important opportunity to understand colleagues' experience, recognise where progress was being made and identify areas requiring further attention.

13. CE Dashboard

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

CEO DASHBOARD

October 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**
  Transition planning to the new organisational arrangements is focused on continuity of care, with existing cross-Humber arrangements continuing unless a specific decision is made to change them.
- **People**
  Local Trust-level leadership and accountability are being established for NLAG as part of the transition.
- **Population**
  Future arrangements will support local accountability while retaining collaboration where this benefits patients, services and clinical sustainability.

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- Friends & Family results remain strong for inpatient and outpatient services at both Trusts, with July scores above 97%. A&E and antenatal scores remain below target.
- Complaint response timeliness still requires improvement, although 60-day complaint compliance has improved.

STAFF EXPERIENCE

- The NHS Staff Survey opened on 1 October, providing colleagues across both Trusts with an opportunity to share their experience and identify areas for improvement.
- Alongside this, workforce controls continue to implemented with an explicit focus on protecting quality and operational delivery while improving financial sustainability.

Monthly Trend Key

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

SAFETY AND QUALITY PRIORITIES

- Sepsis
- IPC
- Safer surgery
- Insulin prescribing
- Deconditioning

OPERATIONAL PERFORMANCE (AUG 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

Metric	Period	Latest	Previous	Change
A&E - 4 Hour Standard (All)	Aug-26	61.4%	62.2%	↓ -0.9%
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	70.0%	67.3%	↑ 2.7%
Cancer - 62 Day All Referral Sources	Jul-26	54.5%	54.4%	↑ 0.1%
Diagnostics - 6 Week Standard	Jul-26	36.6%	37.2%	↑ -0.6%
Inpatient - Bed occupancy classed as clinically ready for discharge	Aug-26	27.4%	27.1%	↓ 0.2%
RTT - Incomplete 18 Week Standard	Jul-26	56.0%	56.8%	↓ -0.7%
Theatres - Capped Theatre Utilisation	Aug-26	81.9%	82.2%	↓ -0.3%

NLaG

Metric	Period	Latest	Previous	Change
A&E - 4 Hour Standard (All)	Aug-26	68.0%	69.1%	↓ -1.1%
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	68.7%	64.0%	↑ 4.6%
Cancer - 62 Day All Referral Sources	Jul-26	56.7%	64.1%	↓ -7.5%
Diagnostics - 6 Week Standard	Jul-26	33.5%	32.6%	↓ 0.9%
Inpatient - Bed occupancy classed as clinically ready for discharge	Aug-26	16.8%	16.6%	↓ 0.2%
RTT - Incomplete 18 Week Standard	Jul-26	59.8%	61.6%	↓ -1.9%
Theatres - Capped Theatre Utilisation	Aug-26	85.6%	81.5%	↑ 4.1%

PEOPLE (AUG 26)

IPR

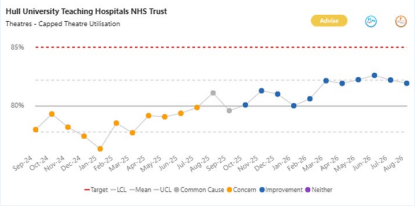
Metric	Period	Latest	Previous	Change
Staff Appraisal Rate (AfC)	Aug-26	80.9%	81.1%	↓ -0.1%
Staff e-Job Planning	Aug-26	78.5%	94.3%	↓ -15.8%
Staff Mandatory Training - Core	Aug-26	84.8%	83.0%	↑ 1.8%
Staff Mandatory Training - Role Specific	Aug-26	82.3%	81.3%	↑ 1.0%
Staff Sickness Absence Rate	Jul-26	5.2%	5.4%	↑ -0.2%
Staff Turnover Annual FTE Rate	Aug-26	7.2%	7.2%	↑ 0.0%

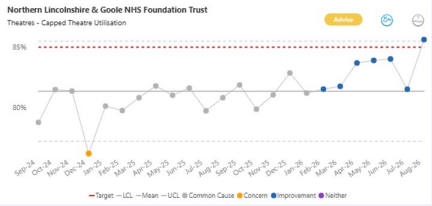
GROUP FINANCIAL POSITION (AUG 26)

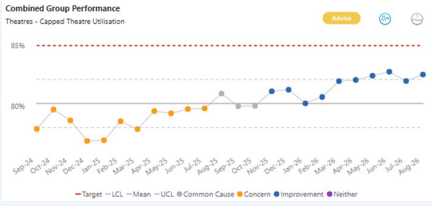
IPR

Metric	Period	Latest	Previous	Change
Finance - CIP YTD against Plan	Aug-26	56.2%	57.6%	↓ -1.4%
Finance - Planned Surplus/Deficit	Aug-26	(23,665)	(23,665)	—
Finance - Variance YTD to Financial Plan	Aug-26	(1,837)	(1,858)	↓ 21

THEATRE PRODUCTIVITY (AUG 26)







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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)237

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	09 October 2026
Director Lead	Lyn Simpson, Group Chief Executive Officer (IIP) Hilda Gwilliams, Group Chief Patient Safety Officer (CQC)
Contact Officer / Author	Ryan Sutton, Group Associate Director Improvement
Title of Report	Our Improvement Plan – Listening to Clinicians, Learning from Patients; including delivery of CQC 29A Warning Notices
Executive Summary	The Humber Health Partnership (HHP) continues to operate within a challenging regulatory, operational and financial environment, remaining in the lowest segment of the NHS Oversight Framework and retaining a red Provider Capability Assessment rating. The refreshed Integrated Improvement Plan (IIP) has been established as the Partnership's single improvement framework, bringing together regulatory requirements, external review recommendations and improvement priorities within a strengthened governance and assurance structure. September 2026 marked continued progress in embedding programme governance and delivery oversight. The IIP Oversight Group is now fully established, monitoring 207 deliverables across the programme and providing increased challenge, support and escalation. Workstream plans, recovery actions and assurance arrangements continue to mature, with improved visibility of delivery progress, risks, dependencies and barriers. Significant work has been undertaken to align the IIP with the CQC Section 29A Warning Notices. Stakeholder reviews identified a limited number of enhancements to delivery plans and assurance processes, which are now being implemented. Progress is also evident in several priority areas, including improvements in Duty of Candour compliance, reductions in patient safety investigation backlogs, continued improvement in complaints management and strengthened risk oversight arrangements. The organisational context has evolved further following the establishment of the Financial Recovery Programme (FRP) and Transition Programme. Together with the IIP, these now represent the Partnership's three principal programmes of work, with governance arrangements in place to ensure alignment and management of interdependencies. Whilst measurable organisational impact remains at an early stage, this is consistent with the programme's current maturity, with many workstreams only recently moving from planning into implementation. No programme-wide issues requiring immediate Board intervention were identified during September. However, active Executive oversight

	continues in relation to EPR readiness, operational performance recovery, diagnostics capacity, workforce capacity, risk management maturity and the quality of KPI reporting and benefits realisation. The next phase of delivery will focus on demonstrating measurable impact, strengthening assurance, embedding effective risk management and evidencing sustainable improvement against the outcomes required by the Trust Boards, NHS England and regulators. The Trust Boards-in-Common are invited to: • **Note** the September 2026 IIP delivery position and discuss progress against the Partnership's improvement priorities. • **Note** progress made in strengthening the Partnership's response to the CQC Section 29A Warning Notices and the development of enhanced reporting, evidence and assurance arrangements. • **Receive assurance** that no new programme-wide issue requiring immediate Board intervention was identified during September, whilst recognising the continued oversight of material risks relating to EPR readiness, operational performance, diagnostics recovery, workforce capacity and reporting maturity.
Background Information and/or Supporting Document(s) (if applicable)	National Oversight Framework 26/27 – can be found at NHS England » NHS Oversight Framework 2026/27 **Appendix A** - *'Listening to Clinicians, Learning from Patients'* IIP Board report.
Prior Approval Process	IIP Oversight Group
Financial Implication(s) (if applicable)	There is alignment to the Financial Recovery Programme and Transition Programme.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Consideration of EDI and health inequalities is taken into account throughout delivery of workstreams.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

1. Introduction and background

1.1 The Humber Health Partnership (HHP) continues to operate in a highly challenging environment. The Partnership remains within the lowest segment of the NHS Oversight Framework (NOF) and following the most recent Provider Capability Assessment, retains a 'red' capability rating. This reflects the scale of the improvement challenge facing the organisation and the need for sustained demonstrable progress across several critical domains.

1.2 In March 2026 the Partnership was formally enrolled onto the National Provider Improvement Programme (NPIP) alongside the receipt of formal regulatory undertakings. In April 2026, HHP was also enrolled in NHS England's (NHSE) Intensive Recovery Programme (IRP) who then commissioned external support from Carnall Farrar to review the Partnership's operating model and identify opportunities to strengthen organisational effectiveness, governance and delivery.

1.3 While progress has been made in several areas, significant challenges remain. Performance continues to fall short of required standards across urgent and emergency care, elective recovery and cancer services. Alongside these operational pressures, the Humber health and care system faces one of the most significant financial challenges in the country. As part of the Partnership planning submission, it plans to have a combined deficit of £63 million, driven in part by reductions in income, and is required to deliver recurrent savings of at least £105 million during 2026/27. Sustained leadership instability and the complexity of the current group governance model have further impacted organisational effectiveness, weakened accountability and constrained the pace of improvement.

1.4 Feedback from colleagues also highlights the cultural and organisational challenges facing the Partnership. National Staff Survey results remain below the national average across all People Promise domains, with particularly concerning results relating to staff engagement and advocacy. Measures relating to whether staff would recommend the organisation as a place to work or receive care continue to deteriorate, reinforcing the need to improve organisational culture, leadership visibility and staff experience.

1.5 In recognition of these challenges, and as the organisational context has evolved, the Partnership identified the need to refresh and strengthen its existing improvement programme. In May 2026, work commenced to update our Integrated Improvement Plan (IIP), *'Listening to Our Clinicians, Learning from Patients',* ensuring it reflected the needs, insights and priorities of our patients, staff, the organisation, external reviews and regulatory feedback.

1.6 The refreshed IIP provides the Partnership with a single, integrated framework for recovery and sustainable improvement. It brings together improvement activity and external recommendations across all major organisational domains into a coherent plan with clear outcomes, measurable benefits, defined accountability and robust governance arrangements. Supported by strengthened programme management, oversight and assurance processes, the IIP will enable the Partnership to evidence sustainable improvement, increase organisational capability, provide assurance to regulators and stakeholders and support progression within both the Provider Capability Framework and NOF.

1.7 In July 2026, the Boards-in-Common reviewed and approved the strategic intent of the refreshed IIP comprising improvement domains, each led by an Executive Senior Responsible Officer (SRO) and supported through dedicated workstreams and delivery plans.

1.8 Since Board approval, the scale and urgency of the Partnership's financial challenge have resulted in the establishment of a dedicated Financial Recovery Programme (FRP), with separate governance, oversight and reporting arrangements. While finance is no longer a standalone domain within the IIP, the FRP remains intrinsically linked to the broader improvement agenda through a formal alignment and reporting mechanism.

1.9 Care Quality Commission (CQC) completed a Well-Led assessment at HUTH and NLAG in June 2026. On the 28 July, under Section 29A of the Health and Social Care Act 2008, issued warning notices to notify the Partnership that CQC has formed the view that the quality of health care provided by both Trusts for the regulated activities relating to treatment of disease, disorder or injury requires significant improvement.

1.10 The operating environment has further evolved following outcome of the Carnall Farrar Organisational Form Review and the subsequent establishment of a Transition Programme. Together the IIP, FRP, Transition Programme now forms the Partnership's principal programmes of work. They will require careful alignment to ensure that organisational change supports, rather than distracts from, delivery of agreed improvement priorities and recovery objectives.

1.11 To transition from the highest level of oversight, the Partnership must:

- Demonstrate continual and sustainable progress against regulatory undertakings.
- Demonstrate continual and sustainable progress across all areas of the Medium-Term Plan submitted by the Partnership (in quality, finance and performance).
- Establish a credible and realistic integrated improvement plan.
- Address findings from previous and current diagnostics and regulatory assessments.
- Provide sufficient assurance to NHS England North-East and Yorkshire (NHSE NEY) that improvements are robust and will be maintained beyond the period of intensive scrutiny.

1.12 Improvement in the Partnership's NOF segmentation will require delivery against an agreed set of national performance measures and a demonstrable improvement in organisational capability, outcomes and delivery confidence.

1.13 The NOF has recently been refreshed reflecting the ambitions and priorities set out in the 10 Year Health Plan, reinforcing expectations around quality, productivity, financial sustainability and organisational improvement. Further information can be found at NHS England » NHS Oversight Framework 2026/27.

1.14 Progression within both the NHS Oversight Framework and response to the CQC Section 29A Warning Notices will require demonstrable improvement against nationally and regulator-defined measures, together with evidence of improved organisational capability, governance, delivery maturity and sustainable outcomes.

1.15 This report summarises the IIP delivery position in September 2026 and further detail is shared in Appendix A.

2. IIP Progress September 2026

2.1 In this reporting period, the finance-related improvement activities originally incorporated within the IIP have now been aligned to the FRP.

2.2 CQC stakeholder workshops were held on 2 & 8 September 2026 to undertake a collaborative review of all relevant workstream delivery plans, identify gaps, strengthen actions and agree any additional measures required to support regulatory compliance,

sustainable improvement and enhanced assurance. PMO is now implementing the agreed amendments and updating delivery plans accordingly. The originally proposed Well-Led workstream is now closed.

2.3 The IIP Oversight Group is now fully established and provides a coordinated mechanism for challenge, support and performance review across all domains. A more comprehensive understanding of programme blockages and dependencies through this forum has enabled targeted intervention and escalation where required in month.

2.4 The Terms of Reference for the IIP Oversight Delivery Group was ratified.

2.5 The September reporting cycle monitored 207 deliverables, of which 22 were reported as off track and 9 were reported as complete. Workstream plans, recovery actions and assurance arrangements continue to mature, with Executive SROs providing increased challenge and oversight to strengthen delivery confidence. This has provided increased visibility of delivery progress with a stronger narrative on improvement made, risks, dependencies and barriers across all areas of the programme.

2.6 It is recognised the Operational Performance domain and workstreams requires strengthening and this work will commence in the next reporting period with support from PMO.

2.7 Development of National Oversight Framework (NOF) reporting continues, with significant learning emerging from the initial reporting cycles. Further work is required to refine the metrics including validation of baselines, strengthen data quality and establish meaningful and necessary trajectories that support both assurance and improvement.

2.8 Risk management arrangements continue to strengthen, although further work is required to ensure the most significant risks to delivery are consistently identified, articulated and understood. The next reporting period will focus on enhanced SRO "confirm and challenge", including validation of risk scoring, mitigations and controls. Following ratification of the BAF in November, IIP risks can where required be formally aligned to strategic risks. A clear theme continues relating to data and BI support. Collation of further detail is underway to support prioritisation.

2.9 Communications and organisational engagement activity has continued, including publication of the first IIP workstream lead briefing to share progress, learning and emerging good practice across the Partnership and programme delivery.

2.10 Whilst measurable organisational impact is not yet consistently evident, this is anticipated given the programme remains in the early stages of delivery. The next reporting cycle will place greater emphasis on evidencing impact, benefits realisation and ensuring deliverables remain on track.

2.11 Key benefits of escalation to the IIP oversight group during September include:

- Mobilisation of additional PALS capacity to address operational pressures and support service improvements.
- Approval of investment in data and reporting capabilities, improving access to information and enabling more timely decision-making.
- Progress within the Ward Accreditation Programme, increasing visibility of workforce requirements and supporting delivery of a sustainable accreditation model.

2.12 No programme-wide issue requiring immediate Board intervention was identified during the reporting period. However, a number of risks remain subject to active executive oversight, including:

- EPR readiness and implementation.
- Operational capacity and performance recovery.

- Diagnostics recovery and capacity constraints.
- Workforce capacity and organisational change impacts.
- Risk management maturity.
- KPI quality, reporting and benefits realisation.

2.13 The table below shows September 2026 status for each workstream;

Workstream RAG tracker

	August	September
Leadership		
1.1 Governance Reset & Stabilisation		
1.2 Board & Exc Development		
1.3 Well Led		Closed
Clinical Governance		
2.1 Clinical Governance Improvement		
2.2 PSIRF		
2.3 Ward Accreditation		
Safety and Quality		
3.1a Quality Priorities Sepsis		
3.1b Quality Priorities Insulin		
3.1c Quality Priorities Infection Reduction		
3.1d Quality Priorities Safer Surgery		
3.1e Quality Priorities Preventing Deconditioning		
3.2 Patient Experience, Complaints & PALs		
3.3 CQC Actions		
3.4 Maternity	To be progressed	To be progressed
3.5 Nursing & Midwifery Workforce		Transferred to FRP
Medical/Clinical Model		
4.1 Clinical Policy Group		
4.2 Optimising Medical Workforce		Transferred to FRP
4.3 LISA Development		
4.4 EPR		
Operational Performance		
5.1 Unplanned Care (UEC)		
5.2a Outpatients		
5.2b Theatres		
5.2c Cancer		
5.2d Diagnostics		
5.2e RTT		
5.3 Care group Recovery	To be progressed	To be progressed
5.4 Humber Acute Services		
5.5 Tertiary	To be progressed	To be progressed
People		
6.1 Workforce planning and performance		Transferred to FRP
6.2 Corporate Transformation / Targeted operating model		Transferred to FRP
6.3 Staff Culture, leadership & Experience		
Finance		
7.1 Financial Governance and Management		Transferred to FRP
7.2 Finance Capacity and Capability		Transferred to FRP
7.3 Procurement and Contract Efficiency		Transferred to FRP

Executive Sponsor Assurance RAG for Workstreams	
Significant	**Board Assurance Rating: Thorough or extensive, to complete or in full.** •Delivery of the metrics evidenced and ahead of plan. •Controls are well designed and are applied consistently. •The level of risk carried is below the agreed risk appetite. •Any weaknesses are minor and are considered unlikely to impair the achievement of the deliverables and core objective of the workstream.
Reasonable	**Board Assurance Rating: Assurance is moderate to tolerable, or sufficient.** •Delivery of the metrics evidenced and on plan. •Controls are generally sound and operating effectively. •The level of risk carried is in line with the agreed risk appetite. •However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some deliverables and the core objective of the workstream.
Limited	**Board Assurance Rating: Assurance is inadequate, limited to unsatisfactory or lacking, additional assurance is required or needs to be stronger.** •Delayed-delivery of the metrics with some falling below the acceptable standard. •The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. •Delivery cannot be fully evidenced, with some deliverables off track. •There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key deliverables and the core objective of the workstream.
Minimal	**Board Assurance Rating: Little or insignificant assurance, to zero or no assurance.** •Non-delivery of the metrics with the majority falling below acceptable thresholds. •The organisation is exposed to significant risk (due to non-compliance). •Delivery cannot be evidenced or is behind plan, with majority of deliverables off track. •There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. •Urgent corrective action is required if controls are to effectively address the risks to the achievement of key deliverables and the core objective of the workstream.
	•Workstream Plan on Page, Delivery Plan and Highlight reporting requires further work. •Paused due to alignment with Financial Recovery Programme.

2.14 Key updates against workstreams in September are;

- **Well-Led:** Following review and discussion, a separate Well-Led workstream is no longer required and now closed. The key themes have been incorporated within existing IIP domains and governance arrangements
- **Maternity:** The programme has been incorporated within the Safety & Quality domain, with work continuing to draft the workstream plan on page against national recommendations and Partnership priorities.
- **Nursing & Midwifery Workforce, Optimising Medical Workforce, Finance Domain**: Following review, it has been agreed that these workstreams / domains will be governed, monitored and reported through the Financial Recovery Programme (FRP)
- **Care Group Recovery:** Work is underway to further develop this workstream including the appointment of a dedicated Workstream Lead and establishment of supporting governance, delivery and reporting arrangements.
- **Tertiary Services:** The workstream has now commenced, with initial scoping and engagement underway. The immediate priority is to finalise and agree the Plan on a Page, which will be presented for review and discussion at the next governance meeting.
- **People Domain:** The Staff Culture workstream will continue within the IIP, with governance and delivery arrangements now established. Following review, it has been

agreed that the Workforce Planning and Corporate Transformation workstreams will be removed from the IIP and will continue to be governed, monitored and reported through the FRP. Whilst strong foundations are now established, measurable impact and benefits realisation remain at an early stage across many workstreams. This is not unexpected given the majority of interventions have only recently progressed from planning into implementation.

2.15 The next phase of the programme will focus on evidencing impact, strengthening delivery assurance, embedding risk management and demonstrating sustainable improvements in quality, safety, workforce outcomes, operational performance and patient experience. Future reporting will increasingly focus on outcomes, benefits and learning rather than activity alone.

CQC 29A Warning Notices Progress

2.16 During September, progress was made across both delivery and programme infrastructure, strengthening the governance, assurance and reporting arrangements required to support sustainable regulatory improvement towards the required outcomes of the CQC 29A Warning Notes. Key developments during the month are summarised below;

- Work to align the IIP with the CQC Section 29A Warning Notices has continued, supporting a single, integrated approach to improvement and assurance.

- CQC stakeholder workshops held on 02 and 08 September 2026 reviewed relevant workstream delivery plans against regulatory requirements, identifying opportunities to strengthen actions, assurance and evidence of compliance. PMO is now implementing the agreed enhancements for inclusion in October reporting.

- The below workstreams are considered priority in supporting the CQC requirements;

	CQC	IIP
1	Ineffective governance, performance and risk management processes to ensure the safe and effective delivery of care	**Domain 1: Leadership** 1.1 Governance Reset and Stabilisation 1.2 Board & Executive Development **Domain 2: Clinical Governance** 2.1 Clinical Governance Improvement **Domain 6: People** 6.3 Staff Culture and Experience
2	Delays in learning from incidents and lack of action planning leading to opportunities being missed to prevent patients being exposed to the risk of harm	**Domain 2: Clinical Governance** 2.1 Clinical Governance Improvement 2.2 Patient Safety Incident Response Framework (PSIRF)
3	Lack of responsiveness and action planning regarding patient experience (PALS and Complaints) leading to opportunities being missed to prevent patients being exposed to the risk of harm	**Domain 3: Quality & Safety** 3.2 Patient Experience, Complaints and PALS Improvement
4	Ineffective systems and processes to prevent, detect and control the spread of infection.	**Domain 3: Quality & Safety** 3.1c Quality Priorities – Infection Control Alert Organism Rate Reduction

- In-month improvement towards CQC requirements include;
  - BAF redesign scheduled for Trust Board ratification.
  - Reduction in overdue PSII investigation cases on trajectory for backlog completion by December 2026.
  - CQC regulation 20: Duty of Candour compliance significantly improved, current position, nil overdue.
  - CQC regulation 16: Receiving and acting on Complaints and Concerns, significant improvement in backlog of concerns from circa 900 to 150.

Complaints response with 60-days timeframe has seen a continuous upward trend from below 40% in October 2025 to 60% in September 2026.
- Risk register deep dive completed in August in relation to high rated risks, risk validation including controls, mitigation and rating reviewed.
- Development of a framework for learning and sharing from safety incidents and patient experience.

Transition of workstreams to the Financial Recovery Programme

2.17 The Financial Recovery Programme (FRP) continues to operate as one of the Partnership's three principal programmes of work alongside the IIP and new Transition Programme.

2.18 Following review through the IIP Oversight Delivery Group and Executive governance arrangements, it has now been agreed that several workstreams originally incorporated within the IIP will continue to be managed and reported through the FRP. These include Finance, Workforce Planning and Performance, Corporate Transformation, Nursing & Midwifery Workforce and Optimising Medical Workforce. This provides greater clarity regarding accountability and reporting while reducing duplication across programmes.

2.19 The IIP and FRP continue to operate through complementary governance and assurance arrangements, with shared oversight of dependencies relating to workforce, operational performance, productivity, quality and organisational change. This approach supports a coordinated narrative of recovery, enables more effective management of cross-cutting risks and ensures programme interventions remain aligned to organisational priorities.

2.20 The Oversight Group reviewed progress regarding alignment between the IIP and FRP and reaffirmed the principle that the IIP remains the Partnership's single source of truth for improvement delivery and assurance reporting. Existing governance arrangements are expected to increasingly utilise IIP reporting as the primary mechanism for escalating improvement risks, dependencies and delivery issues.

2.21 Regular reporting and escalation arrangements are now established across the IIP, FRP and Transition Programme, enabling greater visibility of programme interdependencies, delivery risks and corrective actions required. These arrangements are expected to continue maturing over the coming months as programmes move further into delivery

Transition Programme

2.22 Following consideration of the Carnall Farrar Organisational Form Review recommendations by the Trust Boards-in-Common, work has commenced to establish a formal Transition Programme. Alongside the IIP and FRP, this now represents one of the Partnership's three principal programmes of work.

2.23 A key focus during September has been ensuring that implementation of organisational form recommendations remains aligned to the Partnership's wider recovery objectives. There is broad recognition that successful delivery will require clear programme management, defined accountability, effective dependency management and continued alignment with both the IIP and FRP governance arrangements.

2.24 The Oversight Group recognised the potential impact of organisational transition activity on workforce capacity, leadership focus and implementation pace across a number of workstreams. As a result, specific monitoring arrangements will be established to ensure that organisational change activity supports, rather than detracts from, delivery of agreed improvement objectives.

3. Summary

3.1 In summary, whilst the programme remains in its early stages significant progress has been made across workstreams providing increased visibility of delivery progress with a stronger narrative on improvement made, risks, dependencies and barriers across all areas of the programme. No programme-wide issue requiring immediate Board intervention has been identified; however, active oversight continues in relation to EPR readiness, operational capacity, diagnostics recovery, workforce capacity, risk management maturity and the quality of KPI and benefits reporting.

3.2 Positively, early examples of improvement impact are beginning to emerge. Collectively, these improvements demonstrate that the programme is beginning to translate strengthened governance and oversight into tangible operational benefits.

3.3 The next phase of activity will focus on accelerating delivery against agreed priorities, strengthening programme assurance, embedding effective risk management and demonstrating measurable improvement against the outcomes required by the Trust Boards, NHS England, regulators and key stakeholders. Particular emphasis will be placed on benefits realisation, alignment to National Oversight Framework measures, response to the CQC Section 29A Warning Notices and maintaining the IIP as the Partnership's single source of truth for organisational improvement.

4. Recommendations

The Trust Boards-in-Common are invited to:

- **Note** the September 2026 IIP delivery position and discuss progress against the Partnership's improvement priorities.
- **Note** progress made in strengthening the Partnership's response to the CQC Section 29A Warning Notices and the development of enhanced reporting, evidence and assurance arrangements.
- **Receive assurance** that no new programme-wide issue requiring immediate Board intervention was identified during September, whilst recognising the continued oversight of material risks relating to EPR readiness, operational performance, diagnostics recovery, workforce capacity and reporting maturity.

NHS
Humber Health
Partnership

Listening to Clinicians Learning from Patients

Our Improvement Plan – Delivery Progress August 2026

Introduction

This report provides an update to the Humber Health Partnership Board-in-Common on September 2026 progress in delivering the Integrated Improvement Plan (IIP), *Listening to Clinicians, Learning from Patients*. It summarises: the overall programme position, monthly assurance ratings across each workstream, plans to share impact on National Oversight Framework (NOF) metrics and CQC 29A Warning Notices and the most significant risks to delivery, including current mitigation actions. In addition, workstream highlight summary reports are provided within the appendices to provide further information on delivery, impact to KPIs, risks and next steps.

Delivery of the IIP is overseen by the IIP Oversight Group, chaired by the Chief Executive Officer (CEO). The IIP comprises 6 core domains: Leadership, Clinical Governance, Quality & Safety, Medical/Clinical Model, Operational Performance and People. Workstreams are focused on delivering sustainable improvement and ensuring monthly highlight reports and evidence meets regulatory and assurance requirements. Submitted highlight reports are subject to scrutiny and challenge by Executive Senior Responsible Owners (SROs) to assess progress and impact, this confirms the overarching Executive Assurance Sponsor rating for each workstream.

The Trust Boards-in-Common will receive a monthly update on delivery of the IIP focusing on impact, success, outcomes, challenges and actions to mitigate any key risks to delivery. The IIP Executive Assurance RAG aligns to the Board Assurance RAGs already in place and has been enhanced to align with a usual PMO assessment framework to ensure consistent application of assurance commences and understanding of the status of each workstream.

Overarching RAG definitions are;

- Minimal
- Limited
- Reasonable
- Significant

Executive Summary

Strong foundations are now in place through established governance, oversight and risk management arrangements. The priority for the coming months is to translate increasingly mature plans and assurance processes into demonstrable improvements in quality, safety, performance and patient outcomes, whilst maintaining the IIP as the Partnership's single version of the truth. Key developments during the month are summarised below;

- The IIP, Financial Recovery Programme (FRP) and Transition Programme remain the Partnership's three principal programmes of work. Alignment across these programmes continues to strengthen governance, manage interdependencies and support a coordinated approach to delivery, assurance and Board oversight.

- In this reporting period, the finance-related improvement activities originally incorporated within the IIP have now been aligned to the FRP.

- CQC stakeholder workshops were held on 2 & 8 September 2026 to undertake a collaborative review of all relevant workstream delivery plans, identify gaps, strengthen actions and agree any additional measures required to support regulatory compliance, sustainable improvement and enhanced assurance. PMO is now implementing the agreed amendments and updating delivery plans accordingly. The originally proposed Well-Led workstream is now closed.

- The IIP Oversight Group is now fully established and provides a coordinated mechanism for challenge, support and performance review across all domains. A more comprehensive understanding of programme blockages and dependencies through this forum has enabled targeted intervention and escalation where required in month.

- The Terms of Reference for the IIP Oversight Delivery Group was ratified.

- The September reporting cycle monitored 207 deliverables, of which 22 were reported as off track and 9 were reported as complete. Workstream plans, recovery actions and assurance arrangements continue to mature, with Executive SROs providing increased challenge and oversight to strengthen delivery confidence. This has provided increased visibility of delivery progress with a stronger narrative on improvement made, risks, dependencies and barriers across all areas of the programme.

- It is recognised the Operational Performance domain and workstreams requires strengthening and this work will commence in the next reporting period with support from PMO.

- Development of National Oversight Framework (NOF) reporting continues, with significant learning emerging from the initial reporting cycles. Further work is required to refine the metrics including validation of baselines, strengthen data quality and establish meaningful and necessary trajectories that support both assurance and improvement.

- Risk management arrangements continue to strengthen, although further work is required to ensure the most significant risks to delivery are consistently identified, articulated and understood. The next reporting period will focus on enhanced SRO "confirm and challenge", including validation of risk scoring, mitigations and controls. Following ratification of the BAF in November, IIP risks can where required be formally aligned to strategic risks. A clear theme continues relating to data and BI support. Collation of further detail is underway to support prioritisation.

- Communications and organisational engagement activity has continued, including publication of the first IIP workstream lead briefing to share progress, learning and emerging good practice across the Partnership and programme delivery.

- Whilst measurable organisational impact is not yet consistently evident, this is anticipated given the programme remains in the early stages of delivery. The next reporting cycle will place greater emphasis on evidencing impact, benefits realisation and ensuring deliverables remain on track.

Key benefits of escalation to the IIP Oversight Group during September include:

- Mobilisation of additional PALS capacity to address operational pressures and support service improvements.
- Approval of investment in data and reporting capabilities, improving access to information and enabling more timely decision-making.
- Progress within the Ward Accreditation Programme, increasing visibility of workforce requirements and supporting delivery of a sustainable accreditation model.

- No programme-wide issue requiring immediate Board intervention was identified during the reporting period. However, a number of risks remain subject to active executive oversight, including:
    - EPR readiness and implementation
    - Operational capacity and performance recovery
    - Diagnostics recovery and capacity constraints
    - Workforce capacity and organisational change impacts
    - Risk management maturity
    - KPI quality, reporting and benefits realisation.

Listening to Clinicians, Learning from Patients

Workstream Progress Summary – September 26

NHS Humber Health Partnership

Executive Sponsor Assurance RAG for Workstreams	
Significant	**Board Assurance Rating: Thorough or extensive, to complete or in full.** •Delivery of the metrics evidenced and ahead of plan. •Controls are well designed and are applied consistently. •The level of risk carried is below the agreed risk appetite. •Any weaknesses are minor and are considered unlikely to impair the achievement of the deliverables and core objective of the workstream.
Reasonable	**Board Assurance Rating: Assurance is moderate to tolerable, or sufficient.** •Delivery of the metrics evidenced and on plan. •Controls are generally sound and operating effectively. •The level of risk carried is in line with the agreed risk appetite. •However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some deliverables and the core objective of the workstream.
Limited	**Board Assurance Rating: Assurance is inadequate, limited to unsatisfactory or lacking, additional assurance is required or needs to be stronger.** •Delayed-delivery of the metrics with some falling below the acceptable standard. •The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. •Delivery cannot be fully evidenced, with some deliverables off track. •There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key deliverables and the core objective of the workstream.
Minimal	**Board Assurance Rating: Little or insignificant assurance, to zero or no assurance.** •Non-delivery of the metrics with the majority falling below acceptable thresholds. •The organisation is exposed to significant risk (due to non-compliance). •Delivery cannot be evidenced or is behind plan, with majority of deliverables off track. •There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. •Urgent corrective action is required if controls are to effectively address the risks to the achievement of key deliverables and the core objective of the workstream.
	•Workstream Plan on Page, Delivery Plan and Highlight reporting requires further work. •Paused due to alignment with Financial Recovery Programme.

Workstream RAG tracker

	August	September
Leadership		
1.1 Governance Reset & Stabilisation		
1.2 Board & Exc Development		
1.3 Well Led		Closed
Clinical Governance		
2.1 Clinical Governance Improvement		
2.2 PSIRF		
2.3 Ward Accreditation		
Safety and Quality		
3.1a Quality Priorities Sepsis		
3.1b Quality Priorities Insulin		
3.1c Quality Priorities Infection Reduction		
3.1d Quality Priorities Safer Surgery		
3.1e Quality Priorities Preventing Deconditioning		
3.2 Patient Experience, Complaints & PALs		
3.3 CQC Actions		
3.4 Maternity	To be progressed	To be progressed
3.5 Nursing & Midwifery Workforce		Transferred to FRP
Medical/Clinical Model		
4.1 Clinical Policy Group		
4.2 Optimising Medical Workforce		Transferred to FRP
4.3 LISA Development		
4.4 EPR		
Operational Performance		
5.1 Unplanned Care (UEC)		
5.2a Outpatients		
5.2b Theatres		
5.2c Cancer		
5.2d Diagnostics		
5.2e RTT		
5.3 Care group Recovery	To be progressed	To be progressed
5.4 Humber Acute Services		
5.5 Tertiary	To be progressed	To be progressed
People		
6.1 Workforce planning and performance		Transferred to FRP
6.2 Corporate Transformation / Targeted operating model		Transferred to FRP
6.3 Staff Culture, leadership & Experience		
Finance		
7.1 Financial Governance and Management		Transferred to FRP
7.2 Finance Capacity and Capability		Transferred to FRP
7.3 Procurement and Contract Efficiency		Transferred to FRP

Key Updates in Month:
Strong governance foundations are now in place. The focus for the coming months is to demonstrate measurable improvement outcomes, embed consistent risk and performance management, and maintain alignment across the IIP, FRP and Transition Programme.

Key updates against workstreams in September are;

- **Well-Led:** Following review and discussion, a separate Well-Led workstream is no longer required and now closed. The key themes have been incorporated within existing IIP domains and governance arrangements
- **Maternity:** The programme has been incorporated within the Safety & Quality domain, with work continuing to draft the workstream plan on page against national recommendations and Partnership priorities.
- **Nursing & Midwifery Workforce, Optimising Medical Workforce, Finance Domain:** Following review, it has been agreed that these workstreams / domains will be governed, monitored and reported through the Financial Recovery Programme (FRP)
- **Care Group Recovery:** Work is underway to further develop this workstream including the appointment of a dedicated Workstream Lead and establishment of supporting governance, delivery and reporting arrangements.
- **Tertiary Services:** The workstream has now commenced, with initial scoping and engagement underway. The immediate priority is to finalise and agree the Plan on a Page, which will be presented for review and discussion at the next governance meeting.
- **People Domain:** The Staff Culture workstream will continue within the IIP, with governance and delivery arrangements now established. Following review, it has been agreed that the Workforce Planning and Corporate Transformation workstreams will be removed from the IIP and will continue to be governed, monitored and reported through the FRP.

High-level Domain Summary

Leadership Domain

- **Governance Reset & Stabilisation – (Limited assurance)** Positive progress has been made in the development of a revised Board Assurance Framework (BAF) and alignment with wider governance improvement activity. Work continues to pilot the AAA reporting framework, strengthen risk and performance oversight, and continued review the Governance Manual. Further evidence of traction for improved foundational governance is required before the assurance rating can improve.
- **Board & Executive Development – (Minimal assurance)** Executive and NED appraisals have been completed. However, assurance remains minimal as a number of foundational deliverables remain in development, including the behavioural compact and agreement how to progress with the Board and Executive Development Programme. Some milestones have also been reprofiled. Further implementation and evidence of impact are required before assurance can improve
- **Well-Led - (Closed):** Following review through the IIP Oversight Group, it has been agreed that a standalone Well-Led workstream is not required. The four principal Well-Led themes are aligned to existing IIP domains and workstreams and will continue to be delivered, monitored and assured through established governance arrangements. This approach avoids duplication and ensures Well-Led priorities remain embedded across the wider improvement programme.

Clinical Governance Domain

- **Clinical Governance – (Minimal assurance)** The workstream has continued to make positive progress in strengthening governance, risk and assurance arrangements across the Partnership. Key achievements include progression of the risk register review, redesign of the EQIA process, development of a Partnership-wide governance framework and continued work to improve governance standardisation across care groups. Progress has also been made in preparatory work to align the corporate risk register when the refreshed BAF is ratified. Several significant deliverables remain in progress or off-track further evidence of implementation, sustained delivery and measurable improvement against agreed KPIs is required before the assurance rating can improve.
- **PSIRF – (Minimal assurance)** Good progress has been made in strengthening PSIRF governance arrangements, developing Group-wide documentation and procedures, and progressing incident data validation processes. Clinical ownership and oversight continue to develop, with work underway to improve the consistency and quality of investigations across the Partnership. Assurance remains limited due workforce capacity constraints and the need to fully embed learning, action tracking and assurance processes
- **Ward Accreditation – (Limited assurance)** Whilst the accreditation framework has been approved and launched, and Cohort 1 implementation continues to progress, the assurance rating has reduced from Reasonable to Limited in month following review of delivery capacity and programme dependencies in this reporting period. To address this escalation, funding has now been identified to implement a digital accreditation solution and increase dedicated staffing capacity to support rollout and sustainability.

High-level Domain Summary

Safety and Quality

- **Quality Priority – Sepsis – (Limited assurance)** Significant progress has been made through the establishment of task and finish groups, delivery of PDSA cycles, completion of the NG254 gap analysis and development of the paediatric workstream. Early improvement is now evident in key outcome measures. Whilst some South Bank data continues to be collected manually, additional audit and validation processes have been implemented to mitigate to provide assurance and support performance oversight moving forward. Work continues with Digital and Clinical teams to strengthen data capture and reporting, enabling more robust and sustainable assurance arrangements for the future.
- **Quality Priority – Insulin – (Limited assurance)** Positive progress has been made through the launch of diabetes training, establishment of DKA and Glycaemic Control Task and Finish Groups, and a reduction in insulin-related harm incidents. Delivery is now moving from mobilisation into implementation; however, further work is required to strengthen performance reporting, develop the dashboard and complete actions arising from the insulin safety gap analysis. Assurance remains limited until these improvements are embedded and sustained outcomes can be demonstrated
- **Quality Priority - Infection Reduction – (Limited assurance)** Good progress has been made in progressing antimicrobial stewardship initiatives and developing KPI and dashboard reporting. The workstream is also supporting delivery of Infection Prevention & Control actions arising from the CQC programme and the anticipated NHSE review feedback. Assurance remains limited due to dependencies on KPI validation, dashboard development and BI capacity, with further evidence of sustained impact and reductions in infection risk required.
- **Quality Priority - Safer Surgery – (Limited assurance)** Good progress has been made in embedding NatSSIPs2 monitoring, theatre training and safer surgery governance arrangements, with audit compliance improving and ongoing oversight through monthly Safety Summits. Following a recent Never Event outside theatres, a new programme of work to implement LocSSIPs in procedural areas has commenced. Assurance remains limited until audit compliance, standardisation and sustainable improvement are consistently demonstrated across the Partnership.
- **Quality Priority - Preventing Deconditioning – (Limited assurance)** The pilot wards are agreed and delivery activity is underway across North and South Bank sites. Work continues to develop baseline measures, KPI validation and reporting arrangements.
- **Patient Experience, Complaints & PALs – (Minimal assurance)** Progress has been made in reducing backlogs particularly at HUTH, ratifying the Complaints SOP, developing the Patient Experience Policy and strengthening Care Group oversight arrangements. However, assurance remains limited due to overdue deliverables, workforce capacity pressures, and insufficient evidence to date of sustained improvement against key KPIs. Delivery remains focused on recovery actions, backlog reduction and demonstrating measurable improvements in patient experience outcomes.
- **CQC Actions – (Limited assurance)** Robust governance, monitoring and escalation arrangements are established and embedded, providing clear oversight of CQC action delivery from ward to Board. Monthly review meetings, quarterly challenge sessions and core service reporting are in place, supporting accountability and progress monitoring. The rating remains limited as further work is required to evidence the sustained impact of improvements and establish KPI baselines for continued oversight.
- **Maternity – (To be developed)** Development of the Maternity Plan on a Page is underway ensuring alignment with national recommendations and Partnership priorities. The next phase will focus on defining clear deliverables, milestones and measures of success, with formal review and sign-off required through the appropriate governance arrangements..

High-level Domain Summary

Medical/Clinical Model

- **Clinical Policy Group – (Limited assurance)** Initial work to establish the Clinical Policy Group has commenced, with progress being made to define the workstream scope, governance arrangements and operating model. The workstream remains in early stages.
- **LISA Development – (Minimal assurance)** Through escalation to the Oversight Group it was agreed to progress a single Quality Improvement (QI) methodology across the Partnership to support delivery of a successful learning academy and consistent approach to improvement. Assurance remains minimal pending agreement of the final deployment model, prioritisation approach and governance arrangements required to support implementation and demonstrate impact. Further work is underway to define this and share with execs.
- **EPR - (Minimal assurance)** Good progress has been made through completion of discovery workshops, design sessions, infrastructure upgrades and programme mobilisation, providing increased confidence in delivery of the next implementation phase. Key design and implementation decisions have now been progressed, and planning activity continues with suppliers and stakeholders to support deployment. Assurance remains limited as elements of delivery continue to be dependent on final design decisions, supplier deliverables and implementation planning. Continued oversight is required to maintain momentum, manage dependencies and ensure successful transition into implementation.

Operational Performance Domain

- **Outpatients - (Limited assurance)** Good progress has been made with SPOA development, directory of service mapping, specialty deep dives and follow-up pathway reviews, with emerging themes and improvement opportunities identified. Whilst delivery remains on track, the assurance rating has reduced from Reasonable to Limited Assurance as the programme has moved into a more detailed design and implementation phase, highlighting dependencies on the national SPOA programme, pathway redesign decisions and the need to evidence measurable improvements in performance and patient outcomes. Further implementation and demonstration of impact are required before a higher assurance rating can be achieved.
- **Theatres - (Limited assurance)** Delivery continues broadly in line with plan, with significant progress made in elective capacity and demand modelling, GIRFT pre-assessment review, elective hub accreditation and the development of Group-wide improvement programmes. However, the assurance rating has reduced from Reasonable to Limited Assurance following a review of performance and delivery risks. Whilst strong foundations are in place and clinical engagement remains positive, KPI performance remains below target in a number of areas. Workforce pressures continue to impact theatre capacity, and key digital and operational dependencies remain. Assurance will improve as planned interventions translate into sustained improvements in utilisation, productivity and elective performance outcomes and as the impact of improvement initiatives can be consistently evidenced.
- **Cancer - (Limited assurance)** Significant progress has been made in pathway redesign, diagnostic improvement initiatives, workforce planning and strengthening governance arrangements. However, due to capacity constraints across key tumour sites continue to impact delivery of cancer waiting time trajectories and performance targets. Whilst improvement plans are established, performance remains dependent on resolving workforce and diagnostic capacity challenges towards plan and demonstrating sustained improvement against key cancer standards. Continued executive oversight is required to maintain momentum and support delivery of planned performance improvements.

High-level Domain Summary

- **Diagnostics - (Minimal assurance)** Assurance remains minimal due to ongoing workforce, equipment, utilisation and capacity challenges, alongside the need to validate baseline data, agree performance trajectories and demonstrate delivery against recovery plans. Strengthened workstream plans are required to be developed to support sustainable performance improvement and enable recovery to be evidenced.
- **RTT - (Minimal assurance)** Progress has been made in developing and testing demand and capacity models with Care Groups, improving understanding of specialty-level challenges and recovery opportunities. Assurance remains minimal as recovery trajectories, baseline positions, performance measures and specialty-level recovery plans continue to be refined and validated. Whilst the programme has established stronger foundations for recovery planning, further work is required to translate modelling assumptions into agreed delivery plans and demonstrate measurable improvements in RTT performance before assurance can improve.
- **Care Group Recovery - (To be developed)** Assignment of a new workstream lead is imminent through additional resource. The next phase will focus on defining clear deliverables, milestones and measures of success, with formal review and sign-off required through the IIP oversight group.
- **Humber Acute Services – (Limited assurance)** Good progress has been made in consolidating Ophthalmology, ENT, Cardiology and Gastroenterology pathways, with governance and monitoring arrangements in place to track benefits and ensure alignment with the agreed service model. Planning for future specialty consolidations and critical care developments is also progressing. Assurance remains limited as the length of stay and admission avoidance improvements underpinning the original business case have not yet been realised. Combined with higher-than-expected emergency demand and bed capacity constraints, this is impacting the pace and full implementation of the workstream. Continued oversight is required to manage these dependencies and support delivery of the planned benefits.
- **Tertiary - (To be developed)** Confirmation of the workstream lead needs to take place in month. It will also focus on defining clear deliverables, milestones and measures of success, with formal review and sign-off required through the appropriate governance arrangements.

People Domain

- **Staff Culture and Experience - (Limited assurance)** Initial governance arrangements are established, and early mobilisation activity is underway.

Listening to Clinicians, Learning from Patients

The IIPs Impact to National Oversight Framework (1)

NHS Humber Health Partnership

The NOF dashboard continues to be developed as the principal mechanism for demonstrating the impact of the IIP on the Partnership's key quality, operational and workforce. Automated data feeds are also being progressed into the IIP highlight reports, aligned with the Integrated Performance Report. This will provide a single source of truth and improve the accuracy, consistency and timeliness of reporting. Baselines and trajectories are being validated, initially for Quality and subsequently for Workforce and Finance, building on the work completed for Operational Performance. Future reporting to the IIP Oversight Board will focus on exceptions, progress against agreed trajectories and evidence that IIP interventions are delivering measurable and sustainable improvement.

Group summary - Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (All - Footprint)	Aug-26	70.9%	-0.4%	≥ 75.0%	≥ 78.9%				Alert
A&E - 4 Hour Standard (All)	Aug-26	64.9%	-1.1%	≥ 69.7%	≥ 74.6%	≥ 82.0%			Alert
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	69.5%	3.5%	≥ 70.7%	≥ 80.0%	≥ 80.0%			Alert
Cancer - 62 Day All Referral Sources	Jul-26	55.1%	-2.4%	≥ 55.9%	≥ 69.9%	≥ 80.0%			Alert
Diagnostics - 6 Week Standard	Aug-26	36.8%	1.5%	≤ 29.7%	≤ 21.1%	≤ 1.0%			Alert
Finance - Bank YTD actual spend against previous year (000's)	Aug-26	77.4%	1.2%			≤ 70.0%			Alert
Finance - CIP YTD against Plan	Aug-26	64.6%	-2.0%						Alert
Finance - ECP YTD actual spend against previous year (000's)	Aug-26	160.5%	4.2%			≤ 70.0%			Alert
Finance - Overtime YTD actual spend against previous year (000's)	Aug-26	91.2%	-2.2%			≤ 70.0%			Alert
Healthcare Worker Flu Vaccination Rate	Apr-26	51.1%	-0.3%			≥ 60.0%			Alert
Inpatient - Bed Days Lost to NCTR Patients	Aug-26	9,620	2,743						Alert
Inpatient - Days between DRD and Discharge Date	Aug-26	12.5	7.3	≤ 4.1	≤ 4.1				Alert
RTT - Incomplete 18 Week Standard	Aug-26	56.5%	-0.8%	≥ 58.4%	≥ 65.3%	≥ 92.0%			Alert
RTT - Patients waiting 52+ weeks for Community Services	Aug-26	16.7%	0.7%						Alert
RTT - Percentage of 52+ Week Waits	Aug-26	3.9%	0.2%	≤ 3.7%	≤ 3.6%	≤ 1.0%			Alert
Staff Sickness Absence Rate	Jul-26	4.8%	0.0%			≤ 4.0%			Alert
Staff Survey - Raising Concerns sub-score	Aug-26	6.1	0.0						Alert
CQC Inpatient Survey Satisfaction Mean Score	Aug-26	8.2	0.0						
CQC Safe Inspection Score	Aug-26	1.5	0.0						
Falls - Moderate and above (per 1,000 bed days)	Aug-26	0.1	0.0						
Finance - Planned Surplus/Deficit	Aug-26	-63,065	0						
Finance - Variance YTD to Financial Plan	Aug-26	-16,383	-3,081						
Infections - C.Difficile (per 1,000 bed days)	Jul-26	0.2	0.0						
Infections - E.Coli (per 1,000 bed days)	Jul-26	0.4	-0.1						
Infections - MRSA (per 1,000 bed days)	Jul-26	0.0	0.0						
Inpatient - Emergency Readmissions within 30 days	Jul-26	10.4%	0.0%						
Patient Safety Incidents - % Harmful	Aug-26	3.0%	0.1%						
RTT - Difference between actual and planned 18 week performance	Aug-26	-1.9%	-2.4%						

The IIPs Impact to National Oversight Framework (2)

Group summary – Advise:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (Type 1)	Aug-26	49.5%	-0.7%	≥ 52.0%	≥ 59.3%				Advise
A&E - Patients Waiting > 12 hours in Department	Aug-26	12.4%	0.8%	≤ 12.0%	≤ 14.6%	≤ 0.0%			Advise
A&E - Total Time in A&E (Patients >=65 years)	Aug-26	426	10			≤ 160			Advise
Mortality - SHMI	Apr-26	1.0	0.0			≤ 1.0			Advise

Group summary – Assure:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - Corridor Care in Dept	Aug-26	34	11						Assure
Finance - Agency YTD actual spend against previous year (000's)	Aug-26	67.2%	0.2%			≤ 70.0%			Assure
Infections - MRSA (Cumulative)	Jul-26	1	0						Assure
Inpatient - Corridor Care on Wards	Aug-26	20.6	-0.9						Assure
Staff Turnover Annual FTE Rate	Aug-26	6.9%	-0.4%			≤ 8.0%			Assure

Listening to Clinicians, Learning from Patients

The IIPs Impact to National Oversight Framework (3)

NHS Humber Health Partnership

HUTH summary – Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (All - Footprint)	Aug-26	70.8%	0.2% ↑	≥ 74.2% ⊗	≥ 79.4%				Alert
A&E - 4 Hour Standard (All)	Aug-26	61.4%	-0.9% ↓	≥ 64.6% ⊗	≥ 72.0%	≥ 82.0%			Alert
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	70.0%	2.7% ↑	≥ 71.0% ⊗	≥ 80.0%	≥ 80.0%			Alert
Diagnostics - 6 Week Standard	Aug-26	39.1%	2.6% ↓	≤ 30.3% ⊗	≤ 24.1%	≤ 1.0%			Alert
Finance - Agency YTD actual spend against previous year (000's)	Aug-26	71.6%	0.3% ↓			≤ 70.0%			Alert
Finance - Bank YTD actual spend against previous year (000's)	Aug-26	105.9%	2.4% ↓			≤ 70.0%			Alert
Finance - ECP YTD actual spend against previous year (000's)	Aug-26	107.7%	2.7% ↓			≤ 70.0%			Alert
Finance - Overtime YTD actual spend against previous year (000's)	Aug-26	93.3%	-1.8% ↑			≤ 70.0%			Alert
Healthcare Worker Flu Vaccination Rate	Apr-26	51.0%	-0.3% ↓			≥ 60.0%			Alert
Inpatient - Bed Days Lost to NCTR Patients	Aug-26	9,620	2,743 ↓						Alert
Inpatient - Days between DRD and Discharge Date	Aug-26	4.7	-0.6 ↑	≤ 4.4 ⊗	≤ 3.7				Alert
RTT - Incomplete 18 Week Standard	Aug-26	55.4%	-0.6% ↓	≥ 57.6% ⊗	≥ 65.0%	≥ 92.0%			Alert
Staff Sickness Absence Rate	Jul-26	4.5%	0.1% ↓			≤ 4.0%			Alert
Staff Survey - Raising Concerns sub-score	Aug-26	6.0	0.0 —						Alert
CQC Safe Inspection Score	Aug-26	1.0	0.0 —						
Falls - Moderate and above (per 1,000 bed days)	Aug-26	0.1	0.0 ↑						
Finance - CIP YTD against Plan	Aug-26	69.9%	-2.3% ↓						
Finance - Planned Surplus/Deficit	Aug-26	-39,400	0 —						
Finance - Variance YTD to Financial Plan	Aug-26	-14,546	-3,102 ↑						
Infections - C.Difficile (per 1,000 bed days)	Jul-26	0.2	-0.1 ↑						
Infections - E.Coli (per 1,000 bed days)	Jul-26	0.5	0.1 ↓						
Infections - MRSA (Cumulative)	Jul-26	0	0 —						
Infections - MRSA (per 1,000 bed days)	Jul-26	0.0	0.0 —						
Inpatient - Emergency Readmissions within 30 days	Jul-26	9.9%	0.0% ↑						
Patient Safety Incidents - % Harmful	Aug-26	2.3%	-0.2% ↑						
RTT - Difference between actual and planned 18 week performance	Aug-26	-2.2%	-2.2% ↓						

HUTH summary – Advise:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (Type 1)	Aug-26	48.6%	-1.3% ↓	≥ 50.0% ⊗	≥ 60.7%				Advise
A&E - Total Time in A&E (Patients >=65 years)	Aug-26	406	28 ↓			≤ 160			Advise
Mortality - SHMI	Apr-26	1.1	0.0 ↓			≤ 1.0			Advise

HUTH summary – Assure:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - Corridor Care in Dept	Aug-26	22	9 ↓						Assure
A&E - Patients Waiting > 12 hours in Department	Aug-26	7.6%	2.0% ↓	≤ 10.1% ✓	≤ 14.2%	≤ 0.0%			Assure
Cancer - 62 Day All Referral Sources	Jul-26	54.5%	0.1% ↑	≥ 54.1% ✓	≥ 66.0%	≥ 80.0%			Assure
Inpatient - Corridor Care on Wards	Aug-26	40.8	-0.2 ↑						Assure
RTT - Percentage of 52+ Week Waits	Aug-26	4.0%	0.2% ↓	≤ 4.3% ✓	≤ 4.0%	≤ 1.0%			Assure
Staff Turnover Annual FTE Rate	Aug-26	6.8%	-0.7% ↑			≤ 8.0%			Assure

NLAG summary – Alert:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (All - Footprint)	Aug-26	71.1%	-1.1% ↓	≥ 75.9% ⊗	≥ 78.4%				Alert
A&E - 4 Hour Standard (All)	Aug-26	68.0%	-1.1% ↓	≥ 73.9% ⊗	≥ 76.7%	≥ 82.0%			Alert
A&E - Corridor Care in Dept	Aug-26	13	3 ↓						Alert
A&E - Patients Waiting > 12 hours in Department	Aug-26	17.1%	-0.3% ↑	≤ 14.0% ⊗	≤ 15.0%	≤ 0.0%			Alert
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	68.7%	4.7% ↑	≥ 70.0% ⊗	≥ 80.0%	≥ 80.0%			Alert
Cancer - 62 Day All Referral Sources	Jul-26	56.7%	-7.5% ↓	≥ 60.1% ⊗	≥ 80.2%	≥ 80.0%			Alert
Diagnostics - 6 Week Standard	Aug-26	33.6%	0.1% ↓	≤ 29.0% ⊗	≤ 17.9%	≤ 1.0%			Alert
Finance - CIP YTD against Plan	Aug-26	56.2%	-1.4% ↓						Alert
Finance - ECP YTD actual spend against previous year (000's)	Aug-26	325.7%	9.0% ↓			≤ 70.0%			Alert
Finance - Overtime YTD actual spend against previous year (000's)	Aug-26	85.2%	-3.4% ↑			≤ 70.0%			Alert
Healthcare Worker Flu Vaccination Rate	Apr-26	51.1%	-0.3% ↓			≥ 60.0%			Alert
Inpatient - Days between DRD and Discharge Date	Aug-26	28.1	22.9 ↓	≤ 3.8 ⊗	≤ 4.4				Alert
Inpatient - Emergency Readmissions within 30 days	Jul-26	11.0%	0.1% ↓						Alert
RTT - Incomplete 18 Week Standard	Aug-26	58.6%	-1.2% ↓	≥ 60.3% ⊗	≥ 66.0%	≥ 92.0%			Alert
RTT - Patients waiting 52+ weeks for Community Services	Aug-26	16.7%	0.7% ↓						Alert
RTT - Percentage of 52+ Week Waits	Aug-26	3.7%	0.4% ↓	≤ 2.6% ⊗	≤ 2.6%	≤ 1.0%			Alert
Staff Sickness Absence Rate	Jul-26	5.2%	-0.2% ↑			≤ 4.0%			Alert
CQC Safe Inspection Score	Aug-26	2.0	0.0 —						
Falls - Moderate and above (per 1,000 bed days)	Aug-26	0.0	-0.1 ↑						
Finance - Planned Surplus/Deficit	Aug-26	-23,665	0 —						
Finance - Variance YTD to Financial Plan	Aug-26	-1,837	21 ↓						
Infections - C.Difficile (per 1,000 bed days)	Jul-26	0.2	0.0 ↓						
Infections - E.Coli (per 1,000 bed days)	Jul-26	0.3	-0.4 ↑						
Infections - MRSA (Cumulative)	Jul-26	1	0 —						
Infections - MRSA (per 1,000 bed days)	Jul-26	0.0	0.0 ↑						
Inpatient - Corridor Care on Wards	Aug-26	0.4	-1.6 ↑						
Patient Safety Incidents - % Harmful	Aug-26	3.9%	0.5% ↓						
RTT - Difference between actual and planned 18 week performance	Aug-26	-1.7%	-2.9% ↓						

NLAG summary – Advice:

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (Type 1)	Aug-26	50.4%	-0.1% ↓	≥ 54.0% ⊗	≥ 57.9%				Advise
A&E - Total Time in A&E (Patients >=65 years)	Aug-26	444	-6 ↑			≤ 160			Advise

NLaG summary – Assure:

Finance - Agency YTD actual spend against previous year (000's)	Aug-26	64.9%	0.2% ↓			≤ 70.0%			Assure
Finance - Bank YTD actual spend against previous year (000's)	Aug-26	67.7%	0.8% ↓			≤ 70.0%			Assure
Mortality - SHMI	Apr-26	1.0	0.0 ↓			≤ 1.0			Assure
Staff Survey - Raising Concerns sub-score	Aug-26	6.1	0.0 —						Assure
Staff Turnover Annual FTE Rate	Aug-26	7.2%	0.0% ↑			≤ 8.0%			Assure

Listening to Clinicians, Learning from Patients

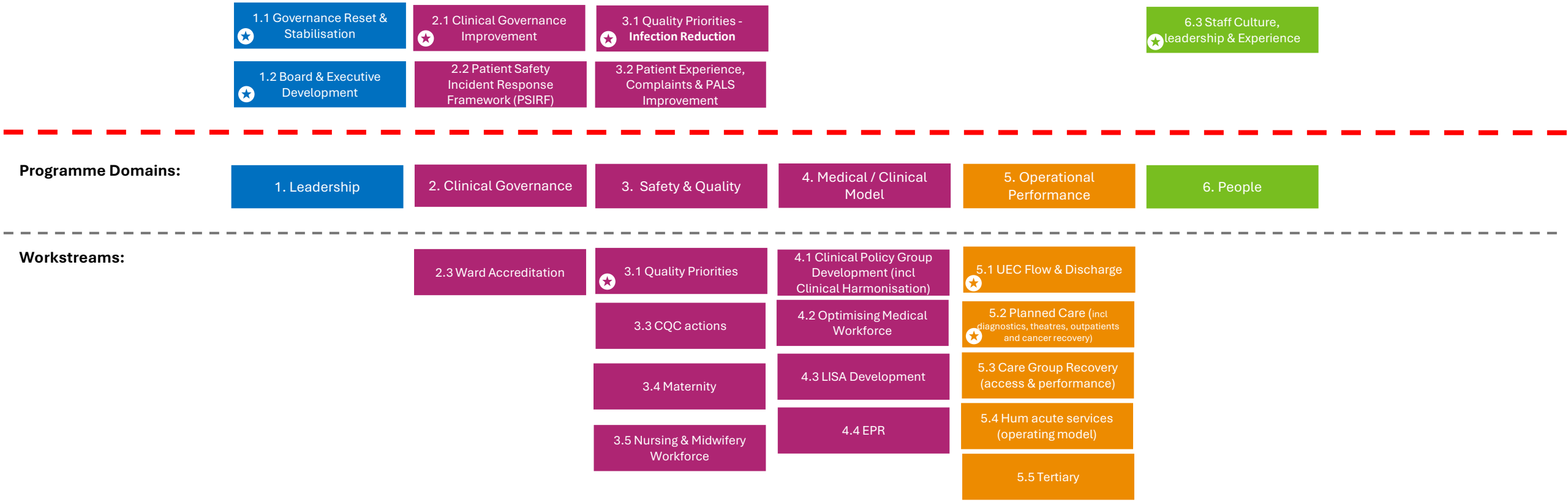
The IIPs Impact to Section 29a

NHS Humber Health Partnership

The priority workstreams have been identified as critical to delivering the improvements required by 31 March 2027. Stakeholder reviews led by the Group Chief Patient Safety Officer and Group Chief Nursing Officer on 2 and 8 September 2026 assessed delivery plans against CQC requirements and identified a small number of enhancements required, particularly in relation to organisational learning from incidents and IPC governance and assurance. PMO is implementing the agreed changes for inclusion in October reporting. Progress against the Section 29A Warning Notices, including evidence of implementation and impact, will be routinely monitored through the IIP governance and reporting framework from October 2026 onwards.

In-month Improvement include;

- BAF redesign scheduled for Trust Board ratification.
- Reduction in overdue PSII investigation cases on trajectory for backlog completion by December 2026
- CQC regulation 20: Duty of Candour compliance significantly improved, current position, nil overdue.
- CQC regulation 16: Receiving and acting on Complaints and Concerns, significant improvement in backlog of concerns from circa 900 to 150. Complaints response with 60-days timeframe has seen a continuous upward trend from below 40% in October 2025 to 60% in September 2026.
- Risk register deep dive completed in August in relation to high rated risks, risk validation including controls, mitigation and rating reviewed.
- Development of a framework for learning and sharing from safety incidents and patient experience.



Highest Risks to Delivery

Whilst the IIP has transitioned successfully into delivery, further work is required to strengthen the quality and consistency of risk reporting across workstreams. The PMO will support the development of a comprehensive IIP Risk Register during October, with current overarching themes captured below providing initial oversight and high-level mitigation. Maintaining delivery momentum will require continued executive oversight, focused prioritisation, timely decision-making, sufficient capacity and strong clinical ownership to support benefits realisation and improved assurance ratings across the programme.

Risk	Description	Impact	Mitigation
Workforce	Variability in skills, knowledge and capability across key workstreams may impact the pace, quality and impact of delivery.	• Delays to implementation of plans, inconsistent delivery and reduced ability to achieve planned benefits and sustain improvements.	• Executives focusing domains and workstreams to priorities and relevant capacity required. • Support from external resource (e.g. NHSE, GT, Value Circle).
Data Quality, Reporting and BI Support	Incomplete baselines, inconsistent or no data availability and limited BI capacity are hindering performance monitoring and assurance.	• Reduced ability to track delivery, demonstrate impact and support decision-making.	• Evaluate and prioritise BI support through Oversight Group. • Develop standardised dashboards and KPI frameworks. • Strengthen data quality controls and implement routine assurance reporting.
Clinical Engagement and Ownership	Delivery is dependent on sustained clinical leadership, engagement and agreement of service models and recovery plans.	• Delays or nonsuccess of implementation and reduced pace of improvement.	• Strengthen clinical leadership arrangement through enhanced comms and governance. • Confirmation of accountable leads. • Maintain SRO oversight and embed clear ownership across Care Groups and specialties.
Governance and Programme Maturity	Several workstreams remain in mobilisation with governance, reporting and assurance processes still developing.	• Limited assurance towards progress and delayed benefits realisation.	• Embed governance structures. • Agree KPIs and reporting cycles. • Implement and embed AAA assurance processes to strengthen delivery oversight.

IIP Communications and Engagement

First IIP Workstream Lead Briefing launched

A new monthly communication to strengthen visibility, engagement and shared learning across the IIP.

1 Monthly briefing agreed

The IIP Oversight Group agreed that the briefing will be issued each month to share progress, achievements, learning and key areas of focus.

2 Supporting staff engagement

The Chief Executive has agreed to use the briefing at staff roadshows, helping colleagues understand the IIP and how improvement activity is progressing.

3 Building the IIP BRIDGET page

Issue 1 is the starting point for a dedicated IIP BRIDGET page, creating a central space for programme updates, evidence of impact and shared learning.

BOARD MESSAGE **The IIP briefing is becoming the primary mechanism for communicating improvement progress, learning and impact across the Partnerships, supporting the IIP as the organisation's single source of the truth.**

IIP Workstream Lead Briefing – Issue 1

Helping us move from reporting activity to demonstrating improvement

NHS Humber Health Partnership

Thank you for your continued commitment and support in delivering the Integrated Improvement Programme (IIP). As we move into the next reporting cycle, we wanted to take a moment to recognise the significant progress made to date, share some key updates and highlight how your reporting continues to strengthen oversight, assurance and decision-making across the Partnership.

What have we achieved together?

23 workstreams now reporting

...through the IIP framework; with agreed plans and governance arrangements in place. This achievement meets the target set for the programme and represents a significant milestone in establishing a consistent approach to improvement delivery across HHP.

3 workstreams not yet reporting

But there is clear understanding and rationale for why reporting has not yet commenced. Plans are in place either to progress these workstreams into reporting arrangements or where appropriate, transition them into the Financial Recovery Programme (FRP).

Improving reporting

The quality of highlight reporting continues to improve. Priorities are becoming clearer, progress and impact are more visible and reporting is supporting constructive conversations with Executive SROs.

First IIP Board report

We produced the first IIP board report in September. Yes it wasn't perfect but the Board acknowledged the significant work completed and thanked all involved for helping them to understand progress, organisational priorities and impact to undertaking and the NOF!

Demonstrating Impact

Importantly, your reporting is not simply providing assurance; it is actively informing decisions and driving improvement. Recent examples include:

PALS – identification and mobilisation of additional capacity

Helping reduce backlogs and create headroom for sustainable process improvements.

Investment in data & reporting

Approval of investment in enhanced data collection and reporting tools, enabling faster access to information, improved analysis and more timely implementation of improvements.

Ward Accreditation Programme

Increased visibility of the workforce requirements needed to successfully deliver a sustainable Ward Accreditation Programme, supporting discussions around ensuring the programme achieves its ambition of delivering excellence for patients.

These examples demonstrate the value of the governance arrangements now in place. Through open and transparent discussions, effective engagement with Executive SROs and your clear articulation of risks, challenges and impact, the programme is enabling timely decisions that directly support improvement delivery.

Notices

Group Model Review

Recent Board communications regarding the Group Model Review do not change our current priorities or immediate plans. Delivery of the IIP remains the priority and workstreams should continue to focus on agreed objectives, deliverables and improvement activities. Please maintain the momentum and any questions or concerns should be raised through your Executive SRO rather than allowing uncertainty to detract from improvement delivery and the outcomes we are seeking to achieve.

Highlight Reports

Less War and Peace, More Executive Summary

We have now transitioned to the AAA reporting format across the Partnership: Alert, Assure, Advise. The quality of submissions continues to improve – thank you for your efforts!

ALERT – What does your SRO, the IIP Oversight Group and The Board most need to know?

ASSURE – Provide confidence in delivery, recovery plans and impact.

ADVISE – Share the value and impact of the work - achievements, improvements, opportunities and learning.

Remember to triangulate progress against deliverables with risks, KPIs and intended outcomes. Deliverables may be progressing, but is this translating into meaningful improvement and impact?

RAGs to Riches

RAG ratings are one of the quickest ways for leaders to understand where attention is needed, so consistency is really important.

- Is the RAG rating supported by evidence rather than optimism?
- Are deliverables still achievable as planned and having an impact to the KPIs?
- Do you have some high risks but are they successfully being mitigated?
- Would an independent reviewer reach the same conclusion?

Remember: Limited (amber) is not a failure, it is often a sign that work continues to be progressed, risks have been identified early enough for action to be taken, and plans are in place.

Keep Calm and Follow the Plan (on a Page)

Strong delivery starts with a clear and realistic plan. Please continue to ensure

- Deliverables reflect the current position
- Risks, issues and actions are up to date
- Dependencies are highlighted early
- Benefits and outcomes remain visible

The better our plans reflect reality the easier it is for us to provide meaningful programme assurance. Don't be afraid to take stock and update your plans. This shows you are continuously assessing 'is the work I'm doing with my team making an impact to the KPIs and desired outcome?'

PMO: Here to Help, Not Just Chase Reports

The PMO team remains available to support workstreams and will continue to help with:

- Reporting and governance advice
- Risk, issue and dependency management
- Delivery planning and deliverable milestone tracking
- Dashboard development and reporting improvements

Our role is to support delivery, provide assurance and help remove barriers wherever possible.

Final Thought

Assurance is a Team Sport

Good reporting is not about producing paperwork. It helps us understand whether improvements are being delivered, identify issues early and give Boards, Executive Teams and NHS England confidence in progress.

Improvement together makes a difference

NHS
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Appendices

Listening to Clinicians, Learning from Patients

Our Improvement Plan – Domains and Workstreams Refresh

NHS Humber Health Partnership

Assurance to Trust Board-in-Common and region

SRO: CEO

HHP Senior Leadership Team meeting

HHP IIP Oversight Delivery Group

HHP Financial Recovery Programme

Senior Responsible Owners:

SRO: CEO | SRO: CPSO | SRO: CNO | SRO: CMO | SRO: CDO | SRO: CPO

Programme Domains:

1. Leadership
2. Clinical Governance
3. Safety & Quality
4. Medical / Clinical Model
5. Operational Performance
6. People

Workstreams:

- 1.1 Governance Reset & Stabilisation ★
- 1.2 Board & Executive Development ★
- 2.1 Clinical Governance Improvement ★
- 2.2 Patient Safety Incident Response Framework (PSIRF)
- 2.3 Ward Accreditation
- 3.1 Quality Priorities ★
- 3.2 Patient Experience, Complaints & PALS Improvement
- 3.3 CQC actions
- 3.4 Maternity ★
- 4.1 Clinical Policy Group Development (incl Clinical Harmonisation)
- 4.3 LISA Development
- 4.4 EPR
- 5.1 UEC Flow & Discharge ★
- 5.2 Planned Care (incl diagnostics, theatres, outpatients and cancer recovery) ★
- 5.3 Care Group Recovery (access & performance)
- 5.4 Hum acute services (operating model)
- 5.5 Tertiary
- 6.3 Staff Culture, leadership & Experience ★

Key Enablers

1. Digital
2. Estates & Facilities
3. Strategy
4. PMO
5. Business Intelligence

★ *Indicates regulatory undertaking aligned to this workstream*

Listening to Clinicians, Learning from Patients

1.1 Governance Reset & Stabilisation

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Work is progressing, but the current pace and dependencies on the Carnall Farrar review and Scheme of Delegation mean that reasonable assurance cannot yet be provided.	• Undertakings; 1.1 – Apply principles, systems and standards of good corporate governance, 1.2 – Review board leadership and governance arrangements, 1.3 – Develop an action plan in response to the findings and recommendations for the review set out in 1.2. • CQC 29A Theme 1 - You do not operate effective governance, performance and risk management processes to ensure the safe and effective delivery of care. • Value Circle & NPIP recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
14	2	1	3	0	0	8

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action			Agreed Outcome
Issue	**Detail**	**Key Decision/Support Required or Relevant Information**	
Delay to target date for deliverable 2	BAF refresh; additional time is required to complete executive validation of the BAF, ensure committee review and incorporation of feedback before a refreshed version can be shared for ratification with the Audit Committee and Trust Boards-in-Common.	➢ Request to extend deliverable 2 completion date from 29/10/26 to 13/11/26	✓ Confirmed date can extended.
Delay to target date for deliverable 4	Systematic BAF review cycle; To align with the above, additional time is required to complete the refreshed BAF, agree supporting governance arrangements and establish a consistent review framework to support ongoing assurance, challenge and oversight.	➢ Request to revise deliverable 4 target date from 29/10/26 to 12/11/26.	✓ Confirmed date can extended.
Delay to target date for deliverable 6	Deliver a revised governance framework that defines clear accountability and decision rights across the Partnership; to enable completion of the Scheme of Delegation review, Governance Manual development, stakeholder engagement, Board review and final ratification additional time is required.	➢ Request to extend deliverable 6 completion date from 31/10/26 to 26/02/26.	✓ Confirmed date can extended.

1.2 Board & Executive Development

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE**. Whilst delivery is progressing and a number of deliverables remain on track, the group considered that progress against activities and milestones does not constitute assurance. There are 4 deliverables which are off track.	• Undertakings; 1.2 – Review board leadership and governance arrangements, 1.3 – Develop an action plan in response to the findings and recommendations for the review set out in 1.2. • CQC 29A Theme 1 - You do not operate effective governance, performance and risk management processes to ensure the safe and effective delivery of care. • Value Circle & NPIP recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
17	7	2	1	2	0	5

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action			Agreed Outcome
Issue	**Detail**	**Key Decision/Support Required or Relevant Information**	
Delay to target date for deliverable 4	Devise a recruitment plan to appoint substantive Executive roles to accelerate appointments: Recruitment activity has been paused pending the outcome of the Carnall Farrar review of the organisational structure and clinical model.	➢ Acknowledge.	✓ Acknowledged.
Bring forward deliverables 11 & 12	Executive and Board Development Programmes (2027/28): The Steering Group agreed to progress development of both programmes in Quarter 3 and revise milestones accordingly. Updated delivery dates will be confirmed following discussions with Value Circle and the Group Chair.	➢ Acknowledge & approve	✓ Confirmed date can extended.
Delay to target date for deliverable 13	Develop a forward programme for the Board and its sub-committees: Commencement remains dependent on Board Assurance Framework ratification. Due to wider governance and review dependencies.	➢ Request to extend deliverable 13 completion date from 08/10/26 – 12/11/26.	✓ Confirmed date can extended.

Listening to Clinicians, Learning from Patients

2.1Clinical Governance

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** Delays with BAF and Risk and Register alignment and limitations of implementation plans in respect management structure potential changes.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services. • CQC 29A Theme 1 - You do not operate effective governance, performance and risk management processes to ensure the safe and effective delivery of care. • CQC Theme 2 - You do not ensure that incidents reported are reviewed and acted upon in a timely manner. The potential for learning lessons from incidents and lack of action planning means opportunities are missed to prevent patients being exposed to the risk of harm. • Value Circle, NPIP & KPMG recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
11	7	4	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

NOF1.19 Number of national clinical audit outliers

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delay to target date for deliverable 2	Ensure that there is an effective audit plan, prioritised and optimally supported with resources to provide assurance on care provision to evidence based standards; Progress remains subject to the outcome of the Care Group Management Review. Final reporting of the Clinical Audit Plan has been delayed following cancellation of the August Clinical Effectiveness Group, and guidance for the Audit Outlier Alerts NOF KPI metric remains outstanding.	➢ Request to extend deliverable 2 from 31/08/26 to 31/10/26	✓ Confirmed date can extended.
Delay to target date for deliverable 4	Completion of Partnership wide risk register cleanse ensuring alignment with Board Assurance Framework and implement a clear cyclic process for future review; Progress remains dependent on approval of the refreshed Board Assurance Framework (BAF) by the Board on 11 November 2026.	➢ Request to extend deliverable 4 from 31/08/26 to 30/11/26	✓ Confirmed date can extended.

Listening to Clinicians, Learning from Patients

2.2 PSIRF

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** Due to some timescale impacts due to the Group model review and care group management structure review, although note progress in several areas has been achieved.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services. • CQC Theme 2 - You do not ensure that incidents reported are reviewed and acted upon in a timely manner. The potential for learning lessons from incidents and lack of action planning means opportunities are missed to prevent patients being exposed to the risk of harm. • Value Circle & ICB recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
10	6	3	1	0	0	0

High-Level Risks

Risk	Mitigation	Score
Workforce reductions within the Patient Safety Team and across the Group result in insufficient capacity and capability to undertake high-quality patient safety investigations and learning reviews.	• Incorporate workforce and investigator capacity requirements into wider workforce planning and organisational redesign programmes. • Streamline reporting, incident management and assurance processes to reduce administrative burden and improve efficiency. • Ensure workforce implications are considered as part of Care Group redesign and wider organisational change programmes for patient safety. • Review the Patient Safety Team operating model to ensure available resource is aligned to PSIRF requirements and highest-risk investigations. • Maintain a register of trained PSIRF investigators and maximise the use of investigators across Care Groups. • Develop additional investigator capacity through targeted training and accreditation programmes. • Implement a prioritisation framework to ensure available resources are focused on incidents with the greatest potential for learning and improvement. • Strengthen local ownership of patient safety learning within Care Groups through designated safety leads and governance structures. • Undertake routine quality assurance reviews of completed investigations to ensure consistency and compliance with PSIRF standards. • Monitor investigation timeliness, quality and capacity through through regular reporting to governance and quality committees.	15

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Patient Safety Incidents - % Harmful	Aug-26	3.9%	0.5% ↓						

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Potential impact of Care Group Management Review	Proposed organisational changes may require revisions to the PSIRF governance and oversight arrangements currently being developed.	➢ Confirm whether proposed management changes will affect the future PSIRF governance model and provide SRO direction as required.	✓ This work/decision will form part of the transition programme; however, current arrangements will continue unchanged in the interim.
Change to KPI	The KPI for mean days to complete proportional learning responses has been revised from <56 days to <90 days, reflecting the increased complexity of PSIRF investigations. The target will reduce to 28 days following future policy updates and aligns with approaches adopted elsewhere.	➢ Note the revised KPI target and endorse its adoption pending implementation of updated policy requirements.	✓ Noted

2.3 Ward Accreditation

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Cohort 2 delivery is off track due to gap analysis findings, resulting in delays to programme rollout and delivery across further areas.	

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
5	2	0	0	0	1	2

High-Level Risks

Risk	Mitigation	Score
The absence of a dedicated digital accreditation platform and limited analytical capability reduce the ability to efficiently manage the accreditation process, monitor compliance, track progress, and provide timely performance insight. These challenges are further compounded by competing organisational priorities, which constrain the availability of digital and assurance support.	• Escalate digital infrastructure requirements through programme governance and executive reporting routes to ensure visibility of risks to delivery and sustainability. • Maintain programme oversight through the Accreditation Forum, governance groups and PMO reporting until a digital solution is implemented. • Assurance Team provides support where possible to wards and areas, monitoring progress through use of manually updated trackers, and addressing barriers to delivery.	15

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Low self-assessment completion rates	Self-assessment completion remains significantly below plan in a number of areas (H100 7%, Amethyst 2%, Ward 23 23%). Quality summits are scheduled during September to review progress and agree recovery actions.	➢ Oversight Group to note progress and support escalation where recovery plans are not delivering expected improvements.	✓ Noted
Accreditation data and reporting risk	A gap analysis has identified that the current spreadsheet-based accreditation process is unsustainable and presents a delivery risk due to limitations in reporting, monitoring and analytical capability. Investment in a dedicated digital solution, or enhanced data analytics support, is required to improve compliance monitoring, progress tracking and reporting.	➢ Confirm approach to addressing digital and data capability requirements and review implications for programme delivery.	✓ Funding has been secured to enable the procurement and implementation of a digital solution
Cohort 2 delivery at risk	Delivery of Cohort 2 is dependent upon additional resource including uplift of 0.15WTE for Band 7 Accreditation Lead Nurse resource and increased clinical and operational capacity at ward level.	➢ Decision required on resource allocation.	✓ Funding has been secured for additional staffing capacity to support delivery, oversight, and programme objectives.

3.1a Quality Priority – Sepsis (recognition, identification, prevention and treatment)

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Ongoing reporting, data and digital dependencies limit the ability to consistently evidence performance and benefits realisation across the Group, requiring continued monitoring and mitigation.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
10	7	0	2	0	0	1

High-Level Risks

Risk	Mitigation	Score
Inability to automatically report on South Bank metrics at present – no current resource to manually report.	• Move towards standardisation across digital systems for automatic data extraction, uniform and consistent across the Group. • Explore options of possibility regards what data can be gathered.	20

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Mortality - SHMI	Apr-26	1.0	0.0 ↓			≤ 1.0			Advise

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Data reporting and dashboard development remain the key delivery risks	Data collection and reporting capability across the South Bank remains a significant challenge due to differences in clinical systems, limited electronic extraction capability and reliance on manual audit processes. Discussions continue with BI, Digital and clinical teams to agree an interim reporting solution and identify metrics that can be reported consistently and reliably. Development of the Sepsis Quality Priority dashboard remains dependent on BI capacity and competing organisational priorities. Current indications suggest delivery may be delayed by several months, reducing the ability to monitor performance consistently and provide Group-wide assurance.	➢ Endorse a pragmatic interim reporting approach where full automation is not currently achievable. ➢ Support prioritisation of BI and Digital resource for delivery of key quality dashboards. ➢ Confirm risk appetite and escalation arrangements should dashboard delivery timelines continue to slip.	✓ Discussion took place regarding the unavailability of NLAG data. In the interim, a programme of audits has been implemented to provide assurance and mitigate reporting gaps.

3.1b Quality Priority - Safe Care for Patients Prescribed Insulin

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	AMBER 'LIMITED' ASSURANCE: There are some actions relating to the Hypo awareness week which have been flagged as overdue, however these will be resolved by 1st September. In addition, the overarching KPI (percentage of insulin incidents causing harm) is making progress towards the aim, but is not yet at the target.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
6	4	0	0	2	2	0

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Dashboard development remains dependent on BI and Digital capacity	Additional BI resource is required to support dashboard development. While the project benefits from strong support from the Pharmacy Data Information Analyst, further BI and potentially Digital/ePMA support may be required to deliver reporting requirements and future system integration.	➢ Endorse prioritisation of BI and Digital resource to ensure delivery milestones are achieved and reporting capability is sustainable.	✓ Wider review regarding power BI resource and conversation with new Performance Director is required. This will be progress next month.

Listening to Clinicians, Learning from Patients

3.1c Quality Priority - Infection Reduction

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE**: Implementation is progressing with core workstreams established and delivery remaining achievable. However, workforce capacity, stakeholder engagement, KPI development and dashboard reporting continue to present risks to delivery and assurance and require ongoing oversight and management.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services. • CQC Theme 4 – You do not operate effective systems and processes to prevent, detect and control the spread of infection.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
9	7	0	1	0	0	1

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Infections - C.Difficile (per 1,000 bed days)	Jul-26	0.2	0.0 ↓						
Infections - E.Coli (per 1,000 bed days)	Jul-26	0.3	-0.4 ↑						
Infections - MRSA (Cumulative)	Jul-26	1	0 —						
Infections - MRSA (per 1,000 bed days)	Jul-26	0.0	0.0 ↑						

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
BI capacity to support KPI reporting	KPI reporting and performance monitoring are dependent on securing sufficient BI resource and prioritisation. Delays may impact the workstream's ability to provide timely performance intelligence and demonstrate improvement against agreed measures.	➢ Escalation to secure BI resource and prioritisation of dashboard development and KPI reporting requirements.	✓ Wider review regarding power BI resource and conversation with new Performance Director is required. This will be progress next month.
Residual risk of non-achievement of Infection Prevention and Control KPI targets.	MRSA and C. difficile performance has already exceeded 2025/26 thresholds, with further breaches possible during 2026/27. While improvement actions are in place, benefits will take time to embed and translate into measurable reductions. In particular, C. difficile interventions may not demonstrate impact for several months. Performance is also influenced by wider operational factors including activity levels, patient flow, corridor care and workforce pressures.	➢ Approval requested for a revised KPI trajectory and scope to reflect current performance, projected Q2 position and a realistic improvement trajectory for the remainder of 2026/27. ➢ The proposed approach retains alignment with national thresholds and NOF expectations while introducing more achievable internal improvement targets. ➢ Despite revised trajectories, the workstream remains committed to delivering year-on-year improvement against 2025/26 performance.	✓ Noted.

3.1d Quality Priority – Safer Surgery and Interventions

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Good assurance can be provided that safer surgery controls, audit arrangements and governance oversight are established and operating effectively. The focus remains on reducing variation between sites, strengthening engagement in debrief processes, and maintaining performance through routine audit, training and governance mechanisms.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
6	4	2	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
None			

3.1e Quality Priority – Preventing Deconditioning

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Delivery remains achievable; however, assurance is currently limited by the need to establish baseline measures and develop sustainable KPI reporting and dashboard capability before programme benefits can be demonstrated.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
10	5	0	1	1	1	3

High-Level Risks

Risk	Mitigation	Score

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Falls - Moderate and above (per 1,000 bed days)	Aug-26	0.0	-0.1 ↑						

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Transition from discovery to implementation presents a risk that learning from pilot wards is not translated into timely improvements, delaying benefits realisation and reductions in deconditioning-related harm.·	Pilot activity has identified a disconnect between staff perceptions of promoting mobility and patient experiences of prolonged inactivity. Whilst significant learning has been generated, interventions and outcome measures are still being developed, limiting the ability to demonstrate impact.	➢ Note the emerging findings from pilot wards and support continued focus on improving patient activity, independence and experience during admission. ➢ Support progression from evidence gathering into implementation and testing of agreed improvement interventions. ➢ Endorse development of a proportionate outcome measurement framework to support benefits realisation and ongoing assurance.	✓ Noted and supported.

3.2 Patient Experience, Complaints & PALS Improvement

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MIMINAL' ASSURANCE:** Due to overdue deliverables and the likelihood of further deliverables to fall behind schedule owing to issues with Ulysses, development work required as part of contract.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services. • CQC Theme 3 - You do not ensure that complaints and PALS contacts are reviewed and acted upon in a timely manner. The potential for learning lessons from complaints and lack of action planning means opportunities are missed to prevent patients being exposed to the risk of harm.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
19	11	3	1	1	0	3

High-Level Risks

Risk	Mitigation	Score

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
System and telephony infrastructure constraints	Ongoing issues with Ulysses are affecting data consistency, reporting and alignment across PALS and Complaints services. In addition, unresolved technical infrastructure issues relating to the Group Telephony System are preventing consistent KPI reporting, call recording and the ability to flex resource across the Group to respond to areas of highest demand.	➢ Note the continuing operational impact of Ulysses and Group Telephony system limitations on service delivery and performance reporting. ➢ Support escalation through contractual and digital governance routes to secure resolution and delivery timescales.	✓ Whilst the digital element remains an important enabler, it is not anticipated to significantly contribute to the reduction of PALS volumes.
Workforce capacity pressures	Staff shortages at NLAG have seen a lack of recording for PALS Open for the first two weeks of August with a notable increase in the number awaiting upload and action (118 to 181).	➢ Note the increase in outstanding PALS cases and associated risk to performance and patient experience. ➢ Support recovery actions and workforce mitigation measures to reduce the backlog and restore reporting compliance.	✓ Additional support for the PALS team has been agreed. Value Circle has completed a review of existing processes and identified actions to introduce and embed improved working practices.

3.3 CQC Actions

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Due to the level of delivery around the governance and process arrangements that are now in place related to CQC Actions but collation of evidence is now required to show these processes are embedded and also evidence of them in action.	• Undertakings; 3.4.2 - Deliver services on a financially sustainable basis taking into account: Impact on delivery of other licence conditions including those pertaining to the quality and safety of services. • Value Circle recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Evidenced and closed	Not started
9	8	1	0	0	0	0

High-Level Risks

Risk	Mitigation	Score

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
CQC Inpatient Survey Satisfaction Mean Score	Aug-26	8.2	0.0						

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Request for removal of Deliverables 5 & 9	It is deemed two deliverables are not required as processes are in place in relation to recording of monitoring of evidence, identifying issues and barriers, escalation routes and a tiered accountability process right up to the Executive Lead. Any issues are raised through the monthly Performance and Accountability meetings with the ability to pull in additional resource/support should the need arise.	➢ Remove deliverables as should the need arise, the Risk and Compliance Team have the processes to stand-up and establish weekly and fortnightly meetings, as was done previously for Maternity when a Section 31 was issued. 5) Establish a weekly regulatory action tracker review, chaired by the accountable senior lead, to confirm progress against each priority action, record evidence of completion, identify overdue milestones, and escalate unresolved barriers through the agreed governance route. 9) Implement a tiered accountability review process where service leads provide fortnightly progress updates to care group teams, care groups report monthly to the executive lead, and unresolved barriers are formally escalated with named owners, timescales, and required decisions.	✓ Agreed to close.

4.1 Clinical Policy Group Development

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** owing to a lack of names against deliverables, unscored risks and is in the very early stages of delivery. Work is also required to develop the KPI's. A significant risk to delivery has emerged in light of the outcome of the organisational structure review.	N/A

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
7	0	0	0	2	5	0

High-Level Risks

Risk	Mitigation	Score
Lack of clinical engagement	• TBC	TBC
Competing policy priorities across the group	• TBC	TBC
Lack of agreement on pathway standardisation	• TBC	TBC

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Strategic direction, scope and priorities for workstream required.	This workstream was established to build on the development of the Partnership's Clinical Policy Group to lead the development and delivery of a shared clinical strategy, harmonise clinical policies and pathways, and reduce unwarranted variation across HHP, enabling consistent, clinically led decision-making, workforce transformation and service improvement.	➢ Agree the future desired state and strategic direction of the workstream, including the Partnership's approach to clinical harmonisation. ➢ Determine the priority areas of focus for the workstream to ensure it delivers maximum value in supporting clinical leadership, service transformation and improvement objectives. ➢ Agree the ongoing role, remit and utilisation of the Clinical Policy Group to drive and oversee clinical harmonisation, standardisation and continuous improvement across the Partnership.	✓ The group agreed to continue meeting and to strengthen clinical engagement. Face-to-face sessions have now been scheduled at Goole. Work will continue with clinicians to agree priorities and focus areas for delivery over the coming months.

4.3 LISA Development

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** due to unresolved methodology and deployment arrangements, coupled with demand for LISA support significantly exceeding current specialist capacity and prioritisation processes, creating a risk to timely delivery and organisational impact	• NPIP recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
6	6	0	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
Demand for LISA support exceeds capacity with no defined triage/prioritisation model.	• Develop a governance-led, risk-based triage and prioritisation model. • Create a stepped-care deployment framework for LISA support. • Map existing improvement capability across HHP and maximise use of trained staff. • Complete a capability gap analysis and workforce planning exercise. • Align prioritisation decisions to organisational risk, IIP requirements and NHS Impact principles. • Set realistic delivery timescales and escalation routes through the Steering Group and Executive governance structure	20
Competing operational priorities and limited leadership capacity reduce the pace and effectiveness of improvement delivery.	• None at present. This risk remains the same. Until the outcome of the Carnell Farrar review is known and then this will have to be reviewed.	16

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Lack of agreed methodology, deployment model and governance arrangements for the HHP Improvement Way.	The key dependency to delivery remains agreement of the HHP Improvement Way, LISA deployment model and supporting governance arrangements. Until agreed, there is a risk of inconsistent approaches to improvement, unclear prioritisation and inefficient deployment of limited specialist resources. Demand for improvement support is expected to exceed capacity, increasing the need for a consistent and transparent approach to prioritisation.	➢ Clarification is required on the appropriate decision-making forum (IIP Oversight Group or Executive Team Meeting) for consideration of the options paper and approval of the HHP Improvement Way, LISA deployment model and associated governance arrangements. ➢ Sufficient discussion time will be needed to achieve consensus and secure Board endorsement by the target date of 30 November.	✓ Agreement reached to reintroduce the established Group-wide improvement methodology, leveraging existing training and capability already in place.

4.4 EPR

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** Ongoing discussions to understand the product readiness.	N/A.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
12	0	0	1	0	11	0

High-Level Risks

Risk	Mitigation	Score
As a result of the FOT nature of this ORBIS U Implementation, there is a risk that key functionality will not be available in time for go live which would cause potential delays and a reduction in benefits realisation	• None	25
Due to the delay in production of the DIP, there is an issue that the Critical Path is not understood which could lead to delays	• None	16
Due to a lack of clarity around the approach to DM, there is a risk that DM delays will impact programme milestone dates	• None	16

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delays to target date deliverable 1 - ORBIS U Clinical Functionality - M3 Design Complete (full design of clinical EPR completed and approved).	Progress has been made towards a shared implementation plan, with the proposed delivery approach and implementation methodology now better understood. Agreement has been reached to refocus implementation on a module-based approach, rather than by care pathway. This will enable the targeted deployment of subject matter experts from across HHP, improving resource utilisation, ownership and implementation readiness.	✓ Information for IIP oversight Group - At this stage, there remain significant functional requirements that are not yet available within the product. These gaps present a material risk to implementation and would currently prevent a safe and effective go-live. Discussions are ongoing to assess product readiness against the contractual requirements. Further engagement will continue once Dedalus has provided a formal response, including a product roadmap demonstrating how outstanding requirements will be addressed.	✓ Discussion led to further needing to understand the impact on capital that would have on EFD. To be progressed next month.

Listening to Clinicians, Learning from Patients

5.1 UEC Flow and Discharge (1)

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** several key deliverables are delayed and have not yet demonstrated consistent implementation or measurable impact. The principal concerns relate to North Bank modelling, UEC governance, Care Group implementation, KPI assurance, SDEC capacity and outstanding winter readiness actions, although recovery activity and revised delivery dates are now in place.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture. • Value Circle recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
10	6	0	4	0	0	0

High-Level Risks

Risk	Mitigation	Score
Cultural change program – having engagement across all care groups to work to deliver the ask.	• None	16

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
A&E - 4 Hour Standard (All - Footprint)	Aug-26	70.9%	-0.4% ↓	≥ 75.0% ⊗	≥ 78.9%				Alert
A&E - 4 Hour Standard (All)	Aug-26	64.9%	-1.1% ↓	≥ 69.7% ⊗	≥ 74.6%	≥ 82.0%			Alert
A&E - 4 Hour Standard (Type 1)	Aug-26	49.5%	-0.7% ↓	≥ 52.0% ⊗	≥ 59.3%				Advise
A&E - Corridor Care in Dept	Aug-26	34	11 ↓						Assure
A&E - Patients Waiting > 12 hours in Department	Aug-26	12.4%	0.8% ↓	≤ 12.0% ⊗	≤ 14.6%	≤ 0.0%			Advise
A&E - Total Time in A&E (Patients >=65 years)	Aug-26	426	10 ↓			≤ 160			Advise
Inpatient - Bed Days Lost to NCTR Patients	Aug-26	9,620	2,743 ↓						Alert
Inpatient - Corridor Care on Wards	Aug-26	20.6	-0.9 ↑						Assure
Inpatient - Days between DRD and Discharge Date	Aug-26	12.5	7.3 ↓	≤ 4.1 ⊗	≤ 4.1				Alert
Inpatient - Emergency Readmissions within 30 days	Jul-26	10.4%	0.0% —						

5.1 UEC Flow and Discharge (2)

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delay to target date for deliverable 1	Demand, capacity, workforce and bed modelling is being undertaken to validate operational requirements, workforce actions and plan deliverability, providing assurance to the Unplanned Care Board. An extension is required to allow completion of modelling, assurance, sign-off and final decision-making processes.	➢ Request to extend deliverable 1 completion date from 31/07/2026 to 31/10/2026	✓ Confirmed date can extended
Delay to target date for deliverable 2	Develop shared performance dashboards and KPIs to support oversight of delivery, progress and assurance. Additional time is required to complete assurance and embedding activities and confirm full implementation of all associated actions.	➢ Request to extend deliverable 2 completion date from 31/07/2026 to 31/10/2026	✓ Confirmed date can extended
Delay to target date for deliverable 3	Establish a coordinated, Partnership-wide improvement framework to drive measurable improvements in patient flow, safety and the reduction of corridor care. Additional time is required to implement revised governance arrangements, embed the framework and confirm completion of all outstanding actions.	➢ Request to extend deliverable 3 completion date from 31/07/2026 to 31/10/2026	✓ Confirmed date can extended
Delay to target date for deliverable 4	Lessons learned and continuous improvement. Supports delivery through monitoring progress, refining recovery actions and evidencing sustained improvement. Additional time is required to complete implementation across Care Groups, undertake assurance activity, address variances and confirm improvements are fully embedded.	➢ Request to extend deliverable 4 completion date from 31/08/2026 to 31/10/2026	✓ Confirmed date can extended
Paediatric performance	July performance remained below standard: North Bank 73.7% with 454 breaches from 1,726 attendances; South Bank 84.7% with 182 breaches from 1,191 attendances.	➢ Post-July actuals are not yet available, so achievement of August milestones cannot be assured.	✓ Acknowledged
SDEC and ambulatory capacity	Overnight bedding and delayed transfer after decision to admit are compromising SDEC capacity on both banks.	➢ Frailty SDEC staffing and protection of ambulatory capacity remain material risks, including inappropriate inpatient use at Scunthorpe.	✓ Acknowledged
Pathway reliability	ED remains the default front door where specialty access, hot clinics, trusted-assessor arrangements, diagnostics, operating hours or Directory of Services information are unclear.	➢ This threatens delivery of the Alternatives to ED programme before winter.	✓ Acknowledged
Winter readiness	South Bank modelling identifies a bed deficit, while North Bank surge areas, staffing, lead times and activation criteria are not fully confirmed.	➢ Respiratory/IPC cohort capacity, safe staffing, costs, system commitments and key funding dependencies remain unresolved.	✓ Further work is needed to review bed modelling assumptions and identify any supporting actions.
Benefits and delivery	Several baselines, numeric targets, deadlines and data sources remain incomplete.	➢ Without consistent coding and Informatics support, the Board cannot yet demonstrate reductions in ED attendance, conveyance, admission or four-hour breaches.	✓ Wider review regarding power BI resource and conversation with new Performance Director is required. This will be progress next month.

Listening to Clinicians, Learning from Patients

5.2a Planned Care - Outpatients

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Although several actions are progressing to schedule, the workstream's risks and KPIs have not yet been fully established to determine impact of progress.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
7	7	0	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
Initial risk of spend to implement the new model of care and clearing the backlog.	• Business case to model impact of SPOA and options for reducing wait to FA.	16
Variability in clinical engagement creating delay in safe implementation of pathways at specialty level.	• Develop specialty level roll out plan for elective SPoA, First appointment wait reduction, follow up pathway, GIRFT implementation. • Specialty level confirm and challenge to support the roll out programme.	16
Digital interface enabler for reducing number of systems to enable test requests, clinical actions and patient management.	• Advice and Refer process needs to be updated for SPOA. This is to enable clinicians to request STT at point of triage.	16
Scarce administrative resource to support transformation.	• Approve vacancy requests at control group	15

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delay to the realisation of Single Point of Access (SPoA) benefits	National delay relating to the implementation of SPoA to 4th December (initially 1st October 26), with enhanced functionality pending national technical specifications. These external dependencies present an ongoing risk to the programme delivery and the anticipated reduction in First appointment waits and the RTT waiting times.	➢ Note the national delivery constraints and the likely impact on local SPoA implementation timelines and associated benefits realisation.	✓ Acknowledged.
Workforce capacity constraints impacting programme delivery	Vacancy levels (12.4%), staff turnover (33%) and sickness absence (7.8%) have reduced clinical administrative capacity within Outpatients, creating delivery risks for SPoA and productive care workstream implementation. Vacancy approval has recently been agreed for 18.3WTE. Further workforce plans are being developed whilst ensuring delivery of the CIP with options being considered to balance delivery requirements against potential expenditure controls.	➢ To note at this stage and Executive consideration will be required regarding administrative recruitment once the plans are developed to work to 4% vacancy as optimal staffing whilst delivering the in year total CIP.	✓ Acknowledged and will await further detail.
Digital	Delivery of the Outpatient Transformation Programme is being constrained by limited digital and business intelligence capacity. Progress towards establishing a single, agreed OP dashboard with KPI reporting framework has commenced but has been slower than anticipated due to resource limitations and competing organisational priorities, including the EPR programme. Additional technical development is required to enable transformation objectives, including ISLA deployment, HL7 integration, automation opportunities and digital patient solutions such as check-in kiosks and voice technologies. These capacity and technical constraints continue to delay specialty roll-out, reduce pace of implementation and impact the timely realisation of programme benefits.	➢ Executive support is required to prioritise digital and BI resources, agree system integration priorities and secure the clinical and technical engagement necessary to progress automation and specialty deployment plans.	✓ Wider review regarding power BI resource and conversation with new Performance Director is required. This will be progress next month.

Listening to Clinicians, Learning from Patients

5.2b Planned Care - Theatres

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Whilst several actions are progressing as per timescales others have been delayed, due to interdependences of many of these actions this has pushed subsequent actions back against plan.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture. • Value Circle recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
10	6	3	1	0	0	0

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delay to target date for deliverable 4	Complete standardised capacity and demand modelling for both acute and elective theatres across the group inclusive of recovery requirements: - to complete the remaining acute and elective models, collate outputs and secure specialty and governance sign-off additional time is required.	➢ Request to extend from 30/09/2026 to 31/11/2026.	✓ Following challenge and discussion, the completion date was requested to be only extended to 31 October 2026.

5.2c Planned Care – Cancer (1)

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Due to core capacity shortfalls in recovery plans and improvement interventions to meet CWT trajectories.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
5	5	0	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
Diagnostic Capacity for Tumour Sites: Colorectal Endoscopy and CTVC, UGI Endoscopy, NSS pilot u/sound, x-ray and CT to (NLaG), Urology u/sound capacity to implement risk stratified haematuria pathway.	• Explore alternative opportunities/options, locums, outsourcing	16
Insufficient funding in the budget to provide the required level of workforce to provide core capacity to meet demand. Tumour sites: urology, gynae, lung, LGI, breast radiology, Head and Neck, skin.	• Continue to work collaboratively with NHSE and Cancer Alliance to identify external sources of funding whilst progressing internal business cases. • Robust cancer specific operational plans to be developed for 2026/27	16
Inability to increase treatment numbers on a monthly basis as required due to limitations with surgical capacity. Tumour Sites: Urology, Gynae-onc, lung, head and neck.	• Explore alternative opportunities/options, locums, WLIs, outsourcing	16
Cross cutting – Radiotherapy. Capacity issues leading to delays in treatment.	• Business case approved. • Expected recovery March 2028. • Continue to manage through clinical prioritisation plan.	20
Cross cutting – digital. Lack of HDigital resource to support cancer programme deliverables and timelines due to conflicting priorities	• Early escalation of gaps to executive team via operational planning process	16

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	69.5%	3.5% ↑	≥ 70.7% ⊗	≥ 80.0%	≥ 80.0%			Alert
Cancer - 62 Day All Referral Sources	Jul-26	55.1%	-2.4% ↓	≥ 55.9% ⊗	≥ 69.9%	≥ 80.0%			Alert

5.2c Planned Care - Cancer

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Cancer performance remains dependent on external funding sources and temporary recovery arrangements	Continuing reliance on funding from the Cancer Alliance and NHSE to support additional capacity. Whilst this is helping maintain current performance levels, there is limited assurance regarding how performance will be sustained if this support reduces or ceases. Reductions in extra-contractual activity are affecting performance.	➢ Agreement on whether additional recurrent investment is required to maintain performance trajectories ➢ Business case reviews.	✓ CDO to review and provide update at next oversight meeting
Insufficient diagnostic capacity is limiting the ability to improve cancer waiting times	Significant risks remain across endoscopy, CTVC, ultrasound, CT scanning and urology diagnostic pathways. These constraints continue to impact timely diagnosis and represent a fundamental barrier to improving both the Faster Diagnosis Standard and 62-day performance.	➢ Agreement on recruitment, outsourcing or investment decisions required to close capacity gaps. ➢ Assurance that demand and capacity modelling supports delivery of recovery trajectories.	✓ CDO to review and provide update at next oversight meeting
Workforce capacity shortages	Workforce shortages across multiple specialties including urology, gynaecology, lung, breast radiology, head and neck and skin services.	➢ Understanding of the impact if workforce gaps cannot be closed.	??CDO to review and provide update at next oversight meeting

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5.2d Planned Care - Diagnostics

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMAL' ASSURANCE:** Recovery delivery has not yet been evidenced as KPI positions remain incomplete; the delivery plan, baselines and trajectories have not been fully agreed; and significant demand, capacity, workforce, equipment and utilisation constraints remain unresolved.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
6	0	0	6	0	0	0

High-Level Risks

Risk	Mitigation	Score
None		

Review and return a corrected, assured set of diagnostics actions.

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Diagnostics - 6 Week Standard	Aug-26	36.8%	1.5% ↓	≤ 29.7% ⊗	≤ 21.1%	≤ 1.0%			Alert
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	69.5%	3.5% ↑	≥ 70.7% ⊗	≥ 80.0%	≥ 80.0%			Alert

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Delay to deliverables 1 – 5 all due by 30th September. Likely delay to deliverable 6 due 31st December.	Deliverables relating to; 1. Backlog reduction trajectory, to provide measurable milestones to reduce waits and demonstrate delivery against recovery plans. 2. Demand and capacity modelling to align capacity to current and future demand. To support with realistic planning, review and revision of recovery actions based on demand. 3. Validation and waiting list improvement approach, to Improve confidence in data and provides evidence for assurance reporting. 4. Governance, reporting and assurance framework to provide oversight, progress reporting and evidence that actions are delivered and assured.	➢ July DM01 actual s and trajectories reconciled by Trust and modality. Highest gaps are HuTH MRI +1259, HuTH NOUS+906 and NLaG MRI +632 soc week waiters above trajectory. **Funded capacity, workforce and start dates remain to be agreed.** ➢ Priority capacity gaps are identified. **Modelling must now confirm staffed sessions, equipment availability, achievable activity, cost and start dates** for HuTh MRI, HuTH NOUS, NLaG MRI, HuTH Audiology and NLaG DEXA. ➢ Performance baselines have been reconciled. **The validation SOP, named cohort owners, validation capacity and the exception dashboard are not yet evidenced as complete.** ➢ A six-slide Tier 1 performance pack now reports overall performance, monthly movement, pressure areas and actions. **Named postholders, weekly action closure and escalation thresholds must be confirmed.** ➢ **Workforce is a material delivery dependency.** Each priority modality must quantify funded establishment, vacancies, skill mix, temporary staffing, staffed sessions and the activity impact by 30 September.	✓ CDO to review the diagnostics actions and return to next oversight meeting with a corrected and assured action set, including clear ownership, delivery dates, dependencies and measures.

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5.2e Planned Care - RTT

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**RED 'MINIMIAL' ASSURANCE:** The plan records 34 August actions without completion evidence and 37 September actions as Not On Track. No confirmed work-stream lead handovers are recorded. KPI gaps also remain, including Power BI support needed to populate the full NOF position.	• Undertakings; 2.1 – 2.8 Ensure compliance with health care standards & recovery planning including assess senior clinical and operational leadership, operational culture. • Value Circle recommendations aligned to relevant deliverables.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
5	4	1	0	0	0	0

High-Level Risks

Risk	Mitigation	Score
None		

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
RTT - Difference between actual and planned 18 week performance	Aug-26	-1.9%	-2.4%						
RTT - Incomplete 18 Week Standard	Aug-26	56.5%	-0.8%	≥ 58.4%	≥ 65.3%	≥ 92.0%			Alert
RTT - Patients waiting 52+ weeks for Community Services	Aug-26	16.7%	0.7%						Alert
RTT - Percentage of 52+ Week Waits	Aug-26	3.9%	0.2%	≤ 3.7%	≤ 3.6%	≤ 1.0%			Alert

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Workstream delivery, leadership continuity and reporting capacity risk	The workstream plan records 34 August actions without completion evidence and 37 September actions reported as Not on Track, indicating a risk to delivery confidence and assurance. No confirmed workstream lead handover arrangements have been documented, creating a potential leadership and continuity risk. In addition, KPI reporting gaps remain, with insufficient BI/Power BI capacity currently available to support completion of the full reporting position.	➢ Oversight Group support is required to secure BI capacity for the workstream. ➢ Confirm succession and handover arrangements for the replacement Workstream Lead.	✓ Wider review regarding power BI resource and conversation with new Performance Director is required. This will be progress next month. ✓ Update provided from SRO on new governance arrangements, with handover arrangements now in place.

5.3 Care Group Recovery (access & performance)

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG		

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed

High-Level Risks

Risk	Mitigation	Score

NOF Key Performance Indicators

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Workstream is yet to be mobilised	The desired outcomes for this workstream require further definition and agreement.	➢ Is this still a required workstream in the IIP? ➢ Workstream Lead?	✓ Discussion and agreement that SRO would take the workstream forward with a discussion at Execs to start to formalise with New Director of Performance

5.4 Humber Acute Services (Operating Model)

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE:** Previous modelling assumptions that supported the ICB's Decision Making Business Case regarding length of stay reductions, the full benefits accruing to SDEC and integrated assessment, improved day case rates and admissions avoidance / frailty model benefits have not yet taken place.	N/A

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
6	5	0	0	0	1	0

High-Level Risks

Risk	Mitigation	Score
Because of the lack of progress that has been made on reducing length of stay, admissions avoidance, day case conversion and other efficiency metrics that were included in the HASR modelling assumptions, this could lead to insufficient beds being available in the right place to support new models of care, further cost pressures and no funding freed up for new service models / 7 day working. This could lead to the case not being optimally implemented and lack of progress on the poor performance and patient outcomes that HASR was intended to address.	• Further demand & capacity analysis and bed modelling prior to any further changes in service configuration. Unplanned Care Board (HHP) focussed on LoS and relaunch of expected standards in relation to timely review (Internal Professional Standards.) Perfect Week initiatives. Focus with partners on reducing NCTR bed days. Place Neighbourhood focus on admissions avoidance, particularly frail elderly population. Reporting through system UEC Board and Oversight Board with Council Senior officer, ICB Place Director and HHP Exec attendance. • The current score has been revised upwards further to discussion at Implementation Group, lack of progress in reducing the bed gap to support full implementation, and both sites regularly at escalation level 3 / 4.	16

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Planned benefits have not yet been realised.	Sustained growth in emergency admissions continues to increase bed demand and constrain implementation, particularly at DPoW. Trauma bed requirements and Respiratory delivery at SGH remain under review.	➢ For information	Nothing to note
Bed capacity and workforce constraints	Emergency admission growth has continued to exceed modelled assumptions over the past three years, resulting in higher bed occupancy than planned and reducing the capacity available to support programme implementation. In particular, limited bed availability at DPoW presents a significant constraint to delivering the full specialty reconfiguration programme without further investment. The bed capacity required to support Trauma consolidation remains under review. In addition, concerns remain regarding the viability of the proposed Respiratory model at SGH due to the dependency on General Medicine rota cover.	➢ For information	Nothing to note

5.5 Tertiary

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG		

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed

High-Level Risks

Risk	Mitigation	Score

NOF Key Performance Indicators

N/A

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Workstream is yet to be mobilised	The desired outcomes for this workstream require further definition and agreement.	➢ Is this still a required workstream in the IIP? ➢ Workstream Lead?	✓ Discussion and agreement that SRO would take the workstream forward.

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6.3 Staff Culture & Experience

NHS Humber Health Partnership

Assurance	Rationale for Current Assurance RAG	Does the workstream link to any statutory requirements or external recommendations?
Executive Sponsor RAG	**AMBER 'LIMITED' ASSURANCE**. The delivery plan is on track for timely completion, however, two of the risks to project delivery have increased from a score of 16 to 20 in the last week due to the outcome of the Carnell Farrah Report. This may impact on project delivery timelines. The main areas for concern are psychological safety, the delivery of the Civility Framework and capacity issues for specialists to deliver the project's targeted interventions	• Undertakings 3.4.1 – Deliver services on a financially sustainable basis taking into account: Alignment with local system service and sustainability plans and strategies including workforce. • CQC 29A theme 1 – You do not operate effective governance, performance and risk management processes to ensure the safe and effective delivery of care. • Value Circle & NPIP recommendations.

Total Deliverables	In progress/ on track	Off track / recoverable (within 1 month)	Off track / escalate	Complete	Not started	Evidenced and closed
7	1	0	0	0	6	0

High-Level Risks

Risk	Mitigation	Score
Impact of efficiency initiatives may negatively impact workforce fragility driver – i.e., staff transport cuts, recruitment freeze, headcount reductions, workload conflict, parking availability and charges.	• Successful and effective engagement with Unions, Networks and wider workforce. • The revised EQIA process should flag potential issues before projects are approved.	25
Impact of organisational change – structural changes, operating model changes, with additional cognitive load on individuals.	• Robust consultation process with adequate staff support systems in place such as coaching, counselling, mediation and training and development.	20
A lot of the deliverables have 'targeted intervention' however, there will be limited capacity in the Directorates delivering the targeted intervention	• Good prioritisation and triage process to ensure the right work gets done in the right order. • Effectively using support in NHSE and ICB. • Reach out to several areas at once – learning experiences could bring in range of people from several areas to ensure effective use of time. • Reviewing deadlines/timelines to maximise on team capacity and reduce duplication of work	16

NOF Key Performance Indicators

Metric	Period	Actual	Change MoM	Plan	EoY Target	National Target	Variation	Assurance	Status
Staff Sickness Absence Rate	Jul-26	4.8%	0.0%			≤ 4.0%			Alert
Staff Survey - Raising Concerns sub-score	Aug-26	6.1	0.0						Alert
Staff Turnover Annual FTE Rate	Aug-26	6.9%	-0.4%			≤ 8.0%			Assure
Healthcare Worker Flu Vaccination Rate	Apr-26	51.1%	-0.3%			≥ 60.0%			Alert

ALERT: Alert to matters that require the IIP Oversight Group attention or action

Issue	Detail	Key Decision/Support Required or Relevant Information	Agreed Outcome
Workforce capacity and wellbeing risks arising from the scale of organisational change.	The scale of organisational change has dramatically increased following the Carnell Farrer review and this will cause additional cognitive load on individuals. It will almost certainly have a negative impact on workforce, particularly mid-level management including adverse consequences on morale, sickness, staff survey, etc.	➢ Note the workforce risks associated with the scale of change. ➢ Support the implementation of appropriate workforce and wellbeing mitigations. ➢ Ensure ongoing monitoring of workforce indicators and impacts on improvement delivery.	✓ Item deferred to the next meeting due to time constraints.

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Provider Regulatory Undertakings

NHS Humber Health Partnership

1 Board Governance

1.1 – Apply principles, systems and standards of good corporate governance.

1.2 – Review board leadership and governance arrangements.

1.3 – Develop an action plan in response to the findings and recommendations for the review set out in 1.2.

2 Operational Recovery

2.1 – Ensure compliance with health care standards including those set out in operational and strategic planning guidance.

2.2 – Co-operate and work with any improvement directors and colleagues supporting approved by NHSE in support of action outlined in 2.1.

2.3 – Submit a recovery plan setting out the steps it will take to achieve the actions outlined in 2.1.

2.4 – The Recovery Plan must assess senior clinical and operational leadership, operational culture (including the normalisation of emergency department overcrowding), and the required actions.

2.5 – The Recovery Plan must specify timescales for completion of identified actions.

2.6 – Periodically review and revise the Recovery Plan as required to ensure deliverability and alignment with section 2.1, subject to NHSE approval.

2.7 – Deliver the Recovery Plan in accordance with the timescales specified in the Recovery Plan.

2.8 – Provide a report demonstrating how the board is assured that the objectives in 2.1 have been met

3 Financial Recovery

3.1 – Take all reasonable steps to ensure it is applying systems and/or processes to ensure compliance with its duty to operate efficiently, economically and effectively.

3.2 – Submit a Financial Recovery Plan to NHSE setting out actions to deliver the objectives in section 3.1, including optimising financial delivery in 2526, aligning sustainability plans with wider recovery actions, and specifying timescales for delivery.

3.3 – Take all reasonable steps to improve its financial position and minimise its external funding requirements both within the 25/26 financial year and on a recurrent basis.

3.4 – Deliver services on a financially sustainable basis taking into account

- **3.4.1** – Alignment with local system service and sustainability plans and strategies including workforce.
- **3.4.2** – Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

4 Funding conditions and spending approvals

4.1 – Where interim support financing or planned term support financing is provided, comply with any terms and conditions which attach to the financing.

4.2 – Comply with any reporting requests made by NHSE in relation to any financing.

4.3 – Comply with any spending approvals processes that are deemed necessary by NHSE.

5 Delivery of undertakings

5.1. – Implement sufficient governance arrangements to enable delivery of these undertakings. Such governance arrangements must enable the board to:

- **5.1.1** – Obtain clear oversight over the process in delivering these undertakings;
- **5.1.2** – Obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
- **5.1.3** – Hold individuals to account for the delivery of the undertakings.

6 Meetings and reports

6.1 – Attend meetings or, if NHSE stipulates, conference or on-line calls, at such times and places, and with such attendees, as may be required by NHSE.

6.2 – Provide reports in relation to the matters covered by these undertakings as NHSE may require.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)239

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Friday 9 October 2026
Director Lead	Hilda Gwilliams – Group Chief Patient Safety Officer Jo Ledger – Interim Group Chief Nurse Peter 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 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: **Alert** • Infection control alert organisms monthly update with threshold trajectory data. • There has been a Never Event in August 2026, with a intervention procedure on the wrong patient. Immediate Response Meeting held. **Advise** • Patient safety incidents reported from August 2026 • Inquests and Regulation 28 Prevention of future deaths letters update ○ No new Regulation 28 reports. • Patient Experience contacts from August 2026 and improvement plans **Assure** • Current workstreams for Patient Safety Incident Response Framework (PSIRF) learning responses and Patient Safety Incident Investigation (PSII) tracking. • Safer Surgery National Safety Standards for Invasive Procedures (NatSSIPS) audit engagement and reliability improvement. • Learning from experience examples demonstrate outcomes from investigations. **Recommendation** The committee is asked to take assurance from the processes outlined the content of the report.
Background Information and/or Supporting	This is a monthly summary report that builds on some previously reported information, providing updates to the data and

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)238

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	9 October 2026
Director Lead	Lyn Simpson, 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 for the period of September. The items are published from:
	• NHS England (NHSE)
	  ○ Implementation of Martha's Rule in Emergency Departments
	  ○ Unauthorised Access to Confidential Patient Information — Guidance
	• Department of Health and Social Care (DHSC)
	  ○ No items
	• Health Services Safety Investigations Body (HSSIB)
	  ○ Response to the Thirlwall Inquiry Report
	  ○ Mental Health Crisis Care: Patients in Emergency Departments — Investigation Report
	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:

Source	Date	Title & Link	Brief Synopsis	Lead officer
NHS England	21 Sep	**Implementation of Martha's Rule in Emergency Departments** https://www.england.nhs.uk/long-read/implementation-of-marthas-rule-in-emergency-departments/	Mandatory phased rollout to all EDs by Mar 2028. 24/7 independent clinical review route for patients/families/staff concerned about deterioration. Funded programme.	Mr Sedman, Deputy Group Chief Medical Officer
NHS England	25 Sep	**Unauthorised Access to Confidential Patient Information — Guidance** https://www.england.nhs.uk/long-read/unauthorised-inappropriate-and-unjustifiable-access-to-confidential-patient-information/	Zero-tolerance: unauthorised access = gross misconduct. Sets disciplinary framework aligned with Acas Code.	Alasdair Pickering, Group Chief Information Officer
HSSIB	15 Sep	**Response to the Thirlwall Inquiry Report** https://hssib.rkhdigital.com/news-events-blog/response-to-the-publication-of-the-thirlwall-inquiry-report/	Endorses inquiry findings; emphasises listening to concerns, safeguarding culture & effective investigation as system-wide priorities.	Jo Ledger, Interim Group Chief Nurse
HSSIB	16 Sep	**Mental Health Crisis Care: Patients in Emergency Departments — Investigation Report** https://www.hssib.org.uk/patient-safety-investigations/safety-issues-for-people-experiencing-a-mental-health-crisis-who-come-into-contact-with-urgent-and-emergency-care-services/investigation-1-report-2-of-2/	Finds EDs are unsuitable default settings for mental health crises — prolonged waits, poor environments, insufficient dedicated space/staffing. Recommends national standards & expanded community crisis alternatives.	Sam Peate, Group Chief Delivery Officer

Document(s) (if applicable)	workstreams being applied to manage issues and risks.
Prior Approval Process	**None**
Financial Implication(s) (if applicable)	**None directly**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**None directly**
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below

Patient Safety Report, August 2026

This report contains data from the reporting period of August 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. HUTH has had an increased rate of reporting which was previously reported and now returned to with the upper and lower control limits.

- Distribution of harm levels

The harm rates are distributed in a similar respect with greater no harm and near miss reporting than incidents with harm, and a smaller proportion of moderate and greater harm rates.

- 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, or the duty of care of our services. These incidents are recorded as no harm from a reporting perspective. Falls in the hospitals and Pressure Ulcers in Hospital and North Lincolnshire Community team continue to be the most frequently reported patient safety incidents. Moderate harm rates are a greater proportion in NLAG due to community pressure ulcer cases with the North Lincolnshire team.

Figure 1 – Patient Safety Incident Overview Dashboards

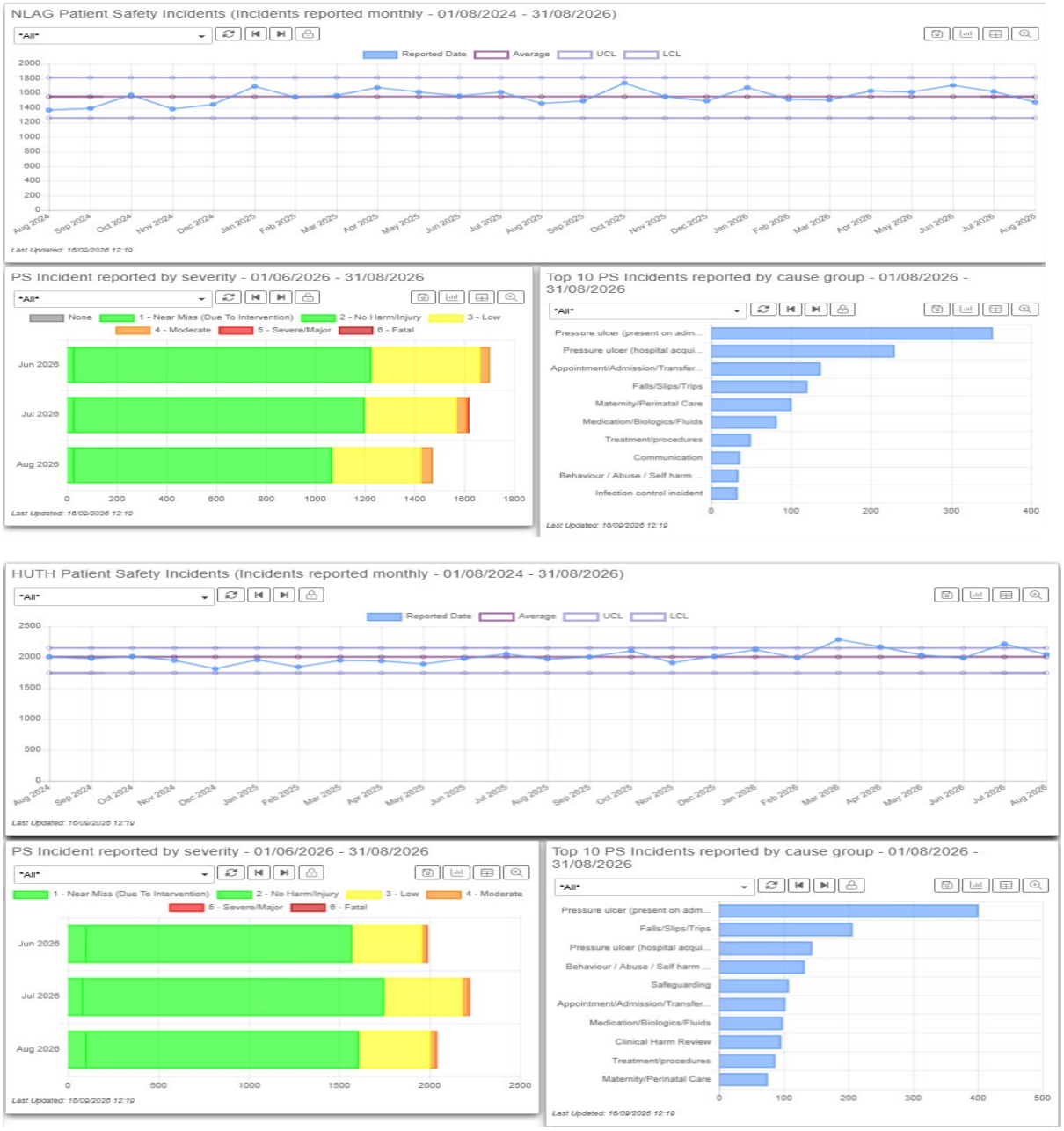


Figure 2: Patient Safety incidents with moderate or greater severity grading by Group and Trust.

Reported in August 2026	NLAG	HUTH	HHP
Fatal	0	3	3
Severe/Major	1	3	4
Moderate	46	33	79
Total	**47**	**39**	**86**

All 86 cases are under review by care group Nurse Directors and through relevant reporting routes of the Falls Group, Pressure Ulcer review groups and the Weekly Learning Response Panel.

Section 2: Infection Prevention Control (IPC)

Context

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

Quality and Safety Performance

The Partnership currently reports separately both HUTH and NLAG position, relating to the reporting of mandatory organisms (Health care associated infections (HCAIs)). The tables below report the current position for both HUTH and NLAG, using the thresholds set nationally. The NHS Outcomes framework for Q1 2026/27 shows NLAG and HUTH in quartile 4 for the safety domain overall. HUTH is quartile 3 for C.difficile, and quartile 2 for E.coli. NLAG is in quartile 4 for both C.difficile and E.coli.

Figure 3: HUTH current HCAI figures

HUTH Mandatory Reportable Organisms	FY 2025/26 Thresholds	FY 2025/26 Performance end of August	FY 2026/27 Thresholds	FY 2026/27 Performance end of August	Trust performance against previous year
C. Difficile	61	38	61	48	Deteriorated
E. Coli	203	109	192	90	Improved
P. aeruginosa	30	11	26	11	Equal
Klebsiella spp.	72	32	69	30	Improved
MRSA Bacteraemia	0	3	0	0	Improved
MSSA Bacteraemia	No Threshold	34	No Threshold	29	Improved

Figure 4: NLAG Current HCAI figures

NLaG Mandatory Reportable Organisms	FY 2025/26 Thresholds	FY 2025/26 Performance end of August	FY 2026/27 Thresholds	FY 2026/27 Performance end of August	Trust performance against previous year
C. Difficile	16	16	18	23	Deteriorated
E. Coli	57	32	57	30	Improved
P. aeruginosa	5	8	5	7	Improved
Klebsiella spp.	34	16	34	8	Improved
MRSA Bacteraemia	0	1	0	1	Equal
MSSA Bacteraemia	No Threshold	12	No Threshold	10	Improved

IPC improvement plans are part of the Quality Priorities workstreams, that also feed into the integrated improvement plan, which is now established and good progress has been made in supporting delivery including a series of interventions. The IPC update reports provide more specific details of these improvement plans, oversight and enhance surveillance.

Section 3: 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 115 patient safety learning responses in progress, reduced from 141 two months ago. 45 Patient Safety Incident Investigations (PSII) and 70 proportionate learning responses (After Action Review and MDT Reviews). A breakdown by Trust is captured below. The red marker on the tables is the demarcation line for targeting completion in 6 months for PSII and Proportionate learning response recovery, with PSIRF guidance advising complexity may require longer time to complete for PSII cases.

PSII Position NLAG

For the reporting period up to the end of August, there are 14 open PSII cases. There is progress across many of the investigations within our control:

- 2 cases are externally investigated by the Maternity and Newborn Safety Investigations (MNSI) Team hosted by the Care Quality Commission (CQC).
- 1 case is on hold due to a police force investigation, allergic reaction to penicillin from 2023.
- Of the remaining 11 cases:
  - 3 PSII reports are the final report stage with family engagement
  - 4 reports are being quality checked before presenting to the PSIRF Oversight Group to approve.
  - This leaves 4 cases being investigated and compiling reports, three of these being over 6 months.
- There are no cases declared in August 2026.

Figure 5: PSII open casework

NLAG PSII	2023	2024	2025							2026		Grand Total
	Oct	Nov	May	Jul	Aug	Sep	Oct	Nov	Dec	Mar	Apr	
Grand Total	1*	1	2	2	1	1	2	1**	1	1	1**	14

*Footnote: * Police investigation, **MNSI cases.*

Proportional Learning Response Position NLAG

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

The below table summarises the position at the end of July 2026, in relation to the total number of open Proportional Learning Responses is 22, with 5 cases in the quality checking process for completion. 6 reports are being written and 11 cases in progress. There are a reducing number of long standing proportionate response remaining open with 7 closed since the last reporting cycle.

Figure 6: Proportional Learning Responses

NLAG Proportional Learning Response stages in process	2025		2026								Grand Total
	Sep	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Assurance				1		1		1			3
PSIRF Oversight	1				1						2
Report		1			1	1	1	2			6
Review			1		1	1		2	4	2	11
Grand Total	1	1	1	1	3	3	1	5	4	2	22

PSII Position HUTH

There is a gradual reduction in the number of open PSII cases over recent months, with more PSII's closed than declared.

- For the reporting period up to the end of May, there are 31 open PSII cases with 3 of these being externally investigated by MNSI.
- 3 cases are going through draft report engagement with patients and their families.
- 11 PSII reports are at various stages of sign off through the Report QA process.
- 3 PSIIs have been completed over the past month, with 2 cases declared in August.
- 13 cases are under active investigation.

Figure 7: HUTH PSII open casework

	2024	2025							2026					Grand Total
HUTH PSII	Nov	Mar	Apr	Jun	Jul	Sep	Nov	Dec	Feb	Apr	Jun	Jul	Aug	
Grand total	1	2	3	3	1	2	1	1	3	4*	5*	1	2*	28

*Footnote: * MNSI case in each month shown.*

Proportional Learning Response Position

The below table summarises the current position as of July 2026, in relation to the total number of open Proportional Learning Responses is 50, with 3 cases completed in the previous month (one PSIRF Oversight meeting was postponed), 13 cases in the quality checking and sign off process.

Figure 8 - HUTH Proportional Learning Responses

HUTH Proportional Learning Responses stages in process	2024	2025								2026							Grand Total
	Dec	Feb	May	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	May	Jun	Jul	Aug	
In progress	0	1	2	3	1	1		1	1	3	2	2	1	4	6	9	37
Sign off process	1	0	1	1	0	2	1	1	0	0	1	2	1	1	1	0	13
Grand total	1	1	3	4	1	3	1	2	1	3	3	4	2	5	7	9	50

Section 4: 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 Improvement Plan

As a result of the poor performance related to the volume of Never Events across the Partnership since its inception through to quarter 3 in 2025/26, significant improvements were identified as high priority and incorporated in the co-designed integrated improvement plan (IIP).

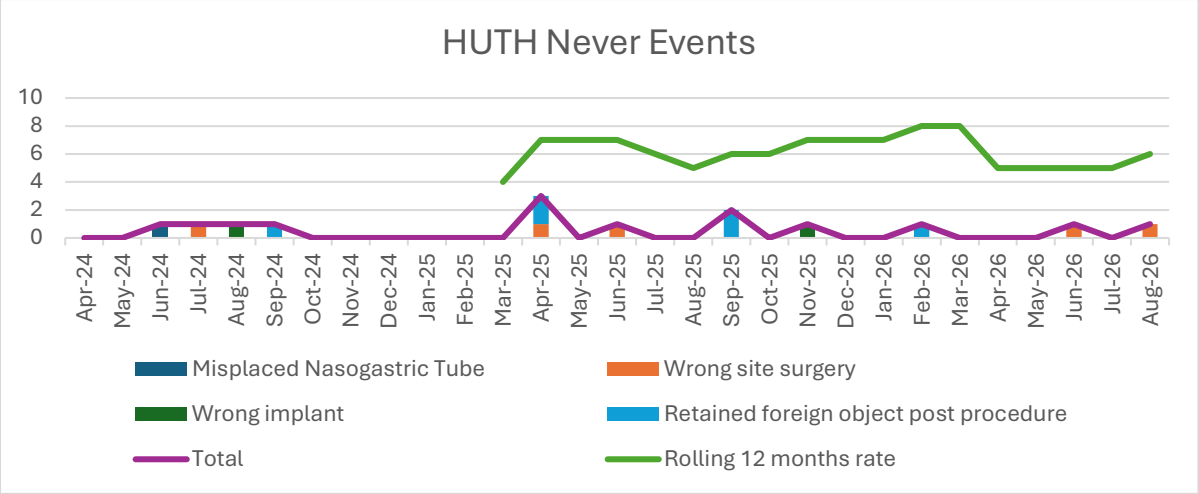
The improvements journey included 2 phases with phase 1 specifically focused on the Theatre, Anaesthetics and Critical Care (TACC) Care Group as circa 70% of all Never Events occurred in this environment. In September 2026, phase 2 has been implemented for all areas undertaking invasive procedures outside of the TACC Care Group with a quality summit scheduled in month.

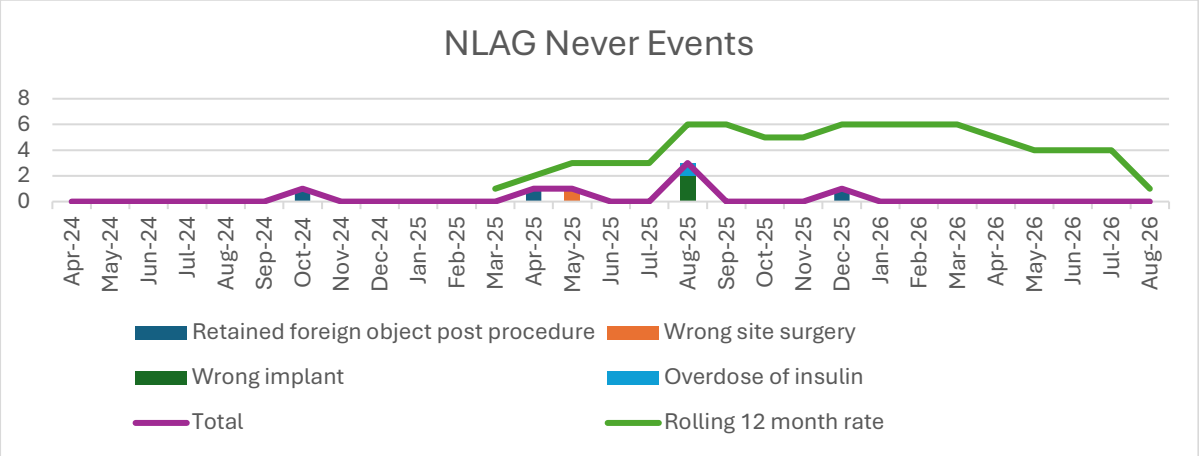
Never Event Position

There were no cases declared in August 2026, however an incident from 31st August 2026 was reported and a wrong site surgery (lumbar puncture) was performed on the incorrect patient. An immediate response meeting has been held and a further proportionate learning response using after action review is to be completed. No significant harm has been identified. Immediate learning identified that a patient identity confirmation was completed based on the verbal handover. However, in line with the local safety checklist, there was a failure to confirm the procedure against the correct patient. The confusion arose through handover between shifts on required clinical interventions. This case is the second Never Event at HUTH in this financial year, following the case reported in June 2026.

The charts below provide an overview of the reduced frequency of Never Events in NLAG and improvement, with the 12 month rolling rate. HUTH has a reduction, when considering the case reported in February 2026 originated in 2023.

Figure 9 – Never Event charts





Safer Surgery Audits continue with monthly reporting with team leaders in theatres across the group. The documentation audits are identifying issues in completion of checklists during ward to theatre transfers and this is being fed back to the relevant services.

Figure 10 – Safer Surgery Audit results in March to August 2026

Audit overview

Audit	Frequency	Compliance over last 6 periods					
(HHP) Invasive Procedure Safety Checklist DOCUMENTATION Audit (NatSSIPs2)	M	87.5%	92.4%	88.9%	89.7%	92.8%	90.9%
(HHP) Invasive Procedure Safety Checklist OBSERVATION Audit (NatSSIPs2)	M	99.7%	99.8%	99.7%	99.4%	99.5%	99.7%
(HHP) Safer Surgery List Brief Audit (NatSSIPs2)	M	96.2%	95.1%	95.6%	95.3%	94.6%	96.6%
(HHP) Safer Surgery List Debrief Audit (NatSSIPs2)	M	97.8%	97.3%	96.9%	98.4%	95.9%	98.4%
(HHP) STOP before you block audit (NatSSIPs2)	M	100.0%	99.4%	99.0%	100.0%	98.9%	99.7%

Further detailed reports, with site breakdown have been presented at the Clinical Effectiveness Group and shared with TACC care group for remedy. Documentation issues predominantly feature in the ward to theatre checking processes.

Improvement actions include:

- A series of safety summits commenced on 8 May 2026 supporting

improvements in patient safety and culture for TACC care group, covering Digestive Diseases and Families care groups so far.
- A Surgical Safety series of engagement sessions are planned throughout 2026, including professional standards setting.
- Implementation of the NatSSIPS2 theatre checklists for south bank is being supported with training and group wide audit of processes, checking documentation and direct observation.
- The learning from 2 completed investigations is also included in section 7 of this report.

Section 5: 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 no Regulation 28 Letters issued in August 2026.

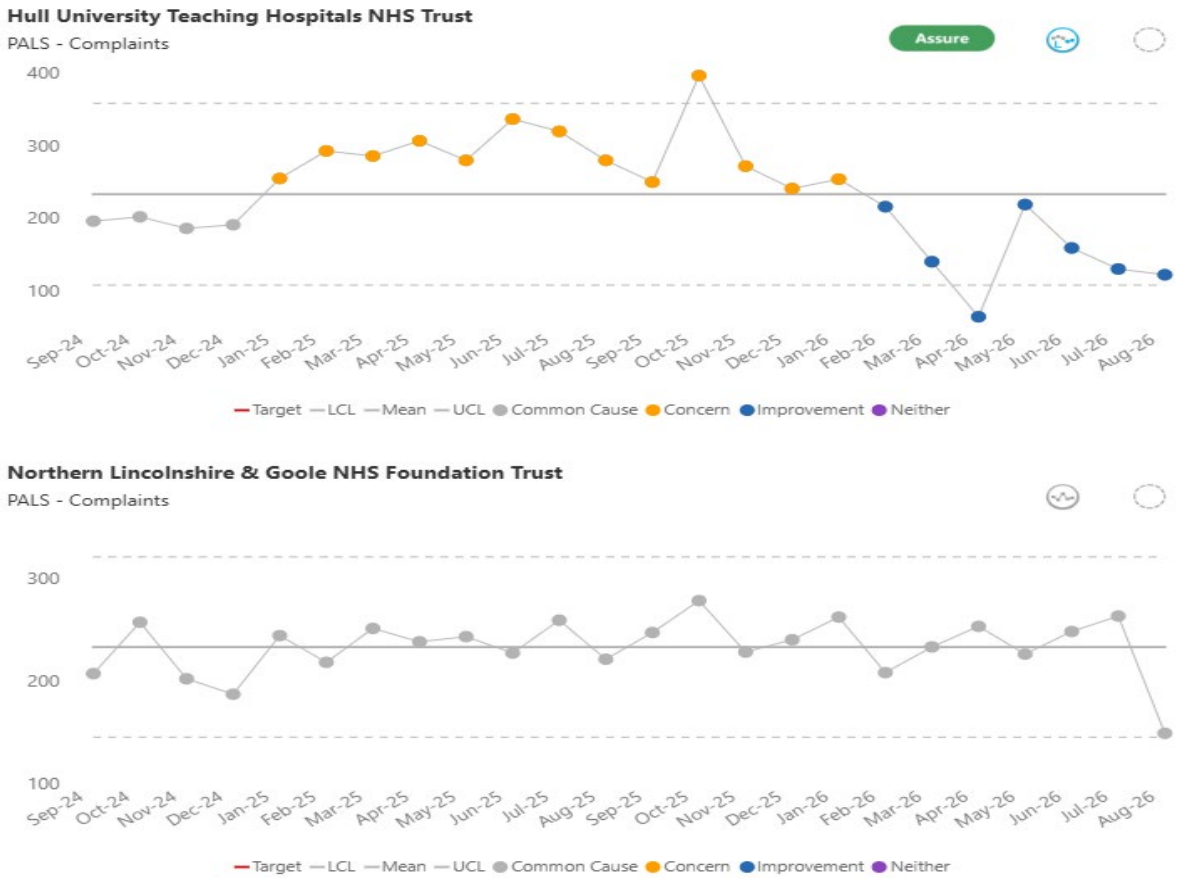
Section 6 - Patient Experience, Patient Advice Liaison Service (PALs) and Complaints

The learning from harm Patient Experience, PALs and Complaint Section provides an update across the Group. Work is being undertaken to note the changes over time with themes and trends and any harms that are found and reviewed via the

PALs and complaints route. In addition, the Patient Experience team collect feedback via compliments, Friends and Family Tests and other annual report, this information is provided in Quarterly Patient Experience reports.

The charts below show the PALS contacts by month. NLAG shows common cause variation, and HUTH showing a reduction from the mean for the last 7 data points.

Figure 11 PALs cases logged



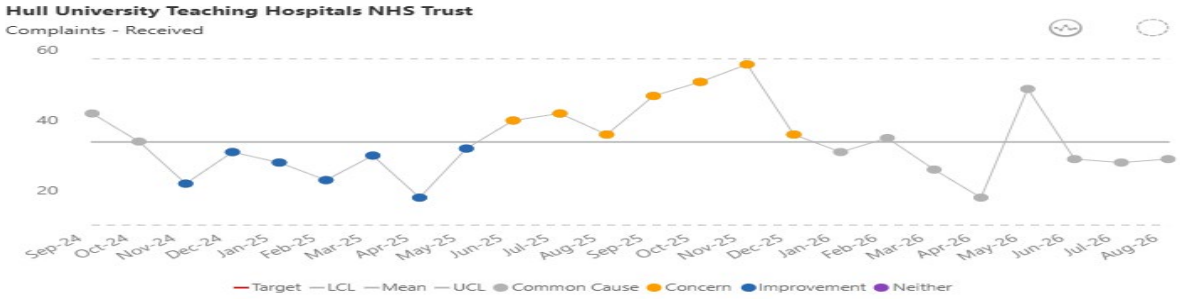
Responding to PALS contacts is at 27.3% within 10 days at HUTH and 54.7% at NLAG.

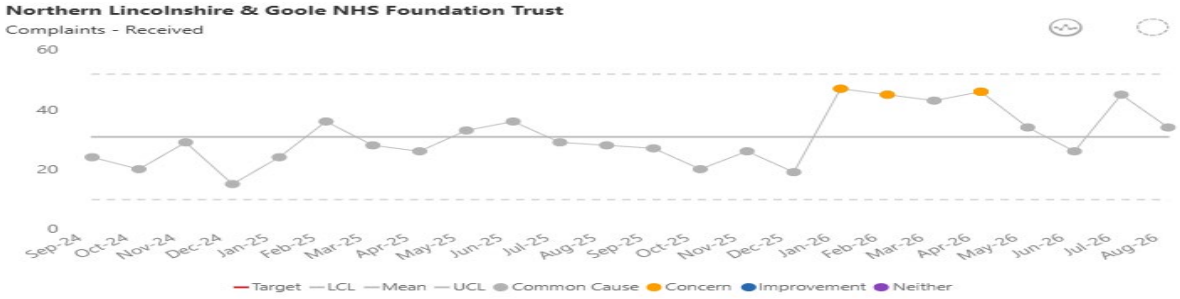
<u>HHP PALS Themes and Learning</u>

- Communication
- Delays (including OPA, wait times & cancellations)
- Clinical Care
- Nursing Care
- Staff Attitude

<u>Complaints</u>

Figure 12: Complaints received and Response performance





Complaint response with 60 days remains under the target for completion time at 57-69%.

There are ongoing activities to learn from patient experience and improve, as well as improve the timeliness of responses to complainants.

HHP Complaints Themes and Learning

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

Section 7: Learning from experience safety actions

Summarised examples of finalised PSII cases are provided below:

PSII Report 329607 - (Retained Guidewire Never Event)

Case summary:
A critically ill patient undergoing central venous catheter (CVC) insertion during an overdose admission had a guidewire unintentionally retained during the procedure. The retained guidewire was visible on a chest x-ray but was not acted upon promptly due to failures in handover, delayed review of imaging, and ineffective escalation of abnormal radiology findings. The guidewire was identified and removed the following day without lasting patient harm.

Key safety findings

- Guidewire was not kept under continuous control during CVC insertion.
- No detailed SOP existed for clinicians routinely performing CVC insertion.
- Outstanding chest x-ray was not effectively handed over during transfer of care.
- Abnormal radiology findings were sent to a generic mailbox that was not monitored.
- Required procedural documentation and checklist were not completed.

Key safety actions

- Audit compliance with the new CVAD checklist.
- Introduce a robust escalation process for abnormal radiology findings.
- Share learning regarding retained guidewires as a Never Event.
- Develop and implement a standardised CVC insertion SOP.

PSII 2024 8498 (Aspiration Pneumonia and Feeding Management)

Case summary

A patient with learning disability, autism, previous stroke and deteriorating neurological condition developed aspiration pneumonia during a prolonged admission. Multiple swallow assessments could not be completed because of reduced responsiveness. Unapproved feeding and medication administration devices were used, and NG feeding was delayed. The patient's condition deteriorated despite treatment and he subsequently died, with aspiration pneumonia and stroke recorded as the causes of death.

Key safety findings

- Swallow assessment was never successfully completed.
- SLT concerns were documented but not verbally escalated to the medical team.
- Improvised feeding and medication devices were used outside approved practice.
- Medication administration and drug policies were not consistently followed.
- Mental capacity assessments and covert medication processes were incomplete.
- Learning disability support and MDT involvement were delayed and inconsistent.

Key safety actions

- Develop guidance for assessing patients unable to participate in swallow assessments.
- Introduce a therapy escalation SOP when assessments cannot be completed.
- Improve awareness and use of NEWT medication guidance.

- Deliver pharmacy-led training on medicines administration for patients with swallowing difficulties.
- Implement a Mental Capacity Act quality improvement programme and audit process.
- Improve learning disability and autism training and strengthen specialist team involvement.

PSII 2025 1878 (Anticoagulation Decision-Making Following New AF)

Case summary

A patient developed new atrial fibrillation during admission. Due to significant bleeding risk, impaired renal function and patient preference, long-term anticoagulation was deferred for GP review following discharge. Before anticoagulation was commenced, the patient suffered a stroke and pulmonary embolism and subsequently died. The investigation concluded that the evidence did not support a finding that discharge without anticoagulation directly caused the patient's death because of the complexity of the clinical circumstances and competing risks.

Key safety findings

- Anticoagulation decisions required complex balancing of stroke and bleeding risks.
- Patient preference appropriately informed decision-making.
- Documentation of risks, benefits and treatment decisions was insufficient.
- Reliance on post-discharge GP review may not always be achievable within intended timescales.

Key safety actions

- Update the anticoagulation patient decision aid leaflet.
- Reinforce documentation standards for complex shared decision-making.
- Share learning through Frailty governance processes.
- Improve consideration of whether post-discharge review timelines are realistically achievable.

Section 8: Summary

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

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

ADVISE, ALERT and ASSURE REPORT	
Meeting	Quality and Safety Committees-in-Common
Meeting date	24 September 2026
Chair	David Sulch, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Mandatory Training Compliance and Medical Engagement	Concerns were raised across multiple reports regarding declining mandatory training compliance, particularly within medical staff groups. Committee members noted that this issue appeared repeatedly in maternity, children and young people, and safeguarding discussions.	Concerns were linked to ongoing job planning challenges and lack of an agreed joint Job Planning Policy.	The Committee agreed this should be highlighted as a standalone Board escalation	

IPC Annual Report and current position	Controls are not yet consistently safe across all sites and there was continuing concerns about healthcare-associated infections, estate constraints, antimicrobial use, workforce capacity and audit assurance. Governance, digital surveillance, outbreak control, policy alignment and patient information have improved, but C Difficile and bloodstream-infection performance remains concerning. HUTH recorded 107 cases of C Difficile against a threshold of 61 and NLAG 33 against a threshold of 18. Eighty-one IPC audits became overdue due to workforce capacity. Sustainable capacity and target investment was required.		The Boards are asked to: • Endorse one measurable HHP IPC Improvement Programme • Ensure Board to ward engagement and ownership • Set expectations for Care Groups • Support targeted investment • Build winter resilience early	
Quality Priorities	The CiC agreed that sepsis remains a persistent quality concern, with delays in	The sepsis SHMI for HUTH had improved from 1.36 to 1.30, while	Consideration is being given to a dedicated clinical sepsis lead who would sit outside of	

	recognition, prescribing and antibiotic administration linked to digital systems, vascular access, workforce pressures, inconsistent coding and gaps in training. Concerns were raised with under-coding and over diagnosing sepsis which meant that interpretation of performance was challenging. Electronic prescribing (prescribers moving on without effective handover) and vascular access delays also impact on performance. The CiC also discussed preventing deconditioning and the team is developing ward-level KPIs and a care bundle while avoiding duplication of existing assessments. Safer Surgery: There had been two Never Events during the year. NatSSIPs rollout and regular audits showed more than 90%	NLAG remained broadly static.	the IPC Team. Digital priorities for safety to be added to the Board Development programme.	

	compliance and training was commencing through the TACC Group.			
Never Event Prevention and Invasive Procedures	It was reported that the second phase of the Never Event Programme extended theatre learning and safety checks to invasive procedures across wards, emergency care, intensive care and outpatient areas. The CiC were given confirmation that consequences and accountability processes were being developed and this would start with a review of training and support, before escalation where repeated non-compliance is documented.	Phase two covers invasive procedures outside theatres, including ED, ITU and outpatient areas. Existing LOCSIPS tools will be reviewed and strengthened using lessons from the theatre programme with clearer education, documentation and verification requirements.	Concerns raised regarding organisational distractions. Attention to surgical safety must not be reduced. October Safety Summit with Care Group leaders will ensure that comparable arrangements can be implemented in other procedural areas.	
Maternity and neonates	Concerns raised regarding: • the risk of not meeting element 3 of Saving Babies' Lives care bundle with regards to rediced scan capacity for those attending with RRFM (Pan Group). • Caesarean Section		Training compliance is generally acceptable, but doctors' attendance remains an issue.	

	capacity at HUTH – agreement now in place for additional lists until November to facilitate progression of business case and maintain safety • Gap in MNVP function since 31/07/2026 – work continues to devise and interim solution			
Martha's Rule, 10 Point Plan Submission	The submission of compliance against each of the points was reviewed by the CiC which included incident response, homebirth review, triage audit, and the mortuary assurance statement.	The most significant gaps included documented dual executive accountability, inequalities data, neonatal workforce alignment with the standards, elements of the maternal care bundle, anesthetic and triage arrangements and completion of a resource deployment review.	The CiC approved (on behalf of the Board) the compliance levels for submission to NHS England.	
Children and Young People	Workforce gaps, a fragile Hospital@Home service and a priority paediatric sepsis concern were raised. A risk was raised relating to the reporting mechanism for	The CiC commended the team on their Duty of Candour compliance.	There are significant workforce gaps against the RCN 2025 Workforce Standards. Substantial workforce investment or service redesign is required.	

	Sepsis at NLAG sites where limitations in digital infrastructure, variation in systems and lack of automated reporting continues to impact on the ability to provide comprehensive sepsis performance data.		Hospital@Home Service is currently suspended on the DPOW site and is fragile on the SGH site. Mandatory training compliance has deteriorated across the Group.	
Safeguarding	The AGNI ruling changes the interpretation of deprivation of liberty and increases the importance of robust mental capacity assessments, best interest decisions, restraint documentation and care planning.		A Group-wide action plan is being developed to cover policy, pathways, governance documentation, training and communications, pending updated DoH guidance. An updated paper will be presented at the Boards in October 2026. Safeguarding training and supervision compliance is being monitored through the Safeguarding Board. Recovery plans are being scrutinised at the Nursing and Midwifery Committee.	
CQC Improvement Plan and warning notices	The Section 29A gap analysis was now complete and actions had been included in the IIP with named owners and delivery timescales.	The CQC Well-Led reports were expected in mid to late October 2026. A pragmatic approach was being	The CiC agreed that the next meeting should focus specifically on the Section 29A requirements to give clearer assurance on	

		taken regarding the new organisational changes and the relevance of the actions against each Trust.	delivery against the warning notices.	
Learning from deaths	SHMI and HSMR positions across the Group were favourable and there was improved SJR oversight.	There had been two Regulation 28 cases involving sepsis and a fall. The cases were currently being investigated.	Clarity was required as to how Urgent Treatment Centres recognise and route patients meeting sepsis criteria.	
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Integrated Performance Report	The IPR remains under development because data sources do not yet align consistently and the current report contains excessive alerts and repetition.		The metrics to be refined before further use at the Committees and the Board.	
Triangulate Themes Report incidents, legal, complaints and PALs.	The report brings together themes from incidents, legal matters, complaints and PALS. It identifies learning and outcomes within each source, and consolidates group-wide themes for action		The CiC supported the shared priorities and learning across the Group and suggested this continued after the dis-establishment of the Group.	

	through the IIP.			
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Quality				
Putting Patients First	The accreditation pilot overed 23 inpatient wards and received positive staff feedback, with teams preferring a supported improvement journey to historical unannounced visits. Subject matter expert audits have resumed across nutrition, falls, tissue viability and IPC, although monitoring of resulting actions still needs strengthening.	The improvement programmed will drive quality improvements at ward level and will be monitored through Care Group governance.	The CiC approved moving from a manual spreadsheet to the bespoke Audit R digital platform to strengthen assurance and reporting.	

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)241

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Friday 9 October 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	Maternity 10-point plan & Triage Submission
Executive Summary	The Maternity 10-point plan & Triage Submissions for HUTH and NLAG were approved at the Quality & Safety Committees in Common on 24/09/26 prior to submission on 25/09/26
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built arou existing governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on t submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will rev returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not availab Evidence may support more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:	Hull University Teaching Hospitals
Report prepared by:	Yvonne McGrath
Report date:	9/16/2026
Reporting period covered:	Baseline

Baseline Assessment		
Key Metrics		
Total deliverables		**26**
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	**1**	0	0	0	1
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	**3**	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	1	1	0
5. Addressing inequalities in maternity and neonatal outcomes	**3**	0	1	2	0
6. Ensuring 24/7 safety and responsiveness of services	**7**	0	1	4	2
7. Trust review of homebirth services	**2**	0	0	0	2
8. Responding to incidents, complaints and concerns with humanity and candour	**3**	0	0	0	3
9. Deliver safe and effective triage in maternity services	**3**	0	0	1	2
10. Post death care	**2**	0	0	0	2

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.*
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Compliant			Task and Finish Group commenced on the 14th of September 2026 for both Maternity and Neonates.	The Trust will need to continue to progress against the agreed national timescales to remain complaint. Key Stakeholders attended this meeting on the 14/09/26, minutes not yet available at time of completion of the reporting
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						#
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-02 Audit Programme	MNVP currently not operational, limiting independent co-production and challenge. FFT response rates remain variable and may not be representative of all service user groups. Limited triangulation of experience data across maternity and neonatal pathways. Limited assurance that seldom-heard groups are proportionately represented within feedback.	Re-establish substantive MNVP arrangements and agree interim engagement model. Implement targeted engagement for women from ethnically diverse communities and areas of deprivation. Introduce specialty-level FFT reporting and trends analysis. Develop integrated maternity and neonatal patient experience dashboard.	
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-09 Minutes of Trust Board Meetings EV-08 Neonatal Governance highlight reports and minutes EV-21 - Maternity Governance highlight reports and minutes	Limited visibility of action completion and impact following board discussion. Inconsistent reporting of patient experience, outcomes and safety themes within a single integrated report.	Introduce action tracking and impact monitoring arising from Board scrutiny. Develop exception reporting framework for escalation of emerging concerns.	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-03 Savings Babies Lives Quarterly Report and Element Reports EV-04 Quarterly Theming Reports EV-05 Monthly SPC underpinned dashboards for stillbirths and neonatal deaths EV-06 Quarterly PMRT Reports EV-07 Deep Dives EV-09 Minutes of Trust Board Meetings	Neonatal ethnicity and deprivation analysis not fully embedded. Limited reporting of outcomes by protected characteristic across all pathways. Some datasets remain incomplete due to coding and data quality limitations.	Incorporate equity dashboard metrics into monthly assurance reporting. Expand outcome reporting by ethnicity, deprivation, language needs and protected characteristics. Complete data quality review and implement improvement plan for demographic recording.	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Non-compliant		No formally agreed governance framework defining shared accountability between Medical Director and Chief Nurse for maternity and neonatal services. Executive oversight arrangements not yet explicitly documented within Trust governance structures.	Develop formal statement of joint accountability endorsed by the Board. Update governance framework and committee Terms of Reference. Include maternity and neonatal delivery, safety and workforce metrics within executive performance oversight.	
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV-09 Minutes of Trust Board Meetings	Currently only the Director of Midwifery attends Trust Board routinely	Formalise attendance for expectations for Director of Midwifery, Clinical Directors Obsterics and Neonates and Neonatal Nurse Director within governance processes.	
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant		Programme onboarding still underway. Release arrangements and completion trajectory not yet fully established across all professional groups.	Develop implementation plan with tracked completion rates. Ensure participation includes medical, midwifery, neonatal nursing and support workforce.	
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-05 Monthly SPC underpined dashboards, including stillbirths and neonatal deaths and pre-term birth rates EV-01 Maternity & Neonatal Assurance Report EV-09 Minutes of Trust Board Meetings	Variable availability of neonatal inequalities data. Limited routine reporting of outcomes by ethnicity, deprivation and language needs. Population-health intelligence not yet fully integrated into service redesign processes.	Implement six-monthly inequalities deep dive. Complete review of interpreter utilisation. Use equity intelligence to inform service improvement priorities, including preterm birth and maternal morbidity reduction work.	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Non-compliant	EV-01 Maternity and Neonatal Assurance Reports	Implementation plan not yet formally approved.	Present implementation plan to Quality Committee and Board in October and Novemeber respectively Establish quarterly reporting cycle with milestone tracking.	
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-10 Audit of Consultant Attendance and AMaT report EV-22 - Obstetrician job plans			
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Partially compliant		Audit is currently being completed - no agency bookingsoccured from January to mid August 26. Locum nest and Retinue are used. Retinue (third-party provider) does not permit applications from Obstetric & Gynaecology registrar or consultants who do not hold an RCOG Certificate of Eligibility or who are not on the Specialist Register. This provides assurance that applicants who do not meet the required eligibility criteria are filtered out during the application process.		
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	EV-11 Neonatal Nursing BAPM benchmarking EV-12 - Neonatal Medical BAPM benchmarking	Gap remains between funded establishment and BAPM benchmarked requirement. Recruitment challenges continue within specialist neonatal workforce groups.	Implement neonatal workforce action plan. Develop recruitment and retention strategy aligned to BAPM standards.	

6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	EV-13 Bi-annual Staffing Report EV-14 Midwifery Staffing Business Case EV-24 BR+ Review			
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Partially compliant	EV-15 Anaesthetic Roster and assistant roster EV-13 Bi-annual staffing paper	Full compliance with ACSA standards requires ongoing workforce sustainability review.		
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-13 Bi-annual staffing paper EV-09 Minutes of Trust Board Meetings	Variable fill rates and periods of escalation continue to impact service resilience. Ongoing reliance on redeployment and escalation processes during periods of high demand. Continuing delays in induction and caesarean pathways during periods of peak activity.	Implement workforce improvement actions identified through BR+ review and staffing reports. Continue monitoring service pressures through MNAG and Trust governance routes.	MNAG report includes SITREP data (delays to induction and caearean section and service suspensions and closures), fill rates and red flags. Vacancy rates are also included
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant		Review not yet completed. Limited assurance regarding resilience when specialist roles are unavailable.	Undertake structured skill-mix and deployment review. Develop cross-training plan for specialist functions including bereavement and infant feeding. Present recommendations to Board by agreed timeline.	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV-01 Maternity & Neonatal Assurance Report			
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Compliant	EV-01 Maternity & Neonatal Assurance Report			
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-16 - PSIRF policy EV-17 - Maternity Patient Safety systems and culture document EV-01 Maternity & Neonatal Assurance Report	Absence of a functioning LMNS reduces opportunities for system-wide sharing of learning. Variable opportunities for regional benchmarking and shared learning.	Maximise opportunities through regional safety networks and peer review forums. Strengthen cross-system learning arrangements.	Extra evidence - PSIRF - Patient Safety Incident Response Framework on Trust site. Patient safety training also available. Lack of an LMNS and limited regional sharing events limits sharing of learning
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-04 Quarterly theming reports, inclusive of scorecard EV-01 Maternity & Neonatal Assurance Report			Complaints feedback at CG meetings
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-18 Bereavment debrief SOP and bereavment guideline			
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Compliant	EV-23 - Maternity Triage Specification Benchmarking Audit Tool Dashboard			
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-05 Monthly SPC underpinned dashboards for stillbirths and neonatal deaths	Not all triage performance indicators are not yet routinely reported in a comprehensive dashboard. Limited routine reporting of waiting times, category response times, delays, redeployment activity and inequalities measures. National specification requirements not yet fully implemented across all domain	Introduce monthly triage dashboard. Implement triage specification action plan. Develop routine reporting of demographic and equity measures. Undertake quarterly review of compliance against the national maternity triage specification	
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Compliant				
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-19 - Post death care board assurance statement			
10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	EV-20 - QSC minutes			

he baseline assessment. Where a deliverable has already been reported as achieved in the baseline
where any progress updates are required.

afety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms
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Current Status	RAG	Evidence ID *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence
strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing eviden
assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as n

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset
EV-01	2.1, 2.3, 6.6	Assurance report	Maternity and Neonatal Assurance Report
EV-02	2.1	Forward plan	Audit Programme
EV-03	2.3	Reports	HHP Saving Babies' Lives Quarterly report, Q1 underpinning element reports, implementation tool
EV-04	2.3, 8.2	Theming report	Quarterly theming paper including local claims scorecards
EV-05	2.3	Dashboard	Monthly SPC dashboards - SB & NND
EV-06	2.3	Reports	Quarterly PMRT reports
EV-07	2.3	Presentation	Deep dives - Preterm thematic review
EV-08	2.2	Report and minutes	Neonatal Governance highlight report and minutes
EV-09	3.2	Board minutes	Trust Board minutes
EV-10	6.1	Audit report	Audit of Consultant attendance
EV-11	6.3	nmarking and action plan	Neonatal Nursing BAPM benchmarking and action plan
EV-12	6.3	nmarking and action plan	Neonatal Medical BAPM benchmarking and action plan
EV-13	6.4, 6.5	Report	Bi-annual Staffing report
EV-14	6.4	Business case	Midwifery Staffing Business Case
EV-15	6.5	Rota	Anaesthetist and ODP representative roster
EV-16	8.1	Policy	PSIRF policy
EV-17	8.1	Policy	Maternity Patient Safety Systems and culture document
EV-18	8.3	Guideline and SOP	Bereavement guideline and Debrief SOP
EV-19	10.1	Board statement	Post-death care Board Assurance statement

EV-20	10.2	Minutes	QSC minutes
EV-21	2.2	Highlight reports	Maternity Governance Highlight reports and minutes
EV-22	6.1	Job plan	Obstetric job plan
EV-23	9.1	Audit tool	Maternity Traige Specification Benchmarking Audit Tool Dashboard
EV-24	6.4	Workforce report	BR+ Review
EV-25			
EV-26			
EV-27			
EV-28			
EV-29			
EV-30			

can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is
ıce and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate

eeded. Please note the evidence submitted should be accessible externally (to the trust).

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Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
January-August 26				
26/27				
Q4 25/26, Q1 26/27				
Q4 25/26, Q1 26/27				
Ongoing				
Q4 25/26, Q1 26/27				
06/26				
April-September 26				
April-September 26				
06/26				
07/26				
07/26				
05/26				
11/25				
April 26 and July 26				
11/23				
08/25				
Oct 24 and Dec 24				
07/26				

April-July 26				
May and August 26				
04/26				
09/26				
04/25				

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance**. Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to undertstand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	•Board Report •Review report

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a greenrating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply*.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Trust Board sign off date:

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Compliant			Task and Finish Group commenced on the 14th of September 2026 for both Maternity and Neonates.	The Trust will need to continue to progress against the agreed national timescales to remain complaint. Key Stakeholders attended this meeting on the 14/09/26, minutes not yet available at time of completion of the reporting template. Key stakeholders
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-02 Audit Programme	MNVP currently not operational, limiting independent co-production and challenge. FFT response rates remain variable and may not be representative of all service user groups. Limited triangulation of experience data across maternity and neonatal pathways. Limited assurance that seldom-heard groups are proportionately represented within feedback.	Re-establish substantive MNVP arrangements and agree interim engagement model. Implement targeted engagement for women from ethnically diverse communities and areas of deprivation. Introduce specialty-level FFT reporting and trends analysis. Develop integrated maternity and neonatal patient experience dashboard.	
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-03 Maternity and Neonatal governance (Highlight reports and minutes)	Limited visibility of action completion and impact following board discussion. Inconsistent reporting of patient experience, outcomes and safety themes within a single integrated report.	Introduce action tracking and impact monitoring arising from Board scrutiny. Develop exception reporting framework for escalation of emerging concerns.	
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-04 Savings Babies Lives Quarterly Report and Element Reports EV-05 Quarterly Theming Reports & Scorecard EV-06 Monthly SPC underpinned dashboards for stillbirths and neonatal deaths EV-07 Deep Dives in various areas EV-08 Quarterly PMRT reports	Neonatal ethnicity and deprivation analysis not fully embedded. Limited reporting of outcomes by protected characteristic across all pathways. Some datasets remain incomplete due to coding and data quality limitations.	Incorporate equity dashboard metrics into monthly assurance reporting. Expand outcome reporting by ethnicity, deprivation, language needs and protected characteristics. Complete data quality review and implement improvement plan for demographic recording.	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Non-compliant		No formally agreed governance framework defining shared accountability between Medical Director and Chief Nurse for maternity and neonatal services. Executive oversight arrangements not yet explicitly documented within Trust governance structures.	Develop formal statement of joint accountability endorsed by the Board. Update governance framework and committee Terms of Reference. Include maternity and neonatal delivery, safety and workforce metrics within executive performance oversight.	
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV-09 Minutes of Trust Board Meetings	Currently only the Director of Midwifery attends Trust Board routinely	Formalise attendance for expectations for Director of Midwifery, Clinical Directors Obsterics and Neonates and Neonatal Nurse Director within governance processes.	
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant		Programme onboarding still underway. Release arrangements and completion trajectory not yet fully established across all professional groups.	Develop implementation plan with tracked completion rates. Ensure participation includes medical, midwifery, neonatal nursing and support workforce.	
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-06 Monthly SPC underpined dashboards for stillbirths and neonatal deaths and pre-term birth rates.	Variable availability of neonatal inequalities data. Limited routine reporting of outcomes by ethnicity, deprivation and language needs. Population-health intelligence not yet fully integrated into service redesign processes.	Implement six-monthly inequalities deep dive. Complete review of interpreter utilisation. Use equity intelligence to inform service improvement priorities, including preterm birth and maternal morbidity reduction work.	
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Non-compliant		Implementation plan not yet formally approved.	Present implementation plan to Quality Committee and Board in October and Novemeber respectively Establish quarterly reporting cycle with milestone tracking.	
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-10 Audit of Consultant Attendance			

6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Partially compliant		Audit is currently being undertaken		
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant	EV-11 Neonatal Nursing benchmarking	Updated neonatal medical workforce benchmarking and trajectory to achieve BAPM standards is not yet complete. Full assurance regarding compliance with recommended neonatal medical staffing standards is therefore not yet available	Complete updated neonatal medical workforce benchmarking and develop associated action plan. Present findings through neonatal governance and Trust Board assurance processes, with identified workforce gaps incorporated into workforce planning arrangements.	
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Compliant	EV-12 Bi-annual Staffing Report EV-13 Midwifery Staffing Business Case			
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Partially compliant	EV-14 Anaesthetic Roster June 2026 EV-12 Bi-annual staffing paper	Full compliance with ACSA standards requires ongoing workforce sustainability review.		
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report	Workforce challenges continue to affect service resilience at times, requiring ongoing use of escalation processes and close operational oversight	Continue monitoring fill rates, red flags, vacancy rates, service pressures and escalation activity through the Maternity and Neonatal Assurance Report and staffing reviews.	MNAG report includes SITREP data (delays to induction and caearean section and service suspensions and closures), fill rates and red flags. Vacancy rates are also included
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant		Review not yet completed. Limited assurance regarding resilience when specialist roles are unavailable.	Undertake structured skill-mix and deployment review. Develop cross-training plan for specialist functions including bereavement and infant feeding. Present recommendations to Board by agreed timeline.	
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV-01 Maternity & Neonatal Assurance Report			Audit of homebirths currently ongoing
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Compliant	EV-01 Maternity & Neonatal Assurance Report			
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-01 Maternity & Neonatal Assurance Report (MNSI, Incidents, PMRT, PQOM) EV-17 Patient Safety Incident Response Framework Policy EV-18 Maternity Patient Safety Systems Teams and Culture	Absence of a functioning LMNS reduces opportunities for system-wide sharing of learning. Variable opportunities for regional benchmarking and shared learning.	Maximise opportunities through regional safety networks and peer review forums. Strengthen cross-system learning arrangements.	Extra evidence - PSIRF - Patient Safety Incident Response Framework on Trust site. Patient safety training also available. Lack of an LMNS and limited regional sharing events limits sharing of learning
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-05 Quarterly Theming Report & Scorecard			Complaints feedback at CG meetings
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-19 Perinatal Mortality and Morbidity Group Terms of Reference EV-20 PMRT/MNSI/EN Parental and Family Engagement Process			
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Compliant	EV-21 - Maternity Triage Specification Benchmarking Audit Tool Dashboard			
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV-01 Maternity & Neonatal Assurance Report EV-05 Monthly SPC underpinned dashboards for stillbirths and neonatal deaths	Not all triage performance indicators are not yet routinely reported in a comprehensive dashboard. Limited routine reporting of waiting times, category response times, delays, redeployment activity and inequalities measures. National specification requirements not yet fully implemented across all domain	Introduce monthly triage dashboard. Implement triage specification action plan. Develop routine reporting of demographic and equity measures. Undertake quarterly review of compliance against the national maternity triage specification	
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Compliant				
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV-15 Post Death Board Assurance Statement			
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	Compliant	EV-16 QSC minutes			

10-Point Plan for Maternity & Neonatal Services

How to Use This Template

The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Materntiy and Neonatal Services in England is the responsibility of each organisation and ttrustrusts must demonstrate compliance with the 10 Point Plan .

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governar structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission proc Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provic constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may sup more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/

1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply*.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation:	ıern Lincolnshire and Goole Foundation
Report prepared by:	Yvonne McGrath
Report date:	9/16/2026
Reporting period covered:	Baseline

Baseline Assessment		
Key Metrics		
Total deliverables		**26**
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	**1**	0	0	0	1
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	**3**	0	0	3	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	1	1	0
5. Addressing inequalities in maternity and neonatal outcomes	**3**	0	1	2	0
6. Ensuring 24/7 safety and responsiveness of services	**7**	0	1	4	2
7. Trust review of homebirth services	**2**	0	0	0	2
8. Responding to incidents, complaints and concerns with humanity and candour	**3**	0	0	0	3
9. Deliver safe and effective triage in maternity services	**3**	0	0	1	2
10. Post death care	**2**	0	0	0	2

baseline assessment. Where a deliverable has already been reported as achieved in the baseline
ıere any progress updates are required.

ety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms

Current Status	RAG	Evidence ID *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	2.1, 2.2, 2.3, 6.6, 7.1, 7.2, 8.1	Assurance report	Maternity and Neonatal Assurance Report	January-September 26				
EV-02	2.1	Forward plan	Audit Programme	26/27				
EV-03	2.2	Highlight reports and minutes	Maternity and Neonatal Governane Highlight Reports and Minutes	April 26 to September 26				
EV-04	2.3	Reports	HHP Saving Babies' Lives Quarterly reports, underpinning element reports, implementation tool	Q4 25/26, Q1 26/27				
EV-05	2.3, 8.2	Theming report	Quarterly theming paper including local claims scorecards	Q4 25/26, Q1 26/27				
EV-06	2.3, 5.2	Dashboard	Monthly SPC dashboards - SB & NND	Ongoing				
EV-07	2.3	Reports	Deep Dives - Thematic Reviews (IOL / PPH)	Aug / Sept 26				
EV-08	2.3	Reports	Quarterly PMRT reports	Q4 25/26, Q1 26/28				
EV-09	3.2	Board minutes	Trust Board minutes	April-September 26				
EV-10	6.1	Audit report	Audit of Consultant attendance	06/26				
EV-11	6.3	Benchmarking and action plan	Neonatal Nursing BAPM benchmarking and action plan	07/26				
EV-12	6.4, 6.5	Report	Bi-annual Staffing report	05/26				
EV-13	6.4	Business case	Midwifery Staffing Business Case	11/25				
EV-14	6.5	Rota	Anaesthetist representative roster	6/1/2026				
EV-15	10.1	Board statement	Post-death care Board Assurance statement	07/26				
EV-16	10.2	Minutes	QSC minutes	April-July 26				
EV-17	8.1	Policy	Patient Safety Incident Response Framework Policy	11/23				
EV-18	8.1	Policy	Maternity Patient Safety Systems and culture document	08/25				
EV-19	8.3	TOR	Perinatal Group Mobidity and Mortality TOR					
EV-20	8.3	Flowchart	PMRT, MNSI, EN Engagement Flowchart	Aug-26				
EV-21	9.1	Audit tool	Maternity Triage Specification Benchmarking Audit Tool Dashboard	Sep-26				
EV-22								
EV-23								
EV-24								
EV-25								
EV-26								
EV-27								
EV-28								
EV-29								
EV-30								

Evidence: examples

This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform . Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance. **Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	• Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to undertstand process and next steps and continue work with the Martha's rule team to commence roll out.
Action 2	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	• Analytical reports
	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	• Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	• Board report and minutes • Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	• Board ToR • Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	• Job plans • Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	• Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	• Board report • Quarterly MIS thematic report • Equity dashboard reports • Core20PLUS5 reporting • Maternity equity action plans
	5.3	Is the trust board receiving reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	• Maternal Care Bundle implementation plans. • Board Report • MIS return
Action 6	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	• Workforce plan • Biannual workforce papers • Staff experience survey • Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obsletric rotas? *(In line with MIS Year 8)*	• Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	• Workforce plan • Biannual workforce papers • BAPM workforce standards compliance • Staff experience survey
	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including co sideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 yeas?	•Board Report •Review report

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)243

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9th October 2026
Director Lead	Sam Peate, Group Chief Delivery Officer Emma Sayner, Group Chief Finance Officer
Contact Officer / Author	Rob Stones, Director of Performance, Planning and Business Intelligence Jackie Railton, Deputy Director, Planning and Performance Louise Topliss, Head of Performance
Title of Report	Group Performance Report
Executive Summary	Key messages: • Significant challenges remain across all constitutional standards • Both HUTH and NLAG remain under Tier one oversight for UEC, Cancer, Diagnostics and RTT • Activity is on plan for HUTH Year to date but off plan at NLAG • RTT activity is seeing material growth in the overall waiting list size and volume of patients waiting beyond 52 weeks • 12 hour UEC performance for HUTH showing as most improved in last 12 months nationally
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common escalation report included within this paper.
Prior Approval Process	
Financial Implication(s) (if applicable)	Report references delivery of activity versus plan with inherent links to income generation via block contract.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Report references delivery of access targets, with inherent links to equity of access across the Group
Recommended action(s) required	☐ Approval ✓ Information ✓ Assurance ☐ Other – please detail below:

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)242

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Friday 9 October 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Debbie Bray, Nurse Director Family Services
Title of Report	Thirlwall Inquiry Report: Humber Health Partnership Response, Governance Framework and Support for Neonatal Families
Executive Summary	The final report of the Thirlwall Inquiry, published on 15 September 2026, identifies significant learning for patient safety, safeguarding, organisational culture, governance, leadership accountability and the escalation of concerns. Its 17 recommendation areas have implications across Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust, extending beyond maternity and neonatal services. The accompanying briefing proposes a single Humber-wide gap analysis, a time-limited Executive Oversight Group, a formal implementation programme and assurance framework, and a phased transition into the future independent Trust governance arrangements. The accompanying parent and carer letter provides compassionate, practical information for neonatal families and signposts support through neonatal teams, chaplaincy, PALS and Bliss. The Boards are asked to note the Inquiry findings, approve the proposed gap analysis, oversight and implementation arrangements, endorse the phased transition approach, and receive quarterly progress reports.
Background Information and/or Supporting Document(s) (if applicable)	Supporting documents: 1. Thirlwall Inquiry Executive Briefing Paper - CEO Submission. 2. The Thirlwall Inquiry: support for neonatal families - parent and carer letter. The briefing summarises the Inquiry findings, the 17 recommendation areas, local implications, governance proposals, transition risks and proposed next steps.
Prior Approval Process	Prepared for CEO submission and onward consideration by the Humber Health Partnership Executive Team, Quality Committees and Trust Boards. Any additional prior approval is to be confirmed.

Financial Implication(s) (if applicable)	No quantified financial implications are identified at this stage. The proposed gap analysis should determine any resource, workforce, digital, estates, monitoring technology and capital requirements arising from implementation of the 17 recommendations. There will likely be financial requirements which may be significant.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The Inquiry response should support equitable access to safe care, effective escalation and safeguarding across both Trusts. Communications with neonatal families should be compassionate, accessible and responsive, with clear routes to neonatal teams, chaplaincy, PALS and independent support through Bliss. The gap analysis should identify any differential impacts on protected groups and people experiencing health inequalities.
Recommended action(s) required	☒ Approval ☒ Information ☒ Assurance ☐ Other - please detail below: Approval is requested for the Humber-wide gap analysis, Executive Oversight Group, implementation programme and assurance framework. Endorsement is requested for the phased transition approach and quarterly reporting to Quality Committees and Trust Boards.

NHS Northern Lincolnshire and Goole NHS Foundation Trust
NHS Hull University Teaching Hospitals NHS Trust

Executive Briefing Paper

Thirlwall Inquiry Report (Published 15 September 2026)

Humber Health Partnership Response, Governance Framework and Organisational Transition Considerations

Prepared for: Humber Health Partnership Executive Team, Quality Committees and Trust Boards
Scope: Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

Author: Debbie Bray, Nurse Director

Purpose

To provide a strategic overview of the findings and recommendations of the Thirlwall Inquiry, outline the implications for Humber Health Partnership, and recommend a system-wide approach to implementation, governance and assurance, taking account of the forthcoming separation of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG).

The paper proposes a comprehensive gap analysis against all 17 recommendations and sets out the executive and operational governance arrangements required to ensure effective implementation and sustainable organisational learning.

Executive Summary

The Thirlwall Inquiry represents one of the most significant patient safety inquiries undertaken within the NHS. Its findings, identify important lessons in relation to patient safety, safeguarding, organisational culture, governance, leadership accountability and the escalation of concerns.

The Inquiry makes recommendations across 17 distinct areas designed to strengthen patient safety oversight, managerial accountability, mortality surveillance, safeguarding arrangements, workforce culture and regulatory assurance. These recommendations extend beyond maternity and neonatal services and require NHS organisations to examine how concerns are escalated, investigated and acted upon across all clinical services.

For Humber Health Partnership, the Inquiry provides an important framework against which to review existing arrangements across HUTH and NLAG.

Whilst many relevant improvement programmes are already underway, including PSIRF, safeguarding governance, mortality review processes, Freedom to Speak Up and patient safety programmes, further assurance work will help identify where existing arrangements are strong and where further development may be required.

The impending organisational separation of HUTH and NLAG creates an additional strategic consideration. There is a need to ensure that implementation is undertaken through a coordinated Humber-wide approach initially, while simultaneously developing sustainable governance arrangements that can transfer into independent Trust structures following separation. Failure to do so risks inconsistencies in implementation, duplication of effort and variation in patient safety oversight arrangements.

Key Findings of the Inquiry

Theme	Principal Finding
Patient Safety	Concerns regarding unexpected neonatal deaths and collapses were not acted upon promptly.
Governance	Governance systems failed to recognise and respond effectively to emerging risks.
Leadership	Inadequate challenge, oversight and decision-making occurred following escalation of concerns.
Safeguarding	Opportunities to protect vulnerable infants were missed due to ineffective safeguarding processes.
Organisational Culture	Staff concerns were not always listened to or acted upon appropriately.
External Oversight	External assurance mechanisms failed to identify warning signs.
Data & Intelligence	Available safety intelligence was not effectively analysed or escalated.
Accountability	Existing arrangements for managerial accountability were insufficient.

The 17 Inquiry Recommendations and Local Implications

The Inquiry recommendations span seventeen areas requiring consideration by NHS providers. Initial assessment suggests that the majority have direct implications for HUTH and NLAG, particularly within Family Services, safeguarding, workforce, governance and patient safety functions.

No.	Recommendation area	Requirement summary	National timeframe / milestone	Humber-wide assurance implication
1	CCTV and neonatal monitoring	All cots and incubators in neonatal units should have livestreaming baby monitors, supported by centrally managed, ring-fenced funding.	Urgent national planning. NHS England implementation roadmap by 31 March 2027.	Assess neonatal camera requirements, capital, information governance, cyber security, consent, estates and parent communication.

No.	Recommendation area	Requirement summary	National timeframe / milestone	Humber-wide assurance implication
2	Insulin safety	Restrict insulin access to authorised staff using digital controls; record access; use interim CCTV; make national laboratory insulin/C-peptide guidance mandatory.	CCTV focused on neonatal insulin storage by 30 November 2026 at the latest, retained for at least 28 days, until biometric access is in place. Full GIRFT access-control and storage compliance by 31 March 2027.	Complete gap analysis against GIRFT; install interim CCTV; confirm retention and access arrangements; audit access, storage and laboratory handling.
3	Bereavement care	Implement the National Bereavement Care Pathway for neonatal death nationally and in all Trusts.	Immediate improvement action by ICBs and providers. Full national and Trust implementation by 31 August 2027.	Assess compliance with the pathway, staffing, training, family support and evidence of implementation.
4	Safeguarding and employment	Provide role-appropriate safeguarding training to all staff and Board members, including deliberate harm; amend employment contracts to require compliance with safeguarding guidance.	Immediate assurance on training compliance and escalation routes. Existing NHS hospital contracts amended by March 2027; agency, bank and all new contracts must include the obligation.	Confirm training compliance, Board assurance, escalation routes, contract changes and links to the Suspicion of Deliberate Harm Protocol.
5	Operating systems and interoperability	Provide a timed route to harmonised NHS systems and implement a mandatory interoperability standard as soon as possible.	NHS England route by 31 March 2027; systems harmonised across the NHS by December 2028; information standard implemented as soon as possible.	Map neonatal, maternity, laboratory, incident and mortality systems; identify interoperability, data quality and investment gaps.
6	Monitoring deaths in hospitals	Establish Board-level monitoring of all deaths of babies and children and a predetermined route for escalating concerning trends or patterns.	Both requirements in place by 31 March 2027.	Test mortality surveillance, Board reporting, triangulation and escalation thresholds across HUTH and NLAG.
7	Data reporting	Name a trained lead reporter for MBRRACE data; input and review data regularly; escalate urgent data and report routinely to the Board.	Data input and real-time review at least weekly. Immediate reporting to the Medical Director and Board where action is required. Otherwise, Board reporting at least every six months.	Appoint lead reporters, define cover, competency, escalation and six-monthly Board assurance.
8	SUDIC	Apply SUDIC to sudden and unexpected deaths of babies who have never left hospital; inform staff and Boards; revise national guidance and simplify forms.	Immediate NHS England notification; Trust communication within seven days. NHS England operational deadline: no later than Monday 28 September 2026. Revised guidance distributed by 31 March 2027.	Evidence completion of communication to neonatal staff and Boards; align SUDIC and internal reporting; update policy and training when revised guidance is issued.
9	Suspicion of Deliberate Harm Protocol	NHS England to issue a one-page protocol and short guidance; concerns raised in good faith must be acted on immediately; Trusts must embed both.	National protocol and guidance by 31 March 2027. Good-faith concerns acted upon immediately. No separate Trust embedding deadline is specified.	Review safeguarding, HR, patient-safety, police escalation and neutral workforce action pathways; prepare for rapid local adoption.
10	Independent panel of experts	DHSC should seriously consider a multidisciplinary independent expert panel able to undertake swift technical investigations.	No fixed establishment date in the recommendation; investigations are described as swift when the panel is used.	Define access to independent clinical expertise and escalation routes pending any national panel.
11	Medical examiners	Issue neonatal-death steps for medical examiners; incorporate SUDIC guidance; ask direct safeguarding questions; record relevant staff contacts that day where concerns arise; provide neonatology support.	One-page document by 31 March 2027. Relevant staff contact details recorded that day where a concern may exist. Medical Examiner system reviewed in 2027; subsequent reviews as directed.	Review neonatal death scrutiny, direct safeguarding enquiry, same-day documentation, neonatology advice and funding arrangements.
12	Paediatric and perinatal pathology	Increase the paediatric and perinatal pathology training workforce and retain the incentive scheme.	37 doctors in training posts by June 2033; incentive scheme remains until at least 37 are in training.	Assess access, referral routes, turnaround, resilience and escalation for specialist pathology.
13	Accountability and regulation of managers	Introduce a barring system, strengthen movement controls, individual duty of candour and patient-first leadership standards.	Barring system by September 2027; review in 2030; aim for full statutory regulation by September 2032. Leadership and Management Framework Code amendment is urgent.	Align fit and proper person processes, senior-manager movements, contracts, duty of candour and leadership standards.
14	Care Quality Commission oversight	Use without-notice departmental inspections with at least two current practising experts; test effectiveness rather than process compliance alone.	No fixed timeframe in Recommendation 14; action should be taken forward with urgency. The PDF endnote cites a related recommendation for a specialist maternity and neonatal regulatory unit within nine months.	Maintain evidence of effective practice, staff and family experience, safety outcomes and readiness for expert-led unannounced inspection.

No.	Recommendation area	Requirement summary	National timeframe / milestone	Humber-wide assurance implication
15	Assessment of CQC performance	Health and Social Care Committee to review CQC performance rigorously and consistently.	Initially annually; once satisfied, every three years or another frequency determined by the Committee.	Track national oversight developments and retain robust evidence of regulatory assurance.
16	Parliamentary and Health Service Ombudsman	Transfer National Guardian Office functions to the Ombudsman and extend powers concerning NHS whistleblowing complaints and oversight.	No fixed implementation date is specified.	Monitor national arrangements and ensure local complaints, Freedom to Speak Up and whistleblowing pathways remain clear during transition.
17	Implementation auditing	Give the National Audit Office responsibility for auditing implementation of statutory NHS inquiry recommendations and provide staffing.	National Audit Office to be able to begin work by September 2027.	Maintain a complete recommendation tracker, evidence repository, risk log and Board assurance trail.

Sources: Thirlwall Inquiry Recommendations PDF and NHS England operational narrative dated 22 September 2026. PDF endnote timeframes are shown separately where they relate to aligned recommendations from the National Maternity and Neonatal Investigation.

NHS England Immediate Actions and Assurance Requirements

The following actions supplement the Inquiry recommendations and should be recorded in the Humber-wide implementation tracker. The requirements apply beyond neonatal services where stated, including every Trust and ICB Board.

Action	Required timeframe	Evidence / assurance expected
Trust and ICB Board review	Next available public Board meeting	Review the report; consider whether similar events could occur locally; seek assurance on safety, safeguarding, professional curiosity and speaking up; discuss identified risks urgently with the regional team.
SUDIC communication	No later than Monday 28 September 2026	All Trusts with a neonatal unit to inform relevant staff and the Board that SUDIC applies to qualifying sudden and unexpected deaths, including in neonatal units; retain evidence of communication. SUDIC reporting runs alongside internal reporting.
Bereavement care	Immediate action	ICBs and providers to improve bereavement care in line with the Medium Term Planning Framework, while working toward full implementation by 31 August 2027.
Interim insulin CCTV	By 30 November 2026 at the latest	CCTV focused on neonatal insulin storage pending biometric access; recordings retained for at least 28 days.
Insulin controls and storage	By 31 March 2027	All neonatal units to meet GIRFT requirements for access control and insulin storage.
Safeguarding assurance	Immediate action	Confirm role-appropriate staff and Board training compliance, clear escalation routes, and adequate Board prominence for safeguarding babies and children.
Parent assurance and staff wellbeing	Immediate local review	Consider local support and assurance for families receiving neonatal care and review psychological support mechanisms for staff caring for very sick babies.
National policy actions	Urgent / dates governed by the relevant recommendations	Support national plans for baby monitors, strengthened insulin and Medical Examiner guidance, safeguarding review, manager barring arrangements and continued bereavement pathway rollout.

Related Time-Bound Commitments Referenced in the PDF Endnotes

These are not additional Thirlwall recommendations. They are related National Maternity and Neonatal Investigation commitments cited in the Inquiry PDF and should be tracked as linked dependencies where relevant.

Linked area	Referenced timeframe	Relevance to local assurance
Maternity and neonatal estates and digital systems	12-month, 5-year and 10-year investment commitments and implementation deadlines	Track as a dependency for monitoring technology, digital interoperability and infrastructure planning.
Specialist maternity and neonatal regulatory unit	Within nine months	Relevant to regulatory readiness and specialist clinical input into assessment.
Quality and accountability of investigations	Within 12 months	Relevant to investigation quality, transparency, oversight, learning and demonstrable action.

Implications for Humber Health Partnership

The findings are particularly relevant to neonatal, maternity, paediatric and safeguarding services; however, the recommendations extend far beyond Family Services and should be considered within a whole-organisation patient safety framework.

Priority areas requiring review include:

- Escalation of safety concerns and professional disagreement.
- Freedom to Speak Up effectiveness and organisational culture.
- Mortality surveillance and learning from deaths.
- Safeguarding governance and escalation pathways.
- Leadership accountability and executive oversight.
- Patient safety intelligence and data triangulation.
- Duty of Candour compliance.
- Learning from complaints and incidents.
- Organisational response to suspected deliberate harm.
- Governance arrangements for implementation of national recommendations.

The Inquiry reinforces that compliance with processes alone is insufficient. Organisations must be able to demonstrate that concerns are heard, appropriately challenged, acted upon promptly and subject to effective executive scrutiny.

Impact of Humber Health Partnership Separation

The planned separation of HUTH and NLAG is an important implementation and transition consideration. A coordinated approach will be needed to support consistent implementation of the Inquiry's recommendations across both organisations during the transition.

Potential risks include:

- Inconsistent interpretation of recommendations across organisations.
- Variable patient safety standards.
- Duplication of work and increased resource burden.
- Loss of shared learning and organisational memory.

- Reduced visibility of emerging risks.
- Fragmentation of governance and assurance arrangements.

To mitigate these risks, implementation should be structured through a phased approach.

Phase One: Humber-Wide Implementation

Prior to transition:

- Complete a single Humber-wide gap analysis against all 17 recommendations.
- Establish shared standards and assurance requirements.
- Develop a common implementation framework.
- Identify resource, workforce and capital implications.
- Report progress through joint governance arrangements.

Phase Two: Transitional Arrangements

During transition:

- Focus on the development of robust transitional arrangements to deliver Thirlwall recommendations
- Continue joint oversight of shared risks.
- Benchmark implementation plan across both organisations.

Phase Three: Transition Handover Document

Following transition:

- HUTH and NLAG maintain independent implementation programmes.
- Trust Boards receive separate assurance reports.
- Joint learning and benchmarking arrangements continue.
- Annual peer review of implementation progress is established.

Recommended Governance Framework

Executive Oversight

Humber Health Partnership Thirlwall Executive Oversight Group

A time-limited Executive Oversight Group should be established immediately to coordinate the response across both organisations.

The Group will report through the Board governance arrangements of both Trusts, providing clear non-executive oversight and challenge.

Responsibilities

- Commission the gap analysis.

- Monitor delivery against all 17 recommendations.
- Identify strategic risks.
- Coordinate resource requirements.
- Oversee organisational transition arrangements.
- Provide assurance to both Trust Boards.
- Review progress and impact.

Membership

- Group Chief Nurse
- Group Chief Medical Officer
- Group Chief Operating Officer
- Group Director of Midwifery
- Care Group Nurse Director
- Director with Workforce Portfolio
- Head of Safeguarding
- Quality Governance Leads
- Group Director of Patient Safety and Assurance

Operational Oversight

Thirlwall Implementation Programme Board

A dedicated Programme Board should oversee implementation through the following workstreams:

Workstream	Executive Sponsor
Patient Safety & Governance	Chief Nurse
Safeguarding	Executive Safeguarding Lead
Mortality & Medical Examiners	Medical Director
Workforce & Culture	Director of Workforce
Freedom to Speak Up	Chief Nurse
Digital & Data Intelligence	Chief Digital Officer
Medicines Governance	Chief Pharmacist
Family Services	Care Group Directors

Each workstream should maintain:

- Delivery plan.
- Milestones.
- Risk register.
- Assurance dashboard.
- Evidence repository.
- Quarterly reporting arrangements.

Humber-Wide Gap Analysis

A comprehensive Humber-wide gap analysis should be undertaken against all 17 recommendations.

The review should assess:

Governance & Leadership

- Board assurance arrangements.
- Executive oversight structures.
- Leadership accountability.
- Decision-making frameworks.

Patient Safety

- PSIRF implementation.
- Mortality review processes.
- Safety surveillance.
- Escalation arrangements.

Workforce & Culture

- Speaking Up effectiveness.
- Staff confidence in reporting concerns.
- Safeguarding competence.
- Leadership behaviours.

Digital & Infrastructure

- System interoperability.
- Data reporting capability.
- Monitoring systems.
- Digital investments required.

Safeguarding

- Governance structures.
- Deliberate harm pathways.
- Multi-agency working.

Regulatory Readiness

- Medical Examiner arrangements.
- Complaint management.
- CQC readiness.
- Recommendation tracking.

The output should identify:

- Current position.
- Compliance status.
- Gaps and risks.
- Resource implications.
- Required actions.
- Responsible leads.
- Delivery timescales.

Proposed Next Steps

Immediate (0-3 Months)

Plan for GIRFT insulin access-control and storage compliance by 31 March 2027.

Complete immediate assurance reviews of bereavement care, safeguarding training, escalation routes, parent assurance and staff wellbeing.

Schedule Trust and ICB consideration at the next available public Board meeting.

Install interim CCTV focused on neonatal insulin storage by 30 November 2026 and retain recordings for at least 28 days.

Confirm and evidence completion of the SUDIC communication required no later than 28 September 2026.

1. Establish the Executive Oversight Group.
2. Commission the Humber-wide gap analysis.
3. Identify Executive and Operational Leads.
4. Develop the implementation programme.
5. Produce baseline risk assessment.
6. Create a recommendations tracker and assurance dashboard.
7. Review safeguarding, mortality and Speaking Up arrangements.
8. Confirm governance arrangements during organisational transition.

Medium Term (Alignment with Transition Plan)

1. Complete detailed implementation plans.
2. Report progress through governance structures.
3. Assess resource, workforce and capital requirements.
4. Develop future-state governance arrangements.
5. Undertake organisational readiness assessments for separation.

Long Term (Post-transition)

1. Transfer oversight to individual Trust governance structures.

2. Maintain annual benchmarking and peer review.
3. Continue shared learning across organisations.
4. Provide annual Board assurance on implementation and sustainability.

Board Recommendations

The Board is asked to:

Note

- The findings and recommendations of the Thirlwall Inquiry.
- The significant implications for patient safety, governance, safeguarding and leadership accountability.

Approve

- Commissioning of a Humber-wide gap analysis against all 17 recommendations.
- Establishment of a Humber Health Partnership Thirlwall Executive Oversight Group.
- Development of a formal implementation programme and assurance framework.

Endorse

- A phased approach to implementation supporting both current partnership arrangements and future independent governance structures for HUTH and NLAG.
- Quarterly progress reports to Quality Committees and Trust Boards.

Executive Assurance Statement

The Thirlwall Inquiry reinforces the importance of robust patient-safety governance, timely escalation of concerns and effective challenge.

For Humber Health Partnership, the recommendations provide an opportunity to test the effectiveness of existing governance arrangements and strengthen assurance regarding how concerns are identified, escalated and acted upon.

Completion of a Humber-wide gap analysis, supported by strong executive leadership, clear operational accountability and a structured transition plan for the separation of HUTH and NLAG, will provide assurance that both organisations are embedding the lessons from Thirlwall and establishing sustainable arrangements that protect patients, support staff and strengthen organisational accountability for the future.

Thirlwall Inquiry Implementation Action Plan

Board focus: Top five immediate priorities

Purpose: To provide the Board with a concise assurance view of the five immediate priorities, including accountability, deadlines, RAG status, current position and ongoing delivery actions.

Board action plan

Priority	Required action	Accountable lead	Deadline	Current position and ongoing actions	RAG	Board assurance / decision required
Critical overdue assurance	Confirm and evidence completion of the SUDIC communication requirement, which was due on 28 September 2026.	Executive Safeguarding Lead / Care Group Directors	Immediate	Position: Completion evidence to be confirmed. Ongoing actions: SUDIC Education and relaunch of SUDIC Policy and requirements ongoing over October 26 – specific focus across Maternity Services as SUDIC process embedded across neonates and paediatrics. SUDIC Policy is being revised to explicitly document the requirements for SUDIC activation in the event of all babies who die that have never left the hospital setting.	AMBER	Board to seek immediate confirmation of completion, evidence and any residual risk.
Urgent operational delivery	Install interim CCTV focused on neonatal insulin storage and confirm recordings are retained for at least 28 days.	Chief Pharmacist / Chief Digital Officer / Director of Estates	30 November 2026	Position: Delivery status to be validated. Ongoing actions: CCTV in place for HUTH Neonatal Unit. NLAG position scoping underway - will require procurement and installation agreement to develop installation plan by unit – financial impact not yet known SOP/Policy under development to cover Camera coverage, recording retention, information governance controls, access arrangements and audit protocol.	AMBER	Board to note progress, confirm deliverability by the deadline and seek escalation of any capital, estates, digital or IG constraints.
Board assurance	Place the Inquiry report and local assurance assessment on the next available public Board agenda.	Chief Nurse	Next available public Board meeting	Position: Agenda scheduling and paper status to be confirmed. Ongoing actions: Finalise the local “could this happen here?” assessment, identify principal gaps and risks, and prepare evidence of decisions and regional escalation where required.	AMBER	Board to confirm the reporting date, paper owner and required assurance evidence.
Programme mobilisation	Establish the Executive Oversight Group, Programme Board, workstreams, controlled tracker, risk register and evidence repository.	Chief Nurse / Exec Director of Patient Safety and Assurance	Immediate	Position: Governance arrangements and named membership to be validated. Ongoing actions: Approve terms of reference, confirm workstream leads and reporting routes, establish the programme dashboard, risk escalation process and evidence repository.	AMBER	Board to confirm executive accountability, governance cadence and escalation arrangements.

Priority	Required action	Accountable lead	Deadline	Current position and ongoing actions	RAG	Board assurance / decision required
Baseline assessment	Complete one Humber-wide gap analysis covering all 17 recommendations, immediate actions, required resources and organisational transition risks.	Thirlwall Programme Board	Immediate; local target to be agreed	Position: Scope, ownership and completion date to be confirmed. Ongoing actions: Complete and quality-assure the gap analysis; identify compliance gaps, resources, dependencies, milestones and risks; convert findings into a prioritised delivery plan.	AMBER	Board to agree the local completion target and require reporting of material gaps, resource implications and transition risks.

Board reporting expectation

- Each priority should be updated before each reporting cycle with a confirmed executive lead, operational lead, current position, next milestone, principal risk and evidence reference.
- Any missed national or NHS England deadline should be escalated immediately through the Executive Oversight Group and recorded on the programme risk register.
- Shared risks and standards should remain under joint oversight during organisational transition until formally handed over to the future HUTH and NLAG governance arrangements.

V2

NHS
Humber Health
Partnership

Integrated Performance Report

Reporting Month:
August 2026

United by Compassion:
Driving for Excellence

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

disability confident EMPLOYER

VETERAN AWARE

CiC Oversight Dashboard

Operational Performance

HUTH

Metric	Period	Latest	Previous	Change
A&E - 4 Hour Standard (All)	Aug-26	61.4%	62.2%	-0.9%
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	70.0%	67.3%	2.7%
Cancer - 62 Day All Referral Sources	Jul-26	54.5%	54.4%	0.1%
Diagnostics - 6 Week Standard	Jul-26	36.6%	37.2%	-0.6%
Inpatient - Bed occupancy classed as clinically ready for discharge	Aug-26	27.4%	27.1%	0.2%
RTT - Incomplete 18 Week Standard	Jul-26	56.0%	56.8%	-0.7%
Theatres - Capped Theatre Utilisation	Aug-26	81.9%	82.2%	-0.3%

NLaG

Metric	Period	Latest	Previous	Change
A&E - 4 Hour Standard (All)	Aug-26	68.0%	69.1%	-1.1%
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	68.7%	64.0%	4.6%
Cancer - 62 Day All Referral Sources	Jul-26	56.7%	64.1%	-7.5%
Diagnostics - 6 Week Standard	Jul-26	33.5%	32.6%	0.9%
Inpatient - Bed occupancy classed as clinically ready for discharge	Aug-26	16.8%	16.6%	0.2%
RTT - Incomplete 18 Week Standard	Jul-26	59.8%	61.6%	-1.9%
Theatres - Capped Theatre Utilisation	Aug-26	85.6%	81.5%	4.1%

Monthly Trend Key

- ↑ Improvement on previous reported month
- ↓ Deterioration on previous reported month
- — No change on previous reported month

Financial Position

Group

Metric	Period	Latest	Previous	Change
Finance - CIP YTD against Plan	Aug-26	64.6%	66.6%	-1.9%
Finance - Planned Surplus/Deficit	Jun-26	(63,065)	(63,065)	0.0%
Finance - Variance YTD to Financial Plan	Jun-26	(10,207)	(5,972)	41.5%

People

Group

Metric	Period	Latest	Previous	Change
Staff Appraisal Rate (AfC)	Jul-26	81.6%	81.8%	-0.2%
Staff e-Job Planning	Aug-26	85.1%	94.3%	-9.2%
Staff Mandatory Training - Core	Jul-26	85.3%	87.1%	-1.8%
Staff Mandatory Training - Role Specific	Jul-26	81.2%	82.9%	-1.6%
Staff Sickness Absence Rate	Jul-26	4.8%	4.8%	0.0%

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1. Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. The IPR is underpinned by a broader range of metrics and evidence for clinical governance and operational management.

SAFE: Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

EFFECTIVE: People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

RESPONSIVE: People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment are easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality.

CARING: People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

WELL LED: There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

2. Regulation and Compliance

CQC assessment ratings per hospital site and service can be found on the CQC website.

Hull University Teaching Hospitals (HUTH) was rated as **Requires Improvement** by the Care Quality Commission on 23 March 2023.

Safe	Effective	Caring	Responsive	Well-Led	Overall
Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Northern Lincolnshire and Goole Hospitals (NLAG) was rated as **Requires Improvement** by the Care Quality Commission on in December 2022.

Safe	Effective	Caring	Responsive	Well-Led	Overall
Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

3. HHP Key Metric Oversight Scorecard

Oversight Framework

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Oversight Group	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Access to Services	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	56.2%	62.2%	70.8%	65.8%	64.1%	55.9%	72.9%	73.0%	68.4%	66.2%	66.1%	69.5%	
		Cancer - 31 Day All Stages	≥ 94.0%	77.9%	73.9%	79.9%	78.2%	81.1%	72.6%	80.0%	82.6%	78.7%	78.7%	80.7%	79.3%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	55.9%	52.9%	59.7%	61.0%	57.4%	55.4%	55.3%	61.3%	56.9%	53.6%	57.4%	55.1%	
	Elective Care	Outpatient - Follow-up Overdue Backlog (3+ months)		80,774	80,205	80,277	81,157	82,616	81,155	80,063	80,952	81,089	82,310	82,550	83,655	83,969
		RTT - 52+ Week Waits		4,286	4,261	4,215	4,279	3,987	4,087	3,983	3,616	3,803	4,107	4,406	4,743	
		RTT - 65+ Week Waits	≤ 0	116	149	123	163	154	157	147	97	130	191	302	375	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	57.5%	57.6%	57.6%	57.1%	56.8%	56.0%	56.2%	58.0%	58.0%	58.8%	58.4%	57.3%	
		RTT - Total Incomplete Pathways		120,353	120,729	121,435	120,086	120,937	120,981	120,762	120,651	124,408	125,756	126,198	128,361	
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		73.8%	70.9%	69.9%	68.7%	69.3%	69.6%	72.4%	73.8%	73.7%	70.8%	69.6%	71.4%	
		A&E - 4 Hour Standard (All)	≥ 82.0%	68.5%	65.0%	63.4%	62.5%	62.9%	62.0%	66.3%	68.1%	67.8%	65.0%	64.2%	66.0%	64.9%
		A&E - 4 Hour Standard (Type 1)		50.8%	45.4%	44.4%	43.1%	44.8%	42.2%	50.6%	52.8%	52.6%	48.8%	48.8%	50.2%	49.5%
		A&E - 4 Hour Standard (Type 3 - Footprint)		96.6%	95.6%	95.2%	93.9%	94.3%	95.9%	94.2%	96.1%	95.7%	94.2%	92.3%	94.0%	
		A&E - 4 Hour Standard (Type 3)		97.9%	97.2%	95.7%	94.7%	96.3%	96.8%	96.4%	97.2%	96.5%	96.2%	94.1%	96.5%	95.9%
		A&E - Ambulance Handovers within 45 minutes		90.4%	89.8%	90.8%	85.2%	80.9%	75.9%	82.2%	90.7%	87.6%	90.7%	90.1%	87.4%	88.3%
		A&E - DTA to Admission > 12 hours	≤ 0.0%	17.0%	24.8%	26.1%	24.6%	26.8%	37.6%	27.4%	19.9%	20.3%	24.1%	24.6%	21.8%	23.0%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	12.1%	15.3%	17.1%	15.9%	16.0%	20.2%	14.7%	11.7%	11.4%	12.8%	12.9%	11.6%	12.4%
Effectiveness & Experience	Effectiveness	Inpatient - Bed occupancy classed as clinically ready for discharge		23.0%	23.9%	24.4%	25.3%	26.9%	25.1%	25.8%	25.9%	24.2%	23.9%	24.9%	23.2%	23.2%
		Inpatient - Cancelled Operations 28 Day perfomance	≤ 5.0%		29.4%			30.6%			33.5%			29.2%		
		Inpatient - Days between DRD and Discharge Date		4.6	4.5	4.1	4.5	4.6	4.3	5.5	5.1	5.2	4.8	5.2	5.2	12.5
Finance & Productivity	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	81.0%	80.0%	80.0%	81.2%	81.4%	80.2%	80.8%	82.1%	82.2%	82.5%	82.8%	82.1%	82.6%
Reducing Inequalities	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	36.2%	33.4%	35.3%	38.5%	43.7%	44.9%	36.6%	31.8%	35.9%	36.8%	35.2%	35.2%	
		Diagnostics - Total Activity Levels		44,830	45,747	46,366	43,164	42,817	46,564	45,800	52,808	36,658	36,089	37,605	40,623	

4. HHP Group Executive Summary – Performance

Executive Lead: Sam Peate, Group Chief Delivery Officer

Accountable to: Performance, Estate and Finance Committee

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 72.6%	70.6%		
A&E - 4 Hour Standard (All)	Aug-26	≥ 64.6%	61.4%		
A&E - 4 Hour Standard (Type 1)	Aug-26	≥ 50.0%	48.6%		
A&E - 4 Hour Standard (Type 3 - Footprint)	Jul-26	≥ 95.0%	90.0%		
A&E - 4 Hour Standard (Type 3)	Aug-26	≥ 95.0%	92.0%		
A&E - Ambulance Handovers within 45 minutes	Aug-26	≥ 96.4%	98.9%		
A&E - DTA to Admission > 12 hours	Aug-26	≤ 0.0%	8.8%		
A&E - Patients Waiting > 12 hours in Department	Aug-26	≤ 10.1%	7.6%		
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	≥ 71.0%	70.0%		
Cancer - 31 Day All Stages	Jul-26	≥ 76.0%	76.4%		
Cancer - 62 Day All Referral Sources	Jul-26	≥ 54.1%	54.5%		
Diagnostics - 6 Week Standard	Jul-26	≤ 31.3%	36.6%		
Diagnostics - Total Activity Levels	Jul-26	≥ 21,850	21,652		
Inpatient - Bed occupancy classed as clinically ready for dis...	Aug-26		27.4%		
Inpatient - Cancelled Operations (%)	Jul-26	≤ 0.7%	1.3%		
Inpatient - Cancelled Operations 28 Day perfomance	26/27 Q1	≤ 5.0%	36.7%		
Inpatient - Days between DRD and Discharge Date	Aug-26	≤ 4.4	4.7		
Outpatient - Follow-up Overdue Backlog (3+ months)	Aug-26		47,359		
RTT - 52+ Week Waits	Jul-26	≤ 3,308	3,331		
RTT - 65+ Week Waits	Jul-26	≤ 0	277		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 56.0%	56.0%		
RTT - Total Incomplete Pathways	Jul-26	≤ 83,196	85,756		
Theatres - Capped Theatre Utilisation	Aug-26	≥ 85.0%	81.9%		

Northern Lincolnshire and Goole NHS Foundation Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
A&E - 4 Hour Standard (All - Footprint)	Jul-26	≥ 75.9%	72.2%		
A&E - 4 Hour Standard (All)	Aug-26	≥ 73.9%	68.0%		
A&E - 4 Hour Standard (Type 1)	Aug-26	≥ 54.0%	50.4%		
A&E - 4 Hour Standard (Type 3 - Footprint)	Jul-26	≥ 95.0%	98.8%		
A&E - 4 Hour Standard (Type 3)	Aug-26	≥ 99.0%	98.8%		
A&E - Ambulance Handovers within 45 minutes	Aug-26	≥ 88.5%	74.4%		
A&E - DTA to Admission > 12 hours	Aug-26	≤ 0.0%	48.3%		
A&E - Patients Waiting > 12 hours in Department	Aug-26	≤ 14.0%	17.1%		
Cancer - 28 Day Faster Diagnosis Standard	Jul-26	≥ 70.0%	68.7%		
Cancer - 31 Day All Stages	Jul-26	≥ 95.0%	92.8%		
Cancer - 62 Day All Referral Sources	Jul-26	≥ 60.1%	56.7%		
Diagnostics - 6 Week Standard	Jul-26	≤ 29.7%	33.5%		
Diagnostics - Total Activity Levels	Jul-26	≥ 28,830	18,971		
Inpatient - Bed occupancy classed as clinically ready for dis...	Aug-26		16.8%		
Inpatient - Cancelled Operations (%)	Aug-26	≤ 0.7%	2.4%		
Inpatient - Cancelled Operations 28 Day perfomance	26/27 Q1	≤ 5.0%	12.5%		
Inpatient - Days between DRD and Discharge Date	Aug-26	≤ 3.8	28.1		
Outpatient - Follow-up Overdue Backlog (3+ months)	Aug-26		36,610		
RTT - 52+ Week Waits	Jul-26	≤ 887	1,412		
RTT - 65+ Week Waits	Jul-26	≤ 0	98		
RTT - Incomplete 18 Week Standard	Jul-26	≥ 58.6%	59.8%		
RTT - Total Incomplete Pathways	Jul-26	≤ 40,093	42,605		
Theatres - Capped Theatre Utilisation	Aug-26	≥ 85.0%	85.6%		

Chief Delivery Officer Update – Performance Overview (August 2026)

Whilst delivery of activity at an aggregate level is broadly on plan RTT performance in July and August shows some deterioration in compliance and further growth in the overall Trust waiting list size in both HUTH and NLAG. Cancer standards deteriorated across the principal measures and diagnostics remain significantly off the national standard and continue to be constrained by Outpatient capacity.

Cancer performance was mixed in July, 62-day compliance for HUTH remains close to plan with some deterioration in month at NLAG. HUTH improved against the Faster Diagnosis, 62-day and 31-day standards in month. Performance at NLAG showed some improvement on the Faster Diagnosis standard up to 68.7% from 64% in the previous month. Working with NHS England, HHP have been allocated a Cancer Turnaround Director who commenced in post in September and will be working with the Cancer Alliance and other key partners to stress test some of the improvement plans we now have in place.

Diagnostics performance continues to be a major constraint to elective and cancer recovery. Six-week performance remains static at both Trusts, but total waits increased and performance remains materially above the 1% standard, requiring modality- and site-level recovery trajectories for MRI, CT, NOUS and endoscopy, alongside system agreement on capacity, workforce, reporting turnaround and seven-day CDC utilisation. Some improvements in use of the CDC estate have been seen at East Riding Community Hospital and Scunthorpe in recent months.

Unplanned Care performance in August remained below plan across both Trusts with higher levels of demand than plan being seen in both organisations. 12-hour performance has shown year on year improvement in HUTH, with national information indicating the Trust to be the most improved across this metric in the last 12 months. The overall position reflects sustained Type 1 demand, adverse pathway mix and continuing downstream flow constraints, with NLAG presenting the greater immediate risk.

Admission delay remains the principal operational pressure, particularly at NLAG, where handovers and decision-to-admit waits deteriorated in July. Urgent focus is required on admission flow, senior decision-making, escalation of delays and whole-system discharge capacity.

HUTH has seen some deterioration in the Type 1 performance in month in line with regional and national changes in the last period. Handover compliance remains on plan and ambulance handovers remained assured; however, Type 3 performance and whole-pathway flow remain the key gaps. Although mean time to treatment and non-admitted time improved from June, both remain above target and require sustained focus on UTC access, streaming, rapid assessment and alternatives to ED. The UTC on the HRI site is due to open 24/7 in October 26, to support with some of these changes.

NLAG saw further deterioration in performance due to several factors in month, including increasing levels of patients that did not meet the criteria to reside from Lincolnshire Local Authority and increases in demand. Ambulance handover compliance remains a material risk.

a. Hull University Teaching Hospitals Performance AAA Summary

Count: 12

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 3 - Footprint)
A&E - 4 Hour Standard (Type 3)
Cancer - 28 Day Faster Diagnosis Standard
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations 28 Day perfomance
Inpatient - Days between DRD and Discharge Date
RTT - 52+ Week Waits
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 3

Advise

A&E - 4 Hour Standard (Type 1)
A&E - DTA to Admission > 12 hours
Theatres - Capped Theatre Utilisation

Count: 5

Assure

A&E - Ambulance Handovers within 45 minutes
A&E - Patients Waiting > 12 hours in Department
Cancer - 31 Day All Stages
Cancer - 62 Day All Referral Sources
RTT - Incomplete 18 Week Standard

b. Northern Lincolnshire and Goole Hospitals Performance AAA Summary

Count: 17

Alert

A&E - 4 Hour Standard (All - Footprint)
A&E - 4 Hour Standard (All)
A&E - 4 Hour Standard (Type 3)
A&E - Ambulance Handovers within 45 minutes
A&E - DTA to Admission > 12 hours
A&E - Patients Waiting > 12 hours in Department
Cancer - 28 Day Faster Diagnosis Standard
Cancer - 31 Day All Stages
Cancer - 62 Day All Referral Sources
Diagnostics - 6 Week Standard
Diagnostics - Total Activity Levels
Inpatient - Cancelled Operations (%)
Inpatient - Days between DRD and Discharge Date
Outpatient - Follow-up Overdue Backlog (3+ months)
RTT - 52+ Week Waits
RTT - 65+ Week Waits
RTT - Total Incomplete Pathways

Count: 2

Advise

A&E - 4 Hour Standard (Type 1)
Theatres - Capped Theatre Utilisation

Count: 2

Assure

A&E - 4 Hour Standard (Type 3 - Footprint)
RTT - Incomplete 18 Week Standard

c. Unplanned Care

Four-hour performance remained below trajectory at both Trusts in August. Type 1 performance was 48.6% at HUTH and 50.4% at NLAG, compared with 49.8% and 50.5% respectively in July.

Demand mix remains adverse: Type 1 attendance was above trajectory and Type 3 attendance below trajectory at both Trusts, limiting the expected benefit from UTC and redirection pathways.

Admission delay remains the principal risk. Decision-to-admit waits over 12 hours were 8.8% at HUTH and 48.3% at NLAG. Handovers within 45 minutes were 98.9% at HUTH and 74.4% at NLAG.

Progress

- HUTH handovers strengthened, but Type 1 performance fell to 48.6% and patients waiting over 12 hours increased to 7.6%.
- NLAG handovers improved slightly, but only 74.4% were completed within 45 minutes. Decision-to-admit waits over 12 hours remained very high at 48.3% and 24-hour waits increased to 13.7%.
- Treatment and non-admitted times remained above target at both Trusts, despite improvement at HUTH.
- Front-door frailty, streaming, SDEC, UTC and SHOP work progressed.
- Golden Patient, EDD, criteria-led discharge and Home First remain core flow actions.
- PAU activity, breach and CAMHS analyses are supporting paediatric pathway implementation.

Action

Recover four-hour performance through streaming, SDEC and timely specialty response, focusing on NLAG handovers and admitted flow.

Continual flow model to be implemented in October following a 3 week comms piece at NLaG.

- Taken the South Bank flow-out model to SLT and roll out in three weeks, using North Bank learning and monitoring temporary escalation spaces until morning discharge improves.
- Embed criteria to admit and seven-day senior decision-making across relevant specialties.
- Commence GIRFT length-of-stay rounds at SGH on 14th September, DPoW on 21st September and HUTH on 27th September, starting with stays over 17 days and escalating NCTR barriers.
- Align winter, care-group surge and bed-modelling outputs before Board approval W/C 14th September.

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Corridor Care on Wards		51.8	65.2	60.7	57.4	64.9	70.9	68.8	49.3	40.0	46.8	45.9	41.0	40.8
		Inpatient - Discharge Lounge Utilisation		13.5%	14.3%	12.2%	11.6%	7.3%	11.2%	14.9%	15.5%	14.7%	14.5%	15.0%	16.3%	14.9%
		Inpatient - Discharge to Assess (D2A) over 14 days		2.7%	2.6%	1.7%	1.7%	2.3%	2.4%	3.2%	2.9%	3.0%	2.9%	2.4%	3.1%	2.4%
		Inpatient - Discharges by 5pm		61.7%	63.8%	62.2%	63.9%	65.2%	61.0%	64.7%	64.7%	62.2%	61.6%	63.4%	64.0%	62.8%
		Inpatient - Long Stay Occupancy (21+ days)		196.8	211.8	190.7	183.3	183.3	210.5	208.3	199.2	203.8	192.3	194.5	178.1	185.8
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		71.6%	68.5%	67.3%	67.4%	69.5%	69.8%	70.4%	73.2%	74.6%	70.0%	67.5%	70.6%	
		A&E - 4 Hour Standard (Type 1 - Admitted)		25.8%	21.5%	21.4%	24.9%	26.3%	23.4%	24.2%	26.5%	31.0%	26.0%	26.3%	31.0%	27.5%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		55.5%	51.0%	49.5%	50.5%	56.7%	50.9%	56.4%	61.5%	64.4%	56.7%	55.2%	57.7%	57.4%
		A&E - 4 Hour Standard (Type 1)		46.3%	42.1%	40.9%	42.6%	47.1%	42.6%	46.3%	50.7%	54.1%	47.7%	46.9%	49.8%	48.6%
		A&E - Ambulance Average Handover Time		20.8	23.1	23.8	23.9	23.8	26.6	20.4	19.2	18.6	19.5	20.1	19.1	20.0
		A&E - Ambulance Handovers within 45 minutes		96.8%	95.3%	94.6%	92.8%	93.2%	91.1%	90.4%	98.2%	96.3%	97.8%	98.3%	98.3%	98.9%
		A&E - Ambulance Handovers within 60 minutes		99.1%	98.5%	98.4%	96.5%	97.1%	95.4%	99.2%	99.5%	99.4%	99.5%	99.6%	99.5%	99.6%
		A&E - Corridor Care in Dept		34	48	41	30	33	44	26	22	17	23	29	13	22
		A&E - DTA to Admission > 12 hours	≤ 0.0%	10.5%	19.8%	21.5%	16.3%	19.7%	28.0%	14.7%	11.7%	9.2%	15.0%	14.7%	5.6%	8.8%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	1.4%	3.1%	5.2%	3.4%	4.8%	10.4%	1.0%	0.6%	0.8%	0.3%	0.8%	0.0%	0.1%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	10.1%	15.0%	17.4%	14.2%	14.0%	18.3%	11.8%	9.0%	6.9%	10.5%	10.2%	5.6%	7.6%
		A&E - Specialty Referral to Departure within 30 minutes		11.8%	10.8%	11.0%	11.0%	11.6%	11.1%	13.3%	13.1%	12.0%	10.6%	12.3%	12.4%	11.4%
		A&E - Time to Initial Assessment	≤ 15	20	30	34	29	24	25	19	17	18	20	21	20	21
		A&E - Total Time in A&E (Admitted)	≤ 180	532	668	733	622	638	801	579	509	465	545	543	416	465

NLAG Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Corridor Care on Wards		2.0	3.0	2.4	1.9	3.7	3.8	3.9	4.0	7.3	3.3	3.7	2.0	0.4
		Inpatient - Discharge Lounge Utilisation		19.8%	17.1%	20.9%	16.4%	17.7%	19.5%	19.4%	20.0%	21.2%	19.2%	18.1%	16.0%	15.9%
		Inpatient - Discharge to Assess (D2A) over 14 days		2.3%	2.0%	2.5%	2.2%	3.2%	3.3%	5.1%	4.2%	1.4%	4.5%	3.6%	3.6%	2.5%
		Inpatient - Discharges by 5pm		74.1%	74.7%	72.4%	75.5%	73.6%	71.3%	72.0%	73.1%	71.4%	71.8%	73.7%	71.2%	72.6%
		Inpatient - Long Stay Occupancy (21+ days)		76.6	77.0	78.0	82.9	84.9	85.5	97.3	86.9	81.8	84.8	88.1	88.5	93.6
	Urgent & Emergency Care	A&E - 4 Hour Standard (All - Footprint)		76.1%	73.4%	72.7%	70.1%	68.9%	69.4%	74.6%	74.4%	72.8%	71.7%	71.7%	72.2%	
		A&E - 4 Hour Standard (Type 1 - Admitted)		17.9%	10.1%	11.1%	9.6%	11.2%	7.7%	8.8%	10.8%	8.3%	10.3%	8.7%	8.3%	8.7%
		A&E - 4 Hour Standard (Type 1 - NonAdmitted)		64.5%	57.9%	57.1%	51.9%	50.8%	50.5%	64.0%	64.7%	60.2%	58.3%	58.9%	58.4%	58.4%
		A&E - 4 Hour Standard (Type 1)		55.4%	48.9%	48.0%	43.7%	42.3%	41.8%	54.5%	54.9%	51.2%	49.9%	50.6%	50.5%	50.4%
		A&E - Ambulance Average Handover Time		31.0	29.0	26.0	37.0	51.0	61.0	45.0	32.0	36.0	31.0	32.0	38.0	38.0
		A&E - Ambulance Handovers within 45 minutes		82.4%	83.3%	86.5%	75.6%	65.6%	57.0%	71.5%	81.7%	77.2%	82.5%	80.3%	73.6%	74.4%
		A&E - Ambulance Handovers within 60 minutes		87.7%	89.2%	91.5%	82.8%	72.5%	65.7%	78.6%	87.3%	84.0%	88.1%	86.7%	81.4%	81.3%
		A&E - Corridor Care in Dept		7	9	9	10	11	9	11	9	11	10	10	10	13
		A&E - DTA to Admission > 12 hours	≤ 0.0%	27.4%	33.0%	33.3%	38.0%	37.8%	52.5%	48.9%	32.9%	39.2%	38.5%	41.0%	50.3%	48.3%
		A&E - DTA to Admission > 24 hours	≤ 0.0%	7.5%	7.6%	7.9%	11.0%	11.6%	16.9%	14.7%	6.5%	9.7%	8.1%	10.3%	10.5%	13.7%
		A&E - Patients Waiting > 12 hours in Department	≤ 0.0%	14.2%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%	15.8%	15.0%	15.6%	17.3%	17.1%
		A&E - Specialty Referral to Departure within 30 minutes		6.0%	5.2%	5.0%	4.1%	4.2%	4.5%	4.2%	5.0%	4.0%	3.7%	4.1%	5.0%	3.5%
		A&E - Time to Initial Assessment	≤ 15	43	46	48	53	56	52	43	42	41	41	43	45	42
		A&E - Total Time in A&E (Admitted)	≤ 180	581	670	667	687	667	776	730	667	701	697	710	768	762

i. Emergency Care Standards – 4-hour Performance

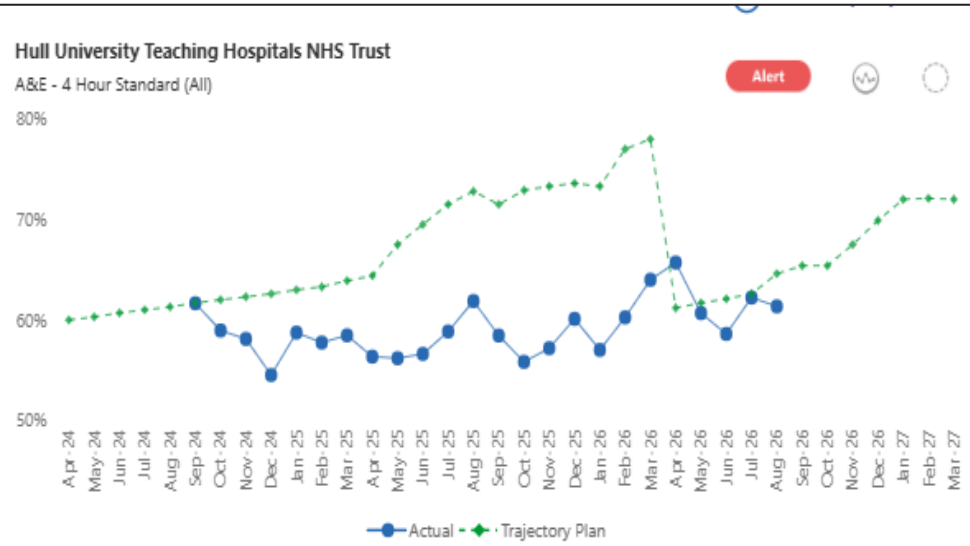
A&E - 4 Hour Standard (All)

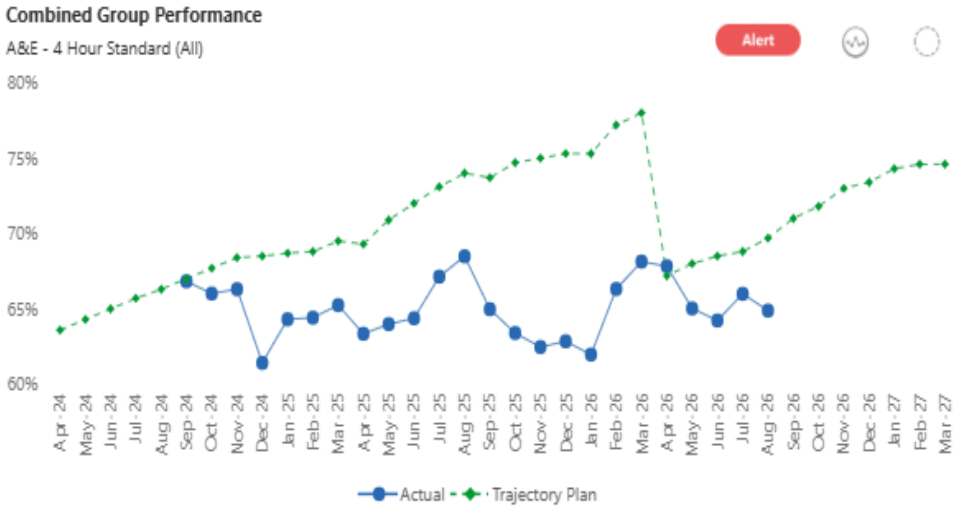
Progress:

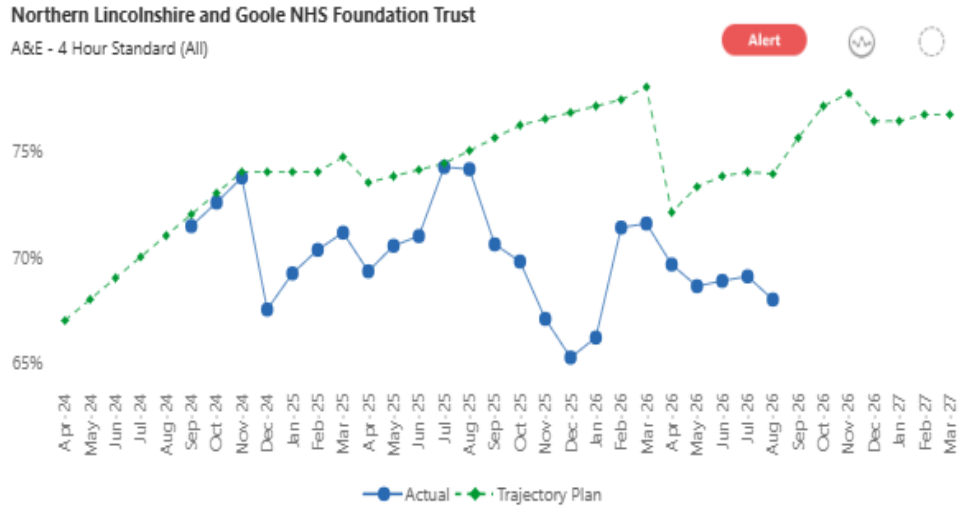
- All-type performance remained below trajectory at both Trusts in August; frailty, UTC, SDEC, paediatric and NCTR work continued.
- HUTH Type 1 performance was 48.6%; handovers remained assured at 98.9% within 45 minutes, but decision-to-admit waits over 12 hours increased to 8.8%.
- NLAG Type 1 performance was 50.4%; handovers improved to 74.4% within 45 minutes and decision-to-admit waits over 12 hours reduced to 48.3%, but both remain material risks.

Action:

- Recover HUTH UTC and Type 3 performance with CHCP; strengthen frailty, streaming and SDEC. Call before conveying to incorporate consultant at SGH from W/C 14th, DPOW from October.
- Implement front-door frailty SDEC and PAU actions; deliver South Bank flow-out to recover handovers and admitted flow.
- Escalate demand, long-stay, NCTR and discharge constraints daily and align with winter and bed-modelling plans.







ii. Enabler Metric 1: Mean Time to Treatment

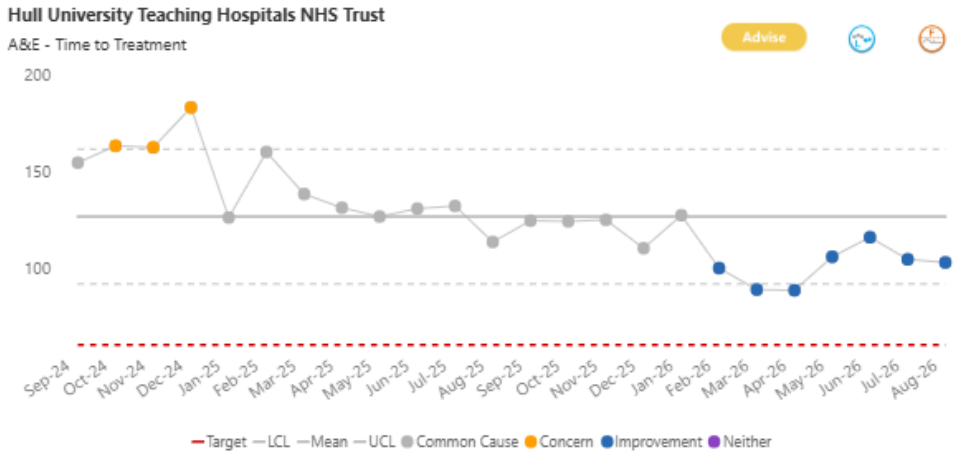
A&E - Time to Treatment

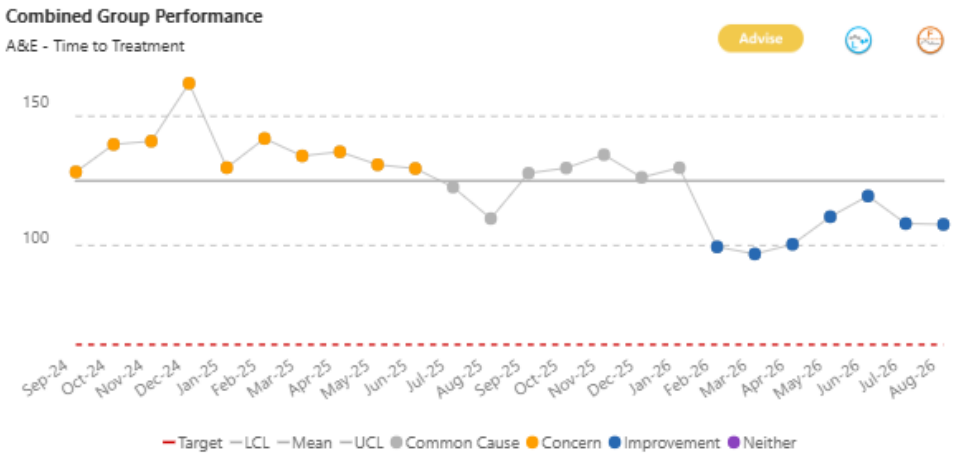
HUTH:

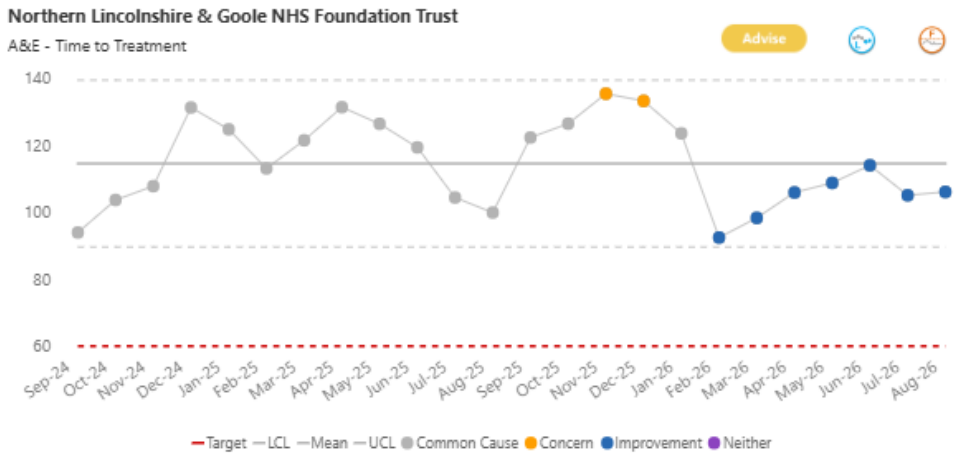
Mean time to treatment improved again in August and remained below the historical mean but was still above 100 minutes and the 60-minute operational target. Early clinical assessment, streaming and rapid decision-making must therefore be sustained at peak times.

NLAG:

Mean time to treatment was broadly stable in August at just over 100 minutes and remained materially above target. Recovery requires rapid assessment, effective streaming, escalation of delay and senior clinical decision-making at the front door.







iii. Enabler Metric 2: Non-Admitted Total Time in Department

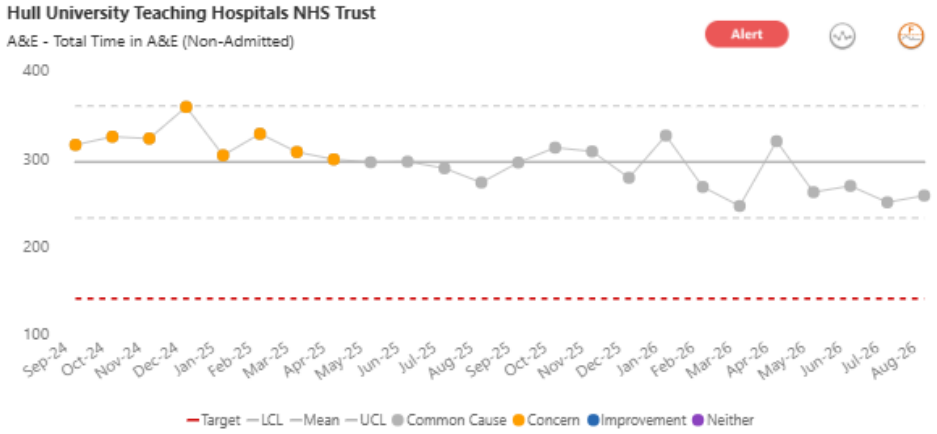
A&E - Total Time in A&E (Non-Admitted)

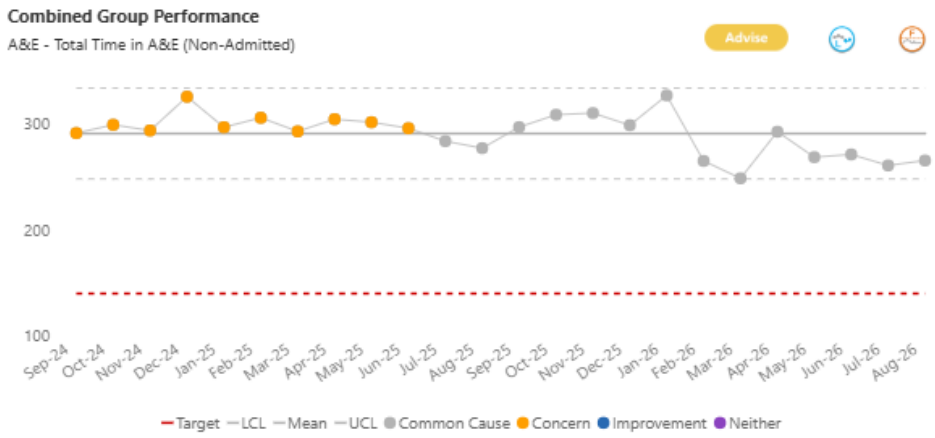
HUTH:

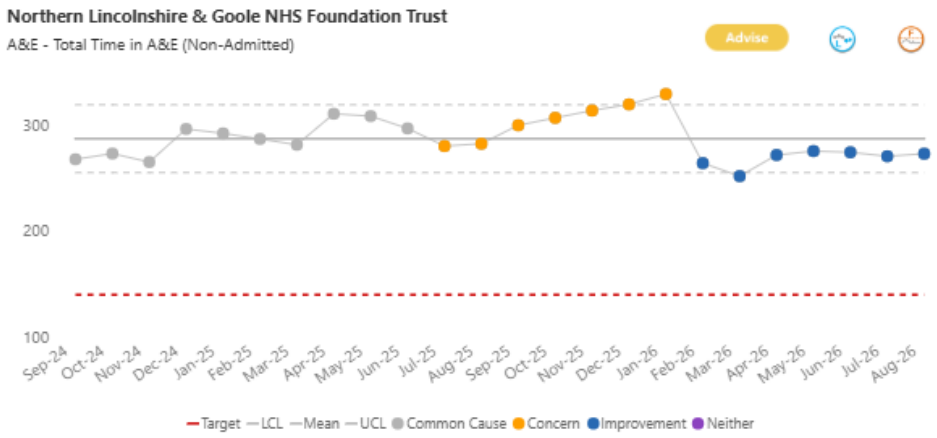
Non-admitted time improved in August but remained substantially above the 140-minute target. The response is to strengthen early streaming, rapid assessment and discharge from ED pathways, with daily review of avoidable waits for patients who do not require admission.

NLAG:

Non-admitted time was broadly stable in August and remained below the historical mean, but was still materially above the 140-minute target. Continued focus is required on UTC streaming, SDEC alternatives, specialty response and timely clinical decision-making.







iv. Enabler Metric 4: A&E Attendances – Type 1 Attendances

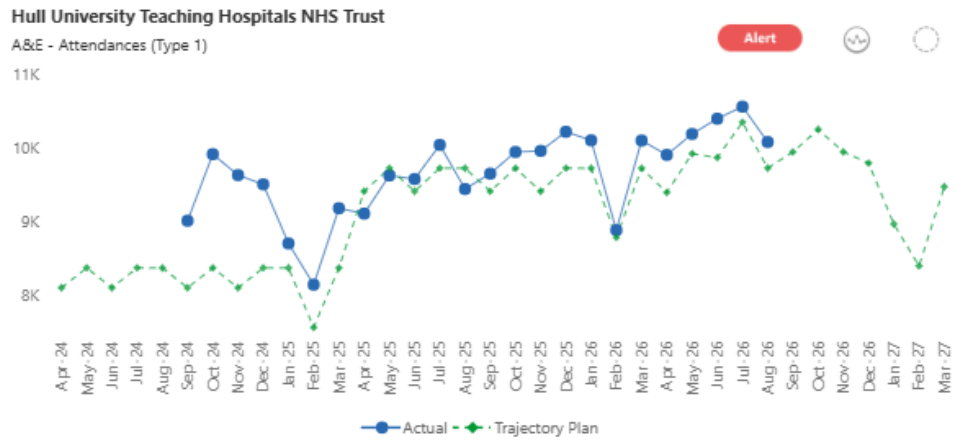
A&E - Attendances (Type 1)

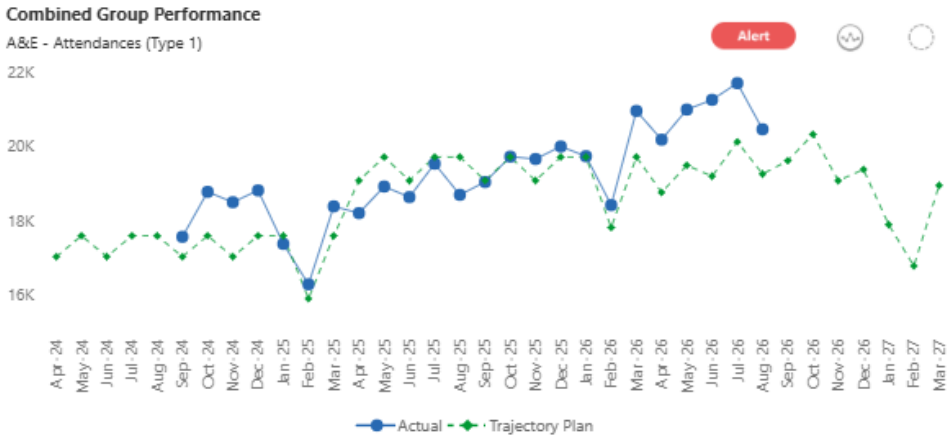
HUTH:

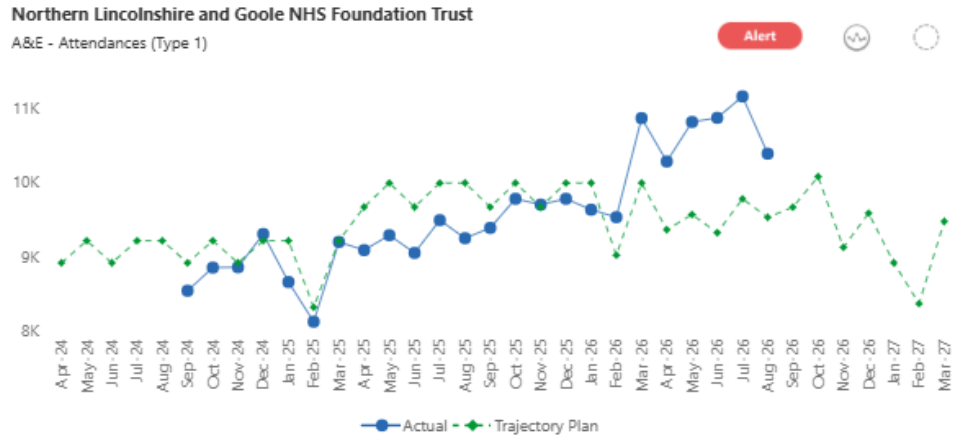
Type 1 attendances reduced from July but remained above trajectory in August, continuing the sustained upward pressure on ED. Action remains focused on streaming, alternatives to ED, SDEC and demand management with system partners.

NLAG:

Type 1 attendances reduced from July but remained materially above trajectory in August, confirming a sustained adverse shift in demand. Recovery requires stronger UTC streaming, alternatives to ED, site-level demand management and system action to reduce avoidable Type 1 conveyance and attendance.







v. Enabler Metric 5: A&E Attendances – Type 3 Attendances

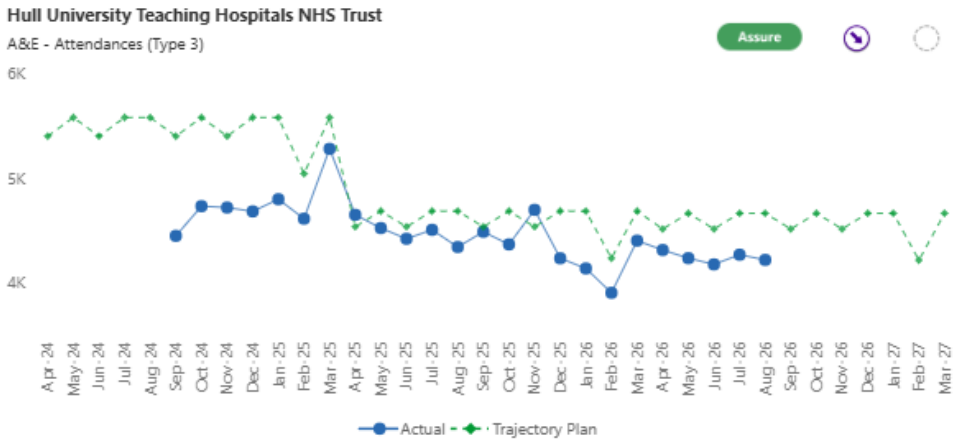
A&E - Attendances (Type 3)

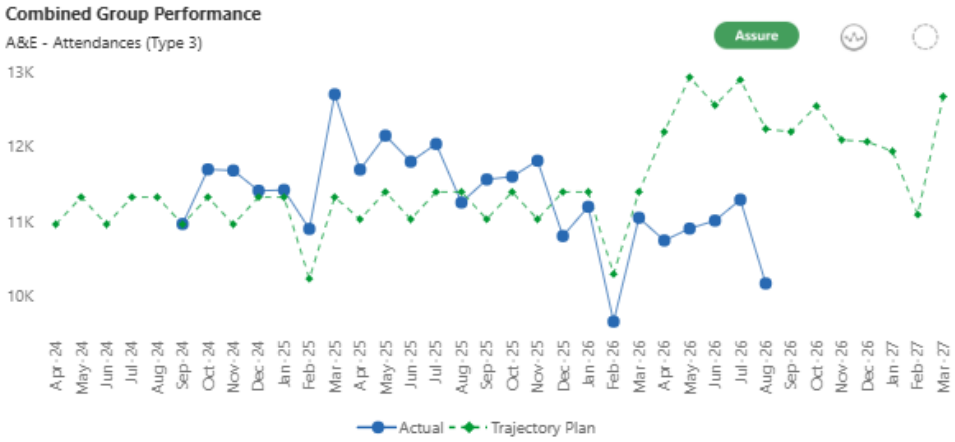
HUTH:

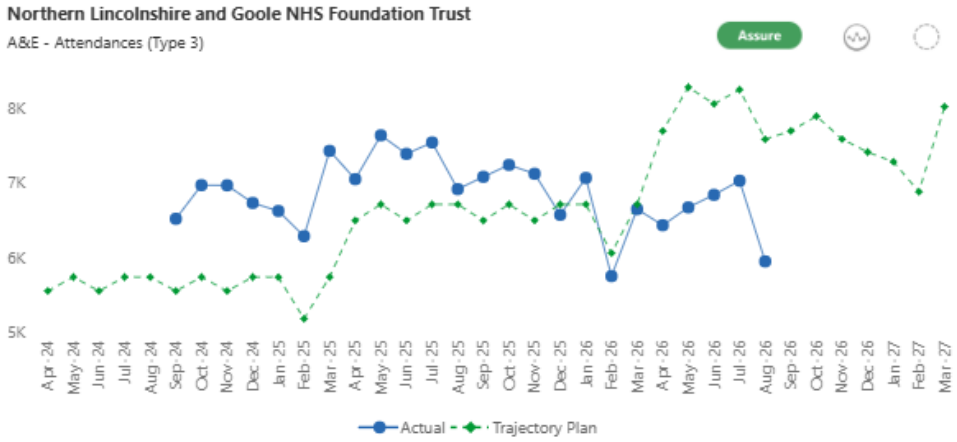
Type 3 attendances remained below trajectory in August while Type 1 demand was above plan. Although the statistical classification is Assure, the demand shift is operationally adverse; UTC access, streaming and redirection pathways require review with system partners.

NLAG:

Type 3 attendances fell further below trajectory in August while Type 1 activity remained materially above plan. The Assure classification reflects the statistical direction, but the pathway mix is adverse; actions are to strengthen UTC utilisation, streaming, redirection and public access to alternatives to ED.







d. Planned Care

National August RTT and cancer data is not yet available because of recent changes to the national submission timetable of monthly RTT submissions. The yellow-highlighted RTT incomplete and 52-week measures therefore remain based on July. All other measures use the latest position shown in the accompanying graphs.

Long waits remain the main risk in the August update. The latest 65-week position indicates 356 patients at HUTH and 163 at NLAG. The yellow-highlighted July 52-week position remains 3,331 at HUTH and 1,412 at NLAG.

Progress

For the August update, the latest available cancer data remains in July. Performance is below standard: 62-day was 54.5% at HUTH (on plan) and 56.7% at NLAG; 31-day first treatment was 83.8% and 93.9%; and Faster Diagnosis was 70.0% and 68.7% respectively – both organizations are operating close to plan for this measure.

The August update uses the latest Time to First Appointment position of 62.6% at HUTH and 69.6% at NLAG. August RTT validation improved to 95.2% at HUTH and 90.0% at NLAG. LUNA-ROVA deployment in August and September will strengthen patient-level tracking and exception management.

For the August update, the latest diagnostic six-week position improved by 0.6 percentage points at HUTH to 36.6% but deteriorated by 0.9 percentage points at NLAG to 33.5%. Both remain materially above the 1% standard.

August theatre utilisation was 81.9% at HUTH and 85.6% at NLAG. The August combined follow-up backlog increased by 314 to 83,969: HUTH reduced to 47,359 but NLAG increased to 36,610.

Action

Maintain weekly specialty trajectories and dated plans for the 52-, 65- and 78-week cohorts; escalate unsecured capacity immediately.

- Recover first outpatient access through slot fill, booking controls, referral management and SPOA/GIRFT pathway changes.
- Sustain weekly RTT validation and track LUNA-ROVA through validation compliance, unresolved exceptions and correction times.
- Agree MRI, CT, NOUS and endoscopy trajectories by modality and site, with confirmed capacity, workforce, reporting and funding.
- Reset tumour-site milestones against Best Practice Timed Pathways and protect diagnostic, pathology, MDT and treatment capacity.
- Recover HUTH theatre utilisation to 85% and maintain NLAG above 85%.
- Maintain a daily cancelled-patient PTL and secure rebooking capacity before day 28. Report trajectory, action impact, owner and delivery date weekly.

HUTH

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	52.1%	59.8%	70.7%	60.2%	58.7%	52.9%	74.6%	76.6%	71.2%	70.6%	67.3%	70.0%	
		Cancer - 31 Day All Stages	≥ 94.0%	74.0%	69.1%	75.5%	74.0%	76.7%	67.5%	76.2%	78.4%	73.5%	75.2%	77.2%	76.4%	
		Cancer - 31 Day First Treatment	≥ 94.0%	76.1%	73.7%	81.1%	80.3%	78.3%	72.3%	77.4%	80.0%	81.2%	79.7%	81.4%	83.8%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	48.8%	50.2%	55.5%	57.4%	53.7%	52.0%	51.6%	56.0%	52.9%	49.4%	54.4%	54.5%	
		Cancer - 62 Day GP Referral	≥ 80.0%	33.2%	44.3%	49.9%	49.7%	43.6%	39.7%	44.5%	55.8%	49.4%	41.2%	44.1%	43.9%	
		Cancer - PTL Waits 104+ days		304	298	336	241	236	222	232	237	232	226	235	249	
	Elective Care	Outpatient - Clinic Slot Utilisation		96.6%	95.4%	94.5%	94.4%	93.3%	95.1%	96.4%	95.6%	96.1%	95.8%	94.9%	95.6%	95.3%
		Outpatient - DNA Rate	≤ 8.5%	6.8%	5.8%	5.8%	5.9%	6.0%	5.9%	5.4%	5.6%	5.7%	5.8%	5.8%	5.9%	5.7%
		Outpatient - Follow-up Overdue Backlog (3+ months)		46,268	46,343	46,284	47,461	48,561	47,880	46,880	47,001	46,354	46,905	46,821	47,753	47,359
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	7.2%	7.0%	7.1%	7.4%	7.0%	6.9%	6.9%	7.0%	6.4%	6.9%	7.1%	7.0%	6.8%
		RTT - 52+ Week Waits		3,261	3,216	3,221	3,291	3,072	3,157	3,110	2,796	2,888	3,069	3,188	3,331	
		RTT - 65+ Week Waits	≤ 0	62	85	96	134	112	131	109	65	89	141	224	277	
		RTT - 78+ Week Waits	≤ 0	0	2	0	0	0	0	2	0	1	3	5	7	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	56.7%	56.7%	56.5%	56.0%	55.6%	54.9%	54.6%	56.3%	56.3%	57.3%	56.8%	56.0%	
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	90.2%	94.9%	93.5%	95.5%	95.6%	96.9%	95.5%	93.9%	92.0%	92.0%	92.5%	95.0%	95.2%
		RTT - Patients waiting <= 18 weeks for 1st appointment		65.1%	64.5%	64.3%	64.4%	62.6%	62.9%	62.9%	64.6%	65.1%	65.4%	64.3%	62.6%	
		RTT - Total Incomplete Pathways		80,655	80,583	81,279	80,790	81,643	81,337	81,319	80,999	83,615	84,208	84,186	85,756	
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	81.1%	79.6%	80.0%	81.3%	81.0%	80.0%	80.6%	82.1%	81.9%	82.2%	82.6%	82.2%	81.9%
		Theatres - Early Finishes		68.4%	65.6%	66.9%	64.2%	66.0%	69.7%	67.6%	67.2%	63.3%	64.8%	62.4%	66.1%	61.2%
		Theatres - Late Starts		65.4%	68.6%	69.9%	68.7%	66.0%	69.0%	65.4%	61.7%	64.7%	65.5%	66.4%	68.6%	67.9%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	32.4%	30.0%	31.3%	34.5%	40.2%	42.8%	35.9%	33.8%	38.1%	38.6%	37.2%	36.6%	
		Diagnostics - Total Activity Levels		18,463	20,488	20,788	19,009	18,875	20,662	20,542	21,934	18,996	19,337	20,386	21,652	
		Diagnostics - Total Waits		15,668	17,424	18,458	19,247	20,037	21,431	21,518	23,025	22,796	22,456	23,901	23,885	

NLAG

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	64.3%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%	63.0%	58.5%	64.0%	68.7%	
		Cancer - 31 Day All Stages	≥ 94.0%	95.1%	94.9%	95.5%	97.3%	98.7%	90.8%	96.0%	98.1%	97.1%	92.2%	94.1%	92.8%	
		Cancer - 31 Day First Treatment	≥ 94.0%	95.1%	96.5%	94.8%	97.3%	98.0%	92.1%	95.8%	98.1%	98.0%	93.8%	93.6%	93.9%	
		Cancer - 62 Day All Referral Sources	≥ 80.0%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	65.0%	64.0%	64.1%	56.7%	
		Cancer - 62 Day GP Referral	≥ 80.0%	66.4%	45.1%	54.8%	58.5%	61.1%	57.1%	58.5%	66.8%	60.1%	61.0%	54.9%	43.2%	
		Cancer - PTL Waits 104+ days		45	42	41	39	34	42	32	40	40	46	35	36	
	Elective Care	Outpatient - Clinic Slot Utilisation		94.9%	95.7%	92.9%	91.9%	92.0%	92.8%	92.3%	92.9%	92.1%	92.3%	93.1%	79.0%	91.9%
		Outpatient - DNA Rate	≤ 8.5%	7.5%	7.6%	7.4%	7.3%	7.6%	7.2%	6.8%	7.0%	7.1%	6.7%	6.8%	6.8%	7.0%
		Outpatient - Follow-up Overdue Backlog (3+ months)		34,506	33,862	33,993	33,696	34,055	33,275	33,183	33,951	34,735	35,405	35,729	35,902	36,610
		Outpatient - Hospital cancellations < 6 weeks	≤ 5.0%	8.3%	8.2%	8.0%	9.1%	8.0%	7.6%	7.5%	8.4%	8.3%	8.8%	7.8%	8.0%	8.7%
		RTT - 52+ Week Waits		1,025	1,045	994	988	915	930	873	820	915	1,038	1,218	1,412	
		RTT - 65+ Week Waits	≤ 0	54	64	27	29	42	26	38	32	41	50	78	98	
		RTT - 78+ Week Waits	≤ 0	2	3	1	0	0	1	2	2	0	1	2	2	
		RTT - Incomplete 18 Week Standard	≥ 92.0%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	61.4%	62.0%	61.6%	59.8%	
		RTT - Pathways Validated within 12 weeks	≥ 90.0%	90.6%	90.2%	89.1%	87.8%	90.0%	85.0%	91.2%	93.0%	86.1%	89.5%	90.4%	87.5%	90.0%
		RTT - Patients waiting <= 18 weeks for 1st appointment		68.4%	67.6%	67.3%	68.0%	67.2%	66.5%	69.7%	71.3%	72.2%	72.4%	71.6%	69.6%	
		RTT - Total Incomplete Pathways		39,698	40,146	40,156	39,296	39,294	39,644	39,443	39,652	40,793	41,548	42,012	42,605	
	Productivity	Theatres - Capped Theatre Utilisation	≥ 85.0%	80.8%	81.9%	79.9%	81.1%	82.9%	81.2%	81.5%	81.8%	83.7%	83.9%	84.0%	81.5%	85.6%
		Theatres - Early Finishes		49.7%	50.3%	61.4%	57.1%	52.4%	53.9%	57.4%	53.2%	58.4%	52.7%	47.4%	58.5%	43.2%
		Theatres - Late Starts		98.0%	100.0%	98.4%	99.0%	99.4%	98.5%	98.2%	98.3%	100.0%	98.7%	98.8%	98.8%	98.7%
Responsive	Primary Prevention	Diagnostics - 6 Week Standard	≤ 1.0%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	33.0%	34.4%	32.6%	33.5%	
		Diagnostics - Total Activity Levels		26,367	25,259	25,578	24,155	23,942	25,902	25,258	30,874	17,662	16,752	17,219	18,971	
		Diagnostics - Total Waits		22,803	23,942	24,162	25,675	26,004	26,804	27,270	24,997	17,062	16,998	18,789	18,447	

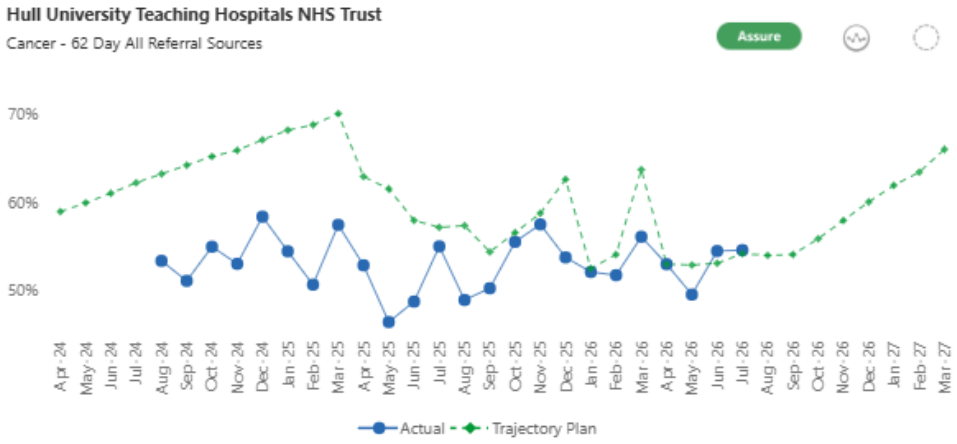
a. Cancer 62 Day First Definitive Treatment

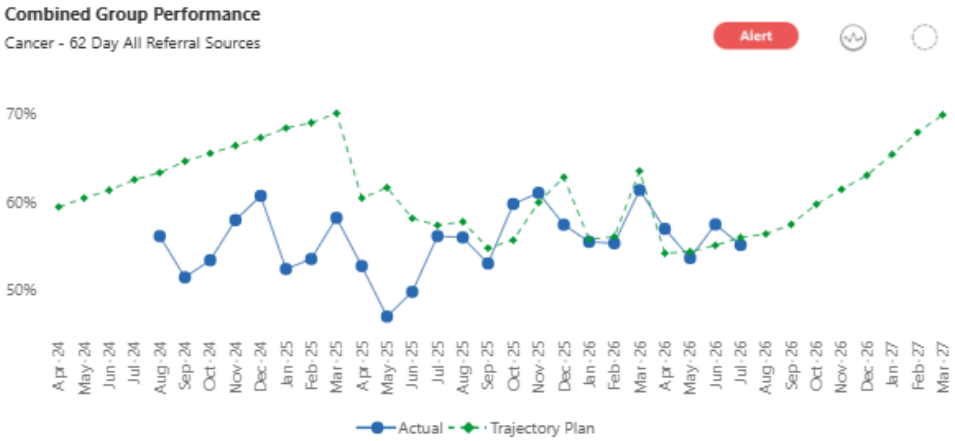
Cancer - 62 Day All Referral Sources

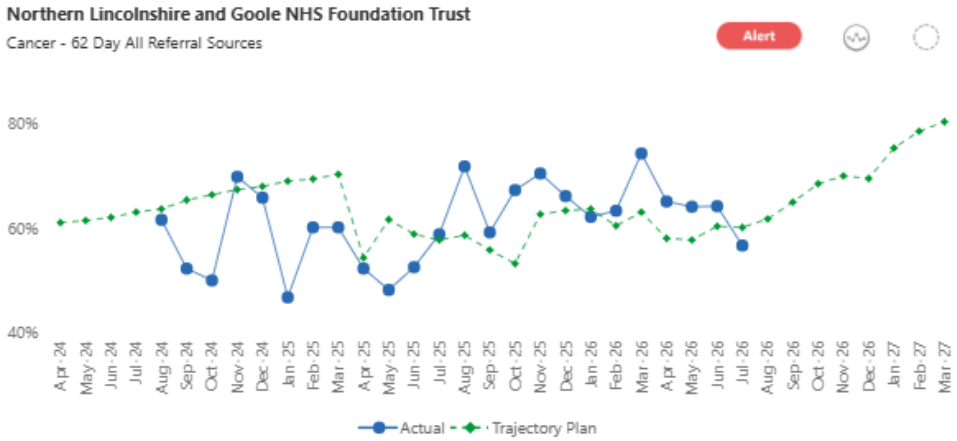
Summary:
August update: the latest available national cancer data remains July. The graph shows 62-day performance of 54.5% at HUTH and 56.7% at NLAG. Both Trusts remain below the 80% standard.

Progress:
HUTH was stable in the latest data, while NLAG reduced from 64.1% in June. Radiotherapy, scheduling, histology and urology actions have not yet produced consistent recovery.

Action:
Complete weekly tumour-level breach analysis and Best Practice Timed Pathway review. Escalate any diagnostic, pathology, MDT, theatre or robotic-capacity gap preventing delivery.







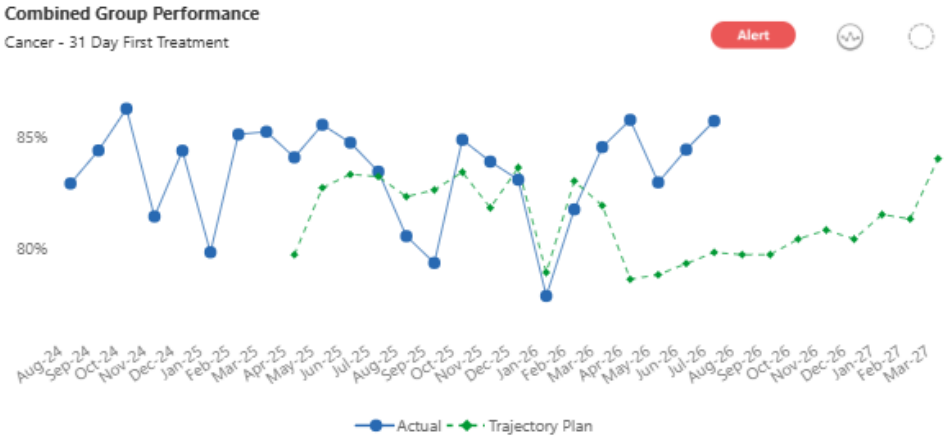
ii. Cancer 31-day First Treatment

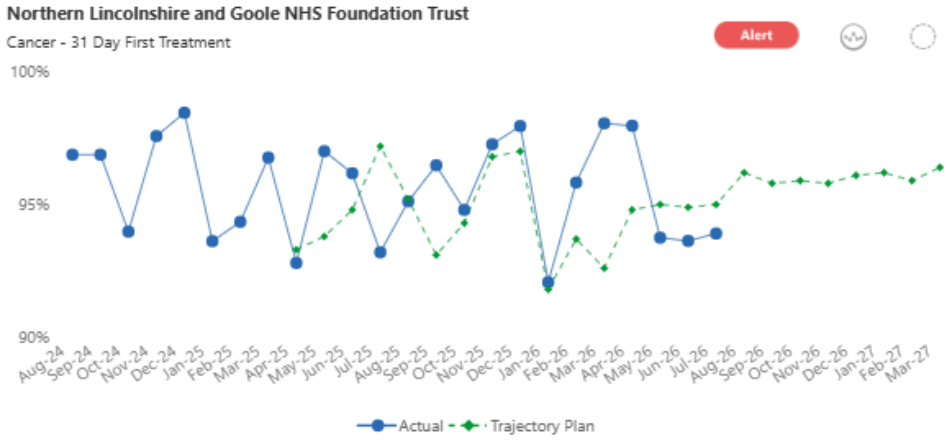
Cancer - 31 Day First Treatment

Summary:
August update: the latest available national cancer data remains July. The graph shows 31-day first-treatment performance of 83.8% at HUTH and 93.9% at NLAG. Both remain below the 94% standard.

Progress:
Both Trusts improved in the latest data, but HUTH remains 10.2 percentage points below standard and current pathway actions are not yet delivering the required recovery.

Action:
Review every 31-day breach weekly and reset tumour-level trajectories. Protect diagnostic, MDT and treatment slots and escalate unresolved capacity gaps.





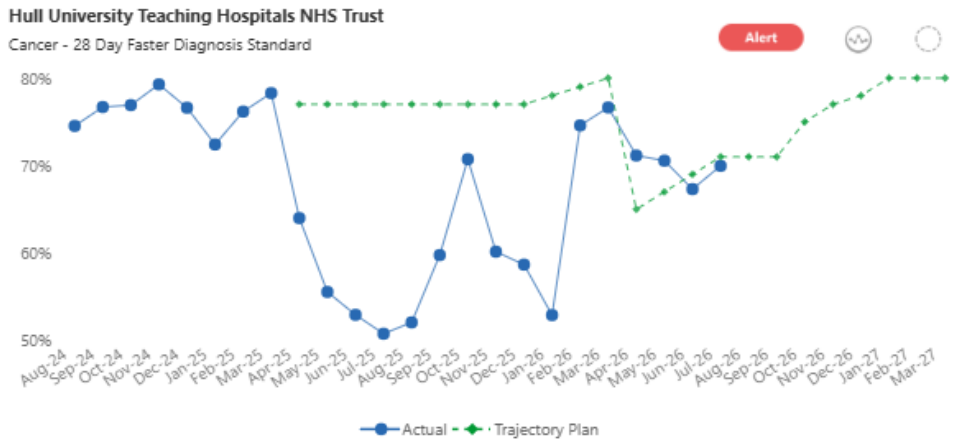
iii. Cancer 28-day Faster Diagnosis Performance

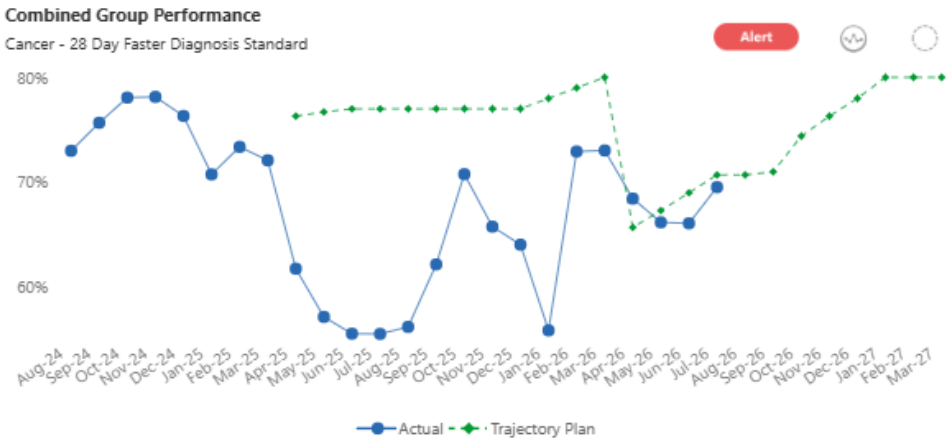
Cancer - 28 Day Faster Diagnosis Standard

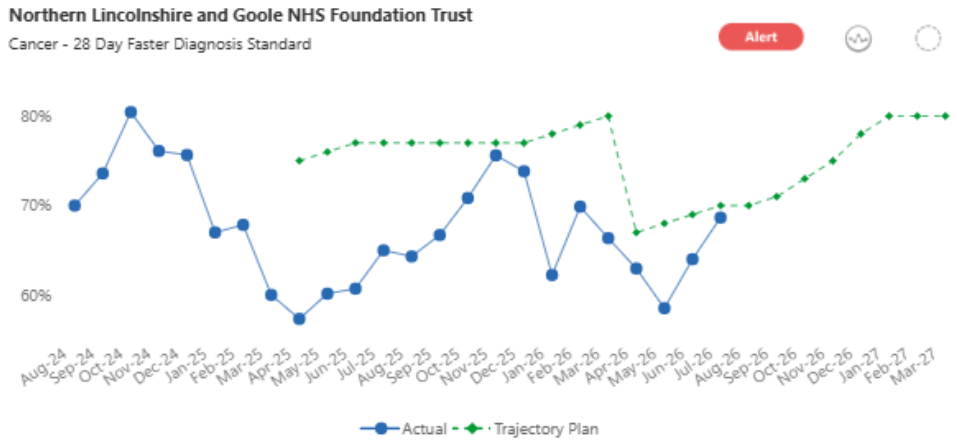
Summary:
August update: the latest available national cancer data remains July. The graph shows Faster Diagnosis performance of 70.0% at HUTH and 68.7% at NLAG. Both Trusts remain below trajectory and the 80% standard.

Progress:
The latest data improved at both Trusts, but delivery remains below the required level across tumour pathways.

Action:
Complete Best Practice Timed Pathway reviews and track diagnostics weekly by tumour site. Resolve breast radiology, fellowship, nurse-endoscopy and reporting-capacity gaps







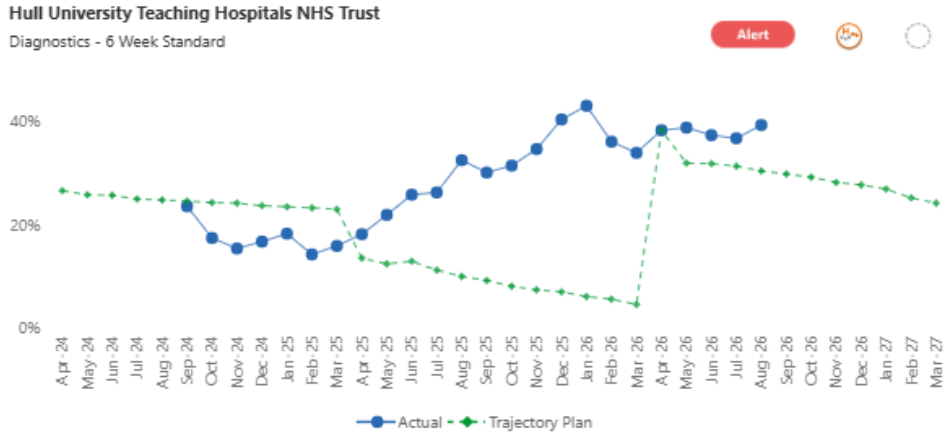
iv. Diagnostic 6-Week Standard

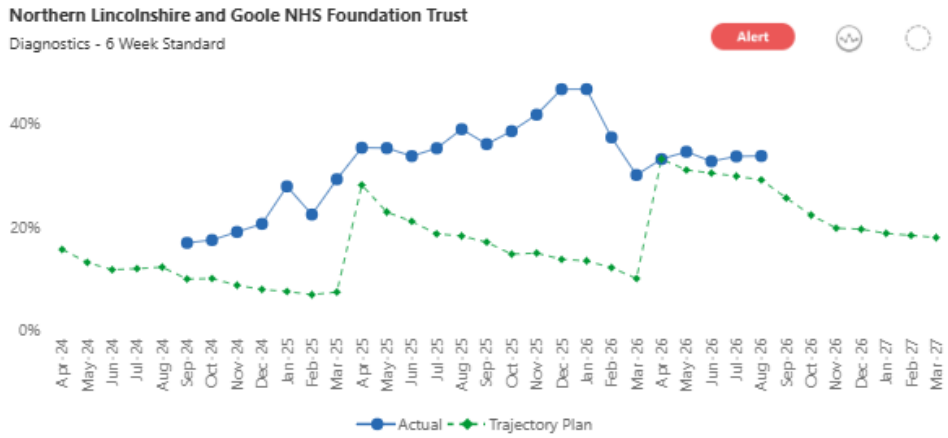
Diagnostics - 6 Week Standard

Summary:
August update: the latest graph position is 36.6% at HUTH and 33.5% at NLAG. Both Trusts remain materially above the 1% six-week standard.

Progress:
CDC, NOUS, non-recurrent investment and Scunthorpe MRI actions are providing some improvement, but delivered capacity remains below demand.

Action:
Agree monthly recovery trajectories by modality and site. Confirm MRI and CT capacity, workforce, reporting turnaround, funding and seven-day CDC utilisation.





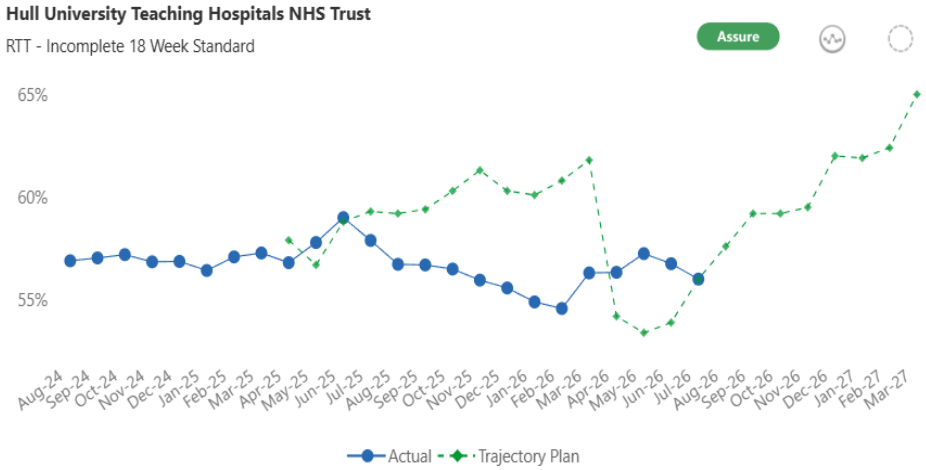
v. RTT Incomplete Performance

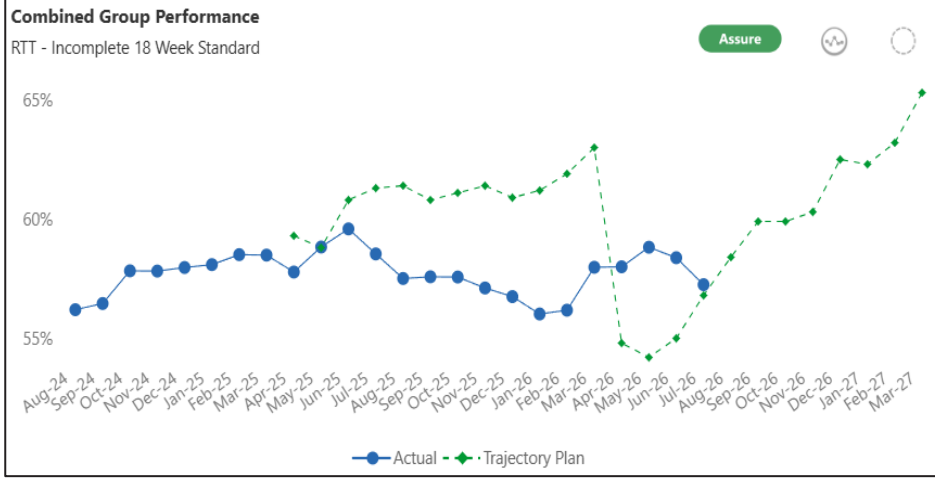
RTT - Incomplete 18 Week Standard

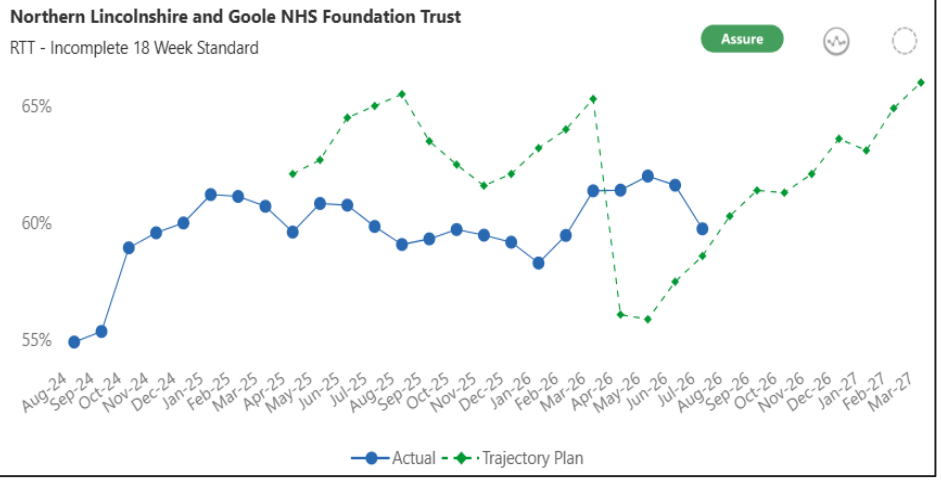
Summary:
July RTT performance reduced by 0.8 percentage points at HUTH to 56.0% and by 1.8 points at NLAG to 59.8%. Both Trusts remain well below the 92% standard and below their July trajectory.

Progress:
Outpatient transformation, demand-and-capacity and scheduler work has not yet produced a sustained improvement in the incomplete position.

Action:
Complete Care Group demand-and-capacity reviews and agreed SPOA and GIRFT changes. Escalate each specialty capacity gap with a named owner and delivery date.







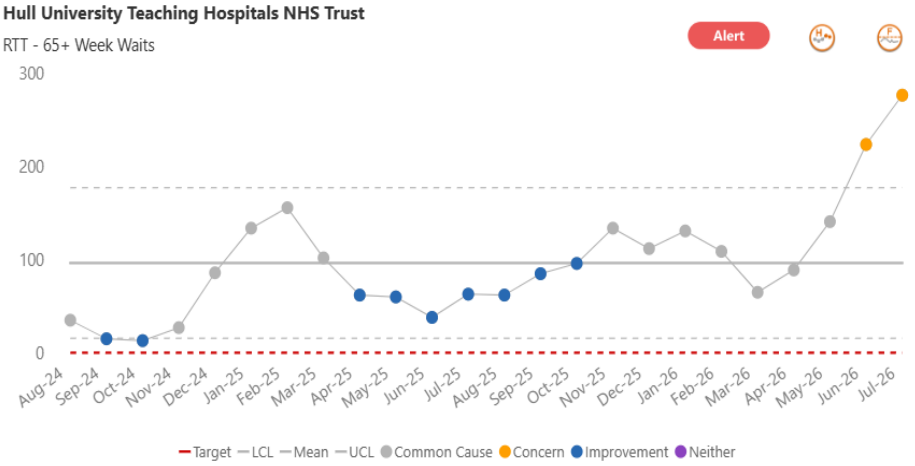
vi. RTT 65 week waits

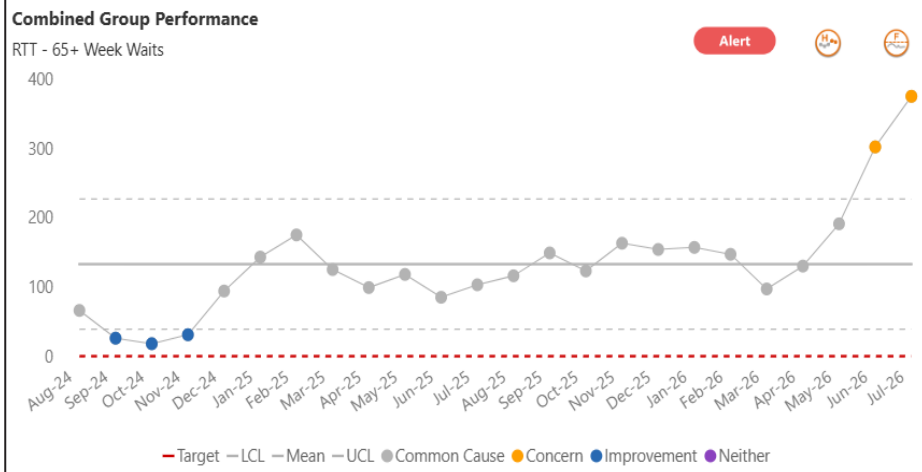
RTT - 65+ Week Waits

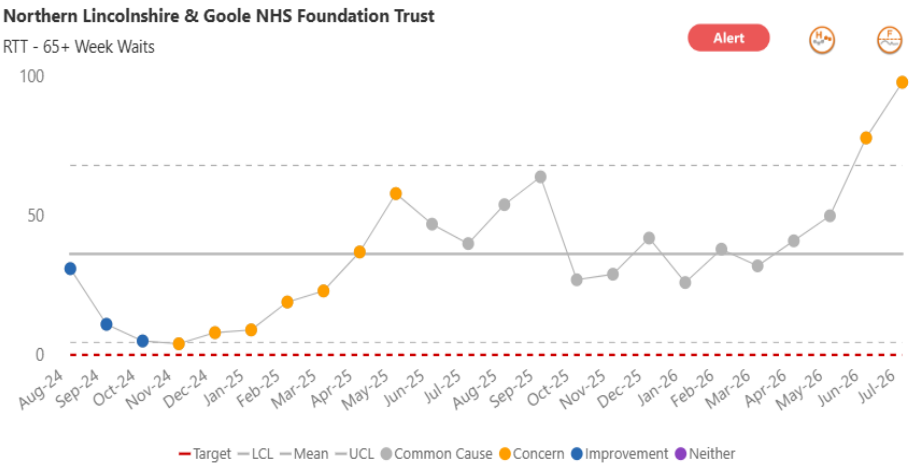
Summary:
65-week waits increased to 355 at HUTH and 163 at NLAG. This sharp deterioration reflects the underlying long wait volumes and capacity restraints.

Progress:
Validation and specialty oversight are established, but replenishment from the 52-week cohort is outstripping treatment capacity.

Action:
Maintain weekly dated-patient plans and protect capacity. Support required: executive escalation of unresolved outpatient, diagnostic, theatre, workforce and mutual-aid gaps.







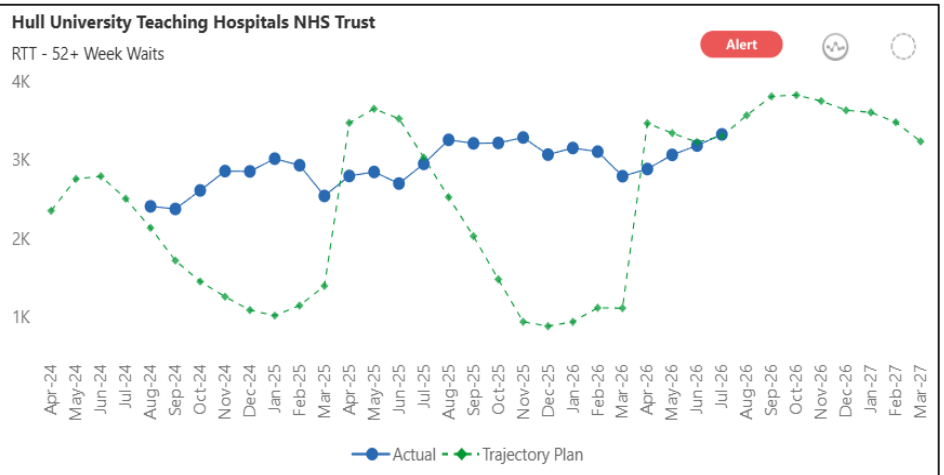
vii. RTT 52 week waits

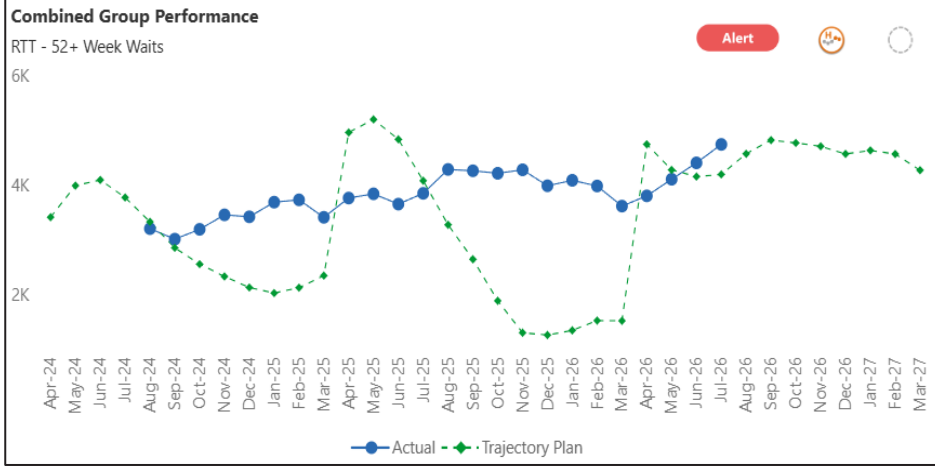
RTT - 52+ Week Waits

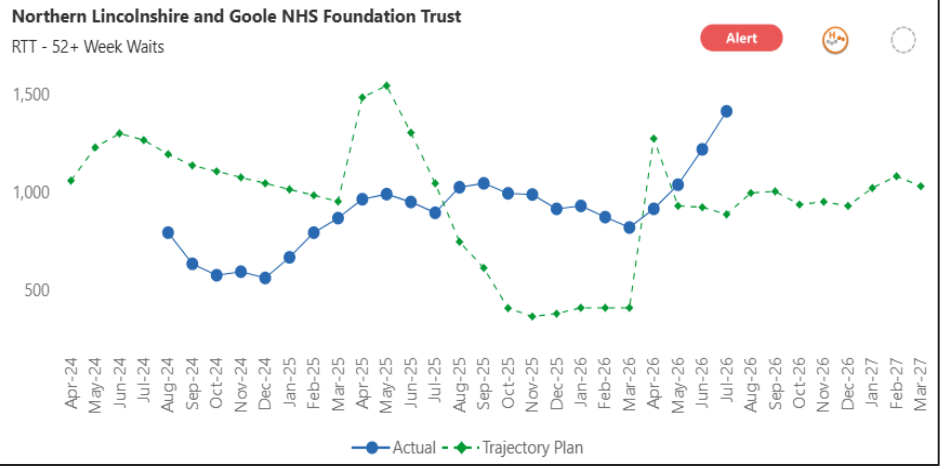
Summary:
52-week waits increased by 141 at HUTH to 3,331 and by 94 at NLAG to 1,412. Growth was not expected; HUTH remains on its plan line, while NLAG is above trajectory.

Progress:
Validation and specialty oversight are in place, but planned recovery has not prevented replenishment of the 65-week cohort.

Action:
Set weekly specialty trajectories and date highest-risk patients. Support required: Care Group ownership and aligned outpatient, diagnostic and treatment capacity.







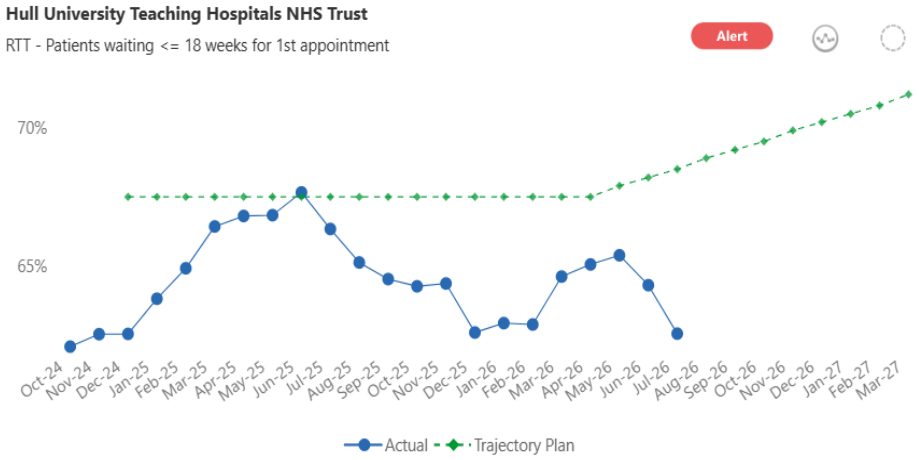
viii. Enabler Metric 1: Time to First Appointment (%)

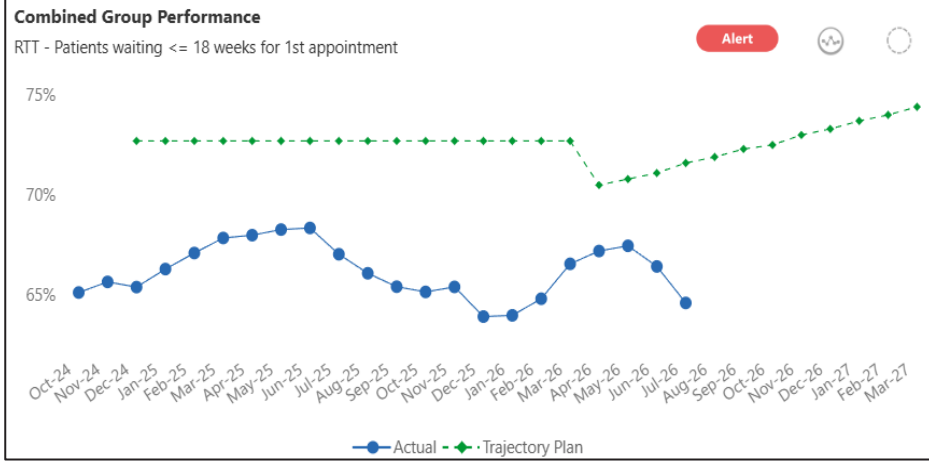
RTT - Patients waiting <= 18 weeks for 1st appointment

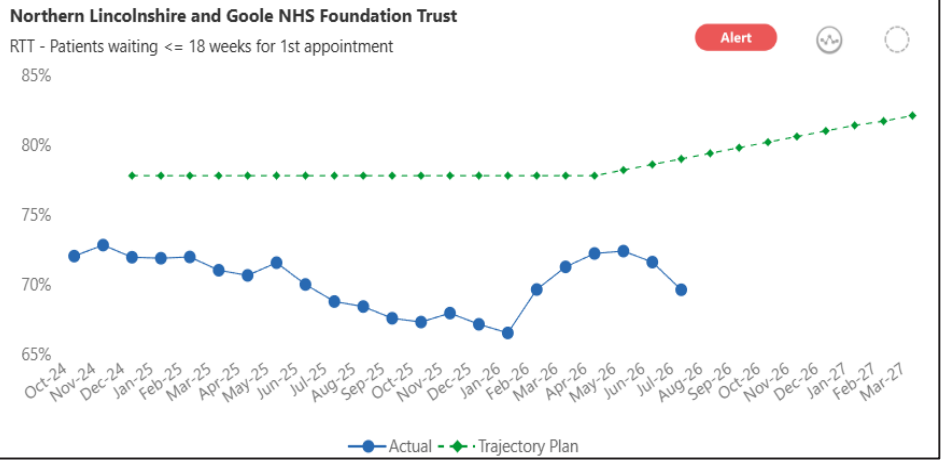
Summary:
August update: the latest graph position is 62.6% at HUTH and 69.6% at NLAG. Both Trusts remain below trajectory for patients waiting no more than 18 weeks for a first appointment.

Progress:
Outpatient transformation and demand-and-capacity reviews have not yet generated the required improvement in first outpatient access.

Action:
Improve slot fill, booking controls and SPOA pathways. Confirm specialty capacity plans, referral-demand controls and resolution of workforce gaps.







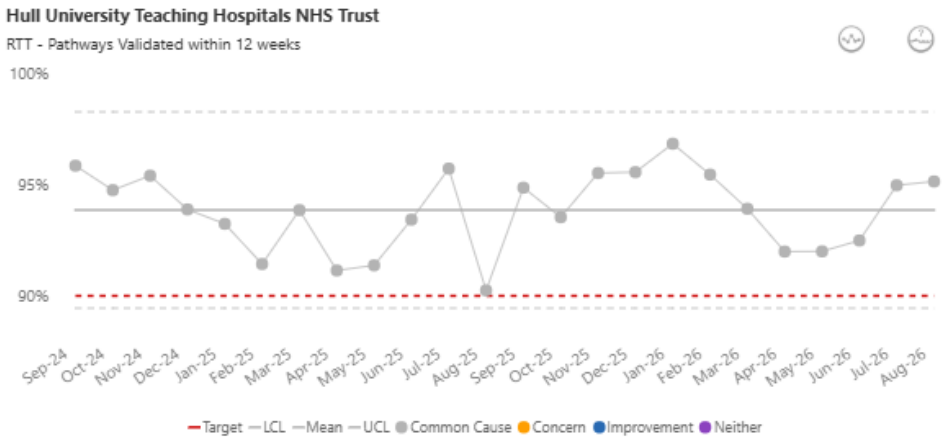
ix. Enabler Metric 2: RTT Data Quality

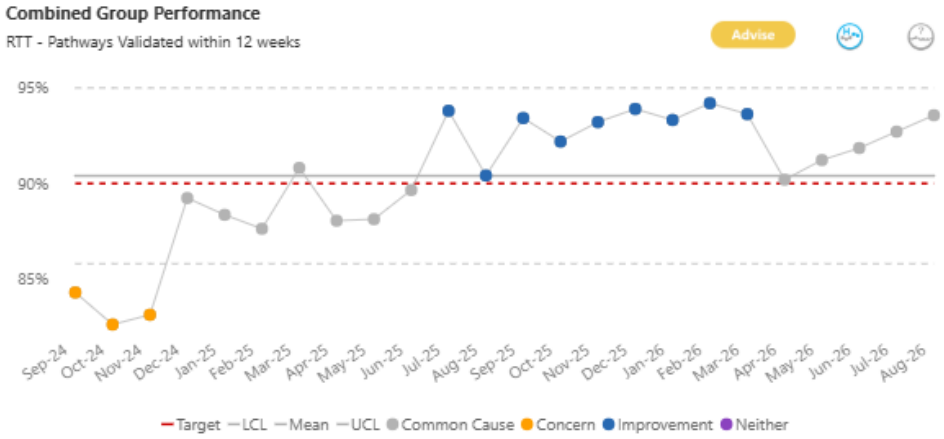
RTT - Pathways Validated within 12 weeks

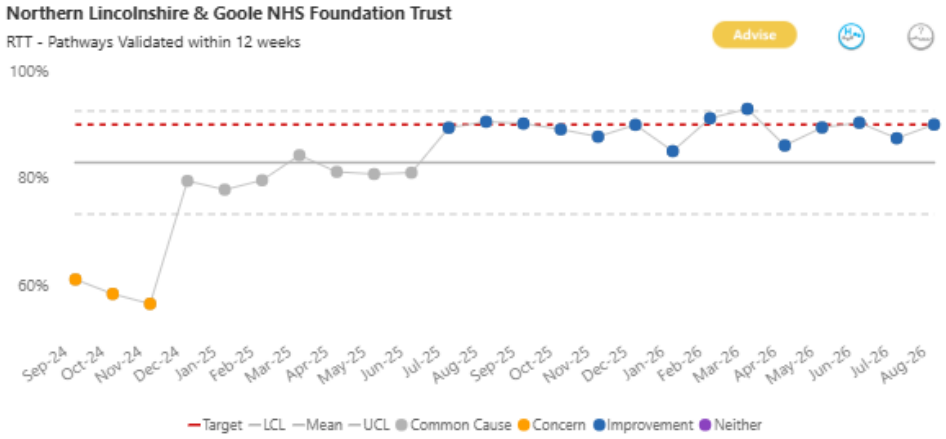
Summary:
August validation improved to 95.2% at HUTH and 90.0% at NLAG. Both Trusts now meet the 90% standard, although NLAG has no headroom.

Progress:
Weekly validation, completeness work and pathway oversight have improved the position. LUNA-ROVA deployment should strengthen patient-level tracking and exception management.

Action:
Sustain validation at or above 90%. Track unresolved exceptions and the time taken to correct records, with immediate escalation where either Trust falls below standard.







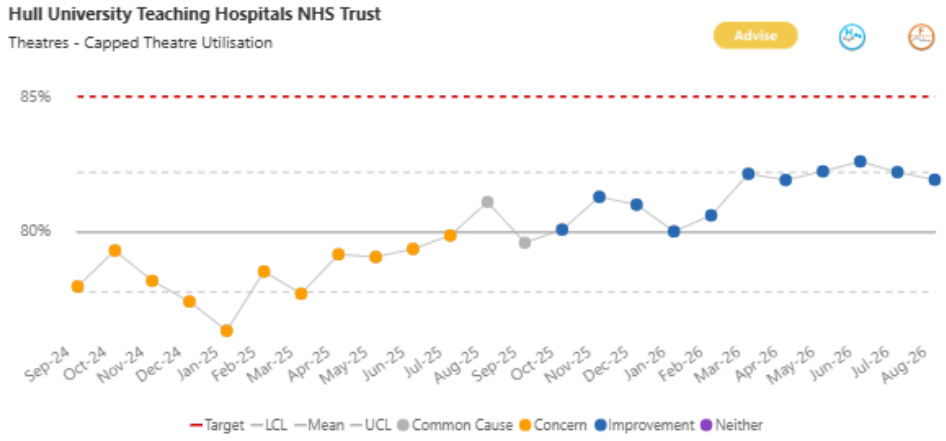
x. Enabler Metric 3: Capped Theatre Utilisation

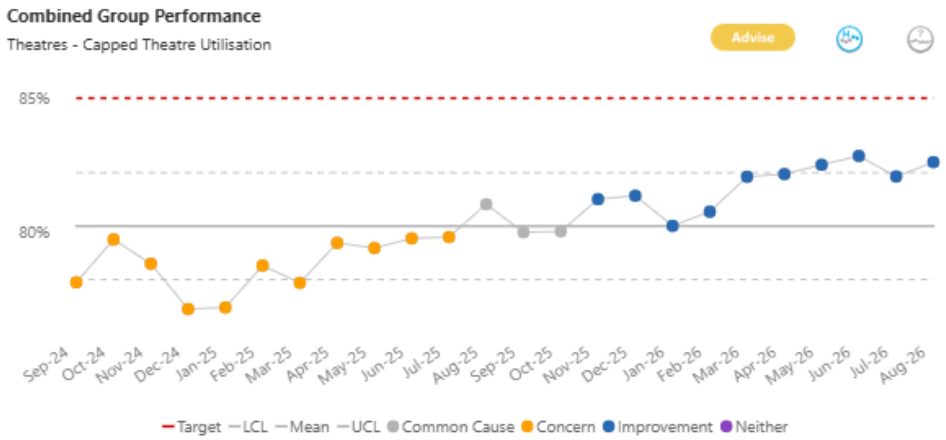
Theatres - Capped Theatre Utilisation

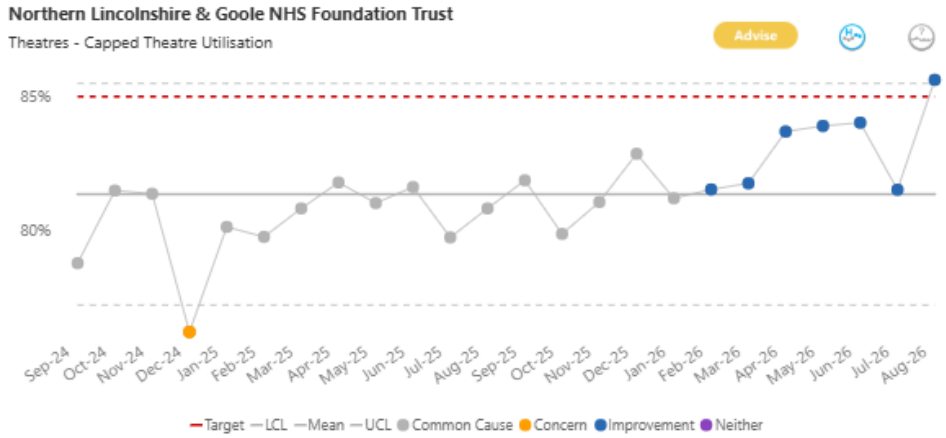
Summary:
August theatre utilisation reduced by 0.3 percentage points at HUTH to 81.9% but improved by 4.1 points at NLAG to 85.6%. NLAG is above the 85% target; HUTH remains 3.1 points below.

Progress:
NLAG has converted improved session delivery into target achievement. HUTH remains off target despite scheduler access and productivity oversight.

Action:
Maintain NLAG above 85% and recover HUTH to 85%. Track session fill, starts, finishes and cancellations weekly, with Care Group action on workforce and long-wait capacity.







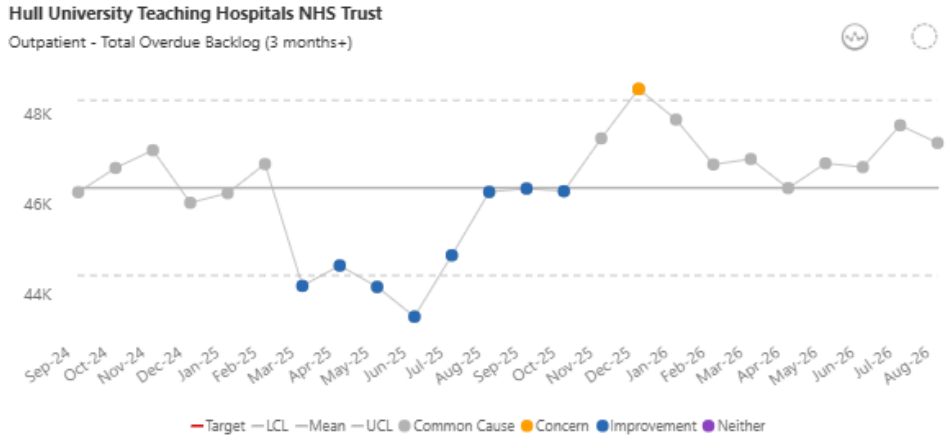
xi. Enabler Metric 4: Outpatient Follow Up Backlog

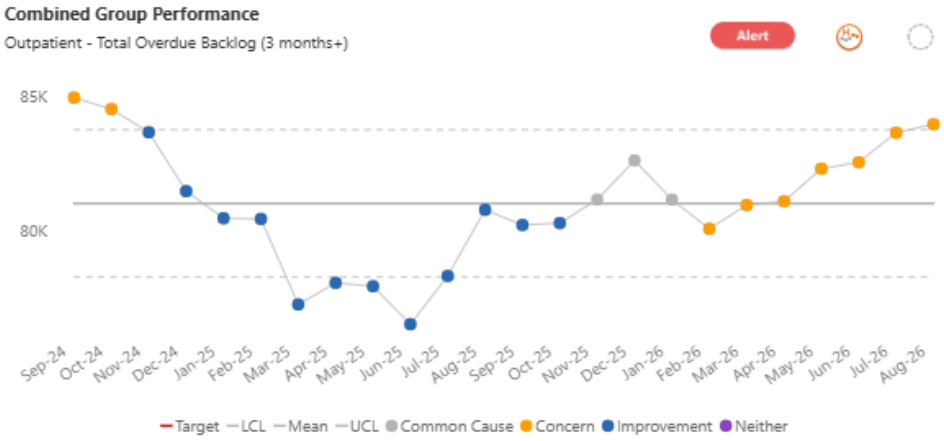
Outpatient - Total Overdue Backlog (3 months+)

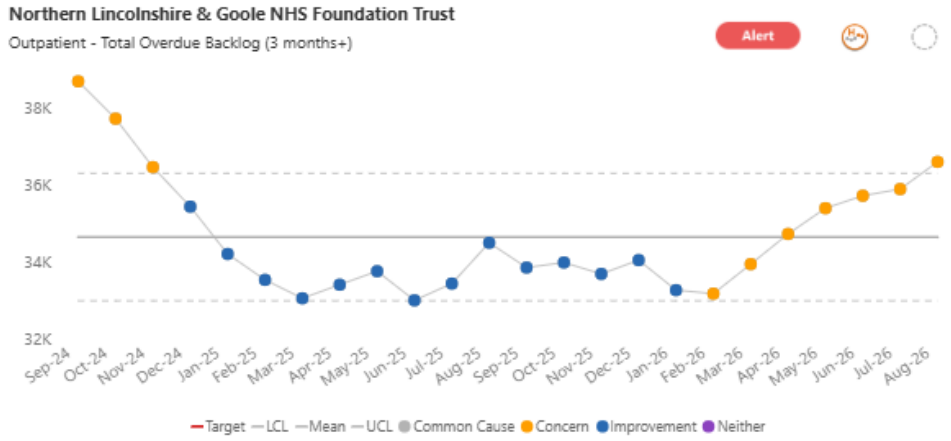
Summary:
The combined August follow-up backlog increased by 314 to 83,969. HUTH reduced by 394 to 47,359, while NLAG increased by 708 to 36,610.

Progress:
HUTH improved in August, but NLAG deterioration prevented a Group-wide reduction and remains the immediate priority.

Action:
Risk-stratify the backlog and assign specialty owners. Set a reduction target and completion date for each priority cohort, using validation, PIFU, discharge and funded capacity.







xii. Enabler Metric 5: Cancelled Operations – 28-day Breaches

Inpatient - Cancelled Operations 28 Day perfomance

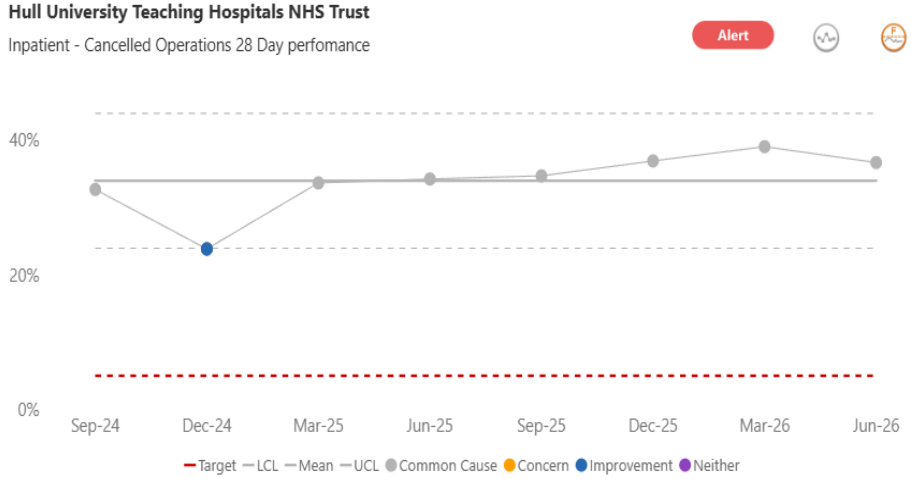
Summary:
August update: the latest quarterly graph remains the June position. Both Trusts improved between March and June, but the proportion of cancelled patients not rebooked within 28 days remains above the 5% standard.

Progress:
The latest direction is positive, but current controls have not yet delivered reliable rebooking within the 28-day guarantee.

Action:
Maintain a daily cancellation PTL with named specialty owners and protected rebooking capacity. Escalate every patient without a replacement date before day 28.

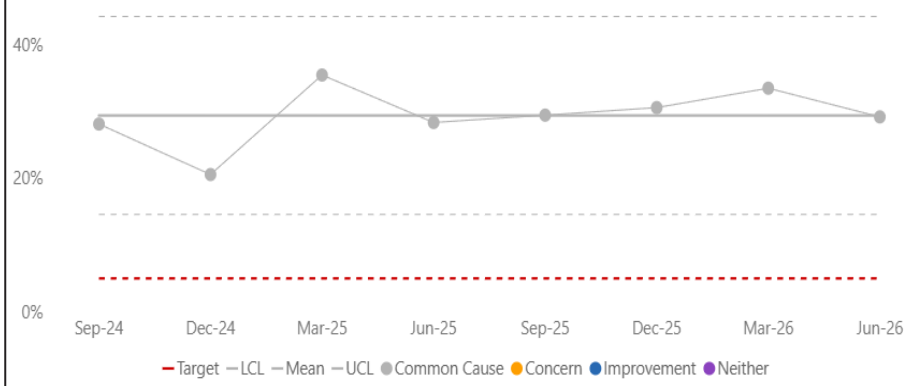
Hull University Teaching Hospitals NHS Trust

Inpatient - Cancelled Operations 28 Day perfomance



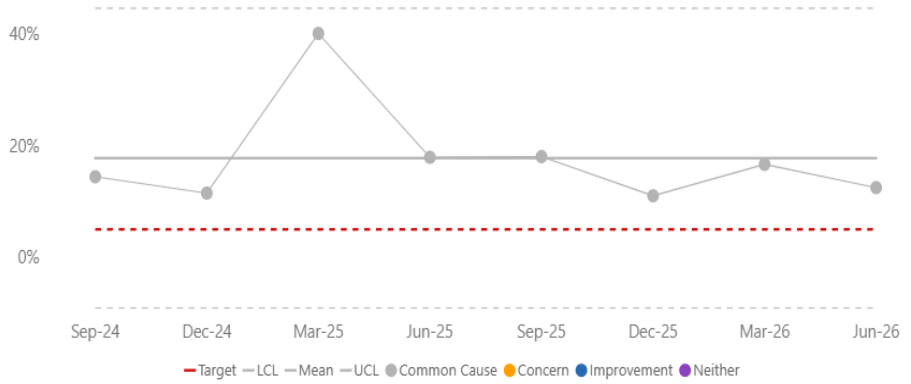
Combined Group Performance

Inpatient - Cancelled Operations 28 Day perfomance



Northern Lincolnshire & Goole NHS Foundation Trust

Inpatient - Cancelled Operations 28 Day perfomance



5. HHP Group Executive Summary – Quality

Executive Lead: Hilda Gwilliams, Group Chief Patient Safety Officer

Accountable to: Quality Safety Committee

Hull University Teaching Hospitals NHS Trust

Right click metric to drill through to SPC chart or view metric breakdown

Metric	Month	Target	Result	Var	Asr
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	7.6		
Complaints - 60 day compliance	Aug-26	≥ 85.0%	56.1%		
Falls - per 1,000 bed days	Aug-26		5.97		
Falls - Serious harm or death	Aug-26		3		
Friends & Family - A&E Score	Jul-26	≥ 85.0%	83.3%		
Friends & Family - Antenatal Score	Jul-26	≥ 95.0%	78.8%		
Friends & Family - Inpatient Score	Jul-26	≥ 95.0%	97.8%		
Friends & Family - Outpatient Score	Jul-26	≥ 95.0%	97.0%		
Infections - C.Difficile (Cumulative)	Jul-26		39		
Infections - E.Coli (Cumulative)	Jul-26		69		
Infections - Klebsiella (Cumulative)	Jul-26		26		
Infections - MRSA (per 1,000 bed days)	Jul-26		0.00		
Inpatient - Corridor Care on Wards	Aug-26		40.8		
Inpatient - Emergency Readmissions within 30 days	Jul-26		9.9%		
Mortality - SHMI	Mar-26	≤ 1.0	1.047		
Never Events	Aug-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Aug-26		1.39		
Pressure Ulcers - Category 3	Aug-26		1		
Pressure Ulcers - Category 4	Aug-26		1		
Pressure Ulcers - Hospital acquired	Aug-26		147		
VTE Risk Assessment 14 Hour Standard	Jul-26	≥ 95.0%	91.7%		

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
Care Hours per Patient Day - Overall	Apr-26	≥ 9.0	9.5		
Complaints - 60 day compliance	Aug-26	≥ 85.0%	68.6%		
Falls - per 1,000 bed days	Aug-26		5.89		
Falls - Serious harm or death	Aug-26		0		
Friends & Family - A&E Score	Jul-26	≥ 85.0%	60.0%		
Friends & Family - Antenatal Score	Jul-26	≥ 95.0%	50.0%		
Friends & Family - Inpatient Score	Jul-26	≥ 95.0%	98.0%		
Friends & Family - Outpatient Score	Jul-26	≥ 95.0%	98.3%		
Infections - C.Difficile (Cumulative)	Jul-26		20		
Infections - E.Coli (Cumulative)	Jul-26		87		
Infections - Klebsiella (Cumulative)	Jul-26		23		
Infections - MRSA (Cumulative)	Jul-26		6		
Inpatient - Corridor Care on Wards	Aug-26		0.4		
Inpatient - Emergency Readmissions within 30 days	Jul-26		11.0%		
Mortality - SHMI	Mar-26	≤ 1.0	0.993		
Never Events	Aug-26		0		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Aug-26		2.77		
Pressure Ulcers - Category 3	Aug-26		12		
Pressure Ulcers - Category 4	Aug-26		3		
Pressure Ulcers - Hospital acquired	Aug-26		232		
VTE Risk Assessment 14 Hour Standard	Jul-26	≥ 95.0%	94.3%		

Group Chief Patient Safety Officer Update – Quality Overview (August 2026)

Quality performance presents a mixed position across HUTH and NLAG, with the most material oversight risks sitting within patient safety and infection prevention, alongside continuing variation in patient experience and effectiveness indicators. The NOF Quality briefing confirms Patient Safety as a distinct provider oversight domain, combining scored metrics for clinical audit outliers, MRSA, E. coli, C. difficile and the staff survey raising-concerns sub-score with contextual indicators for falls causing harm, pressure ulcers and incidents causing harm.

Patient Experience shows improving grip on 60-day complaint response compliance since October 2025, but complaints received and PALS activity remain variable, indicating that earlier resolution, responsiveness and thematic learning are not yet consistently reducing patient concern activity across services.

Safety remains the principal quality risk area. Care Hours per Patient Day requires continued triangulation with acuity, staffing fill and ward-level risk. Infection prevention indicators are particularly important because MRSA, E. coli and C. difficile are NOF scoring metrics. C. Difficile is over trajectory for HUTH and over the annual threshold for NLAG.

Effectiveness is broadly stable but requires continued governance oversight. VTE assessment compliance remains below the 14 hour target, and will be affected by the national change to emergency admission timing from DTA in Quarter 3. SHMI should continue to be handled as a statistical indicator through established clinical governance and coding assurance, while emergency readmissions within 30 days appear broadly stable but should remain subject to specialty-level review of discharge quality, follow-up arrangements and avoidable readmission themes.

Executive focus should be on creating a unified Quality Foundation Scorecard for each Trust, that brings together scored and contextual NOF measures with local quality indicators, providing clear targets, trajectories and accountability. Quality improvement methodology should be applied to support the areas of the NOF that are below the required thresholds and linked through to the relevant Integrated Improvement Plan workstreams. This should enable consistent oversight from Board to care group and ward level, with escalation focused on infection prevention, safe staffing, complaint responsiveness, VTE compliance, SHMI assurance and avoidable readmissions.

a. Hull University Teaching Hospital Quality AAA Summary

Count: 15

Alert

- Care Hours per Patient Day - Overall
- Care Hours per Patient Day - Unregistered
- Complaints - 40 day compliance
- Complaints - 60 day compliance
- Duty of Candour - Verbal apology
- Inpatient - Discharge to Assess (D2A) over 14 days
- PALS - Complaints compliance within 10 working days
- Pressure Ulcers - Category 2
- Pressure Ulcers - Category 4
- Pressure Ulcers - Community acquired
- Pressure Ulcers - Hospital acquired
- Pressure Ulcers - Hospital acquired (per 1,000 bed days)
- Pressure Ulcers - Suspected deep tissue injury
- VTE Risk Assessment
- VTE Risk Assessment 14 Hour Standard

Count: 7

Advise

- Complaints - Average response time
- Duty of Candour - Written apology within 10 working days
- Friends & Family - A&E Score
- Friends & Family - Birth Score
- Friends & Family - Outpatient Score
- Mortality - HSMR
- Mortality - SHMI

Count: 4

Assure

- Inpatient - Corridor Care on Wards
- Inpatient - Discharge Lounge Utilisation
- PALS - Complaints
- Patient Safety Incidents - Low harm

b. Northern Lincolnshire & Goole Hospitals Quality AAA Summary

Count: 11

Alert

- Care Hours per Patient Day - Unregistered
- Complaints - 40 day compliance
- Duty of Candour - Written apology
- Friends & Family - A&E Score
- Infections - MRSA
- Infections - MRSA (Cumulative)
- Infections - MRSA (per 1,000 bed days)
- Inpatient - Annual Growth Under 18s Elective Activity
- Inpatient - Discharge Lounge Utilisation
- Inpatient - Discharges by 12pm (midday)
- Inpatient - Long Stay Occupancy (21+ days)

Count: 1

Advise

- Friends & Family - Postnatal Community Score

Count: 5

Assure

- Care Hours per Patient Day - Registered
- Friends & Family - Community Score
- Friends & Family - Inpatient Score
- Mortality - HSMR
- Patient safety alerts actioned by specified deadline

Experience

Experience narrative updated for August 2026.

Summary

The complaint rate remains static and the timeliness in responding to complaints remains below the target. There has been a reduction in the number of PALS contacts at HUTH latterly. The dashboard data shows some improvement in the mean number of days to respond to complaints in NLAG and this metric should improve as timeliness of responses to complaints improves. The scorecards scope complaints 60-day compliance, complaints received and PALS concerns as the core measures of responsiveness to patient concerns. The strongest improvement signal is complaints 60-day compliance, which has slightly improved since October 2025, although performance remains below the stated compliance level. Improvement in learning from complaints and patient feedback sources is part of a group wide quality improvement plan.

Progress

Since October 2025, both Trusts have shown some improvement on 60-day complaint response timeliness, but further consistency is required to meet the standard reliably. Complaints received remain static and PALS contacts have reduced recently, however the complaint rate does not correlate with this. It may be desirable to have an increased PALS contact rate with reduced complaint rates with more proactive approaches to engage with patients and their families. The pattern suggests earlier resolution and thematic learning are not yet consistently reducing formal complaint or PALS activity.

Action

- Quality Improvement in respect of patient experience interventions, changing behaviours and practice, based on learning identified by care groups.
- Exploration of location of the PALS service are being considered to enable earlier PALS contact in the endeavour to intervene and prevent complaint escalation.
- Sustain the improvement in 60-day complaint compliance through divisional ownership, overdue case escalation and routine review of response quality.
- Strengthening early resolution of concerns to reduce avoidable escalation from PALS to formal complaints, with service-level hotspot review, repeat-theme analysis and evidence of learning embedded through patient experience governance.

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	0.0%	0.0%	0.0%	0.0%	100.0%	72.4%	70.8%	90.0%	71.4%	66.7%	100.0%	83.3%	
		Friends & Family - Antenatal Score	≥ 95.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	81.8%	50.0%	93.8%	100.0%	82.4%	78.8%	
		Friends & Family - Birth Score	≥ 95.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	94.8%	97.8%	98.8%	97.2%	96.2%	96.5%	97.1%	96.1%	96.9%	89.0%	96.9%	97.8%	
		Friends & Family - Outpatient Score	≥ 95.0%	98.8%	96.7%	97.8%	96.7%	94.1%	98.6%	97.1%	96.1%	96.2%	96.2%	97.9%	97.0%	
		Friends & Family - Postnatal Score	≥ 95.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	66.7%	85.7%	100.0%	100.0%	75.0%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	68.2%	71.0%	24.6%	35.4%	51.9%	40.0%	53.5%	50.0%	64.5%	48.8%	57.6%	64.4%	56.1%
		Complaints - Average response time	≤ 40.0	164.4	122.8	116.6	112.1	76.6	77.5	65.2	69.9	47.5	65.8	60.6	48.7	51.2
		Complaints - Received		36	47	51	56	36	31	35	26	18	49	29	28	29
		Complaints - Received (per 1,000 bed days)		1.04	1.37	1.32	1.63	1.11	0.99	1.22	0.69	0.51	1.60	0.93	0.90	0.84
		Complaints - Reopened		3	3	2	1	4	2	2	4	3	2	0	1	0
		PALS - Complaints		280	250	397	272	241	254	216	140	64	219	159	130	122
		PALS - Complaints compliance within 10 working days		49.6%	46.9%	52.5%	42.9%	42.0%	38.3%	47.4%	41.1%	46.6%	55.3%	33.0%	36.4%	27.3%

NLAG Scorecard

Tier 1 - Foundation Scorecard

Oversight | CQC

Right click metric to drill through to SPC chart or view metric breakdown

Tier 1 - Foundation Scorecard

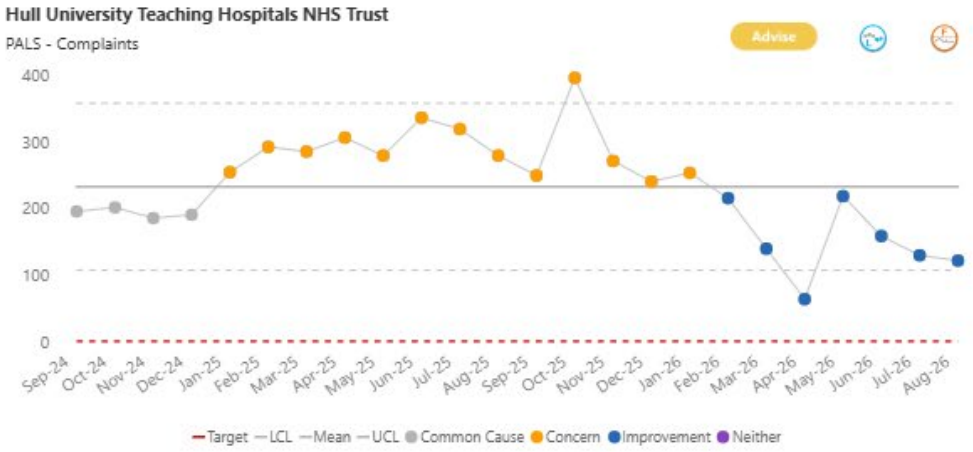
Domain	Subj Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Caring	Experience	Friends & Family - A&E Score	≥ 85.0%	82.0%	75.6%	75.6%	75.6%	75.0%	76.8%	76.8%	76.4%	79.4%	74.3%	76.0%	60.0%	
		Friends & Family - Antenatal Score	≥ 95.0%	82.8%	65.6%	65.6%	76.2%	75.8%	68.0%	96.3%	87.0%	100.0%	66.7%	66.7%	50.0%	
		Friends & Family - Birth Score	≥ 95.0%	91.7%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	
		Friends & Family - Inpatient Score	≥ 95.0%	95.8%	97.4%	97.4%	97.5%	97.2%	97.5%	98.2%	98.7%	98.5%	98.4%	98.6%	98.0%	
		Friends & Family - Outpatient Score	≥ 95.0%	95.1%	96.9%	96.9%	95.9%	97.7%	95.1%	96.9%	95.5%	97.9%	96.3%	97.9%	98.3%	
		Friends & Family - Postnatal Score	≥ 95.0%	92.9%	100.0%	100.0%	92.9%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	66.7%	100.0%	
Responsive	Experience	Complaints - 60 day compliance	≥ 85.0%	36.6%	50.0%	37.1%	53.1%	67.9%	48.3%	63.9%	71.8%	78.6%	59.2%	72.2%	62.1%	68.6%
		Complaints - Average response time	≤ 40.0	69.3	59.5	74.2	67.2	43.8	63.3	55.3	40.8	45.8	48.6	42.4	48.8	40.6
		Complaints - Received		28	27	20	26	19	47	45	43	46	34	26	45	34
		Complaints - Received (per 1,000 bed days)		1.44	1.39	0.97	1.29	0.91	2.22	2.33	2.12	2.30	1.63	1.29	2.22	1.65
		Complaints - Reopened		3	1	1	7	0	5	4	2	6	1	3	0	0
		PALS - Complaints		221	247	278	228	240	262	208	233	253	226	248	263	149
		PALS - Complaints compliance within 10 working days		59.6%	60.9%	59.0%	56.1%	57.3%	61.4%	63.4%	64.8%	66.9%	63.3%	54.0%	59.9%	54.7%

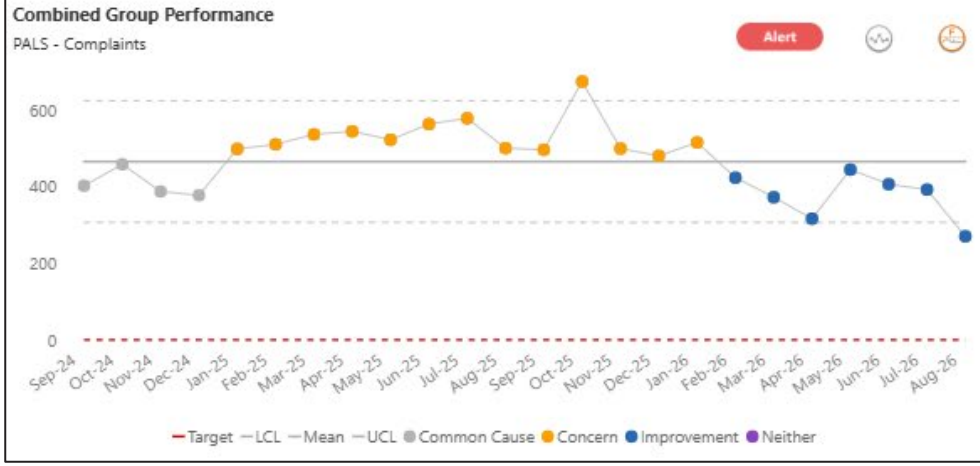
i. PALS Contacts

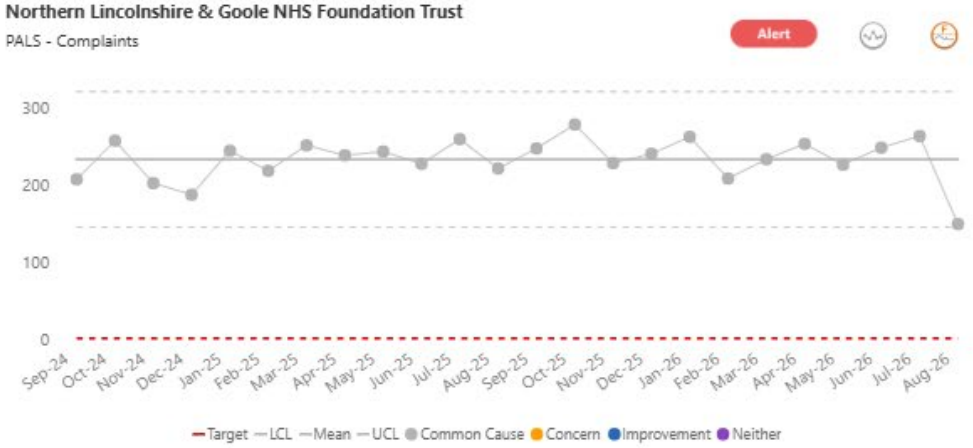
PALS - Complaints

HUTH:
PALS contact rates show continued variation across the period, with a reduction of contacts at HUTH since February 2026, triggering special cause and Advise alert. The trend should be interpreted alongside formal complaints received and complaints 60-day compliance to understand whether concerns are being resolved early or escalating into formal complaint routes.

NLAG:
NLAG shows common cause variation in PALS contacts, with no clear sustained change evident from the chart, however this has triggered an alert on not achieving the target. The balance of the target should be considered in the context of complaints prevention and learning from complaints. Continued focus is required on early resolution, responsiveness to patient concerns and thematic learning, particularly where repeat issues are identified across services.







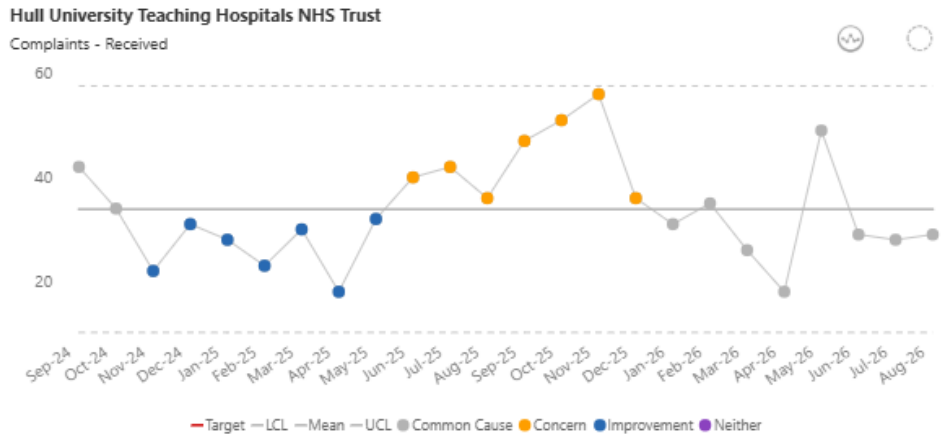
ii. Complaints Received

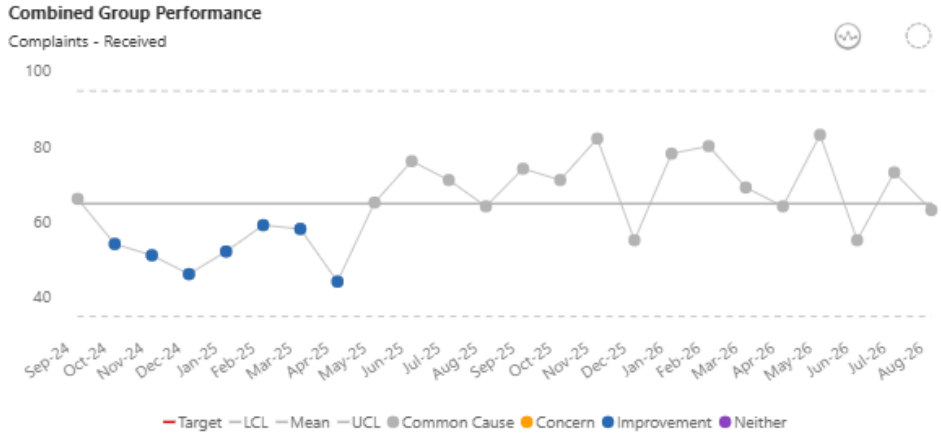
Complaints - Received

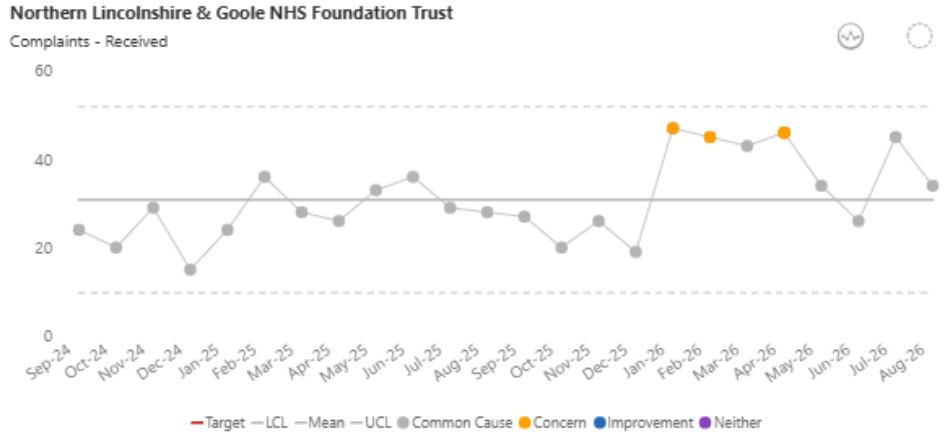
HUTH:
Complaints received rate shows common cause variation over the recent period, with significant variation historically.

NLAG:
Complaints received rate shows common cause variation over the recent period, with an increased rate during the period from January to April 2026.

Continued focus is required on complaint themes, service-level hotspots and early resolution, particularly where repeated issues are driving formal complaints. Targeting learning from complaints and making improvements in patient experience is desired and this improvement activity, if successful, will then show a reduction in complaints and correlating reduction in PALS contacts will demonstrate the required improvement.





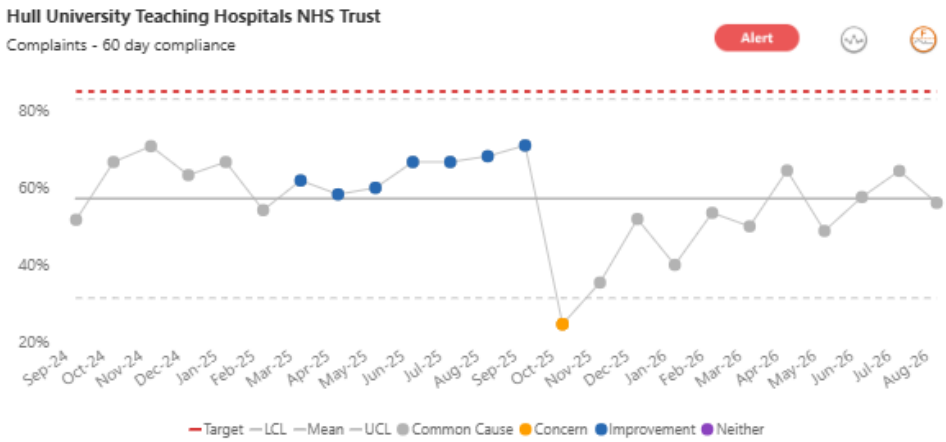


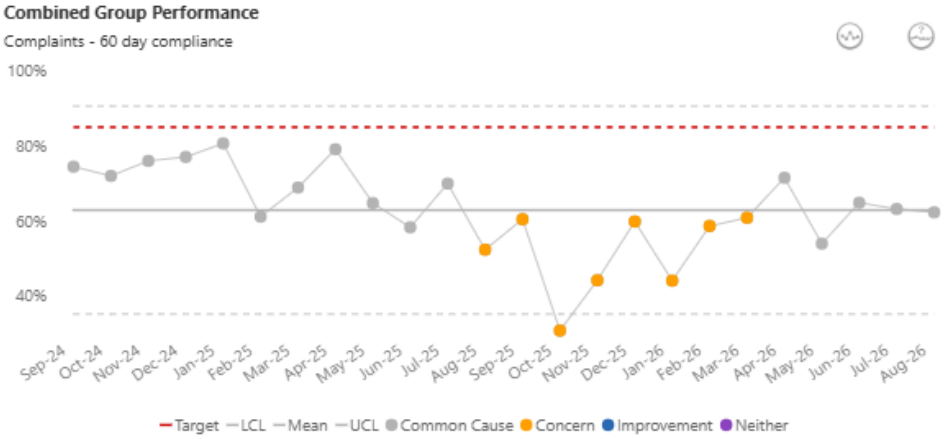
iii. Complaints 60 Day Compliance

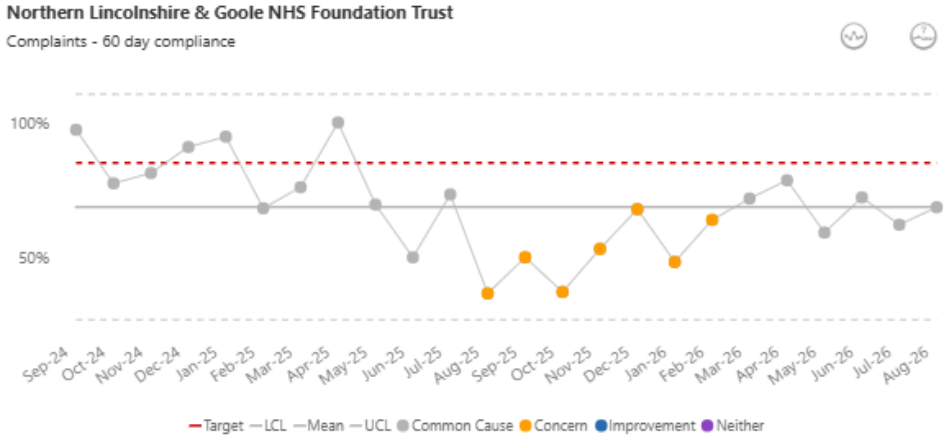
Complaints - 60 day compliance

HUTH:
There is common cause variation seen, with consistency in not achieving the target of 60 days completion. Backlog, complexity and volume of casework are contributory elements. The average number of days to complete is high and close to the target in the dashboard data.

NLAG:
There is common cause variation seen latterly, following a period of completion below the mean, and consistently not achieving the target. Similarly to HUTH the backlog, complexity and volume of casework are contributory elements.







c. Safety

Summary

Safety performance remains mixed. HUTH's overall Care Hours per Patient Day remains under target at 7.6, driven by the unregistered staff group. NLAG also has pressure in unregistered staffing, but stronger registered staffing keeps the overall CHPPD position above target. Infection prevention remains a key safety risk, with C. difficile, MRSA and E. coli requiring continued oversight.

Progress

For infection indicators, the latest FYTD position is C. difficile: HUTH 48 and NLAG 23. MRSA is HUTH 0 YTD and 0 latest month, while NLAG is 1 YTD with 0 in the latest reporting period. E. coli is HUTH 90 FYTD and NLAG 30 FYTD. NLAG has breached the national threshold on C.Difficle, and MRSA bacteraemia. HUTH is over trajectory for C.Difficile and slightly over on E.coli, so opportunity to achieve the threshold remains.

Action

Maintain ward-level safe staffing review, with specific focus on HUTH unregistered fill and NLAG skill-mix balance. Continue systematic IPC case review, thematic learning, antimicrobial stewardship and targeted improvement plans for C. difficile, MRSA and E. coli, with particular executive focus on NLAG MRSA and E. coli and HUTH C. difficile latest-month activity. The Quality Priority workstream and increased surveillance continue.

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	7.3	7.2	7.6	7.6	7.5	7.4	7.3	7.4	7.6				
		Care Hours per Patient Day - Registered	≥ 5.0	4.9	4.9	5.0	5.2	5.2	5.1	5.0	5.1	5.2				
		Care Hours per Patient Day - Unregistered	≥ 4.0	2.4	2.3	2.6	2.4	2.3	2.3	2.3	2.3	2.4				
		Falls - Serious harm or death		3	4	1	0	5	4	4	3	1	2	2	2	3
		Falls - Total incidents		260	279	286	258	271	308	262	284	222	235	214	244	206
		Infections - C.Difficile		6	8	6	6	8	16	9	11	16	10	8	5	
		Infections - E.Coli		20	19	17	14	13	12	16	14	23	17	13	16	
		Infections - Klebsiella		0	3	7	10	5	7	3	10	6	5	8	7	
		Infections - MRSA		0	0	0	0	1	0	0	1	0	0	0	0	
		Infections - MSSA		6	8	12	7	5	8	11	8	11	3	5	7	
		Infections - Pseudomonas aeruginosa		0	3	6	1	4	1	1	2	2	3	1	3	
		Medication Incidents		148	148	103	120	127	94	109	115	100	117	105	102	99
		Patient Safety Incidents - % Harmful		2.3%	3.2%	3.8%	2.7%	3.2%	2.6%	2.1%	2.4%	1.5%	2.0%	1.8%	2.6%	2.3%
		Patient Safety Incidents - Fatal		1	7	4	2	8	3	4	7	2	5	3	4	3
		Patient Safety Incidents - Moderate harm		37	49	63	44	51	43	32	44	29	34	28	50	40
		Patient Safety Incidents - Severe harm		7	9	12	5	5	8	6	5	2	2	5	3	5
		Pressure Ulcers - Category 3		0	0	4	1	2	2	1	1	0	1	1	3	1
		Pressure Ulcers - Category 4		0	0	0	0	0	0	1	0	0	1	0	0	1
		Pressure Ulcers - Community acquired		310	310	390	346	353	406	371	458	416	388	376	397	401
		Pressure Ulcers - Hospital acquired		43	59	109	110	132	129	114	129	146	148	116	135	147
		Pressure Ulcers - Suspected deep tissue injury		16	16	19	26	34	29	22	26	32	27	29	24	38

NLAG Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Care Hours per Patient Day - Overall	≥ 9.0	10.0	9.5	9.2	9.3	9.0	9.2	9.1	9.7	9.5				
		Care Hours per Patient Day - Registered	≥ 5.0	6.0	5.7	5.5	5.7	5.6	5.6	5.6	6.0	5.8				
		Care Hours per Patient Day - Unregistered	≥ 4.0	4.0	3.8	3.7	3.7	3.4	3.6	3.5	3.8	3.7				
		Falls - Serious harm or death		1	0	2	0	3	2	0	0	0	0	2	3	0
		Falls - Total incidents		108	107	149	119	136	139	107	108	125	116	122	128	121
		Infections - C.Difficile		4	3	6	4	7	3	3	6	4	3	5	8	
		Infections - E.Coli		20	28	32	20	18	14	26	15	21	25	21	20	
		Infections - Klebsiella		9	6	12	8	10	6	13	9	7	5	6	5	
		Infections - MRSA		1	0	1	0	1	1	1	2	1	3	1	1	
		Infections - MSSA		6	6	9	6	10	6	3	4	3	10	7	5	
		Infections - Pseudomonas aeruginosa		5	3	3	4	4	1	2	2	0	4	3	2	
		Medication Incidents		65	58	69	89	76	82	78	76	65	71	76	79	81
		Patient Safety Incidents - % Harmful		2.7%	3.2%	3.9%	3.9%	3.2%	2.9%	2.6%	3.2%	2.8%	2.7%	2.8%	3.4%	3.9%
		Patient Safety Incidents - Fatal		2	0	1	1	3	1	3	0	0	0	1	2	1
		Patient Safety Incidents - Moderate harm		37	44	60	55	41	46	36	48	46	43	44	47	53
		Patient Safety Incidents - Severe harm		1	3	6	5	4	2	0	0	0	1	2	6	3
		Pressure Ulcers - Category 3		7	11	6	5	10	13	10	6	5	16	8	16	12
		Pressure Ulcers - Category 4		0	2	4	1	1	0	1	2	0	0	1	1	3
		Pressure Ulcers - Hospital acquired		198	200	244	222	210	267	213	231	210	240	245	207	232
		Pressure Ulcers - Suspected deep tissue injury		34	43	42	40	45	59	54	48	35	51	46	34	46

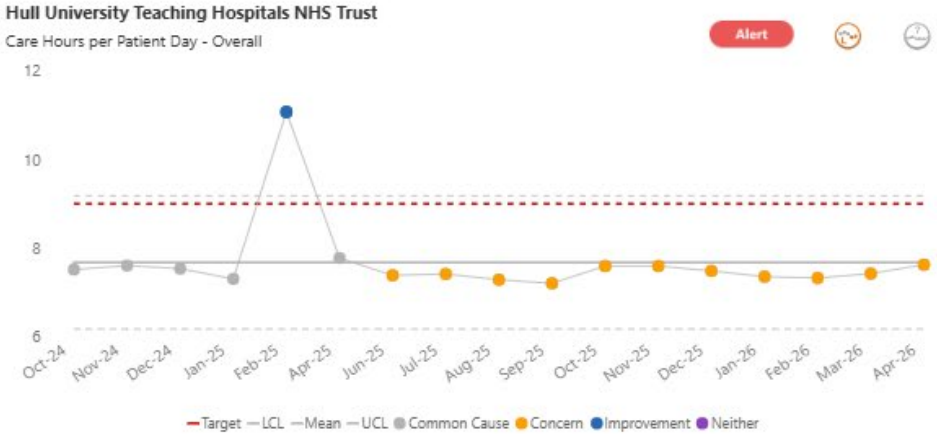
i. Care Hours per Patient Day

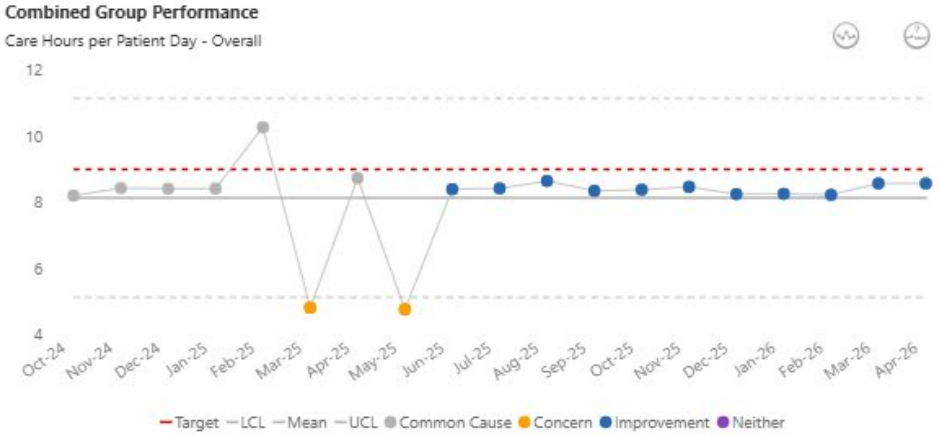
Care Hours per Patient Day - Overall

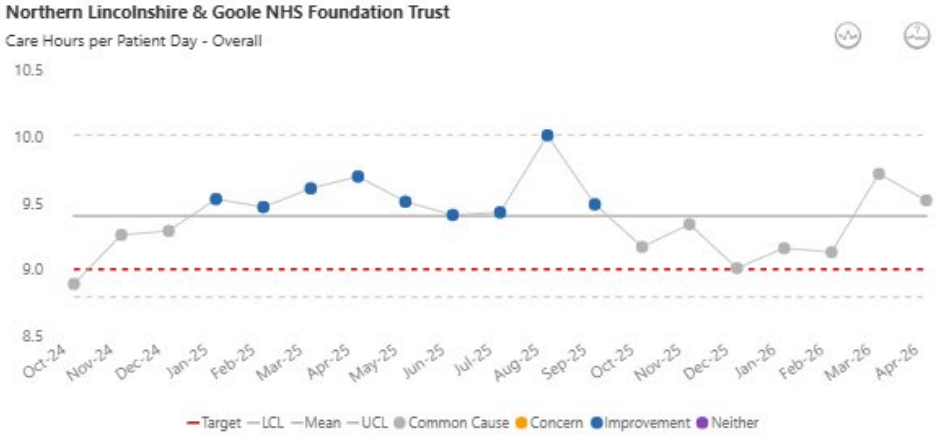
The latest available data in the public domain is from April 2026.

HUTH:
HUTH's overall Care Hours per Patient Day remains under target at 7.6, with the shortfall driven by the unregistered staff group. This indicates that the overall staffing position is being constrained by support workforce capacity, requiring continued ward-level review of roster fill, deployment and escalation where unregistered hours are below planned levels.

NLAG:
NLAG also shows pressure within the unregistered staff group, but this is offset by stronger registered staff performance, keeping the overall Care Hours per Patient Day position above target.







Sample pages only – awaiting further Lead review

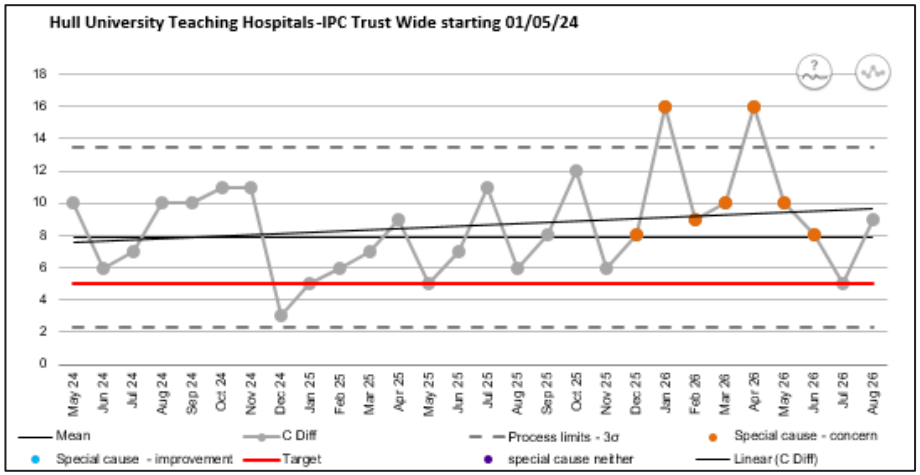
ii. C.Difficile Cases

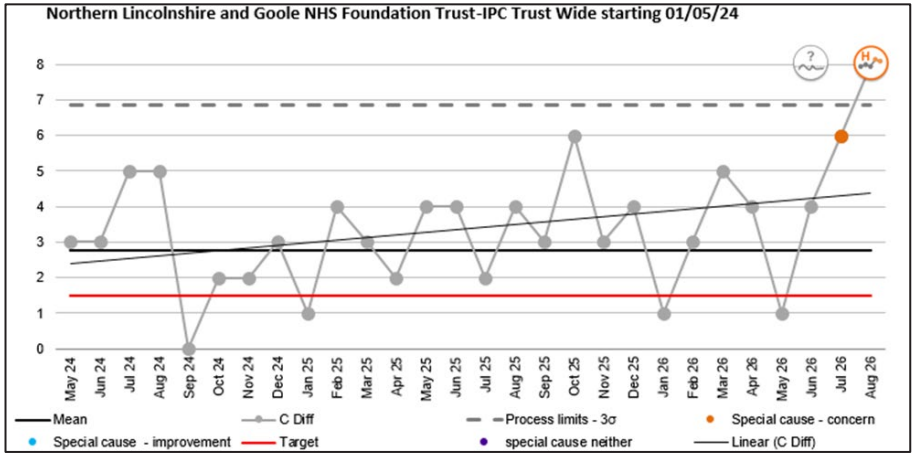
HUTH:
There have been 48 cases in the financial year to date, with a threshold of 61 for the year, so over the trajectory for the financial year at month five.

NLAG:
There have been 23 cases in the financial year to date, with a threshold of 18, so over the financial year threshold at month 5. The August data shows a significant increase at NLAG. This has been reviewed and determined that it is not one specific location or service. Enhanced monitoring and surveillance has been put in place.

A thematic review of C.Difficile cases has been undertaken and reported to Strategic Infection Reduction Committee to support focus on the areas for improvement, linked to the Quality Priority workstreams. Antimicrobial stewardship, handwashing, PPE use, standardising Swarm huddle reviews and action planning oversight, sporicidal cleaning standards for patient equipment.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





iii. MRSA Cases

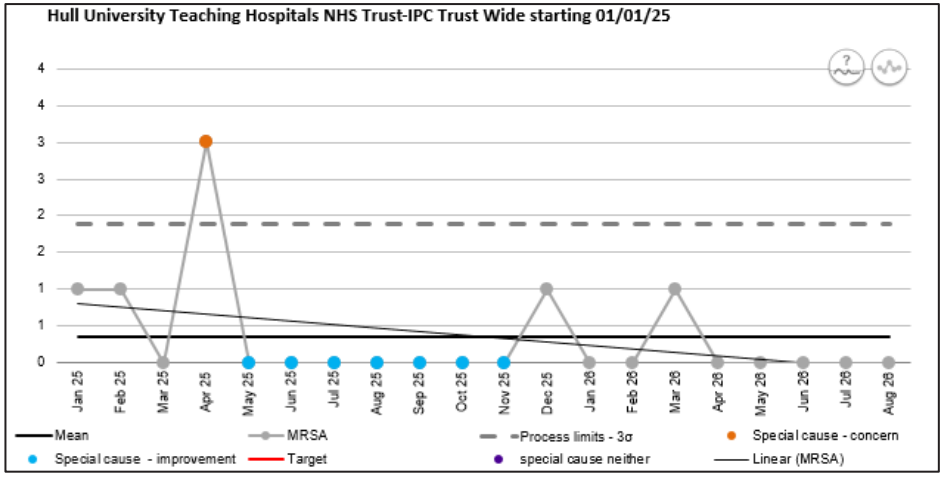
HUTH:
MRSA cases are 0 YTD, with 0 cases in the latest month.

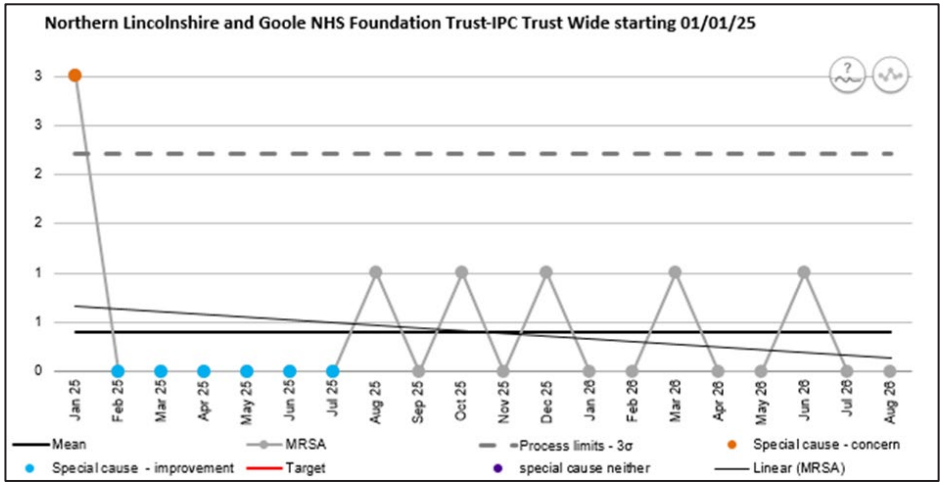
NLAG:
MRSA cases are 1 YTD, with 0 cases in the latest reporting period.

Actions being taken to reduce the risk of MRSA BSI include:

- Review of the MRSA screening and decolonisation policy and alignment to national guidance.
- Review the compliance with the screening and decolonisation processes.
- Aligned with IV device care improvement across all blood stream infections.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





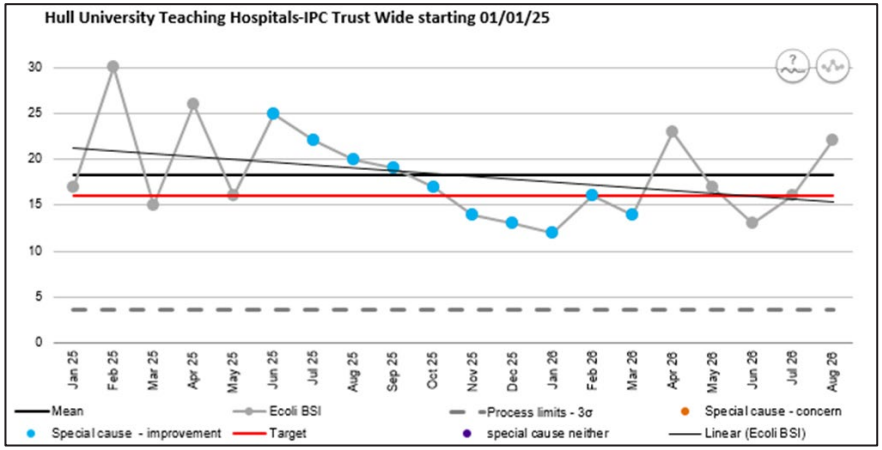
iv. E.Coli Case

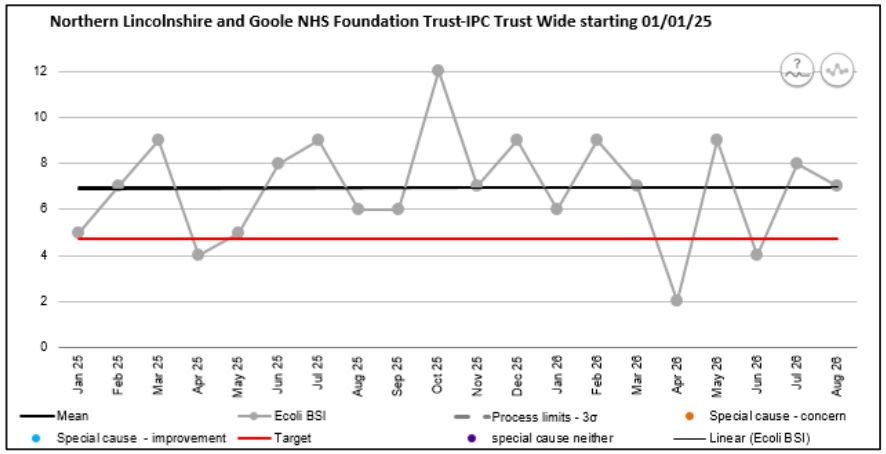
HUTH:
There have been 90 cases reported in the financial year to date against a 192 annual threshold. There is common cause variation for the recent period and more points over the mean in the year to date, so over trajectory, but within the national set threshold.

NLAG:
There have been 30 cases reported in the financial year to date against a threshold of 57 cases for the year. The rate is greater than the threshold trajectory for this point in the year. There is common cause variation shown on the SPC chart.

Similarly to other blood stream infection risks, IV access and management are a focus for assuring compliance to best practice standards, aligned to the Quality Priority workstream for IPC.

The charts used are provided from the IPC team to reflect accurate data and the team are working with Information Services to rectify data quality issues with the BI reports.





d. Effectiveness

Summary

Effectiveness performance is broadly stable overall, with continued monitoring required across VTE assessment, SHMI and emergency readmissions. VTE assessment compliance remains variable and requires consistent completion within the 14-hour standard. SHMI should be interpreted factually as a statistical indicator, with review focused on whether reported values remain within expected limits. Emergency readmissions within 30 days appear broadly stable at both Trusts, with no clear sustained deterioration indicated.

Progress

HUTH and NLAG both require continued operational grip on timely VTE assessment, particularly as national changes to emergency admission VTE assessment timing from DTA are expected to affect Quarter 3 performance. SHMI reporting continues through separate detailed releases to clinical leads, with mutlifactoral aspects of care provision, best practice adherence and documentation of care, coupled with effective clinical coding quality contribution to elements that impact on the SHMI calculations and the patient risk profiles by diagnosis group, with all spells of care, not only those patients who die. Readmissions remain an effectiveness indicator for both Trusts and should continue to be reviewed alongside discharge quality, follow-up arrangements, frailty pathways and avoidable readmission themes.

Action

Maintain ward and specialty-level oversight of VTE assessment compliance, with escalation where completion within 14 hours is inconsistent. Continue factual SHMI review through established clinical governance and coding assurance routes. For readmissions, strengthen specialty-level review of themes, discharge planning, post-discharge support and community interface actions where variation emerges.

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		10.9%	10.3%	10.5%	10.2%	10.5%	10.3%	10.4%	10.4%	10.1%	10.2%	10.0%	9.9%	
		Mortality - Crude Mortality (non-elective)		2.5%	2.5%	2.8%	3.2%	3.2%	3.2%	3.2%	2.9%	2.6%	2.8%	2.4%	2.3%	2.7%
		Mortality - HSMR	≤ 100.0	101.9	101.0	99.9	100.1	100.1	98.6	98.7	98.9	98.9				
		Mortality - SHMI	≤ 1.0	1.020	1.025	1.018	1.023	1.027	1.024	1.038	1.047					
		Mortality - Still Births (per 1,000 births)		2.625	2.439	7.979	2.632	5.115	7.444	2.890	7.853	10.526	0.000	0.000	11.601	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait		83	71					0	0	0	0	0	0	0
		Clinical Harm Reviews - RTT 78 week wait		2	0									0	0	0
		VTE Risk Assessment	≥ 95.0%	93.6%	93.5%	92.4%	92.1%	92.5%	91.8%	91.8%	92.0%	92.3%	92.6%	92.9%	92.1%	92.2%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	92.0%	91.7%	90.5%	90.7%	90.9%	90.1%	90.8%	91.2%	91.8%	92.0%	92.2%	91.7%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Effective	Effectiveness	Inpatient - Emergency Readmissions within 30 days		11.0%	11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%	11.3%	11.0%	11.0%	11.0%	
		Mortality - Crude Mortality (non-elective)		1.6%	1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%	1.9%	2.3%	1.9%	1.6%	1.5%
		Mortality - HSMR	≤ 100.0	93.5	92.3	90.6	89.8	88.5	85.4	85.3	84.8	84.8				
		Mortality - SHMI	≤ 1.0	1.030	1.021	1.009	1.001	0.999	0.976	0.977	0.993					
		Mortality - Still Births (per 1,000 births)		6.135	0.000	9.804	6.024	0.000	3.413	6.645	6.452	3.401	0.000	0.000	0.000	0.000
Safe	Patient Safety	Clinical Harm Reviews - Cancer 104 day wait												0		
		Clinical Harm Reviews - RTT 78 week wait												0		
		VTE Risk Assessment	≥ 95.0%	96.1%	96.5%	95.4%	92.2%	95.6%	96.1%	95.8%	95.7%	96.9%	96.8%	96.6%	96.5%	96.1%
		VTE Risk Assessment 14 Hour Standard	≥ 95.0%	93.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%	94.8%	94.8%	94.5%	94.3%	

i. VTE Assessment within 14hrs

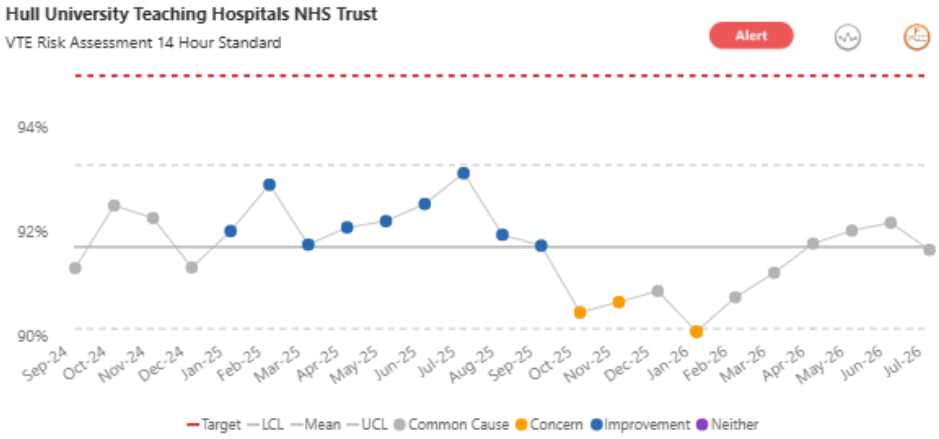
VTE Risk Assessment 14 Hour Standard

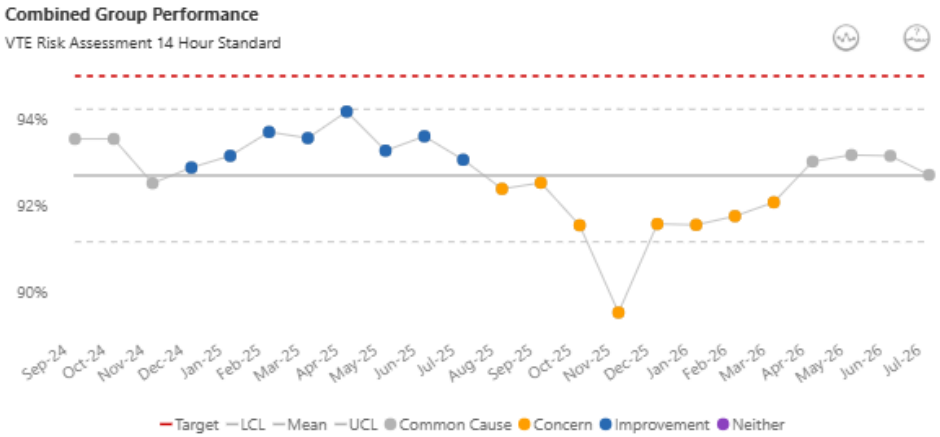
HUTH:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is also below the 95% target.

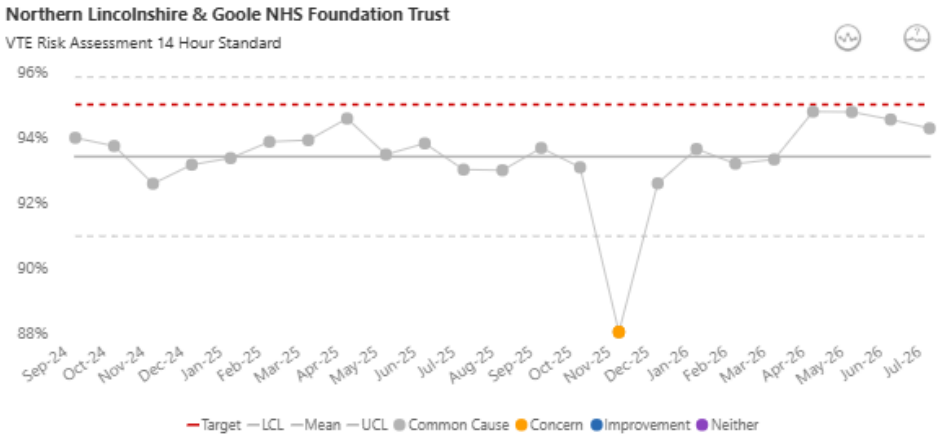
NLAG:
The charts show common cause variation and below the 14 hour target. The dashboard shows overall untimed compliance is over the 95% target.

Continued operational oversight is required to ensure timely VTE assessment completion, with escalation where ward or specialty-level compliance is inconsistent. Local BI data is available to enable targeted monitoring.

National changes to VTE Risk Assessments for Emergency Admissions needing to include time from DTA will have a material impact upon our performance in Quarter 3.





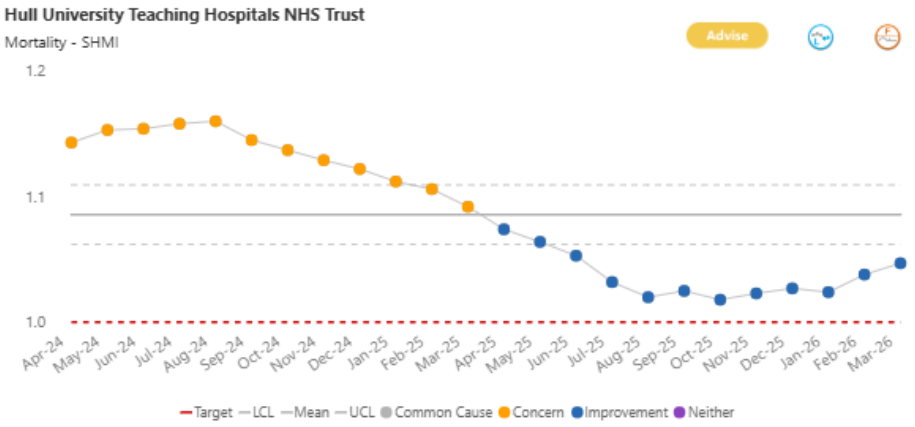


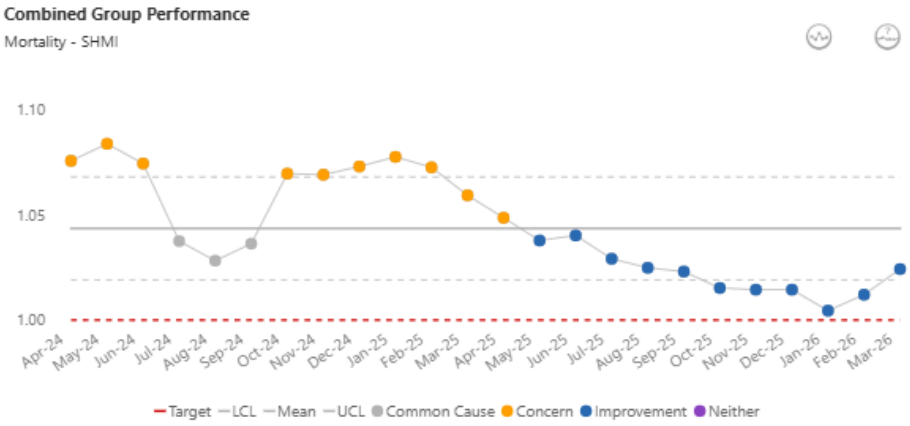
ii. Summary Hospital Mortality Indicator

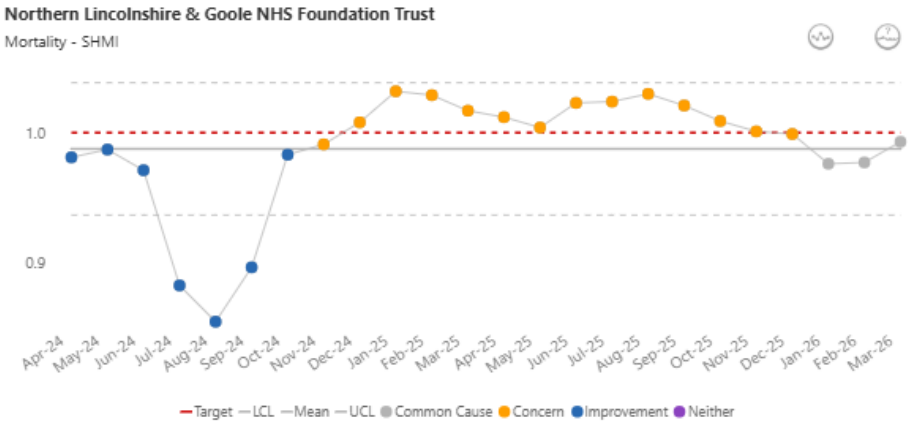
Mortality - SHMI

The national mean is 1.0 with HUTH showing slightly higher rolling 12 month scores and within the overall expected range, with sustained rates below the mean.
NLAG has been reporting a SHMI just under the 1.0 mean for the last 4 data points and has common cause variation.
Separate and detailed SHMI reporting is provided to Clinical Leads upon each release of national data.
Several factors can impact and influence the SHMI score, including:

- Clinical care quality and best practice evidence adherence.
- Depth of coding, accuracy of comorbidities,
- Diagnosis on admission accuracy.
- Sufficient Clinical Coding services crucial for accuracy.







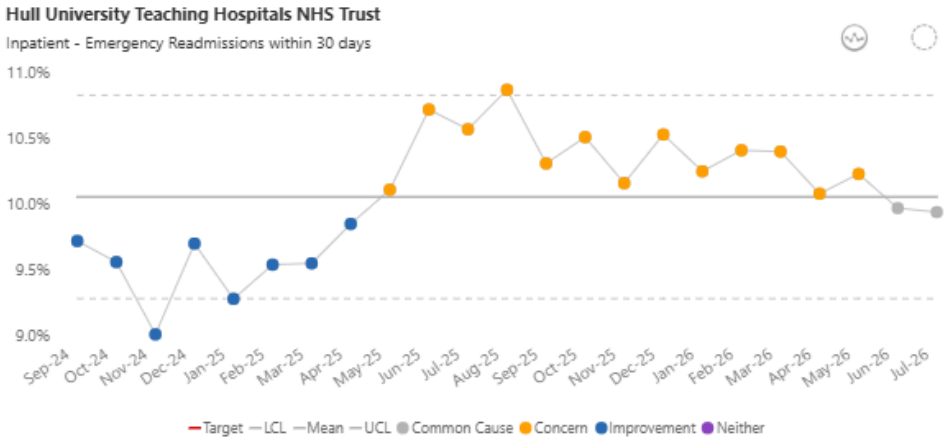
iii. Emergency Readmissions within 30 Days

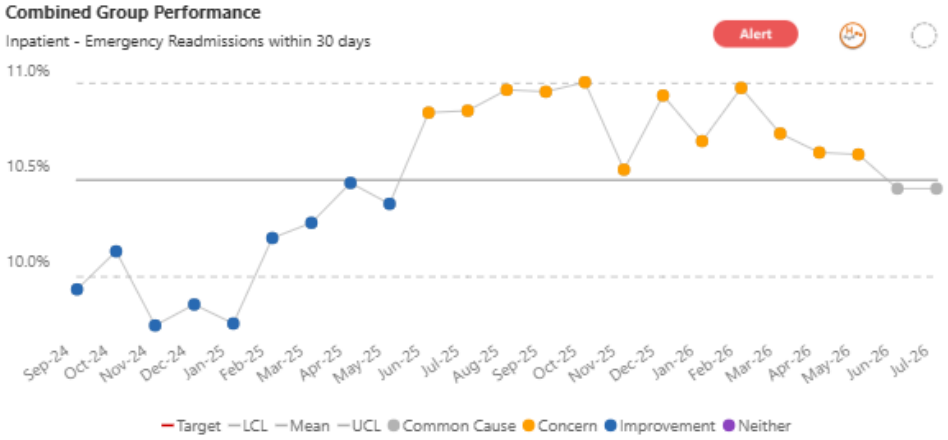
Inpatient - Emergency Readmissions within 30 days

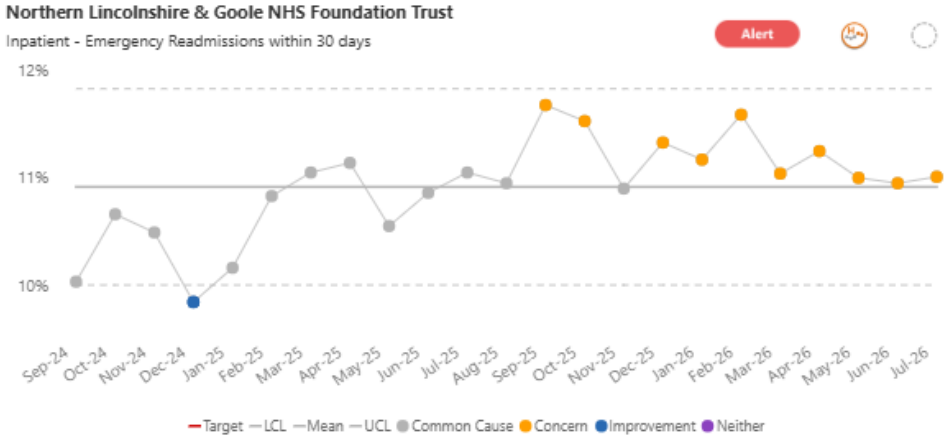
Emergency readmission rates can assist in identifying discharge planning effectiveness, with specialty level analysis over time. The position should continue to be monitored through specialty-level review, with focus on discharge quality, follow-up arrangements and readmission themes where variation emerges.

HUTH:
Emergency readmissions within 30 days shows a return to common cause variation after a period of increased rates of emergency readmission.

NLAG:
The data shows an increased rate above the mean from September 2025.







Sample pages only – awaiting further Lead review

6. HHP Group Executive Summary – Workforce

Executive Lead: Helen Marks, Group Chief People Officer

Accountable to:

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
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.0%		
Staff Appraisal Rate (AfC)	Jul-26	≥ 85.0%	82.0%		
Staff e-Job Planning	Aug-26	≥ 95.0%	89.1%		
Staff Mandatory Training - Core	Jul-26	≥ 85.0%	87.4%		
Staff Mandatory Training - Role Specific	Jul-26	≥ 85.0%	81.2%		
Staff Sickness Absence Rate	Jul-26	≤ 4.0%	4.5%		
Staff Survey - Raising Concerns sub-score	Aug-26		6.0		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.0		
Staff Time to Offer	Jul-26	≤ 2.0	2.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.6		
Staff Turnover Annual FTE Rate	Jul-26	≤ 8.0%	13.7%		

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
Healthcare Worker Flu Vaccination Rate	Apr-26	≥ 60.0%	51.1%		
Staff Appraisal Rate (AfC)	Jul-26	≥ 85.0%	81.1%		
Staff e-Job Planning	Aug-26	≥ 95.0%	78.5%		
Staff Mandatory Training - Core	Jul-26	≥ 85.0%	83.0%		
Staff Mandatory Training - Role Specific	Jul-26	≥ 85.0%	81.3%		
Staff Sickness Absence Rate	Jul-26	≤ 4.0%	5.2%		
Staff Survey - Raising Concerns sub-score	Aug-26		6.1		
Staff Time to Employment Checks	Jul-26	≤ 20.0	21.6		
Staff Time to Offer	Jul-26	≤ 2.0	7.4		
Staff Time to Shortlist	Jul-26	≤ 5.0	7.5		
Staff Turnover Annual FTE Rate	Jul-26	≤ 8.0%	12.0%		

Chief People Officer Update – Workforce Overview (July 2026)

Summary

The workforce position remains mixed across the Group, with the clearest risk in workforce availability and recruitment responsiveness. HUTH sickness absence is showing a deteriorating signal, with the latest four data points above the mean, indicating a sustained adverse shift rather than normal variation. NLAG sickness absence is more stable, remaining around the mean. Across both Trusts, appraisal and role-specific mandatory training remain variable without evidence of sustained improvement. Recruitment timeliness is also variable, with NLAG **Staff Time to Offer** in **Alert**, highlighting a specific risk in converting recruitment activity into timely offers.

Progress

HUTH's workforce culture and experience position is most affected by the sickness absence trend, while appraisal and role-specific mandatory training require continued grip to improve consistency. NLAG does not show the same deterioration in sickness absence, but appraisal and role-specific training completion remain inconsistent. In recruitment and retention, HUTH appears broadly stable but variable across shortlist, offer and employment check stages, with no clear sustained improvement. NLAG shows greater risk across the recruitment pathway, particularly at the offer stage, where the alert status indicates delay against trajectory. Employment checks at both Trusts appear broadly stable but remain a potential later-stage recruitment bottleneck if not actively managed.

Action

Executive focus should remain on targeted sickness absence intervention at HUTH, including divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen workforce governance for appraisal and role-specific mandatory training completion, with routine escalation of areas below trajectory. Recruitment actions should focus on end-to-end pathway grip from vacancy review to start date, including manager shortlisting, interview outcome turnaround, offer approvals and employment check completion. Priority escalation is required for NLAG Time to Offer, with named ownership of delays and routine monitoring of bottlenecks to protect workforce supply.

Sample pages only – awaiting further Lead review

a. Hull University Teaching Hospital Workforce AAA Summary

Count: 6

Alert

- Healthcare Worker Flu Vaccination Rate
- Staff Appraisal Rate (AfC)
- Staff Sickness Absence Rate
- Staff Survey - Raising Concerns sub-score
- Staff Time to Shortlist
- Staff Turnover Annual FTE Rate

Count: 3

Advise

- Staff Mandatory Training - Core
- Staff Mandatory Training - Role Specific
- Staff Time to Offer

Count: 0

Assure

b. Northern Lincolnshire & Goole Hospitals Workforce AAA Summary

Count: 4

Alert

- Healthcare Worker Flu Vaccination Rate
- Staff Sickness Absence Rate
- Staff Time to Offer
- Staff Turnover Annual FTE Rate

Count: 3

Advise

- Staff Appraisal Rate (AfC)
- Staff Mandatory Training - Core
- Staff Time to Shortlist

Count: 1

Assure

- Staff Survey - Raising Concerns sub-score

c. Staff Culture & Experience

Summary

Staff Culture and Experience remains mixed, with no consistent improvement across the three supporting indicators. The key adverse signal is HUTH sickness absence, where the latest four data points sit above the mean, indicating a recent deterioration. NLAG sickness absence remains around the mean, while appraisal and role-specific mandatory training performance at both Trusts remain variable without sustained improvement.

Progress

HUTH has a clear sickness absence deterioration requiring focus, alongside appraisal and role-specific training trends that remain variable rather than improving. NLAG does not show the same sickness deterioration, with absence broadly around the mean, but appraisal and role-specific training completion remain inconsistent and require continued management grip.

Action

Prioritise targeted action on HUTH sickness absence through divisional hotspot review, attendance management and wellbeing support. Across both Trusts, strengthen accountability for appraisal and role-specific mandatory training completion, with routine monitoring of areas below trajectory, escalation of non-compliance and evidence of recovery through workforce governance.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%			28.2%	41.5%	50.8%	51.7%	51.6%	51.3%	51.0%				
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	79.2%	79.7%	80.7%	81.4%	82.3%	80.9%	80.8%	80.1%	81.5%	81.6%	82.2%	82.0%	
		Staff Mandatory Training - Core	≥ 85.0%	86.5%	86.6%	87.7%	88.2%	88.4%	89.4%	89.0%	89.8%	89.8%	87.8%	88.5%	87.4%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	79.4%	80.4%	82.6%	82.0%	82.7%	83.0%	82.0%	82.8%	83.1%	83.3%	83.5%	81.2%	
		Staff Sickness Absence Rate	≤ 4.0%	4.1%	4.2%	4.2%	4.2%	4.3%	4.1%	4.4%	4.4%	4.4%	4.4%	4.4%	4.5%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	Patient Safety	Staff Survey - Raising Concerns sub-score		6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1
	People & Workforce	Healthcare Worker Flu Vaccination Rate	≥ 60.0%			26.9%	43.0%	50.7%	51.7%	51.7%	51.4%	51.1%				
Well Led	People & Workforce	Staff Appraisal Rate (AfC)	≥ 85.0%	82.1%	79.4%	77.9%	78.6%	79.3%	79.3%	78.9%	77.7%	79.1%	79.8%	81.4%	81.1%	
		Staff Mandatory Training - Core	≥ 85.0%	84.9%	86.4%	86.9%	87.5%	84.6%	87.1%	86.9%	89.1%	89.2%	85.1%	85.5%	83.0%	
		Staff Mandatory Training - Role Specific	≥ 85.0%	85.0%	84.7%	83.4%	84.2%	82.7%	80.9%	80.8%	81.5%	80.9%	79.5%	82.0%	81.3%	
		Staff Sickness Absence Rate	≤ 4.0%	5.6%	5.6%	5.5%	5.5%	5.5%	5.5%	5.3%	5.4%	5.4%	5.4%	5.4%	5.2%	

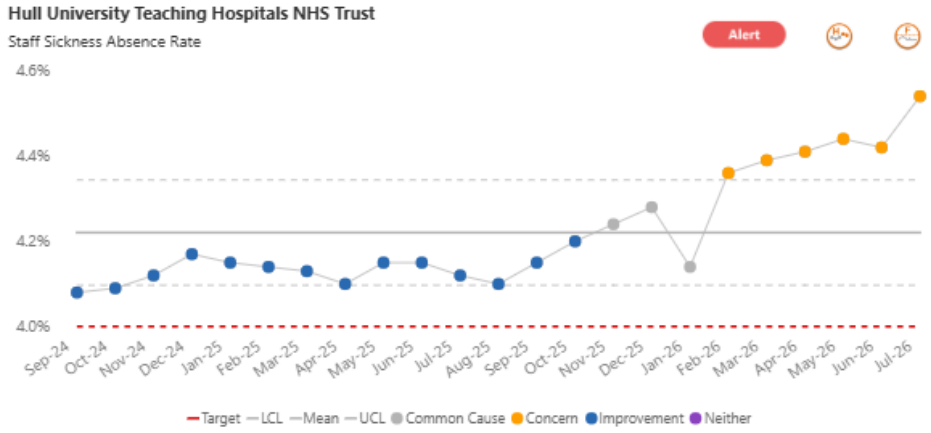
Sample pages only – awaiting further Lead review

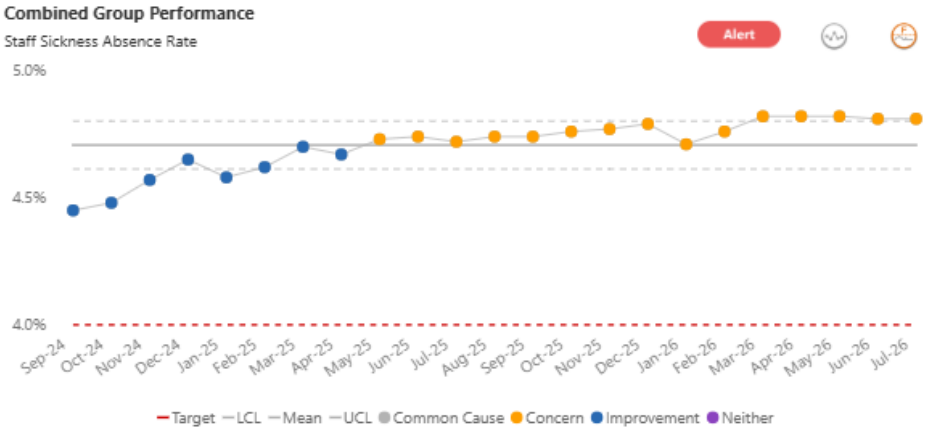
i. Staff Sickness Absence Rate

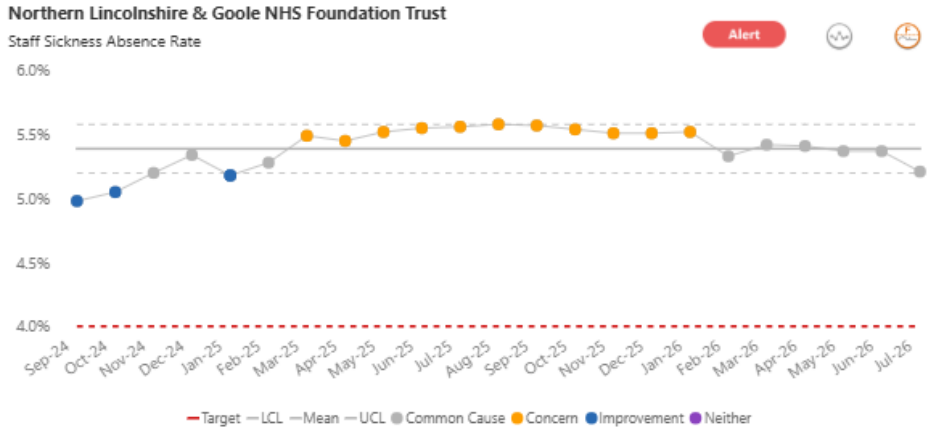
Staff Sickness Absence Rate

HUTH:
Staff sickness absence shows a recent sustained increase, with the latest four data points sitting above the mean. This indicates a deterioration rather than common-cause variation and suggests sickness absence has become a worsening workforce pressure requiring targeted divisional review, hotspot analysis and strengthened attendance management.

NLAG:
NLAG sickness absence remains broadly around the mean, with the latest data points showing normal variation rather than a sustained shift. While absence continues to require active management, the trend does not indicate the same recent deterioration seen at HUTH.







Sample pages only – awaiting further Lead review

ii. Staff Appraisal Rate (AfC)

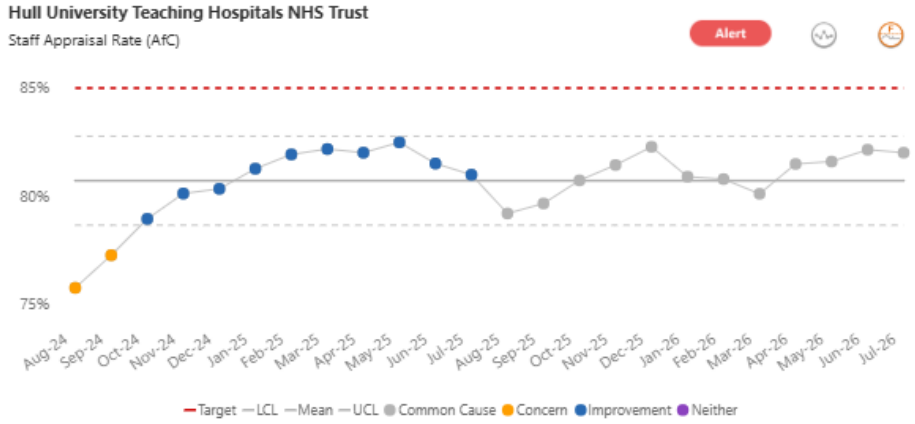
Staff Appraisal Rate (AfC)

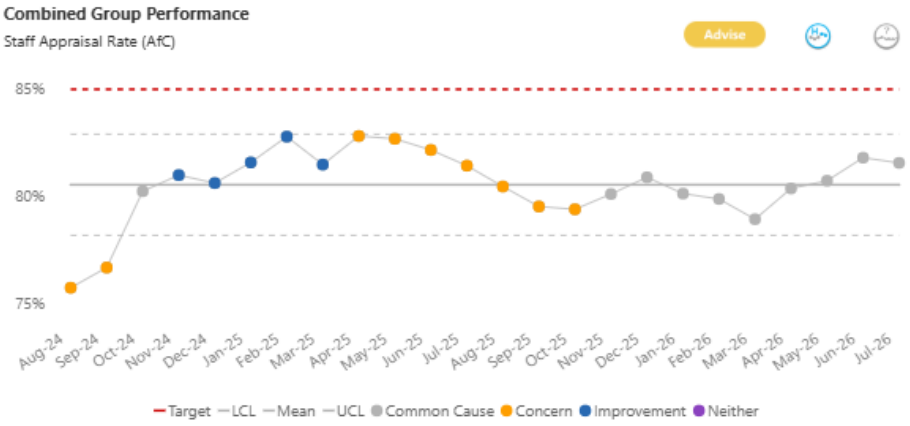
HUTH:

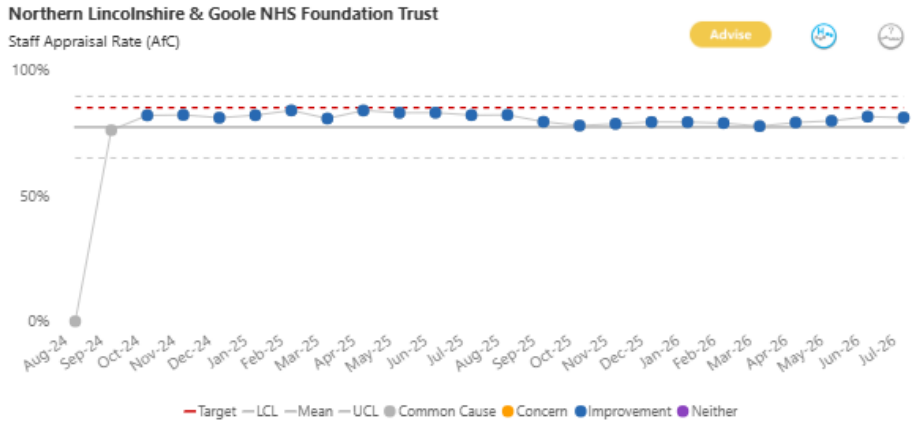
Staff appraisal performance remains variable and does not show a sustained improving trend. Recent data points appear to continue around the mean, indicating normal variation rather than clear recovery. Continued divisional focus is required to improve completion rates and ensure appraisal compliance is delivered consistently.

NLAG:

NLAG appraisal performance also remains variable, with the most recent position not demonstrating sustained improvement. The trend suggests appraisal completion remains inconsistent, requiring tighter management oversight, targeted follow-up of areas below expected compliance and clearer accountability for completion.







Sample pages only – awaiting further Lead review

iii. Staff Mandatory Training – Role Specific

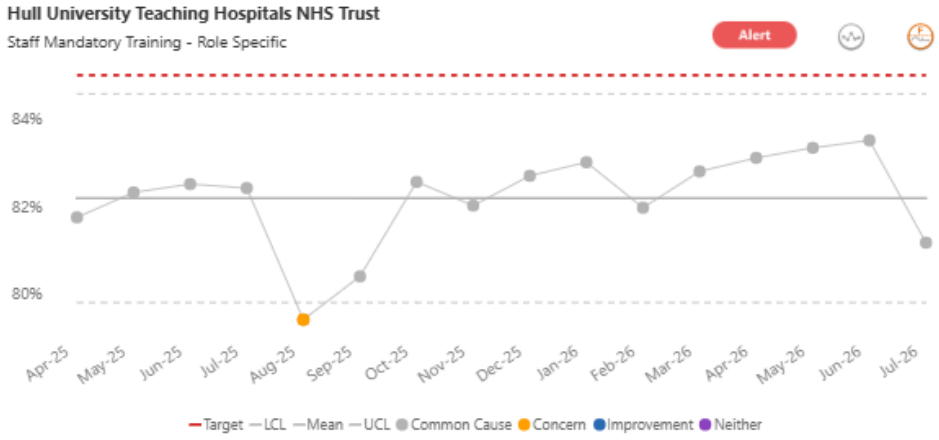
Staff Mandatory Training - Role Specific

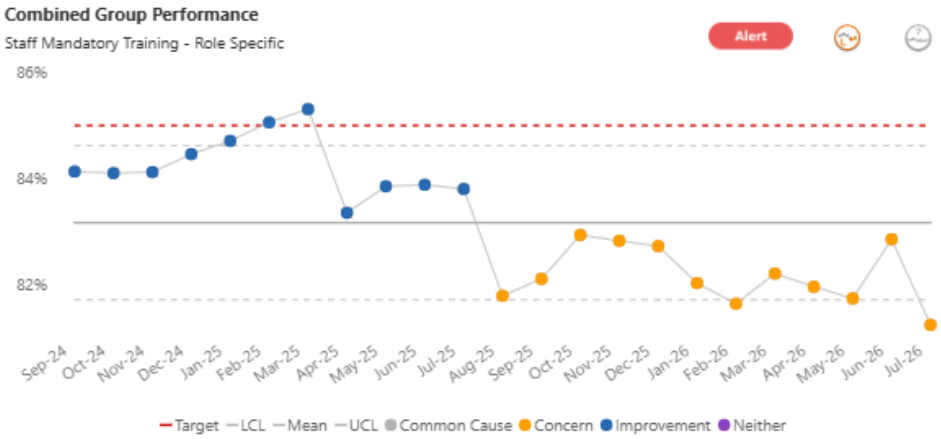
HUTH:

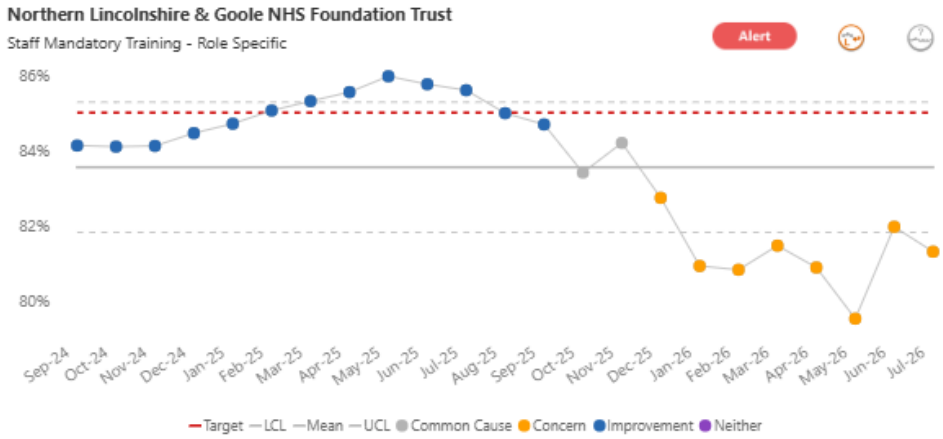
The latest position suggests compliance is not yet consistently improving at the required pace, requiring continued divisional grip, targeted follow-up with areas below trajectory and active monitoring through workforce governance.

NLAG:

NLAG shows a similarly variable trend, with performance not yet demonstrating sustained improvement. Continued focus is required on role-specific training completion, manager accountability and escalation of non-compliance to ensure training gaps do not present an ongoing workforce or assurance risk.







d. Recruitment & Retention

Summary

Recruitment process timeliness remains variable across HUTH and NLAG, with no clear sustained improvement across shortlisting, offer or employment checks. The greatest concern is NLAG Staff Time to Offer, which remains in **Alert**, indicating delays in progressing candidates to offer and a continuing risk to workforce supply.

Progress

HUTH shows broadly stable but variable performance across the recruitment pathway, with no sustained deterioration but limited evidence of improvement. NLAG also remains variable across the pathway, with particular risk at the offer stage. Employment checks at both Trusts appear broadly stable but continue to require oversight to prevent delays later in the recruitment process.

Action

Strengthen end-to-end recruitment grip through timely vacancy review, manager shortlisting, interview outcome confirmation, offer approval and employment check turnaround. Priority focus is required on NLAG Time to Offer, with escalation of overdue decisions, clearer ownership of recruitment delays and routine monitoring of pathway bottlenecks from advert close to start date.

Sample pages only – awaiting further Lead review

HUTH Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	35.0	38.8	38.5	36.4	27.7	48.2	13.8	12.6	13.6	16.0	18.9	21.0	
		Staff Time to Offer	≤ 2.0	6.3	3.3	2.7	2.1	2.1	2.0	2.0	2.2	2.3	2.2	2.3	2.4	
		Staff Time to Shortlist	≤ 5.0	9.2	9.4	8.6	9.0	8.2	8.5	7.1	7.2	7.0	6.6	7.6	7.6	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	7.2%	6.4%	6.7%	6.4%	6.2%	5.8%	6.2%	6.4%	6.3%	6.5%	12.2%	13.7%	

NLAG Scorecard

Tier 1 - Foundation Scorecard

Right click metric to drill through to SPC chart or view metric breakdown

Oversight | CQC

Domain	Subject Area	Metric	National Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Safe	People & Workforce	Staff Time to Employment Checks	≤ 20.0	28.7	41.2	34.6	41.2	41.3	37.4	27.5	27.0	22.0	17.3	17.8	21.6	
		Staff Time to Offer	≤ 2.0	2.4	3.1	2.8	2.6	2.5	2.4	2.2	2.5	2.9	3.4	3.5	7.4	
		Staff Time to Shortlist	≤ 5.0	40.0	50.6	68.2	95.7	110.8	52.3	48.8	47.8	6.1	6.8	6.9	7.5	
Well Led	People & Workforce	Staff Turnover Annual FTE Rate	≤ 8.0%	8.7%	8.4%	8.4%	8.3%	8.0%	8.0%	7.8%	7.6%	6.5%	7.2%	11.9%	12.0%	

Sample pages only – awaiting further Lead review

i. Staff Time to Shortlist

Staff Time to Shortlist

HUTH:

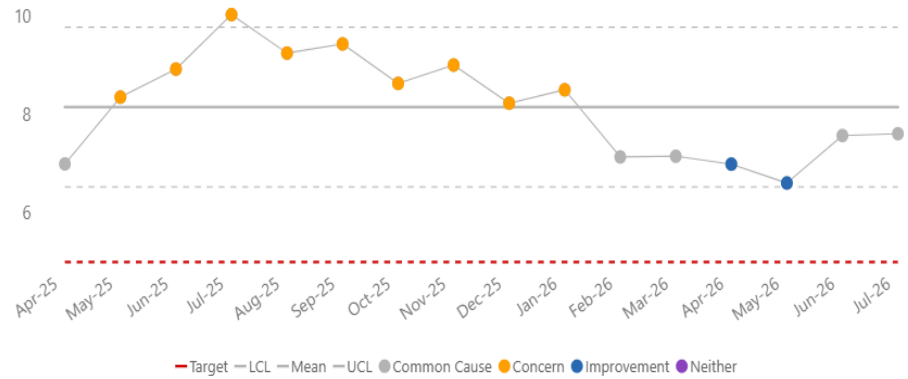
Staff Time to Shortlist shows continued variation across the period, with no clear sustained improvement. The latest position suggests the process remains vulnerable to delays at the early recruitment stage, requiring continued focus on timely vacancy review, manager shortlisting and recruitment team escalation where turnaround is off trajectory.

NLAG:

Staff Time to Shortlist also remains variable, with performance not yet demonstrating a consistent reduction. The trend indicates ongoing risk in progressing vacancies quickly from advert close to shortlist, requiring tighter operational grip on recruiting manager responsiveness, vacancy prioritisation and escalation of overdue shortlisting.

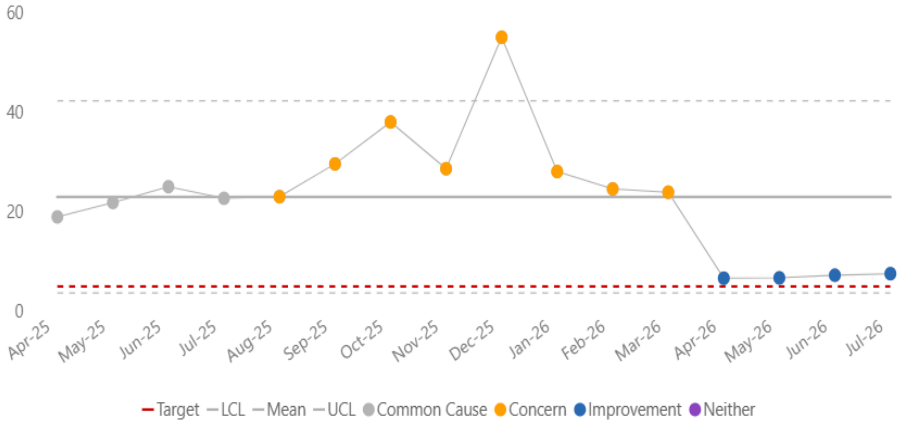
Hull University Teaching Hospitals NHS Trust

Staff Time to Shortlist



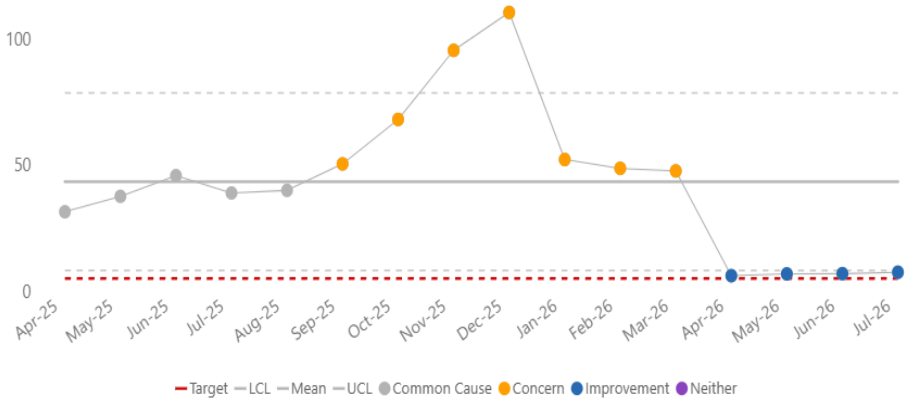
Combined Group Performance

Staff Time to Shortlist



Northern Lincolnshire & Goole NHS Foundation Trust

Staff Time to Shortlist



ii. Staff Time to Offer

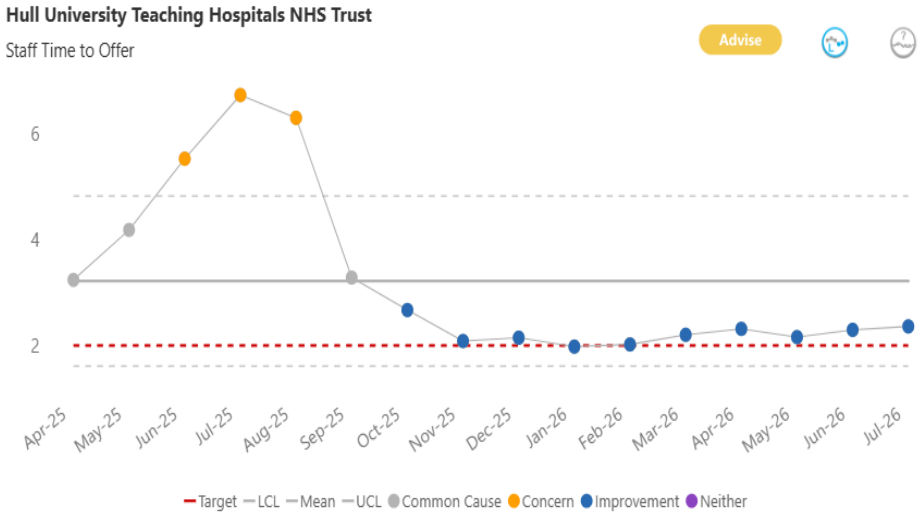
Staff Time to Offer

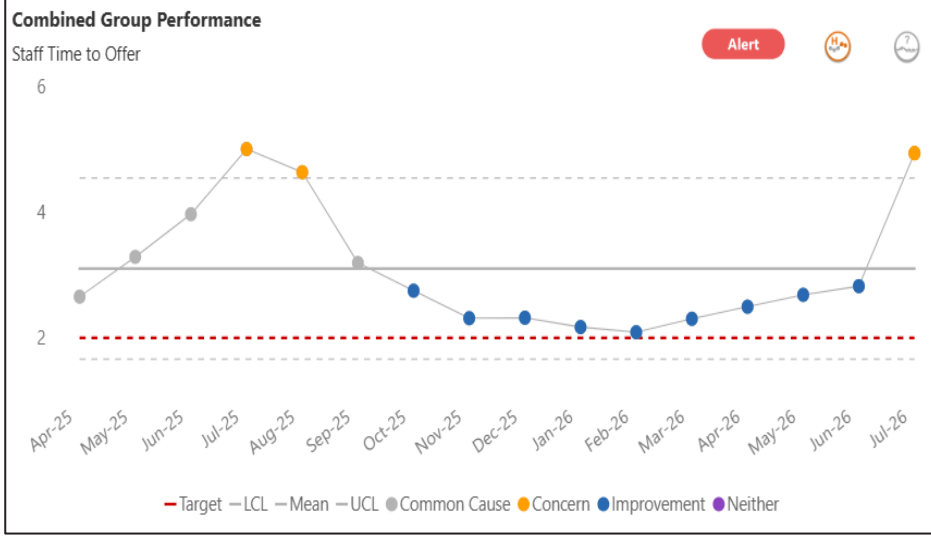
HUTH:

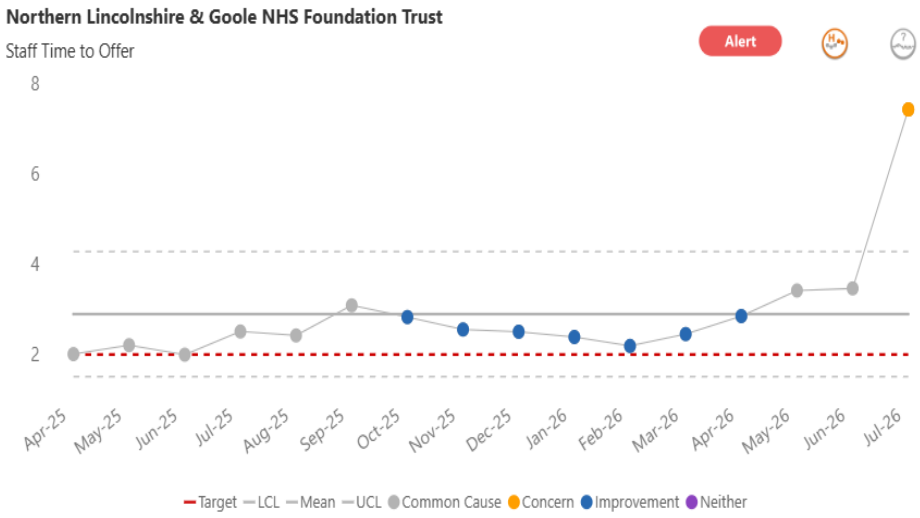
Staff Time to Offer shows variation across the period, with no clear sustained improvement. The recent position appears broadly stable but remains above the level required for consistent recruitment responsiveness, so continued focus is needed on timely interview outcomes, approval steps and offer processing.

NLAG:

Staff Time to Offer remains in Alert, reflecting a concerning position against trajectory. The trend shows continued variation without sustained recovery, indicating that delays in progressing candidates to offer remain a recruitment risk and require targeted operational grip on vacancy management, panel decision turnaround and offer approval processes.







iii. Staff Time to Employment Checks

Staff Time to Employment Checks

HUTH:

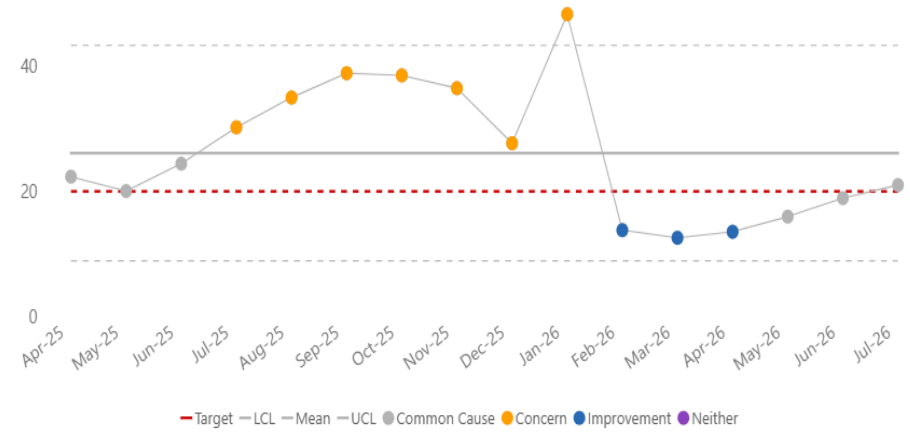
Time to employment checks shows a broadly stable trend with no clear sustained improvement; performance remains variable and should continue to be monitored to ensure checks do not become a recruitment delay point.

NLAG:

NLAG also shows variation across the period, with the position not yet demonstrating a sustained reduction. Continued focus is required on pre-employment check turnaround, escalation of delays and consistent recruitment process grip.

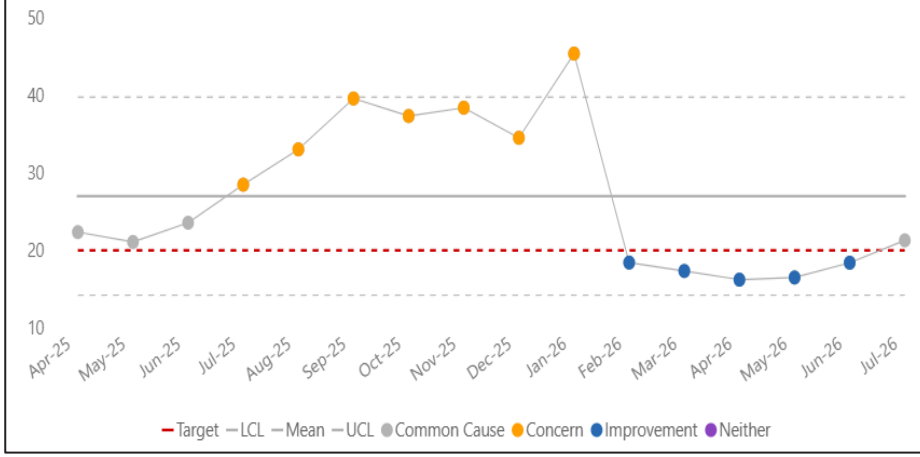
Hull University Teaching Hospitals NHS Trust

Staff Time to Employment Checks



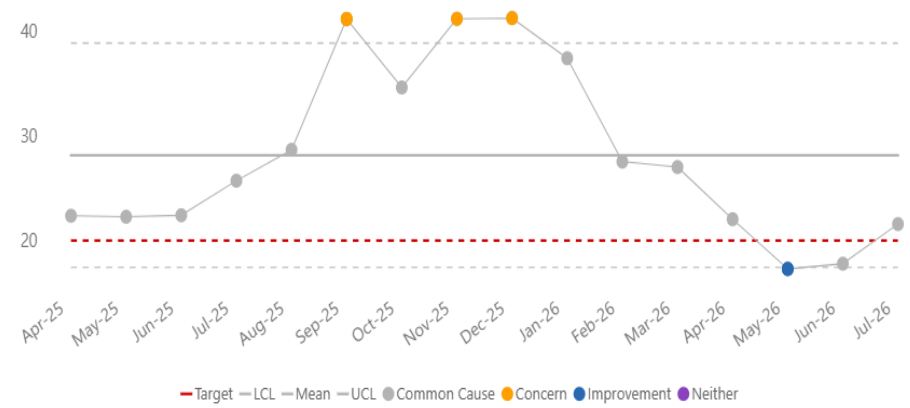
Combined Group Performance

Staff Time to Employment Checks



Northern Lincolnshire & Goole NHS Foundation Trust

Staff Time to Employment Checks



Appendices

1. Key to Statistical Process Control (SPC) Charts

SPC GUIDE

A guide to understanding Statistical Process Control (SPC) charts, variation and assurance icons

Statistical Process Control (SPC) charts help us understand how processes perform over time, distinguishing between normal and special cause variation. These charts follow best practice principles aligned with the **Making Data Count** (MDC) approach. Further details of Making Data Count principles can be found as follows:

https://www.england.nhs.uk/publication/making-data-count/

WHAT YOU'LL SEE

SPC Chart

Each point represents a data value over time. The chart helps you understand how the process is performing, highlighting whether variation is expected (*common cause*) or unusual (*special cause*).
Blue dots indicate improvement (special cause variation); **Amber dots** indicate concern (special cause variation); **Grey dots** indicate expected variation (common cause).

Variation Icons

These summarise the type of variation at a glance.
Blue indicates improvement; **Amber** indicates concerning variation that may require action; **Grey** indicates no significant change (common cause variation).

Assurance Icons

These indicate how reliably the target is being met.
Blue indicates target is consistently achieved; **Amber** indicates target is not consistently achieved; **Grey** indicates target is inconsistently achieved due to random variation.

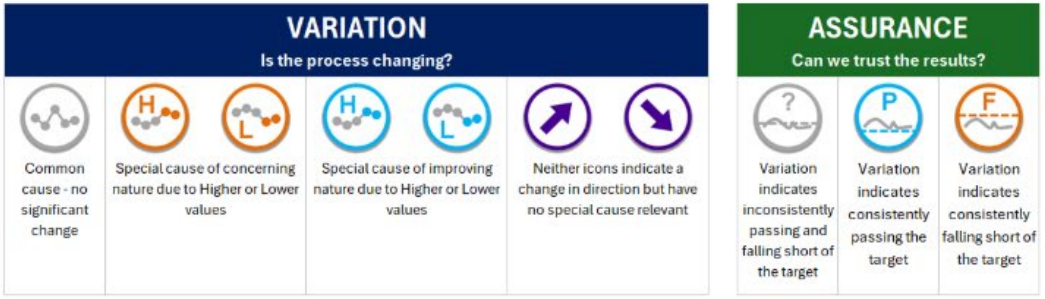
Triple-A Status

Combines variation and assurance to give an overall rating:
Assure, **Advise**, or **Alert**.

Variation	Plan / Assurance	AAA Status
Improving	Meeting	Assure
Normal	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert

SPC Chart

Variation and Assurance Icons



2. National Oversight Framework Definitions

Establishing Average Scores

Step one: score individual metrics

Metric	Value	Score
% of patients waiting over 52 weeks	0.7%	1.00
% of patients waiting less than 18 weeks	59%	2.62
% of urgent cancer referrals diagnosed in 4 weeks	81.5%	1.00
% of cancer treatments within 62 days	82.6%	1.00
% of patients managed in A&E within four hours	80.4%	1.00
% of patients spending over 12 hours in A&E	3.1%	1.4
Planned surplus or deficit	£0.00	1.00
Latest surplus or deficit	-0.73%	3.00
NHS staff survey engagement score	7.17	1.36
NHS staff survey safety score	6.70	1.45
CQC safety rating	Good	2.00

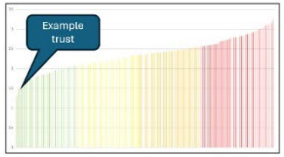
Step two: determine overall score

Sum total of metric scores
16.83

Total number of scores
11

Overall score (Sum total of metric scores / total number of scores)
1.53

Step three: Calculate initial delivery score



All raw domain scores for the organisation type are plotted and evenly quartiles. The example trust's raw score of 1.53 is in the lowest quartile giving a delivery score of 1

After this an adjustment is made for Financial Deficit:

Any provider with a segment of 1 or 2 based on its operational delivery score that is reporting a deficit or is in receipt of deficit support will automatically have its segment downrated to 3. This will be based on organisational not system-wide financial performance.

Then National segmentation is applied as follows:

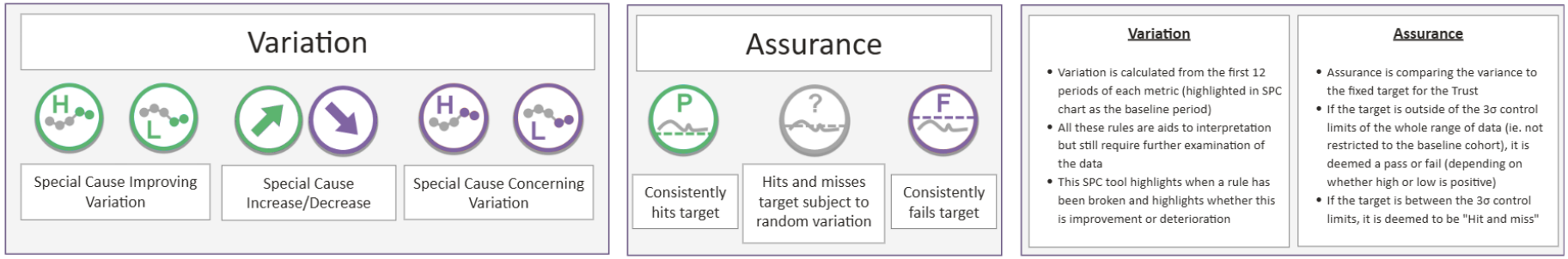
An organisation's organisational delivery score, adjusted if applicable for financial deficit, translates directly to the segment it is allocated. For some providers that are allocated to segment 4, the relevant NHS England region will consider their capability rating and determine whether they should be entered into the Provider Improvement Programme (PIP).

All providers in the PIP will be placed in segment 5.

3. Using Data Insights to identify Alert, Advise and Assure status

Making Data Count is a means to express the variation in trend and, somewhat separately, the achievement of a singular target (assurance).

In most cases, this will yield a continual 'Fail' throughout the year in terms of the MDC Assurance trigger (described below) as this wants a static target.



Equally, in the context of traditional 'National' compliance targets (e.g. ED 4hr =95%) being beyond reach, we require a focus upon what we have agreed to achieve over a performance cycle, with the Medium-Term Plan helping to set this in several key areas.

If the Trust has established a target, these are our Performance Measures for the year and if we have established a target, best practice would be to generate a trajectory to monitor its delivery.

'Assurance' would be better demonstrated by the combination of variation – still using SPC insight – and whether the latest reporting period is matching trajectory.

Using this approach, we will identify the AAA status of each Performance Measure every month based upon the matrix below.

Variation status	Status v Trajectory	AAA Group
Improving	Meeting	Assure
Improving	Missing	Advise
Concerning	Meeting	Advise
Concerning	Missing	Alert
Normal	Missing	Alert
Normal	Meeting	Assure

4. National Oversight Framework

HUTH Overview

Select a trust

Hull University Teaching Hospitals NHS Trust (RWA)

View the glossary page

Average score

3.19

Lower by 0.04 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

134 out of 134

Previous quarter's rank: 134 out of 134

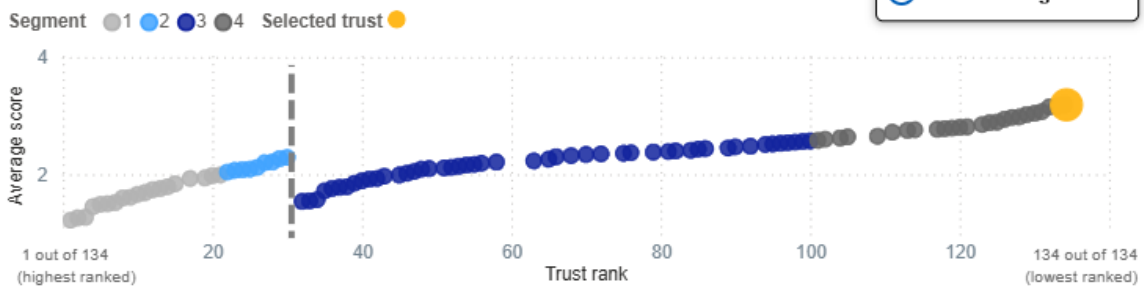
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	2 - Above average
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

NLAG Overview

Select a trust

Northern Lincolnshire and Goole NHS Foundation Trust (RJL)

View the glossary page

Average score

2.79

Lower by 0.07 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

119 out of 134

Previous quarter's rank: 114 out of 134

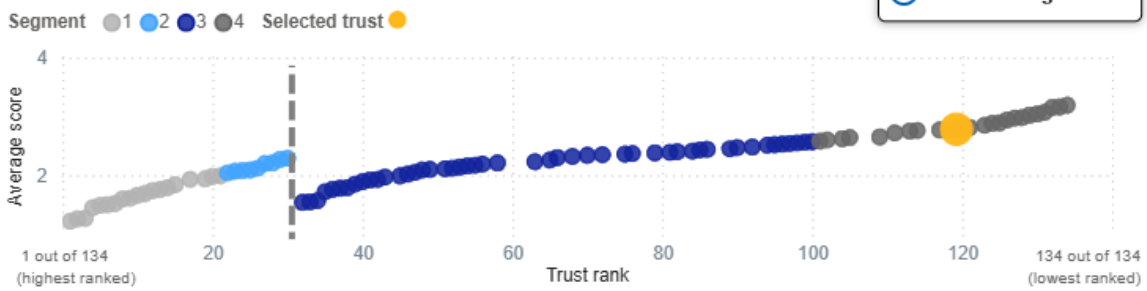
Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	1 - High performing
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



Comparative League table in Appendices

Regional Context – Public View Data Source

Access to Services

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
Cancer - Patients treated within 62 of referral QTD Q2 26/27 80.00%	54.50% 3.86	56.65% 3.84	74.46% 2.51	81.73% 1.00
Cancer - Urgent referrals diagnosis within 4 weeks QTD Q2 26/27 80.0%	70.0% 3.67	68.7% 3.71	73.0% 3.38	86.9% 1.00
Diagnostics - 6 Week Standard Jul 26	36.58% 3.70	33.51% 3.61	22.25% 2.95	30.32% 3.48
ED - Attendances managed within 4 hours - Acute trust footprint QTD Q2 26/27 82.00%	70.55% 3.46	72.22% 3.21	66.02% 3.83	72.63% 3.16
ED - Attendances over 12 hours in department QTD Q2 26/27	5.7% 1.84	17.2% 3.78	14.3% 3.45	1.9% 1.27
RTT - Patients waiting 18 weeks or less Jul 26	56.01% 3.91	59.78% 3.65	58.50% 3.79	73.59% 1.40
RTT - Patients waiting over 52 weeks Jul 26 0.00%	3.88% 3.97	3.31% 3.92	2.05% 3.54	0.06% 2.15
RTT - Planned v actual 18 week performance Q4 25/26 0.0%	-5.5% 3.60	-3.7% 3.24	-3.9% 3.33	5.2% 1.00

Effectiveness & Experience

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
EXPERIENCE OF CARE	MEAN SCORE 2.84	MEAN SCORE 2.84	MEAN SCORE 3.16	MEAN SCORE 1.53
CQC inpatient survey satisfaction rate 2026	4.0 2.00	4.0 2.00	4.0 2.00	4.0 2.00
Patients cared for in corridors - ED QTD Q2 26/27	1,065 2.78	1,256 2.98	4,062 3.88	0 1.00
Staff Survey - Advocacy sub-score 2025	5.92 3.73	6.03 3.55	5.99 3.61	7.14 1.59
EFFECTIVENESS OF CARE	MEAN SCORE 3.33	MEAN SCORE 2.80	MEAN SCORE 1.59	MEAN SCORE 2.27
Delayed inductions rate Q1 26/27	609.4 4.00	30.1 2.40	17.8 1.76	130.6 3.80
Patients readmitted within 30 days of discharge 2025	15.8% 4.00	15.2% 4.00	14.3% 1.00	13.3% 1.00
Summary Hospital Mortality Indicator Apr 26	1.05 2.00	0.99 2.00	0.88 2.00	1.01 2.00

Patient Safety

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
PATIENT SAFETY	MEAN SCORE 3.19	MEAN SCORE 2.59	MEAN SCORE 2.86	MEAN SCORE 1.48
Clinical audit outlier score Q1 26/27	3 3.00	1 1.00	1 1.00	1 1.00
Inpatients who suffer a new hip fracture while an inpatient - YTD 2026	5.0% 3.92	1.5% 1.26	3.7% 3.66	2.0% 1.86
Number of MRSA bacteraemia cases Jul 26 0	2 2.22	5 3.08	5 3.08	1 2.00
Rate of C-Difficile Jul 26	1.87 4.00	2.11	0.92	1.04 3.00
Rate of E-Coli bacteraemia Jul 26	0.00 2.00	0.00	0.00	0.00 1.00
Staff Survey - Raising Concerns sub-score 2025	6.04 3.55	6.09 3.45	6.00 3.70	6.87 1.16

Finance & Productivity

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
FINANCE, PRODUCTIVITY AND INNOVATION	MEAN SCORE 3.04	MEAN SCORE 3.14	MEAN SCORE 3.33	MEAN SCORE 2.93
Clinical trials set up within 90 days Q1 26/27	71.43% 4.00	0.00% 4.00	60.00% 4.00	100.00% 1.00
Data Quality Maturity Index (DQMI) May 26	96.4 1.25	91.0 3.05	91.2 3.03	87.4 3.84
Finance - Combined finance score Q1 26/27	4 4.00	4 4.00	4 4.00	4 4.00
Finance - Planned surplus/deficit Q1 26/27 0.00%	-4.05% 4.00	-3.88% 4.00	-2.56% 4.00	-3.85% 4.00
Finance - Variance year-to-date to financial plan Q1 26/27 0.00%	-3.40% 4.00	-1.22% 4.00	-1.33% 4.00	-7.42% 4.00
Productivity - Implied productivity level Mar 26	-1.0% 3.53	1.3% 2.98	-1.7% 3.64	-0.2% 3.35
Productivity - Relative difference in costs Q1 26/27 100.0%	91.0% 1.00	95.3% 1.00	86.3% 1.00	96.0% 1.00

People & Workforce

Key Performance Indicator	Hull University Teaching Hospitals INDICATIVE DELIVERY SCORE 3.93	Northern Lincolnshire and Goole NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.91	York and Scarborough Teaching Hospitals NHS Foundation Trust INDICATIVE DELIVERY SCORE 3.88	Harrogate and District NHS Foundation Trust INDICATIVE DELIVERY SCORE 1.52
PEOPLE	MEAN SCORE 2.64	MEAN SCORE 3.15	MEAN SCORE 2.73	MEAN SCORE 1.69
Frontline healthcare workers to receive a flu vaccination Q4 25/26	51.0% 2.24	51.1% 2.17	51.1% 2.20	66.4% 1.00
NETS - Overall Experience subscore 2025	71.47 3.57	64.44 3.98	75.25 2.75	81.26 1.31
NHS staff standards sub-score 2026	7.37 3.53	7.38 3.48	7.43 3.14	7.82 1.14
Sickness Absence Rate QTD Q1 26/27	4.23% 1.65	4.97% 2.71	5.27% 3.03	4.83% 2.53
Staff Survey - Engagement Theme Score 2025	6.40 3.75	6.46 3.59	6.51 3.36	7.07 1.50
Temporary staffing cost relative band Q1 26/27	1 1.00	3 3.00	1 1.00	2 2.00

5. Trust League Tables

a. HUTH – Filtered to Teaching Hospitals

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Teaching	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Teaching	Hull University Teaching Hospitals NHS Trust (RWA)	3.19	4	Yes	134	114 to 134	134
Acute - Teaching	James Paget University Hospitals NHS Foundation Trust (RGP)	3.07	4	Yes	131	113 to 134	127
Acute - Teaching	Nottingham University Hospitals NHS Trust (RX1)	3.04	4	Yes	130	103 to 134	132
Acute - Teaching	York and Scarborough Teaching Hospitals NHS Foundation Trust (RCB)	3.02	4	Yes	129	108 to 134	131
Acute - Teaching	East Kent Hospitals University NHS Foundation Trust (RVV)	2.97	4	Yes	127	90 to 134	124
Acute - Teaching	University Hospitals of Derby and Burton NHS Foundation Trust (RTG)	2.89	4	Yes	125	92 to 132	97
Acute - Teaching	Barking, Havering and Redbridge University Hospitals NHS Trust (RF4)	2.88	4	Yes	124	73 to 134	99
Acute - Teaching	Wirral University Teaching Hospital NHS Foundation Trust (RBL)	2.85	4	Yes	123	80 to 133	124
Acute - Teaching	Lancashire Teaching Hospitals NHS Foundation Trust (RXN)	2.81	4	Yes	121	80 to 131	129
Acute - Teaching	University Hospitals Sussex NHS Foundation Trust (RYR)	2.81	4	Yes	121	79 to 132	121
Acute - Teaching	University Hospitals of Morecambe Bay NHS Foundation Trust (RTX)	2.77	4	Yes	117	76 to 130	95
Acute - Teaching	Blackpool Teaching Hospitals NHS Foundation Trust (RXL)	2.72	4	Yes	111	66 to 131	106
Acute - Teaching	Northern Care Alliance NHS Foundation Trust (RM3)	2.72	4	Yes	111	76 to 128	115
Acute - Teaching	Liverpool University Hospitals NHS Foundation Trust (REM)	2.65	4	Yes	109	60 to 128	113
Acute - Teaching	Mid Yorkshire Teaching NHS Trust (RXF)	2.64	4	Yes	105	57 to 129	112
Acute - Teaching	University Hospitals of Leicester NHS Trust (RWE)	2.64	4	Yes	105	64 to 128	99
Acute - Teaching	University Hospitals Plymouth NHS Trust (RK9)	2.64	4	Yes	105	63 to 126	119

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b. NLAG – Filtered to Medium

Quarter	Select trust type(s)	Select trust(s)
Q4 2025/26	Acute - Medium	All

Statistics methodology | Return to overview

Trust type	Trust	Average score	Segment	Trust in financial deficit?	Rank	Likely range of rank	Previous quarter's rank
Acute - Medium	Northampton General Hospital NHS Trust (RNS)	2.98	4	Yes	128	94 to 134	126
Acute - Medium	North Cumbria Integrated Care NHS Foundation Trust (RNN)	2.80	4	Yes	120	81 to 131	130
Acute - Medium	Northern Lincolnshire and Goole NHS Foundation Trust (RJL)	2.79	4	Yes	119	76 to 131	114
Acute - Medium	Medway NHS Foundation Trust (RPA)	2.76	4	Yes	114	64 to 132	116
Acute - Medium	Great Western Hospitals NHS Foundation Trust (RN3)	2.75	4	Yes	113	77 to 129	85
Acute - Medium	Wrightington, Wigan and Leigh NHS Foundation Trust (RRF)	2.56	3	Yes	99	57 to 124	117
Acute - Medium	Gateshead Health NHS Foundation Trust (RR7)	2.53	3	Yes	96	54 to 122	65
Acute - Medium	Croydon Health Services NHS Trust (RJ6)	2.45	3	Yes	89	51 to 118	97
Acute - Medium	Royal United Hospitals Bath NHS Foundation Trust (RD1)	2.40	3	Yes	82	47 to 114	102
Acute - Medium	Sherwood Forest Hospitals NHS Foundation Trust (RK5)	2.40	3	Yes	82	49 to 112	60
Acute - Medium	Surrey and Sussex Healthcare NHS Trust (RTP)	2.35	3	Yes	72	41 to 118	63
Acute - Medium	The Shrewsbury and Telford Hospital NHS Trust (RXW)	2.35	3	Yes	72	41 to 117	78
Acute - Medium	Bedfordshire Hospitals NHS Foundation Trust (RC9)	2.26	3	Yes	65	41 to 104	52
Acute - Medium	Bolton NHS Foundation Trust (RMC)	2.23	3	Yes	63	39 to 103	76
Acute - Medium	The Dudley Group NHS Foundation Trust (RNA)	2.21	3	Yes	58	39 to 96	68
Acute - Medium	Ashford and St Peter's Hospitals NHS Foundation Trust (RTK)	2.16	3	Yes	54	38 to 97	54
Acute - Medium	Stockport NHS Foundation Trust (RWJ)	2.09	3	Yes	48	35 to 89	45

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6. HHP Foundation Scorecards

Embedded in the HHP NOF Scorecard are 4 Foundation Scorecards:

- Quality (CQC: Caring, Safe, Effective),
- Performance (CQC: Responsive)
- Finance (CQC: Effective, Well-led)
- Workforce (CQC: Effective, Well-led)

Each Foundation Scorecard will contain every relevant metric signed off by lead Exec.

Subject to available thresholds each metric will be RAG rated. All RAG rated metrics will be used to derive sub-domain and domain assessment scores

Each metric will also be identified as a defined or enabling NHSE NOF Indicator along with the defined Subject Area (Elective Care, Cancer, UEC, Financial Balance, Productivity).

Each metric will be allocated a unique identifier allowing any combination of summary scorecards to be generated

Every Metric has clear definitions and SPC graphs to support further understanding and act as presentational templates for Care Group performance updates

ADVISE, ALERT and ASSURE REPORT	
Meeting	Performance, Estates and Finance Committees-in-Common
Meeting date	29 September 2026
Chair	Murray Macdonald, Non-Executive Director
Quoracy requirements met	Yes

1. **Key items discussed**

TO ALERT (Areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Performance				
UEC non-compliance with constitutional standards	Performance was broadly static between July and August with a 1.2% fall in four-hour performance. Twelve-hour waits at HUTH have improved compared with previous years and the continuous flow model is planned for NLAG in October.		Frailty SDEC has recently gone live at HUTH, subject to safety checks and internal professional standards.	
RTT 52+ non-compliance with constitutional	A deep dive was presented showing the Groups waiting list is at its highest level, 18 week	Care Group capacity was raised as a concern by the CiC, particularly	The CiC supported a tactical recovery approach focused on activity, prioritisation,	

standards	performance is off trajectory and 52 week waits have deteriorated.	NLAG with a 35% workforce capacity gap. Further Demand and Capacity model shows 22.2% capacity gap in first appointments (n= 55,549) and 42.1% in follow ups (195,100).	governance and clinical ownership before March 2027. A private Board session was in place to explore the detail and likely risks relating to resource and improvement.	
Cancer 28/62 day non-compliance with constitutional standards	62-day cancer performance at NLAG was static but on plan, while HUTH was also being monitored. 31-day first treatment performance is improving at HUTH. The 28-day faster diagnostic standard is improving and is expected to be delivered during the year.		New appointment of a cancer recovery expert.	
Operational Planning	A revised planning process based on specialty-level demand and capacity was taking place. Methodology included GIRFT approved demand and capacity plan	The CiC expressed the requirements for specialty built plans rather than imposed benchmark data.	The CiC requested that Board members and clinical leaders to be involved earlier so that difficult choices and compromises become collectively owned and	

	aligned with recovery.		defended in national discussions. The CiC approved the approach.	
Finance				
Year to date £55m adverse to plan	The forecasted year-end position remains significantly adverse to plan (£55m), with the most likely scenario indicating a deficit substantially in excess of the agreed plan despite financial recovery support and intervention.	Grant Thornton had undertaken discovery work with Care Groups and was providing 20 people as delivery support alongside Keith Pringle as the Financial Improvement Director.	The CiC agreed right-sizing the substantive establishment and matching staff to demand was fundamental in reducing bank, agency and extra-contractual pay. This was linked to improving UEC and reducing waiting times as this would release funds for under-resourced services. Discussions are ongoing with NHS England in terms of the forecast outturn in 2026/27.	
CIP – Financial Recovery Plan	The risk-adjusted Cost Improvement Programme forecast remains materially behind target, with a significant gap between identified and required savings.	Despite the paper on the financial recovery being included in the report and action notes from the FRP Board being shared with PEF the Non-Executive Directors expressed some concern over a lack of	The CiC noted the need for accelerated delivery through the Financial Recovery Programme. PMO to discuss briefing sessions with NED	

		sufficient visibility of the overall recovery programme on all aspects of performance and needed to understand schemes before signing off future plans.	colleagues ahead of scheduling something with the Board.	
Cash Position	The Group's cash position is challenging because of the deficit, with additional cash support requests required and increasing challenges in maintaining supplier payments.	The CiC agreed to increase the Cash risk to 12.	The CiC escalated the risk to the Group's future ability to meet the cash demands.	
Variable Pay	Agency, bank and other variable pay expenditure remains above trajectory, despite the targeted reduction programmes.		The CiC noted limited movement against the expected reduction target and requested continued Board scrutiny.	
Digital				
EPR delivery challenges	The EPR programme has experienced supplier delivery issues and there is increasing concern regarding likely delays and potential reductions in planned functionality.	Concerns were raised relating to patient safety due to the digital requirements.	The CiC agreed this represents a significant Board-level risk requiring detailed discussion at the planned Board Development session.	

Digital Principles for disestablishment of the Board	The separation of the Group into two organisations requires urgent strategic decisions regarding digital infrastructure, data warehouses, integration engines, server architecture and shared systems.		The CiC agreed this requires Board-level direction as several decisions cannot be deferred without operational risk.	
ADVISE (Areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Estates				
Security Incidents and Violence against Staff	A significant increase in reported security incidents has been observed, particularly at HUTH. This included an 80% increase in violent and aggressive incidents.		The CiC noted the potential workforce impact and the need for continued Board oversight of staff safety and violence reduction measures.	
Linen and Laundry Contract	The proposed extension of the linen and laundry contract introduces a recurring cost pressure of approximately £576k across the Group. This will be managed by a joint innovation programme for cost reduction with the supplier on the volume of units specifically.	Whilst recognising the market constraints and resilience risks within the national supplier market, the committee agreed the financial impact should be made explicit to the Board alongside proposed mitigation through innovation projects	The CiC endorsed the extensions for recommendation to the Board for approval.	

Age Profile of Estates Workforce	Vacancy control and recruitment difficulties have increased estates vacancies, with approximately 25% vacancies at SGH. 42% of the Estates workforce is over 55 and 52% is over 50. It was reported that apprenticeships were being explored.	Some posts have now been approved and advertised, but the vacancy position has impacted reactive maintenance and planned preventative maintenance, particularly after an exaggerated August reduction.	The CiC requested a future paper to include transitional arrangements.	
GPR	The Faster diagnostic standard was highlighted as it was showing improvement and there was high confidence that this metric would be delivered this year.	Showing some improvement, some increased concern. No consistency of movement across the dial.	The CiC agreed that the same metrics did not hit the constitutional standards. The CiC noted that although there had been slight movement, there was no sustained improvements.	
ASSURE (Areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Committee Business				
RL Datix Contract	It was proposed that the contract was renewed on a two-plus-one year basis	This contract meant that a three year cost pressure was reported of £201k	Quantification of the potential benefits was requested, linking job planning and E-Rostering.	

	before the current contract expired.	across the Group.	The CiC gave approval in principle providing the benefits were explored with the Senior Leadership Team.	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)244

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9 October 2026**
Director Lead	**Julie Beilby, Chair of Committees-in-Common**
Contact Officer / Author	**Julie Beilby, Chair of Committees-in-Common**
Title of Report	**Workforce, Education and Culture Committees-in-Common Highlight / Escalation Report to the Trust Boards**
Executive Summary	This report sets out the key items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting held on 23 September 2026, including matters that the Committee specifically wishes to escalate to one or both Trust Boards. **Recommendation/s** The Boards-in-Common are asked to note the contents of the escalation report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Any financial implications will be highlighted in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Any EDI implications will be highlighted in the report.
Recommended action(s) required	✓ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	☐
Our People	✓
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

V3

ADVISE, ALERT and ASSURE	
Meeting:	Workforce, Education and Culture Committees in Common
Meeting Date:	23 September 2026
Chair:	Julie Beilby, Non-Executive Director
Quorate:	Yes

KEY ITEMS DISCUSSED AT THE MEETING

TO ALERT (Alert the Board to areas of non-compliance or matters that need addressing urgently)				
Issue	**Update**	**Assurance received:**	**Action**	**Timescale**
Workforce				
Medical Education and GMC Trainee survey	The two reports were taken together. The issues around the GMC survey were still high risk but there were mitigations in place. There was a low fill rate for Deanery training posts and a floating post was required at DPOW and SGH. Educational and clinical	The CiC supported the paper and requested that all collaborative working highlighting benefits should continue once the Group was dis-established.	Generic induction plan was being developed and work was ongoing with the OD team. Additional trainees were required, along with an increase in the establishment for doctors in training.	

	supervision was discussed as not being consistently allocated. A review of education funding was being undertaken to establish whether allocations were appropriate.			
People strategy Update	The CiC received an update regarding the five IIP workstreams relating to the People Strategy. The workstreams are: - Establish and embed a Group wide safety culture model - Civility and Respect Framework - Equality, diversity and inclusion programme - Single raising concerns framework - Leadership visibility The CiC noted the ongoing challenges with mandatory training.	The CiC agreed that the target and messaging around zero tolerance to bullying should be clear. Targets should be both ambitious and realistic, wording and targets should be reviewed without weakening the zero tolerance ambition	The Boards are requested to ensure any work programmes relating to culture continues collaboratively, once the Group has been dis-established. The Committees-in-Common request that the Trust Boards consider the establishment of an Independent Investigation Team for medical workforce cases to ensure investigations are completed in a timely manner and unnecessary delays are avoided.	
Integrated Workforce Data and Assurance	A new workforce performance pack that combined workforce and finance data into one validated source, enabling the CiC and board to assess vacancies, variable pay,	The CiC heard of strengthened controls for vacancies, variable pay, operational workforce usage, establishments, bank staffing and agency	Workforce control steering group Areas requiring attention were:	

	sickness, turnover, training, appraisals and job planning consistently and triangulate information. The CiC agreed that the report was comprehensive with a focus on data quality and triangulation of data which fed into the IIP and FRP. It was noted that significant improvements had been made in this area of work.	costs. It was emphasised that patient safety was central to the decision making in relation to pausing vacancies. Assurance was provided regarding the significant progress made in aligning workforce and finance data to create a single, reliable source of information. Whilst there is still work to do in relation to variable pay and headcount reduction, the improvements made to date are noteworthy.	- Rolling sickness (4.9%); - Return-to-work compliance remains at 14.1%, with 2,163 reviews overdue - First year turnover is 17.1% - Time to Hire remains amber while the seasonal intake clears The CiC suggested that a Board Development Session may be beneficial to enable a deeper exploration of the workforce data and associated trends.	
WRES	The report highlighted concerns regarding the recruitment pathway and disparity between the interview and appointment outcomes for BAME candidates. The CiC noted the worsening position and the need for focused improvement actions. There were issues raised regarding racism from colleagues and patients, the Board diversity and fear of	Whilst there remains more work to do, the Committee received assurance that the organisations have a clear understanding of the areas requiring improvement, based on the data presented, and the actions needed to address them. The CiC thanked Mano Jamison and Karl Portz for the quality of the reports	The CiC were assured due to the comprehensive action plan in place which covered the following themes: - Development of a Zero Tolerance to Racism framework - Develop and grow the BAME staff Network - Support internationally educated staff - Introduce an inclusive recruitment project and toolkit	

	detriment or negative consequences from using reporting mechanisms.	presented and their leadership and expertise within the BAME and Disability Networks.	- Ensure BAME staff are treated equitably in HR processes - Introduce patient racism SOP - Collaborative working across the organisations to develop inclusivity to BAME staff	
WDES	The under-declaration of disability was raised as an issue along with recruitment and career progression disparities and the pressure felt by disabled colleagues to attend work. The importance and value of the staff networks was emphasized as well as the importance of EDI training attendance. Neurodivergent colleagues were being recognised for their strengths and what they could bring to the organisation.	The CiC reiterated that any form of discrimination is not acceptable. Whilst there remains more work to do, the Committee received assurance that the organisations have a clear understanding of the areas requiring improvement, based on the data presented, and the actions needed to address them.	The CiC were assured due to the comprehensive action plan in place which covered the following themes: - Embed the zero tolerance to Ableism framework - Develop and Grow the Disability Staff Network - Introduce an Inclusive Recruitment Project - Embed the reasonable adjustments for Equity, Accessibility and Confidence Hub (REACH) - Supporting staff who are Neuro Divergent	
Educational Funding – NHS England Education Income	The report emphasised that the additional investment received from NHS England was positive and reflected the role of both	The report set out the complex education funding from NHS England. The Group receives	The CiC noted that NHS England benchmarking was underway and would provide a clearer comparative picture in	

	organisations as teaching hospitals. The report provided assurance that all funding received is spent on educational activities and transferred into relevant services rather than being top-sliced centrally.	approximately £65m education income but provides substantial additional investment, estimated at a minimum of £51m. Assurance was provided that the education funding received by the organisations is being utilised appropriately for educational purposes.	the future.	
Job Evaluation	The CiC received an overview of recent actions regarding Job Evaluation. Work was ongoing under joint arrangements with joint panels but reporting as sovereign bodies. There were capacity issues across the Group, but specifically at NLAG which pre-dated the Group formation. There were ongoing challenges for managers to release trained staff as well as funding requirements, but action plans were in place to address this.	The CiC commended discussions with both NLAG and HUTH JNCC's regarding the openness of partnership working in the future.	A risk was highlighted relating to the requirement for executive approval to introduce a mandatory job description review at least every three years as part of the appraisal process. This would have resource and capacity implications for managers, HR teams and Job Evaluation panels.	

ADVISE (Provide here any areas of on-going monitoring where an update has been provided to the Committee AND any new developments that will need to be communicated or included in operational delivery)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				
Policy harmonisation	The CiC discussed how the recommendation to dissolve the Group changes the priority and governance of policy harmonization, but that it was useful to retain shared work and align to national HR policy developments.		Policy development to retain the strongest aspects of both sovereign organisation's policies. The CQC had been approached regarding this particular area to ensure they are fully sighted on the challenges that the organisation now faces in this area.	
Learning Improvement and Safety Academy	The Report highlighted six key programme deliverables which were aligned with the IIP. A significant risk was escalated relating to workforce capacity, with an unmitigated risk score of 20	The CiC confirmed BAU post Carnall Farrar report and Board decision. The CiC requested that future governance arrangements should clarify which elements of the programme will continue collaboratively following the disestablishment	The six deliverables are: -Support the implementation of a single HHP Improvement Methodology and Assurance Framework - Establish a Board-to-Ward Leadership and Management Development approach - Support the HHP Civility and Respect Framework -A governance led, risk based LISA deployment framework to be established -Development of a patient	

			safety, experience and organisational learning programme -Develop and maintain a high quality learning education service	
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Workforce				

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)245

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9th October 2026
Director Lead	Helen Marks, Group Chief People Officer
Contact Officer / Author	Elizabeth Houchin, Freedom to Speak Up Guardian (NLAG) Frances Moverley, Freedom to Speak Up Guardian (HUTH)
Title of Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 1 2026/2027) – NLAG** **Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 1 2026/2027) – HUTH**
Executive Summary	The reports present an overview of number of FTSU concerns raised, national and regional updates and the proactive work undertaken by the NLAG and HUTH FTSU Guardians. **For NLAG:** • The number of concerns received was lower than Q1 2025/2026. • There is a low number of anonymous concerns and below the national average. • Worker safety, HR process and inappropriate behaviours continue to be the top themes. **For HUTH:** • The number of concerns received slightly decreased from the from the previous quarter and were similar to Q1 in 2025/2026. • For the first time, worker safety was the most common reason for reporting; the majority were related to psychological safety and the nature of the concerns impacting wellbeing. Followed by concerns about inappropriate behaviours and role. • No concerns were raised anonymously. **For both NLAG and HUTH:** • Online reporting forms launched to provide an additional way to raise concerns to the FTSUGs. The option to report anonymously meets a finding from a National Guardian Office review of the experiences of internationally educated staff. • An update to the NHSE Board Self-reflection and planning tool action plan is provided in Appendix 1.
Background Information and/or Supporting Document(s) (if applicable)	This document has not previously been considered at other committees. No supporting documents are applicable.
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities	Not applicable

(if applicable)		
Recommended action(s) required	☐ Approval ✓ Assurance	☐ Information ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 1 Report April to June 2026

Liz Houchin
23rd July 2026

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 1 2026/2027

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 1 (Q1) of the 2026/2027 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the 'Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts' published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper satisfies the Trust Strategic Objective of 'Being a good employer' and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

2.2 The report aims to provide assurance to the Group Board on promoting a 'speaking up' culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at NLAG in place that allow staff to raise concerns, including, but not limited to:

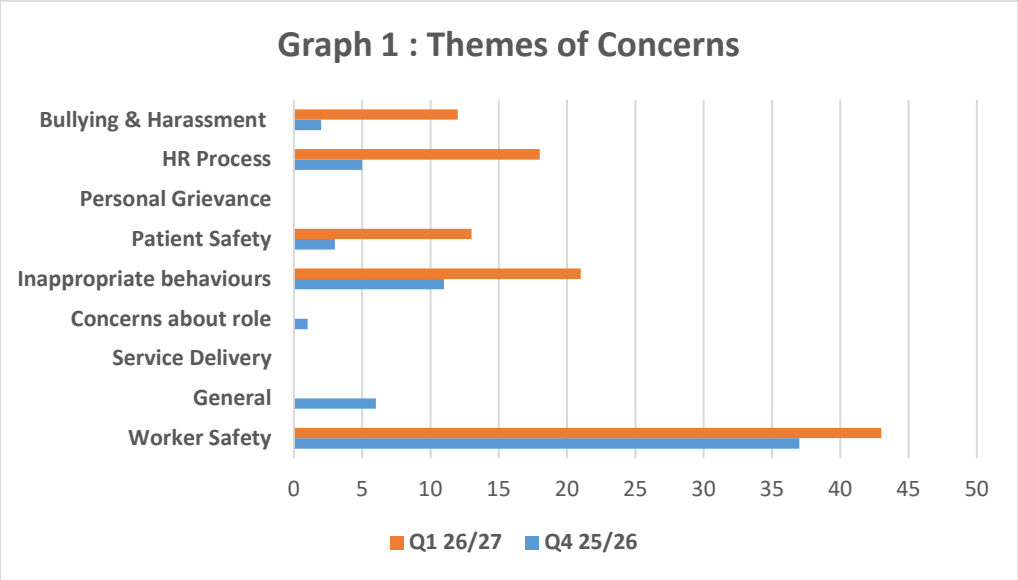
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (CP451)
- Group Conflict Resolution Policy (GP026)
- Group Grievance Policy and Procedure (GP024)
- Ulysses Incident Reporting System

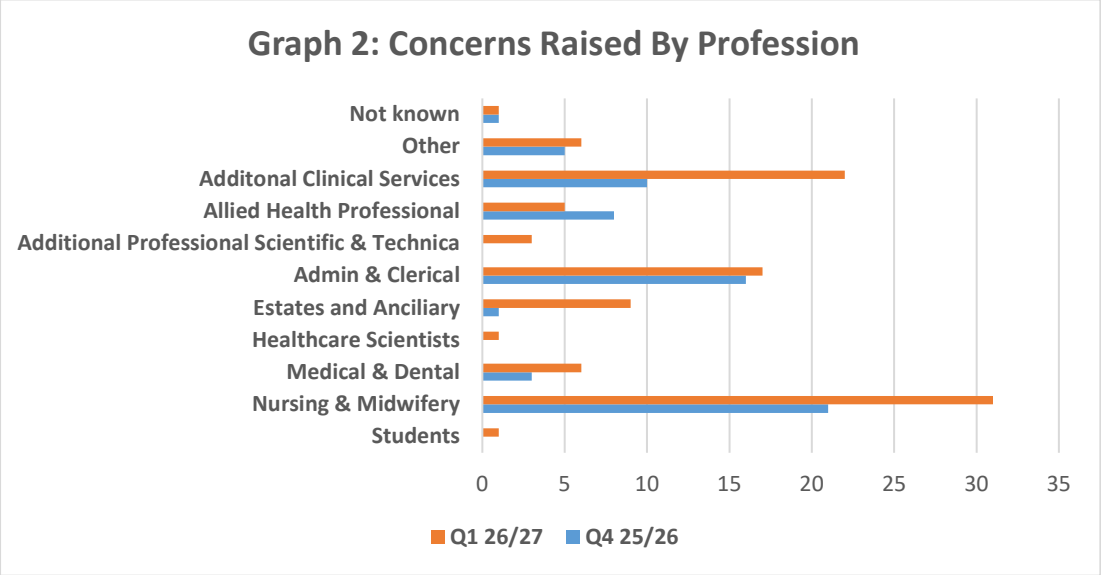
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st April 2026 to 30th June 2026 (Q1) – data, comments and assessment

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and NHSE (from 1st July 2026).

4.2 Graphs 1 and 2 summarises the Q1 data:





4.3 In Q1 2026-27, 102 concerns were received. 4% of these were closed on the same day after giving advice or signposting.

- 3 concerns were raised anonymously in Q1.
- In Q1 13 concerns involved an element of patient safety. This puts the Trust in the high quartile nationally, figures accessed from Model Hospital.
- In Q1 43 concerns involved an element of worker safety which puts the Trust in the highest quartile nationally, the peer median figure being 13.
- In Q1 21 concerns involved an element of inappropriate behaviours, which puts the Trust in the mid quartile nationally, with the peer median figure being 11

NB: Latest data available is from Q4 2025/26 – accessed from Model Hospital July 2026

4.2 The Q1 figure of 102 is lower than Q1 in 2025-26 which was 122. The main themes raised were around worker safety, HR process and inappropriate behaviours.

Almost 50% of the concerns raised had an element of worker safety. When looking at the concerns, analysis indicates 33% cite impact of work on wellbeing, 33% cite they do not feel psychologically safe to speak up and the remainder are either the impact of staffing levels and staff movements or physical factors particularly related to the extreme weather.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed with the CEO /CPO for awareness and support if required.

FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so hotspot areas can be identified, and interventions put in place where needed.

Quarterly Meetings are in place with the Managing Directors, Medical Directors and Directors of Nursing for both Teams North and South for their oversight and awareness.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

Quarter 2026-27	Feedback received	Would you speak up again? Yes
Q1	6	6

Data analysis of the completed evaluation forms indicates colleagues aged between 18-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds accessed the FTSUG in Q1.

Within the feedback received, the following are extracts of qualitative feedback received:

Liz was very reassuring and easy to talk to.

Liz has been friendly, welcoming, considerate and more. Liz took the time to listen and take my concerns seriously. I couldn't have asked for more and Liz is a real asset to the NHS and this trust in particular.

Liz did everything she could, and I am satisfied things are moving forward.

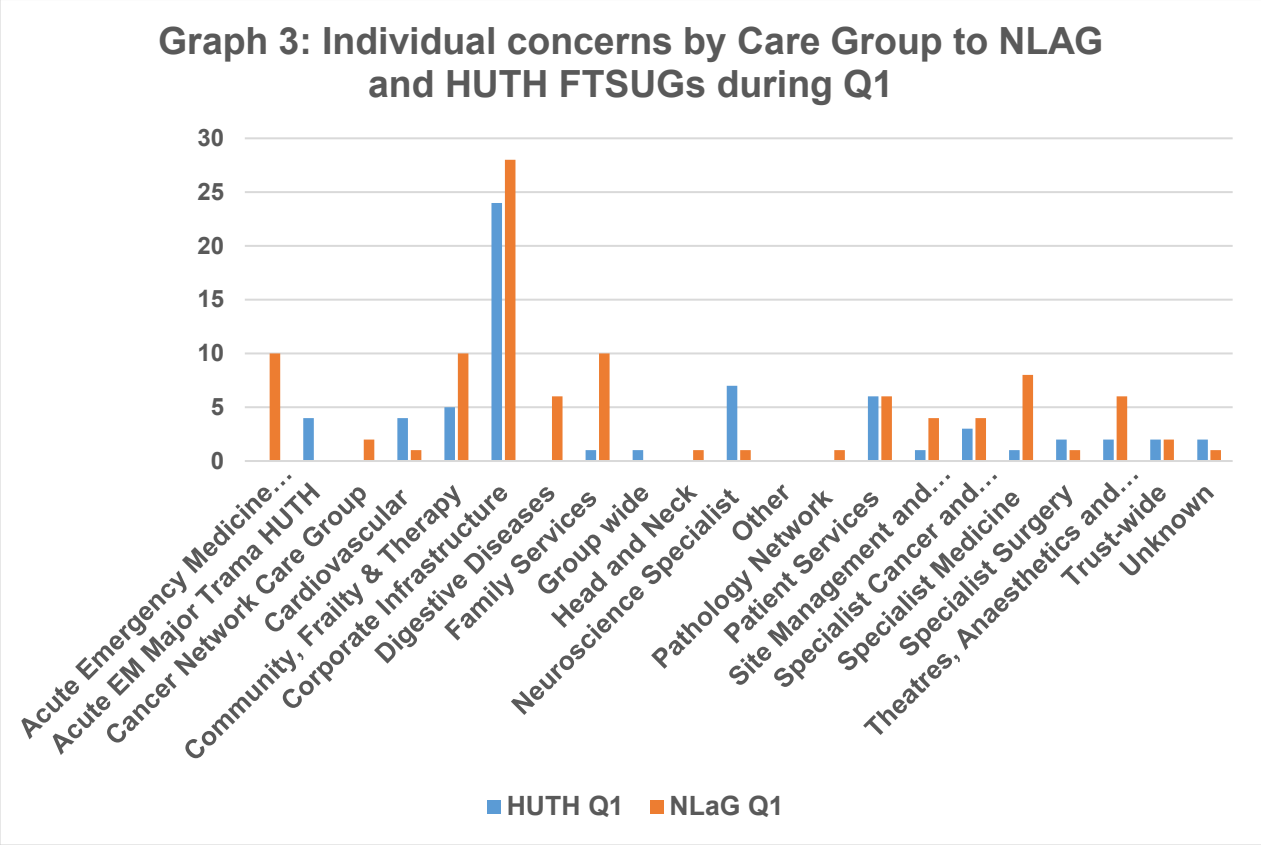
4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The FTSU Guardian was contacted by one of the FTSU Champions. Colleagues from different sites had independently spoken to them about a concern that NEWS information was being amended inappropriately. The FTSUG contacted the management team who assured the FTSUG that NEWS could not be changed from a system perspective, however a wrong set of observations could be inputted. They asked the FTSUG to get further information. This provided clarity that observations were being entered into WEBV and being repeated in line with the policy, and it was at this point observations were being altered before being re-entered. The management team looked into this and spoke to the teams involved. The outcome was clarification and learning for the areas involved.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 3 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.



5. FTSUG activities and proactive work during Q1

5.1 A high level summary of the activities are detailed below:

- Monthly 1 to 1's with DOP
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Trust inductions
- Attendance at Regional NGO meeting
- Facilitated Focus Group Sessions to identify barriers and enablers for staff speaking up – thematic report to be shared with CEO
- Detriment Guidance developed in line with the national guidelines and published on Bridget in May 2026

5.2 Future plans:

- Continue to work with HUTH FTSUG to deliver the FTSU Group Strategy
- Continue to recruit and train FTSU Champions

- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- Attendance at all relevant meetings

5.3 National Guardian Office Self-Assessment and Planning Tool

NHSE recommend the self-reflection tool is repeated every two years, and the Group Boards-in-Common used a Board development session on 8th May 2025 to complete this.

In June 2025, the Board approved the resulting improvements and strengths plans in Appendix 1. The FTSUG has reviewed the action plan, providing an update and comments where applicable for the Boards-in-Common awareness.

As part of the action plan, the FTSUG was tasked with comparing the Improvement and Strengths Plan with two other Trusts, which are in NLaG's peer group (as identified by Model Hospital). The FTSUG has completed this and found both NLaG and the peer organisations (Leeds Community Healthcare and York & Scarborough Teaching Hospital NHS FT) were looking to develop detriment guidance. This indicates that organisations felt that the guidance produced by the NGO did not meet their requirements. In both peer organisations there was an action to decide about the HEE training and whether to make it mandatory, NLaG have already made this decision.

As a result of completing this action, the FTSUG would like to assure the Boards-In-Common that improvement ideas identified by the peer organisations were either included in the NLaG plan or were already embedded in NLaG.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings to discuss and share best practice. Recent discussions have included discussing the NGO Temporary Workers review and how organisations are going to implement the recommendations, and a presentation by the GMC about 'Fitness to Practice.' There was also discussions about working with universities to make sure that students know about the FTSUG role and how to contact FTSUGs when on placement.

6.2 National update

The National Guardian Office closed on 30th June 2026 with their responsibilities transferring into NHSE. Confirmation of the remit and scope of FTSU when it transfers into NHSE is now available: the Future of Freedom to Speak Up, details the changes.

NHSE will assume delivery of some activities previously done by the NGO, with employers being asked to take on greater responsibility and accountability for embedding effective Freedom To Speak Up arrangements.

From 1st July 2026, NHSE have responsibility for collecting data from FTSUGs. The data for Q1 has now been submitted.

The National Guardian Office released annual figures for 2025/26 from all FTSU cases nationally.

Key information included:

- 1% decrease in number of cases nationally – slight reduction in NLaG cases from previous year
- Worker Safety, Inappropriate behaviours and attitudes were the top themes, this is mirrored at NLaG
- Number of anonymous cases remained at 12%, NLaG continues to be significantly lower than this.
- Nurses and Midwives were the professional group most likely to contact FTSUGs, this is mirrored at NLaG

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust, and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

8.3 The Group Trusts Boards-in-Common are asked to ensure they are aware of the revised responsibilities of healthcare leaders, FTSUGs and stakeholders set out by NHSE (section 6.2.1. of this report).

Liz Houchin
23rd July 2025

NGO Reflection Planning Tool – Development Action Plan

Development areas to address in the next 12–24 months	Target date	Action owner	Update
Action 1: Board members to demonstrate and role model living the Group values, welcoming speaking up and being visible to people across the Group.	31.05.27.	Group Boards-in-Common	Review due 31.05.27
Action 2: Fully role out the Putting People First programme in support of the cultural transformation programme. Measures of success include high take up of leaders attending the sessions and putting into place the learning.	31.03.27.	Group Director of Learning and Organisational Development	Will be delivered as part of the Cultural & Staff Engagement workstreams
Action 3: Build in psychological safety and civility as an 'essential' as part of the final CARE (communication & engagement, aid, reward & recognition, essentials) work. Measures of success include improved staff experience evidenced through the future staff survey results.	31.03.26.	Group Director of Learning and Organisational Development	Will be delivered as part of the Cultural & Staff Engagement workstreams
Action 4: Review the ringfenced time for the FTSUG and against the expected release of the 2025 National Guardian Office guidance 'Requirements for recruiting and embedding Freedom to Speak Up Guardians – a framework for organisations and leaders'. Evidence of the completed review to be discussed at Board.	31.03.26.	Executive Sponsor FTSU Non-Executive Sponsor FTSU Group Boards-in-Common	Action Completed FTSUG has completed review against national guidance. No action needed
Action 5: Combine the HUTH and NLaG national freedom to speak up in the NHS policies into one Group policy using the new Group template and to ensure all staff within the Group have a single policy to read and to document case handling procedures as a Group.	31.12.25.	NLaG FTSUG HUTH FTSUG	Action Completed. New Group Policy published April 2026
Action 6: Incorporate into the wider FTSU communications plan, actions to widely communicate the combined Group national freedom to speak up in the NHS policy to ensure all staff know where to find and read the information on how to speak up. Measures of success include evidence of wide-reaching communications across the Group.	31.03.26.	NLaG FTSUG HUTH FTSUG Communications Manager	Action Completed New Group Policy published and available to all staff on Bridget. New Policy communicated across the Group
Action 7: Consider and develop ways to measure the effectiveness of the wider FTSU communications plan.	31.05.27.	Director of Communications & Engagement	Review due 31.05.27
Action 8: Minimum one communication per month sharing learning and positive outcomes from workers speaking up, for example 'You said, We did'. Measures of success include evidence of published communications.	31.05.27.	NLaG FTSUG HUTH FTSUG Communications Manager	Review due 31.05.2027

Action 9: The Board to continue to lead the Cultural Transformation work and delivery plan, in support of the People Strategy across the wider Group. Measures of success to include key milestones of the People Strategy are met and delivered.	31.05.27.	Group Boards-in-Common	Review due 31.05.2027
Action 10: FTSU information to become available on Power BI to enable the Care Groups to triangulate the high-level information with the other workforce and patient experience (e.g. PALS issues, complaints, PSIIs etc.) metrics available metrics available.	31.05.27.	NLaG FTSUG HUTH FTSUG Power BI Team	Review Due 31.05.2027
Action 11: Compare the NHSE Self-Reflection with at least two other Trusts in the peer group (i.e. large acute provider) and identify any areas for improvement. Evidence to be discussed at a future Board meeting.	31.12.25.	NLaG FTSUG HUTH FTSUG	Action Completed FTSUG completed 27/07/2026, Comments in board paper
Action 12: Review the existing internal SOP for FTSUG absence, against the sections relating to absence in the new 2025 guidance: 'Requirements for recruiting and embedding Freedom to Speak Up Guardians – a framework for organisations and leaders'. Update the Board with the results and an overview of the SOP.	31.12.25.	NLaG FTSUG Group Deputy Director of Communications and Engagement (line manager)	Action Completed Internal SOP reviewed and updated in line with National Guidance & agreed with Exec Sponsor and Group Director of Communications & Engagement
Action 13: Trial the implementation of the 'buddy system' to support staff when movement is needed to support safe staffing numbers.	31.12.2026	Group Chief Nurse	Review Due 31.12.2026
Action 14: Agree a Group engagement plan including the forums for engagement to ensure the staff voice is heard and the Board are aware of how staff feel and morale.	31.05.27.	Director of Communications & Engagement	Review Due 31.05.2027
Action 15: Work in partnership with the HUTH FTSUG to produce a Group internal process for reviewing cases where staff allege, they are in receipt of detriment, negative impact or disadvantageous/demeaning treatment as a result of speaking up. Review the new 2025 National Guardian Office Guidance on detriment. Present to Board the results and proposed process.	31.03.26.	NLaG FTSUG HUTH FTSUG	Action Completed Detriment Guidance written & published May 2026 on Bridget

High-level actions needed to share and promote areas of strength	**Target date**	**Action owner**	**Update**
Action 16: Continue to support FTSUGs during pre and post Group formation, at other NHS Trusts.	31.05.27.	HUTH FTSUG NLaG FTSUG	Review Due 31.05.2027

NHS
Hull University
Teaching Hospitals
NHS Trust

Freedom to Speak Up Guardian Quarter 1 Report April to June 2026

Fran Moverley
July 2026

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 1 2026/2027

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during 1st April 2026 to 30th June 2026 - quarter 1 (Q1) of the 2025/2026 reporting year. The paper includes the details of the relevant regional and national updates for comparison and context. Collated Care Group data with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) within the NHS Humber Health Partnership (the Group), is also provided.

1.2 This paper is presented in line with the suggested information FTSUGs should provide in the 'Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts' published by NHS England (NHSE).

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current Group Strategic Objectives of 'Our People', 'We will look after the health and wellbeing of our people', 'Quality & Safety' and 'We will keep our patients safe and reduce avoidable harm'.

2.2 The report aims to provide assurance to the Group Trusts Boards-in-Common on promoting a 'speaking up' culture at HUTH for workers.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are several processes at HUTH in place that allow staff to raise concerns dependent on the situation, including, but not limited to:

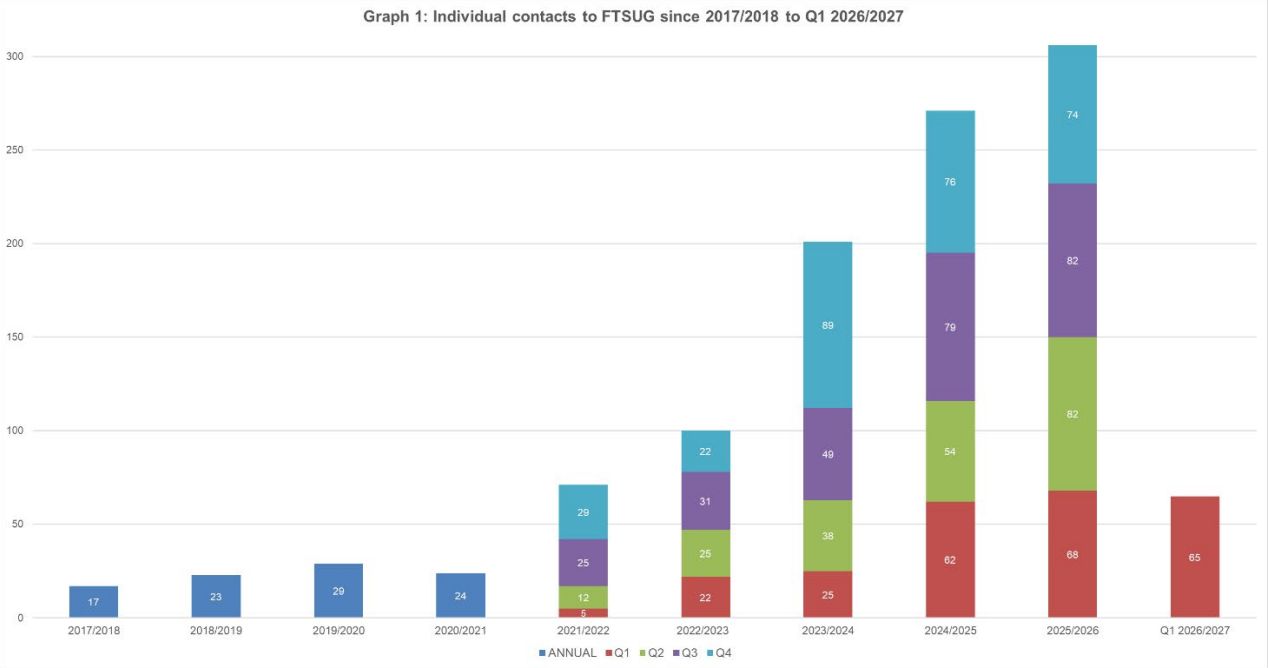
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Group Freedom to Speak Up Policy for the NHS (GP083)
- Group Conflict Resolution Policy (GP026)
- Group Grievance Policy and Procedure (GP024)
- Ulysses incident management system

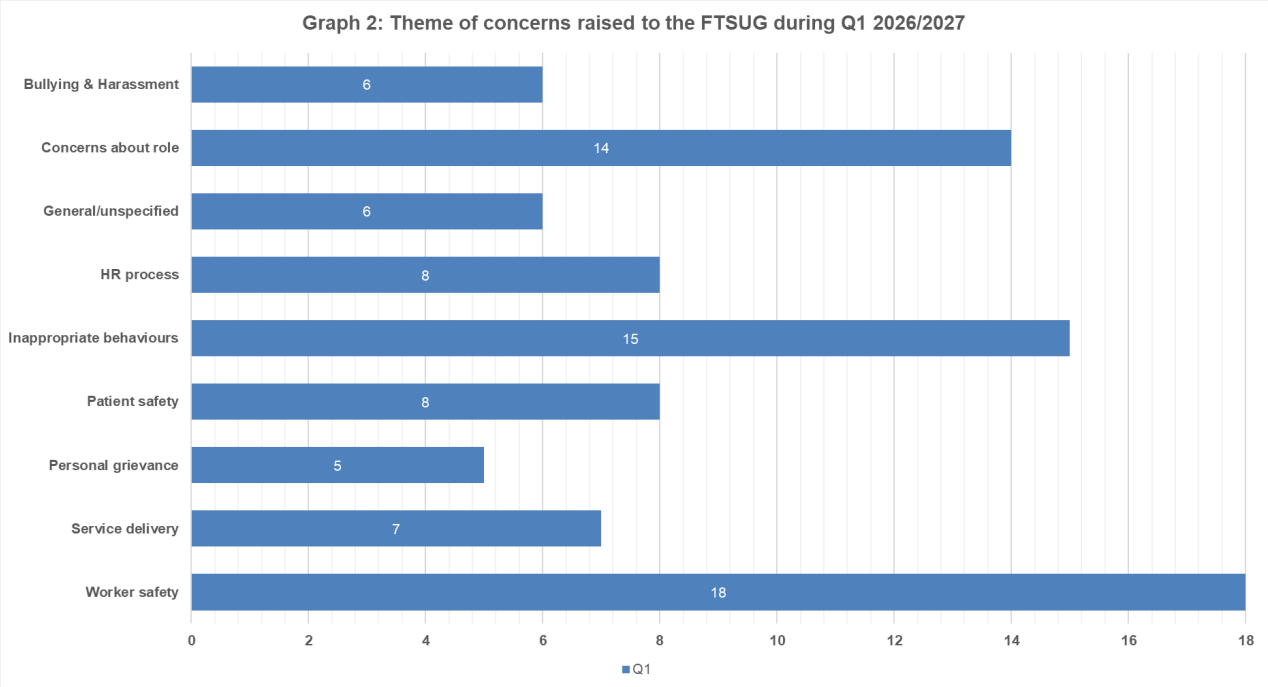
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st April 2026 to 30th June 2026 (Q1) – data, comments and assessment

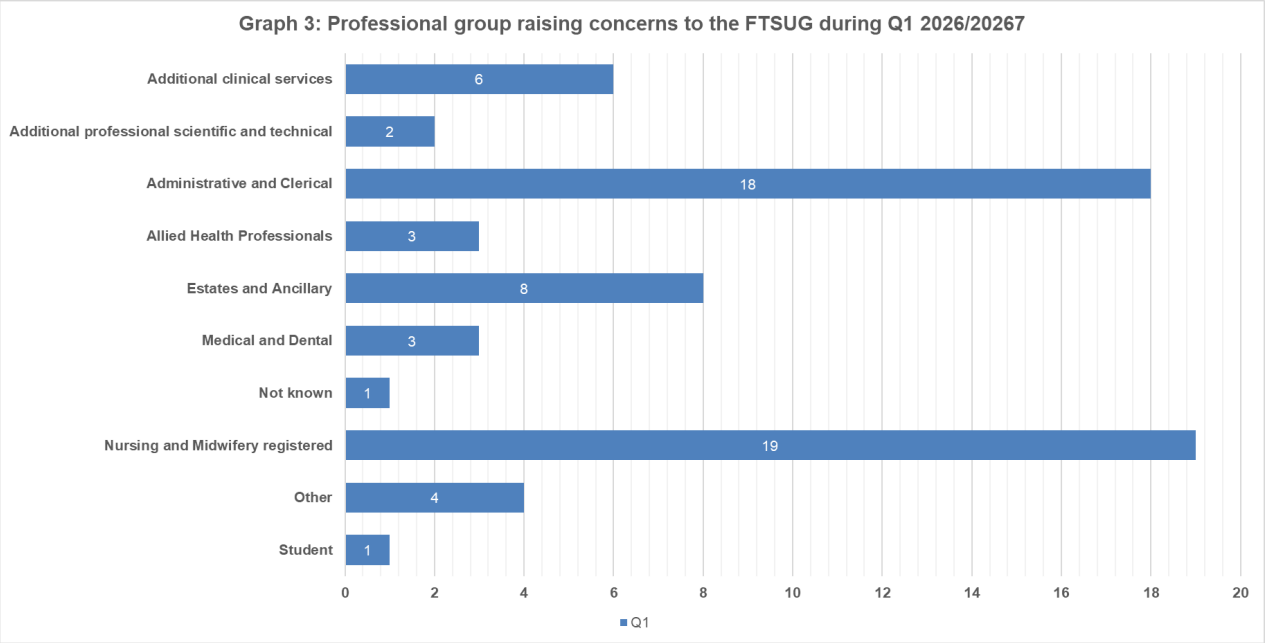
4.1 The FTSUG reports to NHSE and Group committees on the numbers and themes of the overall contacts received from members of staff, students, trainees and volunteers.

4.2 Graphs 1, 2 and 3 summarise the Q1 data:





NB. Please note some concerns may have more than one element



4.3 Observation and comments during Q1:

- The number of concerns slightly decreased from the previous quarter (74) and were similar to the previous Q1 2025/2026 reporting period (68).
- 65% (42) concerns were within the remit of a line manager to resolve; of which 64% (27) had already spoken up to a line manager/other route, prior to approaching the FTSUG (a decrease from 89% in Q4 2025/2026). Of all 65 concerns, 38% (25) of concerns were directly about the line manager.
- No concerns were raised to the FTSUG anonymously. In total 12% of staff asked the FTSUG to protect their identity throughout the speaking up process - an increase from 5.4% in Q4 2025/2026. The FTSUG directly escalated 29% (19) concerns via an appropriate route.
- For the first time, concerns with an element of worker safety were the highest reported; the majority were related to psychological safety and the nature of the concerns impacting on the wellbeing of the individual.
- Inappropriate behaviours returned to the top 3 most common reasons for concerns. Themes included incivility and rudeness from colleagues.
- The most common professional groups raising concerns were nursing and midwifery (19) followed by administrative and clerical (18). However the significant increase in concerns raised by administrative and clerical staff seen in the previous quarter (41) has not continued into Q1.
- Examples of learning points from cases included:
    - Concerns escalating when they are not being dealt informally and could have been resolved at an earlier stage.
    - Learning for a manager who had not followed a HR policy correctly.
    - The importance of having the option of a FTSUG to raise concerns that would not otherwise be raised nor escalated.
    - Unusually, in one case the FTSUG had to break confidentiality to immediately escalate a patient safety issue.
    - Please see section 4.5 for a detailed case study of learning related to inappropriate access to medical records.

4.4 FTSU Guardian Feedback/Evaluation:

The FTSUG offers a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. During Q1, 2 responses to the survey were received. Part 1 asked questions about the staff members' experience of the HUTH FTSUG:

PART 1 RESULTS	Very easy	Fairly easy	Not easy	Difficult
How easy was it to make contact with the FTSUG?	100% (2)	0%	0%	0%
	Excellent	**Good**	**Fair**	**Poor**
How was your experience of the FTSUG?	100% (2)	0%	0%	0%
	Yes	**No**	**Not sure**	
Did you feel supported when speaking up to the FTSUG?	100% (2)	0%	0%	
Given your experience, would you speak up again to the FTSUG?*	100% (2)	0%	0%	
Did you feel your concerns were listened to and taken seriously?	100% (2)	0%	0%	
	Highly likely	**Likely**	**Unlikely**	**Highly unlikely**
How likely are you to recommend to a work colleague to contact the FTSUG?	100% (2)	0%	0%	0%

Comments and observations:

- 100% answered yes to the National Guardian Office (NGO) mandatory question to be included in the survey – '**Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'*.*

Examples of feedback about why the individual would speak up again and what went well with the FTSUG included:

- "*The Speak Up team are a real asset to the NHS. If ever I find myself in a situation where I need additional help and support, I would not hesitate to contact the Team for guidance and support".*

Individuals were asked what could improve the speaking up process:

- No areas of improvement were identified*: "My experience with the Speak Up Guardian was the best thing I did, and I don't believe there is anything about the whole process that could be improved".*

Part 2 asked questions about the staff members' experience of speaking up to the wider Trust:

PART 2 RESULTS	Yes	No	Not sure	Did not raise the concern	In part
Did you feel your concern was treated confidentially?	0%	50% (1)	50% (1)	0%	
Did you feel your concerns were listened to and taken seriously?	0%	100% (2)	0%	0%	
Given your experience, would you speak up again?	100% (2)	0%	0%		
Has your concern been addressed?	0%	50% (1)	50% (1)	0%	0%
Have you experienced any detriment, disadvantageous and/or demeaning treatment, or any negative impact, as a direct result of speaking up?	50% (1)	50% (1)	0%		

Comments and observations:

- The experience of staff speaking up to the wider Trust was less positive than the experience of the FTSUG. However, 100% staff answered they would still speak up again. Example: "*I am a strong believer in if something is wrong you need to speak up regarding how emotionally draining and stressful it may be. Speaking up is the right thing to do".*

Examples of feedback to improve speaking up to the wider Trust included:

- Feedback included that whilst senior staff were sympathetic, concerns were not dealt with effectively. *"Listen to what their staff are telling them. Act on the information they are given quickly and effectively before a situation is allowed to escalate".*

4.5 Case Study

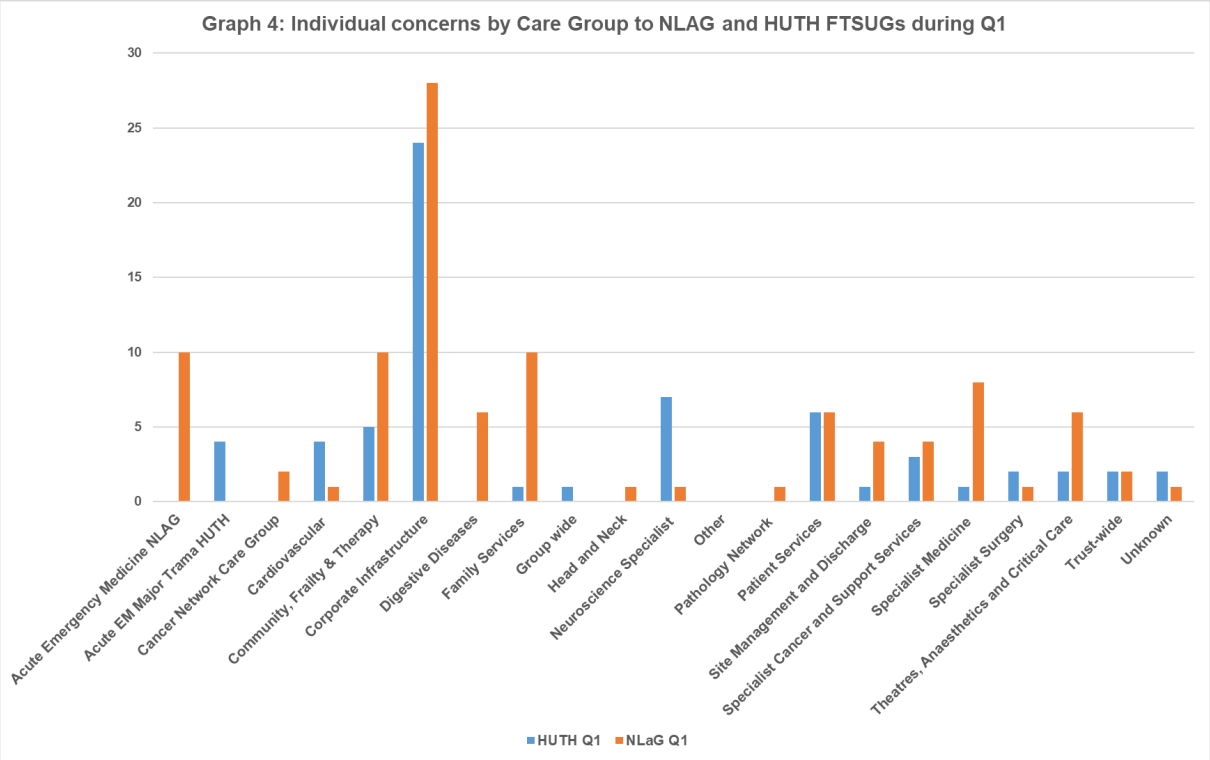
The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, learning for the Trust, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The HUTH FTSUG was contacted by a staff member who had concerns about an individual working for an external contractor. The contractor was asking HUTH staff to access their personal medical records on Lorenzo on their behalf, in order to gain information about their care. The HUTH staff member had refused to access Lorenzo and explained that they were not able to do this as it would be a serious breach of information governance. It is positive that the HUTH member of staff was aware of their responsibilities and felt confident enough to politely but firmly refuse the request.

The staff member agreed the FTSUG could contact the HUTH link manager to the contractor and pass on the information as a general concern for learning. The concern was immediately raised directly with the contractor, with a suggestion for their staff to complete information governance training. The recommendation was acted upon, and refresher training was rolled out at a communications session. The FTSUG feedback to the individual raising the concerns, ensured they were thanked for raising the concern and that they felt comfortable raising the concern by protecting their identity.

4.6 Care Groups – concerns combined

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised during Q1 to the sovereign HUTH and NLAG FTSUGs combined. At HUTH, the highest number of concerns were received related to Corporate Infrastructure departments (24), followed by Neurosciences (7) and Patient Services (6). Graph 4 is sent to the Care Group Triumvirates and HR Business Partners quarterly to enable triangulation alongside other workforce metrics.



5. FTSUG activities and proactive work during Q1

5.1 A high level summary of the FTSUG activities are detailed below:

- Partnership working with the NLAG FTSUG:
  - Worked with the Digital Communications team to launch reporting forms to provide individuals with the option to report concerns easily online. Reports can be made anonymously and meets a key finding from the National Guardian Office review 'Listening and Learning: Amplifying the voices of overseas-trained workers'.
  - Conducted focus groups and an online survey across the Group to establish barriers for speaking up.
  - Combined the previous HUTH and NLAG Freedom to Speak Up in the NHS policies into a single Group policy (reference GP083).
  - Produced guidance for staff on how to raise concerns about experiencing detriment or disadvantage after speaking up.
  - An annual update to the NHSE Board Self-reflection and planning tool (initially completed May 2025) is provided in Appendix 1.
- In line with The Future of Freedom to Speak Up, the external HUTH website has been updated to include details on contacting the HUTH FTSUG (replacing the public-facing guardian registry).
- Initial discussions and meetings established with the new Non-Executive Director for FTSU.
- Presentations provided to Registered Nursing Degree Apprentices,
- Supported walkarounds in different clinical areas with Organisational Development and the new Group Chairman.
- Supported a second AHP Student Forum for physiotherapy, occupational therapy and dietetic students on placement at the Trust, to promote speaking up in scenarios.

- Trained two further cohorts of Speak Up Champions, increasing the total number of Champions in the HUTH Speak Up Champion Network to 61. Training dates continue to be offered for the remainder of 2026.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend the Yorkshire and the Humber and Northeast regional meetings to discuss and share best practice. Recent discussions have included the NGO review of temporary workers and how organisations are going to implement the recommendations, a presentation by the GMC about fitness to practice and also linking in with universities to ensure students know about the FTSUG role. Subsequently, the FTSUG have since been in contact with Hull University to discuss nursing students and the HUTH FTSUG continues to support forums with Allied Health Professional students.

6.2 National update

6.2.1. Transfer to NHSE

On 1st July 2026, part of the responsibilities previously held by the NGO transferred into NHSE. Trusts are expected to take on greater responsibility and accountability for embedding effective FTSU arrangements in line with the newly published The Future of Freedom to Speak Up and information for healthcare leaders, guardians and stakeholder.

The FTSUG has reviewed the revised responsibilities and ensured specific actions have been completed, for example publishing external facing contact details are available.

6.2.2. National annual report 2026/2027

The National Guardian Office have released the annual 2025/2026 figures from all FTSU cases reported nationally. Key information included:

- FTSUGs during 2025/2026 received 37,770 cases nationally; a 1% decrease from 2024/2025 (in comparison in the same reporting period, HUTH increased by 13%).
- Inappropriate behaviours and attitudes were the most commonly reported concern to all FTSUGs (41%) for the third consecutive year. This was mirrored at HUTH, with inappropriate behaviours being the most common reason for the last two annual reporting years.
- Concerns related to worker safety and wellbeing increased and represented 41% of all cases nationally. The HUTH FTSUG also had an increase but cases with an element of worker safety were lower than the national figure, representing 16% of concerns.
- 17.5% of all cases nationally had an element of patient safety, whereas HUTH reported lower at 9.4%.

- Nationally, the number of anonymous cases (where the FTSUG did not know the identity of the individual) remained at 12% - HUTH continued to be significantly lower than nationally, at 0.3% of all cases.
- Nurses and Midwives were the most likely professional group to speak up to FTSUGs (27.7%) – in comparison HUTH was lower (17%). Followed by administrative and clerical workers nationally (20.1%) in comparison HUTH was higher than the national figure (32.8%).

7. Conclusion

7.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up.

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The FTSUG role has been recognised as integrated into NHS Providers and will continue despite changes to the national structure.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's FTSUG arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the FTSUG role and speaking up arrangements in the Trust.

8.3 The Group Trusts Boards-in-Common are asked to ensure they are aware of the revised responsibilities of healthcare leaders, FTSUGs and stakeholders (section 6.2.1. of this report).

APPENDIX 1

Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 12–24 months	Target date	Action owner	Update/comments
Action 1: Board members to demonstrate and role model living the Group values, welcoming speaking up and being visible to people across the Group.	31.05.27.	Group Boards-in-Common	Review due 31.05.27.
Action 2: Fully role out the Putting People First programme in support of the cultural transformation programme. Measures of success include high take up of leaders attending the sessions and putting into place the learning.	31.03.27.	Group Director of Learning and Organisational Development	Actions closed. Both programmes have moved into the deliverables for the Culture and Staff Engagement – new actions are listed below Actions 3a to 3h.
Action 3: Build in psychological safety and civility as an 'essential' as part of the final CARE (communication & engagement, aid, reward & recognition, essentials) work. Measures of success include improved staff experience evidenced through the future staff survey results.	31.03.26.	Group Director of Learning and Organisational Development	
New Action 3a: Establish and embed a Group-wide safety culture model, underpinned by LISA and a standardised safety improvement methodology, enabling systematic identification, escalation and resolution of safety risks at ward, team and board level (NPIP9).	Date TBC	Group Director of Learning and Organisational Development	New actions
New Action 3b: Implement a consistent, organisation-wide Civility and Respect Framework, embedding compassionate leadership behaviours, reducing workplace incivility and improving team-level culture, supported by targeted interventions in high-risk areas and measurable improvements in staff experience (NPIP10).	Date TBC		
New Action 3c: Strengthen staff voice and psychological safety by implementing a single, transparent 'raising concerns to action' framework, improving response quality, timeliness and executive oversight, and demonstrating visible action and learning from staff feedback (NPIP10).	Date TBC		
New Action 3d: Deliver a targeted equality, diversity and inclusion programme that reduces disparities in experience and progression (including WRES/WDES), strengthens inclusive leadership behaviours, and increases influence of staff networks in decision-making.	Date TBC		
New Action 3e: Embed consistent executive and senior leadership visibility and advocacy across HHP, with structured engagement (e.g. Big Conversations, site visits), ensuring clear, two-way communication, visible follow-through, and improved confidence in leadership (NPIP10).	Date TBC		
New Action 3f: Improve staff experience and retention by addressing key drivers of workforce fragility (including wellbeing, workload, facilities and support), delivering measurable improvements in engagement, advocacy, sickness absence and turnover (Value Circle).	Date TBC		
New Action 3g: Establish a single, board-level culture and workforce assurance framework, aligning staff survey metrics, local intelligence, HR indicators and risk, enabling systematic monitoring of culture, clear accountability, and targeted intervention where risks are identified (NPIP10).	Date TBC		
New Action 3h: Strengthen staff voice and psychological safety by implementing a single, transparent 'raising concerns to action' framework, improving response quality, timeliness and executive oversight, and demonstrating visible action and learning from staff feedback (NPIP10).	Date TBC	Group Director of Communications and Engagement	
Action 4: Review the ringfenced time for the FTSUG and against the expected release of the 2025 National Guardian Office guidance 'Requirements for recruiting and embedding Freedom to Speak Up Guardians – a framework for organisations and leaders'. Evidence of the completed review to be discussed at Board.	31.03.26.	Executive Sponsor FTSU Non-Executive Sponsor FTSU	Action completed. FTSUGs have completed the review of working arrangements against the national guidance. No action

		Group Boards-in-Common	needed.
Action 5: Combine the HUTH and NLaG national freedom to speak up in the NHS policies into one Group policy using the new Group template and to ensure all staff within the Group have a single policy to read and to document case handling procedures as a Group.	31.12.25.	HUTH FTSUG NLaG FTSUG	Action completed. New Group policy published April 2026.
Action 6: Incorporate into the wider FTSU communications plan, actions to widely communicate the combined Group national freedom to speak up in the NHS policy to ensure all staff know where to find and read the information on how to speak up. Measures of success include evidence of wide-reaching communications across the Group.	31.03.26.	HUTH FTSUG NLaG FTSUG Communications Manager	Action completed. New Group policy published and available to all staff on Bridget. New policy communicated across the Group.
Action 7: Consider and develop ways to measure the effectiveness of the wider FTSU communications plan.	31.05.27.	Director of Communications & Engagement	Review due 31.05.27.
Action 8: Minimum one communication per month sharing learning and positive outcomes from workers speaking up, for example 'You said, We did'. Measures of success include evidenced of published communications.	31.05.27.	HUTH FTSUG NLaG FTSUG Communications Manager	Review due 31.05.27.
Action 9: The Board to continue to lead the Cultural Transformation work and delivery plan, in support of the People Strategy across the wider Group. Measures of success to include key milestones of the People Strategy are met and delivered.	31.05.27.	Group Boards-in-Common	Review due 31.05.27.
Action 10: FTSU information to become available on Power BI to enable the Care Groups to triangulate the high level information with the other workforce and patient experience (e.g. PALS issues, complaints, PSIIs etc.) metrics available metrics available.	31.05.27.	HUTH FTSUG NLaG FTSUG Power BI Team	Review due 31.05.27.
Action 11: Compare the NHSE Self-Reflection with at least two other Trusts in the peer group (i.e. large acute provider) and identify any areas for improvement. Evidence to be discussed at a future Board meeting.	31.12.25.	HUTH FTSUG NLaG FTSUG	Action overdue Work in progress. FTSUGs to complete present at a future Board meeting.
Action 12: Review the existing internal SOP for FTSUG absence, against the sections relating to absence in the new 2025 guidance: 'Requirements for recruiting and embedding Freedom to Speak Up Guardians – a framework for organisations and leaders'. Update the Board with the results and an overview of the SOP.	31.12.25.	HUTH FTSUG Group Deputy Director of Communications and Engagement (line manager)	Action completed. Internal SOP reviewed, updated in line with national guidance and agreed with Executive Sponsor and Group Director of Communications and Engagement.
Action 13: Trial the implementation of the 'buddy system' to support staff when movement is needed to support safe staffing numbers.	31.12.26.	Group Chief Nurse	Review due 31.12.26.
Action 14: Agree a Group engagement plan including the forums for engagement to ensure the staff voice is heard and the Board are aware of how staff feel and morale.	31.05.27.	Director of Communications & Engagement	Review due 31.05.27.
Action 15: Additional question to be added to the speaking up feedback survey, specifically asking if the individual has been impacted by detriment negative impact or disadvantageous/demeaning treatment as a result of speaking up. To include what specifically the detriment involved and the offer to review/investigate the treatment of the individual. This is to further assist in monitoring if detriment has taken place for individuals speaking up.	30.09.25.	HUTH FTSUG	Action completed. Additional question added to feedback survey and results included in Board reports.
Action 16: Work in partnership with the NLaG FTSUG to produce a Group internal process for reviewing cases where staff allege they are in receipt of detriment, negative impact or	31.03.26.	HUTH FTSUG NLaG FTSUG	Action completed. Detriment guidance developed in

disadvantageous/demeaning treatment as a result of speaking up. Review the new 2025 National Guardian Office guidance on detriment. Present to Board the results and proposed process.			line with national guidelines and published on Bridget in May 2026.

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner	Update/comments
Action 17: Continue to support FTSUGs during pre and post Group formation, at other NHS Trusts.	31.05.27.	HUTH FTSUG NLaG FTSUG	Action completed. HUTH and NLAG FTSUGs have supported several other FTSUGs across England on request, with their move to Group arrangements

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)246

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October 2026
Director Lead	Helen Marks, Group Chief People Officer
Contact Officer / Author	Lucy Vere, Group Director of Learning and Organisational Development
Title of Report	**Workforce Disability Equality Standard (WDES)**
Executive Summary	The purpose of this report is to provide assurance on the 2025/26 Workforce Disability Equality Standard (WDES) position for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), highlighting progress, ongoing areas of concern and the actions being taken to improve the workplace experience of disabled staff. **Alert** • Disabled staff remain less likely to believe their organisation provides equal opportunities for career progression or promotion. At HUTH, 45.3% of disabled staff believed the Trust provides equal opportunities for career progression or promotion, and disabled staff are still 11% less likely to believe this than non-disabled staff. At NLaG, 47.1% of disabled staff believed the Trust provides equal opportunities for career progression or promotion and disabled staff are 5.6% less likely to believe this than non-disabled staff. • Disabled staff continue to experience higher levels of harassment, bullying and abuse than non-disabled staff. HUTH reports disabled staff are nearly 9% more likely to experience harassment, bullying or abuse from staff compared to non-disabled staff, whilst NLaG reports disabled staff are 8.2% more likely to face harassment, bullying or abuse from colleagues compared to non-disabled staff. • Disabled staff continue to experience greater pressure to attend work when unwell. HUTH reports disabled staff felt 9% more pressured to attend work than non-disabled staff, whilst NLaG reports disabled staff felt 9.3% more pressured to attend work than non-disabled staff. • Recruitment outcomes remain less favourable for disabled applicants. HUTH reports 13.4% of disabled applicants were appointed from shortlisting, with non-disabled staff 1.33 times more likely to be appointed from shortlisting compared with disabled applicants. NLaG reports non-disabled staff are 1.06 times more likely to be appointed from shortlisting compared to disabled applicants. • There is currently no disabled representation on the HUTH Board and disability representation among board members at NLaG stands at 33.3%.

	Advise • Continue delivery of the WDES action plans across both organisations, focusing on the Zero Tolerance to Ableism Framework, inclusive recruitment, reasonable adjustments through REACH, support for neurodivergent staff and Equality, Diversity & Inclusion (EDI) education programmes. • Progress the Inclusive Recruitment Project to better understand recruitment trends, disparities and promotion rates through disaggregated analysis of recruitment data by protected characteristics. • Continue embedding reasonable adjustments support, including promotion of Access to Work, manager guidance, disability passports and disability-related workplace support initiatives through REACH. • Continue delivery of education, leadership development and staff network support initiatives to improve workplace experience and inclusion for disabled staff. **Assure** • The percentage of disabled staff has increased in both organisations. HUTH reports disabled staff representation increased from 4.20% to 5.24%, and NLaG reports representation increased from 5.4% to 6.4%. • Reporting of harassment, bullying and abuse incidents has increased. HUTH reports 50.1% of disabled staff who experienced harassment, bullying or abuse reported the last incident, whilst NLaG reports 51% reported the last incident experienced at work. Both reports identify this as encouraging and aligned with the introduction of the Zero Tolerance reporting tool. • Significant work has been undertaken to support disabled staff through the continued embedding of the Zero Tolerance to Ableism Framework and Reporting Tool, which both organisations report is playing a significant part in supporting equality, tackling discrimination and supporting disabled staff. • Reasonable adjustment support has been strengthened. At HUTH, the groundwork and approvals for the Reasonable Adjustments for Equity, Accessibility and Confidence Hub (REACH) have been completed. At NLaG, the central REACH team has been established and provides a dedicated service advocating for individuals requesting reasonable adjustments. • Governance and leadership arrangements are in place to provide oversight and assurance. HUTH has established an Equality, Diversity and Inclusion Steering Group chaired by an Executive Director. This now has established the Group EDI Action Plan and priorities in place. **Recommendation/s** The Trust Boards-in-Common are asked to receive the 2025/26 Workforce Disability Equality Standard reports for HUTH and NLaG, note the progress made during the reporting period, take assurance from the actions in place to address identified inequalities, and approve the reports.
Background Information and/or Supporting	Attached WDES reports and data submissions for HUTH & NLAG

Document(s) (if applicable)	
Prior Approval Process	Workforce, Education and Culture Committees-in-Common, EDI Steering Group and Disability Staff Networks
Financial Implication(s) (if applicable)	No additional financial implications are identified through this report. Delivery of the WDES Action Plans will be undertaken within existing resources and approved budgets.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	This report supports the organisation's commitment to improving equality, diversity and inclusion for disabled staff by identifying areas of inequality and monitoring progress against the Workforce Disability Equality Standard. The associated action plans aim to improve inclusion, workplace experience, career progression and representation for disabled staff across both Trusts.
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

V2

Workforce Disability Equality Standards 25/26

NHS Humber Health Partnership
Hull University Teaching Hospitals NHS Trust

NHS
Humber Health
Partnership

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Introduction

As set out in the National Health Service (NHS) Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare. The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS.

The WDES follows the NHS WDES as a tool and an enabler of change. The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.

The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain. It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation. The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

Disabled staff feel more valued within the organisation than last year

The percentage of disabled staff receiving internal bullying and abuse from Managers and colleauges is down from last year

The number of unknown responses for declaring a disability has increased since last year, across all staff groups

The declaration of disability on ESR has gone up by 25% at 5.24%

Significant work has been done to populate equality and diversity information for trainee medics and the biggest disability declaration rate is 9% for this group

The number of disabled staff experiencing harassment, bullying or abuse from managers compared to non disabled staff has declined for the 3rd consecutive year

Non-Disabled staff are 1.33 more likely to be appointed from shortlisting compared to Disabled staff

Disabled staff are still 11% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff

The percentage of Disabled staff feeling pressured to attend work by their manager has continued to decline since 2022

The engagement score for disabled staff has slightly deteriorated by .09 and is still below the national averages

There is currently zero disabled representation on the HUTH board

The number of disabled staff experiencing harassment, bullying or abuse from staff compared to non disabled staff has declined for the 3rd consecutive year

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	WDES 25/26 Performance Comparison and Summary	24/25	25/26
1	Percentage of disabled staff	4.20%	5.24%
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.10	1.33
3	Relative likelihood of disabled staff entering the formal capability process (excluding ill-health related proceedings) compared to non-disabled staff	7.1	0
4a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	30.1%	30.2%
4b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months	15.3%	13.4%
4c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26.0%	24.1%
4d	Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work	47.5%	50.1%

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	WDES 25/26 Performance Comparison and Summary	24/25	25/26
5	Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion	47.2%	45.3%
6	Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties	29.9%	27.3%
7	Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work	27.7%	27.9%
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	75.4%	71.9%
9	Staff engagement scores	6.0	6.0
10	Disability representation among board members	0	0

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WDES Indicator 1

Table 1: Composition of HUTH Staff

	Clinical	Non-Clinical	Overall Percentage
Disabled	373	170	5.2%
Non-Disabled	7260	2420	93.5%
DIsability Unknown	123	12	1.3%

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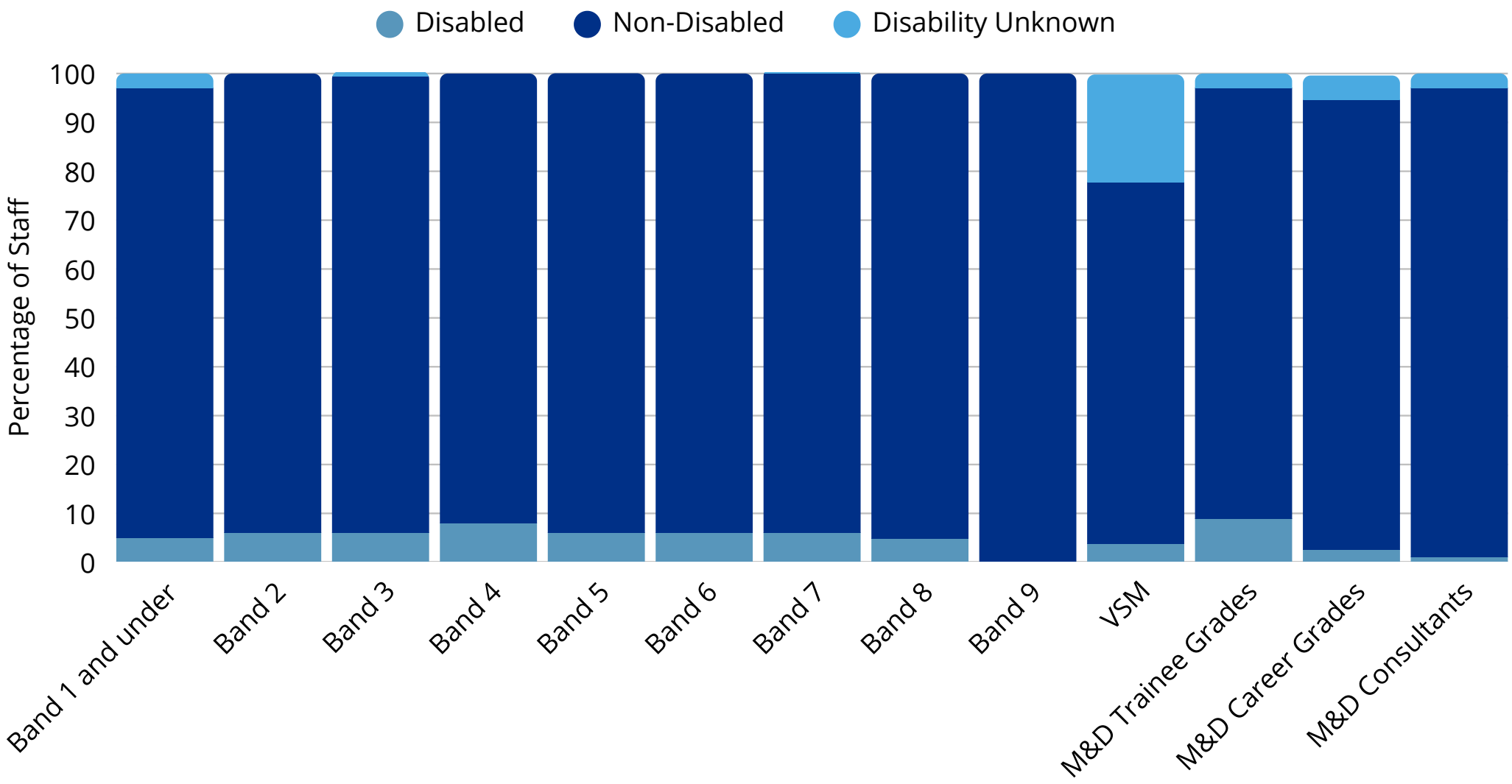
WDES Indicator 1

Figure 1: Composition of HUTH Staff



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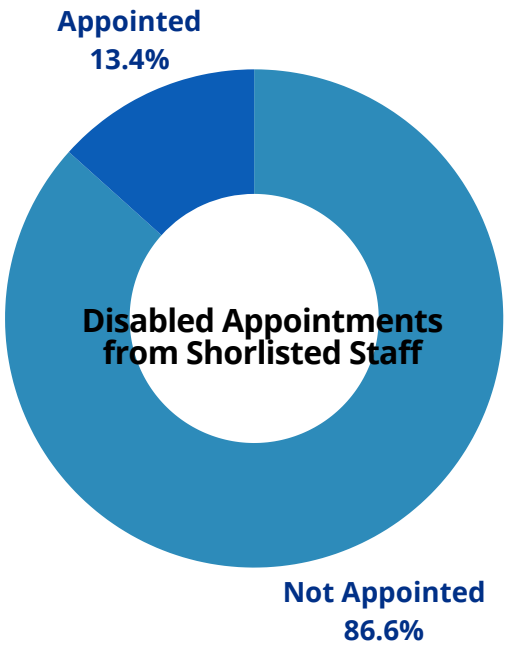
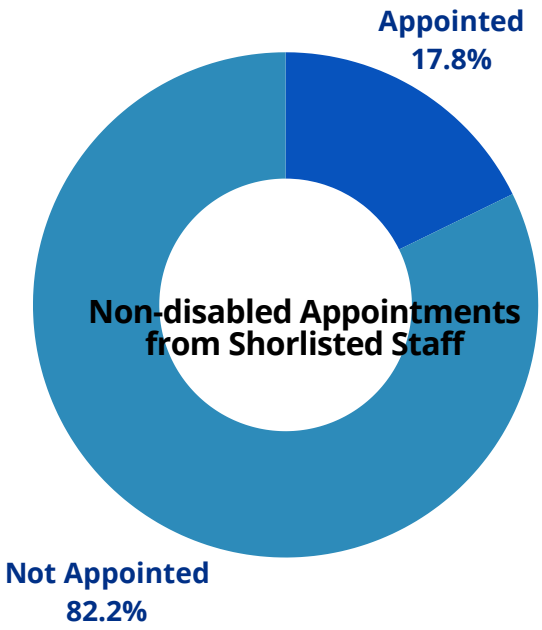
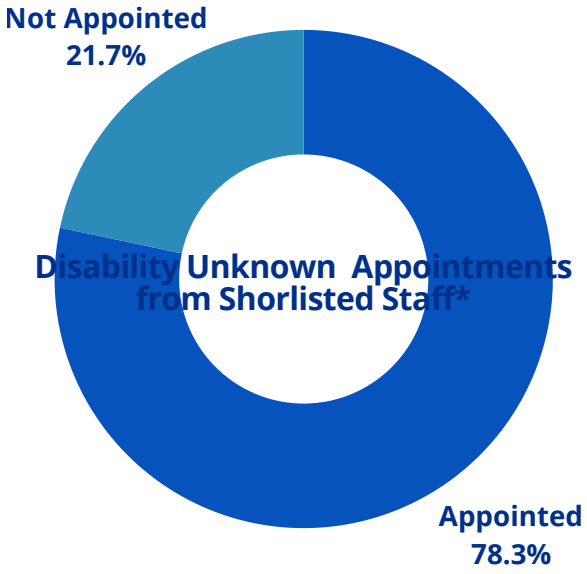
WDES Indicator 2

Figure 2: Appointment from Shortlisting for all staff groups







This year non disabled staff were **1.33** more likely to be appointed from a shortlist which was a deterioration on last year when it was 1.10 more likely. However the actual numbers appointed were very similar at 100 as compared to 102 the previous year.

It is important to highlight that the trust, as part of the Department of Work and Pensions initiative, is recognised as being a Disability Confident Employer and offers a guaranteed interview scheme for disabled applicants who fulfil the minimum person specifications. For all organisations that adopt a guaranteed interview scheme, the data may not be directly comparable to those from organisations that do not have such a program. This information will be recorded on the WDES online reporting form to ensure consistency across organisations.

*48 VSM were appointed with a status of disability unknown skewing this figure

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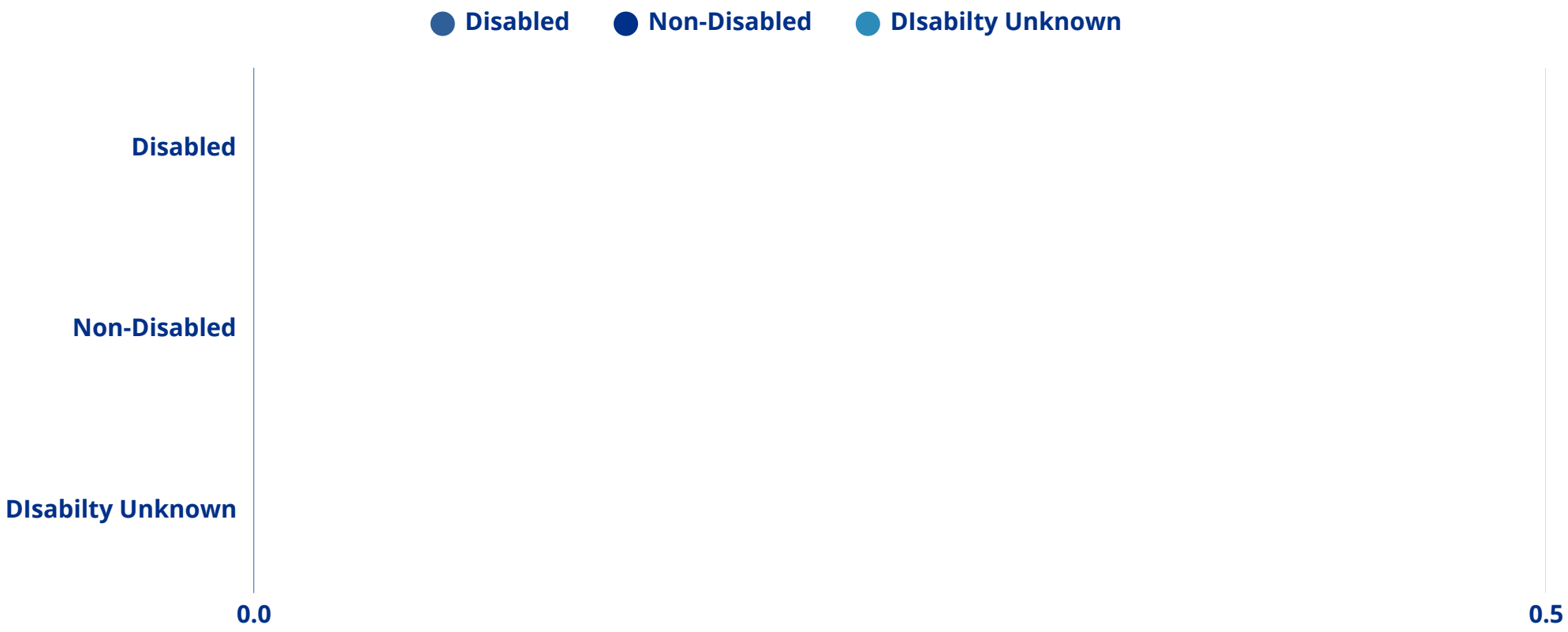
WDES Indicator 3

Figure 3: Likelihood of Staff entering formal capability process



|Zero staff with a disability registered have entered the capability process in this reporting period

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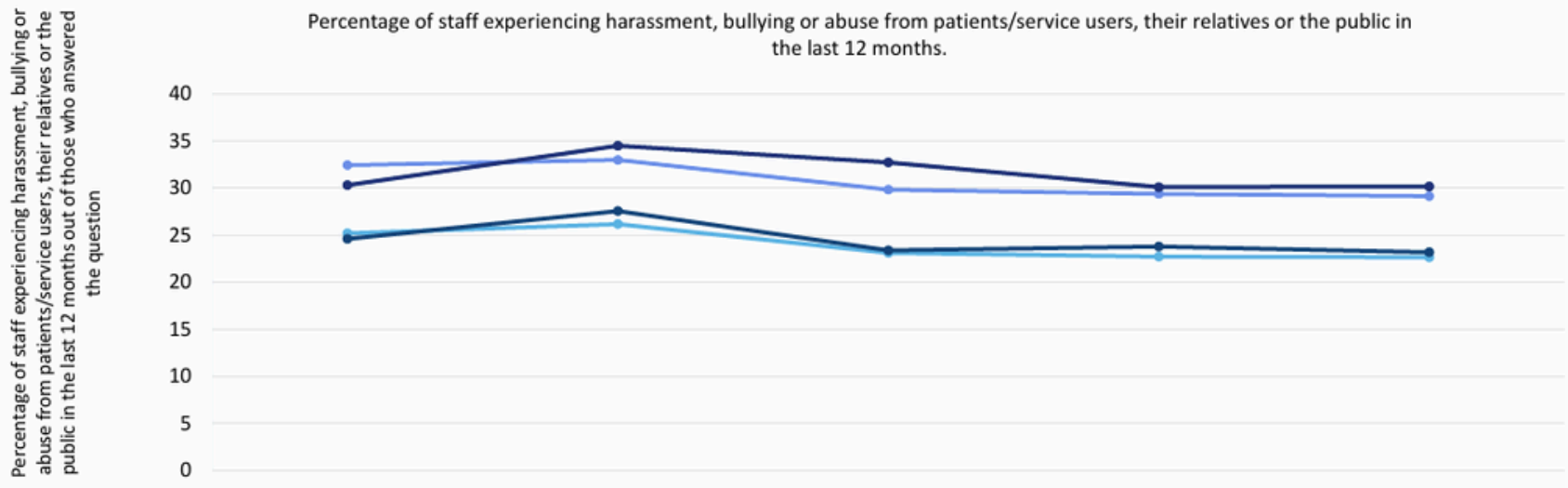
WDES Indicator 4a

Figure 4 : Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	30.29%	34.48%	32.71%	30.09%	30.16%
Staff without a LTC or illness: Your org	24.59%	27.55%	23.38%	23.79%	23.18%
Staff with a LTC or illness: Average	32.43%	32.98%	29.83%	29.37%	29.14%
Staff without a LTC or illness: Average	25.19%	26.16%	23.11%	22.71%	22.64%

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WDES Indicator 4b

Figure 5 : Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months

	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	17.91%	20.56%	16.99%	15.27%	13.35%
Staff without a LTC or illness: Your org	12.58%	12.27%	8.95%	9.45%	7.10%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%

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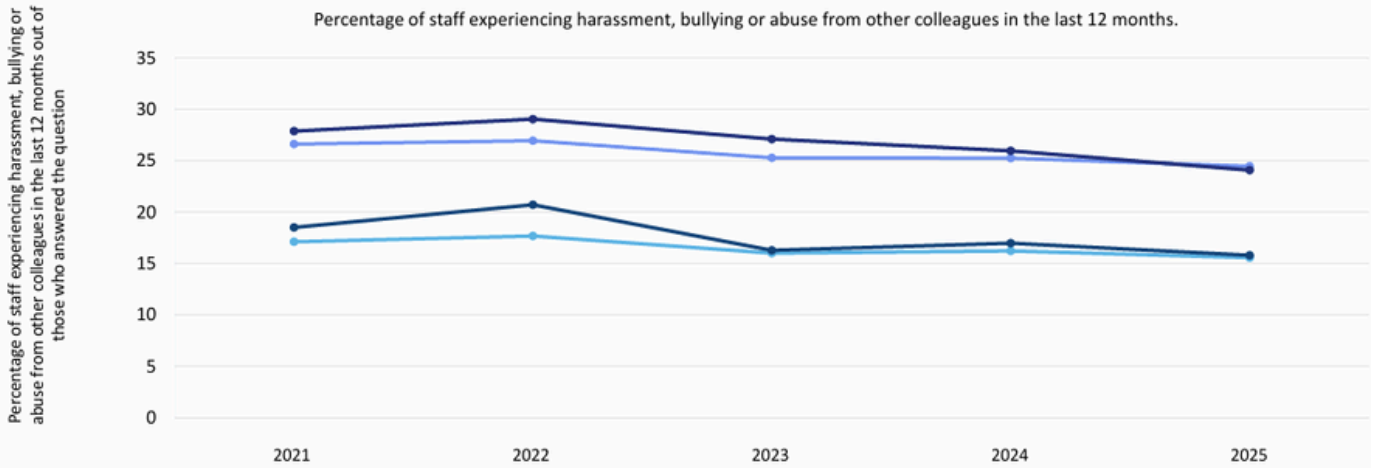
WDES Indicator 4c

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	27.87%	29.03%	27.08%	25.96%	24.07%
Staff without a LTC or illness: Your org	18.51%	20.71%	16.28%	16.97%	15.80%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%

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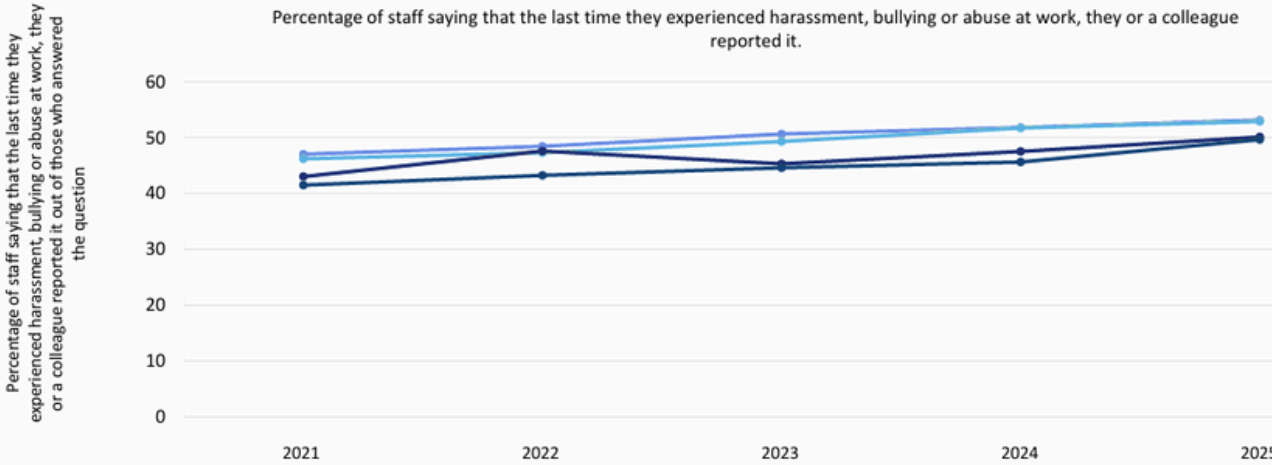
WDES Indicator 4d

Figure 7 : Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	43.02%	47.59%	45.30%	47.52%	50.10%
Staff without a LTC or illness: Your org	41.49%	43.24%	44.60%	45.64%	49.65%
Staff with a LTC or illness: Average	47.03%	48.43%	50.64%	51.82%	53.16%
Staff without a LTC or illness: Average	46.20%	47.30%	49.31%	51.71%	52.89%

50.1% of employees with a disability have reported an incident of harassment, bullying, or abuse at work. This reveals that disabled staff members are more inclined to report incidents compared to their non-disabled peers. The Trust has seen an increase over the past three years in indicator 4d regarding reporting incidents, which is encouraging as it suggests people feel more empowered to speak up. This progress aligns well with the introduction of the zero tolerance reporting tool. This emphasises the importance of fostering a workplace culture that encourages reporting, ultimately contributing to a more supportive and inclusive environment.

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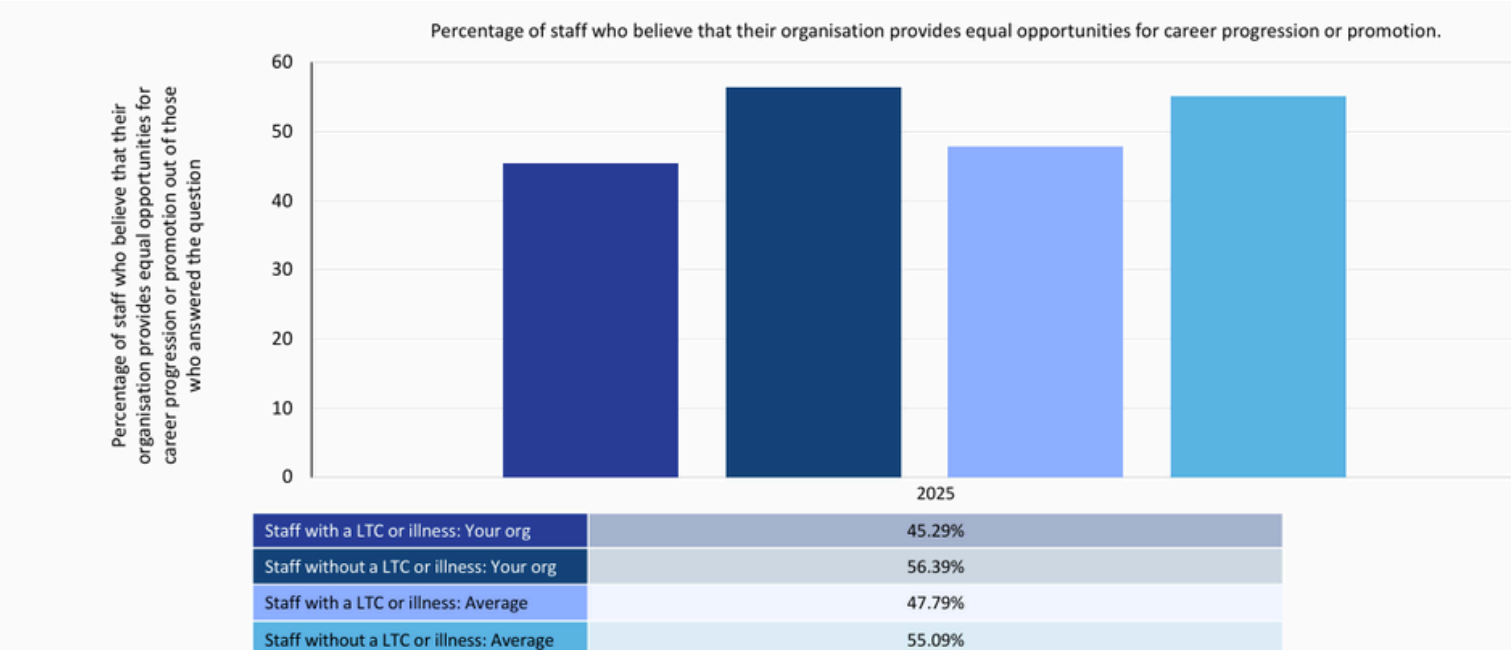
WDES Indicator 5

Figure 8 : Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion



Less than half of disabled staff who completed the staff survey believe that their trust provides equal opportunities for career progression or promotion. Disabled staff are 10.1% less likely to believe that the trust provides equal opportunities for career progression or promotion compared to non-disabled staff.

Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 are not reported.

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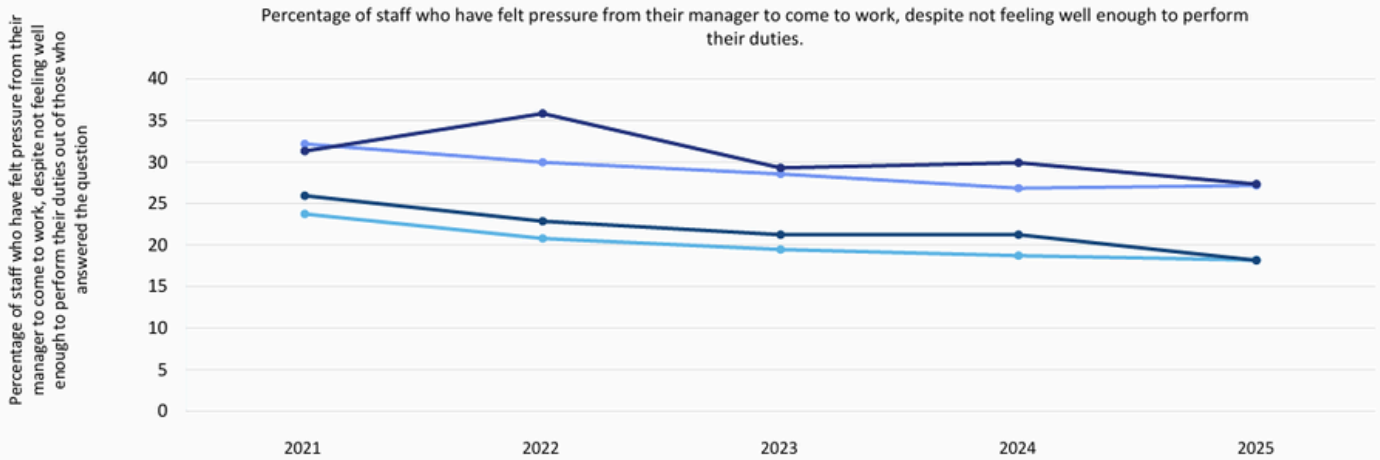
WDES Indicator 6

Figure 9: Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	31.33%	35.85%	29.29%	29.92%	27.33%
Staff without a LTC or illness: Your org	25.94%	22.87%	21.24%	21.24%	18.16%
Staff with a LTC or illness: Average	32.18%	29.97%	28.55%	26.85%	27.19%
Staff without a LTC or illness: Average	23.74%	20.80%	19.46%	18.71%	18.19%

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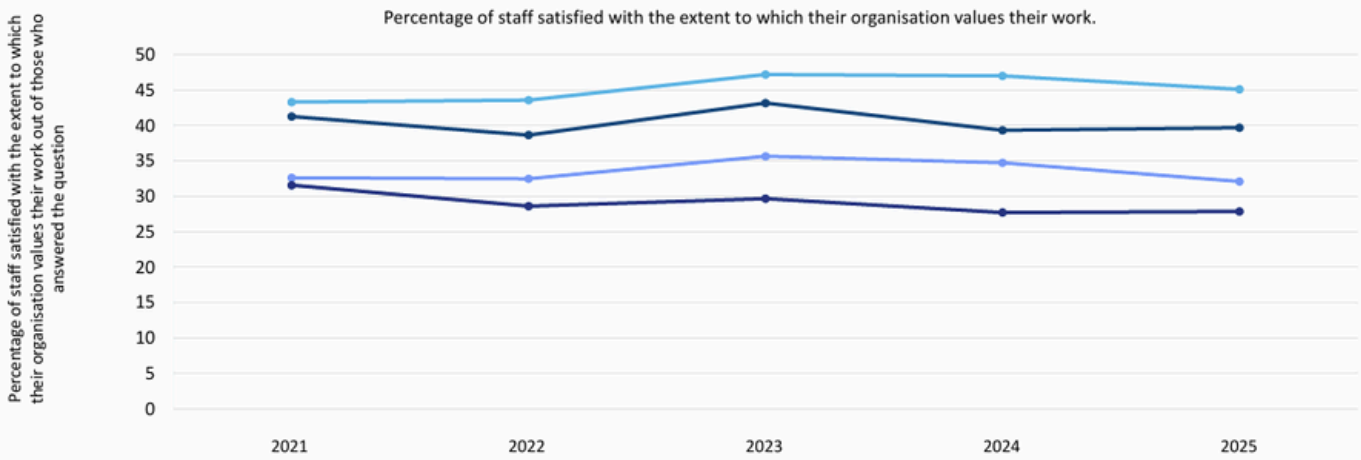
WDES Indicator 7

Figure 10: Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	31.57%	28.61%	29.67%	27.70%	27.85%
Staff without a LTC or illness: Your org	41.26%	38.64%	43.17%	39.32%	39.69%
Staff with a LTC or illness: Average	32.62%	32.46%	35.66%	34.73%	32.09%
Staff without a LTC or illness: Average	43.30%	43.56%	47.19%	46.98%	45.10%

Disabled employees are 11.8% less likely to feel appreciated by the organisation for their workplace contributions.

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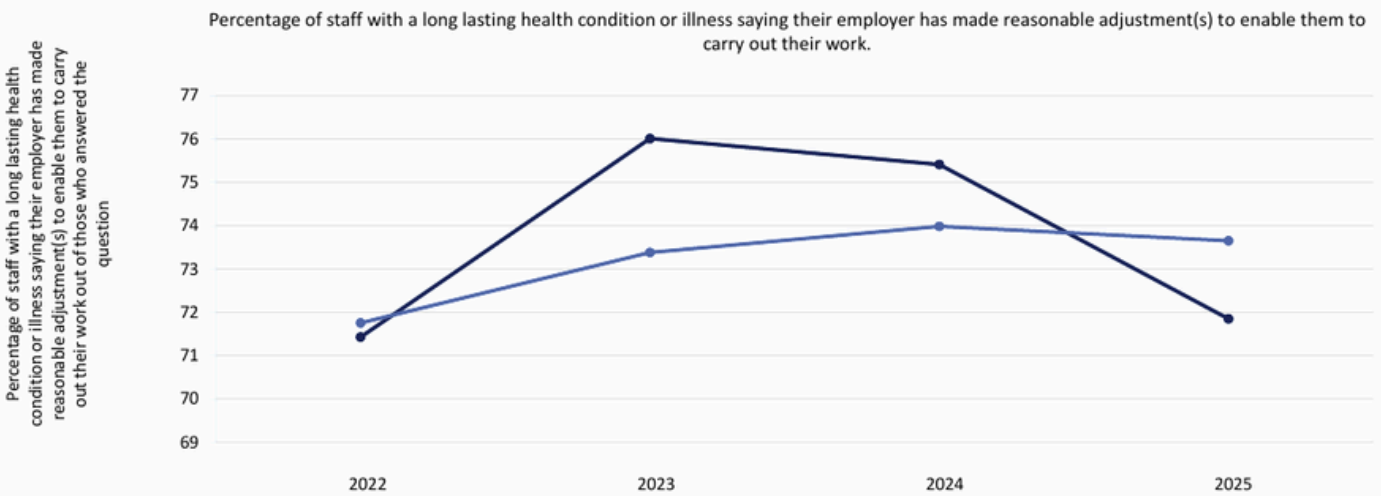
WDES Indicator 8

Figure 11: Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work



	2022	2023	2024	2025
Staff with a LTC or illness: Your org	71.43%	76.01%	75.41%	71.85%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%

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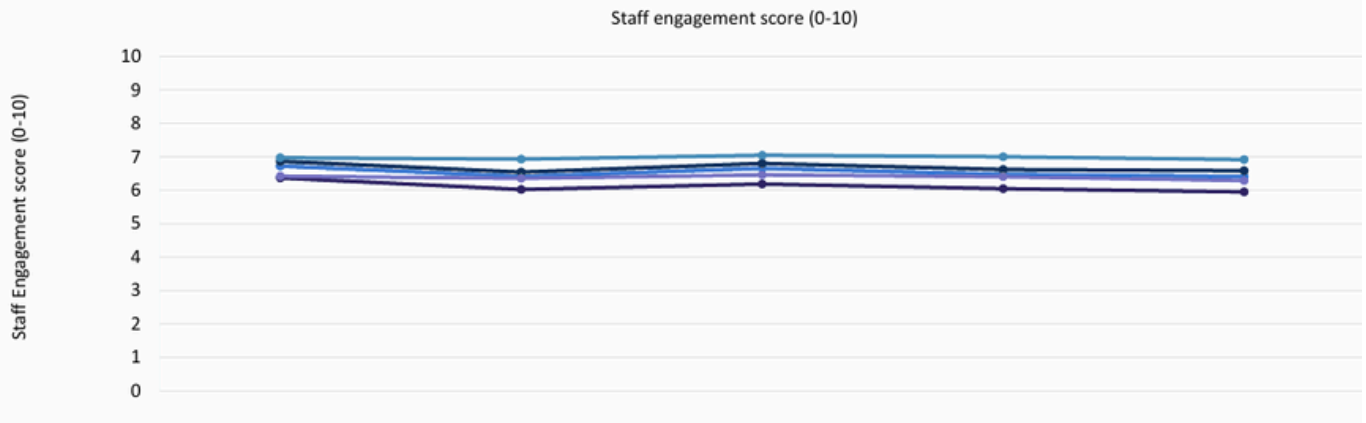
WDES Indicator 9

Figure 12: Staff engagement scores



	2021	2022	2023	2024	2025
Organisation average	6.72	6.41	6.65	6.47	6.41
Staff with a LTC or illness: Your org	6.37	6.02	6.18	6.04	5.95
Staff without a LTC or illness: Your org	6.86	6.54	6.80	6.62	6.58
Staff with a LTC or illness: Average	6.42	6.35	6.46	6.40	6.29
Staff without a LTC or illness: Average	6.97	6.92	7.04	7.00	6.91

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WDES Indicator 10

Figure 13: Disability representation among board members

Figure 13: Total Board Composition

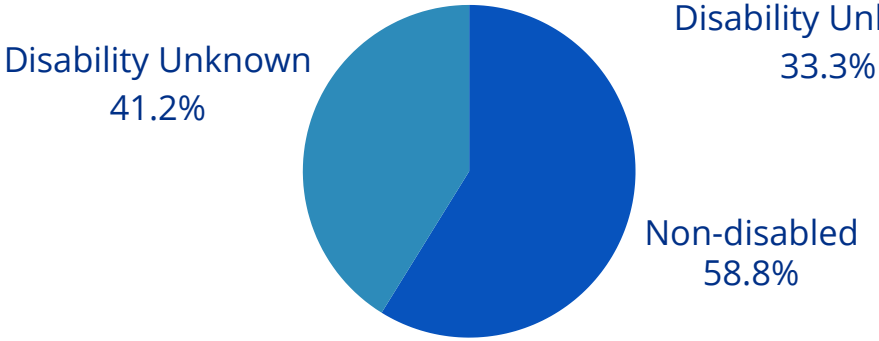


Figure 14: Voting Board Members

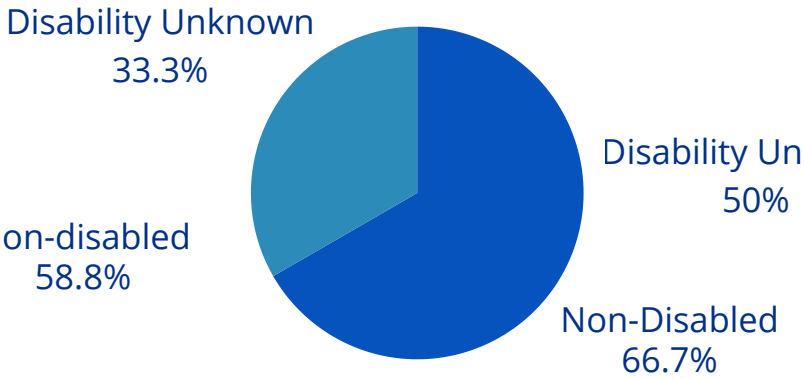
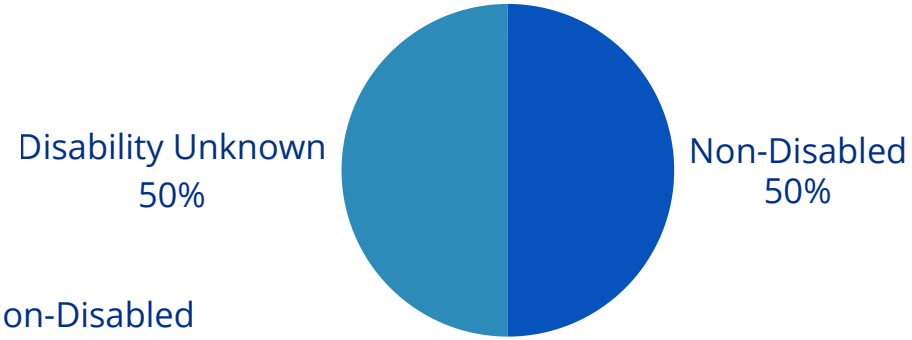


Figure 15: Non-Exec Board members



There is currently no disabled representation on the board either at Exec or Non-exec level. However this position changes when taking into account the joint board.

HUTH is part of NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

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Existing Networks and Programmes

Continued to embed Zero Tolerance to Ableism Framework and Reporting tool. The tool is playing a significant part to assisting how we support equality, to tackle all forms of discrimination and in particular support our disabled staff.

Reasonable Adjustments
The central Reasonable adjustments for Equity, Accessibility and Confidence Hub (REACH) team has been established and provides a dedicated service advocating for individuals asking for reasonable adjustments if they are needed and will escalate to the EDI for support when appropriate.

Governance
The Group Equality, Diversity, and Inclusion Steering Group has been formed to establish the Group's EDI Action Plan and priorities. This group is able to challenge and give the Trust Board assurance in terms of meeting our equality duties.

Education and Development
All new staff receive face to face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a managers leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination and equip leaders to have open and honest conversations with their staff.

Supporting staff who are Neuro Divergent

A groupwide Teams Channel has been established to specifically support staff who are neuro divergent to help them share with each other and to escalate when support is required.

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Action Plan

Although this year's national WDES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of disabled employees within the trust. To address this, an Action Plan has been created based on the 24/25 WDES technical data results, aimed at bridging the gap in workplace experiences between disabled and non-disabled staff.

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
1. Embed the Zero Tolerance to Ableism framework • Ensure staff are aware of this framework • Establish links with the staff network • Relaunch by developing a shortened reference version of the Framework to make it easier for people to read and understand	3, 4a, 4b, 8, 9a, 9b EDS 2022 2B	Ongoing	EDI Team
2. Hold a Groupwide Disability Network Conference • Develop an inspiring Agenda for Members and Allies • Would need to fund an accessbile venue & Transport for staff to get to the Venue.	All EDS 2022 2B	October 2026/Ongoing	EDI Team/Comms/Network Chairs

Action	Metric	Delivery Timescale	Lead Responsibility
3. Introduce an Inclusive Recruitment Project **Stage One Data Analysis:** ○ **Data Analysis Importance:** Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. ○ **Disaggregation by Characteristics:** They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. ○ **Promotion Analysis:** Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	1a, 1b, 2 EDS 2022 2D, 3	February 2027/ Ongoing	EDI Team, Recruitment

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Action	Metric	Delivery Timescale	Lead Responsibility
4. Embed Reasonable Adjustments for Equity, Accessibility and Confidence Hub (REACH) ○ Continue to promote the profile of Access to Work supporting staff to apply and make the application for adjustments via Access to Work simpler we now have in place the centralised process ○ Enable and promote Line Managers to introduce simple adjustments quickly by developing a disability support guide for managers reference. ○ Introduce a Groupwide disability related leave policy that can can be incorporated into HR processes ○ Introduce a "Disability Passport" for colleagues across the Trust.	6, 7, 8, 9a EDS 2022 2A	Ongoing	EDI Team, HR

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Action	Metric	Delivery Timescale	Lead Responsibility
5. **Supporting staff who are Neuro Divergent** ○ Through the staff network provide support to this group of staff. ○ Promote the Teams Channel to Neuro Diverse staff ○ As part of EDI training make managers aware of neuro divergence & Create Guide. ○ Explore reasonable adjustments and how they better support neuro divergent staff.	All EDS 2022 2A, 2B, 2C	April 2027/ Ongoing	EDI Team, Disability Staff Network
6. **EDI Education** ○ Deliver EDI training on all Corporate Induction Course ○ Deliver a range of EDI course each month ○ 'Embracing the Challenges of Inclusive Leadership' ○ Leading without Limits programme group wide bespoke programme for disabled colleagues internally	All EDS 2022 2B, 2C	March 2027/ Ongoing	EDI/OD Teams

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Appendix 1

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	5 *	83.3 %	1 *	%	6
Band 1	1 *	%	12 *	85.7 %	1 *	%	14
Band 2	63 *	%	983 *	93.8 %	2 *	%	1048
Band 3	44 *	%	584 *	92.7 %	2 *	%	630
Band 4	23 *	%	249 *	91.2 %	1 *	%	273
Band 5	11 *	%	202 *	94.8 %	0 *	%	213
Band 6	9 *	%	126 *	93.3 %	0 *	%	135
Band 7	6 *	%	96 *	94.1 %	0 *	%	102
Band 8a	7 *	%	60 *	88.2 %	1 *	%	68
Band 8b	2 *	%	53 *	96.4 %	0 *	%	55
Band 8c	2 *	%	17 *	89.5 %	0 *	%	19
Band 8d	1 *	%	10 *	90.9 %	0 *	%	11
Band 9	0 *	%	4 *	100 %	0 *	%	4
VSM	1 *	%	18 *	58.1 %	12 *	%	31
Other e.g. Agency and/or any other groups, please specify	0 *	%	0 *	%	0 *	%	0

Total non-clinical

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	131	%	1833	93 %	7	0. %	1971
AfC Bands 5, 6 and 7	26	%	424	94.2 %	0	0 %	450
AfC Bands 8a and 8b	9	%	113	91.9 %	1	0. %	123
AfC Bands 8c, 8d, 9 and VSM	4	%	49	75.4 %	12	11 %	65
	170	6.5 %	2419	92.7 %	20	0.8 %	2609

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Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	2 *	%	38 *	95 %	0 *	0 %	40
Band 1	0 *	%	1 *	100 %	0 *	0 %	1
Band 2	12 *	%	301 *	95.9 %	1 *	0. %	314
Band 3	61 *	%	1184 *	94.5 %	8 *	0. %	1253
Band 4	13 *	%	191 *	93.6 %	0 *	0 %	204
Band 5	119 *	%	2037 *	94.2 %	7 *	0. %	2163
Band 6	70 *	%	1084 *	93.7 %	3 *	0. %	1157
Band 7	40 *	%	672 *	93.7 %	5 *	0. %	717
Band 8a	8 *	%	224 *	96.6 %	0 *	0 %	232
Band 8b	2 *	%	59 *	96.7 %	0 *	0 %	61
Band 8c	1 *	%	18 *	94.7 %	0 *	0 %	19
Band 8d	0 *	%	3 *	100 %	0 *	0 %	3
Band 9	0 *	%	2 *	100 %	0 *	0 %	2
VSM	1 *	%	14 *	66.7 %	6 *	28 %	21
Other e.g. Agency and/or any other groups, please specify	0 *	%	0 *	%	0 *	%	0

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Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Medical & Dental Staff, Consultants	13 *	2.: %	553 *	96 %	8 *	1.: %	574
Medical & Dental Staff, Non-Consultants career grade	3 *	5 %	55 *	91 %	2 *	3.: %	60
Medical & Dental Staff, trainee grades	27 *	2.: %	823 *	88 %	83 *	8.: %	933
Total clinical	329	5.: %	5828	94 %	30	0.: %	6187
Total medical & dental	43	2.: %	1431	91 %	93	5.: %	1567
Total clinical & non-clinical	542	5.: %	9678	93 %	143	1.: %	10363

Clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	88	. %	1715	94.6 %	9	0. %	1812
AfC Bands 5, 6 and 7	229	! %	3793	94 %	15	0. %	4037
AfC Bands 8a and 8b	10	: %	283	96.6 %	0	0 %	293
AfC Bands 8c, 8d, 9 and VSM	2	. %	37	82.2 %	6	1: %	45

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Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	749 *	7821 *	0 *
Number appointed from shortlisting	100 *	1390 *	0 *
Likelihood of shortlisting/appointed	0.13	0.18	

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.33

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Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	542	9678	143
Average number of staff entering the formal capability process for any reason	0 *	0 *	0 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process	0.000000	0.000000	0.000000

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff

Notes

This is managed locally and not held centrally

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Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2023.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	9 *	0 *	9
How many are voting members?	0 *	5 *	0 *	5
Number of non-voting members	0	4	0	4
How many are Exec Board members?	0 *	7 *	0 *	7
Number of non-exec members	0	2	0	2
Number of staff in overall workforce (from Metric 1)	542	9678	143	10363
Total Board members - % by Disability	0 %	100 %	0 %	
Voting Board members - % by Disability	0 %	100 %	0 %	
Non-Voting Board Member - % by Disability	0 %	100 %	0 %	
Executive Board Member - % by Disability	0 %	100 %	0 %	
Non-Executive Board Member - % by Disability	0 %	100 %	0 %	
Overall workforce - % by Disability	5.23 %	93.39 %	1.38 %	
Difference % (Total Board - Overall workforce)	-5.23 %	6.61 %	-1.38 %	
Difference % (Voting membership - Overall Workforce)	-5.23 %	6.61 %	-1.38 %	
Difference % (Executive membership - Overall Workforce)	-5.23 %	6.61 %	-1.38 %	

Notes

Please note - we share a group board with Northern Lincolnshire and Goole and these are only the staff whose primary employment sits within our Trust, Therefore this is not a true indication of the make up of the board however as a group we do not wish to overreport.

Workforce Disability Equality Standards 25/26

NHS Humber Health Partnership
Northern Lincolnshire and Goole NHS Foundation trust

NHS
Humber Health
Partnership

Workforce Intelligence
Equality Diversity and Inclusion
nlg-tr.twworkforcedatareqs@nhs.net
nlg-tr.equalitydiversityandinclusion@nhs.net

Introduction

As set out in the National Health Service (NHS) Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare. The NHS WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS.

The WDES follows the NHS WDES as a tool and an enabler of change. The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.

The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain. It was restricted to NHS trusts and Foundation trusts for the first two years of implementation. The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

The trust's WDES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

Reasonable adjustments in the workplace have increased since 2024: 76% of disabled staff reported the trust made necessary adjustments in 2025/26

The percentage of disabled staff in the workforce stands at 6.4% of the total workforce: up from last year by 18.5%

The number of unknown responses for declaring a disability has increased slightly since last year

Most disclosures of disabilities are from staff from bands 1-4

The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process is 4.6 times more likely

18% of disabled applicants were appointed from shortlisting in 2025/26, up from last year

Non-Disabled staff are 1.06 times more likely to be appointed from shortlisting compared to Disabled staff, which is a positive improvement

Disabled staff are still 5.6% less likely to believe that the trust provides equal opportunities for career progression or promotion compared to non-disabled staff

The number of disabled staff who felt pressured to attend work than non disabled staff., has improved by 2.9% since last year

The engagement score for disabled and non disabled staff has remained the same and is still below the national average

6.2% of AfC senior managers band 8 & above classify themselves as having a disability or long-term condition

Disabled staff are 8% more likely to experience harassment, bullying or abuse from colleagues compared to non disabled staff

	WDES 25/26 Performance Comparison and Summary	24/25	25/26
1	Percentage and Number of disabled staff	5.4%	6.4%
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.6	1.06
3	Relative likelihood of disabled staff entering the formal capability process (excluding ill-health related proceedings) compared to non-disabled staff	5.5	4.6
4a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	28.9%	27.8%
4b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months	15.1%	13.7%
4c	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	28.1%	26.7%
4d	Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work	54.8%	51%

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	WDES 25/26 Performance Comparison and Summary	24/25	25/26
5	Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion	48.8%	47.1%
6	Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties	29.6%	26.7%
7	Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work	27%	27.8%
8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	70.9%	76%
9	Staff engagement scores for staff with a disability or long term condition	6	6
10	Disability representation among board members	14.3%	33.3%

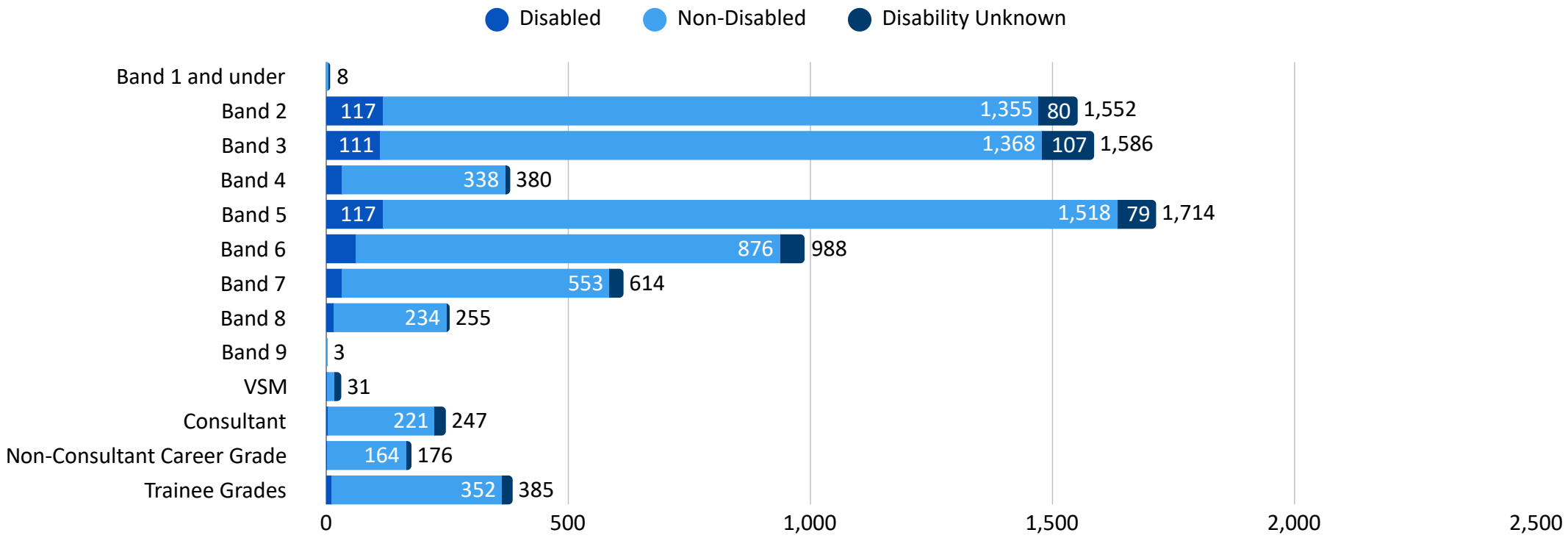
WDES Indicator 1

Table 1: The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric is a snapshot as at 31 March 2025.

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff
Disabled	6.4%	6.9%	6.9%
Non-Disabled	88.3%	88%	87.8%
Disability Unknown	5.3%	5.2%	5.2%

WDES Indicator 1

Figure 1: The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric is a snapshot as at 31 March 2025.



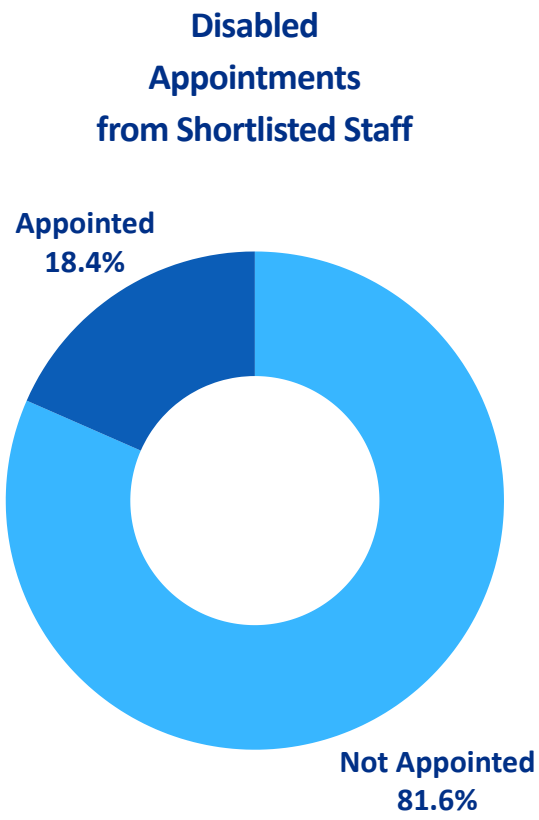
Almost 1 in 4 NHS staff now have lived experience of a disability or long-term condition (NHS England). The chart above highlights a disparity in the representation of staff with disabilities across the trust. The percentage of disabled staff in the non-clinical and clinical workforce stands at 6.4% of the total workforce: up from last year by 1%. The overall number of staff who have disclosed a disability on the Electronic Staff Record (ESR) remains low across the trust. However, the data also reveals that the highest proportion of these disclosures is concentrated in specific categories, notably among staff in bands 1-4. This suggests that while there is an underrepresentation of staff with disabilities generally, there are particular areas within the trust where individuals with disabilities are more prevalent.

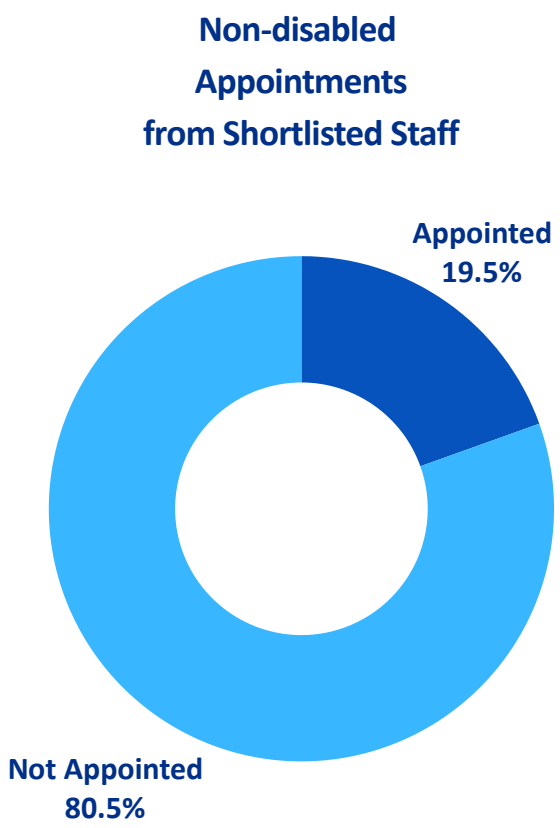
Furthermore, 5.4% of employees have yet to disclose their disability status, with this being most prominent within Very Senior Managers (VSM), where 45% of disability statuses remain undisclosed. When comparing the data with the trust's most recent national staff survey responses regarding the disclosure of long-term health conditions or disabilities, it is evident that employees are hesitant to disclose or update their disability status on ESR. The staff survey responses indicate a greater number of employees with disabilities than ESR data suggests.

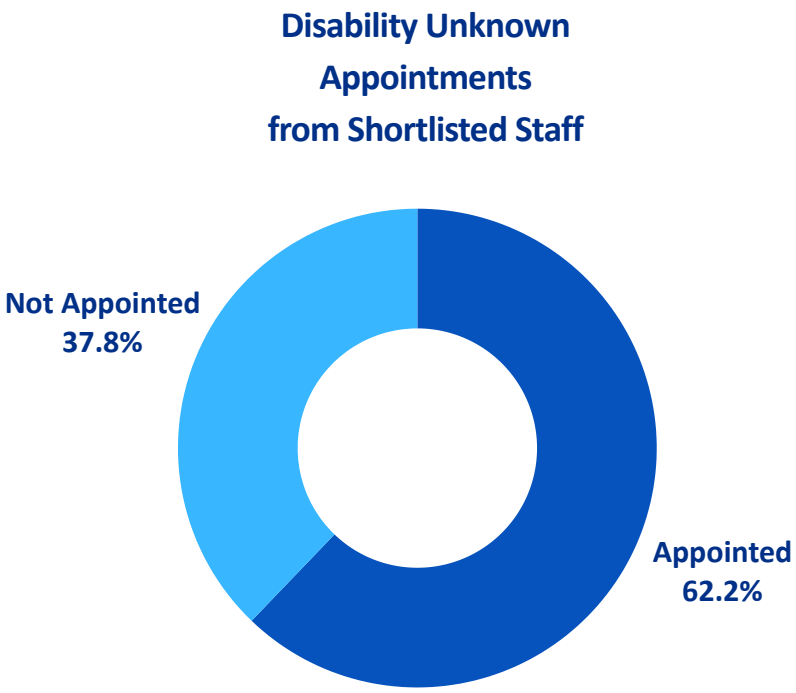
**VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)*

WDES Indicator 2

Figure 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.





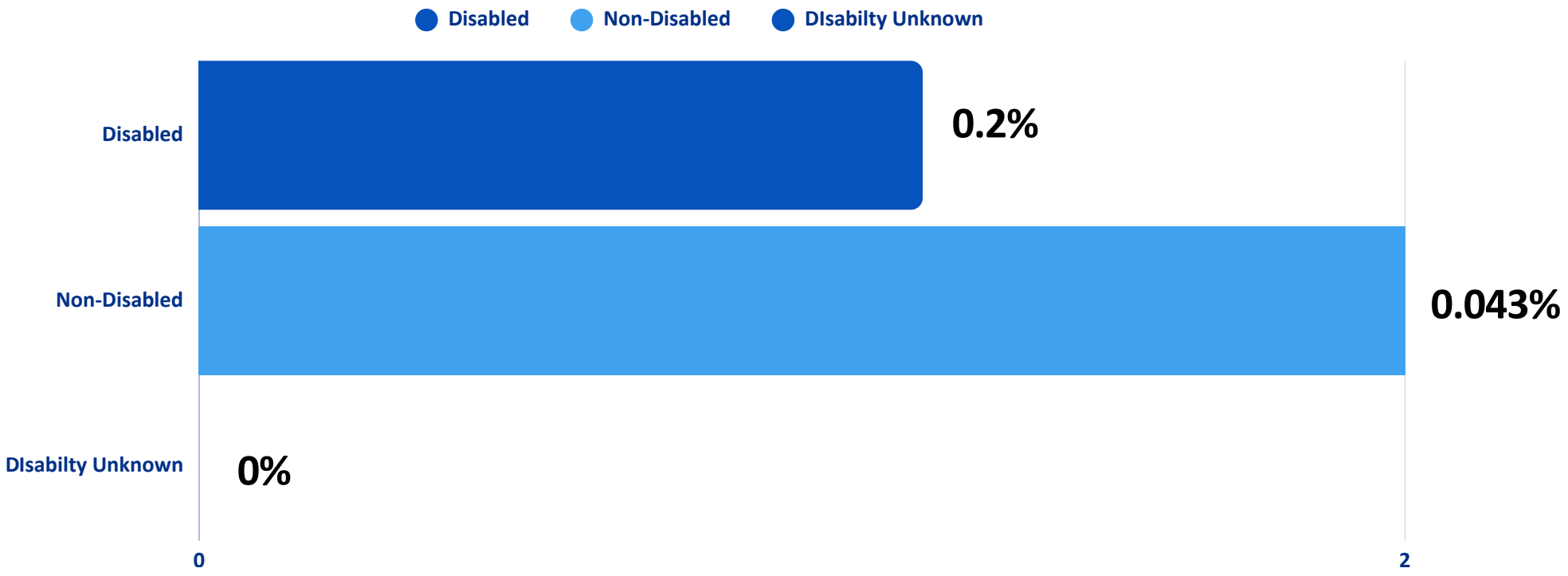


The relative probability of non-disabled staff being appointed from the shortlist, compared to disabled staff, stands at **1.06**. This statistic encompasses both external and internal positions. This ratio has remained unchanged during the past year.

It is important to highlight that the trust, as part of the Department of Work and Pensions initiative, is recognised as being a Disability Confident Employer and offers a guaranteed interview scheme for disabled applicants who fulfil the minimum person specifications. For all organisations that adopt a guaranteed interview scheme, the data may not be directly comparable to those from organisations that do not have such a program. This information will be recorded on the WDES online reporting form to ensure consistency across organisations.

WDES Indicator 3

Figure 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.



The Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff 4.6.

Metric 3 explores the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the number of staff entering the formal capability procedure from a two-year rolling average of the current year and the previous year. This metric applies to capability on the grounds of performance and not ill health.

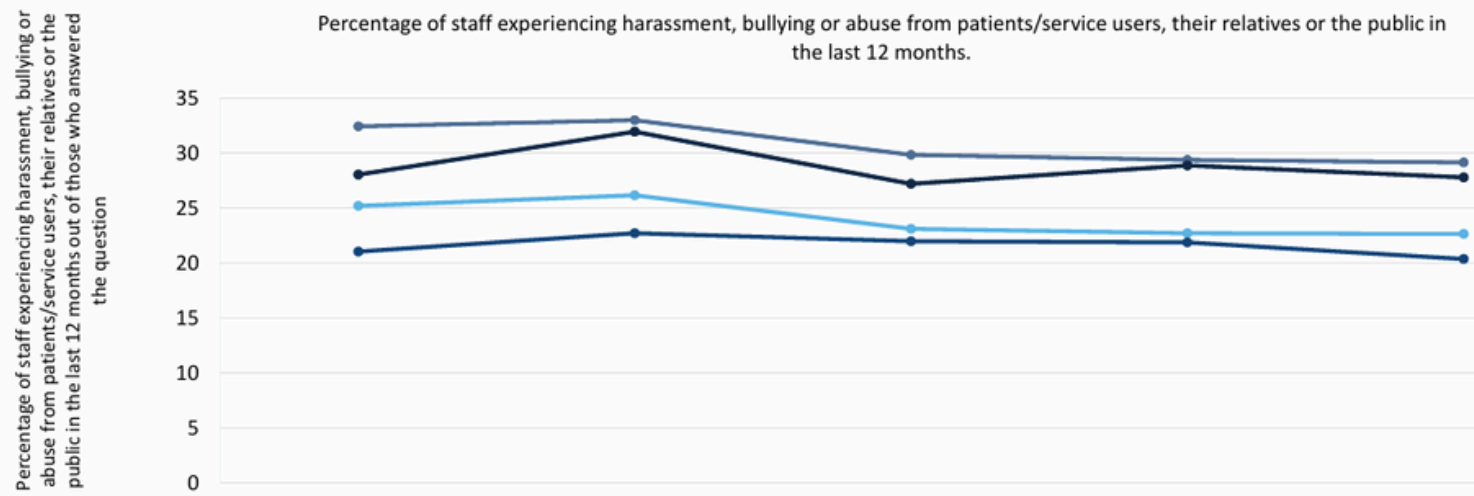
The bar chart indicates the likelihood of disabled staff compared to non-disabled staff entering the capability process reveals: disabled staff are more likely to enter this procedure. It's crucial to note, however, that the overall number of capability cases reported remains very low. The trust no longer captures the numbers of any staff entering the formal capability process. This is managed locally, therefore all figures relate to figures recorded in 2024.

While there is a relative difference in likelihood between the two groups, the figures are not substantial.

WDES Indicator 4a

Metrics 4a-9 represent unweighted question level responses to key findings in the NHS for NLaG staf and the staff survey results surrounding the disabled workforce in 2025.

Figure 4 : Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

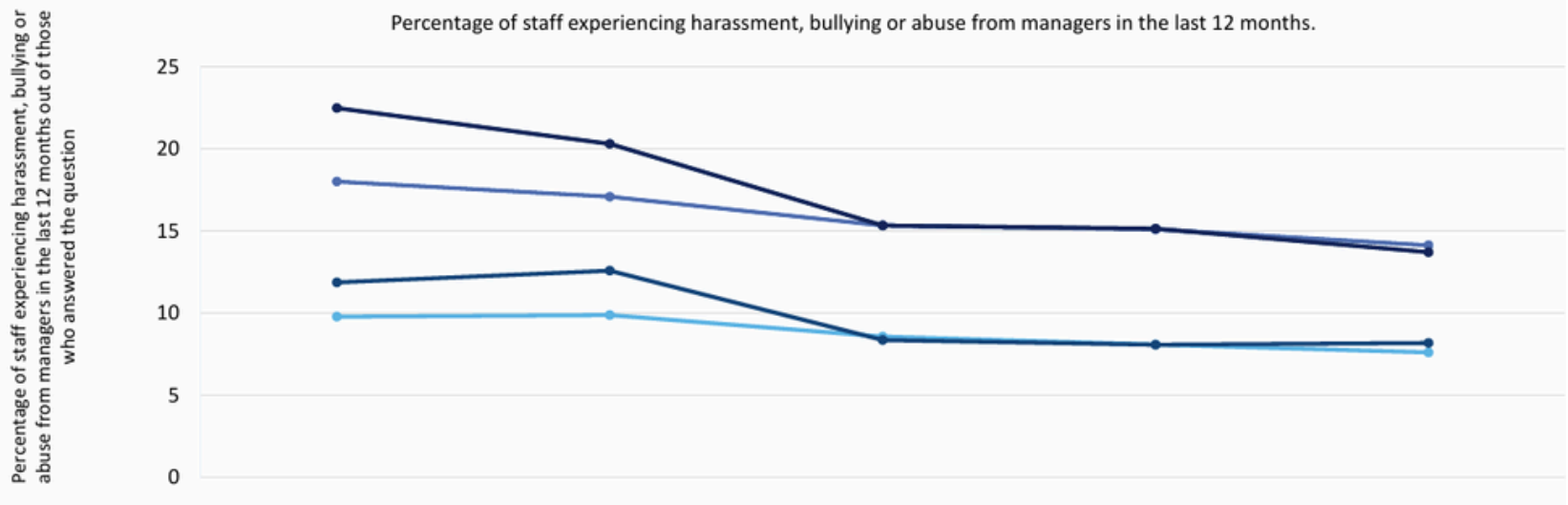


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	28.04%	31.94%	27.20%	28.88%	27.78%
Staff without a LTC or illness: Your org	21.04%	22.71%	21.97%	21.87%	20.36%
Staff with a LTC or illness: Average	32.43%	32.98%	29.83%	29.37%	29.14%
Staff without a LTC or illness: Average	25.19%	26.16%	23.11%	22.71%	22.64%
Staff with a LTC or illness: Responses	560	526	818	800	871
Staff without a LTC or illness: Responses	1792	1814	2259	2350	2328

Disabled employees face a 7.4% higher likelihood of encountering harassment, bullying, or abuse from patients, relatives, and the public when compared to their non-disabled counterparts. This marks an increase from the previous year, highlighting a decline in workplace conditions.

WDES Indicator 4b

Figure 5 : Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months

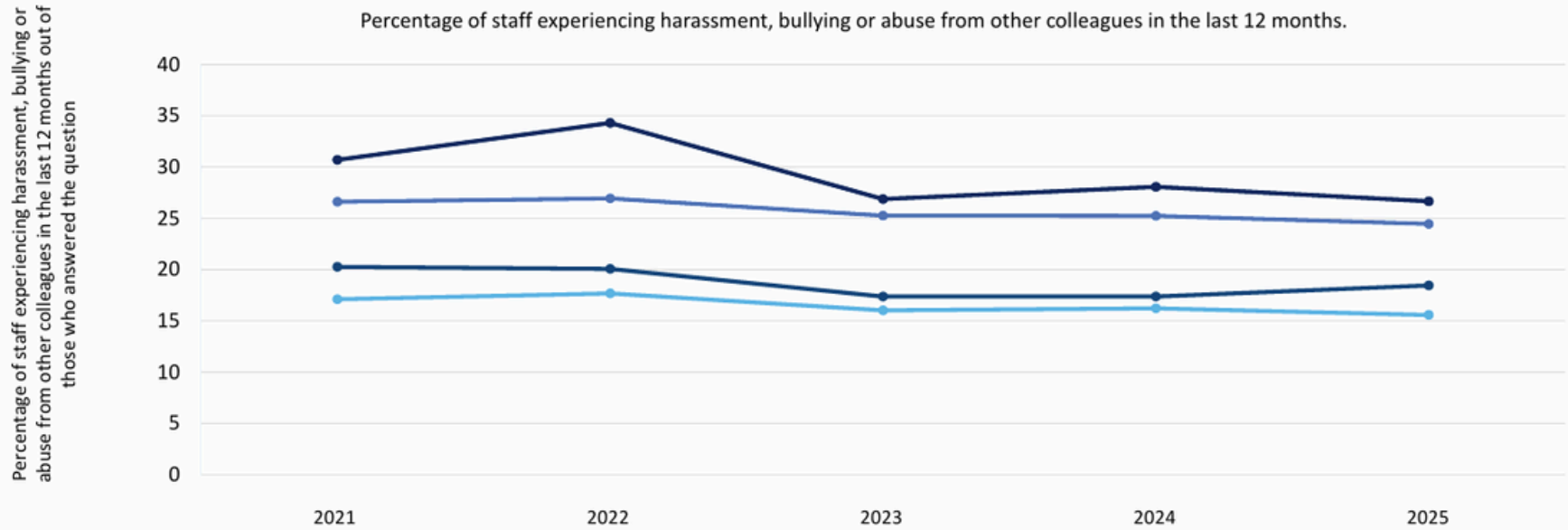


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	22.48%	20.31%	15.33%	15.13%	13.70%
Staff without a LTC or illness: Your org	11.86%	12.58%	8.35%	8.07%	8.18%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	556	522	811	793	861
Staff without a LTC or illness: Responses	1779	1797	2234	2318	2310

Disabled employees are 5.5% more likely to experience harassment, bullying, or abuse from their managers compared to their non-disabled peers. This represents an decrease from the previous year, and since 2021 has come down by 8.78% indicating an improvement in workplace conditions.

WDES Indicator 4c

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

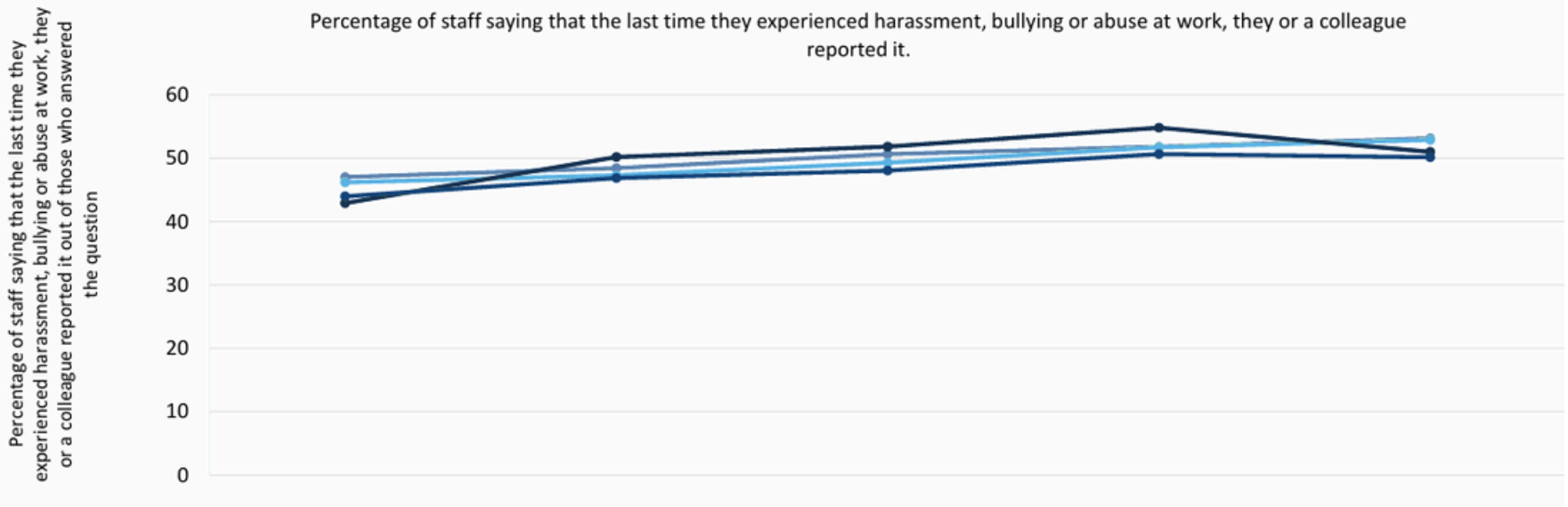


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	30.69%	34.30%	26.88%	28.07%	26.66%
Staff without a LTC or illness: Your org	20.26%	20.07%	17.37%	17.37%	18.45%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%
Staff with a LTC or illness: Responses	554	519	809	791	859
Staff without a LTC or illness: Responses	1777	1794	2229	2309	2304

Disabled employees are 8.2% more likely to face harassment, bullying, or abuse from colleagues compared to their non-disabled counterparts, this has improved in 2025.

WDES Indicator 4d

Figure 7 : Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work



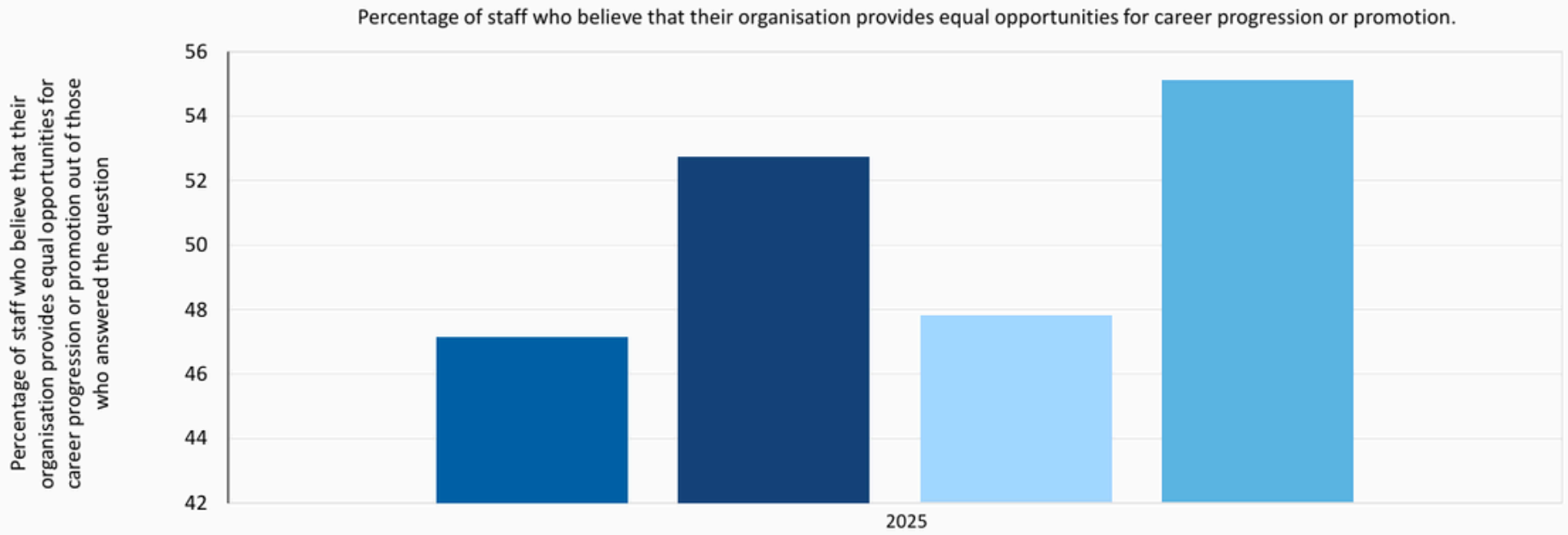
	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	42.91%	50.19%	51.84%	54.82%	51.01%
Staff without a LTC or illness: Your org	43.98%	46.89%	48.05%	50.67%	50.15%
Staff with a LTC or illness: Average	47.03%	48.43%	50.64%	51.82%	53.16%
Staff without a LTC or illness: Average	46.20%	47.30%	49.31%	51.71%	52.89%
Staff with a LTC or illness: Responses	268	257	328	332	347
Staff without a LTC or illness: Responses	573	595	639	675	672

51% of employees with a disability have reported an incident of harassment, bullying, or abuse at work. This reveals that disabled staff members are more inclined to report incidents compared to their non-disabled peers.

The trust has seen an increase over the past years regarding staff reporting incidents, which is encouraging as it suggests people feel more empowered to speak up. This progress aligns well with the introduction of the zero tolerance to ableism reporting tool. This emphasises the importance of fostering a workplace culture that encourages reporting, ultimately contributing to a more supportive and inclusive environment.

WDES Indicator 5

Figure 8 : Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion



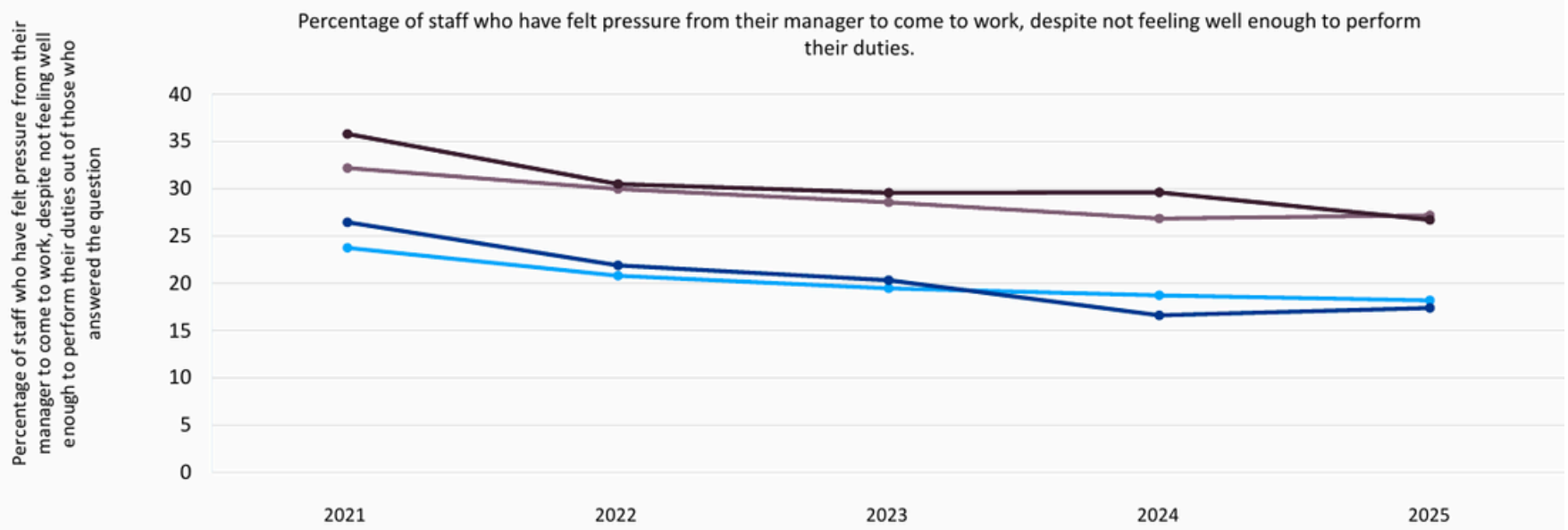
Staff with a LTC or illness: Your org	47.14%
Staff without a LTC or illness: Your org	52.73%
Staff with a LTC or illness: Average	47.79%
Staff without a LTC or illness: Average	55.09%
Staff with a LTC or illness: Responses	857
Staff without a LTC or illness: Responses	2310

Less than half of disabled staff who completed the staff survey believe that their trust provides equal opportunities for career progression or promotion. Disabled staff are 5.6% less likely to believe that the trust provides equal opportunities for career progression or promotion compared to non-disabled staff.

Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 are not reported.

WDES Indicator 6

Figure 9: Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties

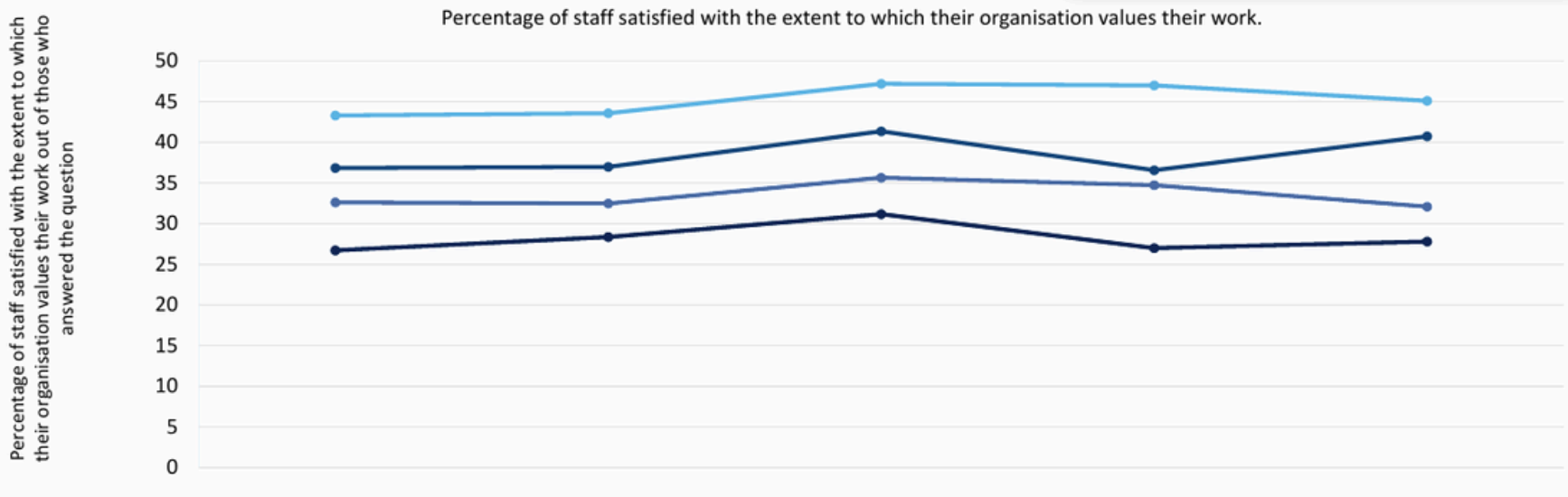


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	35.79%	30.48%	29.56%	29.61%	26.71%
Staff without a LTC or illness: Your org	26.45%	21.89%	20.31%	16.61%	17.40%
Staff with a LTC or illness: Average	32.18%	29.97%	28.55%	26.85%	27.19%
Staff without a LTC or illness: Average	23.74%	20.80%	19.46%	18.71%	18.19%
Staff with a LTC or illness: Responses	380	397	636	591	629
Staff without a LTC or illness: Responses	828	964	1221	1204	1121

Disabled staff felt 9.3% more pressured to attend work than non disabled staff, highlighting a concern in workplace inclusivity and support. This disparity suggests that disabled employees may not be receiving the necessary accommodations or understanding from management, which could impact their overall well-being and job satisfaction.

WDES Indicator 7

Figure 10: Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work

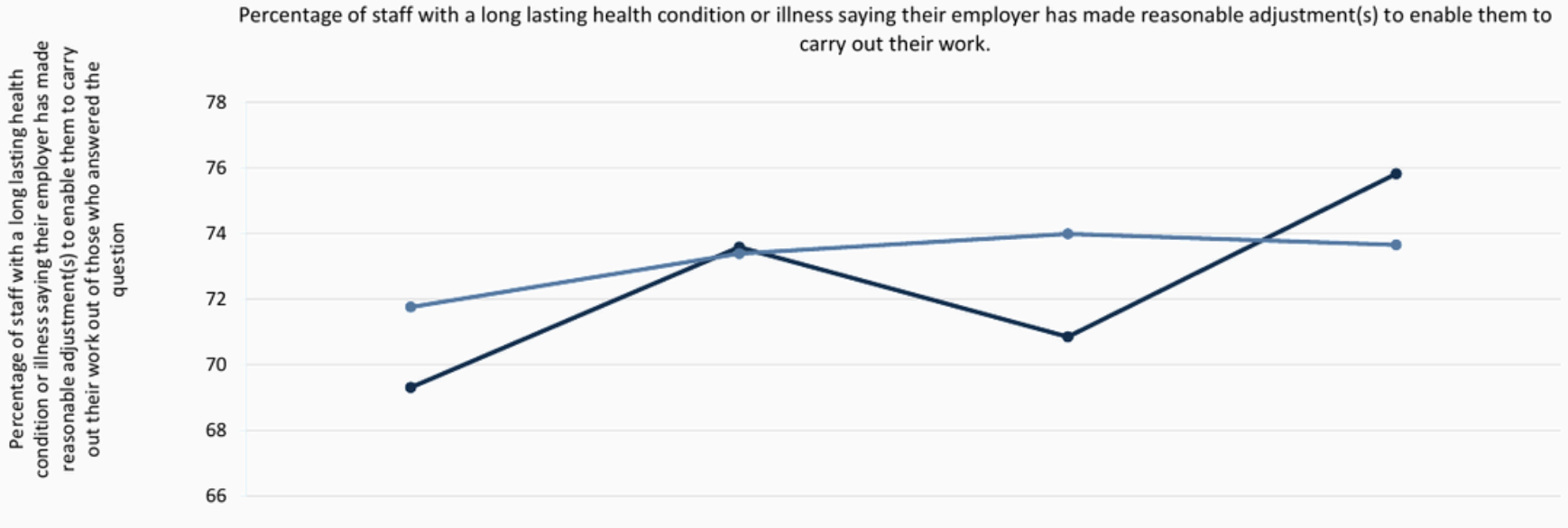


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	26.71%	28.36%	31.17%	26.99%	27.78%
Staff without a LTC or illness: Your org	36.84%	36.99%	41.36%	36.56%	40.74%
Staff with a LTC or illness: Average	32.62%	32.46%	35.66%	34.73%	32.09%
Staff without a LTC or illness: Average	43.30%	43.56%	47.19%	46.98%	45.10%
Staff with a LTC or illness: Responses	569	529	879	804	871
Staff without a LTC or illness: Responses	1846	1814	2522	2352	2332

Disabled employees are 13% less likely to feel appreciated by the organisation for their workplace contributions. This gap in workplace inclusivity and recognition is the highest that it has been.

WDES Indicator 8

Figure 11: Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work

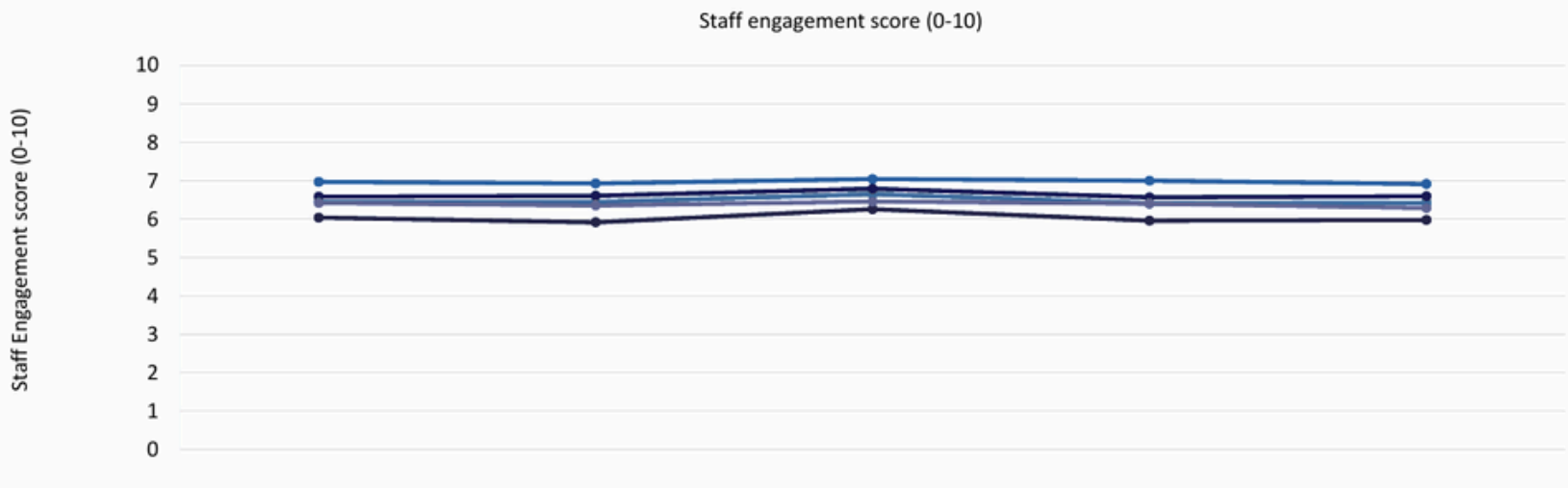


	2022	2023	2024	2025
Staff with a LTC or illness: Your org	69.31%	73.58%	70.85%	75.82%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%
Staff with a LTC or illness: Responses	303	511	494	521

In the recent staff survey, 75.8% of disabled employees expressed that the trust has made adequate adjustments to help them perform their duties. This figure reflects a significant increase compared to 2024/25, indicating a positive trend for disabled employees.

WDES Indicator 9

Figure 12: Staff engagement scores



	2021	2022	2023	2024	2025
Organisation average	6.44	6.44	6.65	6.41	6.42
Staff with a LTC or illness: Your org	6.04	5.91	6.26	5.96	5.98
Staff without a LTC or illness: Your org	6.58	6.60	6.79	6.57	6.59
Staff with a LTC or illness: Average	6.42	6.35	6.46	6.40	6.29
Staff without a LTC or illness: Average	6.97	6.92	7.04	7.00	6.91
Staff with a LTC or illness: Responses	573	529	883	805	873
Staff without a LTC or illness: Responses	1847	1818	2536	2360	2338

The engagement score for employees with disabilities has increased slightly from 5.96 to 5.98, however, still falling below the national average of 6.29 for disabled staff members.

WDES Indicator 10

Disability representation among board members

Figure 13: Total Board Composition

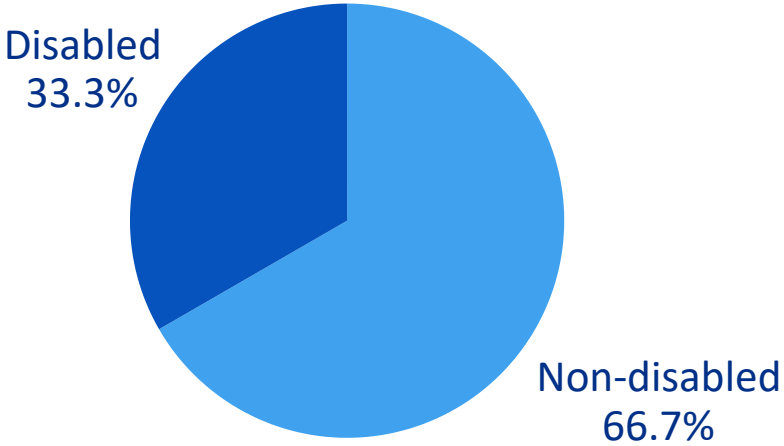


Figure 15: Non-Exec Board members

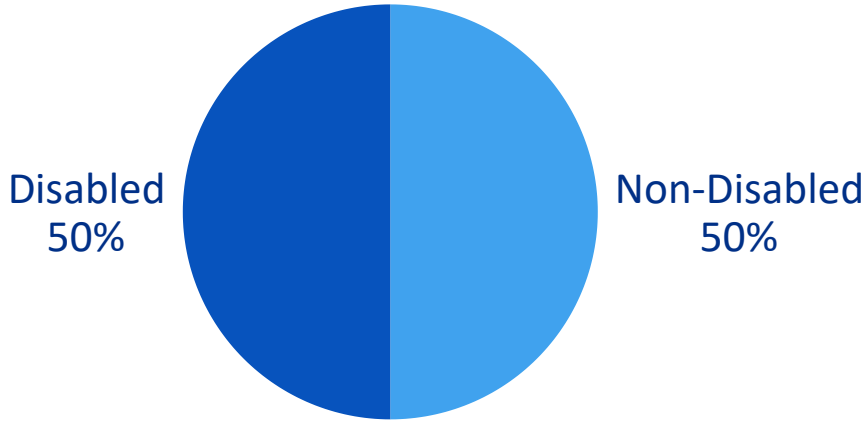
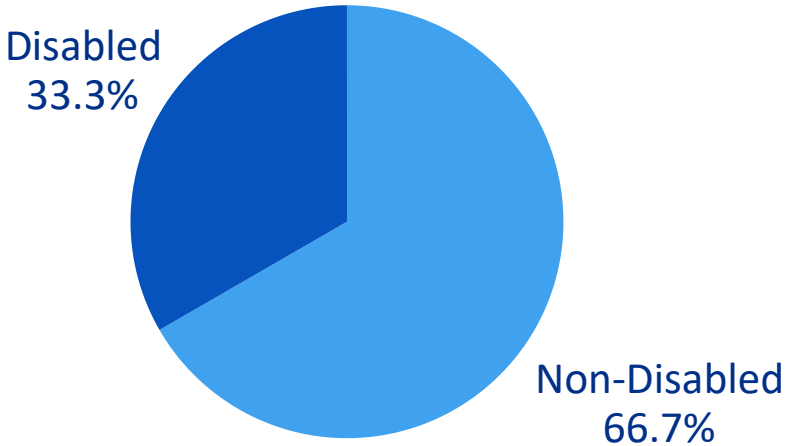


Figure 14: Voting Board Members



Northern Lincolnshire and Goole NHS Foundation trust is part of the NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation trust or Hull University Teaching Hospitals NHS trust. In which case, figures will not be double- counted. The disabled board representation at the trust stands at 33.3%.

Progress to Support Disabled Staff

The advancements made in the past year to assist disabled staff within the workforce are outlined below.

1

Zero Tolerance to Ableism Framework

Continued to embed Zero Tolerance to Ableism Framework and Reporting tool. The tool is playing a significant part to assisting how we support equality, to tackle all forms of discrimination and in particular support our disabled staff.

2

Reasonable Adjustments

IThe central Reasonable adjustments for Equity, Accessibility and Confidence Hub (REACH) team has been established and provides a dedicated service advocating for individuals asking for reasonable adjustments if they are needed and will escalate to the EDI for support when appropriate.

3

Governance

The Group Equality, Diversity, and Inclusion Steering Group has been formed to establish the Group's EDI Action Plan and priorities. This group is able to challenge and give the Trust Board assurance in terms of meeting our equality duties.

4

Supporting staff who are Neuro Divergent

A groupwide Teams Channel has been established to specifically support staff who are neuro divergent to help them share with each other and to escalate when support is required.

5

Education and Development

All new staff receive face to face equality, diversity and inclusion training as part of corporate induction. All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious/implicit bias. Additionally, we are delivering a managers leadership programme which includes; recognising and valuing diversity within our teams, enabling leaders to identify and address all forms of discrimination and equip leaders to have open and honest conversations with their staff.

Action Plan

Although this year's national WDES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of disabled employees within the trust. To address this, an Action Plan has been created based on the 24/25 WDES technical data results, aimed at bridging the gap in workplace experiences between disabled and non-disabled staff.

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
1. Embed the Zero Tolerance to Ableism framework • Ensure staff are aware of this framework • Establish links with the staff network • Relaunch by developing a shortened reference version of the Framework to make it easier for people to read and understand	3, 4a, 4b, 8, 9a, 9b EDS 2022 2B	Ongoing	EDI Team
2. Hold a Groupwide Disability Network Conference • Develop an inspiring Agenda for Members and Allies • Would need to fund an accessbile venue & Transport for staff to get to the Venue.	All EDS 2022 2B	October 2026/Ongoing	EDI Team/Comms/Network Chairs

Action Plan

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
3. Introduce an Inclusive Recruitment Project Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities. d. Explore disability awareness Training for managers and staff taking part in Recruitment processes	1a, 1b, 2 EDS 2022 2D, 3	February 2026/Ongoing	EDI Team, Recruitment

Action Plan

Action	WDES Indicator	Delivery Timescale	Lead Responsibility
4. Embed the Reasonable Adjustments for Equity, Accessibility and Confidence Hub (REACH). • Raise the profile of Access to Work and support staff to apply and make the application for adjustments via Access to Work simpler and explore the feasibility of introducing a centralised process • Explore using reasonable adjustment case studies. • Enable and promote Line Managers to introduce simple adjustments quickly. • Explore with HR how adjustments in relation to disability related leave and absence can be incorporated into HR processes • Introduce a "Disability Passport" for colleagues across the trust.	6, 7, 8, 9a EDS 2022 2A	December 25/Ongoing	EDI Team, HR
5. Supporting staff who are Neuro Divergent • Through the staff network provide support to this group of staff. • Explore various support interventions. • As part of EDI training make managers aware of neuro divergence. • Explore reasonable adjustments and how they better support neuro divergent staff.	All EDS 2022 2A, 2B, 2C	April 2025/Ongoing	EDI Team, Disability Staff Network

Appendix

Welcome to the 2026 Workforce Disability Equality Standard data collection

Thank you for completing this data submission.

Introduction

This data is being collected as part of the 2026 data collection for the Workforce Disability Equality Standard (WDES). The aim of WDES is to improve the working and career experiences of Disabled staff in the NHS. The WDES is mandated through the NHS Standard Contract and has been approved as a data collection by NHS England Data Alliance Partnership Board. It has also been subject to a data protection impact assessment.

The requirement to submit WDES data is outlined in clause 13.8 of the NHS Standard Contract 2022/23 Service Conditions, which state "The Provider (if it is an NHS trust or an NHS Foundation Trust) must implement and comply with the National Workforce Disability Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance".

The Data Collection Framework (DCF) should be used to submit data for the WDES metrics (note the information on the tab for metrics 4 to 9a for NHS trusts). The survey tab contains a series of qualitative questions and should also be completed.

Guidance on how to complete the DCF has been produced and is available on NHS Futures via this link (Link:).

Navigation and Completion

Each section of the DCF can be accessed using the links near the top of the page. Please note:

- White boxes will collect the data. The grey boxes will be automatically filled when all the required information has been entered.
- Items marked with a red asterisk * are compulsory.
- Entries and changes are not saved automatically. At the foot of each section is a button labelled "Save as draft": this should be used as often as possible.
- Once all sections are complete, the "Submit" button can be pressed at the foot of any section.
- Each page may be saved as a PDF or printed using the standard process for your browser. (For example, in Chrome, pressing the three dots at the top-right of the screen brings up several options including Print.)
- Once the data has been submitted, an option will be given allowing a PDF version of the submission to be produced. You are strongly advised to do this and retain it for your records, and to aid in the completion of your 2026 Action Plan.
- Do not use the Back button on your browser: this will return you to the Open Collections screen, and any unsaved data will be lost.

Bank and Agency staff

Trusts should NOT include Band staff in the 2026 return, but do include Agency staff if they were also included in the 2025 return. Please use the Notes sections to indicate whether Agency staff have been included or not.

Deadlines

NHS trusts should submit their data between **1 May 2026** and by **close of business on 31 May 2026**.

The metrics data in this submission should be used to create a SMART action plan, in collaboration with Disabled staff. The action plan should be approved by the trust's Board, and published with the metrics data on the trust's website by 31/10/26. For comparison and benchmarking information on WDES metrics, see the Model Health System (Link:), the NHS Staff Survey (Link:) and the WDES 2021 report (Link:).

Queries

- Guidance on how to complete the submission can also be found in the Guidance Document (Link:)
- Information governance notice can be viewed in the data collection notice (Link:)
- If you have a query about the data definitions used by the collection, or a business or policy query, not answered by the links above please contact us by emailing: england.mandatedstandards@nhs.net (Link:)
- For all other queries including technical queries, adding or removing users, problems logging in and password resets, please contact us by creating a ticket at the National Service Desk NHS customer portal (Link:).
- Guidance on the National Service Desk Portal can be found in the DCF support request guide (Link:).

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	0 %	1 *	100 %	0 *	0 %	1
Band 1	0 *	0 %	1 *	100 %	0 *	0 %	1
Band 2	81 *	7 %	1013 *	87 %	70 *	6 %	1164
Band 3	26 *	5.7 %	406 *	88.3 %	28 *	6.1 %	460
Band 4	16 *	8.3 %	173 *	89.6 %	4 *	2.1 %	193
Band 5	11 *	6.5 %	154 *	91.1 %	4 *	2.4 %	169
Band 6	6 *	6.7 %	81 *	90 %	3 *	3.3 %	90
Band 7	5 *	6.2 %	73 *	90.1 %	3 *	3.7 %	81
Band 8a	4 *	11.8 %	30 *	88.2 %	0 *	0 %	34
Band 8b	5 *	15.6 %	26 *	81.3 %	1 *	3.1 %	32
Band 8c	1 *	5 %	19 *	95 %	0 *	0 %	20
Band 8d	0 *	0 %	10 *	100 %	0 *	0 %	10
Band 9	0 *	0 %	1 *	100 %	0 *	0 %	1
VSM	2 *	11.1 %	10 *	55.6 %	6 *	33.3 %	18
Other e.g. Agency and/or any other groups, please specify	1 *	100 %	0 *	0 %	0 *	0 %	1

Total non-clinical

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	123	6.8 %	1594	87.6 %	102	5.6 %	1819
AfC Bands 5, 6 and 7	22	6.5 %	308	90.6 %	10	2.9 %	340
AfC Bands 8a and 8b	9	13.6 %	56	84.8 %	1	1.5 %	66
AfC Bands 8c, 8d, 9 and VSM	3	6.1 %	40	81.6 %	6	12.2 %	49
	158	6.9 %	1998	87.8 %	119	5.2 %	2275

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2023.

If including Agency staff, please enter them in the "Other" category.

Disability Unknown refers to those staff who have indicated that they prefer not to say, as well as those who have not responded to the disability monitoring question in ESR.

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	1	20 %	3	60 %	1	20 %	5
Band 1	0	0 %	0	0 %	1	100 %	1
Band 2	36	9.3 %	342	88.1 %	10	2.6 %	388
Band 3	85	7.6 %	962	85.6 %	77	6.9 %	1124
Band 4	17	9.1 %	165	88.2 %	5	2.7 %	187
Band 5	106	6.9 %	1364	88.3 %	75	4.9 %	1545
Band 6	56	6.3 %	795	88.9 %	43	4.8 %	894
Band 7	27	5.1 %	480	90.1 %	26	4.9 %	533
Band 8a	4	3.3 %	114	95 %	2	1.7 %	120
Band 8b	2	8.7 %	19	82.6 %	2	8.7 %	23
Band 8c	0	0 %	12	100 %	0	0 %	12
Band 8d	0	0 %	4	100 %	0	0 %	4
Band 9	0	0 %	2	100 %	0	0 %	2
VSM	0	0 %	5	38.5 %	8	61.5 %	13
Other e.g. Agency and/or any other groups, please specify	0	%	0	%	0	%	0
Medical & Dental Staff, Consultants	3	1.2 %	221	89.5 %	23	9.3 %	247
Medical & Dental Staff, Non-Consultants career grade	2	1.1 %	164	93.2 %	10	5.7 %	176
Medical & Dental Staff, trainee grades	11	2.9 %	352	91.4 %	22	5.7 %	385
Total clinical	334	6.9 %	4267	88 %	250	5.2 %	4851
Total medical & dental	16	2 %	737	91.2 %	55	6.8 %	808
Total clinical & non-clinical	508	6.4 %	7002	88.3 %	424	5.3 %	7934

Clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	139	8.2 %	1472	86.3 %	94	5.5 %	1705
AfC Bands 5, 6 and 7	189	6.4 %	2639	88.8 %	144	4.8 %	2972
AfC Bands 8a and 8b	6	4.2 %	133	93 %	4	2.8 %	143
AfC Bands 8c, 8d, 9 and VSM	0	0 %	23	74.2 %	8	25.8 %	31

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	483	5181	533
Number appointed from shortlisting	89	1012	332
Likelihood of shortlisting/appointed	0.18	0.2	0.62

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts 1.06

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Notes:

i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the grounds of performance and not ill health.

iii. If a member of staff enters the capability process for reasons of **both** performance **and** ill health, they should not be included in the count of "ill health only" cases.

iv. For clarification: the data required is the numbers of staff **entering** the capability process from 1 April 2022 to 31 March 2024, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	508	7062	424
Average number of staff entering the formal capability process for any reason	1 *	3 *	0 *
Of these, how many are on the grounds of ill health only?	0 *	0 *	0 *
Likelihood of staff entering the formal capability process	0.001969	0.000428	0.000000

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff: 4.600467

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

If no, please provide an explanation for your answer.

* Yes
* No

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

Notes

Metric 4 - 9a

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

*

*

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2023.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	1 *	2 *	0 *	3
How many are voting members?	1 *	2 *	0 *	3
Number of non-voting members	0	0	0	0
How many are Exec Board members?	0 *	1 *	0 *	1
Number of non-exec members	1	1	0	2
Number of staff in overall workforce (from Metric 1)	508	7062	424	7934
Total Board members - % by Disability	33.33 %	66.67 %	0 %	
Voting Board members - % by Disability	33.33 %	66.67 %	0 %	
Non-Voting Board Member - % by Disability	%	%	%	
Executive Board Member - % by Disability	0 %	100 %	0 %	
Non-Executive Board Member - % by Disability	50 %	50 %	0 %	
Overall workforce - % by Disability	6.4 %	88.25 %	5.34 %	
Difference % (Total Board - Overall workforce)	26.93 %	-21.58 %	-5.34 %	
Difference % (Voting membership - Overall Workforce)	26.93 %	-21.58 %	-5.34 %	
Difference % (Executive membership - Overall Workforce)	-6.4 %	11.75 %	-5.34 %	

Notes

Northern Lincolnshire and Goole NHS Foundation Trust is part of the NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double-counted.

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)247

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October 2026
Director Lead	Helen Marks, Group Chief People Officer
Contact Officer / Author	Lucy Vere, Group Director of Learning and Organisational Development
Title of Report	**Workforce Race Equality Standard (WRES)**
Executive Summary	**Purpose of report:** To present the 2025/26 WRES findings and associated action plans for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), highlighting shared priorities and clearly distinguishing the position and trajectory of each Trust. The Committees are asked to note the findings, receive assurance on current activity and support the proposed areas for action. **Alert** **HUTH:** White staff are 2.75 times as likely to be appointed once they have reached the shortlisting stage compared to Black, Asian, and Minority Ethnic (BAME) staff. The 2024/25 figure was 1.75. **HUTH:** The relative likelihood of BAME staff entering the formal disciplinary process compared to White staff is 1.49. The 2024/25 figure was 0.71. **HUTH:** 32.3% of BAME staff experienced harassment, bullying or abuse from patients, relatives or the public; 27.1% experienced harassment, bullying or abuse from staff; and 17.2% experienced discrimination at work from other staff. **HUTH:** BAME representation among voting Board members is zero. The percentage difference of BAME representation between Board membership and the overall workforce is -21.7%. **NLAG:** The relative likelihood of White applicants being appointed from shortlisting compared to BAME applicants is 2.08. The 2024/25 figure was 2.04. **NLAG:** BAME staff are 1.46 times more likely to enter the formal disciplinary process compared to White staff. The 2024/25 figure was 1.83. **NLAG:** 30.0% of BAME staff experienced harassment, bullying or abuse from patients, relatives or the public; 28.3% experienced harassment, bullying or abuse from staff; and 15.9% experienced discrimination at work from other staff. **NLAG:** BAME representation on the Trust Board is zero. The percentage difference between Board membership and the overall workforce is -18.4% **Advise**

	Combined Actions for HUTH & NLAG • Continue to develop the Zero Tolerance to Racism Framework and reporting tool including an abridged version relaunch it to improve awareness and make reporting easier. • Introduce an Inclusive Recruitment Project and Toolkit, including analysis of recruitment data, disaggregation by protected characteristics and analysis of promotion to higher bandings. • Develop and grow the BAME Staff Networks, including a Groupwide Network conference and the inaugural Dumbor Ngaage award. In addition create full engagement plans and appropriate governance arrangements to support their ongoing success. • Support internationally educated staff through the Bridge programme and the NHSE Step Up programme. • Introduce the Patient Racism Standard Operating Procedure and develop cultural competency workshops. **Assure** **HUTH:** BAME staff represented 21.7% of the workforce, compared with 21.1% in 2024/25. **HUTH:** Harassment, bullying or abuse from staff was 27.1%, compared with 31.8% in 2024/25. Discrimination at work from other staff was 17.2%, compared with 19.1% in 2024/25. **HUTH:** The relative likelihood of White staff accessing non-mandatory training and Continuing Professional Development (CPD) was 0.39, compared with 0.88 in 2024/25. The report states that this metric is missing data because all non-mandatory training and CPD is not held centrally. **HUTH:** Progress reported includes the Groupwide Zero Tolerance to Racism Framework and reporting tool, the BAME Staff Network, support for internationally educated staff, education and development, and Equality, Diversity and Inclusion (EDI) governance. **NLAG:** BAME staff represented 18.4% of the workforce, the same as in 2024/25. **NLAG:** Harassment, bullying or abuse from patients, relatives or the public was 30.0%, compared with 34.1% in 2024/25. Harassment, bullying or abuse from staff was 28.3%, compared with 31.2%. Discrimination at work from other staff was 15.9%, compared with 21.8%. **NLAG:** The relative likelihood of White staff accessing non-mandatory training and CPD was 1.01, indicating near parity. **NLAG:** Progress reported includes the Zero Tolerance to Racism Framework, the BAME Staff Network, support for internationally educated staff, education and development, and EDI governance **Recommendation/s** The Trust Boards-in-Common are asked to note the HUTH and NLAG WRES 2025/26 reports and action plans and receive assurance on the progress reported and approve the report.
Background Information and/or Supporting Document(s) (if applicable)	NLAG and HUTH WRES reports and their data submissions are attached.

Prior Approval Process	Workforce, Education and Culture Committees-in-Common, EDI Steering Group and BAME network meetings (NLAG & HUTH)
Financial Implication(s) (if applicable)	No direct financial decision is requested. Delivery of the action plans may require workforce capacity and specific programme resources, which should be managed through established planning and approval processes.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The report directly addresses racial equity in recruitment, career progression, employee relations, workplace experience and leadership representation. Effective delivery should improve inclusion and staff experience and may support more culturally responsive services; progress will be monitored separately for HUTH and NLAG to avoid obscuring local inequalities.
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

V2

Workforce Race Equality Standards 25/26

NHS Humber Health Partnership
Hull University Teaching Hospitals NHS Trust

NHS
Humber Health
Partnership

Workforce Intelligence
Equality Diversity and Inclusion
nlg-tr.twworkforcedatareqs@nhs.net
nlg-tr.equalitydiversityandinclusion@nhs.net

Introduction

The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).

The WRES seeks to prompt enquiry to better understand why BAME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BAME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BAME staff in the NHS.

The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator. The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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Key Findings

The BAME Staff within the organisation have remained fairly static.

The composition of Medical and Dental Workforce that is BAME stands at 53.3%

White staff are 2.77 x as likely to be appointed once they have reached the shortlisting stage compared to BAME staff, but there is an actual increase in appointments

BAME Staff are more likely to enter the formal discilipinary process

BAME Staff experiencing bullying from other staff has decreased by 4.8% this year

BAME Staff experiencing discrimination at work from patients has increased by 0.2% in year

In last 12 months, BAME staff report a 8.8% higher negative experience than white colleagues in relation to harassment, bullying or abuse from patients, relatives or the public

BAME Staff are significantly more likely to access non-mandatory training and CPD than White Staff

The percentage of BAME Staff in Bands 8-9 and VSM compared to total staff in these bands is 3.4%, none above 8c
but total 8a-8c has risen from 22 to 37

The staff survey results for BAME staffare more positive than last years. Which is a clear indicator that EDI strategies are being impactful when the rest of the organisation struggled

51.3% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion

7% of non-clinical staff are BAME

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	Wres 24/25 Performance Comparison and Summary	24/25	25/26
1	Percentage of BAME staff in NHS trust by ethnicity	21.1%	21.7%
2	The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	1.75	2.77
3	The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	0.71	1.49
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff	0.88	0.39
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	32.1%	32.3%
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	31.8%	27.1%
7	Percentage of BAME staff believing that their trust provides equal opportunities for career progression or promotion	51.4%	51.3%
8	Percentage of BAME staff experiencing discrimination at work from a manager or team leader in the last 12 months	19.1%	17.2%
9	Percentage difference of BAME representation between Board Membership and overall workforce	-15.3%	-21.7%

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WRES Indicator 1

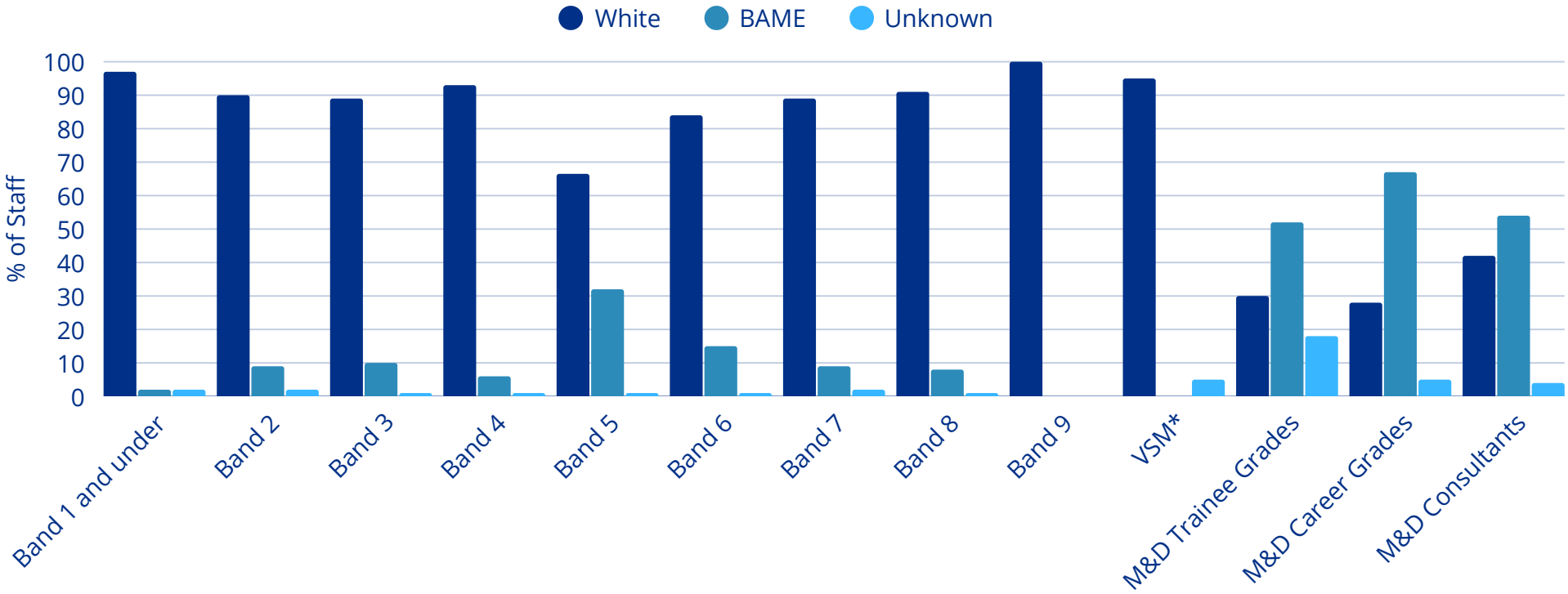
Table 1: Ethnic Composition of HUTH Staff

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff	Composition of Medical and Dental Staff
BAME	2251	2067	184	834
White	7833	5417	2416	533
Not Stated	298	264	34	197

The complement of our BAME staff has remained relatively static year on year with an increase in 'not-stated' ethnicity. There has been a slight increase in non-clinical BAME staff.

WRES Indicator 1

Figure 1: Proportional Ethnic Composition of HUTH Staff



The bar chart illustrates the distribution of individuals identified as white, BAME, and those with an unknown ethnicity, categorised by band. BAME representation is lowest within Bands 4 and again at Band 8 and above. When considered by Agenda for Change (AfC), band 5 continues to see the highest percentage of staff from an ethnic minority, which is similar across all trusts (NHS Providers, 2024).
The percentage of BAME Staff in Bands 8 8%, an improvement on last year. Although, there is zero percentage of BAME staff in Bands 8-9 and VSM . Following NHS England's recommendations, medical and dental grades (including trainee grades) are excluded from the Bands 8-9 and VSM figures, as these categories typically have a much higher proportion of BAME staff.
Across clinical and non-clinical staff bands, white staff make up the majority at all levels, particularly in higher bands and leadership roles, though there is representation of BAME staff across most bands.
***VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)**

*VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)

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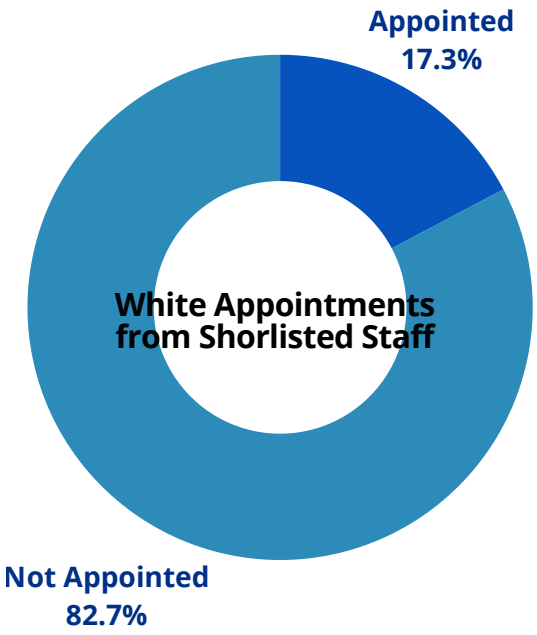
WRES Indicator 2

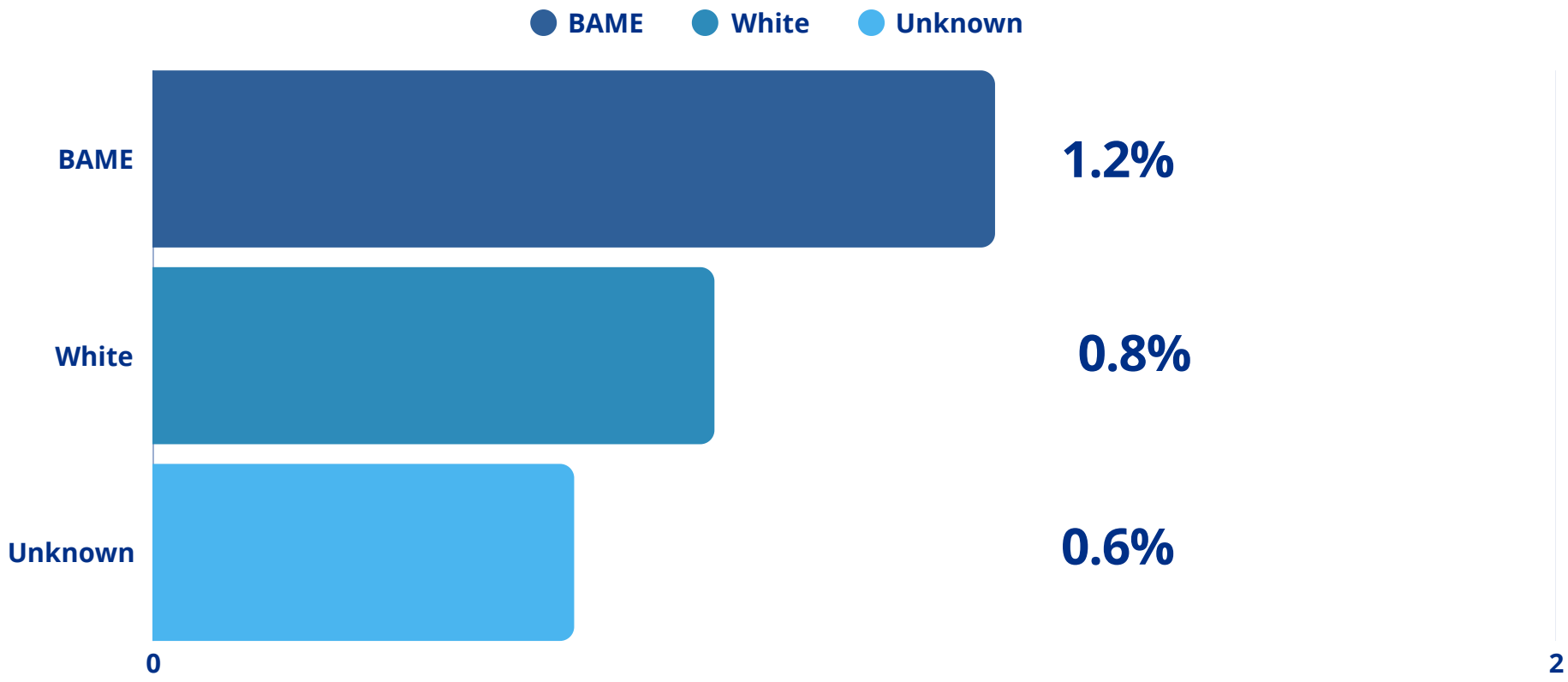
Figure 2: Appointment from Shortlisting for all staff groups



This indicator has a noticeable negative increase, with White staff being **2.77** times more likely to be appointed from a shortlist than BAME staff as opposed to 1.19 times last year, some of that may be due to the sheer number of BAME staff shortlisted which nearly doubled in the year. There were actually 33% more BAME staff appointed in the year.

WRES Indicator 3

Figure 3: Likelihood of Staff entering formal disciplinary procedure



The relative likelihood of BAME staff entering the formal disciplinary process compared to White staff is **1.49**. This is a steep regression on last year's numbers.

While these statistics remain relatively low within the overall workforce, they highlight a disparity; BAME staff are more likely to undergo the formal disciplinary process than white staff.

Note: The data includes informal processes through personal responsibility, meaning instances where no investigation occurred but a disciplinary sanction action was agreed upon.

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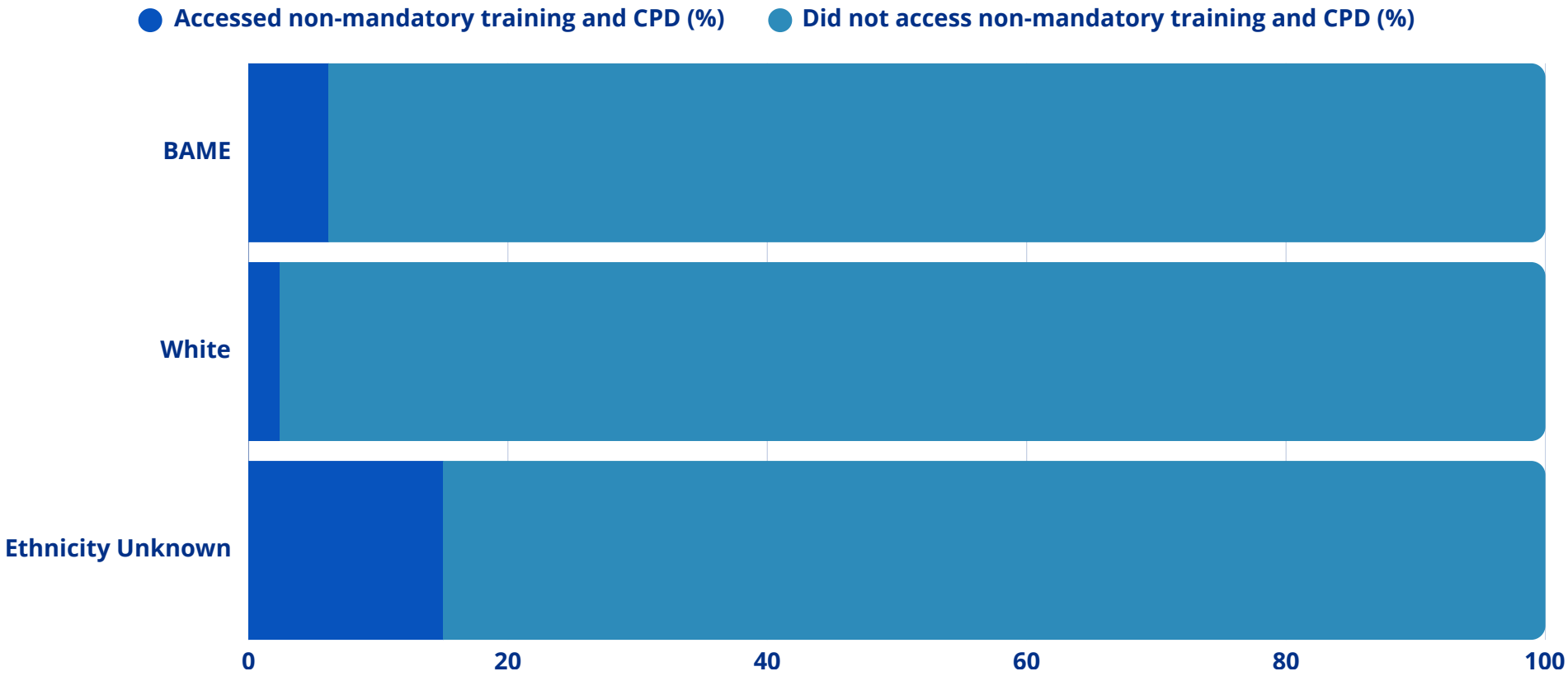
WRES Indicator 4

Figure 4: Likelihood of Staff accessing non-mandatory training and CPD



The relative likelihood of White Staff accessing non-mandatory training and CPD is **0.39** this is an improvement on last year's position however the Ethnicity unknown staff still have a higher access rate.
This metric is missing data as it does not illustrate all non-mandatory training/CPD as this isn't held centrally.

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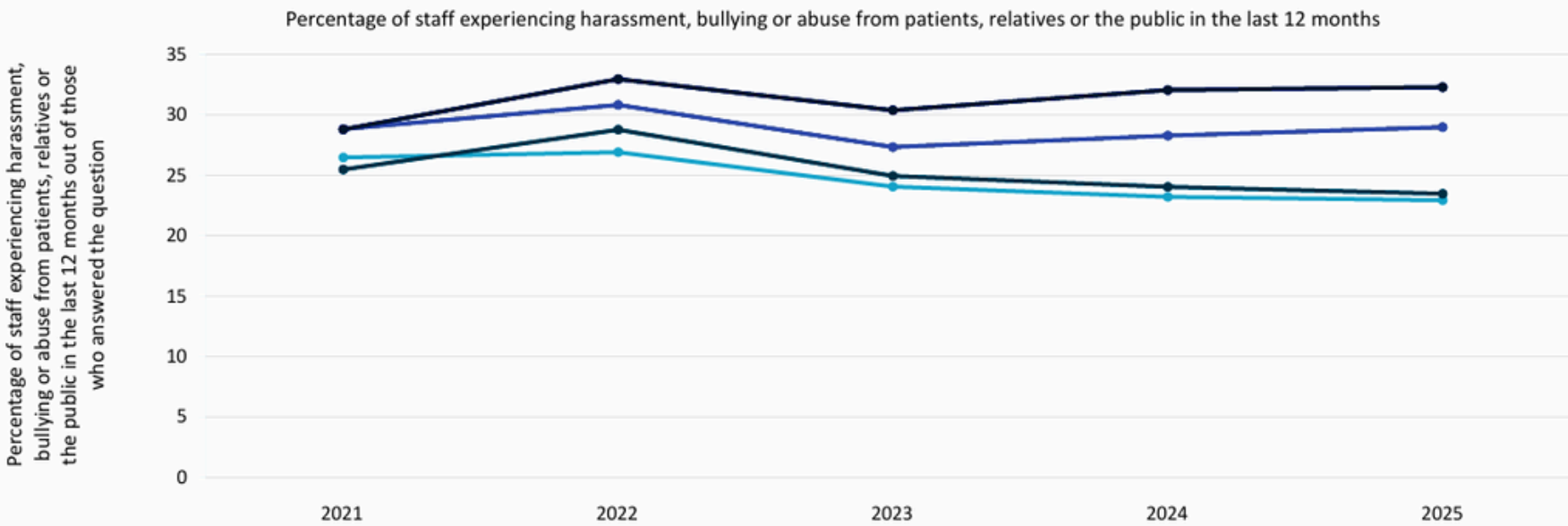
WRES Indicator 5

Figure 5 : Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



	2021	2022	2023	2024	2025
White staff: Your org	25.47%	28.77%	24.93%	24.04%	23.48%
All other ethnic groups*: Your org	28.79%	32.95%	30.37%	32.06%	32.29%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%

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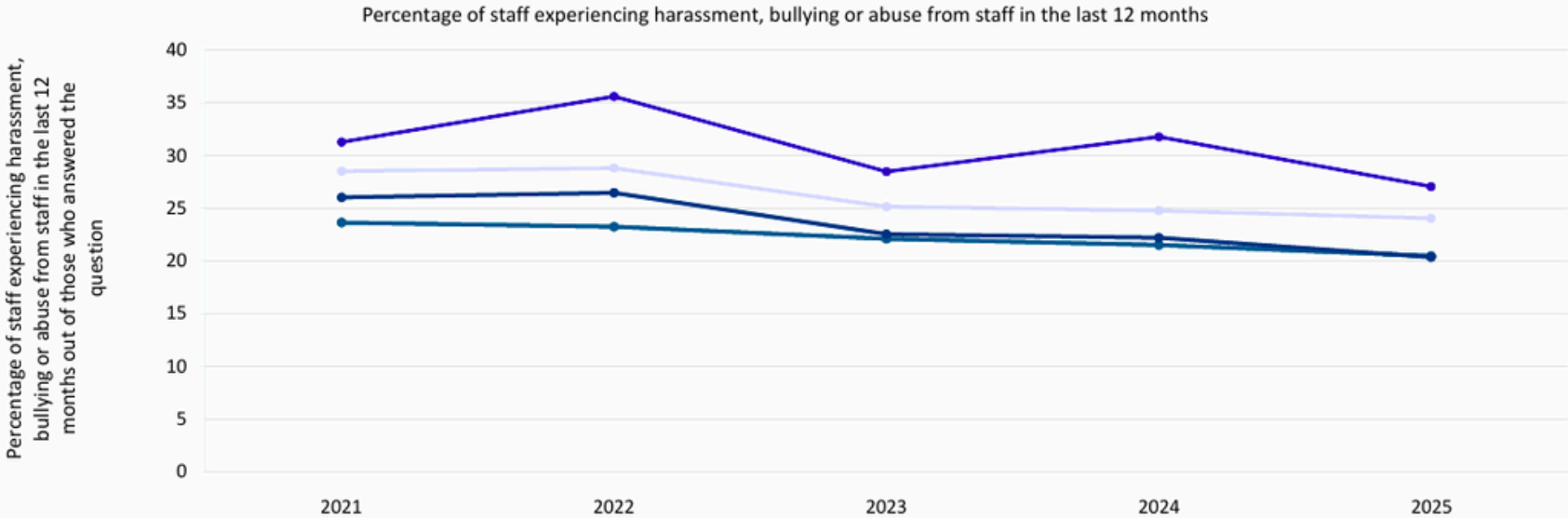
WRES Indicator 6

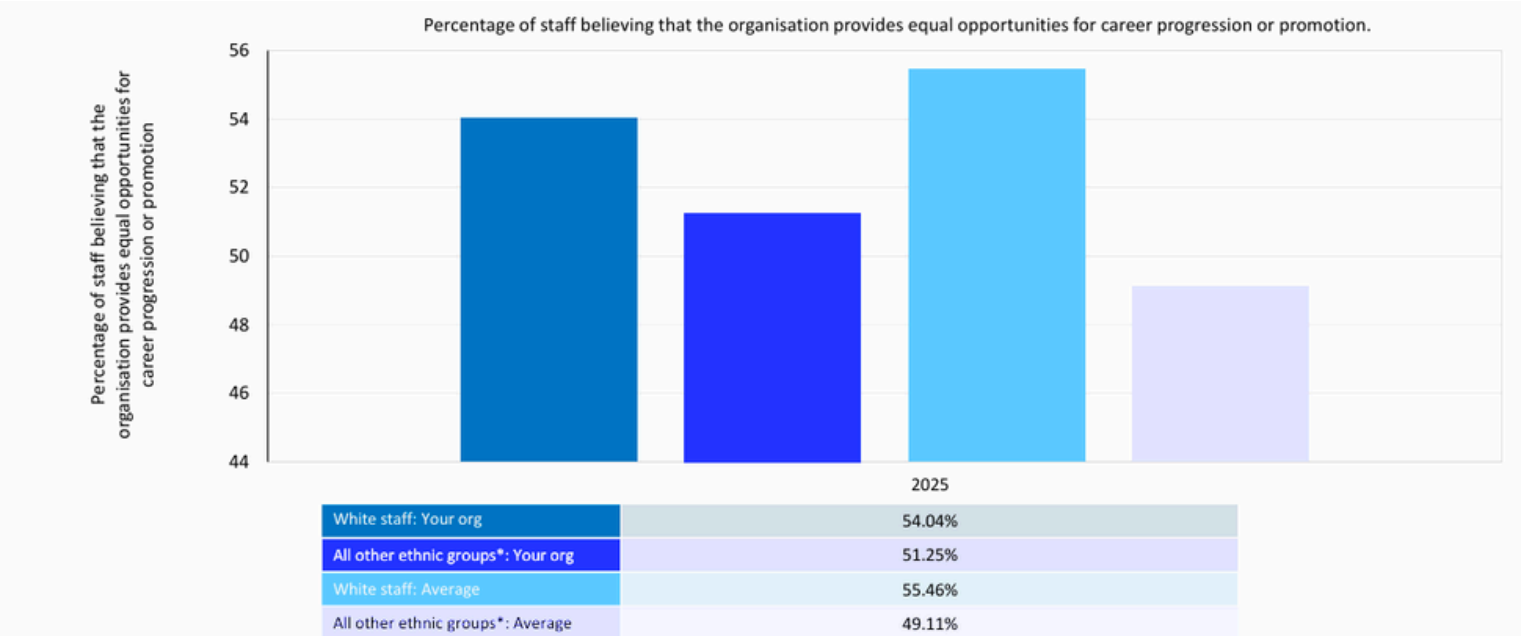
Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



	2021	2022	2023	2024	2025
White staff: Your org	26.04%	26.47%	22.55%	22.20%	20.37%
All other ethnic groups*: Your org	31.28%	35.61%	28.47%	31.78%	27.07%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%

WRES Indicator 7

Figure 7 : Percentage of staff believing that their trust provides equal opportunities for career progression or promotions

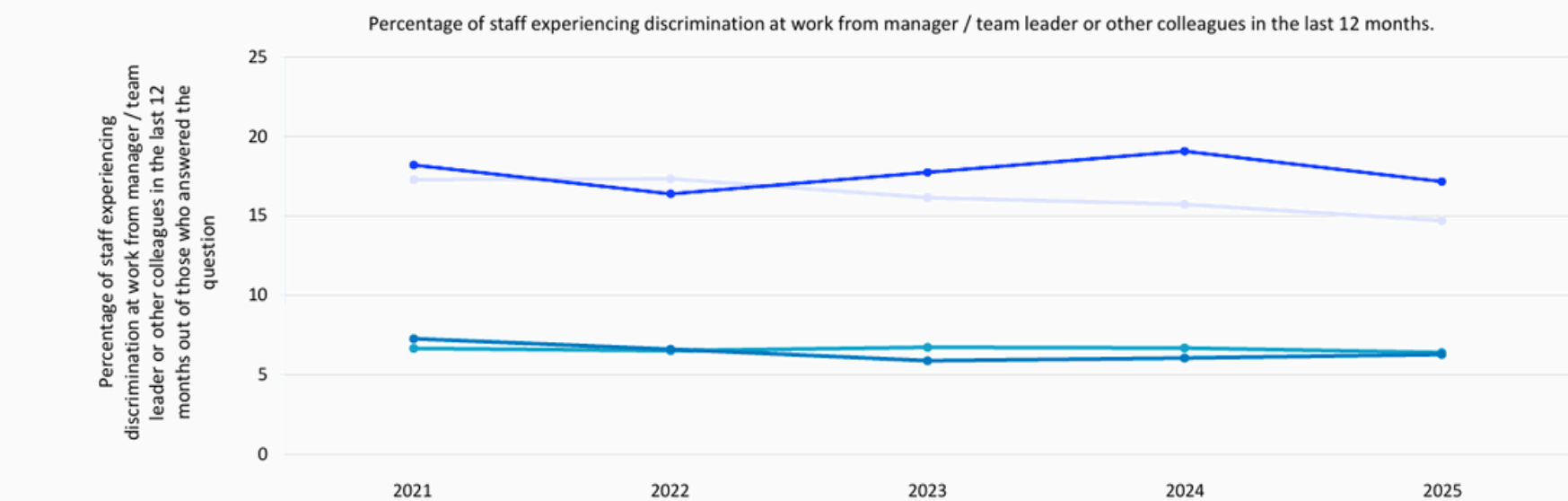


In 2025, 51.25% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion.

Note: Due to changes in the question wording in 2025, previous years' results for indicator 7 are not reported.

WRES Indicator 8

Figure 8 : Percentage of staff experiencing discrimination at work from other staff in the last 12 months



	2021	2022	2023	2024	2025
White staff: Your org	7.27%	6.61%	5.89%	6.05%	6.28%
All other ethnic groups*: Your org	18.20%	16.38%	17.74%	19.07%	17.15%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%

WRES Indicator 9

Figure 9: Total Board Composition

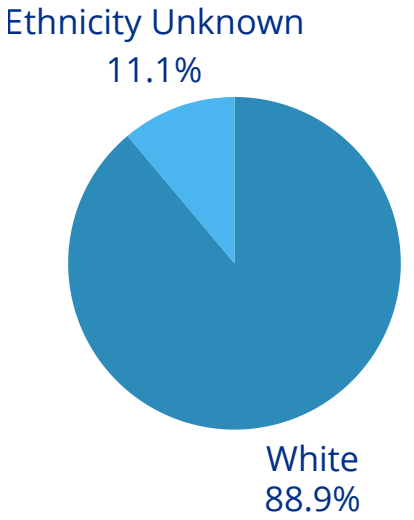


Figure 10: Voting Board Members

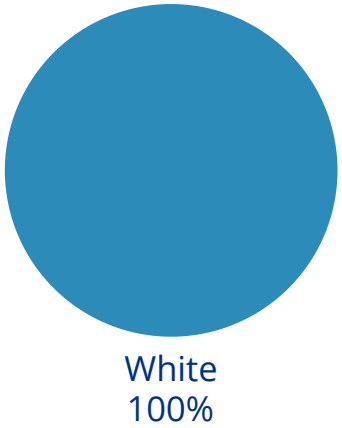
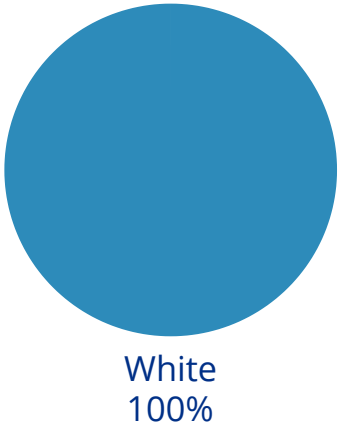


Figure 11: Non-Exec Board members



The BAME representation at board level has is nor reflective of the proportion of BAME staff we have in the organisation. Of the Voting Board members we are currently showing no BAME representation.

Huth is part of NHS Humber Health Partnership, operating under a Shared Group Board and Leadership team. Staff are employed by either Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust. In which case, figures will not be double- counted.

There has been a negative impact since last year's report - BAME representation at Board level witin HUTH is zero

Progress to date to Support BAME Staff

The advancements made in the past year to assist BAME staff within the workforce are outlined below.

1

Continue to embed the Zero Tolerance to Racism Framework

The continuation of the reporting tool has seen regular if not profuse reporting through the year and numerous interventions that have supported BAME staff. The presence of the tool in itself acts as a deterrent to racist behaviours but is not universally welcomed. So BAME staff are reporting less discrimination from colleagues and managers in the Staff Survey. The tool made a significant contribution to NLaG winning an HSJ Patient Safety award

2

Continued support for Internationally Educated Staff

We have monthly wellbeing meetings with our International Educated Staff and the focus of those meetings has shifted from experiencing discrimination to wanting to understand what they have to do in order to be able to progress their careers in the future. The a Stay and Thrive group continues to meet to drive the agenda. A group came together to unofficially organise a social event over the Xmas period for staff that might not otherwise have anybody to spend time with socially over that period.

3

Development of the BAME Staff Network

The BAME Staff Network's across the group are now both active and contributing to supporting staff both from a pastoral basis and to advocate for increased representation and providing a sense of community to staff.

4

Governance

An Equality, Diversity, and Inclusion Steering Group is now operating to inform the work priorities of the EDI team and the broader group of staff support the agenda across the organisation. This group is able to challenge and establish a cohesive workplan that will give the Trust Board assurance in terms of meeting our equality duties.

In addition the network Chair's represent their constituents in the Organisation to help them to have fully inclusive experiences at work The Group Executives now meet on a scheduled basis to help frame Organisation policies.

5

Education and Development

As a development to the EDI training across both sites the Practice learning team along with the EDI Team deliver Cultural Competency training sessions aligned to the NHSE Nursing Directorate National Course.

We have also facilitated NHSE to deliver the Step Up Programme across the organisation to cohorts of our internationally educated colleagues. The Embracing the Challenge of Inclusive Leadership training continues to be delivered across the organisation.

Action Plan

Although this year's national WRES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of BAME employees within the trust. To address this, an Action Plan has been created based on the 24/25 WRES technical data results, aimed at bridging the gap in workplace experiences between BAME and White staff. A comprehensive workplan accompanies the Action Plan.

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
1. Develop an abridged version of the Zero Tolerance to Racism Framework and Relaunch to get better awareness • Support the Trust to tackle all forms of racism • Support our BAME Staff *Prepare a shortened reference version of the Framework to make reporting easier *Create an environment where people aren't reluctant to report	Indicators 5, 6, 8 EDS 2022 2B	2026/27 Ongoing	EDI Team
2. Develop and Grow the BAME Staff Network • Run a Groupwide Network conference to showcase achievements of prominent BAME staff in the Organisation • Introduce the inaugural Dumbor Ngaage award to recognise the contribution of BAME individuals to the organisation	All EDS 2022 2B	February 2027/Ongoing	EDI Team

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
3. Support Internationally Educated Staff • Develop and implement Bridge programme to support children of our International staff who can't access University funding to engage with the education system via Apprenticeships *NHSE Step Up programme (Start to Elevate your Professional Career) for our Nursing & AHP colleagues to be run internally	Indicators 1, 2, 7 EDS 2022 2B, 2C	April 27/ Ongoing	EDI Team / Nursing
4. Introduce an Inclusive Recruitment Project & Toolkit Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	Indicator 2, 7 EDS 2022 2D	March 27/Ongoing	EDI Team/Recruitment

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
5. Ensure BAME staff are treated Equitably in HR Processes • Develop and implement an RCN type programme that trains BAME staff to be cultural inclusion ambassadors so that they can contribute to Recruitment panels and Disciplinary, Capability or Probation processes to ensure BAME staff are treated fairly	Indicators 1, 2, 3, 8 EDS 2022 2B, 2C	April 27/ Ongoing	EDI Team / Nursing
6. Introduce Patient Racism Standard Operating Procedure (SOP) *Pilot a new SOP on how to address the issues of Patients being racist towards our staff *Take through governance and get Board sign off *Identify the resource to take the responsibility to address issue with Patients *Launch across the group in a roll out aligned to the Ward accreditation process	Indicator 3, 5 EDS 2022 2D	Pilot Complete October 26/Launch January 27 then Ongoing	EDI Team/Recruitment

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
7. Work across Organisation to develop inclusivity to BAME staff *Develop a new programme that is personalised to our needs evolving the National NHSE Nursing Directorate course *Deliver Cultural Competency workshops to improve understanding of how to be inclusive *Highlight differences of experience and cultural gaps *Identify the resource to deliver this work plan *Launch across the group in a roll out aligned to the Ward accreditation process	Indicators 1, 2, 6, 8 EDS 2022 2B, 2C	September 26/ Ongoing	EDI Team / Nursing

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Your paragraph text

Appendix

Indicator 1a - Non-Clinical Workforce

	White	BME	Ethnicity Unknown/ Null
Under Band 1	6 *	0 *	0 *
Band 1	12 *	1 *	1 *
Band 2	947 *	102 *	18 *
Band 3	607 *	3 *	3 *
Band 4	259 *	14 *	1 *
Band 5	201 *	11 *	1 *
Band 6	126 *	8 *	1 *
Band 7	91 *	7 *	4 *
Band 8A	61 *	4 *	3 *
Band 8B	53 *	2 *	0 *
Band 8C	18 *	1 *	0 *
Band 8D	11 *	0 *	0 *
Band 9	4 *	0 *	0 *
VSM	20 *	0 *	2 *

Indicator 1b - Clinical Workforce

	White	BME	Ethnicity Unknown/
Under Band 1	40 *	0 *	0 *
Band 1	1 *	0 *	0 *
Band 2	290 *	19 *	4 *
Band 3	1077 *	162 *	16 *
Band 4	185 *	13 *	6 *
Band 5	1389 *	753 *	19 *
Band 6	959 *	188 *	11 *
Band 7	640 *	68 *	9 *
Band 8A	206 *	26 *	1 *
Band 8B	57 *	3 *	1 *
Band 8C	18 *	1 *	0 *
Band 8D	3 *	0 *	0 *
Band 9	2 *	0 *	0 *
VSM	17 *	0 *	0 *

Indicator 1 - Medical and Dental Consultants

	White	BME	Ethnicity Unknown/ Null
Medical & Dental Consultants	240 *	312 *	23 *
Of which Senior Medical Manager	0 *	0 *	0 *
Non-consultant career grade	17 *	40 *	3 *
Trainee Grades	276 *	482 *	171 *
Other	0 *	0 *	0 *

Number of staff in Workforce

White	BME	Ethnicity Unknown/ Null
7833	2220	298

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	White	BME	Ethnicity Unknown/ Null
Number of Shortlisted Applicants	4792 *	6919 *	0 *
Number Appointed from Shortlisting	1000 *	521 *	0 *
Relative likelihood of appointment from shortlisting	20.8 %	7.53 %	0 %
Relative likelihood of White staff being appointed from shortlisting compared to BME staff	2.77		

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data.

	White	BME	Ethnicity Unknown/ Null
Number of staff in workforce	7833	2220	298
Number of staff entering the formal disciplinary process	64 *	27 *	2 *
Likelihood of staff entering the formal disciplinary process	0.8 %	1.2 %	0.6 %
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		1.49	

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	White	BME	Ethnicity Unknown/ Null
Number of staff in workforce	7833	2220	298
Number of staff accessing non-mandatory training and CPD	189 *	139 *	47 *
Likelihood of staff accessing non-mandatory training and CPD	2.4 %	6.2 %	15. %
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.39		

This is only the non-mandatory that is held centrally and does not include all non-mandatory/CPD undertaken.

Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

	White	BME	Ethnicity Unknown/ Null
Total Board members	8 *	0 *	1 *
of which: Voting Board members	5 *	0 *	0 *
Non-voting Board members	3	0	1
Exec Board members	6 *	0 *	1 *
Non-exec Board members	2	0	0
Number of staff in workforce	7833	2220	298

Workforce Race Equality Standards 25/26

NHS Humber Health Partnership
Northern Lincolnshire and Goole NHS Foundation Trust

NHS
Humber Health
Partnership

Workforce Intelligence
Equality Diversity and Inclusion
nlg-tr.twworkforcedatareqs@nhs.net
nlg-tr.equalitydiversityandinclusion@nhs.net

Introduction

The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).

The WRES seeks to prompt enquiry to better understand why BAME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.

In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BAME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BAME staff in the NHS.

The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator. The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BAME representation.

The Trust's WRES submission, including a detailed breakdown of staffing numbers, can be found in the appendix of this report.

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16 Progress to date to Support BAME Staff

17 Action Plan

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Key Findings

The increase in BAME representation in-year is largely due to an increase in BAME staff within the non clinical workforce

The composition of Medical and Dental Workforce that is BAME stands at 71.7%

White staff are more than twice as likely to be appointed once they have reached the shortlisting stage compared to BAME staff

BAME staff are 2 times more likely to enter a formal disciplinary process compared to white staff. This likelihood has deteriorated in-year

The Trust Board BAME representation has decreased in-year from 14.3% to zero

The percentage of BAME Staff in Bands 8-9 and VSM is 6.9%, a decrease in representation since last year

In the last 12 months, BAME staff report a 8.2% higher negative experience than white colleagues in relation to harassment, bullying or abuse from patients, relatives or the public

White and BAME staff have equal opportunities to engage in non-mandatory training and CPD

The percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months is 28.3%, an impovement from 2024

The percentage of BAME Staff in the overall workforce remains at 18.4%. The same percentage as in 2025

46.3% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion

The composition of Non Clinical Staff that are BAME stands at 3.3%

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	WRES 25/26 Performance Comparison and Summary	24/25	25/26
1	Percentage of BAME staff in NHS trust by ethnicity	18.4%	18.4%
2	The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	2.04	2.08
3	The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.83	1.46
4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff	1	1.01
5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	34.1%	30%
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	31.2%	28.3%
7	Percentage of BAME staff believing that their trust provides equal opportunities for career progression or promotion	46.3%	46.3%
8	Percentage of BAME staff experiencing discrimination at work from other staff in the last 12 months	21.8%	15.9%
9	Percentage difference between Board Membership and overall workforce	-4%	-18.4%

WRES Indicator 1

Table 1: Ethnic Composition of NLAG Staff

	Composition of Workforce	Compostion of Clinical Staff	Composition of Non-Clinical Staff	Composition of Medical and Dental Staff
BAME	18.4%	24.5%	3.3%	71.7%
White	78.8%	72.4%	94.7%	19.9%
Not Stated	2.8%	3.1%	1.9%	8.4%

As shown above, BAME staff are more prevelant in the clinical and medical workforce. In contrast, the non-clinical workforce—which includes roles such as estates, administration, domestic staff, and management—exhibits a lower representation of BAME individuals.

Moreover, the percentage of staff who have not disclosed their ethnicity is 2.8% of the total workforce, which is slightly higher compared to the previous year. A third of these 'unknown' ethnicity are among medical and dental staff where 8.4% of the medical and dental workforce have not declared their ethnicity.

The overall percentage of ethnic minority staff within the NHS as a whole, increased to 28.6% in 2024, rising from 17.7% in 2016 (NHS Providers 2024). NLAG falls below the national average for BAME representation. It is essential to acknowledge that this varies across different regions and reflects the diversity within local populations.

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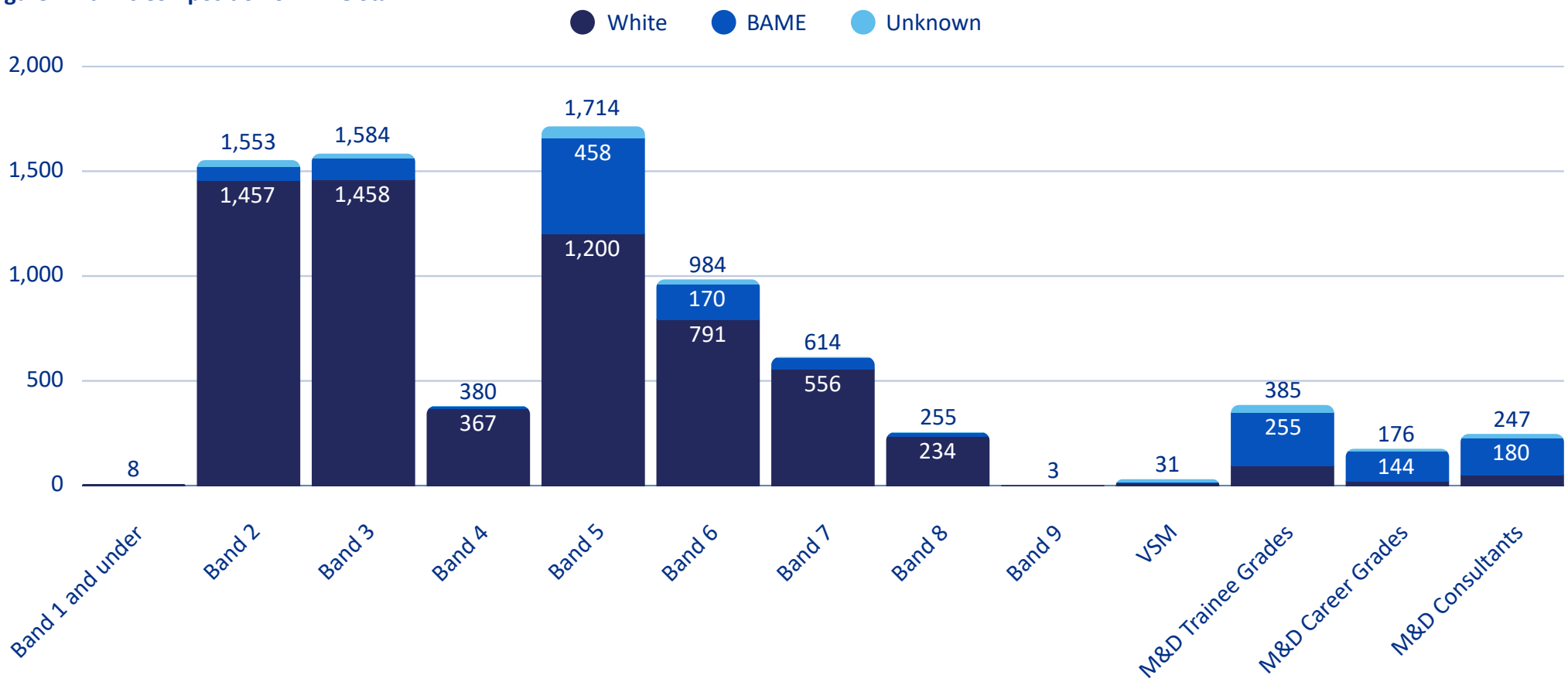
WRES Indicator 1

Figure 1: Ethnic Composition of NLAG Staff



The bar chart illustrates the distribution of individuals identified as white, BAME, and those with an unknown ethnicity, categorised by band. BAME representation is lowest within Bands 2-3 and again at Band 8 and above. When considered by Agenda for Change (AfC), band 5 continues to see the highest percentage of staff from an ethnic minority, which is similar across all trusts (NHS Providers, 2024).

The percentage of BAME Staff in Bands 8-9 and VSM is 8.6%, an improvement on last year. Although, there is a lower percentage of BAME staff in Bands 8-9 and VSM compared to BAME representation within the overall workforce (18.4%). Following NHS England's recommendations, medical and dental grades (including trainee grades) are excluded from the Bands 8-9 and VSM figures, as these categories typically have a much higher proportion of BAME staff.

Across clinical and non-clinical staff bands, white staff make up the majority at all levels, particularly in higher bands and leadership roles, though there is representation of BAME staff across most bands.

**VSM (Very Senior Managers - this payscale is a non-AFC payscale for the most senior management staff and executive team)*

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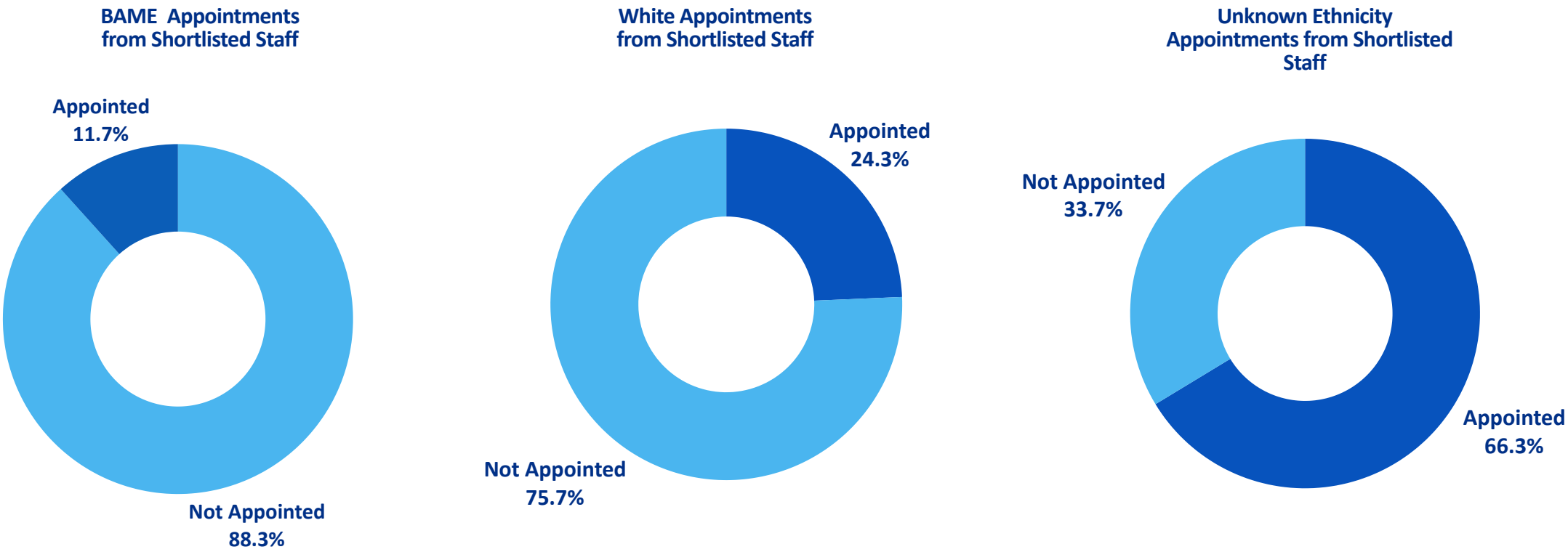
WRES Indicator 2

Figure 2: Appointment from Shortlisting for all staff groups



The charts above illustrates the likelihood of staff being appointed from shortlisting, categorised by ethnicity. BAME staff have a 11.7% chance of being appointed at the shortlisting stage, whereas White staff have an 24.3% likelihood of being shortlisted. Additionally, candidates with unknown ethnicity have a 66.3% chance of appointment, indicating a need for more transparent demographic data collection during the early recruitment stages, particularly with medical and dental recruits.

The relative likelihood of White staff being appointed from shortlisting, compared to BAME staff, is 2.08. This indicates that White staff are twice as likely to be appointed once they reach the shortlisting stage when compared to their BAME counterparts, a very marginal increase since last year.

At NLAG, there has been a noticeable increase in overseas applications—driven by visa rule changes, AFC pay uplifts and increased use of AI-supported applications—which have significantly expanded the pool of BAME applicants entering NHS recruitment pipelines. With application volumes rising faster than available posts, a larger proportion of BAME candidates appear at the application stages.

The national relative likelihood has remained broadly unchanged since the inception of the WRES in 2016, meaning that this metric is proving the most difficult to improve on across the whole of the NHS (NHS Providers, 2024).

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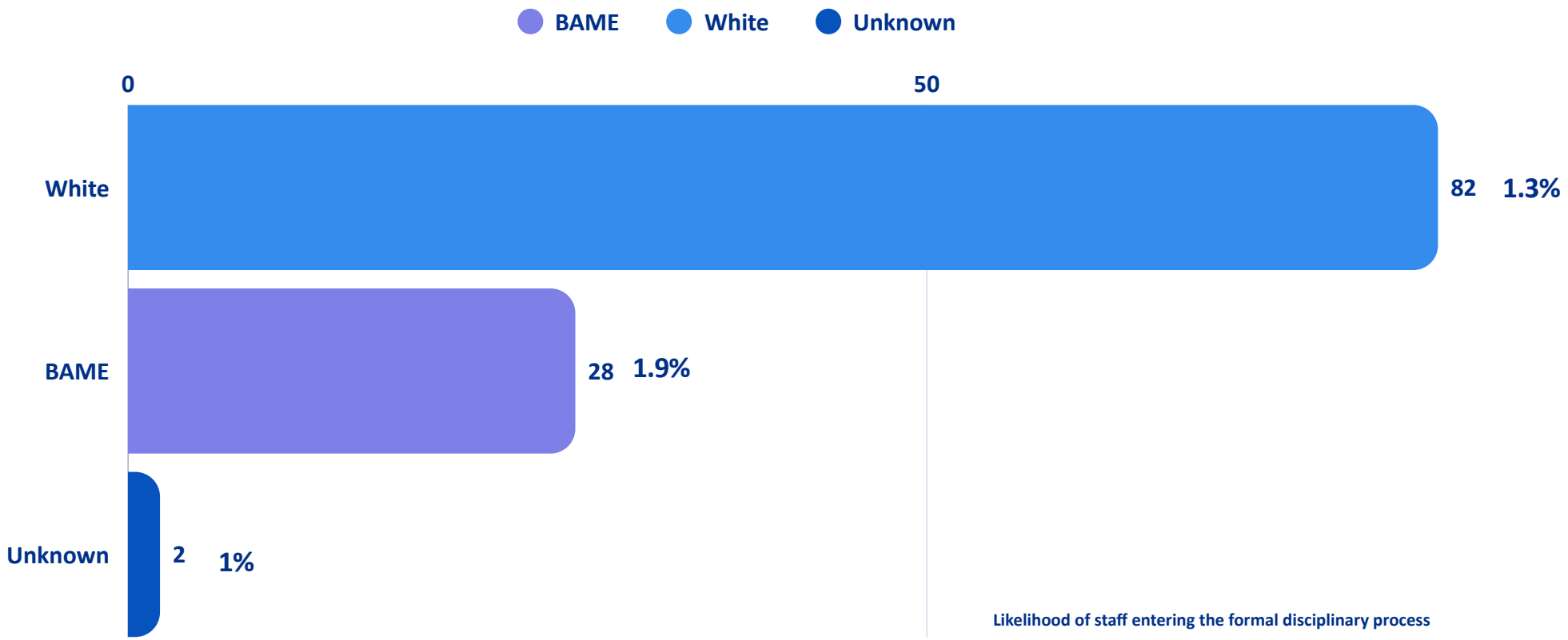
WRES Indicator 3

Figure 3: Likelihood of Staff entering formal disciplinary procedure



The bar chart above depicts the likelihood of BAME staff entering a formal disciplinary process compared to their white counterparts. Currently, BAME staff are 1.46 times more likely to face such a process, which shows a positive change from last year's figure of 1.83.

While these statistics remain relatively low within the overall workforce, they highlight an existing disparity; BAME staff are more likely to undergo the formal disciplinary process than white staff.

Note: The data includes informal processes through personal responsibility, meaning instances where no investigation occurred but a disciplinary sanction was taken.

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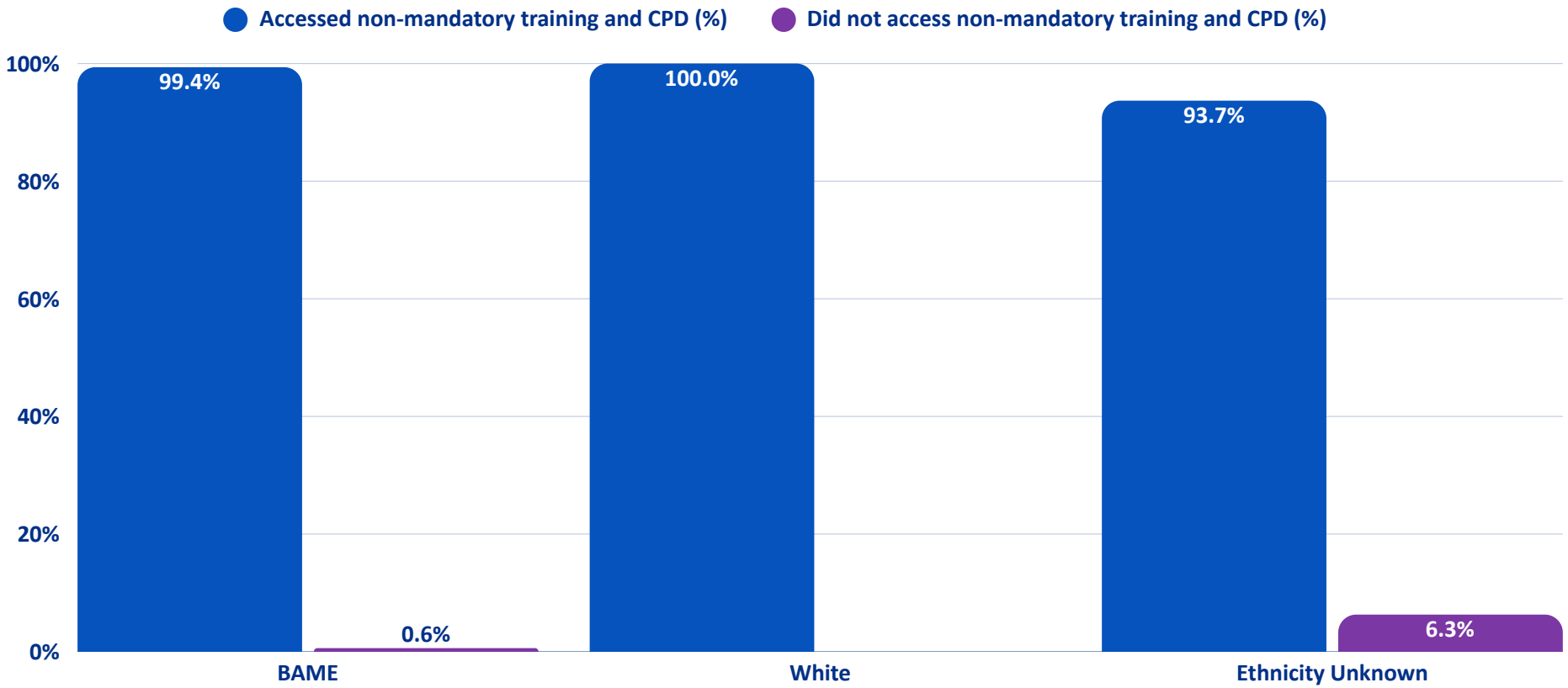
WRES Indicator 4

Figure 4: Likelihood of Staff accessing non-mandatory training and CPD



The probability of White staff participating in non-mandatory training and continuing professional development (CPD) remains at 1.01, mirroring last year's results. This suggests that both white and BAME staff have equal opportunities to engage in non-mandatory training and pursue additional professional development. Consequently, the probability is the same, signifying that accessibility for all staff, irrespective of race, is equal.

The relative likelihood for White staff accessing training is 1.01, indicating near parity.

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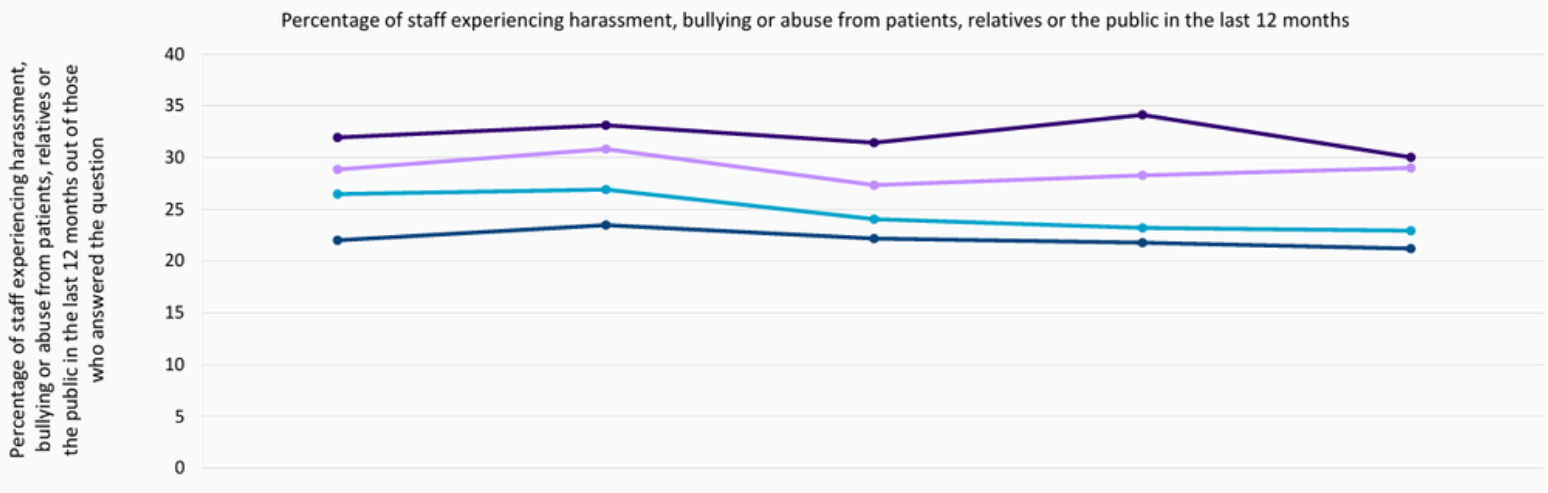
WRES Indicator 5

Figure 5 : Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

The WRES indicators 5, 6, 7, and 8 reflect unweighted responses to essential findings from the NHS staff survey conducted among the staff of the Northern Lincolnshire and Goole NHS Foundation Trust. Additionally, it provides average scores for acute Trusts for comparison purposes.



	2021	2022	2023	2024	2025
White staff: Your org	22.01%	23.47%	22.18%	21.78%	21.20%
All other ethnic groups*: Your org	31.94%	33.12%	31.43%	34.12%	30.02%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%
White staff: Responses	2131	2024	2718	2668	2769
All other ethnic groups*: Responses	216	311	400	510	463

BAME staff report 8.8% higher negative experience than their white colleagues, an improvement from 2024. This is below the average acute Trust score for the BAME staff, emphasising greater steps in creating an inclusive and supportive environment for all employees.

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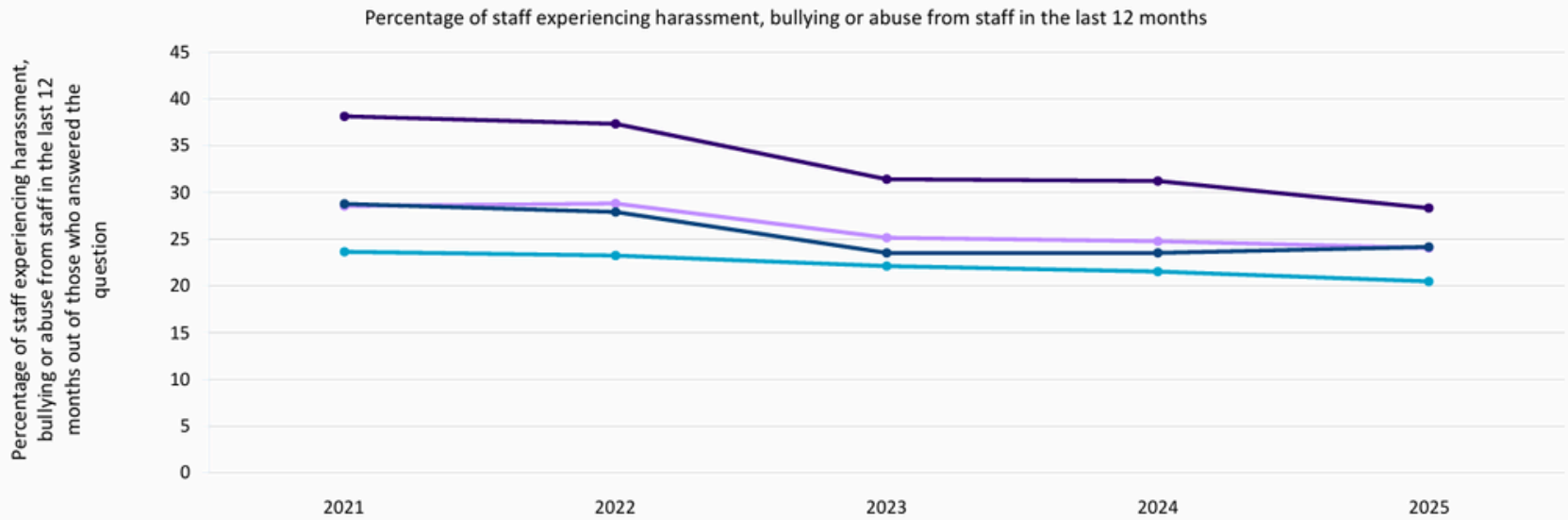
WRES Indicator 6

Figure 6 : Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



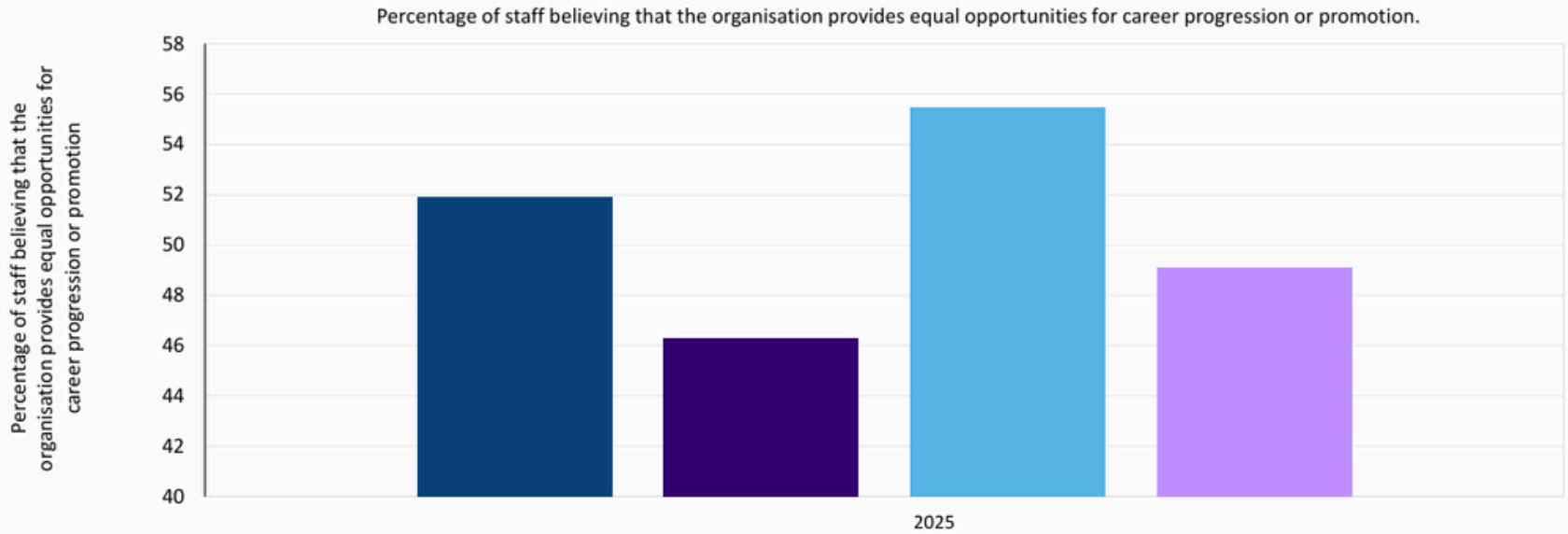
	2021	2022	2023	2024	2025
White staff: Your org	28.77%	27.92%	23.54%	23.53%	24.18%
All other ethnic groups*: Your org	38.14%	37.34%	31.40%	31.23%	28.32%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	2127	2024	2709	2652	2759
All other ethnic groups*: Responses	215	308	394	506	459

*Staff from all other ethnic groups combined

There has been a decline in the number of BAME staff facing harassment, bullying, or abuse from colleagues, however, BAME staff still continue to be more likely to experience harassment, bullying or abuse from colleagues, but with a much reduced gap of 4.14% between white and BAME employees compared to 7.7% the year previously. This figure is above the national average for BAME staff.

WRES Indicator 7

Figure 7 : Percentage of staff believing that their trust provides equal opportunities for career progression or promotions



White staff: Your org	51.90%
All other ethnic groups*: Your org	46.29%
White staff: Average	55.46%
All other ethnic groups*: Average	49.11%
White staff: Responses	2742
All other ethnic groups*: Responses	458

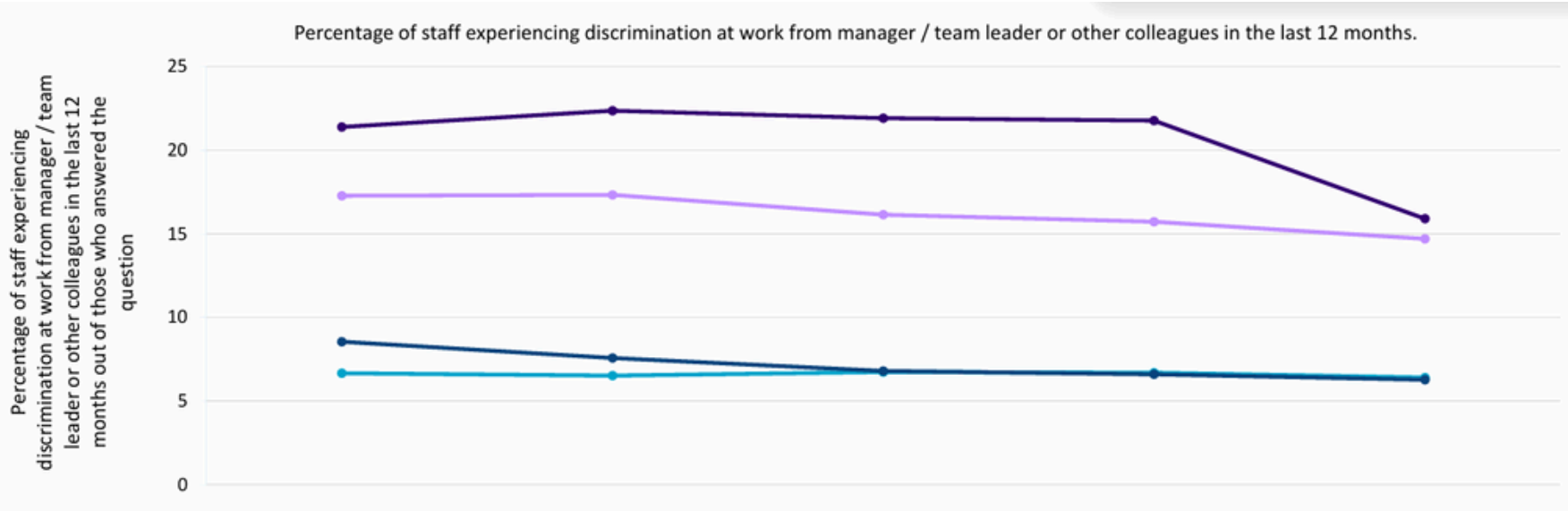
*Staff from all other ethnic groups combined.

In 2025, 46.29% of BAME staff believed that the organisation offers equal opportunities for career advancement or promotion.

Note: Due to changes in the question wording in 2025, previous years' results for indicator 7 are not reported.

WRES Indicator 8

Figure 8 : Percentage of staff experiencing discrimination at work from manager/team leader in the last 12 months



	2021	2022	2023	2024	2025
White staff: Your org	8.55%	7.57%	6.79%	6.60%	6.27%
All other ethnic groups*: Your org	21.40%	22.37%	21.93%	21.78%	15.90%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	2176	2022	2944	2635	2743
All other ethnic groups*: Responses	215	304	488	505	459

*Staff from all other ethnic groups combined

In 2025, 15.90% of BAME employees reported experiencing discrimination at work from their manager, team leader, or colleagues. Whilst this figure is above the national average reported for BAME staff. It is a notable improvement in this metric over the year down by 5.88% which is over a quarter better than the previous year.

WRES Indicator 9

Figure 9: Total Board Composition

100%

Figure 10: Voting Board Members

White
100%

Figure 11: Non-Exec Board members

White
100%

Northern Lincolnshire and Goole NHS Foundation Trust is part of the NHS Humber Health Partnership, functioning under a Shared Group Board and Leadership team. Staff members are employed by either the Northern Lincolnshire and Goole NHS Foundation Trust or Hull University Teaching Hospitals NHS Trust, ensuring that figures are not double-counted.

There has been a negative impact since last year's report - BAME representation at the Trust is zero. The BAME representation on the Trust Board at NLAG has decreased from 14.3% in 2024 to 0% in 2025. Despite the Shared Group Board, there is zero BAME representation at a Group level. The BAME representation at Board level is not reflective of the proportion of BAME staff within the organisation. The Board is reported to be 100% White, in contrast to a workforce that is 78.8% White and 18.4% BAME.

Of the Voting Board members we are currently showing no BAME representation.

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Progress to date to Support BAME Staff

The advancements made in the past year to assist BAME staff within the workforce are outlined below.

1

Continue to embed the Zero Tolerance to Racism Framework

The continuation of the reporting tool has seen regular if not profuse reporting through the year and numerous interventions that have supported BAME staff. The presence of the tool in itself acts as a deterrent to racist behaviours but is not universally welcomed. So BAME staff are reporting less discrimination from colleagues and managers in the Staff Survey. The tool made a significant contribution to NLaG winning an HSJ Patient Safety award

2

Continued support for Internationally Educated Staff

We have monthly wellbeing meetings with our International Educated Staff and the focus of those meetings has shifted from experiencing discrimination to wanting to understand what they have to do in order to be able to progress their careers in the future. The a Stay and Thrive group continues to meet to drive the agenda. A group came together to unofficially organise a social event over the Xmas period for staff that might not otherwise have anybody to spend time with socially over that period.

3

Development of the BAME Staff Network

The BAME Staff Network's across the group are now both active and contributing to supporting staff both from a pastoral basis and to advocate for increased representation and providing a sense of community to staff.

4

Governance

An Equality, Diversity, and Inclusion Steering Group is now operating to inform the work priorities of the EDI team and the broader group of staff support the agenda across the organisation. This group is able to challenge and establish a cohesive workplan that will give the Trust Board assurance in terms of meeting our equality duties.

In addition the network Chair's represent their constituents in the Organisation to help them to have fully inclusive experiences at work The Group Executives now meet on a scheduled basis to help frame Organisation policies.

5

Education and Development

As a development to the EDI training across both sites the Practice learning team along with the EDI Team deliver Cultural Competency training sessions aligned to the NHSE Nursing Directorate National Course.

We have also facilitated NHSE to deliver the Step Up Programme across the organisation to cohorts of our internationally educated colleagues. The Embracing the Challenge of Inclusive Leadership training continues to be delivered across the organisation.

Action Plan

Although this year's national WRES reports indicate positive progress in some areas, it is clear that considerable effort is still required to improve the experiences of BAME employees within the trust. To address this, an Action Plan has been created based on the 24/25 WRES technical data results, aimed at bridging the gap in workplace experiences between BAME and White staff. A comprehensive workplan accompanies the Action Plan.

Action	WRES Indicator	Delivery Timescale	Lead Responsibility
1. Develop an abridged version of the Zero Tolerance to Racism Framework and Relaunch to get better awareness • Support the Trust to tackle all forms of racism • Support our BAME Staff *Prepare a shortened reference version of the Framework to make reporting easier *Create an environment where people aren't reluctant to report	Indicators 5, 6, 8 EDS 2022 2B	2026/27 Ongoing	EDI Team
2. Develop and Grow the BAME Staff Network • Run a Groupwide Network conference to showcase achievements of prominent BAME staff in the Organisation • Introduce the inaugural Dumbor Ngaage award to recognise the contribution of BAME individuals to the organisation	All EDS 2022 2B	February 2027/Ongoing	EDI Team

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
3. Support Internationally Educated Staff • Develop and implement Bridge programme to support children of our International staff who can't access University funding to engage with the education system via Apprenticeships *NHSE Step Up programme (Start to Elevate your Professional Career) for our Nursing & AHP colleagues to be run internally	Indicators 1, 2, 7 EDS 2022 2B, 2C	April 27/ Ongoing	EDI Team / Nursing
4. Introduce an Inclusive Recruitment Project & Toolkit Stage One Data Analysis: a. Data Analysis Importance: Group discussed the importance of analysing recruitment data, including both successful and unsuccessful candidates, to understand trends and disparities. b. Disaggregation by Characteristics: They emphasised the need to disaggregate data by protected characteristics to identify and address any systemic inequities in the recruitment process. c. Promotion Analysis: Highlighted the significance of understanding promotion to higher bandings, expressing interest in seeing data on promotion rates and potential disparities.	Indicator 2, 7 EDS 2022 2D	March 27/Ongoing	EDI Team/Recruitment

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
5. Ensure BAME staff are treated Equitably in HR Processes • Develop and implement an RCN type programme that trains BAME staff to be cultural inclusion ambassadors so that they can contribute to Recruitment panels and Disciplinary, Capability or Probation processes to ensure BAME staff are treated fairly	Indicators 1, 2, 3, 8 EDS 2022 2B, 2C	April 27/ Ongoing	EDI Team / Nursing
6. Introduce Patient Racism Standard Operating Procedure (SOP) *Pilot a new SOP on how to address the issues of Patients being racist towards our staff *Take through governance and get Board sign off *Identify the resource to take the responsibility to address issue with Patients *Launch across the group in a roll out aligned to the Ward accreditation process	Indicator 3, 5 EDS 2022 2D	Pilot Complete October 26/Launch January 27 then Ongoing	EDI Team/Recruitment

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Action	WRES Indicator	Delivery Timescale	Lead Responsibility
7. Work across Organisation to develop inclusivity to BAME staff *Develop a new programme that is personalised to our needs evolving the National NHSE Nursing Directorate course *Deliver Cultural Competency workshops to improve understanding of how to be inclusive *Highlight differences of experience and cultural gaps *Identify the resource to deliver this work plan *Launch across the group in a roll out aligned to the Ward accreditation process	Indicators 1, 2, 6, 8 EDS 2022 2B, 2C	September 26/ Ongoing	EDI Team / Nursing

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Appendix

Collection name: **Workforce Race Equality Standard (WRES) Data Collection**

For: **Northern Lincolnshire and Goole NHS Foundation Trust (RJL)**, FY2025/26

Submitted: **Fri, May 22, 2026, 10:25 AM** by **Marie Hill (marie.hill12@nhs.net)**

Status: **Draft**

Welcome to the WRES 2026 Data collection

Please exclude all NHS held bank worker data from your submission. Bank workers are defined as workers who in your organisation work solely on a zero hour/'bank only' contract.

Thank you for completing this data submission.

Further Information

- Guidance on how to complete the submission can be found in the Guidance (Link:) and Additional Information (Link:) documents.
- Answers to common questions about the Data Collection Framework (DCF) system that is used to collect your data can be found in the DCF submitting data support guide (Link:).
- If you have a query about the data definitions used by the collection, or a business or policy query, not answered by the links above please contact us by emailing: england.mandatedstandards@nhs.net (Link:).
- For all other queries including technical queries, adding or removing users, problems logging in and password resets, please contact us by creating a ticket at the National Service Desk NHS customer portal (Link:).

Indicator 1a - Non-Clinical Workforce

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Under Band 1				1	0	0
Band 1				1	0	0
Band 2				1108	33	23
Band 3				439	15	6
Band 4				185	7	1
Band 5				159	6	4
Band 6				78	11	1
Band 7				79	2	0
Band 8A				34	0	0
Band 8B				30	2	0
Band 8C				19	0	1
Band 8D				10	0	0
Band 9				1	0	0

Indicator 1b - Clinical Workforce

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Under Band 1				5	0	0
Band 1				1	0	0
Band 2				349	31	9
Band 3				1019	89	16
Band 4				182	5	0
Band 5				1041	452	52
Band 6				713	159	22
Band 7				477	53	3
Band 8A				106	13	1
Band 8B				19	4	0
Band 8C				12	0	0
Band 8D				4	0	0
Band 9				2	0	0
VSM				5	1	7

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Indicator 1 - Medical and Dental Consultants

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Medical & Dental Consultants				49	180	18
Of which Senior Medical Manager				2	2	2
Non-consultant career grade				19	144	13
Trainee Grades				93	255	37
Other				0	0	0

Number of staff in Workforce

Last Year			This Year		
White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
			6250	1462	222

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts.

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Number of Shortlisted Applicants				3531	2185	481
Number Appointed from Shortlisting				859	255	319
Relative likelihood of appointment from shortlisting	%	%	%	24.33 %	11.67 %	66.32 %
Relative likelihood of White staff being appointed from shortlisting compared to BME staff				2.08		

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note: This indicator will be based on year-end data.

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Number of staff in workforce				6250	1462	222
Number of staff entering the formal disciplinary process				82	28	2
Likelihood of staff entering the formal disciplinary process	%	%	%	1.31 %	1.92 %	0.9 %
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff					1.46	

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Number of staff in workforce				6250	1462	222
Number of staff accessing non-mandatory training and CPD				6250	1453	208
Likelihood of staff accessing non-mandatory training and CPD	%	%	%	100 %	99.38 %	93.69 %
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff				1.01		

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Indicator 9 - Percentage difference between the organisations' Board voting membership and its overall workforce.

	Last Year			This Year		
	White	BME	Ethnicity Unknown/ Null	White	BME	Ethnicity Unknown/ Null
Total Board members				3 *	0 *	0 *
of which: Voting Board members				3 *	0 *	0 *
Non-voting Board members				0	0	0
Exec Board members				1 *	0 *	0 *
Non-exec Board members				2	0	0
Number of staff in workforce				6250	1462	222
Total Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %
Voting Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %
Non-voting Board Members - % by Ethnicity	%	%	%	0 %	0 %	0 %
Executive Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %
Non-executive Board Members - % by Ethnicity	%	%	%	100 %	0 %	0 %
Overall Workforce - % by Ethnicity	%	%	%	78.8 %	18.4 %	2.8 %
Difference (Total board - Overall workforce)	%	%	%	21.2 %	-18.4 %	-2.8 %

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)248

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	9th October 2026
Director Lead	Lucy Vere, Group Director of Learning and Organisational Development
Contact Officer / Author	Lucy Vere, Group Director of Learning and Organisational Development
Title of Report	**Equality, Diversity and Inclusion (Staff) Programme Update: EDS22, Equality Objectives, and EDI Action Plan**
Executive Summary	**ALERT** The Boards are alerted to the requirement for each Trust to review and reset its equality objectives under the Public Sector Equality Duty. The objectives will need to be based on relevant evidence, engagement and measurable outcomes and approved through the appropriate governance arrangements. The transition towards separate organisational arrangements affects the timing and formal approval route for the refreshed Zero Tolerance Frameworks. Executive agreement and subsequent endorsement by the relevant individual Trust Boards will be required. **ADVISE** The Boards are advised that progress is being made against the EDS 2022 actions and that a consolidated EDI action plan has been developed through the EDI Steering Group, staff networks and wider stakeholder engagement. The action plan brings work together under eight themes. Stakeholder prioritisation has identified culture and belonging, engagement and staff networks, and training and capability as the leading priorities. A methodology is being developed for the next equality objectives. This will use existing evidence where appropriate, align workforce priorities where supported by the evidence and develop locally relevant patient and health inequality objectives for each Trust. The Zero Tolerance Frameworks will be refreshed through executive engagement before being presented to the relevant Trust Boards for formal re-endorsement. **ASSURE** The Boards are assured that EDI work is being brought together into a more coherent programme with clearer themes, ownership, actions and milestones. The programme incorporates EDS 2022, statutory equality responsibilities, workforce equality standards, workforce and patient experience, staff voice, inclusive leadership and organisational culture. Work will continue to be developed collaboratively during the organisational transition where this is beneficial. Formal decisions and approval will follow the relevant governance arrangements of each Trust.

Background Information and/or Supporting Document(s) (if applicable)	Connected to WRES and WDES reports for both organisations (presented at this board) EDS22 Action Plans (Attached) HHP EDI Action Plan (Attached) EDI action plan stakeholder engagement
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	This paper represents our approach to EDI as a Group. Please refer to the executive summary.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

V2

HUTH and NLaG EDS 2022 Action Plan

October 2026 | Updated progress position

Status key: Complete In progress Requires review

Domain	Outcome	Objective	Actions	Progress / evidence	Completion date
Domain 2: Workforce health and well-being	**2A: Staff are supported to manage obesity, diabetes, asthma, COPD and mental health conditions.**	Identify the support required for each condition and assess the capacity needed to provide it.	• Complete a capacity and demand exercise for each condition. • Review mental health support and benchmark against occupational health activity; complete a gap analysis. • Review collection of protected-characteristic data within psychological services. • Incorporate the Health and Wellbeing Strategy, PNA use, ICU support, safeguarding and restorative clinical supervision. • Use the Health and Wellbeing MDT to prioritise interventions and resources. • Promote agreed interventions and roll out the Health and Wellbeing Framework, including health-coaching training.	**Requires review. Current provision includes the Health and Wellbeing Ambassador Network, established social and sports groups, 20 trained Mental Health First Aiders with delivery continuing, the CIC Employee Assistance Programme, the Sexual Safety Charter and Sexual Safety Circle Group. TRiM is embedded on North Bank and available on South Bank, although not yet fully embedded there. The wider capacity-and-demand and gap-analysis actions have not been confirmed as agreed or deliverable within existing Health and Wellbeing and Occupational Health resources. Action scope, ownership and resource requirements therefore need to be reviewed before a revised delivery date is set.**	Original target: March 2026 Revised date: to be agreed
Domain 2: Workforce health and well-being	**2B: Staff are free from abuse, harassment, bullying and physical violence from any source.**	Reduce staff-reported abuse, harassment, bullying and physical violence in the NHS Staff Survey.	• Review and embed zero-tolerance frameworks and reporting tools, including race, disability, LGBTQ+ inclusion and ableism. • Clarify managers' responsibilities and strengthen confidence in managing challenging situations. • Roll out enhanced EDI learning, including mandatory training and inclusive-leadership development.	**In progress. Zero-tolerance frameworks and reporting routes are established, alongside BAME, LGBTQ+ and Disability staff networks. The NHS England Sexual Safety Charter and a Sexual Safety Circle Group are in place. A relaunch is being prepared, including Learning Hub content and ward-based face-to-face sessions. EDI learning includes mandatory training, cultural competency, allyship, inclusive leadership, sexual misconduct awareness, patient-racism SOP content and zero-tolerance training. Executive and Board routes for the refreshed frameworks are being confirmed.**	Original target: June 2026 Current milestone: Oct-Nov 2026
Domain 2: Workforce health and well-being	**2C: Staff can access independent support and advice when experiencing stress, abuse, bullying, harassment or physical violence.**	Ensure staff can speak up, obtain support and resolve concerns without lasting harm to their work or health.	• Review routes to advice and ensure accessibility. • Maximise the Freedom to Speak Up Guardian service and Champion network, with attention to EDI concerns. • Support staff-network Chairs and Vice-Chairs through regular supervision and support. • Promote access to external and impartial trade-union support.	**In progress. Freedom to Speak Up Guardians and Champions continue to promote reporting and support routes. HUTH has monthly Guardian drop-ins at HRI, CHH and on Teams, and the Champion network has grown to approximately 60. Anonymous and confidential speaking-up routes are available and continue to be promoted. The EDI team works with trade-union colleagues and staff networks. Further work is needed to confirm a consistent supervision offer for network Chairs and Vice-Chairs and to complete the accessibility review of all advice routes.**	Original target: June 2026 Revised date: to be agreed
Domain 2: Workforce health and well-being	**2D: Staff recommend the organisation as a place to work and receive treatment.**	Develop a values-led culture where staff feel valued and welcome, supporting safe, high-quality care.	• Create a single route to development through the Learning, Improvement and Safety Academy. • Maintain compassionate and inclusive leadership and people-management development. • Continue and roll out a Group-wide professionalism, civility and respect programme.	**In progress. The Learning Improvement and Safety Academy is developing a single route to individual, team and career development, coaching, mentoring, CQI and clinical and non-clinical training. More than 1,000 staff have completed leadership and management development, with Leadership Essentials, bite-sized learning, the Learning Hub and a new appraisal process launched. Culture and engagement work now includes a safety-culture model, civility and respect, EDI, a single route for raising concerns and leadership visibility. Staff-survey advocacy remains a priority because both trusts remain below the Picker average.**	December 2026

Domain	Outcome	Objective	Actions	Progress / evidence	Completion date
Domain 3: Inclusive leadership	**3A: Board members, Band 9/VSM leaders and line managers demonstrate commitment to equality and health inequalities.**	Embed EDI and health inequalities within relevant leadership performance objectives and accountability arrangements.	• Include Care Group EDI measures and staff-survey scores in Board reporting, supported by improvement plans. • Include EDI and health-inequalities objectives in relevant appraisals. • Build WRES, WDES and LGBTQ+ objectives and progress tracking into reporting and governance.	**In progress. Board reporting is being developed to connect equality objectives with measurable workforce outcomes and protected-characteristic staff-survey measures. The EDI action plan is being refined around culture and belonging, psychological safety, engagement and staff voice, training and capability, and leadership accountability. Workforce equality reports and actions are being aligned to governance and Board reporting. Full evidence that EDI and health-inequalities objectives are consistently included in all relevant appraisals is not yet available.**	December 2026
Domain 3: Inclusive leadership	**3B: Board and Committee papers identify equality and health-inequalities impacts, risks and mitigations.**	Introduce Board and Committee-level accountability for EDI and health inequalities.	• Ensure equality and health-inequalities impact assessments are reviewed by the relevant Committee for service changes. • Provide training and coaching so Non-Executive Directors can critically challenge impact assessments.	**In progress. Equality representatives are included on Trust panels, and work is under way to integrate the EQIA process into core governance, including training for the PMO and managers. The EDI programme is also strengthening Board reporting and governance routes. Evidence was not found confirming completion of the planned Non-Executive Director training and coaching, so this element remains outstanding and requires an updated delivery date.**	Original target: July 2026 Revised date: to be agreed
Domain 3: Inclusive leadership	**3C: Board members and senior leaders use levers to manage performance and monitor progress for staff and patients.**	Demonstrate clear metrics and governance that enable Executive and Non-Executive Directors to track improvement.	• Use governance arrangements to identify improvement and hold Care Groups and Corporate Directorates to account. • Monitor progress through routine Executive, site and performance-management structures.	**In progress. Workforce and finance information is being brought together in a validated performance pack covering vacancies, variable pay, sickness, turnover, training, appraisals and job planning. Care Group and staff-group views are being developed to identify hotspots and support accountability. EDI and equality-objective reporting is being aligned with the integrated improvement plan, routine performance reporting and Board updates. Patient-related measures still need to reflect the distinct communities served by HUTH and NLaG, with named local leads and governance routes to be confirmed.**	Original target: September 2026 Revised date: to be agreed

Bucket / Theme *Theme of project*	Name of project / Activity being delivered? *Include details of frequency / group or site offer / duration / stakeholders needed, etc. How is it being delivered?*	Owners / Accountable Stakeholders *Who is overseeing the project?*	Actions *Additional notes that support decision making regarding project stopping / continuing / changing.*	Area *Is this a Group, NLAG or HUTH initiative?*	Launch Dates / Relaunch / Milestones *Key dates of delivery*
Representation (recruitment, progression)	**Inclusive Recruitment Project**	Mano Jamieson & Recruitment Team	Early action - structure sub-groups in the next 6 weeks	Group	Jan-27
	STEP UP Program	Practice Development Nurses - Pastoral care for Internationally Educated Nurses	Planning needed to decide the structure and content of the Train the Trainer Session. Proposed bimonthly sessions (30-45 people) following on from final sessions from external facilitator Mark.	Group	Sep-27
	1:1 Career Clinics for IENs	Patrisha McKenna	Continue as planned but reconsider the promotion and marketing strategy to communicate the purpose to manage fragility. Also explore how to raise capacity to meet demand.	Group	Ongoing
	Lead without Limits	Elaine Hillaby	Three of the cohort have had successful job interviews, using the tools and skills they have acquired on the programme to gain in confidence and progress their careers. Ran in collaboration with T2, will this be collaborative moving forward? Design needed for what does a positive action for Disability lived experience looks like. Date for Inhouse version TBC. There needs to be discussion re South 2027	HUTH	Jan-27
Health, Wellbeing, Resilience Building	**Monthly Wellbeing meetings**	Patrisha McKenna & Mano Jamieson	Start to collaborate with HUTH and discuss/finalise topics and the group offer. Invite medics for Multi-Professional sessions and begin to advertise. Michio Abe and Patrisha McKenna to shape the agenda and schedule for next year. Need to shape the session to include both teaching and lived experience/concerns sharing. Consider how to embed restorative practice circle approaches into these sessions.	NLAG / Group	Ongoing Monthly
	Restorative Clinical Supervision	Practice Development Nurses, Pastoral care for internationally educated nurses, PNAs, Practice Development Matron	Aligning HUTH and NLAG more utilising the Booking system	Group	Sep-26
	Catch Up Sessions for Nurses	Practice Development Nuyrses, Pastoral care for internationally educated nurses, PNAs, Practice Development Matron	*Same as Monthly Wellbeing meetings (Teaching & lived experience/concerns)	HUTH	Ongoing Monthly

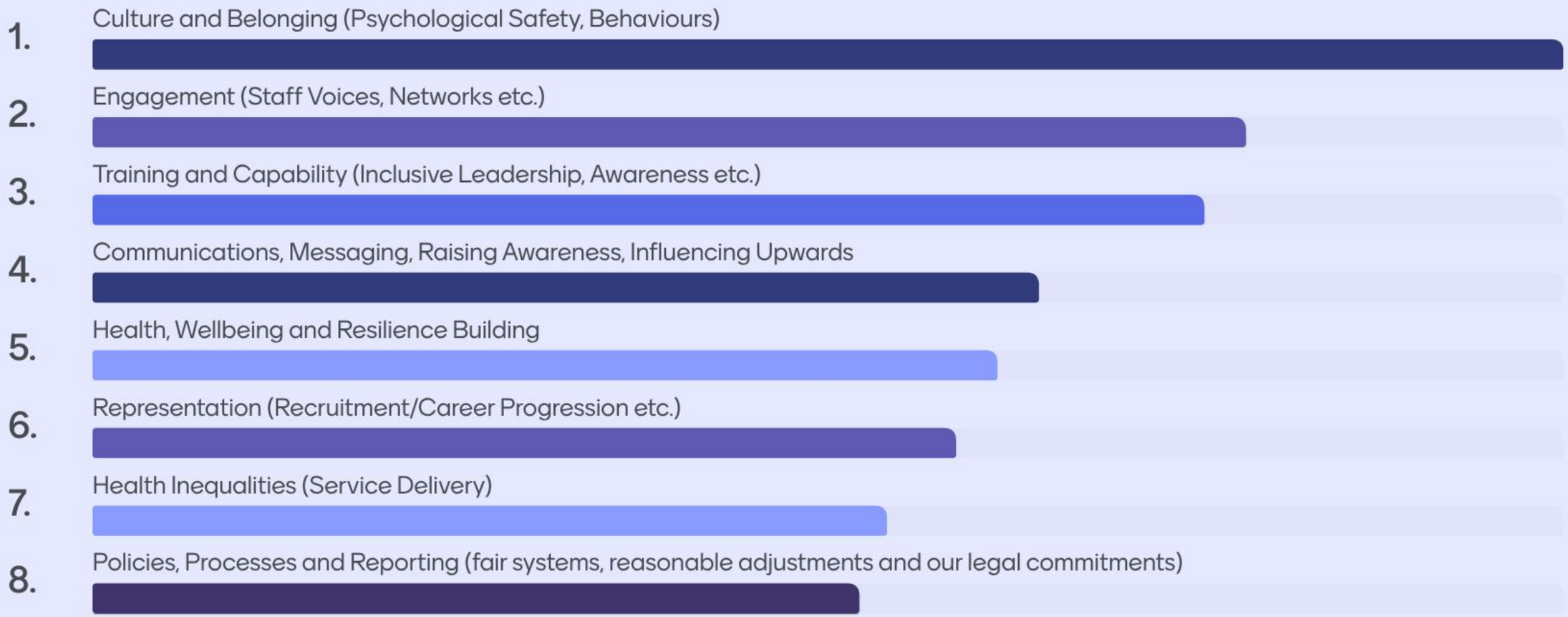
	Menopause Support		Perception that more support is needed. Need to identify what is being done currently and ask staff what further support they need. More research needed.	Group	Oct-26
	REACH / Reasonable Adjustments	Lynne Stothard	Signed off and make widely available	Group	Ongoing
	Staff Networks	Mano Jamieson	The Women's Staff Newtork will require Focus Groups across HHP to establish interest and TOR for the Network	Group	Ongoing
	REACT	Elaine Hillaby / AS / LM	Currently done quarterly but need to look at marketing to the staff networks direct comms and sharing resources	Group	Ongoing
Culture and Belonging (Psychological Safety, Behaviours) *(All training aims to improve culture and belonging).*	**Allyship Session**	Practice Development Nurse	This is being expanded into the joint allyship and Cultural Competency training workshop (half day session)	Group	Aug-26
	Sexual Safety Policy and Reporting Tool	HR / Safeguarding / Group EDI Manager Mano Jamieson	Run a pilot to test and review the training, confirm facilitators and delivery frequency, and agree an appropriate marketing strategy. Group EDI Manager (Mano Jamieson) to Chair the Circle group to maintain consistency of how Circle groups operate	Group	Sep-26
	Patient Racism Standard Operating Procedure	Mano Jamieson, Patrisha McKenna & Michio Abe	Conduct initial Survey of staff, deliver training to Wards, and assess reports that come in and how they are managed. Reassess the SOP and then take through governance before rolling out in stages across HHP	Group	Aug-26
	BRIDGE Programme	Patrisha McKenna	In development / infancy. To be picked up later	Group	Sep-26
	Seasonal Celebration Event	Mano Jamieson	Establish budget. Clarify planning stakeholders. Ensure appropriate marketing of purpose	Group	Dec-26
	Zero Tolerance Frameworks	Mano Jamieson	Identify Accountability Pathway for Care Groups outlining expectations for responding to discrimination. Lack of visibiity across the Group. Continue to market and plan for relaunch with summarised versions. Plan to introduce a Discrimination reporting tool for all other protected characteristics.	Group	Sep-26
	Lead without Limits (Positive Action)	Elaine Hillaby	Three of the cohort have had successful job interviews, using the tools and skills they have acquired on the programme to gain in confidence and progress their careers.	HUTH	Jan-27
	Gender Diversity Training	EE / Patrisha McKenna	Kasper Weber in process of fine tuning for non clinical staff	NLaG	Jul-26

Training and Capability (Inclusive Leadership, Awareness)	**Embracing the Challenges of Inclusive Leadership**	Elaine Hillaby	Continue and adapt	Group	Ongoing
	Cultural Competency Workshop	Practice Development Nurses/ Matron	Patrisha McKenna, Michio Abe, Mano Jamieson, Elaine Hillaby and Nami Sajja to redesign workshop for July. Aim for this to respond to the requirements of the Ward Accreditation self assessments	Group	Aug-26
	Staff Induction	Elaine Hillaby & Karl Portz	Ensuring a Group consistant approach	Group	Sep-26
	Bespoke EDI Interventions	Karl Portz	OD and EDI to work collaboratively to shape an approach for this - decision needed	Group	Ongoing
	EQIA Managing Inclusive Change	Karl Portz	Develop Group Wide Delivery Programe	Group	Oct-26
Policies, Processes and Reporting (Fair systems, reasonable adjustments, legal commitment)	**Group Equality Objectives**	Karl Portz & Mano Jamieson		Group	Dec-26
	WRES, WDES & LGBTQIA+ Action Plans	Karl Portz & Mano Jamieson		Group	Oct-26
	Annual Equality, Diversity and Inclusion Report to the WECC and Trust Board	Karl Portz & Mano Jamieson	Annual Requirement	Group	Apr-27
	Gender Pay Gap Report	Karl Portz	Deadline 30 March 2027	Group	Mar-27
	Disability Pay Gap Report	Karl Portz	Awaiting Final Government Guidance	Group	May-27
	Ethnicity Pay Gap Report	Karl Portz	Awaiting Final Government Guidance	Group	May-27
	Workforce Disability Equality Standard Report and Action Plan	Karl Portz & Mano Jamieson	Data due May 2026 Report due October 2026	HUTH/NLaG	Oct-26
				HUTH/NLaG	Oct-26
	Workforce Race Equality Standard Report and Action Plan	Karl Portz & Mano Jamieson	Data due May 2026 Report due October 2026	Group	Oct-26
				Group	Oct-26
	Moden day Anti-Slavery Statement	Karl Portz	Due August 2026	Group	
	Group Disability Leave Policy, Disability Guidance Framework	Karl Portz & LS		Group	Sep-26
	Transgender Policy, Staff Transitioning Policy	Mano Jamieson	This has to be done in conjunction with the Supreme Court Ruling and NHS national mandated contract	Group	Mar-27
	Prepare and publish EDS22	Mano Jamieson, Karl Portz & Patient Experience Team		NLaG/HUTH	May-27
	Group Equality Impact Assessment System with Screening Tool	Karl Portz		Group	Oct-26

Engagement (Staff Voice, Networks)	**Start Women's Staff Network**	Mano Jamieson	Would need to conduct focus groups to assess demand and need	Group	Jan-27
	Network Conference Schedule 2026/27	Mano Jamieson	Decision needed re this being Group or Site based or if it will only be the Intersectionality Conference	Group	Dec-26
	Network Chairs building relationships and create community & improve relationships with the Board	Mano Jamieson	Schedule first meeting or mini summit	Group	Jun-26
	Intersectionality conference	Mano Jamieson	Planning Group needed to make arrangements	Group	Autumn
Health Inequalities (Service Delivery)	**EDS22**	Karl Portz		Group	May-27
	Health Inequalities working group	Group EDI Steering Group		Group	Jan-27
	Midwifery intervention	Patrisha McKenna / NP		Group	Oct-26
Communications, Messaging, Raising Awareness, Influencing Upwards	**Talking heads / positive news stories relating to initiatives above**	OD and EDI	Prioritise initiatives and create content - Positive Action Programme testimonials	Group	Nov-26
	Religious Calendar of Communitions	Communications Team	Continue	Group	Ongoing
	Communications re Mental health / PCs			Group	Ongoing
	Anti-Discrimination	Karl Portz & Mano Jamieson	Aim for September	Group	Sep-26
	RACE IAG	Mano Jamieson	Ongoing	Group	Ongoing
	Stay and Thrive Meetings	Practice Development Nurse / Matron	Continue	Group	Ongoing
	Supreme Court Ruling Comms	Karl Portz & Mano Jamieson	Awareness and Trust Guidance needed for staff in relation to use of facilities and access of Transgender patients to Healthcare	Group	Aug-26

Mentimeter

From our EDI workplan prioritise the themes below...



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Culture and Belonging

The first step is inclusivity for staff with protected characteristics

Acceptance & Championing of identities

Recognising and appreciating others strengths skills backgrounds - peer responsibility and manager responsibility

Resolving any othering/discrimination early and having feedback conversations about the impact people have on others

Morale feela very low currently, suggesting a lack of sense of belonging

Really clear set of expectations and behaviours that apply to all

There is a lack of exe team role modelling of behaviours we require as an organisation. For our leaders and staff.

Providing a sense of safety irrespective of the individuals identity

Culture and Belonging

Reporting tools are vital and building confidence across the workforce that is is psychological safe to raise concerns and feedback will be provided and action taken where required.

Starts with role modelling from the top. Organisational values need to be lived, so what we say and do match

Who are the people that are more likely to cause issues and non acceptance? How ican it be addressed?

Intersectionality and recognising difference within groups

Would like to see a revamp of the Zero Tolerance frameworks - e.g. positive/culture change rather than seeming solely for more serious/HR/etc situations. Renaming? Rebrand?

My world is walking alongside folk who identify with differing spiritualities, some who feel rightly they are not heard or sense belonging within the partnership. They may belong to multiple groupin

Do we need to look at a general discrimination reporting tool e.g. to also include ability report discrimination related to e.g. maternity, religion etc

Peer support skills

Culture and Belonging

Belonging means not being singled out as a disabled member of staff Culture means not having to explain myself and being accepted as a valuable member of the team

Do our MPs hwve a lot to answer for ?

Tackling discrimination frameworks but also beyond this? What next?

REACT mental health training is relevant do people know how to talk to eachother and check in?

We need measures for evaluating impact.

C&B to me means being able to be myself at work and not worrying about being judged or criticised for being me.

Definitely agree eirh rhr acceptance and nit havjng to constantly explain why....

How do we raise awareness on this and make sure what we're thinking is the same as out there in HHP

Culture and Belonging

Patient racism SOP vital - just need to ensure resource and continuity to make a difference

Can we do more to support groups impacted by negative media narratives ie. racism/ableism/homophobia/transphobia

What role do PNAs and PMAs play?

We need senior leadership engagement to promote and champion culture change.

Celebrating different cultures but recognise the benefits which cultural diversity brings to the group

Skills in debating: disagreeing - doing this badly makes people feel they don't belong

Training needs to equip learners with practical behaviours and skills that they can start putting into practice.

The zero tolerance frameworks in place are really important. Do we have resource/continuity plans in place i.e. Mano is a key person in these tools and he is allowed to have some annual leave :)

Culture and Belonging

We are a global organisation there needs to be a mindset shift there

Need the exe team to engage with the staff and the area. If she doesn't want to belong to and have an interest in the people she serves. How can can she encourage belonging in others

We need a way of engaging with departments to ask them what their local ideas are

Engagement (Staff Voice, Networks)

Support for staff networks to run, as can be difficult to plan around work commitments.

Better promotion of Staff Networks to all employees

Connections between staff networks - intersectionality

Refresh of available Networks important - are all new starters, Resident Doctor rotations, students etc made aware

Intersectionality conference

Exec engagement

Promotion of staff networks with administrative support, chairs supported to utilise this support effectively

The organisation needs to understand the mood of it's colleagues by engaging meaningfully with network representatives

Engagement (Staff Voice, Networks)

Supporting chairs with agenda setting and their leadership of the networks

How do we better and more formally get staff and patient voice into daily business. This will support those without that lived experience to speak more confidently on issues that may affect others

Funding for staff networks

Actually listen to staff and patient concerns. PALS in particular isn't helpful for a lot of patients I chatted with.

How do we make it part of business as usual instrad of it being additional to already demanding workloads

Seeing the importance of staff networks, not just a nice to have. Can be challenging running a network with a full time job alongside

Initiatives that involve staff members in inclusive movements (ie. Rainbow Badge Pledge)

Staff networks need not to feel an inconvenience

Engagement (Staff Voice, Networks)

Promoting of networks for increased awareness in addition to outcomes and activity

Re-energies executive sponsorship of staff networks and give them specific equality objectives

Staff need to feel heard.

Make raising voices easier such as allowing virtual attendance to all Ask The Exec Meetings

Agree staff need to feel heard

Using Zero Tolerance to support areas that need support on inclusion

Engaging all staff not just lived experience groups so accountability sits more broadly - shouldn't be diverse groups having to fix everything - allyship

Promote staff network success (issues raised and solved through network). Encourage more staff to join.

Engagement (Staff Voice, Networks)

Sharing the ethos of "nothing about us, without us"

Quarterly meetings with networks to plan diversity events wanting to promote, involving network members in discussion & involvement, have a 3 month ahead plan to promote what is coming up in org.

Barrier removal needed

Training and Capability

Cultural competency

Access to education and development opportunities

Inclusive Leadership

Targeting those departments/areas that have been identified as hot spots either through the zero tolerance tools, HR cases or FTSU cases. Such as the cultural competence training.

Linking the capability needed to the levels on the Management and Leadership Framework - what levels of knowledge do different staff need?

Training for managers re reasonable adjustments and the equality act

Training for specific initiatives

Ensure there is a golden thread throughout all of our leadership development

Training and Capability

Recruitment training for unconscious bias

Lead without limits

Inducting staff with policies n procedures Leaderships competencies

Secondment opportunities for visible presence at all levels

What are the core skills linked to EDI capability - what would we prioritise? What is then mandated learning for certain groups vs nice to have

Inclusivs for all levels not focusses on nursing and medical.

Linking training to want and desire not just job role.

Training managers to support the needed

Training and Capability

Intervening and supporting teams and staff in being more inclusive is so important. It shows the "zero tolerance' is also about learning.

Covering those managers in operational roles and roles such as the Patient Admin team leaders/supervisors etc into reasonable adjustments and other key areas

Give time for all staff to explore lived experiences during all training

Training in giving feedback or constructive challenge specifically linked to EDI issues

Reasonable adjustments and flexible working - what is fair and equitable?:

Equal opportunities across trust, not dependent on who the manager is

Induction should include more about our expectations of inclusion and relevant context/examples. We can't assume knowledge

Fairness and equitable opportunities in regards with policy in tackling capability challenges.

Training and Capability

I had a discussion with a manager earlier this week who wanted to support for training to assist their teams into how to support colleagues and react to situations e.g. racism from patients.

Training for the Board?

Not having experience based on a manager lottery

A collective review of the different trainings offered. How they contribute to various priorities or whther they can be updated to address priorities more. Seeing how they complement each other

Variation of training .

Training staff what is the actual meaning of equity

Discussion on how inclusion shows up in the real world

Addressing staffing/not being released barriers - some staff say there is zero capacity to get released

Training and Capability

More awareness of support available and that it is a priority. Often too busy firefighting for it

Improve awareness of cultural differences

Training for the SOP using the simulation

Develop capacity in EDI training

Communications, Messaging, Raising Awareness, Influencing Upwards

Communicating the importance of EDI linked to Patient Safety experience and staff experience

Do the Staff Networks have Board members as Exec Sponsors that can hear lived experience

Making all tools available to everyone

Clear communication of supreme court, including different forms of media (not just emails)

Reverse mentoring

Patient stories of what is like to experience our services.

Communicating EDI Calendar of Events, special days - shine spotlight on various cultural days or certain groups

Discussion from Execs (sponsors), with enthusiasm

Communications, Messaging, Raising Awareness, Influencing Upwards

Exec communications highlighting importance of EDI through Broadcast Org communications AND through their directorates in strategic ways

Not being reliant on e comms, many staff are not office based, need to consider how the messages are shared,

Staff network details to engage

Share more videos of how important diversity is within the hospital. In cafes, op areas etc

Outreach to local charities and support groups to advertise what the group is doing to improve care experience for minorities.

Staying updated with changes in policies and procedures Ability to communicate via all tools including Bridget

Sort of communucations to patients the lived experiences of staff what is the impact of discrimination and racism.

Having meaningful conversations with exec sponsors

Communications, Messaging, Raising Awareness, Influencing Upwards

Strategic planned communication for everything on the workplan

Consider barriers, may not be able to read easily etc do how do we ensure everyone gets nessages clearly

Leadership stressing importance of anti discrimination

Increase Resources to aid communication

Reminding staff of the Staff Networks for support. Do we communicate this in welcome packs to new starters

Clincal staff don't usually look at emails or comms on bridget.

Updates with local communities

Increasing the visibility of our work

Communications, Messaging, Raising Awareness, Influencing Upwards

How do we communicate that this is not a separate less important agenda that is not linked to core business?

Addressing barriers both self n teams n with through those down

Series of video of staff sharing their experiences and how important for staff to be well valued to maintain patient safety

Communicating the significance and relevance of EDI to services

Signpost new comers to networks social platforms

How to escalate n report issues incidents

Reduce reliance on tech

comms plan tailored to each objective so it influences behaviour change and it is not putting more noise out there

Communications, Messaging, Raising Awareness, Influencing Upwards

Make more of a focus of edi at trust inductions

Representation

Positive action leadership development

Managers offering training ideas for career progression at appraisal then saying there is no funding.

This might be in the wrong question, but consideration of extending the zero tolerance reporting tools to other protected characteristics. For example maternity, religion, gender etc.

No board representation for any protected characteristic

There appears to be a lack of representation in senior leaders with disablities

Inclusive recruitment, making questions clearer about what we're asking of people rather than it being a "trick"

Regular development conversations for all staff

New Boards being formed - opportunity to increase representation?

Representation

We need to see people of colour especially in senior clinical roles

Can staff decide who represents them?

Do staff know who represents them?

Simple ideas for inclusive recruitment, ask the person who has identified as having a disability what adjustments they may need

More effective role models

It is like a guiness drink and it has not change.

Staff supported with flexible working

How we give staff exposure and useful career experiences to build readiness

Representation

Making sure we are not speaking for people, but being informed by people and amplifying their voice

Acting Up experiences, secondments

Health, Wellbeing, Resilience Building

Circle meetings

External support CIC signposting as well as internal

Relaunch wellbeing champions

Committing to staff wellbeing events for all

Pna/wellbeing meetings

Need to continue to provide a range of staff support options e.g. Occ Health, CIC EAP, Staff Psychology (north), Pastoral & Chaplaincy team etc to allow our colleagues to access wellbeing support

Trauma response for staff experiencing discrimination

Understanding that not everyone experiences the same symptoms ...

Health, Wellbeing, Resilience Building

Wellbeing a priority, not an option

Psychologically safe space to discuss impacts of discrimination

Promoting social activities

The previous staff benefits/wellbeing fairs at the sites were good and an opportunity to get information and have wellbeing tests e.g. blood pressure

Why do we have to learn to be resilient?

Wellbeing options that recognise cultural nuance

Protected time for champions

How to escalate to support systems

Health, Wellbeing, Resilience Building

Training around use of the sickness policy as a health and wellbeing tool not as a punative measure

How well do staff engage with wellbeing initiatives?

Building relationships with team and local communities

Induct to new updates on absence and sickness polices

Barriers to staff engagement.

Link to EDS22 action plans

Use of networks n social platform

Including non-clinical staff in wellbeing comms

Health, Wellbeing, Resilience Building

Understand ing and acknowledging with Cultural differences

Social corporate responsibility to provide staff support/wellbeing support to our colleagues. Given the long community waiting lists and what they are dealing with at work.

Strengthening the allyship

Prioritising

Stress management / risk assessments - manager know how - REACT and conversation skills

Self help guidance

Appendix 4

Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS FT
Equality Objectives Engagement Plan

Promoting Inclusion and Diversity Across Our Organisation

1. Key Stakeholders
   - Employees at all levels
   - Management and leadership teams
   - Human Resources, OD and EDI Team
   - External partners and community groups
2. Suggested Engagement Activities
   - **Awareness Campaigns:** Launch regular internal communications highlighting equality objectives, progress, and opportunities for involvement.
   - **Consultations:** Host workshops and forums to gather input from staff and stakeholders on equality issues and potential solutions.
   - **Feedback Mechanisms:** Establish anonymous channels for staff to report concerns and suggest improvements relating to equality.
   - **Celebrating Diversity:** Organise events and initiatives recognising diverse cultures, backgrounds, and achievements within the organisation.
3. Communication Plan
   - Regular updates via email, intranet, and meetings to ensure transparency and maintain momentum.
   - Clear messaging about the importance of equality objectives and the role each individual plays in achieving them.
   - Sharing success stories and progress reports to reinforce positive outcomes and encourage further engagement.
4. Monitoring and Evaluation
   - Set measurable targets for each equality objective.
   - Conduct regular reviews of engagement activities and outcomes.
   - Adapt the plan as necessary based on feedback and evolving needs.

Conclusion

By implementing this engagement plan, we commit to creating a fair and inclusive environment where equality objectives are actively pursued and achieved. Ongoing involvement and collaboration across all levels of the organisation are vital to making lasting progress.

Phase	Key Activity	Milestone Date
Project Initiation	Launch stakeholder engagement and consultation programme Agree way for at Trust Board meeting	8 October 2026
Engagement & Consultation	Workshops with Senior Leaders, Commissioners, Staff Networks, Healthwatch and community groups completed	30 October 2026
Analysis & Review	Consultation feedback analysed and key themes agreed	6 November 2026
Draft Development	Equality Objectives and Action Plan revised following consultation	13 November 2026
Stakeholder Validation	Updated draft reviewed by staff networks, commissioners and community representatives	27 November 2026
Governance Review	Final draft submitted to EDI Steering Group on 1 December	4 December 2026
Governance Approval	EDI Steering Group endorsement and recommendations completed	11 December 2026
Board Approval	Trust Board review and approval of Equality Objectives and Framework	18 December 2026
Executive Sign-off	HUTH CEO, Director of People and Chair sign-off NLaG CEO, Director of People and Chair sign-off	22 December 2026
Publication & Launch	Equality Objectives and EDI Framework published and communicated across the Partnership	31 December 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)250

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9th October 2026**
Director Lead	**Emma Sayner – Group Chief Financial Officer**
Contact Officer / Author	**Paul Horsefield, Procurement Business Partner, Humber & North Yorkshire Procurement Collaborative**
Title of Report	**Linen and Laundry Services – HHP Procurement Recommendation**
Executive Summary	Approval is sought for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to enter into a new four-year linen and laundry services contracts with Synergy. The awards will be made through the North of England Commercial Procurement Collaborative (NOE CPC) Laundry and Linen Services Total Solutions Framework.
Background Information and/or Supporting Document(s) (if applicable)	Synergy Innovation Paper / proposed Joint Innovations & Cost Savings Programme.
Prior Approval Process	EFD SMT – July 2026 **PEF – September 2026**
Financial Implication(s) (if applicable)	**Four-year option: average linen rental piece price £0.4499 from 1** **April 2026, with annual indexation from 1 April 2027 using 50% change in Living Wage and 50% CPI.** **Short-term one-year option: £0.4650.** **HHP Annual contract increase - £575,800:**

HHP	**1 Year £'000 incl. VAT**	**4 Years £'000 incl. VAT**
Proposed Increase		
HUTH	422.4	1,689.7
NLG	153.4	613.5
	575.8	**2,303.2**

HUTH	**1 Year £'000 incl. VAT**	**4 Years £'000 incl. VAT**
Current Contract	1,948.8	7,795.4
Proposed Contract	2,371.3	9,485.0
Proposed Increase	**422.4**	**1,689.7**

	NLG | 1 Year £'000 incl. VAT | 4 Years £'000 incl. VAT | | Current Contract | 1,345.2 | 5,380.7 | | Proposed Contract | 1,498.6 | 5,994.2 | | **Proposed Increase** | **153.4** | **613.5** |
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**No direct EDI or health inequalities implications have been identified from the pricing decision. Reliable linen and laundry provision supports safe, dignified patient care and effective ward operations across HHP.**
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: 4.10

Name of Meeting	Performance, Estates & Finance route
Date of the Meeting	29 September 2026
Director Lead	Group Director of Estates, Facilities & Development
Contact Officer / Author	Paul Horsefield, Procurement Business Partner, Humber & North Yorkshire Procurement Collaborative
Title of Report	**Linen and Laundry Services – HHP Procurement Recommendation**
Executive Summary	Approval is sought for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to enter into a new four-year linen and laundry services contracts with Synergy. The awards will be made through the North of England Commercial Procurement Collaborative (NOE CPC) Laundry and Linen Services Total Solutions Framework. Linen and laundry is a critical patient-facing service that supports infection prevention, patient dignity, theatres, wards and clinical care across both Trusts. The existing arrangements are approaching renewal, and a decision is required on future provision. The proposed price is £0.4499 per item. This is higher than the current average price of £0.4046, which has remained unchanged since April 2024. The proposed price reflects contractual inflation for April 2025 and April 2026 that was not applied during the existing arrangements. Market intelligence from recent NHS procurements indicates that prices around £0.44 per item are currently being achieved, meaning the proposed price is broadly aligned with the market. **Alert** Synergy applied a 13% increase to HUTH/NLaG invoices without following the usual notification, negotiation and agreement process; HUTH remains in a formal contract until the end of July 2026. The proposal creates an additional annual recurrent unfunded cost

	pressure of £575,800 across HHP: £422,400 for HUTH and £153,400 for NLAG **Assure** The proposed long-term offer price offered by Synergy is an average linen rental piece price of £0.4499 for a four-year term from 1 April 2026, compared with the short-term one-year rate of £0.4650. The consortium's average piece price has remained unchanged at £0.4046 since April 2024, despite inflationary cost pressures. Applying the contractual indexation increases of 4.79% from April 2025 and 6.11% from April 2026 results in an indexed price of £0.4499, which forms the basis of the proposed four-year agreement. Synergy's position is therefore that the proposed contract price reflects the price the consortium would have been paying had indexation been applied during the previous two years, rather than representing a new commercial premium. Approval of the proposed four-year Synergy contract would also result in a cost avoidance charge from Synergy of £150,527 of retrospective inflation-related charges across HHP, comprising £111,476 for HUTH and £39,051 for NLAG. These amounts represent historical underpayments arising from contractual indexation not previously applied and would otherwise have been recoverable by the supplier. Feedback obtained through NHS procurement networks and market testing indicated that prices in the region of £0.44 per piece were being achieved through recent competitive procurements. Procurement advice to the Partnership is therefore that the proposed four-year rate is broadly aligned to current market pricing and that undertaking a further competitive process would be unlikely to secure materially better pricing. Given the limited number of providers operating within the NHS linen and laundry market and recent market intelligence received, there is a risk that a new competition could result in higher prices and delay the implementation of the associated service improvement and innovation programme. Procurement has confirmed that the proposed direct awards are legally compliant and can be made through the NOE CPC Laundry and Linen Services Total Solutions Framework. **Advise** The benefit of the four-year option is not limited to price. Synergy

<table>
<tr><td></td><td>has committed to a Joint Innovations & Cost Savings Programme covering linen usage optimisation, extended textile life through technology, replacement of single-use products with reusable rental textiles, and hospital workflow efficiencies. For HUTH, service improvement is a key condition, including the potential alignment of processing plants across HUTH and NLaG to support more consistent service delivery.

Recommendation/s
The Committee is asked to approve progression of the HHP 4 year deal with Synergy.</td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td>Synergy Innovation Paper / proposed Joint Innovations & Cost Savings Programme.</td></tr>
<tr><td>Prior Approval Process</td><td>EF&D SMT review requested for Friday 17 July 2026, approved, with a Linen & Laundry procurement recommendation paper requested for PEF on 1 September 2026. Approval route to be confirmed through HHP governance and Scheme of Delegation following PEF review.</td></tr>
<tr><td>Financial Implication(s)
(if applicable)</td><td>Four-year option: average linen rental piece price £0.4499 from 1 April 2026, with annual indexation from 1 April 2027 using 50% change in Living Wage and 50% CPI.

Short-term one-year option: £0.4650.

HHP Annual contract increase - £575,800:

<table>
<tr><th><u>HHP</u></th><th>1 Year</th><th>4 Years</th></tr>
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	NLG	1 Year £'000 incl. VAT	4 Years £'000 incl. VAT
	Current Contract	1,345.2	5,380.7
	Proposed Contract	1,498.6	5,994.2
	Proposed Increase	**153.4**	**613.5**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No direct EDI or health inequalities implications have been identified from the pricing decision. Reliable linen and laundry provision supports safe, dignified patient care and effective ward operations across HHP.		
Recommended action(s) required	☒ Approval by CiC ☐ Information ☒ Endorse for approval by Trust Board(s), where required ☒ Assurance ☒ Other – subject to final HUTH pricing confirmation and completion of direct award/waiver records		

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	☒
Our People	☐
Our Partnerships	☒
Our Pioneers	☐
Our Public Purse	☒

Group Directorate of Estates, Facilities and Development (EF&D) Briefing Note – Linen and Laundry Services Contract Award

1.0 Aim

This paper seeks approval for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to enter into a new four-year contract with Synergy for linen and laundry services through the North of England Commercial Procurement Collaborative (NOE CPC) Laundry and Linen Services Total Solutions Framework.

The award will maintain continuity of a critical patient-facing service across Humber Health Partnership (HHP) and support a programme of service improvement and operational efficiencies.

2.0 Background

The existing linen and laundry arrangements are approaching renewal and a decision is required on future provision. These services are essential to daily hospital operations, supporting infection prevention, patient dignity, theatre activity, ward services and clinical care across all sites. Synergy is the incumbent supplier and has served both Trusts for a number of years.

The NHS laundry market is highly constrained, with only a small number of providers able to deliver services at the scale required by large acute hospital organisations. Market analysis indicates that the market effectively operates as a duopoly. The proposed award is a direct award under the NOE CPC framework; the framework was established through a compliant procurement process and permits direct award where its conditions are met.

3.0 Update

The consortium's average linen rental price has remained unchanged at £0.4046 per item since April 2024, despite sustained inflationary pressures affecting wages, energy, transport and laundry processing.

Contractual indexation was not applied during this period. Applying the contractual formula for April 2025 and April 2026 produces an adjusted price of £0.4499 per item, which forms the basis of Synergy's proposed four-year agreement.

Synergy's position is therefore that the rate largely reflects inflationary uplifts that would have been payable under the existing arrangements, rather than a new commercial premium.

Procurement sought intelligence from NHS organisations that had recently completed similar procurements. The evidence indicated that prices around £0.44 per item are currently being achieved in the NHS market. Synergy's proposed rate of £0.4499 is therefore broadly aligned with prevailing pricing.

A competitive procurement process is unlikely to deliver materially lower prices and could expose the Trusts to increased cost, service continuity risks and challenge in a commercially sensitive supplier market.

Negotiations also secured a Joint Innovation and Cost Improvement Programme. This will explore reduced unnecessary linen use, improved textile life through technology and stock management, replacement of disposable products with reusable alternatives where appropriate, improved ward and hospital workflows, and greater alignment of services across HUTH and NLAG.

4.0 Financial Impact

The proposal creates an additional annual recurrent unfunded cost pressure of £575,800 across HHP: £422,400 for HUTH and £153,400 for NLAG.

Agreement of the four-year contract is also expected to avoid approximately £150,527 of retrospective inflation-related charges identified by Synergy as historical underpayments from indexation not previously applied: £111,476 for HUTH and £39,051 for NLAG.

The proposed rate is lower than Synergy's short-term one-year option of £0.4650 per item and secures the associated improvement programme.

5.0 Conclusion and Recommendation

The proposed award is legally compliant through the NOE CPC Laundry and Linen Services Total Solutions Framework.

Not proceeding would create uncertainty over continuity of this critical service, potential further claims for historic indexation, higher short-term pricing, loss of the negotiated innovation programme and the need for another procurement exercise with no assurance of lower prices in a duopoly market.

Following procurement review, market benchmarking and commercial negotiations, the recommendation is that HHP approves a four-year direct award to Synergy.

The proposal is legally compliant, reflects current NHS market pricing, secures continuity of a critical patient service, avoids retrospective charges and provides an associated service improvement and innovation programme.

Decision required:

Approve progression of the four-year linen and laundry services contracts with Synergy for HUTH and NLAG through the NOE CPC framework.

Humber and North Yorkshire Procurement Collaborative

Contract Award Recommendation Report

Contract Details		
Date	14th July 2026	
Project Reference	C176116	
Contract Title	Linen and laundry service	
Procurement Regime	**Public Contract Regulations 2015**	Yes
	Procurement Act 2023	No
	Provider Selection Regime	No
Direct Award:	Yes - Direct Award using the North of England Commercial Procurement Collaborative (NOECPC) Laundry and Linen Services Total Solutions framework	
Procurement Lead	Paul Horsefield	
Project Lead/ Sponsor	Edd James / Zara Ridge	
Sourcing Strategy Approval Date	May 2024	
Contract Classification	Gold	
Spend Controls Obtained?	**Cabinet Office (over £20m)**	Not Applicable
	NHS England (management consultancy over £50k)	Not Applicable
	ICB Double Lock (£50k+)	Not Applicable
Conditions of Approval	Not applicable	
Confirmation Conditions Met	Not applicable	
Proposed Start	1st April 2026	
Contract Length	4 years	
Data Protection	Not applicable	
Maintenance	Not applicable	

Purpose of the Report (put an "X" in all which apply)			
To provide assurance	X	**To obtain approval**	X
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	

To provide advice		To highlight patient or staff experience	

Governance & Assurance Classification		
Route to market: Direct Award via NOECPC Laundry and Linen Services Total Solutions framework		
Technical / compatibility):		Not applicable
Urgency (unforeseeable):		Not applicable
Continuity of Service:		Not applicable
Award without competition (PA23 Schedule 5): Yes		Not applicable
Recorded on Direct Award Register:		Not applicable
This classification is used for internal assurance and reporting of direct awards as exceptions to competition		

SFI Waiver Required:	Not Applicable
Waiver Reference (Atamis):	Not applicable
Approval in line with SoD confirmed:	Not applicable
Waiver - internal permission ***Direct Award - legal route***	

Approval Required (delete the rows of any group/ individual who do not need to approve)		
Authorisation of single contracts (including variation and extension) for revenue or capital over £5m total value (excl. VAT)	Trust Board	Yes

Background Information	
Name and address of the contracting authority	Hull University Teaching Hospitals NHS Trust Hull Royal Infirmary Anlaby Road Kingston upon Hull HU3 2JZ
Subject matter of contract	Linen and laundry services
Reasons for the procurement	This procurement exercise has been undertaken due to renew an existing contract.
Value of the contract	Circa. £9.5M over the four year term.
Savings Achieved or Cost Pressure	Cost pressure – see table below

	1 Year	4 Years
	£'000 incl. VAT	£'000 incl. VAT
Current Contract	1,948.8	7,795.4
Proposed Contract	2,371.3	9,485.0
Proposed Increase	**422.4**	**1,689.7**

Proposed Contract value uplift of £422.4k per annum.

Pre-Procurement Considerations	
Market Analysis	Duopoly market
Choice of Procedure	Direct award to incumbent using the NOECPC Laundry and Linen Services Total Solutions framework
Prior involvement	Not applicable

Pre-Qualification Stage
Not applicable – Direct Award (no competitive process undertaken) under framework

Conduct of the Procurement (Multiple Rounds)	
Names of candidates or tenderers rejected during the procurement procedure	Not applicable
Reasons for rejection of candidates or tenderers in those circumstances	Not applicable

Award Stage	
Name of the successful tenderer(s)	Not applicable
Reasons why the successful tender(s) was selected	Not applicable
Names unsuccessful tenderers during the procurement procedure	Not applicable
Reasons for rejection of tenderers	Not applicable
Subcontracting: (where known and applicable) Guidance note on subs	Not applicable
Abnormally Low Tenders (if applicable)	Not applicable
Name(s) of evaluators	Not applicable

Declaration of Interest	
Conflicts of interests: those conflicts detected and subsequent measures taken	In making this recommendation, all members of the project have confirmed that they do not have any interests of relationships to declare that would have breached the Trust's commitment to transparent decision making.

Signature Panel (delete rows for individuals or groups who do not need to sign)		
Trust Board		

Guidance for Completion
Contract Classification

Gold Contracts - these are the most critical contracts, characterised by a high supply risk and high-cost impact. Characteristics include:

- Service failure would result in complete system failure, potential clinical safety issues, and severe reputational damage.
- Often require 24/7/365 support, high service availability (e.g., 99.9%), and a strong level of governance with executive oversight.
- The NHS Spine is an example of a service with Gold-tier characteristics.

Silver Contracts - these contracts have a high-cost impact but lower supplier risk compared to Gold, or moderate criticality overall. Characteristics include:

- Service interruption might lead to operational difficulties that can be managed for a limited period, with a potential increase in clinical risk.
- They require less intensive management than Gold but still more than Bronze, with specific review cycles and clear succession planning requirements.
- The NHS e-Referral Service (e-RS) is an example of a service with Silver-tier characteristics.

Bronze Contracts - these are the least critical contracts, with a low-cost impact and low supply risk. Characteristics include:

- The absence of the contract would lead to manageable operational difficulties over an extended period.
- Contract management activities are typically limited to ensuring on-time, quality delivery with minimal impact on NHS resources.
- Alternative suppliers are easy to source.

Background

The Procurement Act 2023 (PA23) replaced the Public Contracts Regulations 2015 (PCR15) from 24 February 2025.

Section 98 of the PA23 replaces the prescriptive requirement for a "Regulation 84 Report". Now there is a broader obligation to keep sufficient records to explain all "material decisions" made during a procurement process.

Because some procurements will have predated the implementation of the PA 2023, we are still bound to fully follow the principles set of out in the PCR15 Regulations.

For the avoidance of doubt the PA23, *does not* cover an Award Report for the Provider Selection Regime (PSR)

An annual summary *does have* to be published rather than a single report of all awards.

Governance and Compliance Measures:

Approval in line with Standing Financial Instructions and Scheme of Delegation

Transparency Notice (UK5) to be published *prior to* award	Yes/ No Date published: Standstill applied (if applicable): Yes / No

Contract Award Notice (UK10) to be published	Yes/ No
Record keeping compliant with Section 98 of the Procurement Act 2023	Yes/ No
Time-limited contract with defined plan to return to a compliant procurement route	Yes/No
Approval obtained prior to contract award (no retrospective approval)	Yes/No

Methodology

S98 places a duty to keep records of material decisions in awarding or entering into public contracts.

These records must be kept for in line with Trusts' Document Retention and Destruction Policy after the contract is awarded and are essential for demonstrating transparency and accountability.

This obligation overrides or complements other record-keeping requirements if they mandate a longer retention period.

Key Aspects of Section 98

Record-keeping: We *must* keep records that explain any *"material decision*" made during the procurement process, including decisions about awarding or entering into a public contract. *See Appendix* 1

NB: "material decision" for these purposes will mean any key decision in the procurement that either the Act requires you to make, or that results in you publishing or issuing a formal notice/document about the procurement (e.g. route, exclusion, evaluation, award, modification or termination)

- **Purpose:** The goal is to support transparency, fairness, and accountability in public spending.
- **Duration:** Records must be retained in line with the Trust Retention Policy
- **Exclusions:** The section does not apply to defence and security contracts
- **Communication:** It includes an obligation to keep records of communications with suppliers that occur before a contract is awarded and relate to the procurement or its award

Notices: Where the contracting authority decides not to award a contract after publication of a tender or transparency notice, it must publish a Procurement Termination Notice (UK12). The decision to terminate the procurement is itself a material decision and records must be kept to explain that decision. Under section 98 of the Procurement Act 2023, the specific duty to retain records for that procurement ends on the date the Procurement Termination Notice is given; however, the Collaborative will continue to retain procurement records in line with the NHS Records Management Code of Practice and the HNY ICB Records Retention Management Policy (i.e. the usual corporate / contract retention periods

Humber and North Yorkshire Procurement Collaborative

Contract Award Recommendation Report

Contract Details		
Date	14th July 2026	
Project Reference	C208618	
Contract Title	Linen and laundry service	
Procurement Regime	**Public Contract Regulations 2015**	Yes
	Procurement Act 2023	No
	Provider Selection Regime	No
Direct Award:	Yes - Direct Award using the North of England Commercial Procurement Collaborative (NOECPC) Laundry and Linen Services Total Solutions framework	
Procurement Lead	Paul Horsefield	
Project Lead/ Sponsor	Edd James / Keith Fowler	
Sourcing Strategy Approval Date	May 2024	
Contract Classification	Gold	
Spend Controls Obtained?	**Cabinet Office (over £20m)**	Not Applicable
	NHS England (management consultancy over £50k)	Not Applicable
	ICB Double Lock (£50k+)	Not Applicable
Conditions of Approval	Not applicable	
Confirmation Conditions Met	Not applicable	
Proposed Start	1st April 2026	
Contract Length	4 years	
Data Protection	Not applicable	
Maintenance	Not applicable	

Purpose of the Report (put an "X" in all which apply)			
To provide assurance	X	**To obtain approval**	X
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	

To provide advice		To highlight patient or staff experience	

Governance & Assurance Classification		
Route to market: Direct Award via NOECPC Laundry and Linen Services Total Solutions framework		
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Urgency (unforeseeable):		Not applicable
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Award without competition (PA23 Schedule 5): Yes		Not applicable
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SFI Waiver Required:	Not Applicable
Waiver Reference (Atamis):	Not applicable
Approval in line with SoD confirmed:	Not applicable
Waiver - internal permission ***Direct Award - legal route***	

Approval Required (delete the rows of any group/ individual who do not need to approve)		
Authorisation of single contracts (including variation and extension) for revenue or capital over £5m total value (excl. VAT)	Trust Board	Yes

Background Information	
Name and address of the contracting authority	Northern Lincolnshire and Goole NHS Foundation Trust Scunthorpe General Hospital Cliff Gardens Scunthorpe North Lincolnshire DN15 7BH
Subject matter of contract	Linen and laundry services
Reasons for the procurement	This procurement exercise has been undertaken due to renew an existing contract.
Value of the contract	Circa. £6.0M over the four year term.
Savings Achieved or Cost Pressure	Cost pressure – see table below

	1 Year	4 Years
	£'000 incl. VAT	£'000 incl. VAT
Current Contract	1,345.2	5,380.7
Proposed Contract	1,498.6	5,994.2
Proposed Increase	**153.4**	**613.5**

Proposed Contract value uplift of £153.4k per annum.

Pre-Procurement Considerations	
Market Analysis	Duopoly market
Choice of Procedure	Direct award to incumbent using the NOECPC Laundry and Linen Services Total Solutions framework
Prior involvement	Not applicable

Pre-Qualification Stage
Not applicable – Direct Award (no competitive process undertaken) under framework

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Names of candidates or tenderers rejected during the procurement procedure	Not applicable

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Conflicts of interests: those conflicts detected and subsequent measures taken	In making this recommendation, all members of the project have confirmed that they do not have any interests of relationships to declare that would have breached the Trust's commitment to transparent decision making.

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Trust Board		

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NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)252

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9 October 2026**
Director Lead	**Keith Haynes, Interim Board Secretary**
Contact Officer / Author	**Alison Hurley, Deputy Director of Assurance**
Title of Report	**Trust Constitution amendment - Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**
Executive Summary	Trust Board members are asked to consider and approve the NLaG Trust Constitution changes detailed. The amendments for approval cover the inclusion of a "validity of acts" clause. This is a protective clause which provides that the acts, decisions or proceedings of the Trust remain valid despite a vacancy among Governors or Directors, or a defect in the appointment or election of a Governor or Director. In practical terms, it helps reduce the risk that otherwise lawful decisions could be challenged solely because of a technical vacancy or appointment issue. It would not remove the need to comply with the Trust Constitution and relevant statutory requirements, but it would provide additional assurance in the event of unavoidable vacancies or interim governance arrangements. Currently there is no such clause in the NLaG Trust Constitution and it would be sensible to make provision for this going forward. This could be addressed by the inclusion of the following in the Constitution: 10.4 (Governors) - The validity of any act of the Trust is not affected by any vacancy among the Council of Governors or by any defect in the appointment or election of any Governor. 24.5 (Non-Executive Directors) and 26.4 (Executive Directors) - The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any Director. The revised draft Trust Constitution is appended for review.
Background Information and/or Supporting Document(s) (if applicable)	NHS Constitution
Prior Approval Process	Council of Governors' meeting 20 August 2026
Financial Implication(s)	N/a
Implications for equality, diversity and inclusion, including health inequalities	N/a
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

TRUST CONSTITUTION

Document control use only	
Reference	DCM001
Directorate / Care Group	Group Chief Executive Officer Directorate
Version	~~8.0~~
Result of last review	Validity of Acts clause added
Issue date	~~05/06/26~~

Author / Owner Use Only	
Group or Trust specific document	NLaG
Date approved by owner (for minor changes only outside committee)	N/A
Date approved	20/08/26 / ***09/10/26 TBC***
Approving body	Council of Governors / Trust Board
Next full review date	April 2029
Lead Director	Alan Downey, Group Chair / Lyn Simpson, Group Chief Executive
Document type	Miscellaneous”
Author / Contact	Keith Haynes, Interim, Board Secretary
Key words	Trust Constitution

Printed copies valid only if separately controlled

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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.

10.4 The validity of any act of the Trust is not affected by any vacancy among the Council of Governors or by any defect in the appointment or election of any Governor.

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.

24.5 The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any director.

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.

26.4 The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any director.

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
33. Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. De-duplication of votes
39. Declaration of identity but no ballot paper
40. Sealing of packets

Part 6 – Counting the votes

41. Single Transferable Vote (STV) - Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
44. STV - Rejected ballot papers
45. First Past the Post (FPP) - Rejected ballot papers
46. STV - First stage
47. STV - The quota
48. STV - Transfer of votes
49. STV - Supplementary provisions on transfer
50. STV - Exclusion of candidates
51. STV - Filling of last vacancies
52. STV - Order of election of candidates
53. FPP - Equality of votes

Part 7 – Final proceedings in contested and uncontested elections

54. STV - Declaration of result for contested elections
55. FPP - Declaration of result for contested elections
56. Declaration of result for uncontested elections

Part 8 – Disposal of documents

57. Sealing up of documents relating to the poll
58. Delivery of documents
59. Forwarding of documents received after close of the poll
60. Retention and public inspection of documents
61. Application for inspection of certain documents relating to election

Part 9 – Death of a candidate during a contested election

62. STV- Countermand or abandonment of poll on death of candidate
63. FPP - Countermand or abandonment of poll on death of candidate

Part 10 – Election expenses and publicity Expenses

64. Election expenses
65. Expenses and payments by candidates
66. Expenses incurred by other persons

Publicity

67. Publicity about election by the corporation
68. Information about candidates for inclusion with voting information
69. Meaning of “for the purposes of an election”

Part 11 - Questioning elections and irregularities

70. Application to question an election

Part 12 - Miscellaneous

71. Secrecy
72. Prohibition of disclosure of vote
73. Disqualification
74. Delay in postal service through industrial action or unforeseen event

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

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 shareholdings 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 Performance, Estates and Finance 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 Boards-in-Common, 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.

10.3 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 shareholdings 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.

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)253

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Friday 9 October 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 - July 2026
Executive Summary	The Quality & Safety Committees-in-Common minutes from the meeting held on 23 July 2026
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees-in-Common held on 24 September 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 23 July 2026 at 9.00am to 1.00pm via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Group Non-Executive Director - Chair
Julie Beilby	Group Non-Executive Director
Jo Ledger	Interim Group Chief Nurse
Caroline Hibbert	Medical Director (North)

In Attendance:

Sam Peate	Group Chief Delivery Officer
Rebecca Crashley	Group Deputy Director of Assurance
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Yvonne McGrath	Group Director of Midwifery
Joanne Goode	Chief Pharmacist
Helen Birks	Research, Development & Innovation Matron
James Illingworth	Research & Development Manager
Nicola Buckle	Senior Matron IPC
Michelle Lawtie	Senior Matron IPC
Ryan Sutton	Associate Director of Quality Improvement
Rachel Hoggarth	Enhanced Care Team and Mental Capacity Lead
Jaqueline Fenwick	Senior Nurse Vulnerabilities
Dr Harish Lad	Clinical Lead for Organ Donation - Group
Alison Gresty	Quality and Continuous Improvement Manager – Path Lincs
James MacLean	Chief of Service – Pathology Network
Gerard Curran	Head of Legal
Corinn Manaley	Governor Observer
Jo Palmer (Minutes)	PA to the Group NEDs & Committees-in-Common

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

0.1 Patient Story

Michela Littlewood presented a patient story relating to a seventy-seven year old patient who had attended ED four times over several months with pain following a fall. Eventually, the diagnosis was a compression fracture of the spine, but she had been living with pain that had affected her quality of life. The family had lost confidence in

the care provided and questioned why the diagnosis had not been reached sooner. The investigation identified missed opportunities, particularly considering the patient's age, history of injury, repeated attendances and an opportunity to have diagnostic imaging sooner. A full apology had been issued and some learning taken around missed opportunities as detailed above, along with a senior clinical review possibly enabling an earlier diagnosis.

Jo Ledger reminded colleagues that this was another example of a patient story where the relative had not been heard and this message needed reinforcing amongst staff not only within ED but across the wider organisation.

Julie Beilby was of the same view and considered that a short video of the family may have more of an impact on staff than purely an update on Bridget. Michela Littlewood offered to make some enquiries as to whether the family would agree to feature in a small video that would be included for future Board stories.

ACTION: Michela Littlewood to make enquiries regarding potential families agreeing to a short patient story video

David Sulch questioned how re-attendances were flagged on the ED system for senior review and Dr Hibbert confirmed that such attendances should flag up on the Lorenzo system.

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair, David Sulch, welcomed those present to the meeting. Apologies for absence were received from Dr Kate Wood, Group Chief Medical Officer, Dr Peter Sedman, Deputy Group Chief Medical Officer, David Sharif, Group Director of Assurance, Hilda Gwilliams, Group Chief Patient Safety Officer and Tracy Campbell, Director of Nursing (North).

1.2 Staff Charter & Values

The Chair reminded colleagues to be mindful of these throughout the course of the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 25 June 2026

The minutes of the meeting held on 25 June 2026 were confirmed as a true and accurate record.

1.5 Matters Arising

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

1.6 Review of Action Tracker

The following updates to the Action Tracker were noted:

Item 4.9 - 26 March 2026 - action closed
Item 4.2a) – 30 April 2026 – action closed
Item 4.4 – 28 May 2026 – action closed
Item 4.10 – 28 May 2026 – action closed
Item 4.11 – 28 May 2026 – initial meeting to be followed up and an action plan presented at the September meeting. Action closed
Item 3.2b) – 25 June 2026 – action closed
Item 4.6 – 25 June 2026 – action closed
Item 7.1 – 25 June 2026 – action closed

1.7 **Operational Pressures Update**

Sam Peate updated colleagues on the UEC work being undertaken across the Group. In terms of the North bank, the re-flooring work at HRI ED commenced on 20 July 2026, with the ED having moved to a different location. He was pleased to share that there had been an improvement on the four-hour compliance over the last couple of weeks which had been sustained despite the move, with improvements also in terms of patients waiting longer than twelve hours. For the previous couple of weeks, the Group featured within the Top 50 of the national league table for patients waiting over twelve hours in the department and for one of those weeks, within the Top 30. At the time of this meeting, thirteen days had passed with no patients in ED at HRI for longer than twenty-four hours, which Sam Peate noted to be a key patient safety measure needing close attention.

In terms of the South bank, focus continued around ambulance handover delays. At the recent tiering meeting with NHSE, they recognised that some historic ambulance handover issues had reduced but there was still some further improvement required.

Jo Ledger gave an update on the Listeria issue and confirmed that cases continued to be referred but were so far negative and it was yet undecided whether to proceed with a retrospective look at patients who have passed away but advice was being sought from the UKHSA.

David Sulch welcomed the improvements in ED performance but questioned how these could be sustained. Sam Peate responded that continued focus was required now and over the next six to twelve months during further move-around of specialities within the Estate, particularly at HRI.

2. MATTERS REFERRED

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

There were no matters referred.

3. RISK & ASSURANCE

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

There were no external or internal audit report & recommendations to note.

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

- **Group Policy for the Management of External Agency Visits, Inspections and Accreditations**

Rebecca Crashley reminded colleagues that the Committee wanted assurance on how External Agency Visit reports were communicated to the Committee and Trust Board. Michela Littlewood added that the process was now more robust than previously following ongoing learning through Risk and Compliance, but challenge remained in that the compliance team needed to know that a visit was taking place and who was involved.

The report was accepted by the Committee for information.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

PATIENTS – SAFETY

4.1 **Quality & Safety**

Board Assurance Framework Q1

Rebecca Crashley advised the meeting that Keith Haynes, Interim Board Secretary, was now leading a group along with NHSE and The Value Circle on a complete refresh of the BAF, to be incorporated and aligned with the Integrated Improvement Plan (IIP).

Richard Dickinson asked whether the Trust Board objectives were changing and David Sulch confirmed there had been no such discussion at Trust Board.

Julie Beilby referred to the six P's and considered that 'Pioneering', with its mix of research and digital, was ineffective as the digital risk did not have the sufficient focus. Rebecca Crashley confirmed that there would be a separate digital risk included in the future BAF. Julie Beilby also stressed that if there was to be any removal of mitigations, there should be some self-reflection on why they were indicated in the first place. She was also concerned about the number of green rated actions, considering the risk score had not been reassessed. Rebecca Crashley confirmed that assurance ratings were also being reviewed and the Executive lead, along with the Chair of the CiC, would now be involved in the BAF conversations before presentation at the CiC.

Sam Peate referred to the scored date of the key risks within the summary section and asked for clarity on whether that date was when the issue was agreed as a risk as opposed to when it was received and therefore, it was important that terminology was clear.

It was expected that a refreshed version would be available for approval at the next meeting of the Trust Board in September, ready for presentation of Q2 at the October meeting of this Committee. Joanne Goode asked whether the BAF would

be shared with the wider teams and Rebecca Crashley confirmed it would be updated on Bridget as a live document in due course.

David Sulch looked forward to seeing the new BAF being presented in a way that drives the work of the Committee, reflects activity and aligns with the Risk Register.

4.2

Risk Register Q1

Julie Beilby noted that the temporary escalation spaces (TES) risk was still scored at 20, despite the plan to remove all these spaces by the end of July 2026. The Committee anticipated that all such anomalies would be addressed within the refresh and the Risk Register would be aligned with the refreshed BAF.

4.3

Integrated Performance Report (IPR): Quality & Safety Metrics

Richard Dickinson highlighted improvement within the mortality data for NLaG particularly, with HUTH remaining stable. Duty of candour compliance was also improved following a more reliable process being adopted. He detailed the lowlights as being a reported HUTH Never Event in June 2026 following a six-month period of no Never Events. The safety alert on medical beds continued to be challenging, although there had been some progression. Challenges remained around septicemia across the Group and IPC in general, which would be covered later in the meeting. VTE compliance had slightly improved in position across the Group.

Michela Littlewood gave an update on the HUTH PALS recovery programme and shared that following a review by The Value Circle, there was to be some PALS presence within the HRI foyer, and some training around PALS on the wards, particularly around calls for inpatients. The Friends & Family Test contract was due to expire at NLaG and a meeting would be held to establish whether an in-house model could be implemented or a further outsourced service established.

Julie Beilby pointed out to colleagues that Murray MacDonald, Group Vice Chair, was working with Sam Peate to refresh the IPR and this paper would look different going forward, noting clearly which items needed to be brought to Trust Board attention, Committee attention and which were linked to the intensive recovery plan. Sam Peate added that work had indeed commenced on looking at the new IPR and it was hoped that the new version would be circulated at the beginning of August 2026 to allow people time to comment and then be adopted as the new format from September 2026, for at least a six-month period before further review.

4.4

Learning from Experience and Reviewing Never Events

Richard Dickinson again noted the Never Event from June 2026 and the aim to improve the long investigation periods following patient safety incidents. Challenges around patient experience continued.

Julie Beilby was disappointed to hear of the Never Event and stressed that these events literally should never happen. Any instances should be learned from, and she was keen to understand the sentiment towards Freedom to Speak Up and why no-one did if they saw something was wrong. Any learning taken from this could then be integrated into the Freedom to Speak Up policy to encourage staff to

speak up at the time if patient safety was impacted. Jo Ledger agreed with this comment and noted that international colleagues were less likely to speak out so there was clearly work to be done in this particular area. Dr Caroline Hibbert was keen to assure colleagues that staff were encouraged to speak up, the Stop the Line process is followed, and staff were confident in speaking up.

Michela Littlewood spoke of the work she was doing with Lucy De Vere, Group Director of Learning and Organisational Development, on how staff can be empowered by using what they have learnt from past scenarios to hopefully prevent anything similar from happening in their own area of work.

Julie Beilby shared that at her last meeting with the Freedom to Speak Up guardians, they spoke of the Stop the Line initiative and it was clear that this message needed to continue to be spread across the Group to encourage those slightly less-confident staff members, for whatever reason, to voice their concerns. Dr Caroline Hibbert added that the first of the new theatre safety days had taken place and this subject was indeed covered there.

Yvonne McGrath joined the meeting at 9.50am

David Sulch acknowledged the slight difference between Stop the Line and Freedom to Speak Up and asked whether the Group used simulation to train people in scenarios. Richard Dickinson and Dr Caroline Hibbert confirmed that theatre staff did use the simulation suite at the HRI site, and it was well received by the staff.

This paper was taken by the Committee for information.

4.5

Maternity & Neonatal Assurance Report (including Ockenden, CNST, MIS, incidents/MNSI)

Yvonne McGrath presented her paper, which included the maternity dashboards. Induction of Labour was still challenging, and reporting of data was being reviewed. There had been an early indication of funding to support additional early career midwife posts. She shared that she had begun some work with the NPIP team on how to align the maternity and neonatal improvement plan with the IIP. Improvement against VTE compliance was being sustained. All vacant posts had been recruited into with October/November start dates. £10K support funding per WTE had been received from NHSE and it was hoped that this could be used to support the maternity backfill, which was 50% at HUTH.

Yvonne McGrath also spoke on the 10-point plan which was related to listening to patients and their families by adopting Martha's Rule. Guidance was awaited and a regional and national workshop planned for August and September 2026. In terms of PALS and complaints, accountability would sit with both the Medical Director and Chief Nursing Officer. Data relating to inequalities within midwifery would begin to appear within the dashboard and a perinatal health inequalities steering group had been launched with some related workstreams to follow.

Jo Ledger referred to the dashboard and asked the Committee to indicate if anything else should be included, noting that a glossary was to be added.

In relation to the Ockenden report, Julie Beilby asked around the progress of essential actions with twelve rated as red and was unsure what the barrier was to stopping these from moving forward. Yvonne McGrath responded that NHSE had asked that the Ockenden immediate and essential actions were not reviewed nor action plans formed as a task force would be overseeing this, expected by December 2026. The Department of Health had not accepted all the actions in the second report, and along with the commencement of the new Secretary of State, the situation was uncertain at the moment.

Dr Caroline Hibbert asked how the gap in neonatal vacancies was to be addressed and did note it was a regional issue. Yvonne McGrath explained that there had been a high turnover of staff due to the current work pressures, but recruitment was ongoing.

Helen Birks joined the meeting at 10.25am
James Illingworth joined the meeting at 10.28am

Richard Dickinson noted the comprehensive dashboards but commented on some metrics not having any target dates and asked whether these were being taken in order of priority. Yvonne McGrath replied that the appropriate triangulation would take place across the Group but the metrics with no target were intentional. He also asked how some of the mortality and morbidity indicators could be used through the wider Learning from Deaths learning and welcomed a conversation on how to progress this.

Yvonne McGrath also highlighted the ODN supportive visit paper and the requirement for approval to agree and progress the implementation plan with the ODN and SPECOM to return the SGH neonatal unit to full LNU status. Jo Ledger stressed that Trust Board agreement was sought for this and as there was some discussion around the Committee's delegation rights, Rebecca Crashley confirmed that the Trust Board would need to have knowledge of a topic before delegation to the Committee could be advised. However, it was noted that there was neither a Trust Board nor a Committee meeting until September 2026 and therefore David Sulch offered to contact the Group Chair, Alan Downey, to ask for his advice.

ACTION: David Sulch to contact the Group Chair to ask for advice on how to progress the ODN supportive visit paper

Julie Beilby considered it would be worthwhile having a generic delegation agreement in place between the Trust Board and the Committee to avoid a potential delay with matters in the future and suggested Rebecca Crashley discuss this further with Keith Haynes.

ACTION: Rebecca Crashley to discuss a generic process around delegation from Trust Board to the Committee with Keith Haynes

David Sulch questioned whether the recruitment vacancy freeze was having an impact on the agreed move to invest in maternity and neonatal staffing and Yvonne McGrath replied that in terms of midwifery, there had been a firm focus in Quarter 1 on recruitment but did acknowledge that a few specialist posts would be impacted. David Sulch also considered the value of an action plan being produced by the Department of Health or NHSE for maternity and neonatal services considering the amount of reports that come through to the service with

recommendations and Yvonne McGrath replied that something along those lines was expected around December 2026.

Julie Beilby considered as new Group NEDs were in the process of being recruited, it may be beneficial to arrange a maternity and neonatal Board Development session in the New Year and Yvonne McGrath agreed with this and was aware that NHSE were to hold some bespoke training on maternity for NEDs.

ACTION: Rebecca Crashley to list maternity and neonatal as a potential Board Development session in the New Year

There was some discussion around Martha's Rule and Michela Littlewood added that an increased number of complaints had been received related to Martha's Rule which weren't necessarily appropriate as they did not relate to a deteriorating patient.

Reasonable assurance was provided by the Committee, based on improvements recognised but progress still to be made.

Nicola Buckle joined the meeting at 10.47am
Yvonne McGrath left the meeting at 10.47am

4.6

Research, Innovation & Development Q1, including:

- **Nursing, Midwifery & AHP Strategy overview**

James Illingworth advised that recruitment into research targets for Q1 across the Group were on track. Funding had been received from the Humber Alliance for Health Care Innovation to enable the appointment of the first clinical innovation fellow which would support some of the innovation projects but now also in a clinical way. He was also pleased to share that Prof Bandari had been awarded the William Cullen award for service to renal research and pathways and service development, Mr Ravindran, vascular surgeon and his team won the HSJ Digital award for an AI project in vascular and also the respiratory team working on the Frontier Project for innovation which won the Royal College Excellence in Patient Care award.

Michelle Lawtie joined the meeting at 10.48am

Helen Birks spoke on the nursing, midwifery and AHP research strategy and the progress of the RDI programme so far. She was pleased to advise that good progress had been made in embedding a strong research culture directly into frontline clinical practice across the Group and the strategy was a main feature in this. Implemented through the support, deliver and lead learning pathway (SDL), the strategy group now included senior nursing, midwifery and AHP leadership and used a cross-disciplinary approach. What was worthy of note was that non-research based clinical staff were stepping forward to lead major research initiatives and particularly access learning from it. She reported that recent surveys had indicated a strong enthusiasm for research but there were recognised barriers from access, confidence and protected time. To begin addressing these, initiatives including the potential funding of a protected research time programme for Band 5 staff had been implemented. She was pleased to add that the research champion model continued to gain interest, and there were now forty-eight champions having completed training on the North bank and twenty waiting for training on the South

bank. Supportive material was available to the champions on Bridget, and a newsletter was distributed frequently.

Corinn Manaley joined the meeting at 10.53am

Helen Birks further added that a successful NAHR funding bid had enabled the acquisition of two fully mobile research units, one for each bank. They would also be used as additional clinic space when required but predominantly allowed for increased engagement from the community.

Workstreams were in progress with no risk areas. For the next quarter, the focus would be around hopefully launching the Band 7 protected research time initiative should funding allow and completing the South bank champion training.

Jo Ledger added that the working group had been set up around eighteen months previous and it was clear that a huge amount of work had been done since that time.

Jo Goode informed the Committee that the research opportunity within pharmacy had had to be withdrawn, despite a good deal of interest, as no backfill of existing posts was provided. Jo Ledger offered to investigate this with Jo Goode outside of the meeting.

ACTION: Jo Ledger to meet with Jo Goode to discuss backfilling issues

Michela Littlewood also thanked Helen Birks for her positive and inspirational update and indicated that she would be in touch a little later in the year in respect of some shared learning for a future planned piece of work.

David Sulch recognised the risk of losing research opportunities due to the lack of backfill following the vacancy freeze and asked that this be added to the action tracker.

ACTION: Risk of losing research opportunities due to lack of backfill following the vacancy freeze to be added to the action tracker

Significant assurance was given.

The Committee congratulated the award-winning staff members named earlier in the item and David Sulch asked that the names be highlighted to Trust Board.

James Illingworth and Helen Birks left the meeting at 11.03am

4.7 **IPC current overview and:**

Nicola Buckle alerted the Committee to the significant CDI rates across the Group and the newly published thresholds which in some cases had reduced by 10%. A quality improvement plan had been written and there was due to be the first medical nurse in CDI rounds at HUTH. She also advised of outbreaks of MRSA bacteremia, ESBL and VRE but outbreak management work had supported no further cases. She referred to the national Listeria alert and advised that patients were being monitored within the cancer clinical support care group. She assured the Committee that there was ongoing education, training and development and a

rollout of the training competency package. The IPC digital system ICNet was implemented in HUTH in May 2026 and continued to support incident management. IPC audit completion was improved and the team continued to engage with Care Groups in terms of their red rated poor performance areas.

Sam Peate asked about the threshold levels detailed within the paper and Nicola Buckle stressed that these were those of the previous year so there may be some minimal changes which would be updated. Sam Peate explained that both CDI and E.coli were key metrics within the NOF oversight framework and the scoring, albeit poor, was based on the distance from the trajectory as opposed to infection rates.

Jo Ledger added that as part of the work with the ICB and NHSE, a great deal of data had been provided to them, and they were working on what support could be available to the Group. Elements of poor compliance were being seen, and it was agreed that a different approach was required. In terms of enhanced cleaning, a business case had been developed to ask for funding to continue with this 24/7.

David Sulch asked whether any issues had been identified following the RCAs for CDI 2025/26 cases and Nicola Buckle replied that there were issues around sampling, treatment, compliance and AMS prescribing.

Limited assurance was provided and the Committee acknowledged a great deal of work ongoing but as yet no positive outcomes seen.

- **CPE outbreak internal review findings**

Michelle Lawtie advised that the CPE outbreak at NLaG had affected three hundred and twenty-two patients, nineteen of which were positive for CPE. This took twelve months to clear at DPoW and ten months to clear at SGH. Expert support had been received from NHSE UKHSA and ICB colleagues and the team continued to work to a planned maintenance workstream including sink and drainage replacement work. She added that CPE remained within the community and many patients were being readmitted.

David Sulch thanked her for the report but questioned whether there was an ongoing risk of other infections and viruses laying dormant within the Estate or were some of the initiatives already starting to mitigate the risk. Michelle Lawtie replied that infrastructure issues were a risk and this was included within the Risk Register, particularly wards C5 and C6 at DPoW. David Sulch was clear that this needed further discussion at Trust Board.

Sam Peate shared that a discussion had taken place about decant areas, particularly at SGH and he would raise this at the next meeting.

The meeting paused for a ten-minute break at this point

Jacqueline Fenwick, Rachel Hoggarth, and Alison Gresty joined the meeting at 11.38am

EQIA update

4.8

Ryan Sutton introduced the quarterly assurance paper and spoke on the work being undertaken to address the gaps in the EQIA process, initiated by the EQIA policy being due for renewal in August 2026, new national guidance around EQIA

policies and recent internal learning around EQIAs. He confirmed that a robust governance process was in place with close management of risk during the approval and post-approval stage but shared that there were some areas identified that could be improved. Work was underway to address these issues, and a revised policy would be available early August 2026 for approval.

Dr Caroline Hibbert added that historically, the EQIAs were about CIP but the recent gap analysis could make EQIAs more relevant to how hospitals were managed through service change. She was also conscious of the lack of training in the completion of EQIAs and Ryan Sutton confirmed that this would be looked at as part of the task and finish group being set up to look at improvements in the process.

James Maclean joined the meeting at 11.45am

Julie Beilby suggested that within the front sheet under the section 'implications for equality, diversity and inclusion, including health inequalities', a reference to protected characteristics was added. She also recommended some acknowledgement of socio-demographic issues such as digital exclusion and shared that at a recent Governors' meeting there had been some discussion around digital inclusion being easily overlooked.

David Sulch suggested this item be taken for information rather than assurance and looked forward to seeing the new plan and policy presented at a future Committee meeting.

Ryan Sutton left the meeting at this point

ETOC and Restraint and Restriction update

4.9

Jackie Fenwick shared an update from the last paper presented in March 2026 and was pleased to confirm that as of 1 July 2026, security were no longer being asked to perform bed watch and there had been no increases in patient or staff safety incidents as a result of the change. There was now a move towards providing therapeutic intervention as opposed to bed watch, but the challenge was how to provide this from a workforce perspective. The options were to have a specific ETOC team, as recommended by the NHSE, or to utilise existing ward staff, the latter of which was chosen. Job descriptions would be amended accordingly and a training programme implemented. The vulnerabilities team had demonstrated a pilot for a Vulnerabilities study day with good feedback received and this would be built upon and adopted. Jackie Fenwick updated that NHSE had visited the teams across the Group in March 2026 and were briefed with some recommendations. She had met with them again in June 2026 and they were happy with the progress made so far. A quarterly report would be provided to NHSE on progress related to therapeutic interventions.

Rachel Hoggarth spoke of the work underway to look at the leadership around restraint and restriction and to identify trainers within the existing workforce but recognised the risk around funding for training, competency was for only one year so would need to be renewed to align with the national standard compliance and the restraint and restriction network.

Dr Harish Lad joined the meeting

Julie Beilby was pleased to receive the report after a lot of concern across the various committees around the use of security staff and following the Internal Audit report and recognised the significant progress made. David Sulch agreed with this and pointed out that changing historic behaviours was often challenging but to do so in such a short timeframe was remarkable. In turn, Jackie Fenwick acknowledged and thanked the staff on the wards for their support in following the new way of working.

The Committee noted the report for information.

Jackie Fenwick and Rachel Hoggarth left the meeting at noon

Deep Dive – Fuller Phase 2 Review

4.10

Alison Gresty shared her report and advised that significant progress had been made since the Fuller Phase 2 Review recommendations had been issued. The Review had been undertaken between September 2025 and June 2026 and focussed on mortuary services, body stores and bereavement across the Group. She shared that a governance group had been formed under the leadership of Dr Peter Sedman, Group Deputy Chief Medical Officer and included representatives from mortuary services, pathology labs, bereavement, maternity services, surgery and A&E across the Group. Despite the good progress, there were some significant gaps, mainly around security, governance, assurance, safeguarding and Trust Board oversight, as well as a clear understanding of the HTA licencing and dignity in the deceased. Incidents were being reported and investigated but there was no clear route for escalation or a provision for assurance to Trust Board around dignity, safeguarding and security. The Review recommended that the safeguarding of the deceased forms part of organisational safeguarding arrangements and with the publication of the Safeguarding Assurance Framework 2026, internal policies and processes needed to be improved to align with the guidance. James Maclean clarified that although the Goole body store did not feature within the Review as this was a separately managed service and non-HTA registered, the team were aware of some improvements needed in that area in terms of security.

Julie Beilby noted that there was no action plan with timescales and so on, but hopefully with a proposed task and finish group, this would be implemented and managed. There was also no indication of the amount of funding required to make these improvements nor an indication of priorities to enable budget setting or a request for immediate work. Alison Gresty confirmed that there was an expectation to go through the business case approval process for any work that was required.

David Sulch was concerned about the access issues not having been addressed until now and that a HTA governance process had not been in place until recently.

The Committee gave limited assurance on this item, because of the need for the task and finish group to be established, an action plan in place with indication of timescales and an indication of funding requirements.

Gerard Curran joined the meeting at 12.10pm
James Maclean and Alison Gresty left the meeting at 12.19pm

ANNUAL REPORTS

Medicines Optimisation Annual Report

5.

5.1 Joanne Goode highlighted that the medication safety dashboard had been established and was working well, providing monthly reports to the Care Groups. She advised that pharmacy was also working as an ICB with the single system area prescribing committee, which oversees the Medicines and Therapeutics Committee chaired by Dr Caroline Hibbert and it was supporting the Group task and finish group for insulin safety. Concerns were around controlled drug incidents and unaccounted losses from across the Group. The CQC had recently made some recommendations around the medicines reconciliation rates, particularly at HUTH, but likely required at NLaG also. Activity had begun on decommissioning the nitrous oxide pipelines at NLaG, which had taken place at HUTH a couple of years previous and the new EPR system, ORBIS U, was anticipated to enhance the service going forward.

The report was approved.

Joanne Goode left the meeting at 12.21pm

Organ Donation Annual Report – Group

5.2 Dr Harish Lad shared his report, noting that consents for transplants were reducing not only within the Group but nationally and was impacting the waiting list of around 8500 people currently waiting for a donor, which was at its highest level for at least a decade. Tissue donation continued to be a challenge.

David Sulch thanked Dr Harish Lad for his report and for the continuing efforts of his team.

Dr Harish Lad advised the Committee that there was currently no appointed Chair for the NLaG Organ Donation Committee and asked for its support in securing the position. Sam Peate offered to have a discussion with appropriate medical leads as to how to progress this. Dr Harish Lad clarified that the role was voluntary and a job description was available through the NHSBT website.

ACTION: Sam Peate to discuss how to progress the appointment of a Chair to the NLaG Organ Donation Committee and update at the September meeting

Dr Harish Lad left the meeting at 12.35pm

Legal Service Annual Report

5.3 Gerard Curran reminded colleagues that the data within the report related to treatment that had taken place some years previous and improvements to processes had likely taken place in the time of the incident taking place and the date that the case was settled. He confirmed that an inquest panel had been implemented which ensured that everything had been prepared in advance of an

inquest taking place. He advised that a new Area Coroner had been appointed at Hull, Lorraine Harris, who had indicated that she expected an increase in inquests going forward and had asked the Medical Examiner service to refer all surgical deaths that had not been referred previously for her to review. Gerard Curran pointed out that a request for an inquest did not equate to a suspicion of poor care or harm, but purely to determine how a person came about their death.

Richard Dickinson added that there was a backlog with disclosures and the team was looking at a process of remedy using the disclosure process in health records to reduce the backlog.

Julie Beilby referred to the high number of ongoing open disclosures at NLaG and the high number of open inquests also at NLaG and asked whether action plans were in place to address these. Gerard Curran replied that the issue of the disclosure backlog had been escalated but recovery was incomplete due to internal issues and outsourcing was now being used, with a plan of action implemented and aim for the backlog to be cleared by October 2026. In terms of the open inquests at NLaG, he did not consider this to be an issue at NLaG and reflected that during the COVID pandemic, the North East Lincolnshire coroner closed for two years and has now completely closed and replaced by the Greater Lincolnshire coroner, who was closing some of the backlog down, which in turn would reduce the backlog for the organisation.

Julie Beilby emphasised the need for embedding learning from incidents and noted that the Care Group quality governance teams were asked to use the data, but she indicated that the NEDs are challenged on how to ensure that learning is embedded and followed up. This potentially could be covered by an Internal Audit exercise. It was important that this was addressed as incidents were costly to the organisation and patient safety was a priority.

Dr Caroline Hibbert voiced her concerns over doctors not responding to requests for reports, which was significant at NLaG and somewhat at HUTH and asked Gerard Curran whether he required any support on this. Gerard Curran replied that a good process was in place with regular panel meetings overseen by Dr Peter Sedman, Group Deputy Chief Medical Officer. Dr Caroline Hibbert also referred to the number of doctors who ask for claims reports and do not feel as if they are being heard and she was keen to see the information being used for learning purposes and so considered what the barriers were in terms of the doctors receiving these. Gerard Curran advised that the data migrated onto the Ulysses system was in the process of being verified and it was hoped that this would be complete by the end of August 2026. Once completed, dashboards would be developed where Care Groups can see the data related to their service. He also added that there was good engagement with the Care Groups in terms of giving a case history within their governance processes for learning purposes.

The report was approved.

Gerard Curran left the meeting at 1pm

PSIRF Learning Response Annual Report

5.4 Richard Dickinson reminded colleagues that this report had been deferred at the previous meeting. He advised that the team were aiming to reduce the timescales

for investigations to be undertaken and progress was being made. There were challenges on how investigations were allocated but these were being addressed through the IIP workstreams. He pointed out that there were several examples of learning that were being taken forward and he thanked his colleagues for their efforts.

The report was approved.

HIGHLIGHT REPORTS

Patient Safety & Learning Group

6.

This was noted.

6.1

Maternity & Neonatal Assurance Group

This was noted.

6.2

Risk & Compliance

This was noted.

6.3

ITEMS FOR INFORMATION

Planned Care Board Minutes

7.

These were noted.

7.1

ANY OTHER BUSINESS

8.

8.1 **Any Other Urgent Business**

There was no other urgent business.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

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

There were no matters to be referred to other Board Committees.

9.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

The following items would be escalated to Trust Board:

<u>Alert</u>

- UEC work underway
- IPR to be refreshed

- Patient Experience, PALS recovery and The Value Circle recommendations
- IPC - CDI rates, NOF compliance. CPE outbreak internal review received
- Fuller Phase 2 deep dive received. The CommitteeC has concerns around funding of necessary improvements and the separately managed Goole & District Hospital mortuary and requirements there

Advise

- The Committee heard details of the recent Never Event and again determined that these should never occur
- Board Development session to be arranged at a future date around listening to women
- The Committee recognised the excellent progress around ETOC

Assure

- Work underway to refresh the BAF
- Excellent ongoing work in respect of Research, Innovation & Development, and the Nursing, Midwifery and AHP strategy overview received. The three award winners have been named within the Escalation Report to Trust Board
- A new EQIA process to be adopted, but the task and finish group needed to be further embedded
- Approval of four annual reports

10. DATE OF THE NEXT MEETING

10.1 **The next meeting of the Quality & Safety Committees-in-Common will be held on Thursday 24 September 2026 at 9.00am-1.00pm via MS Teams**

The Chair closed the meeting at 1.06pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2026/2027

Name	Title	2026 / 2027											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y								
Julie Beilby	Non-Executive Director (NLaG)	Y	Y	Y	Y								
Dr Kate Wood	Group Chief Medical Officer	D	D	N	D								
Jo Ledger	Interim Group Chief Nurse	Y	D	Y	Y								
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	N	N	N								
Rebecca Crashley	Group Deputy Director of Assurance	Y	Y	Y	Y								
Yvonne McGrath	Group Director of Midwifery	Y	Y	Y	Y								
Sam Peate	Group Chief Delivery Officer	Y	D	Y	Y								
Hilda Gwilliams	Group Chief Patient Safety Officer	Y	Y	N	N								
Michela Littlewood	Associate Director of Quality Governance (HUTH)	N	Y	N	Y								
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y	Y								
Kevin Allen/ Corinn Manaley	Governor Observer	Y	Y	Y	Y								
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	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) 254

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	Friday 9 October 2026
Director Lead	Jo Ledger, Interim Group Chief Nurse
Contact Officer / Author	Jo Ledger, Interim Group Chief Nurse
Title of Report	Infection Control Annual Report
Executive Summary	The Annual Infection Prevention, Control and Cleanliness Report demonstrates continued progress in strengthening infection prevention, control and cleanliness arrangements across HHP during FY 2025/26. Improvements have been achieved in governance, digital surveillance, policy harmonisation and management of significant incidents. However, variation in HCAI performance and ongoing challenges relating to estate suitability, isolation capacity, audit assurance and workforce resilience mean the organisation cannot yet demonstrate consistent delivery of IPC standards across all sites. HCAI reduction strategies is the priority during FY 2026/27. **Alert:** • HCAIs: C. difficile and bloodstream infection performance • isolation capacity, estate & cleanliness, • audit backlog and; • workforce capacity remain material risks. **Assure:** • Governance, digital surveillance and policy alignment improved. • Successfully management of CPE and VRE outbreaks. • Patient information was standardised. • BAF HUTH zero non-compliant KLOEs at year end • BAF NLAG two non-compliant KLOEs at year end • Evidence of strengthened governance and oversight through the Quality & Safety Committee structure **Advise:** Boards are asked to support delivery of the HHP Infection Improvement Programme and HCAI Reduction strategy during FY 2026/27. • Support targeted investment in workforce, digital surveillance and environmental controls • Receive quarterly BAF and IPC oversight updates through Q&S CiC • Eighteen IPCC owned risks (four high, fourteen moderate at Q4) The report highlights continued risks relating to: • Healthcare-associated infection performance. • Isolation capacity and estate suitability. • Audit compliance and assurance arrangements. • Specialist workforce resilience.
Background Information and/or Supporting	The DIPC Annual Report provides the Trust Boards with an assessment of the effectiveness of infection prevention, control

Document(s) (if applicable)	and cleanliness arrangements across Humber Health Partnership during 2025/26. The report summarises key achievements, areas of ongoing challenge, sources of assurance and principal risks requiring continued executive and Board oversight.
Prior Approval Process	Quality & Safety CiC. ORIC/SIRC
Financial Implication(s) (if applicable)	Targeted investment is required to mitigate identified IPC risks, including specialist workforce capacity, face-fit testing service and expansion, environmental cleaning, vascular access and central line service, medical device standardisation and digital surveillance system (NLAG).
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

V2

NHS
Humber Health
Partnership

HUMBER HEALTH PARTNERSHIP
INCORPORATING
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST (HUTH)
&

LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST (NLAG)

INFECTION PREVENTION AND CONTROL AND CLEANLINESS (IPCC)

ANNUAL REPORT 2025-2026

Written by

Nicola Buckle and Michelle Lawtie, Joint Group Heads of IPCC and Debbie Wearmouth, Infection Control Doctor, HUTH

With contributions from: IPC, Microbiology, Estates, Facilities, Pharmacy AMS teams, Occupational Health and Sepsis team.

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1 Executive Summary

This annual report provides the Board in Common of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) an overview of infection prevention, control and cleanliness across Humber Health Partnership during 2025/26. It demonstrates material progress in governance, digital surveillance, policy alignment and outbreak control. However, preventable infection remains a significant patient-safety and operational risk: both organisations exceeded national thresholds for *Clostridioides difficile* infection and key Gram-negative bloodstream infections, while HUTH remained a significant outlier for MSSA bloodstream infection. Sustained improvement now requires visible Board leadership, clear executive accountability and targeted investment.

Key Achievements:
Key achievements include sustained improvement in IPC Board Assurance Framework compliance, with HUTH ending the year with no non-compliant key lines of enquiry; successful closure of the prolonged NLaG CPE outbreak and containment of CPE and VRE incidents at HUTH; implementation of enhanced screening, rapid diagnostics, digital IPC assessment and surveillance systems; standardisation of patient information and continued rationalisation of the legacy IPC policy library; and development of Partnership-wide improvement programmes for catheter-associated infection, vascular-device safety, antimicrobial stewardship, education and cleanliness.

Areas of Concern:
The principal concerns are the deterioration in C. difficile infection across both organisations; breaches of national thresholds for E. coli and Klebsiella bloodstream infections at HUTH and all three monitored Gram-negative bloodstream infections at NLaG; HUTH's significant regional outlier position for MSSA bloodstream infection; and recurrent evidence of device-related infection, inconsistent fundamental IPC practice and variable cleanliness. These risks are compounded by limited isolation capacity, corridor care, ageing estate and ventilation constraints, incomplete face-fit

testing arrangements, overdue audits, workforce capacity pressures, inconsistent incident coding and incomplete harmonisation of policies. Together, these issues expose patients to avoidable harm and constrain flow, capacity and organisational resilience.

Conclusion:
Overall, HHP can demonstrate committed IPC leadership, important service improvements and effective management of several major outbreaks. Assurance is nevertheless qualified. Current infection performance, workforce and audit gaps, and unresolved built-environment risks show that existing controls are not yet delivering consistently safe standards across all sites. The Partnership must move from predominantly reactive outbreak management to a single, prevention-focused improvement programme, owned from ward to Board and supported by measurable delivery trajectories.

Recommendation for 2026-27:
The Board is asked to: endorse a single HHP IPC improvement programme for 2026/27, prioritising reduction of C. difficile infection, Gram-negative and Staphylococcus aureus bloodstream infections, device-related infection and antimicrobial resistance; assign named executive and clinical owners with monthly trajectories and quarterly Board assurance; require care groups to demonstrate delivery of fundamental IPC, cleanliness, device-care and antimicrobial-stewardship standards; support the specialist workforce and targeted investment needed to resolve audit, face-fit testing, rapid diagnostics, isolation, ventilation and wider estate risks; and hold the organisation to consistent standards across HUTH and NLaG, with prompt escalation where improvement is off track.

2.1 Introduction and purpose of the report

Effective infection prevention, control and cleanliness is fundamental to the delivery of high quality, safe and effective patient care. This remains a significant priority for the Group with an objective for engagement and ownership of infection prevention and control throughout the organisation at all levels from Ward to Board.

The Health and Social Care Act 2008 `Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections` in conjunction with the Care Quality Committee (CQC) regulations, clearly outline Trust Board's responsibilities in providing a collective agreement and overarching strategic direction for IPC, including approval of the Director of Infection Prevention & Control Annual Report.

The following annual report provides a comprehensive overview of infection prevention and control activities within the Humber Health Partnership (HHP), which

includes Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). This report covers the period from April 2025 to March 2026.

2.2 Governance arrangements

2.2.1 Team structure

The Chief Nurse (Amanda Stanford/Heather McNair) was the Trust **Director of Infection Prevention and Control (DIPC)** with executive responsibility for leading and managing the Trust's Infection Prevention, Control and Cleanliness (IPCC) 25/26 plan. The **Group Deputy Director for Infection Prevention and Control (Deputy DIPC)** Wendy Wigglesworth nee Millard is responsible for the strategic leadership of the partnership's Infection Prevention Control and Cleanliness service. During 2025-26 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist at HUTH and Dr Shaktijit Dave, Consultant Microbiologist at NLAG. The remaining infection control team structure is illustrated in **Appendix 2.**

2.2.2 Infection Prevention and Control meeting structure

The infection team has a robust set of meetings to ensure that the Group is meeting it's mandatory and statutory requirements for IPCC. There are the strategic and operational infection reduction committees, which report via the Quality and Safety Committees in Common ultimately to the Trust board. There are several supporting committees and meetings which feed into Strategic Infection Reduction Committee (SIRC) and Operational Infection Reduction Committee (OIRC), including the Antimicrobial Stewardship Committee, HHP Water Safety Group, HHP Ventilation Safety Committee and HHP Decontamination Group.

2.2.3 Reporting to the Trust Board and Board Assurance Framework (BAF)

The IPCT has maintained a relationship with the Trust board, when there are issues of concern that require escalation they have been given the opportunity to raise these in a timely manner to appropriate committees. The HUTH IPC BAF is maintained as a live document, with action plans to support improvements where gaps in compliance or risks have been identified. The NLAG BAF was established during 24/25 and has continued to be populated during 2025-26. An update on progress of the BAF regularly presents updates to the Quality and Safety Committees in Common on a Quarterly basis during 2025-26.

Board Assurance Framework BAF for IPC

The Board Assurance Framework (BAF) is structured around the 10 criteria set out in the *Health and Social Care Act 2008* and comprises 54 key lines of enquiry (KLOEs). Humber Health Partnership has assessed its compliance against these KLOEs using the National Infection Prevention and Control Framework. The figures below illustrate the current position.

HUTH position

HUTH improved its position across all elements of the BAF during the 12-month reporting period. At year end, 38 KLOEs (70%) were compliant, and 16 (30%) were partially compliant, with no KLOEs assessed as non-compliant.

Key achievements included the development of digital IPC assessments with reporting through Nervecentre and preparation for the planned launch of ICNET in quarter 1 of 2026. These systems support more timely assessment, documentation, and monitoring of patients with infections and strengthen outbreak management. Further progress was supported by quality improvement programmes focused on device practice, sepsis, antimicrobial stewardship and intravenous-to-oral antibiotic switching, together with development of the blood culture pathway programme. Education and training were also strengthened following the appointment of the Practice Development Matron for IPCC, as described in the education section of this report.

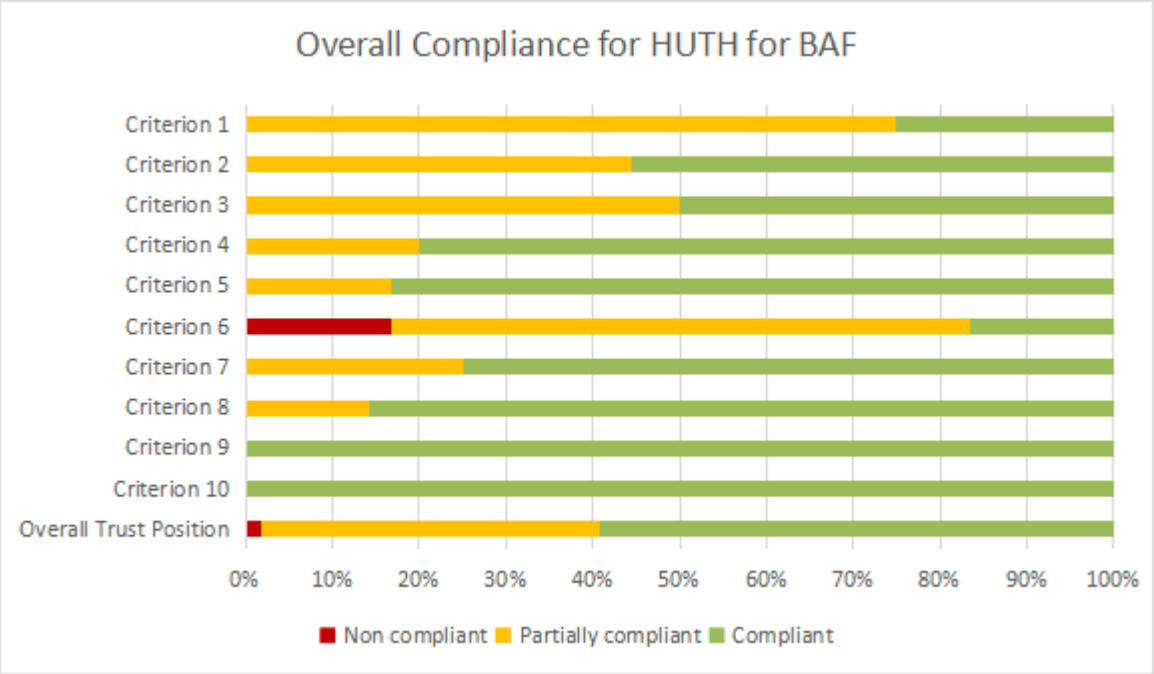


Figure 1: BAF Overall compliance for HUTH: starting position, April 2025

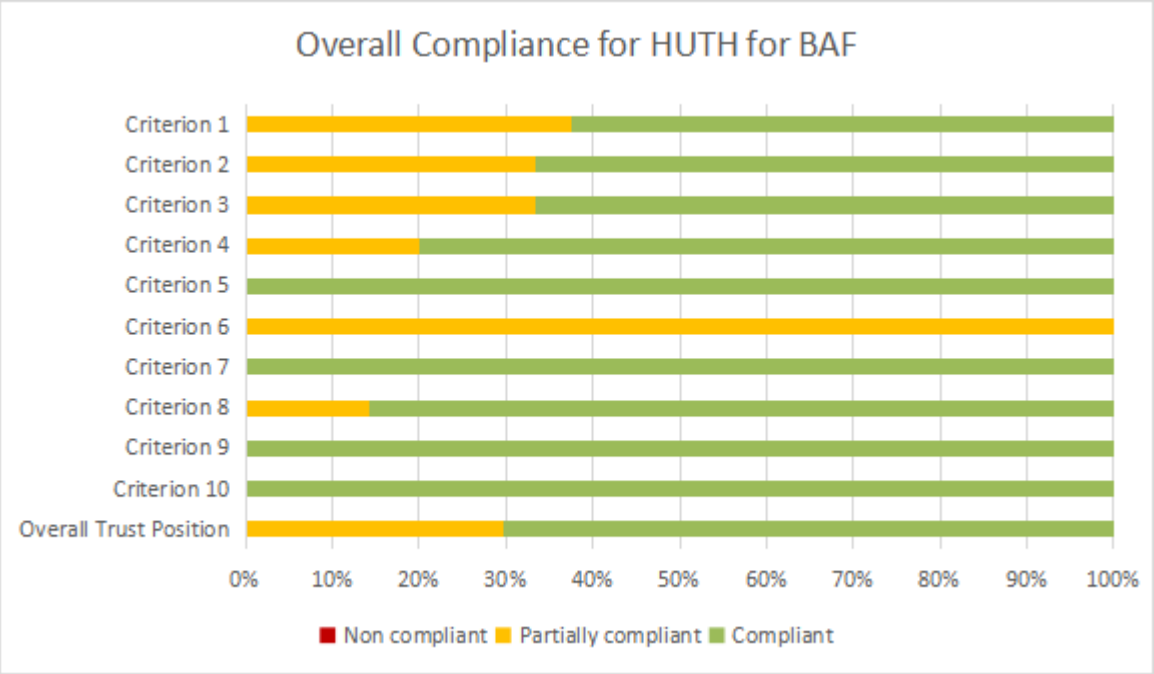


Figure 2: BAF Overall compliance for HUTH: finishing position, March 2026

NLaG position

NLaG also progressed towards partial or full compliance across most BAF elements. At the end of quarter 4 of 2025/26, 21 KLOEs (39%) were compliant, 31 (57%) were partially compliant, and two (4%) were non-compliant.

Key achievements included completion of the baseline BAF assessment across NLaG and improvements in antimicrobial stewardship. These included reduced carbapenem use during the CPE outbreak and stronger assurance that antibiotics were prescribed in line with guidance. Cleaning methods were improved, cleaning products were aligned with national guidance, multidrug-resistant organism screening was introduced, and staff education continued to be delivered.

The principal area of non-compliance remains the need for a robust face-fit testing system. Addressing this gap is necessary to protect staff and patients and will remain a priority alongside the continued rollout of education and training.

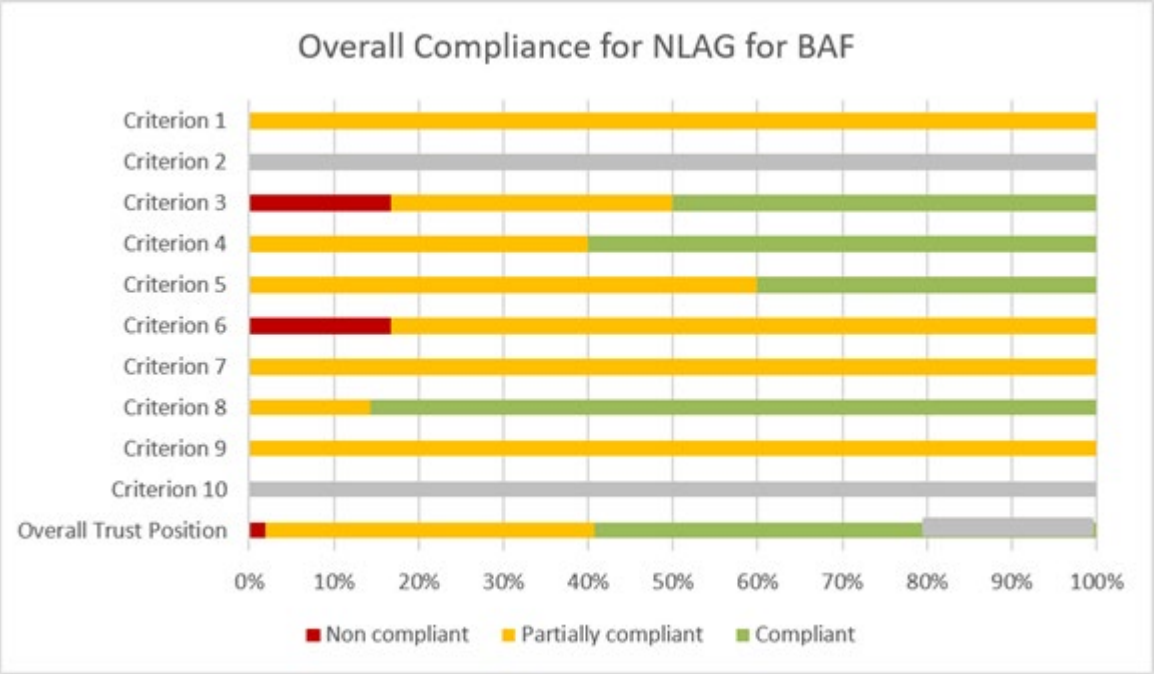


Figure 3: Overall compliance for NLaG: starting position, April 2025

(Please note 2 criterions not assessed at the commencement of April 2025, Criterion 2 & 10)

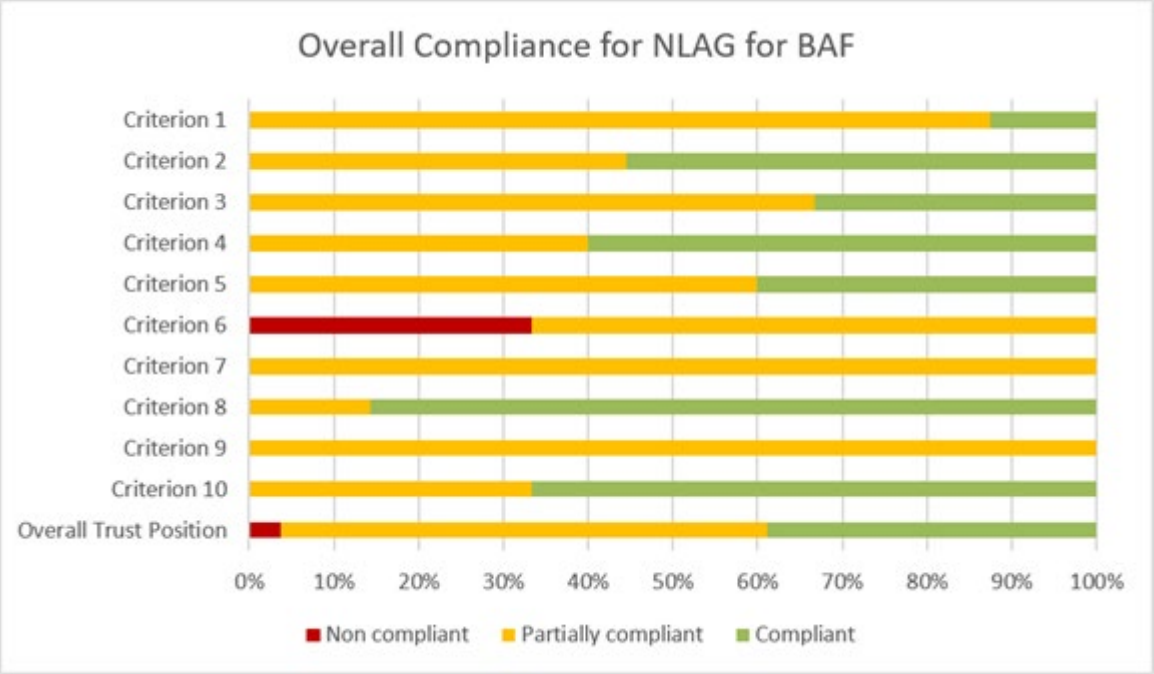


Figure 4: BAF Overall compliance for NLaG: finishing position, March 2026

2.2.4 Policy, Patient Information Leaflets (PILs) and Procedures

Policy Alignment and Harmonisation Framework

Following the formation of Humber Health Partnership (HHP), a review of the combined infection prevention and control (IPC) policy library began during 2025/26.

At the start of 2025/26, HUTH and NLaG held 122 legacy IPC policies. During the year, these were reviewed, rationalised, harmonised or archived to align local guidance with the National Infection Prevention and Control Manual for England, support evidence-based practice and meet duties under the *Health and Social Care Act 2008*.

By the end of 2025/26, the corporate IPC policy register was as follows:

Policy Status	HUTH Legacy	NLaG Legacy	Unified HHP	Total
Active Legacy Policies (Awaiting Alignment)	31	24	-	55
Fully Aligned and Harmonised Policies	-	-	8	8
Archived Policies	12	37	-	49
Reassigned / Merged Policies	0	18	-	18
Total Accounted For	43	79	8	122 (reflecting legacy baseline)

Table 1: IPC policy harmonisation and integration status (HUTH and NLaG)

Policy harmonisation remains in progress. A work plan is in place to review and, where appropriate, merge the remaining 55 legacy policies by quarter 3 of 2026/27. Until this work is complete, legacy policies remain valid within their respective organisations. The IPC team and wider stakeholders monitor and address cross-site differences to reduce the risk of variation in clinical practice.

To strengthen version control and prevent access to outdated guidance, all 49 archived policies were removed from legacy document repositories. The eight harmonised HHP policies were uploaded to the shared staff intranet, providing a single source of current guidance for staff across both organisations.
The review also incorporated learning from local incidents and outbreaks. For example, environmental decontamination procedures were revised in response to outbreaks identified during 2025/26.

In March 2026, NLaG implemented its High Consequence Infectious Diseases policy. Targeted staff education is under way, including assessed competency in donning and doffing personal protective equipment. Policy changes are supported by structured implementation arrangements. Staff awareness is promoted through the Operational and Strategic Infection Reduction Committees, care group governance meetings and targeted education in clinical areas.

Patient Information Leaflet (PIL) Alignment

Patient information leaflets have been successfully standardised and harmonised across HHP, including utilisation of national PILS. In February 2026, all IPC PILs were fully aligned across HHP to ensure equity of information for all service users. To embed the patient voice and guarantee co-production, all updated PILs are routed through the Patient Safety Committee for formal approval and patient feedback synthesis post IPC sign-off.

Monitoring compliance and Board assurance.

Assurance frameworks have been updated to monitor compliance against newly ratified HHP policies throughout 2025/26. The IPC team uses a multi-faceted audit programme to monitor clinical adherence, including:

Standard precautions: Direct monitoring of hand hygiene compliance and correct use of personal protective equipment.
Workforce metrics: Staff training key performance indicators reviewed by ward managers and care groups, alongside face-fit testing compliance.
Environmental standards: Alignment with the National Standards of Healthcare Cleanliness through technical and efficacy audits.
Targeted assurance: Enhanced infection control audits during outbreaks or increased infection incidents, together with detailed IPC expert audits.

Early findings from IPC expert audits show variation in compliance following the introduction of the new auditing system and harmonised policies. Reinforcing fundamental IPC practice therefore remains a high priority for the IPC nursing team, with the aim of achieving consistent standards across all wards.

Audit findings and policy compliance updates are incorporated into the separate HUTH and NLaG IPC Board Assurance Frameworks, as described earlier in this report.

Escalated risk

A significant gap has been identified in face-fit testing compliance at NLaG. Because this may affect the safe and effective use of respiratory protective equipment, the issue has been formally escalated and recorded on the corporate risk register.

Further detail on mitigating actions is provided in the Risks and Mitigations section of this report.

2.2.5 Infection Control Risk Register

During 2025 to 2026, all risks were migrated onto the Ulysses platform for risk management across the Group. Both HUTH and NLAG held separate risk registers historically. IPCC risks were migrated across onto Ulysses for both Trusts and are now under one umbrella of IPCC. It has been agreed some risks can be closed with an overarching Group IPCC risk, where there have been duplicate risks raised at HUTH and NLAG previously, in these cases individual actions are documented within the risk to meet the requirements in terms of the risk through the individual organisation.

At the end of Q4, there were 18 IPCC risks live on the risk register (See Appendix 6 for an overview to the risk and details). Four of these risks were high risks, and fourteen moderate risks. These risks are those directly held by the IPCT and pertain to the individual organisation. The risks are reviewed regularly with the risk management team and discussed at OIRC and escalated to SIRC when appropriate. There is a plan to amalgamate the risk register during the next financial year, where duplicate risks are held by the individual organisation, so that the risk is overarching across the group, with individual actions pertaining to each organisation HUTH and NLAG.

During the launch of the new overall Group risk register, whilst IPCC have risks directly relevant to IPCC, there are links that are required to be established to ensure IPCC oversight for risks owned by other departments which are relevant to IPCC. This work is ongoing in the background with support of the clinical governance team, to ensure IPC have oversight where necessary. During the last financial year, all high risks within the Group were further reviewed by the Chief Nurse at The Risk and Compliance Group Meeting, to ensure a robust system for review has been in place.

Risk Number	Risk Title	Risk Score current scores	Organisation Link	Risk position
2410	Infection Prevention & Control Hygiene Code Board Assurance Framework	C – 8	NLAG	Risk Open

4243	Risk of long-term effects and potential harm to patients due to colonisation of VRE	C – 6	HUTH	Risk Open
4313	Risk of TB infection due to delays in new overseas worker screening	C – 8	HUTH	Risk Open
3945	There is a risk that patients develop a preventable Healthcare Associated Infection during an inpatient/outpatient episode	C – 12	HUTH	Risk Open
3512	CPE Outbreak RISK DPOW	Risk Closed	NLAG	Risk Closed March 2026
3533	There is a risk patients develop a Healthcare Associated Infection during inpatient/ outpatient episode	C – 12	NLAG	Risk Open
4229 3534	Risk of healthcare associated BSI to patients & failure of national threshold due to practice & environmental issues	C – 16	HUTH & NLAG separate	Risk Open
4617	Failure to assure IPC compliance across the group due to a significant backlog of overdue audits	C – 12	Group Wide	Risk Open
4225	Cross infection due to inadequate hygiene facilities and environment no longer fit for purpose inc. bed spacing	C – 15	HUTH	Risk open
4244	There is a risk that healthcare associated multi drug resistant organisms (MDRO) is transmitted to patients due multifaceted environmental factors	C – 16	HUTH	Risk Open

4673	Lack of ventilation in the Tower Block at Hull Royal Infirmary resulting in significant airborne/droplet and D&V outbreaks.	C – 20	HUTH	Risk Open
3535	Patients at increased risk of developing a Surgical Site Infection (SSI) for orthopaedics as HUTH and NLAG is an outlier for SSI	C – 12	Group Wide	Risk Open
4149	Pandemic Influenza	C - 12	HUTH	Risk Open
4672	Inadequate clarity for isolation facilities to allow appropriate isolation facilities room identification to allow infection containment and prevention of airborne/droplet pathogens transmission	C – 12	HUTH	Risk Open
35324226	NLAG and HUTH risk breaching legislative requirements, and risk infection to staff due to lack of provision for Face Fit Testing Service	C – 12	Group Wide	Risk Open
3279	The requirement of enhanced cleaning in line with NIPCM	C - 8	NLAG	Risk Open

Table 2: IPCC risk register summary at the end of quarter 4, 2025/26

2.2.6 External inspections / visits

There have been three external inspections or assessments specific to IPC during 2025-2026, these where an initial CPE Outbreak site visit with follow up visit from the advisory actions and an assurance visit due to the number of beds closed for diarrhoea and vomiting outbreaks in January 2025. There has been a CQC well-led visit to HUTH which was commenced during the period of this report, however further discussion was had with the Deputy DIPC and the Joint Head of IPCC for the group, reviewing IPC processes, policy and practice standards, during the next

financial year and therefore recommendations will be included in 2026/2027 DIPC report.

NLAG External Visits - CPE Outbreak

There has been a protracted CPE outbreak at NLAG, as part of the outbreak, two site visits were undertaken at DPOW with external stakeholders, from an advisory and support perspective. This visit comprised of NHSE representatives, UKHSA representatives, and ICB representatives. These visits were in August 2025 and February 2026. The Gold command structure leads from the CPE outbreak led these visits with the ICD and microbiology team, Deputy DIPC and Deputy Chief Nurse, Chief Pharmacist and AMS Lead, Estates Director and responsible persons for water and ventilation, Facilities leads, and the IPC team. Several ward areas and departments were visited as part of the visit; considering IPC in the built environment; care and management of patients with CPE; IPC practices in the clinical area; and facilities, cleaning, waste management and kitchen/food areas. There was a report provided to the executive team, by the external stakeholders, with recommendations to the organisation, on both occasions. Discussion in relation to the visits occurred in both 'Gold' command structure and the infection control OIRC and SIRC meetings. At the time the recommendations from the external review process for CPE Outbreak were formally provided to the Trust from the ICB, UKHSA and NHSE colleagues, they outlined the below recommendations;

- **Reporting and Governance**

The Trust should continue established operational and strategic CPE governance arrangements, including dedicated focus groups such as Estates, Facilities and Decontamination (EF&D), AMS and Education. Regular reporting to the Trust Board should continue to provide assurance regarding outbreak management, associated risks and delivery of improvement actions. The IPC Board Assurance Framework should be formally reviewed and reported to the Board at least quarterly. Ongoing communication with system partners should be maintained to ensure a coordinated response to any continuing outbreaks.

- **IPC Compliance**

Continued oversight of IPC compliance across the workforce is required. Progress should be made in strengthening Human Resources processes to address persistent non-compliance with mandatory IPC requirements, ensuring appropriate escalation and accountability mechanisms are in place.

- **Education**

The Trust should continue to develop and implement educational pathways to ensure both clinical and non-clinical staff are appropriately informed regarding CPE, antimicrobial resistance and prudent infection prevention and control practices. Training should remain aligned to current national guidance and local risks.

- **Surveillance and Screening**

Routine analysis of epidemiological surveillance data should continue, with emerging trends used to inform operational and strategic decision-making. Screening processes should remain subject to ongoing monitoring and assurance, supported by Business Intelligence reporting and performance metrics.

- **Antimicrobial Stewardship**

The Trust should review current antimicrobial prescribing guidelines and consider opportunities for alignment with neighbouring providers where appropriate. Assurance should be sought that patients receiving intravenous antibiotics are routinely reviewed, including during board rounds, with clear plans established for weekends and out-of-hours periods. Consideration should be given to the implementation and monitoring of ARK (Antibiotic Review Kit) principles. The Trust should ensure completion of the latest NHS England IPC Board Assurance Framework and confirm executive-level accountability for antimicrobial resistance. Opportunities to strengthen links with primary care antimicrobial stewardship programmes should also be explored.

- **Estates and Facilities**

Whilst there is evidence of investment through ward reconfiguration and refurbishment programmes, concerns remain regarding elements of the ageing estate, including areas such as the stroke ward, where upgrades may be required. The Trust should ensure compliance with HTM 04-01 through its Water Safety Plan and HTM 03-01 through its Ventilation Safety Plan, with any identified areas of non-compliance documented within IPC and EF&D risk registers. The Trust should also continue progressing plans relating to the use of Hydrogen Peroxide Vapour (HPV) and Ultraviolet (UV) decontamination technologies.

- **Business Cases**

Business cases previously identified and supported in principle by the Trust Board should continue to progress, particularly those relating to antimicrobial stewardship, microbiology services, estates and facilities improvements. Investment in these areas will be important in supporting long-term IPC resilience and risk reduction.

- **External Peer Support**

A coordinated organisational approach should be adopted when engaging with external peer support opportunities. Relevant Trust teams should be involved from the outset of planning visits and reviews to ensure appropriate representation, maximise learning opportunities and maintain organisational alignment.

- **Winter Planning**

The ongoing impact of CPE outbreaks should be considered within winter planning arrangements. The Trust should assess potential operational and strategic implications for patient flow, capacity, staffing and service delivery, and implement mitigating actions to reduce the impact during periods of increased demand.

- **Conclusion**

The Trust has demonstrated continued commitment to managing CPE risks and improving IPC arrangements. Ongoing focus on governance, compliance, education, surveillance, antimicrobial stewardship, estate improvements and winter preparedness will be essential to sustaining progress and providing assurance that CPE-related risks are being effectively managed.

In terms of progress against above recommendations; significant progress has been made in the management of the CPE outbreak across both DPOW and SGH sites, supported by strong clinical engagement, enhanced surveillance, improved environmental controls and robust governance arrangements. To sustain progress and support outbreak resolution, the following key recommendations are presented for Board consideration:

- **Maintain robust governance and oversight** of CPE and IPC risks through regular Board reporting and review of the IPC Board Assurance Framework.
- **Strengthen IPC compliance** by continuing workforce monitoring and addressing areas of persistent non-compliance through appropriate management and HR processes.
- **Enhance education and training programmes** to ensure all staff remain informed on CPE, antimicrobial resistance and infection prevention and control best practice.
- **Sustain and strengthen antimicrobial stewardship**, including prudent prescribing, routine antimicrobial review processes and executive oversight of antimicrobial resistance.
- **Continue investment in microbiology and antimicrobial stewardship services** through progression of existing business cases.
- **Maintain comprehensive surveillance and screening arrangements**, using epidemiological intelligence and Business Intelligence reporting to inform decision-making and targeted interventions in line with the national screening recommendations.
- **Address risks associated with the ageing estate**, including progression of estates business cases, implementation of improvement programmes and a planned sink replacement scheme where required.
- **Ensure compliance with water and ventilation safety standards**, with non-compliant areas appropriately risk assessed and managed through existing governance structures.
- **Continue implementation of enhanced decontamination technologies**, including Hydrogen Peroxide Vapour (HPV) and Ultraviolet (UV) cleaning systems.
- **Strengthen cleaning and decontamination arrangements** through standardised approaches across the Group, supported by routine deep-clean schedules and responsive cleaning programmes in line with the National Cleanliness Standards.

- **Promote coordinated engagement with external peer support opportunities** to maximise organisational learning and ensure consistent Trust representation.
- **Incorporate ongoing CPE risks into winter planning arrangements**, ensuring mitigation plans are in place to minimise impacts on capacity, patient flow and service delivery.

Overall Assurance: The Trust has demonstrated considerable progress in managing the CPE outbreak to a point where it has been closed, however the long-term effects on the local population remains a challenge for the Trust. Continued Board support, organisational focus and targeted investment in IPC, antimicrobial stewardship, workforce development and estate improvements will be essential to sustain improvements and reduce future infection risks.

HUTH External Visit - Diarrhoea and Vomiting Outbreak

During the end of quarter 3 and beginning of quarter 4, there had been a significant number of closed areas in HUTH due to norovirus, and an external visit was undertaken on Monday 19th January 2026 at Hull Royal Infirmary by NHSE and the ICB, with the Joint Head of IPCC and Nurse Director for Emergency care, to gather assurance, regarding all aspects of IPC in relation to managing patients during outbreaks and winter pressures. The ground floor and several wards were reviewed as part of this visit. There was an overview provided to the executive as part of this visit, with feedback on findings.

Executive Summary and Feedback from NHS England and Humber & North Yorkshire ICB

An Infection Prevention and Control (IPC) visit was undertaken at Hull Royal Infirmary on 19 January 2026 by NHS England and Humber & North Yorkshire ICB following significant operational pressures associated with increased emergency demand, widespread norovirus outbreaks and seasonal influenza activity. The visit sought assurance regarding the Trust's management of infection risks, outbreak control measures, winter planning arrangements, use of Temporary Escalation Spaces (TES), and overall patient safety.

IPC closures HUTH versus Y&H region

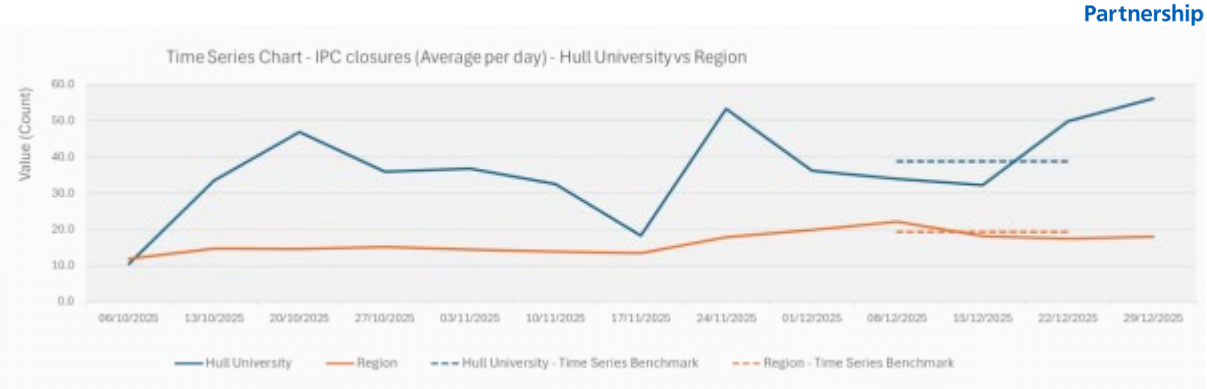


Figure 5: IPC closures at HUTH compared with the Yorkshire and Humber region

The visit found that the Trust has experienced unprecedented levels of norovirus activity, resulting in multiple ward outbreaks, bed closures, reduced patient flow, and increased pressure on urgent and emergency care services. These challenges were further compounded by high levels of influenza and sustained demand across the wider health and care system. Despite these pressures, the IPC team has maintained a visible and proactive role in supporting operational decision-making, outbreak management and patient flow, demonstrating strong clinical leadership throughout the period.

Positive developments included the implementation of enhanced digital IPC tools within NerveCentre to support isolation prioritisation, risk assessment and patient management, together with ongoing plans to implement ICNET to strengthen surveillance, outbreak management and reporting capabilities. Estate improvements on frailty wards have also improved the Trust's ability to safely cohort patients and manage outbreaks.

However, several significant risks were identified. Limited isolation cubicle capacity across the Hull Royal Infirmary site remains a major challenge, with patients requiring isolation not always able to be accommodated appropriately. The extensive use of Temporary Escalation Spaces, including corridor care, created additional infection prevention, patient safety, privacy and dignity concerns. Variable compliance with universal masking, personal protective equipment (PPE) requirements and Bare Below the Elbows standards was observed across a number of clinical areas and by partner organisations working with the Trust. Opportunities were also identified to strengthen communication, visibility of IPC measures, winter planning processes and discharge pathways.

The visit recognised the considerable pressures experienced by frontline teams and the commitment demonstrated by staff across the organisation. Nevertheless, several strategic and operational recommendations have been made to strengthen organisational resilience, improve outbreak preparedness, increase isolation capacity, enhance IPC compliance and ensure that future winter plans are robust, proactive and fully integrated with system partners.

Overall Conclusion

The visit recognised that the Trust and in particular Hull Royal Infirmary experienced exceptional and sustained pressures from concurrent outbreaks and demand surges. While IPC teams demonstrated strong commitment, innovation and operational engagement, significant challenges remain around isolation capacity, escalation space usage, IPC compliance, discharge flow, and organisational resilience. The report recommends both immediate operational improvements and longer-term strategic actions to strengthen preparedness for future winter pressures.

Main Recommendations

Immediate Priorities

1. Review and strengthen winter planning arrangements.
2. Improve communication and escalation processes regarding IPC decisions (e.g. universal masking).
3. Review short- and long-term plans for increasing isolation cubicle capacity.
4. Establish documented mitigation measures when patients requiring isolation cannot be isolated.
5. Continue implementation of ICNET and digital outbreak management tools.

Strategic Priorities

1. Review hospital estate and capacity requirements, particularly at HRI.
2. Evaluate the impact of organisational change on operational delivery and business continuity.
3. Strengthen communication with system partners regarding patient movement and infection risks.
4. Work with Social Services to improve discharge processes for patients on closed wards.
5. Use lessons learnt from winters 2024/25 and 2025/26 to develop system-wide plans for winter 2026/27.

The CQC well led visit summary findings will be included in the 2026/2027 report, as this visit was prepared and undertaken during both financial year periods.

2.2.7 Incidents and Reporting

A comparative review of the Infection Prevention and Control incident profiles across our two organisations reveals distinctly different operational challenges and varying levels of data reporting maturity.

Infection Prevention and Control Incident Profile HUTH (FY 2025/26)

As demonstrated in Figure 6, the distribution of the 448 total IPC incidents recorded at HUTH between June 2025 and March 2026 highlights a diverse profile with clear visibility of specific clinical risks. It is to be noted that from April 2025 to September 2025, HUTH remained on the previous incident reporting system. As the data extract from the legacy system into Ulysses was unsuccessful, this early data period is missing from this contextual analysis.

The leading driver continues to be infections classified as other hospital-acquired infections, accounting for 39.73% (n=178) of all logged incidents. Reducing the number of incidents categorised in this non-specific group is a priority to aid understanding of the drivers.

Parallel to this, clinical practice and operational vulnerabilities represent significant secondary drivers. Inappropriate treatment or procedure for infection constitutes the second-largest portion of the profile at 16.74% (n=75), showing a sharp escalation during November (n=19) and peaking significantly in December 2025 (n=37). Additionally, *Clostridioides difficile* infections account for 10.94% (n=49) of total incidents, maintaining a persistent baseline that spiked to 13 cases in January 2026.

Discrepancies remain between HUTH's internal incident reporting data and HCAI DCS figures regarding mandatory reportable organisms. These variances are primarily attributed to the missing early-year data period, systemic changes and ongoing system integration and data-tethering issues with new users.

Severe seasonal operational impacts are also evident. Unit closure due to infection accounts for 5.36% (n=24) of total incidents, with exactly half of these (n=12) clustering in January 2026. This clearly demonstrates the acute pressure that winter-associated outbreaks placed on the organisation's bed capacity and patient flow during peak periods.

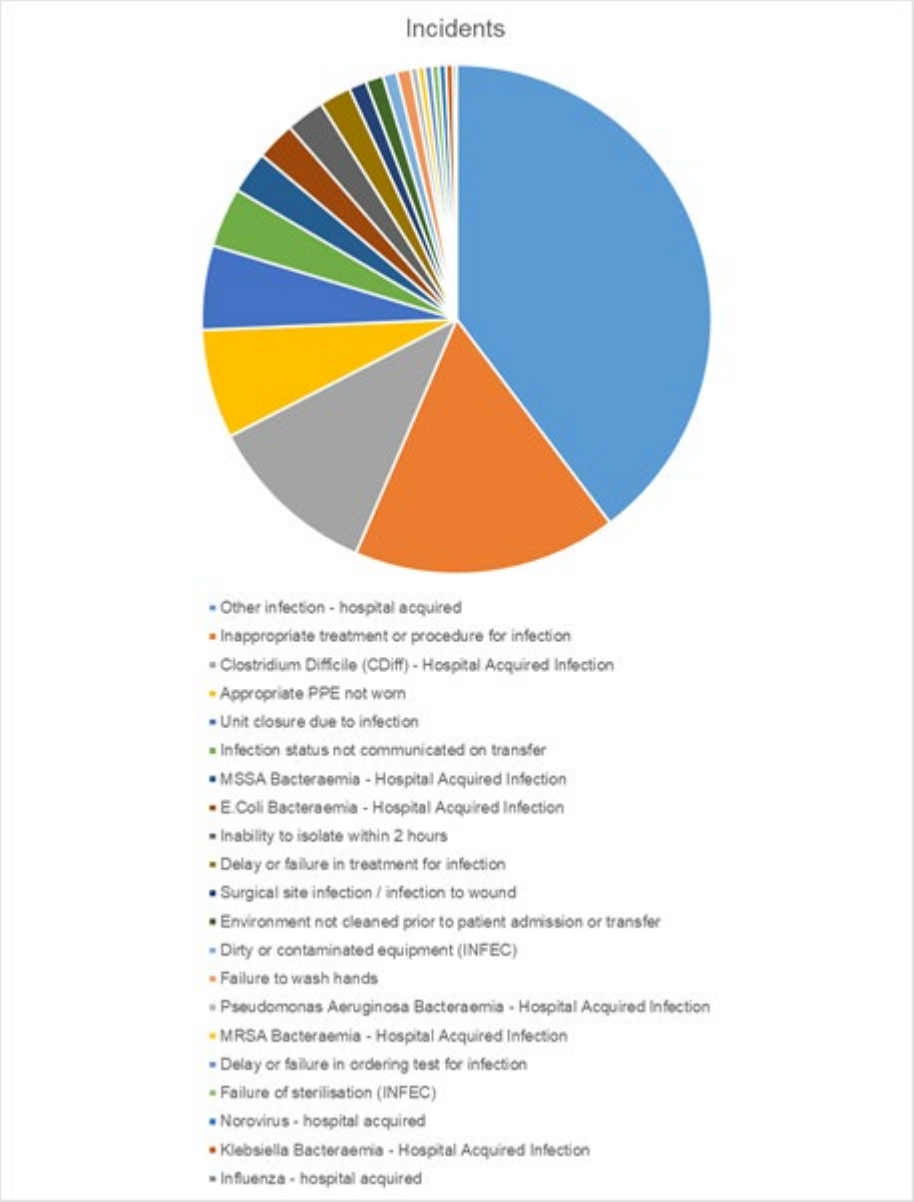


Figure 6: HUTH reported IPC incidents, FY 2025/26

Infection Prevention and Control Incident Profile NLaG (FY 2025/26)

As demonstrated in Figure 7 below, the primary driver of recorded IPC incidents during FY 2025/26 is categorised as other hospital acquired infections, accounting for 49.90% (n=249) of all logged events.

System-wide operational and patient-flow pressures remain a prominent secondary driver. Specifically, patient's infectious status not being communicated on transfer represents 10.42% (n=52) of incidents, while the Inability to isolate within 2 hours accounts for 7.01% (n=35). Together, these metrics clearly expose cross-ward communication gaps and acute bed-capacity challenges that directly compromise

our isolation capacity and protocol compliance, increasing the risk of infection transmission.

While mandatory reportable organisms, such as *Clostridioides difficile, E. coli, MRSA* and *Klebsiella*, appear visually minor on the current chart, a targeted clinical review revealed a significant data-quality anomaly. A substantial volume of these mandatory reportable pathogens were incorrectly catalogued, under the broad other hospital-acquired infections category rather than their dedicated lines.

To ensure a robust IPC incident report moving forward, second-level coding frameworks are being implemented alongside targeted staff education to ensure that internal incident reporting fully aligns with the mandatory reportable organisms within the National HCAI Data Capture Systems.

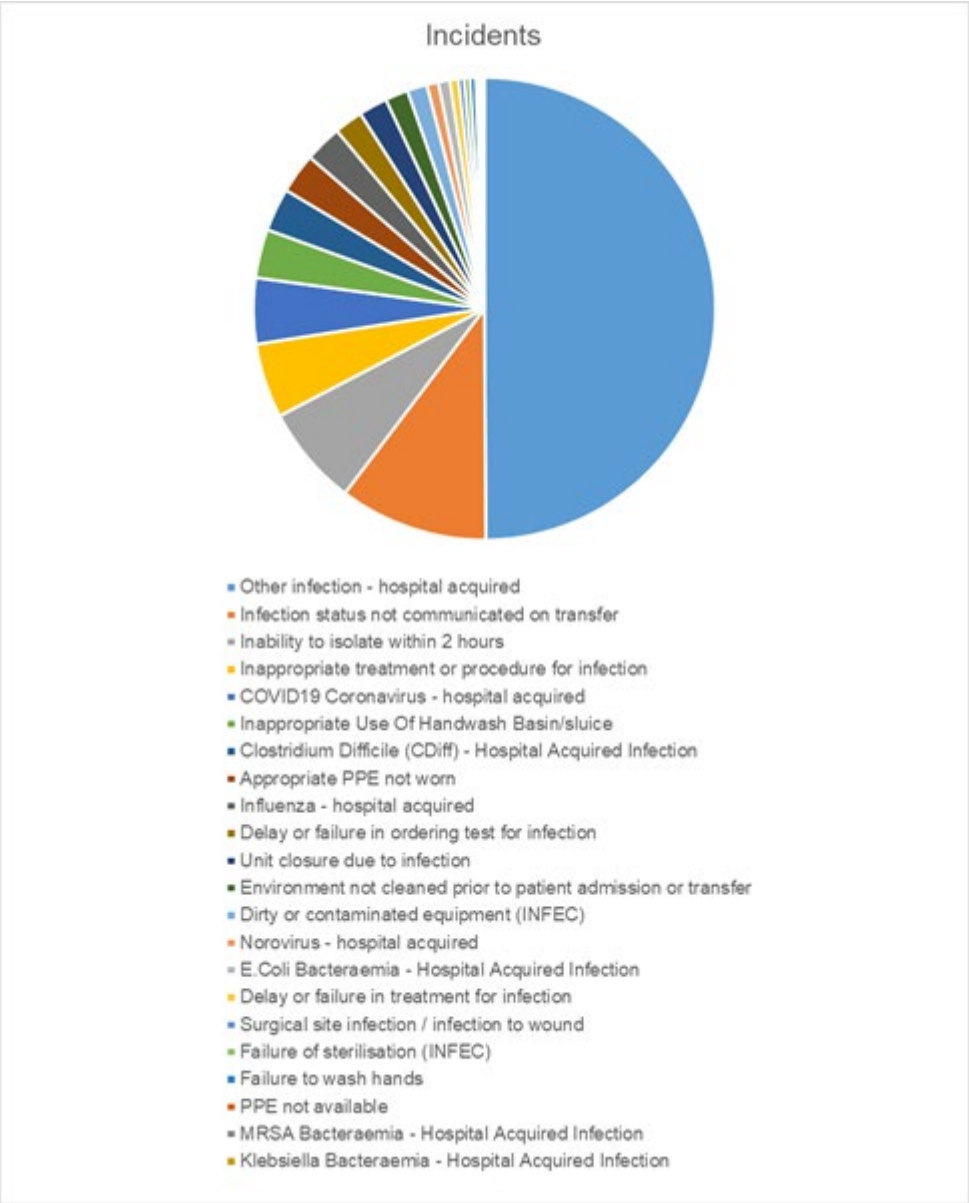


Figure 7: NLaG infection prevention and control incident profile, FY 2025/26

While both organisations exhibit unique local profiles, they share a common strategic requirement for improved data quality and validation. HUTH's discrepancies highlight system-integration and legacy data-loss challenges following the Ulysses transition. Meanwhile, NLaG requires the roll-out of the second-level coding frameworks already established at HUTH.

By cross-referencing these data governance frameworks and aligning internal incident logging with the national HCAI Data Capture System (DCS), the Trust will secure a unified, robust baseline for corporate assurance and targeted profiling across all sites.

2.3 Overview of infection control activities during 2025-26

The IPC Service has a significant and broad remit. The team has developed a work plan, to ensure clear focus on key priorities. Much of the work for IPCT is reactive, including,

- providing advice to care groups and clinical teams on the management of individual patients to prevent onward spread of transmissible infections
- managing outbreaks of infection
- investigating healthcare acquired infections
- providing support to the occupational health team to safely manage infection issues of staff

However, the team plays a more critical role in the proactive prevention of infection and moving forward, this needs to be the greater focus for IPCT. This work includes, but not limited to:

- Learning from healthcare acquired infection and outbreak reviews, and instigating and supporting organisational improvement and development to reduce infections
- supporting estates to ensure the environment is safe and fit for purpose, in relation to water safety, ventilation and the built environment
- advising capital project colleagues on aspects of new builds related to IPC to ensure occupant safety
- working closely with facilities to maintain the cleanliness of the environment
- working with the microbiology department to ensure effective screening of patients at risk of multi-drug-resistant organisms
- working with the antimicrobial stewardship team to reduce antimicrobial resistance
- education and training of staff in all aspects of IPC and antimicrobial stewardship
- winter planning for both organisations
- working with external partners and agencies in managing IPC related issues

- supporting Occupational Health in staff vaccination campaigns and promoting staff health and safety

The remaining report will highlight in more detail some key aspects of this work.

2.3.1 Healthcare Associated Infections (HCAI's)

The Impact of Healthcare-Associated Infections (HCAIs) on Patients and Healthcare Organisations

Healthcare-associated infections (HCAIs) remain one of the most significant threats to patient safety within healthcare systems. They are associated with increased morbidity and mortality, prolonged hospital stays, reduced patient experience, higher antimicrobial use, increased antimicrobial resistance, and substantial financial costs to healthcare providers. HCAIs therefore represent both a major quality of care issue and a significant burden on healthcare resources.

Impact on Patients

HCAIs can result in considerable patient harm. Patients who acquire an infection during healthcare often experience prolonged recovery, increased complications, additional procedures, delayed rehabilitation and longer hospital stays. In severe cases, infections can lead to sepsis, organ failure, long-term disability, or death. The burden is particularly high among older adults, immunocompromised patients, those with chronic disease and individuals requiring invasive devices or procedures.

The impact extends beyond physical illness. Patients who develop HCAIs frequently experience reduced quality of life, delayed return to normal activities, psychological distress and loss of confidence in healthcare services. Family members and carers may also be affected through increased caregiving responsibilities and emotional burden.

Impact on Mortality

HCAIs contribute significantly to avoidable mortality. A modelling study of NHS hospitals in England estimated that HCAIs were associated with approximately 28,500 patient deaths annually. In addition, antimicrobial resistance, which is closely linked to healthcare-associated infection, is a growing contributor to global mortality. Many bloodstream infections caused by organisms such as *Staphylococcus aureus*, Gram-negative bacteria and *Clostridioides difficile* are associated with substantial case fatality rates, in the range of 20-30%, particularly in vulnerable patient groups.

Impact on Healthcare Organisations

For healthcare organisations, HCAIs place considerable pressure on hospital capacity and operational performance. Patients with HCAIs frequently require longer inpatient stays, additional investigations, specialist treatments, isolation facilities and enhanced nursing care. This reduces bed availability and increases demand on already stretched services.

An NHS England modelling study estimated that HCAIs account for approximately 7.1 million occupied bed days annually across NHS hospitals in England, representing around one-fifth of all hospital bed days. These additional bed days reduce organisational efficiency and may contribute to delays in elective care, patient flow challenges and increased waiting times.

HCAIs also affect workforce capacity. Staff exposed to infection may require treatment or absence from work, while outbreaks can consume significant clinical, managerial and infection prevention resources. Organisations experiencing higher infection rates are also more likely to experience regulatory scrutiny and reputational damage, with MRSA, C difficile and E coli infections included as part of the national NHS Oversight Framework (NOF) measures.

Financial Impact

The financial burden of HCAIs is substantial. A UK modelling study estimated that HCAIs cost NHS hospitals in England approximately **£2.7 billion annually**, driven primarily by longer admissions, additional treatment requirements, increased staffing costs and the management of complications.

At a wider international level, HCAIs are associated with millions of additional hospital days and significant healthcare expenditure. In Europe alone, HCAIs are estimated to result in approximately 25 million additional hospital days each year and costs of €13-24 billion.

Why Reducing HCAIs Matters

Reducing HCAIs is one of the most effective ways to improve patient safety and healthcare quality. Effective infection prevention and control (IPC) programmes reduce avoidable harm, prevent deaths, shorten hospital stays, improve patient experience and release valuable healthcare resources. The World Health Organization has reported that evidence-based IPC interventions can reduce HCAI rates by between 35% and 70%, with a positive return on investment.

For NHS organisations, reductions in bloodstream infections, surgical site infections, device-related infections and *C. difficile* infections contribute directly to improved patient outcomes, increased bed capacity, reduced antimicrobial consumption and lower healthcare costs. Preventing infection is therefore not only a patient safety

imperative but also a key component of organisational sustainability, operational efficiency and quality improvement.

2.3.1.1 Surveillance organisms

The NHS Standard Contract 2025-26 includes quality requirements for NHS Trusts and NHS Foundation Trusts to minimise *Clostridioides difficile* (*C. difficile*), Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias and Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias alongside Gram Negative Bloodstream Infections (GNBSIs), down to specific threshold levels set by NHS England. IPC performance against key indicators, including *C difficile*, *MRSA* BSIs, and *E coli* BSIs is also included in the patient safety metrics that contribute to the National Oversight Framework (NOF).

Both trusts are monitored against all healthcare associated cases, encompassing hospital onset hospital associated (HOHA) and community onset hospital associated (COHA).

2.3.1.1.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

Over the last ten years, the Department of Health and Social Care has monitored Trust apportioned MRSA blood stream infections (BSIs) against a strict national policy of ‘zero tolerance of avoidable infection’. While it remains clinically accepted that a minor baseline of infections may occur due to complex, unmodifiable patient endogenous factors, the national objective continues to target an irreducible minimum.

In accordance with the NHS England HCAI Operational Guidance and the Health and Social Care Act 2008, all NHS trusts are required to minimise MRSA exposure through admission screening, targeted suppression therapy and robust vascular device management.

To ensure the national zero-tolerance mandate is achieved, every hospital-onset MRSA BSI detected across our organisations is subject to a formal, multi-disciplinary team post infection review (PIR). This tends to be led by IPCT in conjunction with the patient's primary team to determine;

- Any lapses in care during the patient's pathway;
- Corrective action plans to prevent future cases;
- System learning where other partners or acute providers are involved in the patient pathway.

The total volume and hospital-onset breakdown of MRSA BSIs diagnosed across both Trusts over a two-year surveillance period (April 2024 to March 2026), are detailed in the charts below.

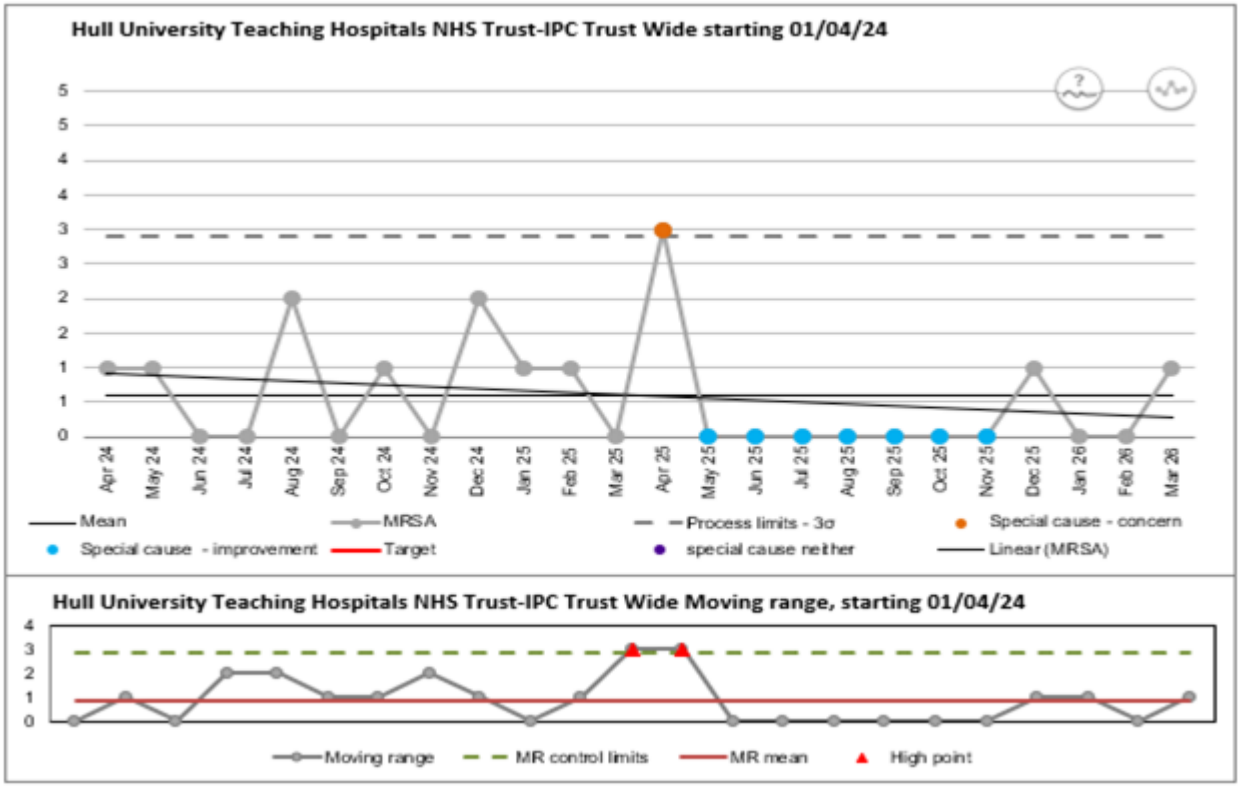


Figure 8: HUTH SPC chart: MRSA bloodstream infections, FY 2024/25 and FY 2025/26

Throughout FY 2024/25, the organisation had poor performance against the zero trajectory with 9 MRSA BSIs, followed by 3 more in April 2025. This period of concern, along with other factors, led to a review of MRSA screening and implementation of a revised policy for the management of high risk surgical patients. Subsequently HUTH sustained seven consecutive months of zero MRSA BSIs between May 2025 and November 2025. This prolonged run below the mean demonstrates a period of clinical control.

While late-year fluctuations occurred with single cases logged in December 2025 and March 2026, the overall linear trend line maintains a downward trajectory. Moving forward, the focus remains on sustaining the zero-case baseline to align fully with the national zero-tolerance mandate.

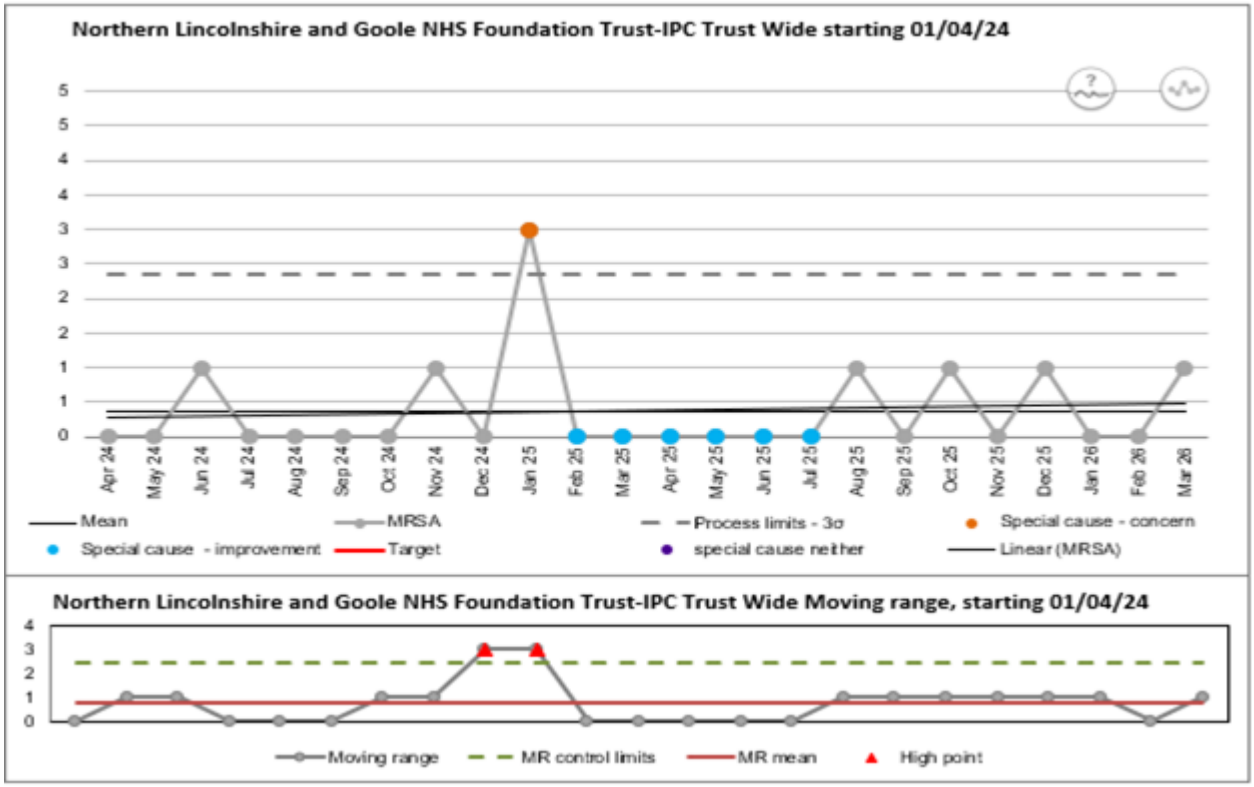


Figure 9: NLaG SPC chart: MRSA bloodstream infections, FY 2024/25 and FY 2025/26

Throughout 2024-25 and 2025-26, NLAG maintained similar performance with 5 cases 2024-25 and 4 in the reporting period 2025-26.

After an initial period without MRSA BSIs, in the latter part of the surveillance period (August 2025 to March 2026), the trust experienced a return to a fluctuating baseline, logging single cases in August, October and December 2025 and finishing the year with a single case in March 2026. While the linear trend line remains flat, the recurring single cases underscore the need for persistent, focus on the basics of IPC to prevent infections, including aseptic non-touch technique (ANTT) and vascular access device care to achieve and sustain the national zero-tolerance mandate.

Regional Benchmarking

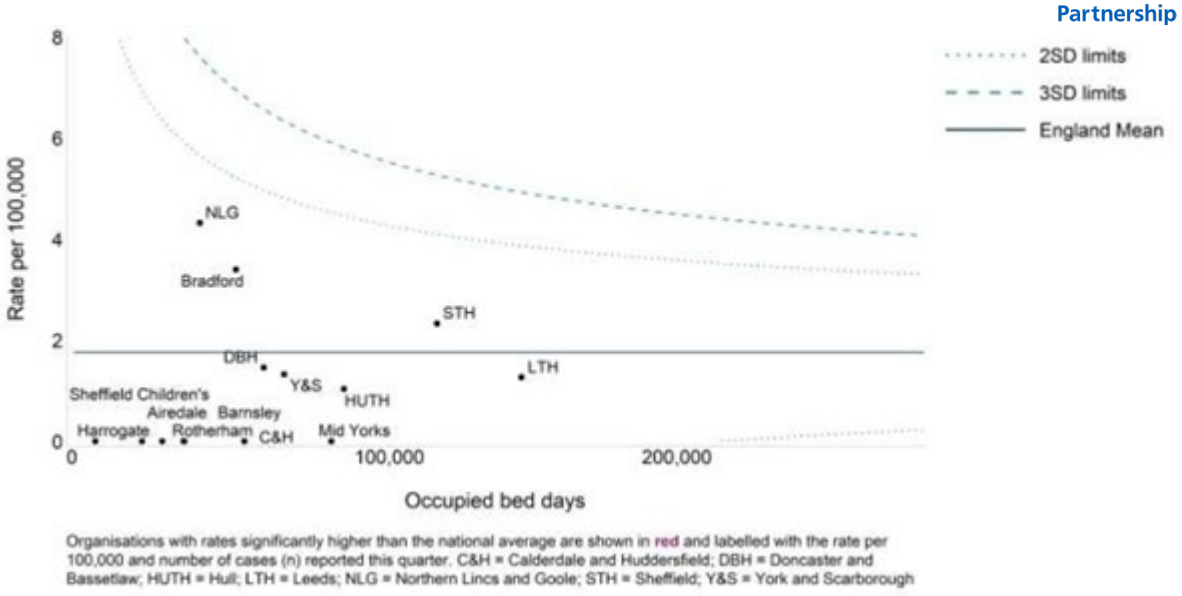


Figure 10: Regional healthcare-associated MRSA bacteraemia rates per 100,000 occupied bed days, January to March 2026

To provide regional context, Figure 10 benchmarks the healthcare-associated MRSA BSI rates per 100,000 occupied bed days for acute trusts across the Yorkshire and the Humber region against the national england average for the period of January 2026 to March 2026.

A comparative review of both our trusts demonstrates positioning:
HUTH occupies a favourable regional position. With a rate sitting visibly below the national England mean (solid horizontal line), the trust demonstrates strong clinical control relative to its high volume of occupied bed days (90,000). HUTH is firmly situated within expected statistical boundaries, well below the 2 Standard Deviations (2SD) warning limit.

NLaG exhibits a higher comparative rate per 100,000 bed days (4.3), placing it above the national England mean. However, due to NLaG lower volume of occupied bed days (40,000), this rate remains well within the 2SD control limits. The trust is not flagged as a statistical outlier, representing normal expected baseline variation under national monitoring parameters. Whilst NLaG is not outside the national England average, it does remain one of the highest rates per 100,000 bed days in the region.

When interpreting NLaG current position, it is crucial to note that historical attributions of mandatory reportable organisms at NLaG suffered from data inaccuracies, resulting in baseline underreporting. Following a targeted data-cleansing and reconciliation from February 2025 onwards, reporting practices were robustly corrected and accurate moving forward.

Consequently, the apparent inflation in NLaG rate during the subsequent quarters reflects a transition to complete, precise clinical capturing rather than an escalation in acute hospital-acquired transmissions.

MRSA Post Infection Review (PIR) Findings and Extracted Themes

Throughout the financial year, both individual Trust IPCTs have actively collaborated with integrated care system partners and regional acute trusts. This joint participation in formal PIRs is crucial for cases where complex patient pathways crossed multiple acute providers and primary care boundaries.

The multi-agency PIR investigations identified five distinct clinical and operational themes driving Trust-apportioned MRSA BSIs across HHP:

- Theme 1: Invasive device management and Compliance: Lapses in vascular access device care and maintenance, specifically non-adherence to localised ongoing line-care bundles and length of device *in situ.*
- Theme 2: Decolonisation timeliness: Delayed initiation of suppression/decolonisation therapies when patients frequent multiple acute trusts, compounded by administrative delays in prescribing and dispensing regimes via General Practitioners upon discharge. Differences between Primary Care MRSA guidance and Acute Trust guidance were noted as a key factor.
- Theme 3: Complex multi-system patient pathologies: High-risk patients with multiple co-morbidities and risk factors undergoing complex cardiothoracic, major vascular or major trauma interventions, where severe physiological vulnerability increases susceptibility to deep-seated infection.
- Theme 4: Healthcare system communication gaps regarding MRSA: Failure to communicate known MRSA colonisation status across the healthcare system, eg between regional acute trusts, GP and the patient. This lack of notification directly delayed targeted suppression therapies, compromised the scheduling and antimicrobial prophylaxis of subsequent surgical interventions.
- Theme 5: Deep-seated surgical site infections (SSIs): Confirmed deep-tissue or organ-space surgical site infections acting as the primary clinical source seeding the subsequent MRSA bacteraemia.

Targeted Actions:

- Device audits: Execution of Trust-wide clinical audits focusing on both peripheral and central venous line insertion and ongoing maintenance bundles across all clinical areas to inform improvement actions.
- Transfer protocol review: During the scheduled transition to the new Electronic Patient Record (EPR) system in FY 2026/27, a standardised

transfer document featuring mandatory infection prevention and control fields will be deployed to secure reliable communication of infection status across HHP. As an immediate operational mitigation, the group-wide HHP IPC assessment electronic tool remains active to support accurate, real-time assessment of all patients admitted across the organisations.

- Primary care liaison: Enhance regional ICB engagement within the formal PIR process to ensure that necessary primary care actions are actively reviewed, tracked and implemented accordingly.

2.3.1.1.2 Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infection (BSI)

Meticillin sensitive *Staphylococcus aureus* (MSSA) is a ubiquitous bacterium commonly found on human skin. While frequently harmless in healthy populations, it acts as an opportunistic pathogen in healthcare settings, where invasive procedures, vascular access devices (VADs) and surgical interventions breach natural anatomical barriers. When MSSA enters the bloodstream, it can cause severe, life-threatening bacteraemia, leading to complications such as infective endocarditis, osteomyelitis and septic shock.

Unlike MRSA, which has a strict national zero tolerance, MSSA BSIs are not currently subject to a zero-tolerance national threshold. However, under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections, all NHS Trusts are mandated to submit epidemiological data on MSSA BSIs to the UKHSA Healthcare associated Infection data capture system (HCAI DCS).

Sustained reduction of MSSA BSIs remains a core clinical priority for both organisations. Minimising these infections is a key marker of quality assurance, reflecting the efficacy of our vascular access care bundles, surgical site infection prevention pathways and overarching aseptic clinical practices.

In accordance with NHS England's Making Data Count guidance, this report utilises Statistical Process Control (SPC) XmR charts to monitor trust-wide MSSA BSI incidence.

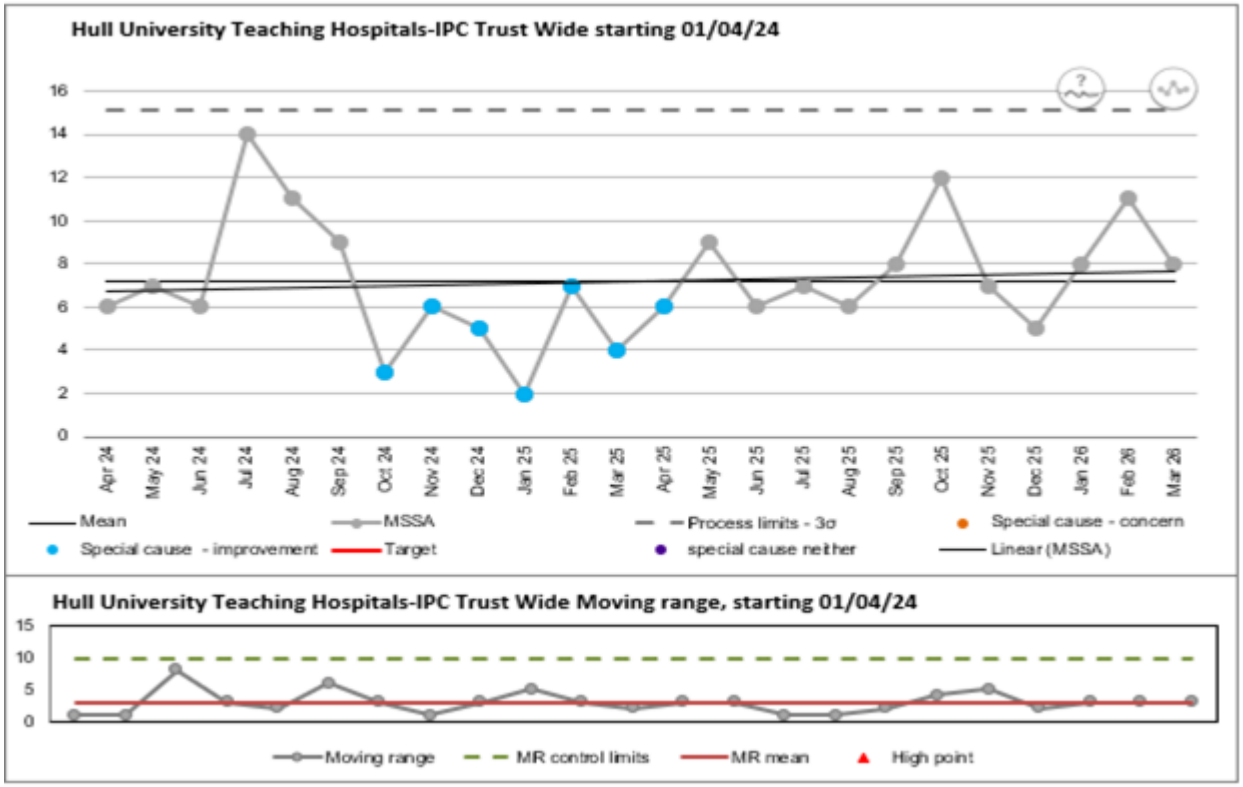


Figure 11: HUTH SPC chart: MSSA bloodstream infections, FY 2024/25 and FY 2025/26

The SPC chart in Figure 11 shows HUTHs MSSA BSI profile across the two financial years (2024/25 and 2025/26) and demonstrates a statistically stable baseline for MSSA BSIs, averaging approximately 7.2 cases per month.

The notable highlight of the performance data was a sustained downward shift below the mean between October 2024 and April 2025, which met the NHS thresholds for special cause variation of an improving nature. This reduction indicates that targeted clinical interventions or seasonal care optimisation successfully supressed infection rates below historical norms during the winter period.

However, from May 2025 onwards, the data returned to common cause variation, fluctuating around the mean. Peak months were observed in July 2024 (14 cases) and October 2025 (12 cases). Because these peaks remained within our upper process limit of 15.2 cases, they do not statically represent an out-of-control process or an acute outbreak, but rather the upper threshold of normal system variation under current clinical constraints.

The moving range chart confirms process volatility remained tightly controlled, with month-to-month variance consistently staying well below the upper moving range control limit of approximately 10. Consequently, while the system is stable, the flat

linear trend line underscores that further structural or behavioural interventions are required to fundamentally lower the baseline mean in the upcoming financial year.

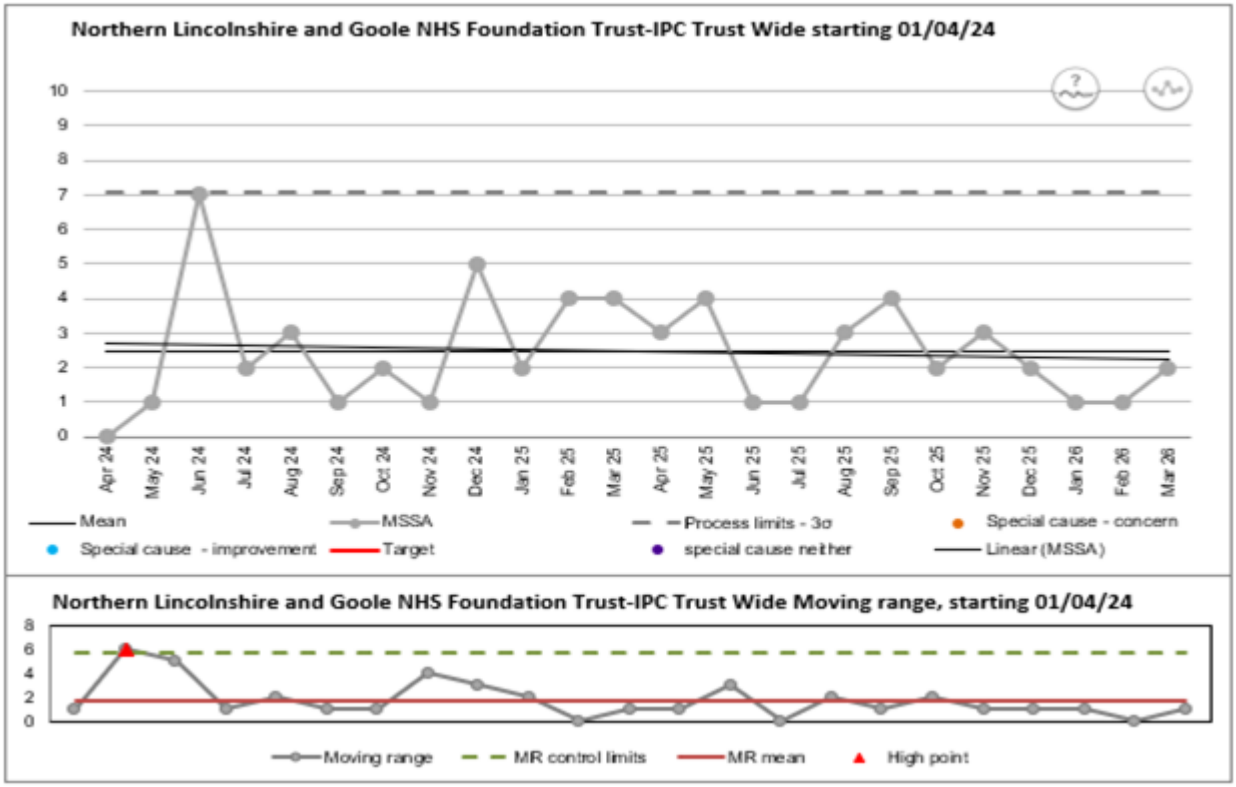


Figure 12: NLaG SPC chart: MSSA bloodstream infections, FY 2024/25 and FY 2025/26

As illustrated in Figure 12, during the 2024 – 2026 reporting cycle, NLaG maintained a low and statistically stable baseline for MSSA BSIs, averaging approximately 2.5 cases per month.

The data over the two-year period reflects entirely common cause variation, demonstrating that the organisations infection rates are stable and predictable within the parameters of current clinical delivery.
The linear trend line shows a slight downward trajectory over the 24 months, indicating that ongoing IPC vigilance is successfully sustaining a low-incidence baseline across NLaG.

Regional Benchmarking

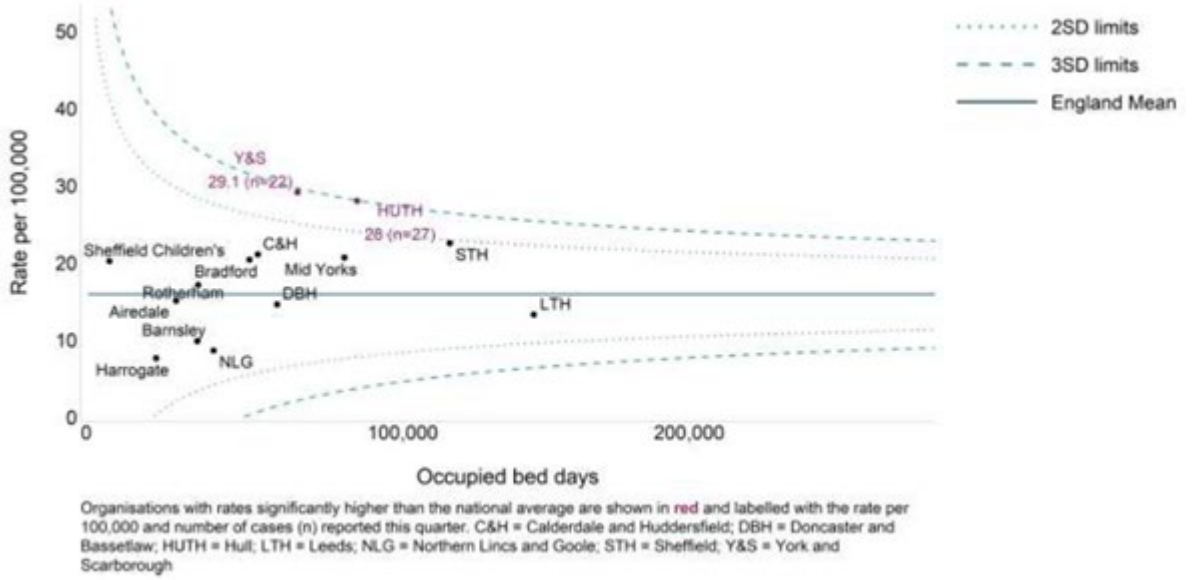


Figure 13: Regional healthcare-associated MSSA bacteraemia rates per 100,000 occupied bed days

Healthcare associated MSSA Bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2025.

A comparative regional analysis utilising national funnel plot data reveals a stark variance in performance profiles between our two organisations, as demonstrated in Figure 13.

NLaG continues to demonstrate excellent assurance, sustaining an MSSA BSI rate that sits comfortably below the national England Mean line. NLaG ranks among the lowest-incidence acute providers within the regional peer group, demonstrating that current standard operating procedures regarding device management and aseptic techniques are keeping baseline risk structurally suppressed. Additionally, the vascular access team provide robust, consistent and compliant insertion requirements supporting this continued low incidence rates.

Conversely, HUTH stands out as a significant regional and national outlier. Recording a rate of 28.0 per 100,000 occupied bed days, HUTH has breached the upper 3SD control boundary. This position flags a statistically significant over-generation of MSSA BSIs relative to the Trusts size and activity level and serves as an indicator that immediate, targeted clinical interventions are required. This is being incorporated into the 2026-27 Quality Priorities and Integrated Improvement Plan for FY 2026/27.

While HUTH absolute scale and high acuity tertiary caseload naturally increase patient's exposure to invasive procedures, this is not universally seen across comparable regional peers. It has been noted that a disproportionate number of

HUTHs cases originate from specialised units that NLaG does not operate, such as major trauma, cardiothoracic surgery, renal dialysis and vascular surgery which will provide a focus for improvement actions.

MSSA BSI Learning

During the current reporting period, a formal, standardised PIR or RCA framework was not systematically undertaken for Hospital-Onset Healthcare-Associated (HOHA) MSSA BSIs across either organisation. However, all MSSA bacteraemia cases are reviewed by the infection department in HUTH with input into patient management, and many undergo detailed review as part of the large ongoing research trial, Staphylococcus aureus Network Adaptive Platform (SNAP). Therefore, data can be analysed for thematic reviews and learning and to inform the required improvement actions. Below is a summary of the Q4 findings Jan-March 2026.

***Staphylococcus aureus* Bloodstream Infections (SA BSI): HUTH, January to March 2026**

Between January and March 2026, 34 episodes of *Staphylococcus aureus* bloodstream infection (SA BSI) were recorded across the HUTH. The patient cohort was predominantly middle-aged and older adults, with a median age of 59.5 years and a mean age of 60.5 years. Approximately half of all cases occurred in female patients and half in male patients. The vast majority of infections were caused by methicillin-sensitive *Staphylococcus aureus* (MSSA), with only a single MRSA isolate identified during the period.

Most infections were community-onset, accounting for 20 of the 34 episodes (58.8%). Thirteen episodes (38.2%) were classified as hospital-onset, with one additional episode representing a documented relapse of a previous infection. Assessment of hospital-onset cases demonstrated that 11 of the 13 episodes (84.6%) were considered truly hospital-associated, the other 2 representing delayed identification of community associated cases. These infections were predominantly related to invasive devices, particularly central venous catheters or peripheral cannulae (62% of patients with hospital acquired MSSA BSI), haemodialysis access and temporary pacing wires, highlighting the ongoing importance of device-related infection prevention measures.

Patients experiencing SA BSI had a high burden of underlying comorbidity. Diabetes was the most frequently identified risk factor and was present in 58.8% of cases, while chronic kidney disease (CKD) was documented in 47.1%. Immunosuppression was recorded in 14.7% of patients and 11.8% were receiving haemodialysis. A small number of cases occurred in people who inject drugs (5.9%), while cardiac device-

related risk factors were uncommon, with only one patient having a pacemaker and no patients recorded as having a prosthetic valve. These findings demonstrate that SA BSI continues to disproportionately affect patients with significant underlying health conditions, particularly those with diabetes and renal disease.

Clinical outcomes reflect the severity of infection within this patient population. Six patients died during their admission, giving a crude in-hospital mortality rate of 17.6%. Two relapse episodes were identified during the reporting period, representing 5.9% of recorded episodes. Overall, the data indicate that SA BSI remains associated with substantial morbidity and mortality, particularly in patients with multiple comorbidities and those requiring invasive vascular access devices.

In summary, SA BSI cases during the first quarter of 2026 were characterised by a predominance of community-onset infection, a significant contribution from hospital-associated device-related infections, and a high prevalence of diabetes and renal disease among affected patients. The findings reinforce the importance of continued focus on vascular access management, device care, early source control, and targeted prevention strategies for patients with complex comorbidities in order to reduce the incidence and impact of SA BSI across the Partnership.

Key improvement actions identified

- Improvements in peripheral intravenous cannula insertion and ongoing care bundle compliance
- Improvements in central vascular access device insertion and management
- IV to oral medication switch improvements to reduce the requirements for IV access
- Review of MSSA decolonisation in high risk patient groups

2.3.1.1.3 Gram Negative Blood Stream Infections (GNBSIs)

For the operational period 1st April 2025 to 31st March 2026, UKHSA and NHS England required NHS Trusts to continue to report cases of BSIs due to *E coli*, Klebsiella species and *Pseudomonas aeruginosa (P. aeruginosa)*. These were based against set threshold targets outlined by NHSE, the below Table 1 and 2 show the NHSE thresholds set for HUTH and NLAG, and the performance against these thresholds for 2025-26.

Blood stream infection	2025-2026 upper threshold as per standard contract (HOHA* & COHA* cases combined)	Year-end actual reported case total (HOHA* & COHA* cases combined)	Performance
E coli	203	214	Exceeded threshold Decrease on 2024-25 (220)
Klebsiella species	72	77	Exceeded threshold Increase on 2024-25 (74)
Pseudomonas aeruginosa	30	29	Below threshold Increase on 2024-25 (26)

Table 3: HUTH Gram-negative bloodstream infection national thresholds and year-end performance, 2025/26

Blood stream infection	2025-2026 upper threshold as per standard contract (HOHA* & COHA* cases combined)	Year-end actual reported case total (HOHA* & COHA* cases combined)	Performance
E coli	57	89	Exceeded threshold Increase on 2024-25 (69)
Klebsiella species	34	43	Exceeded threshold Increase on 2024-25 (32)
Pseudomonas aeruginosa	5	16	Exceeded threshold Increase on 2024-25 (13)

Table 4: NLaG Gram-negative bloodstream infection national thresholds and year-end performance, 2025/26

***E. coli* bloodstream infections**

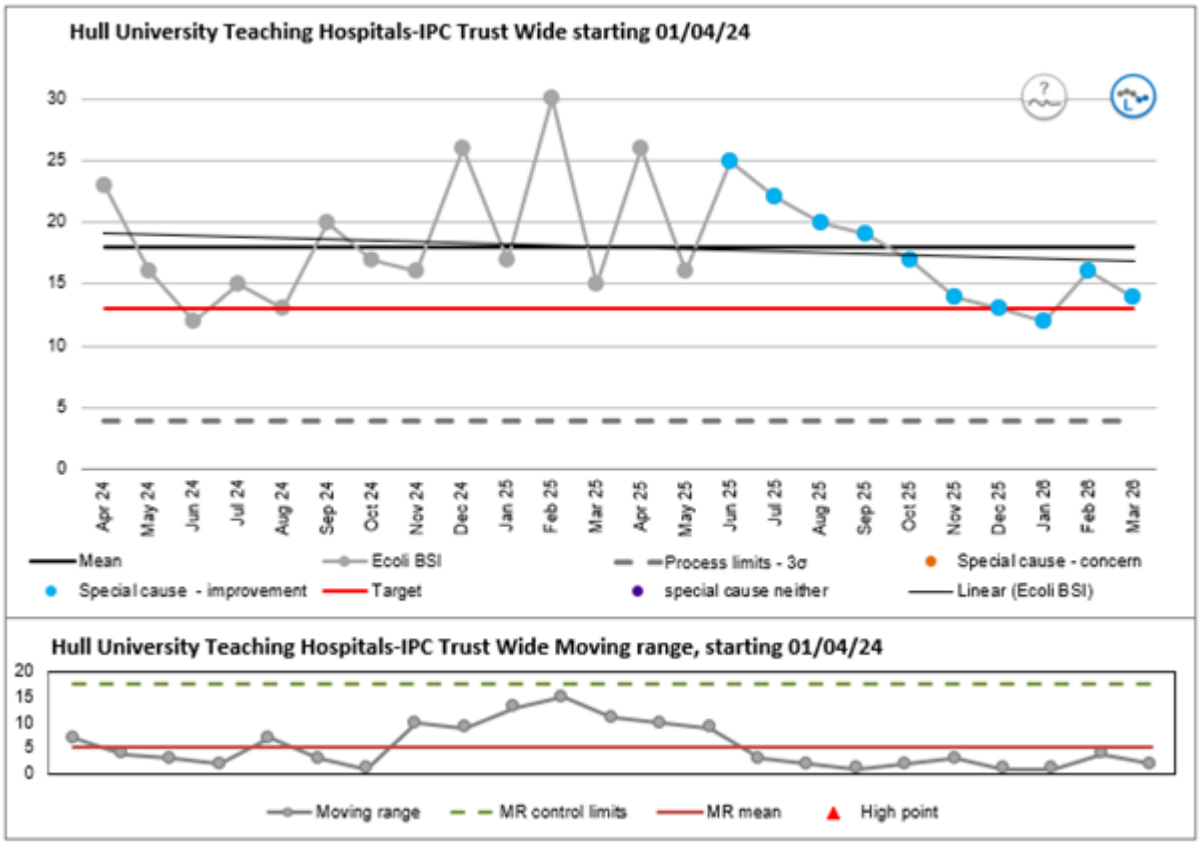


Figure 14: HUTH SPC chart: E. coli bloodstream infections, FY 2024/25 and FY 2025/26

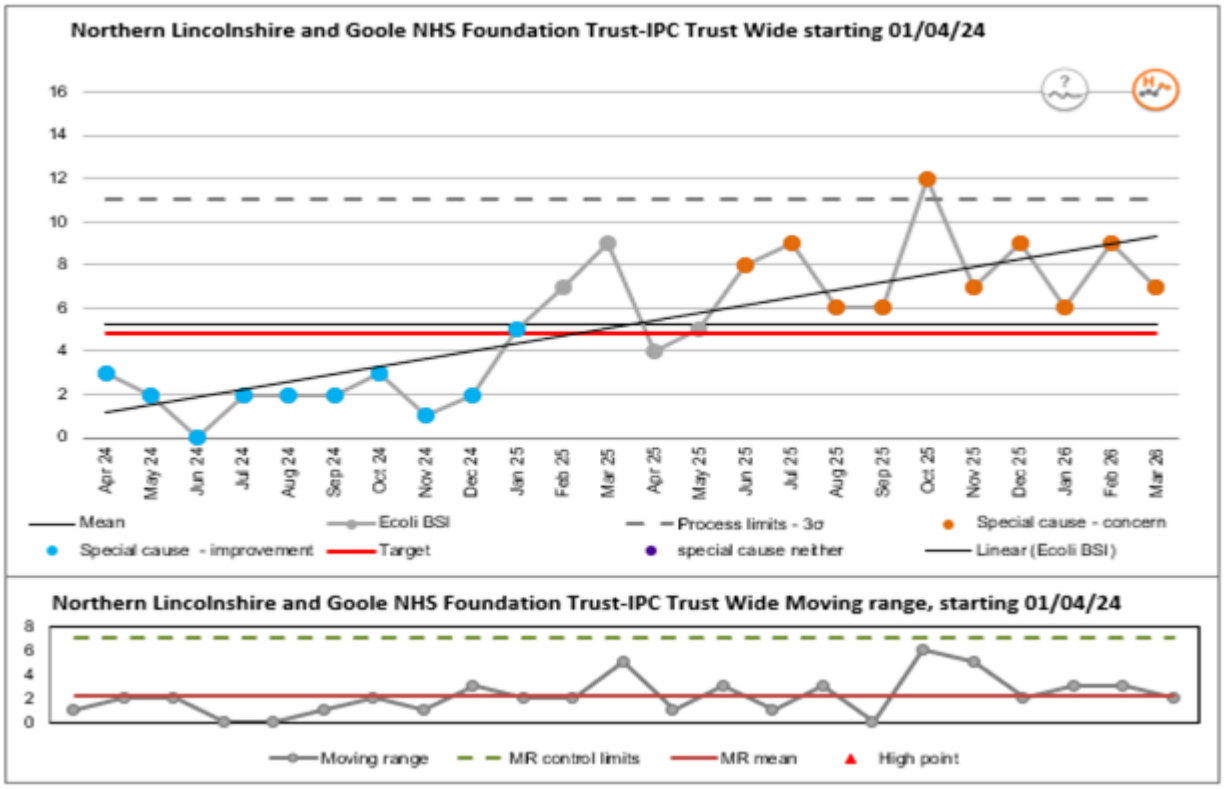


Figure 15: NLaG SPC chart: E. coli bloodstream infections, FY 2024/25 and FY 2025/26

Healthcare associated *E. coli* Bacteraemia rates per 100,00 bed days for Yorkshire and Humber acute trusts in comparison to England average, January to March 2026.

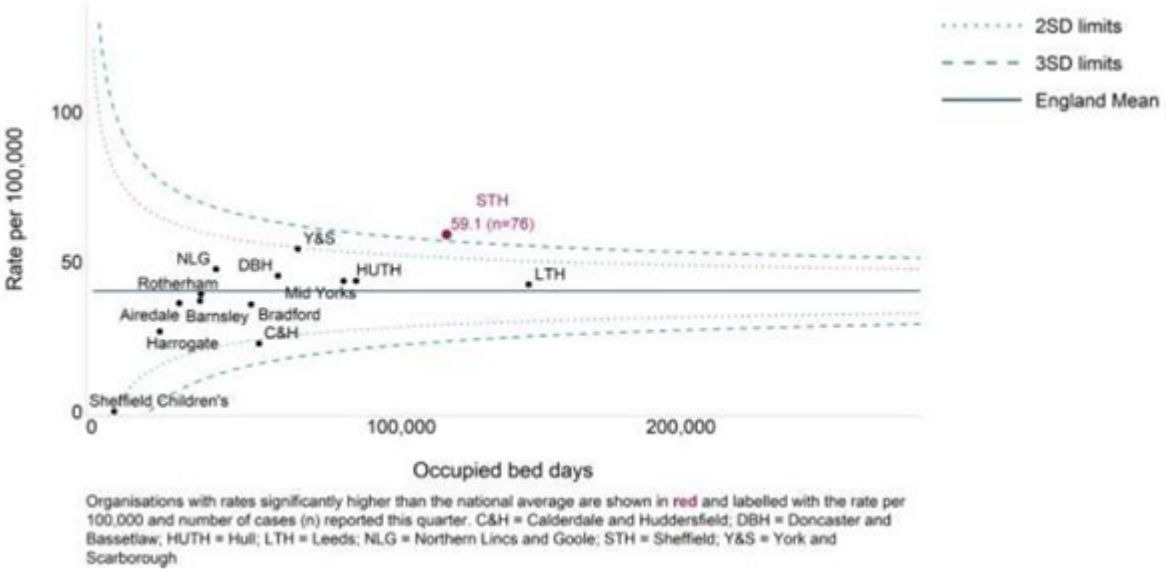


Figure 16: Regional healthcare-associated E. coli bacteraemia rates per 100,000 occupied bed days, January to March 2026

Although both organisations exceeded their *E coli* annual thresholds, HUTH absolute numbers have reduced and there has been a significant improvement in the rate per 100,000 occupied bed days from previous years. NLAG also exceeded their threshold and although the rate per 100 000 occupied bed days is above the mean, the organisation is not a negative outlier.

Local post infection reviews of E coli bacteraemia identified that one of the key modifiable risk factors for E coli and Klebsiella bacteraemias is the association with urinary catheter associated urinary tract infections (CAUTI). Therefore, this was identified as an area for quality improvement focus.
Subsequently, as part of the sepsis quality priority, the IPCT have supported a HHP wide CAUTI quality improvement programme to reducing catheter-associated harm across HUTH and NLAG. Significant progress has been made in developing surveillance systems, establishing baseline infection rates, designing a CAUTI dashboard, standardising catheter policies and training, developing electronic trail without catheter (TWOC) pathways, and preparing a catheter equipment standardisation programme. The next phase focuses on implementation at ward level, reducing unwarranted variation, supporting timely catheter removal and achieving measurable reductions in catheter-associated infection rates. This work will continue into 2026-27.

There will be additional focus on other areas where there is proven evidence to support gram negative BSI reduction including improving patient hydration and other UTI prevention measures.

Klebsiella species bloodstream infections

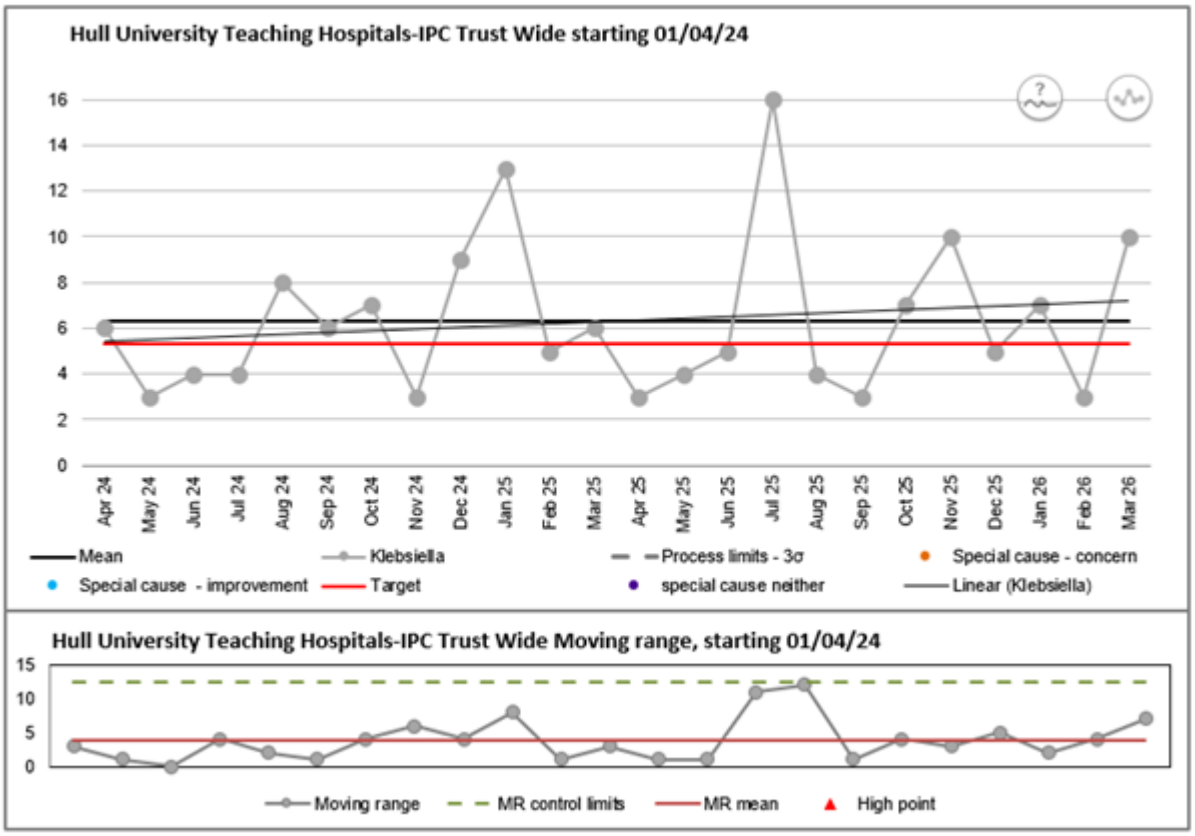


Figure 17: HUTH SPC chart: Klebsiella species bloodstream infections, FY 2024/25 and FY 2025/26

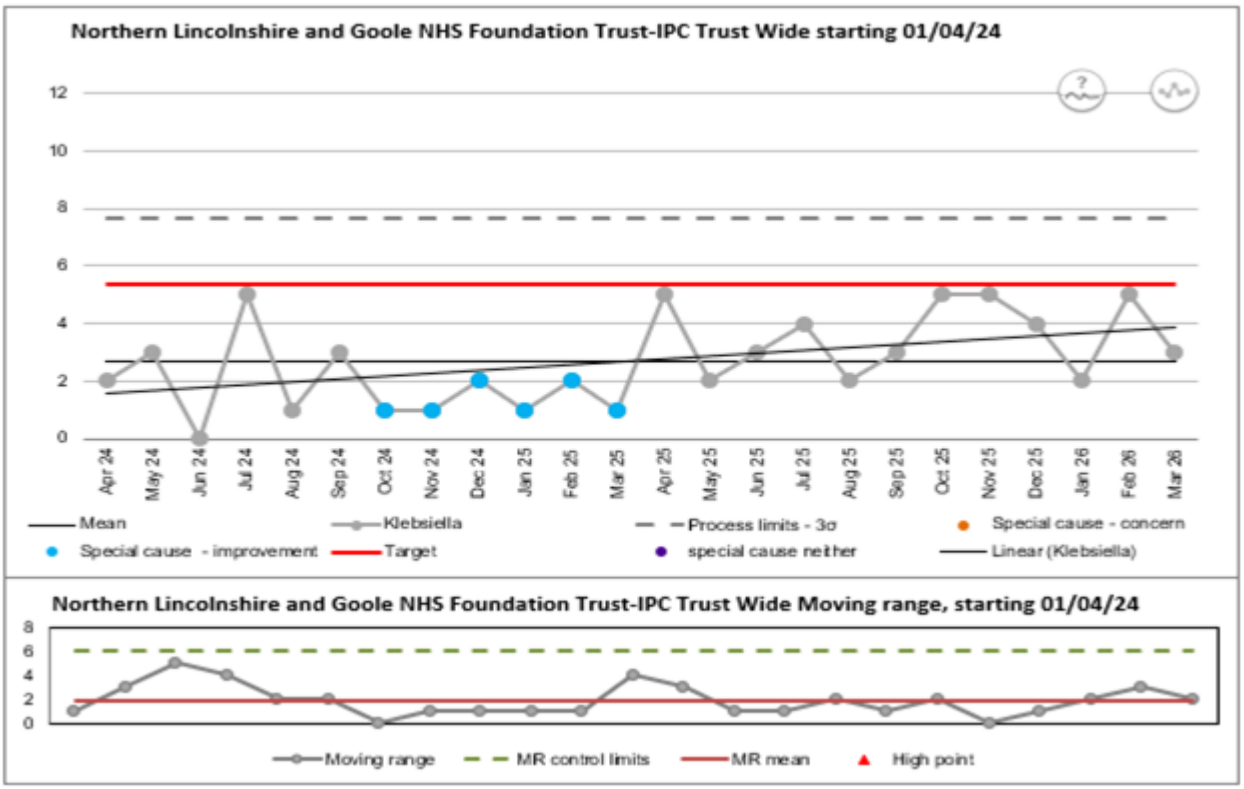


Figure 18: NLaG SPC chart: Klebsiella species bloodstream infections, FY 2024/25 and FY 2025/26

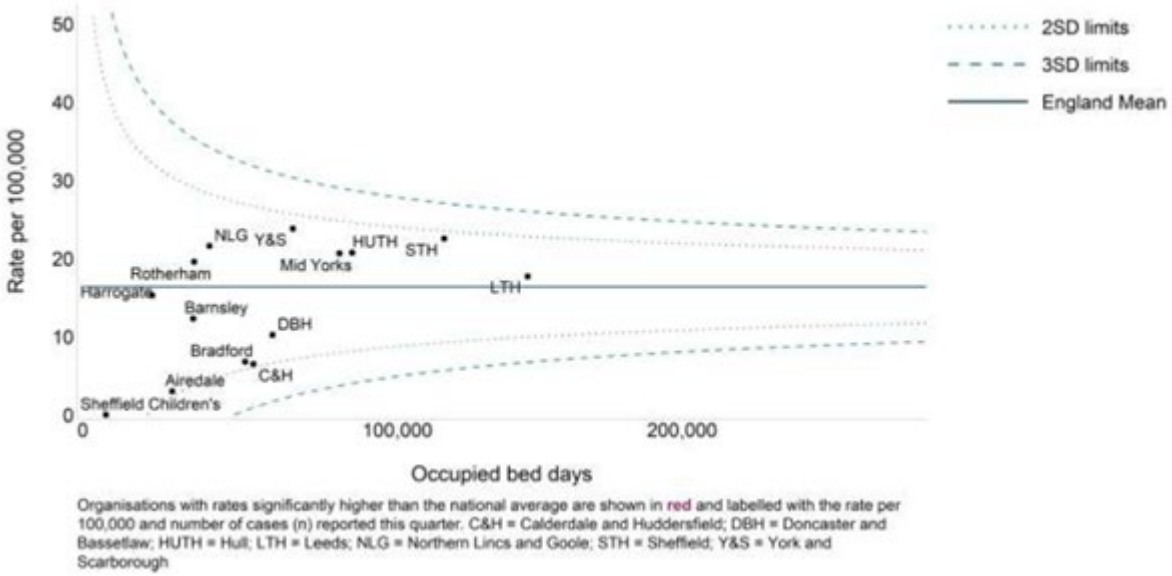


Figure 19: Regional healthcare-associated Klebsiella species bacteraemia rates per 100,000 occupied bed days

Like E coli bacteraemias, Klebsiella species blood stream infections have exceeded thresholds and increased year on year. The risk factors for these infections are similar to those for E coli, and improvement strategies should be effective to reduce both.

***Pseudomonas aeruginosa* bloodstream infections**

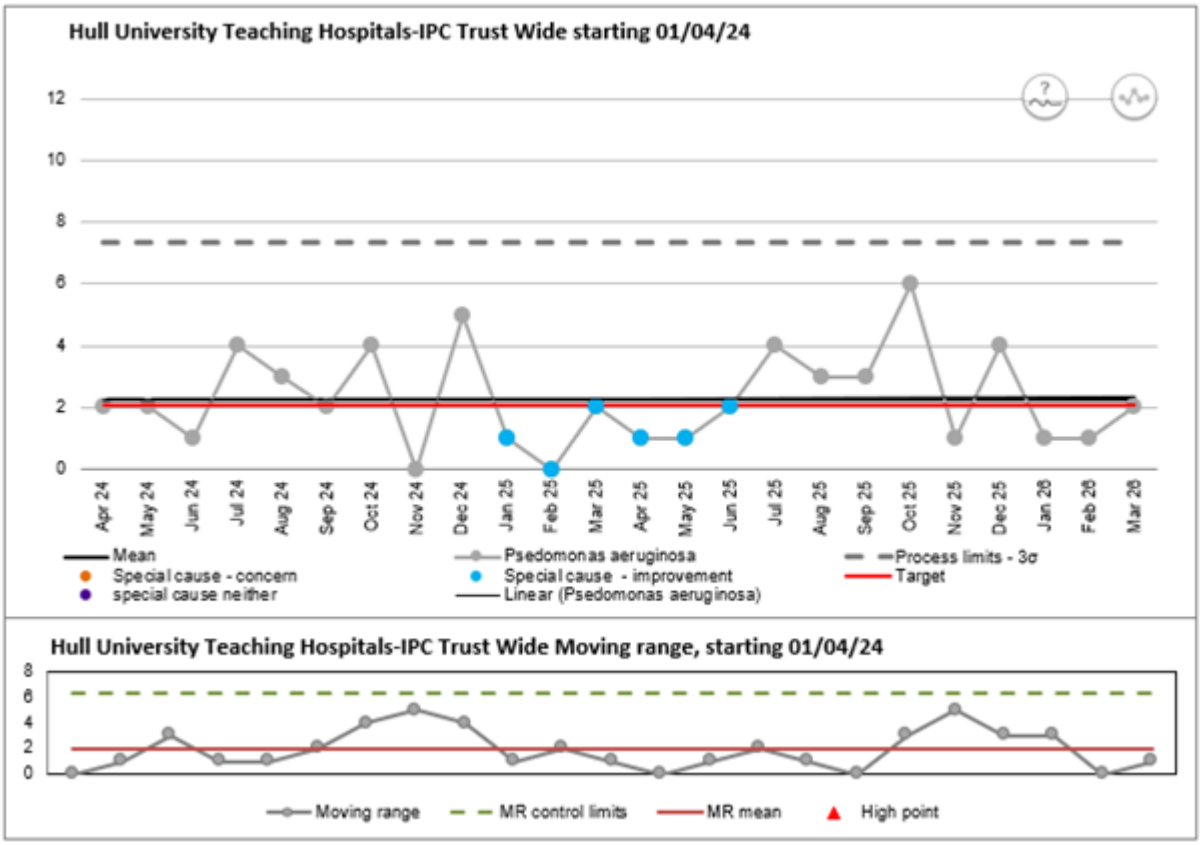


Figure 20: HUTH SPC chart: Pseudomonas aeruginosa bloodstream infections, FY 2024/25 and FY 2025/26

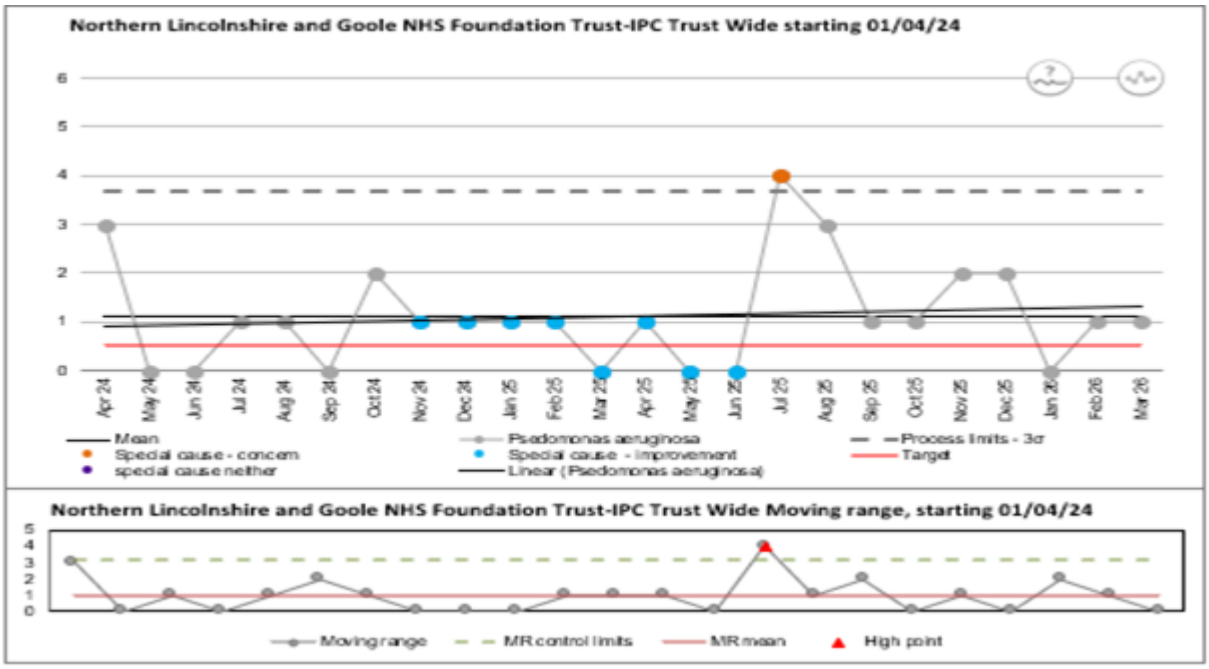


Figure 21: NLaG SPC chart: Pseudomonas aeruginosa bloodstream infections, FY 2024/25 and FY 2025/26

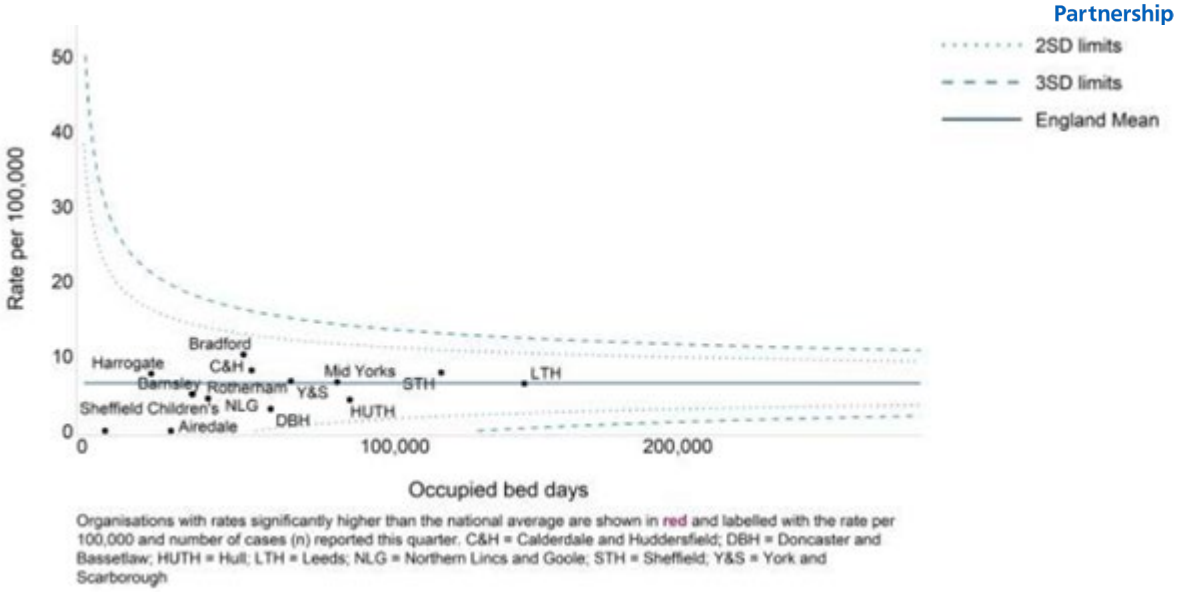


Figure 22: Regional healthcare-associated Pseudomonas aeruginosa bacteraemia rates per 100,000 occupied bed days, January to March 2026

HUTH had a small increase in *Pseudomonas aeruginosa* BSI from 2024-25 but was still under threshold and the rates per 100,000 were below the national mean. NLAG exceeded the threshold and had an increase on 2024-25 but remain under the England mean rate. Quality improvement work undertaken in HUTH has identified that a significant proportion of Pseudomonal bacteraemias are associated with central line usage, and improvements in care of lines may lead to reductions. There is a business case in progress for a line insertion and care service. Support for this business case is vital to the infection prevention workstreams for both gram positive and gram negative blood stream infections.

2.3.1.1.4 *Clostridioides difficile* Associated Diarrhoea (CDAD)

During 2025-26 both HUTH and NLAG have significantly deteriorated in performance for the number of reported CDI cases. Both Trusts have breached their thresholds, which has contributed to the organisations overall performance against the national oversight framework.

HUTH has seen a special cause for concern start to emerge during quarter 4 of the financial year 2026 and commencement of the new financial year April 2026. A plan to develop a Trust improvement plan with a CDI action plan will be discussed in the 2026/2027 DIPC report, as a result of this emerging cause for concern.

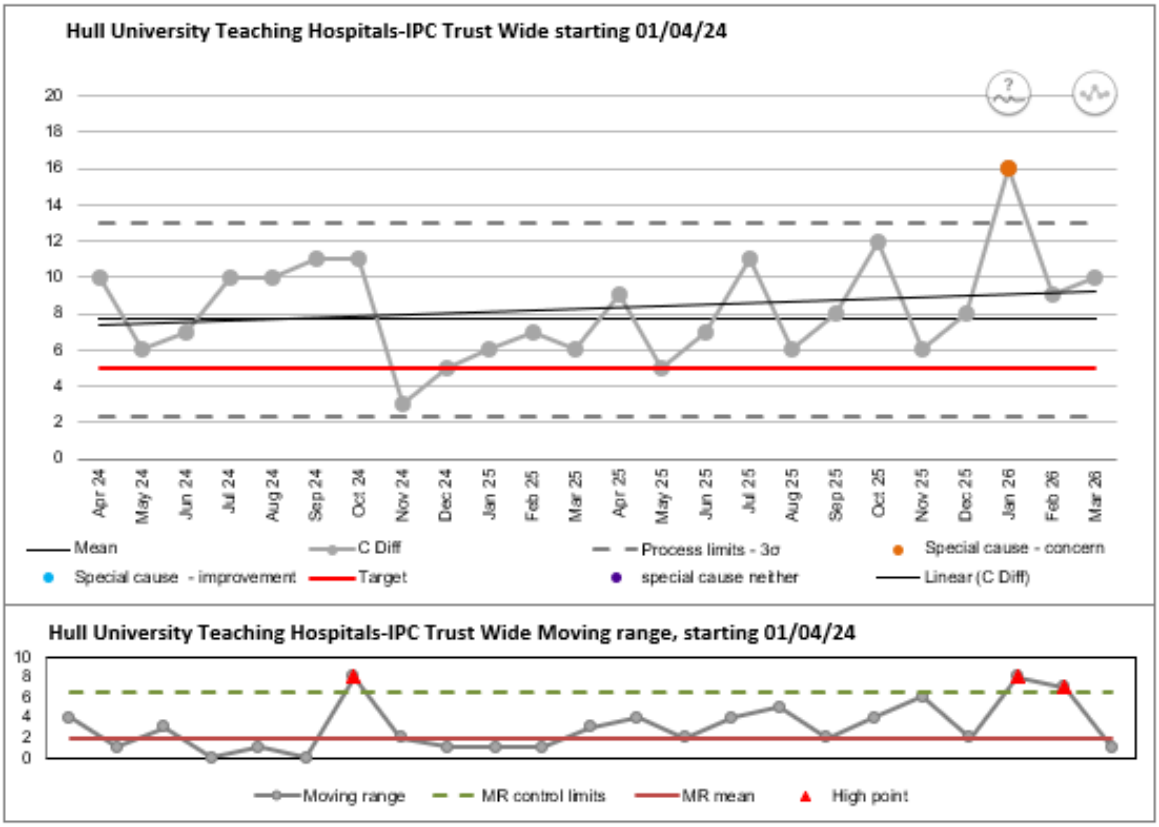


Figure 23: HUTH SPC chart: C. difficile infections, FY 2024/25 and FY 2025/26

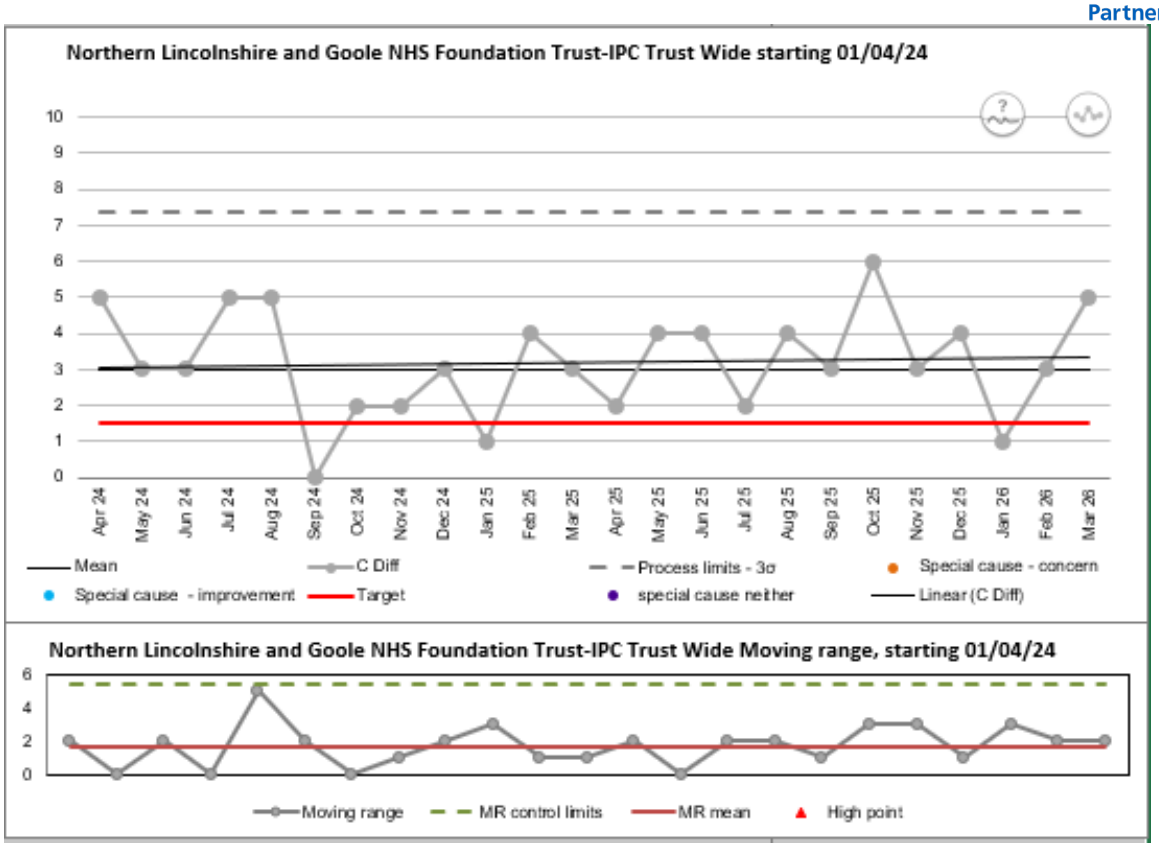


Figure 24: NLaG SPC chart: C. difficile infections, FY 2024/25 and FY 2025/26

To provide regional context, Figure 25 benchmarks the Healthcare associated CDI rates in patients over 2 years of age per 100,000 bed days for acute Trusts across Yorkshire and the Humber region against the national England average for the period of January 2026 to March 2026.

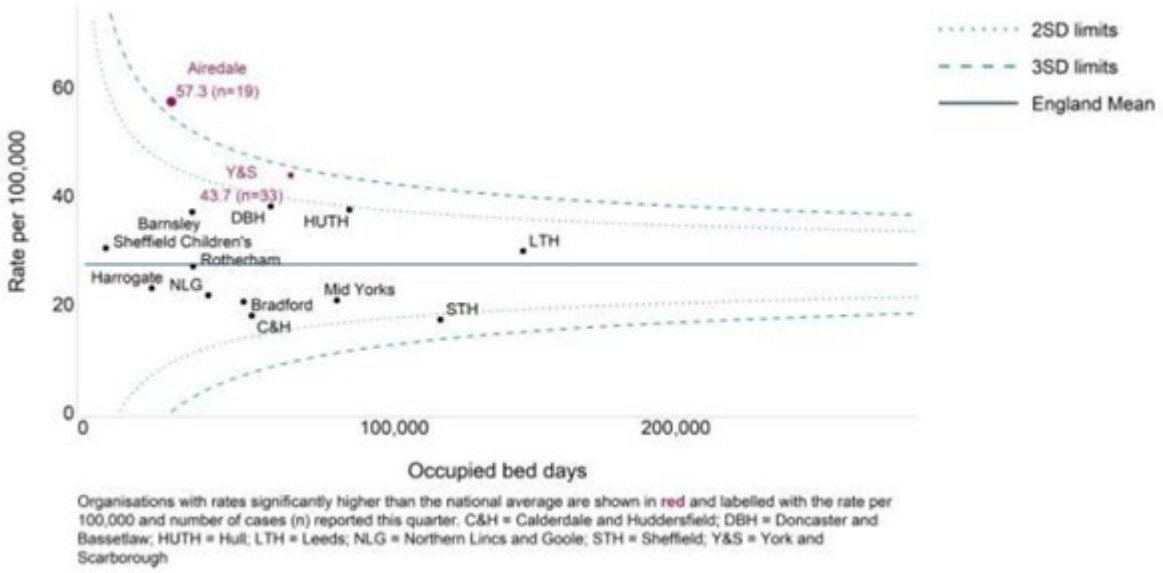


Figure 25: Regional healthcare-associated C. difficile infection rates per 100,000 occupied bed days, January to March 2026

C difficile cases have risen across all regions of the UKHSA in the past 5 years. There have been substantial and sustained increases of both hospital associated and community associated cases, with hospital associated cases making up just under 50% of the total. UKHSA's 2025 national investigation concluded that no single explanation accounts for the increase. Instead, it is likely to be multifactorial. Antimicrobial prescribing is still likely to be one of the most significant factors, but pressures on the healthcare system including high bed occupancy, increased patient movement and corridor care and treatment in non-standard clinical environments are likely factors contributing to cases.

NLAG occupies a favourable regional position with a rate sitting visibly below the national England mean (solid horizontal line). Therefore, the trust demonstrates that despite increasing CDI rates locally there remains some clinical control relative to the moderate volume of occupied bed days (40,000).
HUTH, however, exhibits a higher comparative rate per 100,000 bed days, placing it above the national England mean and sitting close to the 2SD control limit, whilst just inside this limit. The trust is currently not flagged as a statistical outlier, representing normal expected baseline variation under national monitoring parameters, however, given the significant increase seen locally further improvement works are planned during quarter 1 of the next financial year 2026-27.

In terms of emerging themes from the HUTH CDI cases, a large volume of the patients identified to have CDI had complex health needs, with underlying medical conditions. The burden of non-community-associated C. difficile cases is concentrated within Specialist Cancer & Support, Acute & Emergency Medicine, Community Frailty & Therapy, Specialist Medicine and Digestive Diseases care groups, which together account for approximately 78% of all cases during 2025/26. The most common theme was association with antimicrobial therapy, with a reasonable proportion of patients having multiple and or extended courses. A small number of these had inappropriate antibiotics (wrong agent, unnecessary therapy or longer course than required). Any exposure to antibiotics increases the risk of CDI and in the case of some patients has led to avoidable harm.
However, in many CDI cases the causation is likely to include multifactorial concerns, including environmental factors. Examples include where audits have shown poor compliance to IPC practices, inadequate cleaning of the environment and in particular dirty commodes. As a result, actions included promoting compliance with hand hygiene audits across care groups, initiatives for world hand hygiene day, enhanced environment cleaning and implementing commode audits in areas where increased incidence has been seen.

The renal ward at Hull Royal Infirmary had 9 cases of CDI in the 2024/2025 financial year, a significant proportion of which were the same ribotype, CE001. This suggests transmission on the unit, and given these cases emerged over several months, suggests transmission linked to the environmental or equipment as a likely causative factor. There were several incident management team (IMT) meetings once this outbreak of CDI was identified, and a full deep clean and HPV treatment of the environment was enacted to prevent further transmission. Since this was undertaken there have been no further cases reported to date, the last case being in January 2026.

Given HUTH have seen significant rises in the numbers of cases over the past 3 years and whilst NLAG remain below the England mean have similarly seen rising numbers of cases and have breached their threshold, a C difficile improvement plan based on a thematic review of cases will be a priority for 2026-27. This multi-faceted plan will include workstreams looking at improved diagnosis, patient management, environmental cleanliness, IPC practice, antimicrobial usage and learning and education.

2.3.1.2 Multi-Drug-Resistant Organisms (MDROs) e.g. Carbapenemase producing Enterobacterales (CPE) and Vancomycin Resistant Enterococci (VRE)

HUTH Carbapenemase producing Enterobacterales (CPE)

HUTH has completed the planned role out of multi-drug-resistant organism (MDRO) screening for CPE to improve compliance against the National Framework of Actions to Contain CPE guidance. During the financial Year (FY) 2025/26, HUTH recorded a single, localised CPE outbreak. While CPE represents a significant antimicrobial resistance (AMR) threat within acute hospital environments, this incident was successfully contained and closed within 40 days of its formal declaration. The transmission vector was halted through rapid containment measures, supported by clinical buy-in from the care group medical and nursing leadership. Surveillance of CPE continues to ensure that transmission and subsequent outbreaks are minimised, this is supported by the introduction of ICNET.

Northern Lincolnshire and Goole Hospitals (NLaG) CPE

NLAG had a protracted CPE outbreak over 12 months, as part of this outbreak a full report into the outbreak has been written for and presented at Quality in Commons (QiC) committee, the Executive Summary from this CPE Outbreak at NLAG is provided below.

Context and Clinical Impact

Between February 2025 and March 2026, Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) managed its first major outbreak of Carbapenemase-producing Enterobacterales (CPE). CPE represents a critical threat to patient safety and operational continuity due to its resistance to last line carbapenem antibiotics.

The outbreak affected **322 patients** across two main sites:

- **Diana Princess of Wales Hospital (DPOW):** 253 cases (242 colonisations, 11 clinical infections including 3 bloodstream infections) across 16 clinical areas over a 12-month period.
- **Scunthorpe General Hospital (SGH):** 69 cases (61 colonisations, 8 clinical infections) across 6 clinical areas over a 10-month period.

Following extensive interventions, SGH was declared clear in December 2025, and DPOW followed in March 2026.

Source and Epidemiological Profile

The outbreak was multi-factorial, driven primarily by environmental reservoirs within an aging estate. Whole-Genome Sequencing (WGS) supported by the UKHSA identified *Klebsiella michiganensis* carrying the bla-KPC-2 gene as the dominant strain. WGS established a direct genomic link between infected patients on adjacent wards C5 and C6 and environmental reservoirs in a shared ward kitchen (specifically the handwash basin, sink, and hydration trolley).

Key Containment Interventions

A robust Gold/Silver Command governance structure was established alongside external partners (ICB, UKHSA, NHSE) to execute five core tactical workstreams. The following key highlights identified gaps and implementation:

- **Surveillance:** Launched universal adult admission and weekly screening in March 2025. This was upgraded to rapid molecular PCR testing in August 2025 and mandatory 48-hour pre-discharge screening for social care transfers.
- **Patient Flow:** Patient tagging via WebV. Positive patients were isolated or transferred to a dedicated CPE ward at DPOW. Widespread bay and ward closures caused severe disruptions to overall Trust bed capacity.
- **Facilities:** Transitioned the Trust to fully BS EN-compliant disinfectants by May 2025. Implemented a 24/7 rapid cleaning team, deployed Hydrogen Peroxide Vapour (HPV) deep-cleaning, and executed a full decant of wards C5 and C6.

- **Estates:** Rectified some non-compliant clinical handwash basins (HTM guidelines), add kitchen splash screens, and resolved some drainage vulnerabilities.
- **AMS:** Stock carbapenems were removed from wards, mandating formal microbiologist approval and pharmacy dispensing restrictions.
- **Education:** Clinical staff knowledge base of CPE and MDRO.

Financial Impact and Strategic Recommendations

The known financial exposure from this outbreak exceeds £3 million in urgent investment through approved business cases to address critical service gaps. Total direct and indirect costs are currently being finalised for the final Incident Management Team (IMT) report.

To preserve system assurance and mitigate risks on the corporate IPC Risk Register, the Trust Board is asked to approve the following long-term business cases:

1. **Capital Estates Funding:** A proactive, planned infrastructure remediation programme for a comprehensive sink and drainage replacement scheme across SGH and DPOW.
2. **Decontamination:** Recurrent funding to secure the 24/7 reactive deep-clean team and the HPV decontamination system permanently.
3. **Diagnostic Mechanisms:** Capital to maintain rapid laboratory PCR diagnostic screening capabilities.
4. **Workforce Accountability:** Continued deployment of the IPC clinical competency framework, backed by formal HR enforcement processes to address persistent staff non-compliance.

Vancomycin Resistant Enterococci (VRE)
Hull University Teaching Hospitals (HUTH)
During the financial year (FY) 2025/26, HUTH managed four declared VRE outbreaks. VRE is a highly resilient antibiotic-resistant organism capable of prolonged survival on environmental surfaces. While three of the outbreaks were rapidly contained, the most complex and long-standing outbreak persisted for 8 weeks before formal closure criteria were satisfied.

Despite the sustained transmission pressure, all incidents were successfully resolved through a coordinated, multidisciplinary response. This success was driven by immediate clinical buy-in from the care group nursing and medical leadership, combined with targeted operational changes at the bedside.

To break the chain of transmission during the VRE outbreaks, the IPCT implemented a series of enhanced environmental and equipment controls:

- Enhanced equipment decontamination: In accordance with the national standards of healthcare cleanliness, ward-based housekeepers were given dedicated time to manage the rigorous cleaning schedules for reuseable medical equipment. This intervention successfully closed gaps in asset decontamination.
- Transition to single-use consumables: To eliminate the risk of cross-contamination via shared clinical assets, affected departments transitioned to single-use patient equipment, where clinically feasible.
- Enhanced cleaning and surveillance: Clinical areas deployed enhanced disinfection cleaning. This was paired with enhanced surveillance tracking, which included mandatory weekly screening of all patients on the ward, admission screening and screening within 48-hours of discharge to social care settings, this was to allow early detection of asymptomatic patients. Additionally, HPV cleaning was implemented to add enhanced cleaning to reduce transmission.

HUTH *Haemophilus influenzae* Queens Oncology
During the latter part of quarter 4 2025/26, HUTH had an emerging outbreak of a highly resistant strain of *Haemophilus influenzae*, in the Queen's oncology centre at CHH. This manifested as several patients developing respiratory symptoms, including cough, fever, shortness of breath, in an immunocompromised patient group. An IMT was set up and included key stakeholders, including UKHSA, the national reference laboratory and the ICB, and control measures were instituted. These included respiratory screening for all admissions, universal mask wearing in the clinical area affected, enhanced auditing, senior ICD review, review of the ventilation system, and prophylactic antimicrobial therapy. Further review of this outbreak will be included in the future 2026/2027 DIPC report.

2.3.1.3 Respiratory viruses: Influenza, COVID-19 and RSV

Influenza – Influenza (commonly known as flu) is a respiratory infection, the two most common strains seen in the patients in healthcare facilities are Flu A and Flu B and these are the two strains which usually cause the seasonal epidemics seen each winter. Both HUTH and NLAG have seen significant pressure due to respiratory virus in the last financial period. This was a particular challenge when it coincided with other outbreaks, putting increased pressure on flow and capacity.

RSV – Respiratory syncytial virus (RSV) is a common cause of coughs and colds, and whilst often seen in the paediatrics, the last season we have seen increased cases amongst the vulnerable adults population within the healthcare setting. Whilst the adoption of an RSV vaccination programme in terms of public health, which is

offered to those pregnant, aged over 75 and live in care facilities. There is still a significant number cases.

COVID-19 – Coronavirus SARs-CoV-2 has continued to affect a large volume of patients seen in the organisations post pandemic. Whilst the rates are now lower than or seasonal Flu cases, it still causes disruption to the flow or patients through isolation of those with symptoms. Similarly public health offer covid-19 vaccines to those highest risk group patients including those clinically vulnerable patients and frailty patients.

Organisation/ Organism	HUTH	NLAG
Influenza Total Numbers (April 2025-March 2026)	**971**	**878**
Covid-19 Total Numbers (April 2025-March 2026)	**597**	**482**
RSV Total Numbers (April 2025-March 2026)	**307**	**N/A**

Table 5: HHP respiratory virus case totals, April 2025 to March 2026

Period	Flu A	Flu B	RSV	Covid-19
Apr 2025	19	12	2	29
May 2025	11	0	2	25
Jun 2025	4	0	1	47
Jul 2025	4	0	1	17
Aug 2025	1	3	0	40
Sep 2025	3	0	0	119
Oct 2025	41	1	3	160
Nov 2025	189	1	28	53
Dec 2025	455	2	107	27
Jan 2026	184	1	109	39
Feb 2026	26	8	35	23
Mar 2026	6	0	19	18
Total Apr 2025 to Mar 2026	**943**	**28**	**307**	**597**

Table 6: HUTH monthly respiratory virus case totals, April 2025 to March 2026

Period	Flu A	Flu B	RSV	Covid-19
Apr 2025	42	14	Not available	10
May 2025	14	5	Not available	28

Jun 2025	4	0	Not available	22
Jul 2025	5	1	Not available	27
Aug 2025	8	0	Not available	78
Sep 2025	18	0	Not available	118
Oct 2025	56	0	Not available	101
Nov 2025	228	0	Not available	33
Dec 2025	335	0	Not available	28
Jan 2026	108	1	Not available	10
Feb 2026	21	2	Not available	14
Mar 2026	12	4	Not available	13
Total Apr 2025 to Mar 2026	**851**	**27**	**N/A**	**482**

Table 7: NLaG monthly respiratory virus case totals, April 2025 to March 2026

There continues to be a background of respiratory viral infections caused by Covid-19 with non-seasonal peaks which in 2025-26 occurred late summer/early autumn. The numbers of cases seen did not have a significant impact on the normal delivery of healthcare for either organisation.

In the autumn of 2025, the Influenza season started early, with cases rising significantly through October and November and peaking in December. This possibility was predicted from a similar picture seen in the Southern hemisphere, but unfortunately neither organisation was fully prepared to cope with the resultant surge in admissions. This resulted in unplanned ward closures, late decision making and an excess of in-hospital transmission significantly impacting the flow of patients through the organisation. Cohort areas were designated in each acute hospital, to reduce the impact on other ward areas. Significant numbers of staff contracted the virus, partly due to delayed uptake of the influenza vaccine.

The ICB is leading on ensuring lessons learnt from the 2025-26 winter season are built into the planning process for 2026-27, and the IPC leads have requested early involvement in the planning process.

2.3.1.4 Outbreaks and infection incidents of note

Hull University Teaching Hospitals (HUTH)

Reporting Period	Total Bed Days Closed	Equivalent daily beds closed	Net Trust capacity closed (%)	Unoccupied capacity	% Unoccupied capacity
FY 2024/25	9,547	26.16	2.20%	1,275 Bed Days	0.29%
FY 2025/26	13,762 (↑)	37.70 (↑)	3.17% (↑)	1,356 Bed Days (↑)	0.31% (↑)
Net Variance	+4,215 Days (↑)	+11.54 Beds (↑)	+0.97%	+81 Days (↑)	+0.02%

Table 8: HUTH overview of infection-related beds closed or unoccupied, FY 2024/25 and FY 2025/26

Reason for Closure	FY 24/25 Bed Days Closed	FY 25/26 Bed Days Closed	FY 25/26 Of Which Remaining Unoccupied Total Bed Days Lost	FY 25/26 Equivalent Daily Beds Closed	Year on Year Volume Variance (%)
Adult Beds					
Closed due to D&V, Norovirus-like Symptoms	4,462	8,267	694	22.6 beds	**+85.72%**
Closed due to COVID-19	1,610	1,405	147	3.9 beds	**-12.73%**
Closed due to other infection reasons	3,283	3,961	493	10.9 beds	**+20.65%**
Paediatric Beds					
Closed due to D&V, Norovirus-like Symptoms	0	0	0	0 beds	**0.00%**
Closed due to COVID-19	39	20	2	<0.1%	**-48.72%**
Closed due to other infection reasons	49	106	20	0.3 beds	**+116.33%**
Closed due to RSV	104	3	0	<0.1 beds	**-97.12%**
HUTH Total	**9,547**	**13,762**	**1,356**	**37.7 beds**	**+44.15%**

Table 9: HUTH bed-closure impact by infectious agent, FY 2024/25 and FY 2025/26

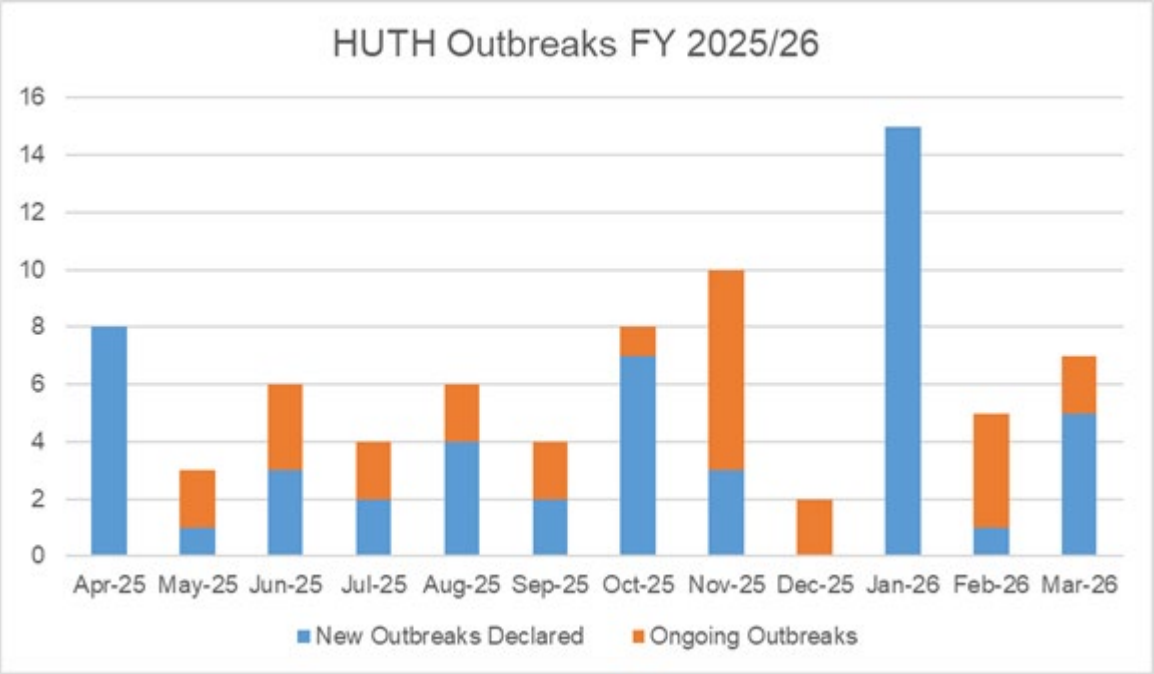


Figure 26: HUTH monthly outbreak trends, FY 2025/26

The analysis of the bed impacts is benchmarked against the Trust's operating baseline of 1,190 acute beds, translating to 434,350 total available bed days per financial year within HUTH.

Figure 26 demonstrates the monthly volatility and distribution of both new and ongoing outbreaks across the FY 2025/26. The data highlights a critical operational crisis in January 2026 (Q4 Peak), where new outbreak declarations spiked abruptly due to 15 concurrent incidents. This severe volume overstretched IPC nursing resources and serves as the direct driver behind many of the 13,762 total bed days lost detailed in the tables above.

October was impacted by a relatively early start to the Influenza season and November had ongoing pressures, as whilst new declarations were moderate, ongoing outbreaks peaked at 7. This indicates prolonged ward closures, resulting in a decrease in active bed capacity during the crucial pre-Christmas winter surge. Subsequently the Influenza season developed to be a moderate season with a lower impact than other recent years, although the overlap with norovirus and other winter vomiting illnesses had a significant impact in January.

During FY 2025/26, HUTH experienced a significant escalation in viral gastrointestinal activity declaring a total of 51 outbreaks and increased incidents of infections. This surge was primarily driven by a substantial winter spike in Norovirus and acute diarrhoea & vomiting (D&V) illness. More unusually, there were also a number of localised scabies outbreaks with some small impact. This reflected an increase in scabies being seen in community care settings.

A critical governance development during this financial year was the formal reinstatement of the Hospital Norovirus Outbreak Reporting System (HNORS). Prior to this winter cycle, HUTH has not utilised this national reporting framework since 2012.

- System Benefits: Reintroducing HNORS allowed the IPCT to benchmark our gastrointestinal outbreak data against national trends in real time.
- Data Accuracy: While the system documented a significant increase in reported outbreaks compared to previous years, this spike reflects both a genuine increase in community viral shedding and improved reporting accuracy driven by the new tool.

Figure 27 below shows the impact of organisational pressures on infection rates. Although causation cannot be assumed, there is a strong correlation between the number of patients manged in non-standard care spaces and infection rates. This has been noted in many organisations and is one of the key drivers for the eradication of corridor care.

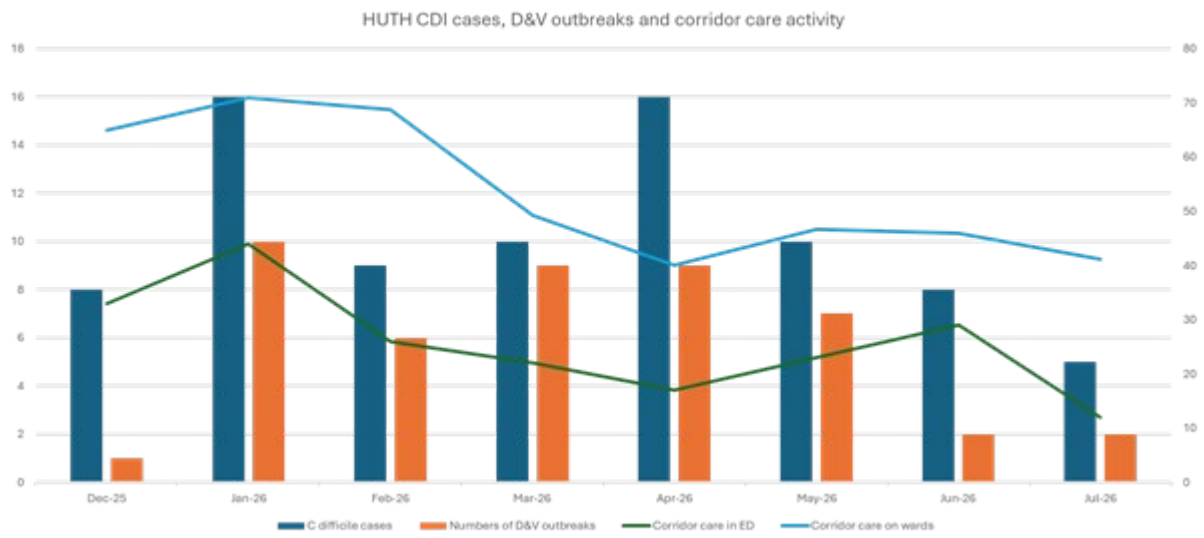


Figure 27: Correlation of corridor care activity, diarrhoeal illness outbreaks and C. difficile cases at HUTH, winter 2025/26

Analysis of Main Pathogen Drivers

- **Norovirus Dominance**: Viral gastrointestinal infections (D&V and Norovirus-like symptoms) was the single largest impact to capacity. This pathogen alone accounted for 8,267 bed days lost, compromising 60.1% of the Trust's total outbreak burden.
- **Other Infectious Pathogens:** Diverse infectious threats (including Scabies and Multi-resistant organisms) represented the second-largest operational pressure point, 3,961 bed days lost (28.8%).

- **COVID-19 & RSV Stabilisation:** Outbreak footprints linked to COVID-19 have stabilised, accounting for a combined adult and paediatric total of 1,425 bed days lost (10.3%). Adult COVID-19 bed day losses fell by 12.73%, and paediatric COVID-19 footprints halved (-48.72%). Crucially, paediatric RSV closures saw a near-total reduction (-97.12%), dropping from 104 to 3 bed days, likely due to the impact of the RSV vaccination programme.

Adult inpatient care bore the brunt of outbreak pressures, absorbing 99.1% of all capacity losses (13,633 bed days lost).
Paediatric units demonstrated exceptional containment and resilience, accounting for just 129 total closed bed days (0.9%), with zero closures originating from Norovirus.

The empirical data collected across these 51 outbreaks directly supports and validates the Trust's current positioning on the Corporate Risk Register, which explicitly highlights the severe operational risks posed by our limited single side room capacity, bed-spacing and lack of specialist isolation rooms. The winter surge of gastrointestinal outbreaks placed severe stress on our hospital footprint, exposing operational and structural vulnerabilities, which were also documented within the PLACE report.

- **Shared Bathrooms**: Norovirus spreads rapidly via aerosols and surfaces. The aging infrastructure of the HRI tower block, which significantly lacks mechanical ventilation and relies on shared multi-bed bay toilets rather than single ensuites isolation rooms, accelerated cross-contamination between patients.
- **Overcrowding / bed spacing**: many of the wards at HRI (in the tower block) do not meet the current recommendations for space between patient beds, leading to increased infection transmission. As noted in our PLACE Report, the historical loss of patient day rooms to accommodate additional beds increased ward density. High bed occupancy makes it difficult to isolate entire bays quickly, resulting in longer ward closures during the winter period.
- **Terminal Cleaning Limitations**: Effective containment of Norovirus and other infectious agents requires rigorous deep cleaning. Managing these 51 outbreaks without a HUTH decant ward facility forced cleaning staff to work around active clinical areas, extending bay closures times and restricting overall hospital patient flow.
- **Ventilation Deficit (HRI Tower Block)**: Crucially, most of the Norovirus outbreaks occurred within the Hull Royal Infirmary (HRI) tower block, an environment characterised by a lack of functional mechanical ventilation. This risk sits within the Corporate Trust Risk Register. Norovirus spreads rapidly via heavy environmental shedding and aerosolised vomitus particles. Without continuous mechanical air changes to dilute and extract these viral particles,

the stagnant air within the tower block creates high-density transmission zones, allowing the virus to easily affect surrounding areas.

- **'Nightingale ward' layouts** A moderate proportion of our tower block wards still have multi-bed open bays with incomplete partitioning between bays. This means that this is essentially a single airspace which allows ease of spread of infectious particles. Completing the work scheme to provide full wall to ceiling partitions in all wards should be seen as an infection reduction priority.

To support the reduction in transmission, the IPCT launched a new admission IPC infection risk assessment. This tool supports early identification of patients at risk of infectious and or multidrug resistant organisms and provides care plan advice. Improved utilisation from initial decision to admit, throughout the patient pathway will help reduce transmission risk by identifying those patients most at need of isolation. An isolation priority guide is used alongside the assessment to support best use of the available capacity, as the introduction of the assessment has highlighted the significant gap in the number of patients requiring cubicles and the available rooms.

The clear operational penalty of this structural layout is visible in the 1,356 bed days lost which remained unoccupied during the FY 2025/26 within closed outbreak bays. This empty buffer space represents 9.9% of all lost capacity (amounting to 3.7 beds kept empty every day of the year).

If the Trust possessed a higher ratio of single isolation rooms, these 1,356 empty beds within bay footprints could have been safely utilised for acute admissions. This structural vulnerability forces a severe operational compromise on the organisation during periods of high winter pressure and outbreak surges.

However, a key performance success, while total closures rose sharply (+44.15%), the unoccupied bed spaces metric grew by only 6.35% (from 1,275 to 1,356 bed days lost). This demonstrates that despite handling significantly more outbreak closures, the IPC and environmental services team kept clean-turnaround delays relatively flat, limiting further operational inefficiency.

The cumulative loss of 13,762 bed days equates to an average operational deficit of 37.70 acute beds completely offline every single day of the year. This loss represents a permanent 3.17% reduction of the entire Trust's bed capacity across the year, severely compromising patient flow, elective surgery capacity and tertiary referral pathways.

Northern Lincolnshire and Goole Hospitals (NLaG)

Reporting Period	Total Bed Days Closed	Equivalent Daily Beds Unavailable	Net Trust Capacity Closed (%)	Unoccupied Idle Capacity

FY 2024/25	434	1.19	0.16%	Unavailable
FY 2025/26	2,153	5.90	0.79%	Unavailable
Net Variance	+1,719 Days (↑)	+4.71 Beds (↑)	+0.63% (↑)	Unavailable

Table 10: NLaG overview of infection-related bed bays lost, FY 2024/25 and FY 2025/26

Reason for Closure	FY 24/25 Bed Days Closed	FY 25/26 Bed Days Closed	FY 25/26 Of Which: Remaining Unoccupied Bed Days Lost	FY 25/26 Equivalent Daily Beds Closed	Year on Year Volume Variance (%)
Adult Beds					
Closed due to D&V, Norovirus-like Symptoms	355	94	Unavailable	0.26 beds	**-73.52%**
Closed due to COVID-19	65	369	Unavailable	1.01 beds	**+467.69%**
Closed due to other infectious reasons	0	1,094	Unavailable	3.00 beds	**New Baseline**
Paediatric Beds					
Closed due to D&V, Norovirus-like Symptoms	3	6	Unavailable	0.02 beds	**+100.00%**
Closed due to COVID-19	1	0	Unavailable	0.00 beds	**-100.00%**
Closed due to other infectious reasons	0	219	Unavailable	0.60 beds	**New Baseline**
Closed due to RSV	0	1	Unavailable	0.00 beds	**New Baseline**
NLaG Total	**434**	**2,153**	Unavailable	**5.90 beds**	**+396.08%**

Table 11: NLaG bed-closure impact by infectious agent, FY 2024/25 and FY 2025/26

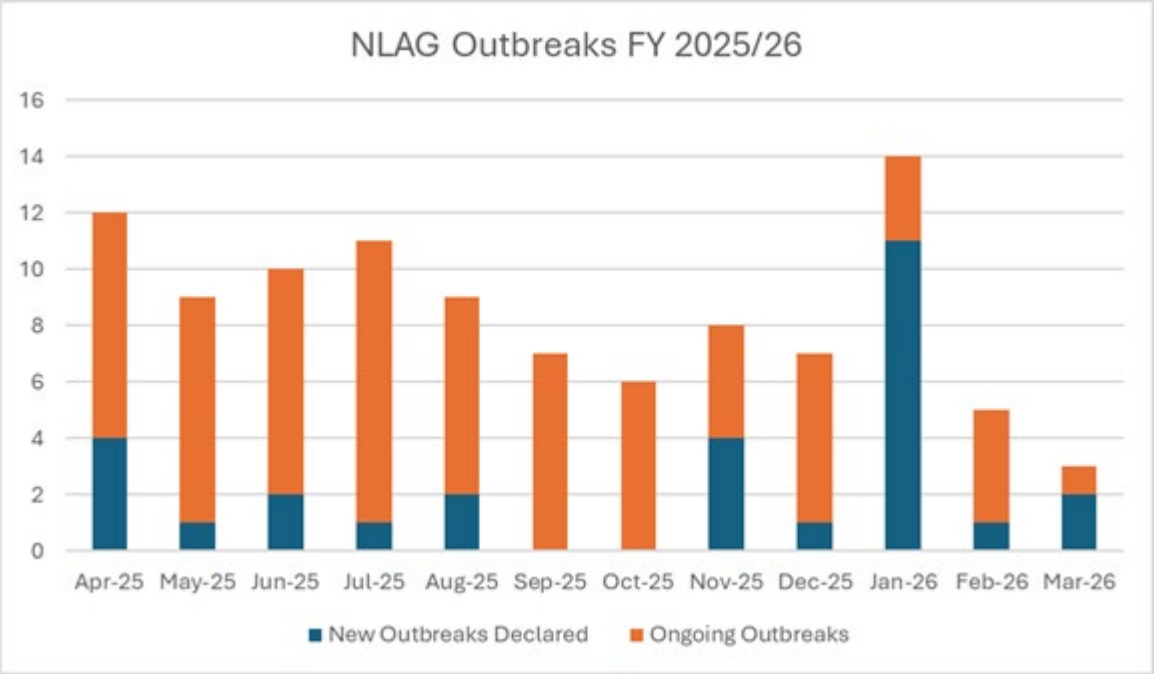


Figure 28: NLaG monthly outbreak trends, FY 2025/26

Figure 28 illustrates a heavy baseline of infection pressure, documenting 101 total individual ward outbreaks managed across the sites. Unlike typical seasonal viral trends that spike exclusively during winter, NLaG sustained an elevated outbreak from Q1 through Q3, driven by persistent outbreaks of CPE.

A peak is noted in January 2026, where new outbreak declarations abruptly escalated to 11 concurrent events, driven by winter respiratory viral and diarrhoeal illnesses. However, February and March 2026 demonstrates a decline, directly mirroring the active containment and formal step-down of CPE outbreaks at DPoW and SGH with concurrent reductions in influenza and norovirus.

During FY 2025/26, NLaG managed 101 declared outbreaks across its 750 acute beds, representing an overall +396.08% in annual bed capacity degradation compared to FY 2024/25. While total capacity lost surged from 434 to 2,153 total bed days lost, the underlying data indicates that this was not a standard seasonal viral winter spike, but a structural shift due to the extensive CPE outbreak.

Seasonal gastrointestinal pathogens (D&V) trended down by –73.52% (down to 94 days), while endemic adult respiratory burdens via COVID-19 escalated significantly by +467.69% to account for 369 lost bed days.

The primary clinical and structural risk managed by IPCT was a prolonged, high-profile Carbapenemase-Producing Enterobacteriaceae (CPE) outbreak. See also

section 2.3.1.2 Multi-Drug-Resistant Organisms (MDROs) e.g. Carbapenemase producing Enterobacterales (CPE) and Vancomycin Resistant Enterococci (VRE)

During quarter 1, 2025/2026, there was an increased incidence of chicken pox seen in both HUTH and NLAG, subsequently IMTs were held in conjunction with key stakeholders, actions included sending a number of warm and inform letters to both staff and patients (parents of babies in NICU), to increase awareness of potential risk and exposure; both babies and staff contacts had checks for immunity; non-immune parents identified, and timely and co-ordinated prophylaxis to those most at risk (NICU babies). Subsequently, there was proper communications which went to staff in relation to both chicken pox and shingles awareness across the Trusts.

Both HUTH and NLAG had increased incidences of scabies during the 2025/2026 financial year. Whilst locally in the community the ICB reported a significant number of care homes had outbreaks of scabies, thus impacting the acute setting. The scabies cases, mainly impacted patients in the frailty care group, although they were also seen in general medical wards, the renal unit and stroke unit. There were a small number of reports of staff cases of scabies having worked in affected areas. Scabies is an itchy rash caused by mites that spread through close skin contact, which can take several weeks to manifest. As with any other outbreak, IMTs were implemented where two or more cases were identified, key stakeholders including external partners ICB supported these outbreaks and worked in conjunction with system partners including the ambulance service, to allow pre-alert of care homes affected by scabies outbreaks to the ED departments. The IMTs included containment measures, isolation of affected patients, skin treatment including prophylaxis for those who met the criteria regarding skin-to-skin contact timings, enhanced environmental cleaning, enhanced IPC audits and reviews, appropriate PPE measures and continued monitoring of those areas. No further scabies outbreaks have occurred since the end of quarter 3 for both HUTH and NLAG.

2.3.1.5 Surgical Site Surveillance

Surgical site surveillance (SSI) in England is a mandatory requirement for all care providers in the orthopaedic category, for a minimum of one quarter per financial year. The Surgical Site Infection Surveillance Service (SSISS), managed by the UK Health Security Agency (UKHSA), supports hospitals in systematically tracking surgical site infections (SSI). A surgical site infection occurs when microorganisms infect the area of the body operated on, potentially causing extended hospital stays, pain, and increased healthcare costs. SSISS aims to enhance patient care by enabling hospitals to compare their SSI rates over time and against national benchmarks

The four categories are; hip replacements, knee replacements, repair of neck of the femur and reduction of long bone fractures. Both HUTH and NLAG have undertaken SSI during Q4 of 2024/2025; HUTH collating data on hip replacements, fracture neck of femur, and knee replacements whilst NLAG collated data on hip replacements. This data was reconciled in Q1 of 2025/2026 and published in Q3 of 2025/2026. Similarly, HUTH and NLAG have gathered data during Q4 of 2025/2026, which will be reconciled and reported in 2026/2027.

HUTH had received a notification for being an outlier for SSI rates during the previous data capture in Q4 of 2023/2024 which was reported in last year's DIPC report. A task and finish group was set up at the time, with actions to improve outcomes for patients undergoing orthopaedic procedures. The completed actions included;

- increase surveillance monitoring; and improved follow up process through hip fracture specialist nurse;
- review decolonisation processes for all orthopaedic patients;
- Review of wound dressings used on orthopaedic patients;
- improve patient pathway to theatre including hygiene requirements prior to theatre;
- review of theatre processes and sterile field usage including trolley set up and preparation;
- review post operative phase and reinforce best practice on wound care;
- review of AMS and antimicrobial guidelines for orthopaedic patients.

All actions were implemented and completed based on the above requirements during the last year 2025/2026, and the group has been stepped down as the results for 2025/2026 were improved on the previous financial years performance. A further data set is due for submission by the end of Q1 of 2026/2027, seeking assurance the improvements made have had longevity in meeting the requirements.

NLAG results historically for several years have reported 0% SSI on UKHSA data capture. Process errors had been identified when the Trust joined as a Group, and for submission of Q4 2024/2025, there had been several SSIs confirmed as part of the data capture. During Q2 2025, the Chief Medical Officer (CMO) received a letter from UKHSA, confirming NLAG and specifically the Goole hospital site, had been identified as one of five Trusts noted as a high outlier for SSI rates, Goole had an SSI risk rate of 0.8% for the previous four periods combined. This was reported through the clinical effectiveness group by the CMO. The TACC care group manage orthopaedic surgery at Goole and were asked to lead an improvement programme, which requires similar review to process as HUTH previously undertook. A further data set is due for submission by the end of Q1 of 2026/2027, for NLAG, this will support checking the baseline data recently set, does show NLAG require to

undertake the improvement programme, or whether the data was a one-off episode of increased incidence of SSI.

2.3.2 Infectious Diseases and Public Health

The Trust continues to work closely with UKHSA and the local health protection teams. There is an organised weekly huddle for the regional IPCC senior nurses lead by Integrated Care Board (ICB). This forum allows discussion of regional issues and any emerging themes and shared learning. It provides senior IPCN support and has improved communication and relationships across the region. There is a monthly infection control and antimicrobial stewardship collaborative forum which discusses healthcare acquired infection themes, trends and required actions. The trust ICD and deputy director of infection prevention and control (DIPC) are members of the Humber & North Yorkshire Integrated Care System (ICS) antimicrobial stewardship steering group and the HUTH ICD is a member of the ICS AMR and IPC Programme Board, representing the ICS acute Trusts. A quarterly report is produced for both Hull and North Lincolnshire Health Protection Board.

The partnership infection teams support UKHSA in urgent actions required to protect patients and the public from infectious diseases, for example, supporting the supply and delivery of urgent interventions, such as immunoglobulins for post exposure prophylaxis in varicella zoster (chicken pox) cases.

2.3.3 Built Environment

2.3.3.1 Isolation facilities

The availability of compliant isolation facilities remains a critical operational challenge and direct patient risk across HUTH and NLaG NHS Trusts. This deficit is driven by an ageing estate and shortage of single rooms. Consequently, this risk remains appropriately escalated on the Trust Corporate Risk Register with a residual score of 12.

A comprehensive cross site audit of the available single rooms is underway to map the availability of cubicles and understand the ventilation supply so that we can identify and validate specialist isolation facilities. These specialist rooms are classified into negative pressure, positive pressure and Positive Pressure Ventilated Lobby (PPVL) suites. To prevent clinical ambiguity and enforce source control, any isolation room failing to meet technical validation standards will be formally reclassified as a standard side-room cubicle.

2.3.3.2 Capital Projects

The capital works programme for both Hull University Teaching Hospital NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation (NLAG) Trust delivered the following schemes with a particular link to IPC in 2025-26.

- Improvements to the staff wellbeing suite at HUTH.
- Creation of Hull CDC.
- Creation of a temporary discharge lounge.
- Refurbishment of theatres 5 and 6 at CHH.
- Refurbishment of theatres 8 and 9 at HRI.
- Replacement of the air conditioning within clinical skills.
- C6 ward refurbishment at DPOW
- Ventilation: air handling unit (AHU) and controls updates and reconfiguration

The following schemes have been identified and are under delivery in 2026-2027 works programme:

- Surgical SDEC at HUTH.
- New discharge lounge at HUTH.
- Medical SDEC at HUTH.
- Refurbishment of theatres 3 and 4 at CHH.
- Refurbishment of theatres 6 and 5 at HRI.
- ICU3 chiller at CHH
- Replacement flooring to H36 approach corridor.
- Replacement flooring at ED at HRI.
- Improvements to the brachytherapy facility at CHH.
- New VIE for oxygen supplies at SGH.
- Refurbishment of theatres B and C at SGH.
- MRI3 at DPOW
- Development of new ITU at DPOW

IPC are heavily involved in the development of all schemes taking a key role in participating in the peer reviews and actively shaping designs, with notable examples being the reduction of water outlets (clinical hand wash basins) to improve water safety in the proposed surgical SDEC at Hull Royal Infirmary and the future ITU at Diana Princess of Wales Hospital in Grimsby.

During 2025/26, decant wards have been established at DPoW and SGH to facilitate essential estates works, including major refurbishment and infrastructure replacement programmes. HUTH continues to have limited decant capacity, restricting the ability to undertake planned refurbishment, deep cleaning programmes and rapid ward closures during infection outbreaks. A ward closure programme has been developed for the Return to Constitutional Standards improvements and long

term it is likely such a facility will be required for the tower block cladding replacement programme.

Following a joint review with IPC and clinical teams, Estates has commenced the phased removal of temporary Architectural Wallsz isolation pods installed during the COVID-19 pandemic, reflecting changes in operational requirements and updated research and learning from the rapid pandemic mitigations put in place.

All capital schemes involving water systems continue to be governed through the Project Water Safety Group, ensuring appropriate stakeholder engagement and compliance with HTM 04-01 requirements. Where possible the principles of water light are being adopted in conjunction with the IPC team to ensure HTM 04-01 is being met but with a focus on ensuring water usage risks are minimised. The new ITU at DPOW is an example of water light design and will feature enhancements and greater control of the water systems.

In collaboration with IPC, Estates and Capital have adopted a revised Aspergillus risk assessment which is now undertaken for both HUTH and NLAG capital schemes. Handover processes have been strengthened with a greater focus on IPC sign off before opening to patient and public use.

2.3.3.3. Estates Speciality

During FY 2025/26, estates, IPC and clinical teams continued to strengthen collaborative working through joint governance arrangements, including the Water Safety Group, Ventilation Safety Group, Project Water Safety Group and other associated project groups. This multidisciplinary approach has improved assurance, supported clinical risk-based decision making and ensured that estates-related infection prevention risks continue to be identified, managed and escalated appropriately.

2.3.3.4 Water safety

The national guidance on water safety, Health Technical Memorandum (HTM) 0401: Safe water in healthcare premises provides guidance on the legal requirements; design, maintenance and operation of hot and cold-water supply, storage, and distribution of all water systems in healthcare premises. During 2025-26, water safety continues to be monitored by the Water Safety Group (WSG), which is required to report into OIRC & SIRC.

The WSG is now a Group meeting, chaired by estates, with an increased attendee list and continues to develop collaboratively across the Group, including the lead for Private Finance Initiative (PFI) buildings within HUTH in attendance. Both Trusts have a Water Safety Plan (WSP) which provides a risk-management approach to the

safety of water and establishes good practices in local water usage, distribution, and supply. Water safety remains a shared organisational responsibility supported by Estates, clinical services and IPC. Estates continue to strengthen organisational awareness through regular communications, training and multidisciplinary engagement.

There is now a Group Authorising Engineer (AE) (Water) appointed to oversee HUTH and NLaG. This will support greater standardisation of policy and process across the group and offers standardised assurance to the Group. The AE's recent audits confirmed that all the sites had appropriate Pre-Planned Maintenance (PPM), with other records present and well completed, there were only a small number of minor exceptions and records were in accordance with current task standard operating policies (SOPs).

Estates continued to operate a comprehensive programme of water monitoring, particularly within augmented care areas and locations accommodating immunocompromised patients. HUTH have now reviewed augmented care area sampling and refined it to clinically facing outlets only. Additionally, all legionella sampling across HUTH now includes high risk areas that fall outside of the augmented care classification. Any positive water samples culturing Legionella and/ or Pseudomonas are reported by Eurofins to both the Estates team and key members of the Infection Prevention and Control Team with prompt actions to reduce risks to patients, including escalation and control of infection incident meetings.

Wastewater blockages continue to present operational and infection prevention challenges across both organisations, primarily due to inappropriate disposal of materials. Clinical hand wash basin blockages remain a recognised risk factor for CPE management and continue to be addressed jointly by Estates, IPC and Microbiology. Sluice hoppers in the HRI tower block have been isolated, this has significantly decreased the number of blockages and major floods, including that previously seen on the 4th floor in the last financial year.

During 2025/26 Estates undertook innovative drainage engagement remediation trials at DPoW Ward C5 and C6, including steam cleaning and biofilm inhibition treatments, as a continuation of work under the previous CPE outbreak management. Initial results to date in FY 26/27 demonstrate improved drainage performance, with further environmental assessment ongoing to evaluate longer-term benefits.

Despite maceratable wipes being used across the Group, blockages continue to be reported on the Group risk management system and were escalated to IPCT and the relevant clinical area to allow investigation and tracking. This is a key priority in terms of ensuring the workforce are appropriately educated.

All capital schemes involving water systems continue to be governed through the Project Water Safety Group, ensuring appropriate stakeholder engagement and compliance with HTM 04-01 requirements. Where possible the principles of water light are being adopted in conjunction with the IPC team to ensure HTM 04-01 is being met whilst minimising patient risk from water outlets. The New ITU at DPOW is a perfect example of water light design and will feature enhancements and greater control of the water systems for the future.

In line with recommendations in HTM 01-04 the IPC and estates team continue to review water outlets such as drinking fountains and ice machines to minimise patient risk. Those outlets that will remain under regular maintenance and have been fully risk assessed appropriately.

2.3.5 Ventilation Safety

The partnership-wide Ventilation Safety Group (VSG) provides strategic oversight of ventilation safety and compliance across HHP. Chaired by Estates, with representation from Infection Prevention and Control (IPC), clinical teams and the Private Finance Initiative (PFI) compliance team, the VSG oversees compliance with Health Technical Memorandum (HTM) 03-01.

Assurance has been strengthened through the appointment of a group wide external Authorising Engineer (AE) for Ventilation and greater clinical care group engagement. The VSG is underpinned by site-specific Heating, Ventilation, and Air Conditioning (HVAC) sub-groups for HUTH and NLaG. Care group attendance at these operational meetings has improved over the period, supporting more consistent governance and understanding of clinical risk.

A formal theatre closure planning framework was implemented with Estates, clinical teams and IPC during 2025/26 to support safe completion of the planned preventative maintenance backlog. HUTH's theatre closure plan is reviewed annually so that lessons learnt inform the following year's plan (see Appendix XX). The VSG also monitored microbiological air sampling in HUTH theatres; all results were within acceptable parameters, with no unexpected findings. During 2026/27, the VSG will review the wider sampling programme to define proportionate, risk-based criteria and targeted clinical indications, informed by forthcoming national guidance.

A growing risk is that some clinical areas are now used for purposes or levels of acuity beyond their original engineering design. Estates and IPC therefore completed a joint review of critical ventilation areas to assess whether existing controls remain appropriate for current clinical use. This has strengthened baseline assurance but increased the ongoing maintenance, testing and compliance requirements.

IPC, Estates and clinical teams continue to undertake risk assessments for procedures performed outside formal mechanically ventilated environments. Assessments are benchmarked against national frameworks, including GIRFT's Right Patient, Right Procedure guidance and the Healthcare Infection Society's minor procedure room standards. Targeted capital programmes support the phased refurbishment of theatres and ageing ventilation plant across the partnership estate.

Ventilation operational incidents, issues & mitigation:

- **SGH Wards 16/17**: SGH Wards 16 and 17: Structural deterioration of external ductwork required precautionary isolation of the associated air-handling unit. A rapid multidisciplinary risk assessment was completed, with temporary controls introduced pending remedial work. These included portable HEPA filtration, enhanced environmental cleaning and optimised natural ventilation where clinically appropriate.
- **Climate & Capacity Vulnerabilities**: Climate and capacity vulnerabilities: High ambient temperatures during 2025/26 affected the performance of several legacy HVAC systems designed to historic climatic tolerances. This remains an estate risk and can result in unsuitable conditions for patients and staff. Alternative cooling measures, including fans and portable air-conditioning units, are subject to risk assessment to minimise the risk of infection transmission.
- **Replacement of fans within air handling unit (AHU)**: Unexpected fan failures affected CHH Theatres 7 and 9, ICU 3 and HRI IRT 2. Replacement fans were installed within seven days.
- **DPoW Maternity Theatre**: Planned preventative maintenance of the theatre ventilation system remains overdue because no suitable decant theatre is available to allow safe access while maintaining emergency surgical capacity. The risk is recorded on the Care Group Risk Register. Estates, IPC and clinical teams are working together to identify a sustainable solution that maintains emergency capacity while enabling the required engineering assurance.

2.3.6 Decontamination of medical devices and equipment

During 2025/26, HHP strengthened its decontamination governance and leadership arrangements. A Strategic Executive Lead and a single partnership-wide Authorising Engineer for Decontamination were appointed, providing clear accountability and consistent technical assurance across both organisations.
The HHP Decontamination Committee met throughout the year to oversee the safe decontamination of reusable medical devices, surgical instruments, endoscopes and healthcare equipment. Chaired by the Allied Health Professional for Theatres,

Anaesthetics and Critical Care, with the Nurse Director for Digestive Diseases as Deputy Chair, the Committee brought together Sterile Services, Endoscopy, Estates, Facilities, IPC and clinical teams. Governance and assurance were aligned with HTM 01-01, HTM 01-04, HTM 01-05 and HTM 01-06.

By the end of the reporting period, the Committee was embedded within the partnership governance structure and was moving to being chaired and facilitated by the estates team. Multidisciplinary representatives attended regularly and undertook specialist decontamination training to strengthen organisational competence and support consistent oversight.
External assurance was provided through the Joint Advisory Group accreditation process, with particular scrutiny of endoscopy safety, quality and decontamination infrastructure. NLAG maintained accreditation and HUTH were undergoing the process to obtain accreditation, which commenced in 2025/26 and will conclude in 2026/27.

Statutory testing, validation and planned preventative maintenance of sterilisation equipment, washer-disinfectors and endoscope reprocessors remained largely compliant. BSI recertification audits of Sterile Services were completed successfully, with identified non-conformities managed through formal action plans, engineering validation schedules, internal audit and quality management systems.

A key priority was the development of a partnership-wide decontamination asset register to improve oversight of equipment decontaminated locally. The register will define ownership, methods, frequency, traceability and assurance arrangements across clinical and non-clinical areas. This action will be prioritised within the 2026-27 period.

Strategic risks remained under active review, including ageing infrastructure in the Central Decontamination Unit, particularly the air-handling system; workforce and capacity pressures in Sterile Services; and the need to strengthen local decontamination governance and Authorised Person functions. Mitigations included workforce development, enhanced performance monitoring and investment planning. Endoscope decontamination services maintained testing and validation schedules. Water-quality monitoring confirmed that systems remained controlled, although an increase in borderline samples prompted corrective action. Funding was secured to replace ageing endoscopy decontamination equipment and support continued compliance with HTM 01-06.

During 2025/26, the Decontamination Committee provided specialist oversight and assurance for the replacement of laboratory autoclaves within the University of Hull research facilities in the Daisy Building, Castle Hill Hospital. The Committee reviewed the suitability of proposed replacement equipment, identified that initially

purchased second-hand autoclaves did not meet required decontamination standards, and commissioned further technical assessment from Estates, Infection Prevention and Control and Decontamination specialists. Through this process, the Committee ensured that risks associated with the processing of microbiological waste were identified, escalated and managed appropriately, supporting the introduction of equipment capable of meeting the required safety, validation and governance standards for laboratory decontamination activities

Overall, substantial assurance was available regarding decontamination arrangements across HHP. Although infrastructure, governance and capacity risks remain, Committee oversight, engineering assurance, audit programmes and active mitigation continue to support safe and effective services.

2.3.7 Facilities

2.3.7.1 Cleaning

HHP has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals, this is now a key element of how each hospitals performance is judged, and it is assessed in several ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety. The National Standards of Healthcare Cleanliness (2025) apply to all healthcare environments and replace the National Specifications for Cleanliness in the NHS 2007, with amendments published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations, and good practice.
Cleaning services have two systems in place, HUTH have an outsourced service with OCS and NLAG have an in-house managed service.

HUTH Cleaning Services

During 2025-26, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for HUTH. Healthcare demand post pandemic and a rise in reported resistant organisms have brought challenges with regards cleaning services, especially during surges of infection. Enhanced cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract have been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV).

During the financial year the IPCT attended monthly operational meetings. Facilities, in addition to the operational meetings, hold a 6-monthly review meeting and an annual contract review meeting. Furthermore, ad-hoc meetings are held to share

information with regards to risk and / or issues related to respiratory infections, HCAIs and outbreaks, equally to acquire assurance that hospital cleanliness remained a priority. Support and flexibility have been shown collaboratively between the IPCT and facilities in times of high demand. The below table shows the number of discharge cleans across the 2025-26 year.

Clean Type	Total Number
Green (Clinell)	6010
Amber (Tristel)	7215
Purple (HPV)	559

Table 12: HUTH discharge cleans performed, 2025/26

National Standards of Healthcare Cleanliness (2025) apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007, with amendments published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations, and good practice. HUTH continues to be compliant with the National Standards of Healthcare Cleanliness (2025), initiating local enhancements to cleaning as needed in collaboration between OCS, HUTH Facilities and IPCT. The maintenance of star ratings of 4 and 5 has been good, with few areas requiring action plans due to 1-3 star ratings. See the graph below for the numbers of areas on action plans per month.

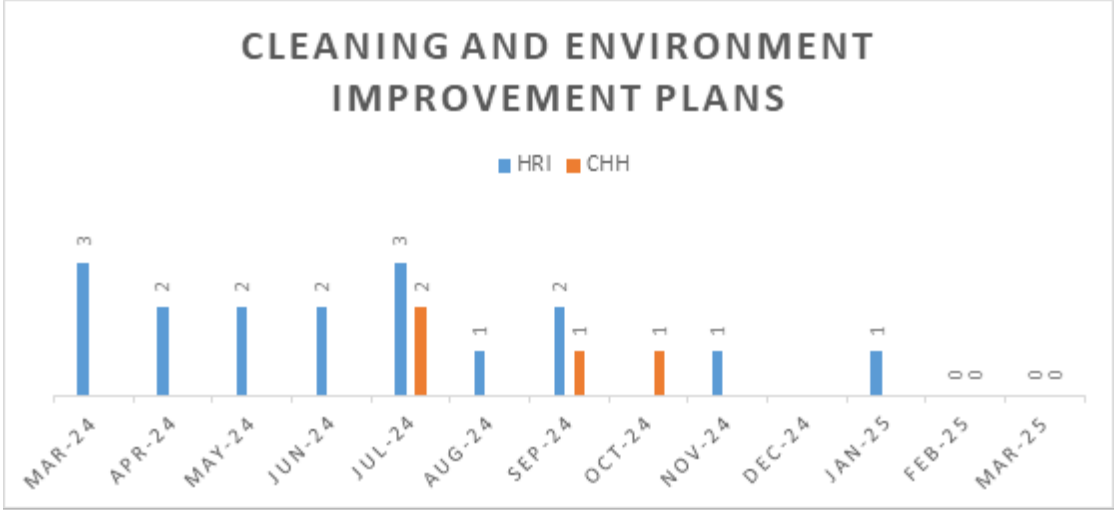


Figure 29: HUTH cleaning action plans by month, 2025/26

Environmental auditing remains a priority for both the Trust, facilities team, OCS, and IPCT to ensure the Trust remains compliant with the standards. Efficacy auditing is

required annually for all patient facing areas with remedial action and re-auditing needed when areas fall below a score of 80% on the efficacy audit.

We take a collective multi-disciplinary team approach for any improvement plans that are identified as necessary across the technical audits that take place. All improvement plans are placed onto a tracker that is reported to the EFD Group Governance Committee. These are reported into both OIRC and SIRC where facilities have attended and are engaged.

During 2025-26, due to an increase in resistant infections affecting patients both at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH), additional specialist cleaning and decontamination processes were required. These processes involved primarily the use of HPV and were delivered on an ad-hoc call out basis by Sanondaf, who have facilitated this since January 2023. There is a significant cost burden associated with this. The cost for Sanondaf from April 2025 to March 2026 was £705,867 (ex VAT).

As part of the Group Cleaning Harmonisation project an options appraisal paper to scope acquiring a Group HPV decontamination service, enabling reactive and proactive decontamination is awaiting approval. Functional risk categories and cleaning roles and responsibilities have been reviewed and aligned across the group. The HUTH Domestic Services provision is due to be tendered later this year.

NLAG Cleaning Services

The NLAG cleaning service is an in-house cleaning service that is managed by the facilities team. Many areas maintained the expected standards of cleaning, gaining the required 4 and /or 5 star results consistently in audits. However, there where areas where cleaning audit performance fell below the 5 star standard. This was concentrated predominantly at Diana, Princess of Wales Hospital (DPOW), with excellent performance seen at the Goole DGH site. The scores were submitted alternate months to OIRC, and when the data was collated across the year some areas had recurrent scores of less than 4 stars. The most frequently recurring areas were Urgent and Emergency Care at DPOW, C5, B3, C2, the DPOW Cath Lab, Short Stay and the Main Block Theatre Suite. One-star ratings occurred in several clinical areas, including Urgent and Emergency Care, the Cath Lab, C5, Short Stay, C1 Glover, C2 and Endoscopy. The recurrence of low ratings in these areas indicates a need for continued local improvement action, repeat audit and oversight through the appropriate facilities, IPC and governance arrangements.

During 2025/26, South Bank Facilities worked with IPC, Estates, Microbiology and operational teams to support management of the CPE outbreak across DPoW and

SGH. A coordinated action plan strengthened environmental controls and contributed to closure of the outbreak within the reporting period.

The response included introduction of a range of effective new cleaning products which are aligned to UK standards including a new disinfectant agent that was rolled out across the Trust in response to the extensive transmission of CPE being experienced. Advanced Peracetic Acid products, including Clinell Enhanced Pods and drain disinfection treatment were also used to improve surface and drainage decontamination while reducing the corrosive effects associated with chlorine-based products. Targeted treatment was undertaken on affected wards, alongside revised Domestic and Catering practices that established exclusion zones around sinks and outlets to reduce the risk of splash-related environmental transmission.

Cleaning arrangements were also reviewed in response to VRE, with Tristel products and revised methodologies introduced to improve consistency and reduce cross-contamination. These changes supported the move from traditional socket mops to a Vileda flat-mop and trolley system, responding to UKHSA concerns about the infection risks associated with damp or inadequately laundered mops and aligning South Bank practice with the wider Group cleaning model. Disposable microfibre mop heads remain an interim measure and will continue to be used in outbreak and isolation areas. Facilities are assessing options for on-site laundering of reusable microfibre mops and is also discussing rented and Return to Sender services with Synergy to identify a sustainable, value-for-money solution.

A 24/7 Reactive Clean Team was established through redesign of the former weekday Deep Clean Team, providing rapid enhanced cleaning to support infection control, bed availability and patient flow across both acute sites. The team supported trials of Hydrogen Peroxide Vapour at DPoW and Ultraviolet-C decontamination at SGH. Both trials have concluded and the equipment has been returned; IPC continues to explore funding for a permanent decontamination system, while Sanondaf remains available to provide external HPV services when required. Initial funding for the Reactive Clean Team was provided through the CPE outbreak response. A business case has been submitted to secure recurrent funding; without approval, the service will revert to its previous weekday model from July 2026, reducing out-of-hours capacity to respond to outbreaks and operational pressures.

Overall, these developments strengthened environmental cleanliness and infection prevention arrangements and are expected to support improved PLACE outcomes in 2026. Further work will focus on aligning cleaning standards, functional risk management and service delivery across Humber Health Partnership. Ageing infrastructure remains a significant constraint, but Facilities teams continue to identify, report and escalate defects that may affect cleanliness or infection prevention.

2.3.7.2 Linen

HUTH

During 2025-26, Synergy Linen Management Services has been responsible for providing linen services for HUTH. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained. Regular reports are submitted regarding linen to the (EFD) Group Governance Committee and to the Decontamination Group Meeting to ensure that linen remains safe and up to standard for our patients.

During the 2025-26 year, members of the HUTH Facilities Hotel Services team alongside members from the IPCT conducted an audit and site walk of the Synergy Sheffield laundry factory to ensure the correct procedures were followed and that high standards were upheld and followed.

Synergy provides a monthly report to the Trust detailing costs, performance, linen and scrub usage, cage management and cleanliness, the proportion of items rejected, customer survey results and details of microbiological monitoring. The company have maintained performance in all areas with no significant concerns highlighted during the year.

NLAG

During 2025-26, Synergy Linen Management Services has been responsible for providing linen services for NLaG. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained. Regular reports are submitted regarding linen to the (EFD) Group Governance Committee. FY 2026/27 linen reports will also go to the HHP Decontamination Group Meeting to ensure that linen remains safe and up to standard for our patients.

Synergy provides a monthly report to the Trust detailing costs, performance, linen and scrub usage, cage management and cleanliness, the proportion of items rejected, customer survey results and details of microbiological monitoring. The company have maintained performance in all areas with no significant concerns highlighted during the year. In the FY 2026/27, the NLaG facilities team alongside members from the IPCT will conduct an audit and site walk of the Synergy Derby laundry site to ensure the correct procedures are followed and that high standards are upheld and followed as per the Sheffield laundry site.

2.3.7.3 Food hygiene

During FY 2025/26, catering services across both HUTH and NLaG maintained robust food safety management.

Food safety practices at ward level are adapted to match the specific catering delivery models across the group:

- At HUTH, patient meals are received, heated in ward-based regeneration ovens, and served directly to patients from the ward kitchens by dedicated catering staff. Catering teams routinely monitor and log oven core temperatures to ensure required food temperatures are attained prior to service.
- At NLaG, meals are prepared in the central production kitchen and decanted into temperature-controlled distribution trolleys for ward delivery. This model relies on dual-role Health Support Assistants (HSAs), who manage both ward cleanliness and catering duties. IPCT and facilities management try to ensure oversight of the HSAs to ensure clear segregation between cleaning tasks and food handling duties, mitigating cross-contamination risks, however this does continue to pose a risk if there is deviation from the recommended practice.

Across both organisations, ward teams conduct daily checks of patient food and beverage refrigerator temperatures. Where localised omissions in manual logging were identified through routine kitchen audits/inspections, these were addressed immediately via ward-level escalation and education.

2.3.7.4 Waste Management

During FY 2025/26 both HUTH and NLaG continued to update their local waste management policies to ensure compliance with the Health Technical Memorandum (HTM) 07-01: Safe and sustainable management of healthcare waste and to ensure alignment with the national directive of the NHS Clinical Waste Strategy.

The IPCTs collaborated closely with the facilities departments throughout the year to optimise the offensive waste stream across all acute wards. This partnership included delivering targeted staff education and ensuring clear, consistent messaging regarding waste segregation. Improvement work included the changes required to implement the requirements of NHS premises around waste separation before collection. The trusts both now ensure dry recyclable waste, food waste and residual non-recyclable waste are collected into appropriate containers and disposed of via the appropriate waste streams.

Furthermore, waste management teams actively contributed to the facilities report submitted to the Operational Infection Reduction Committee, providing crucial oversight on audit results and driving targeted action plans for areas requiring improvements.

2.3.8 Audit Programme

2.3.8.1 PLACE inspections

Overall, the 2025 PLACE programme provided broad assurance across the five hospital sites, while identifying specific infrastructure and environmental risks requiring continued oversight. Improvement actions should be monitored through the relevant Estates, Facilities, IPC and care group governance arrangements, with significant risks escalated through established organisational processes.
Patient-Led Assessments of the Care Environment (PLACE) are national self-assessments of healthcare premises. They assess the quality of the care environment from the patient perspective and are completed by a multidisciplinary team comprising Estates, Facilities, Infection Prevention and Control and nursing representatives, together with at least two independent patient assessors.
The 2025 PLACE assessments were undertaken between 19 September and 1 December 2025. They covered 43 inpatient wards and 37 outpatient departments across five hospital sites: Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH), Diana, Princess of Wales Hospital (DPoW), Scunthorpe General Hospital (SGH) and Goole District Hospital (GDH). This broad coverage enabled comparison across both organisations and provided a partnership-wide view of environmental quality.

Site	Number of Wards	Number of Outpatient Departments	Number of Food Assessments	Emergency Department Assessment
HRI	10	11	5	ED – Paeds
CHH	10	11	4	N/A
DPoW	10	7	4	ED
SGH	10	6	4	ED
GDH	3	2	1	N/A

Table 13: Locations included in the 2025 PLACE assessments

The assessments identified several areas of good practice, including improved staff knowledge, investment in ward environments and examples of strong practice in dementia-friendly design. However, they also identified recurring concerns relating to the age and condition of the estate, cleanliness, food service, staff knowledge and the consistent application of cleaning and maintenance standards.

At an organisational level:

- HUTH fell below national averages in 5 out of 8 scored domains, outperforming benchmarks only in food services.
- NLAG fell below national averages in 7 out of 8 scored domains, demonstrating critical vulnerabilities across acute locations.

While structurally operating under distinct peer groups, acute teaching hospitals for HUTH and acute medium trusts for NLaG, the data has been aggregated below to provide a group-wide baseline for our evolving, collaborative Estates and Facilities governance model. The full site-level report data has been included as an Appendix to this annual report to ensure accountability, regulatory compliance and triangulation with our healthcare-associated infection (HCAI) data.

The following table summarises the performance of the partnership against national benchmarks and show the domains that are currently performing below the national average that require strategic intervention.

Domain	National Average	HUTH Score	NLaG Score	HHP Group Average	Group vs. National Average
Cleanliness	98.55%	96.53%	94.29%	95.41%	Below benchmark
Condition, Appearance and Maintenance	97.00%	93.61%	85.54%	89.57%	Below benchmark
Combined Food	92.13%	94.42%	85.63%	90.02%	Below benchmark
Organisation Food	92.79%	97.92%	93.02%	95.47%	Above benchmark
Ward Food	92.30%	93.74%	83.87%	88.80%	Below benchmark
Privacy, Dignity and Wellbeing	89.37%	86.04%	79.51%	82.77%	Below benchmark
Dementia	85.68%	79.93%	73.67%	76.80%	Below benchmark
Disability	87.12%	80.52%	73.47%	76.99%	Below benchmark

Table 14: HHP performance against national PLACE averages, 2025 collection

The long-term performance graphs, within the Appendix, demonstrate that between 2018 – 2022, both trusts maintained relatively high, stable environmental standards. However, since the 2023-24 reporting periods, both organisations have demonstrated a downward trajectory across nearly all physical environment indicators, coinciding with sustained organisational and financial pressures alongside an aging estate.

Cleanliness

Cleanliness scores declined across both Trusts during 2025, with HUTH achieving 96.53% and NLaG 94.29%, compared with a national average of 98.55%. Across Humber Health Partnership, common themes included inadequate high-level dusting, inconsistent floor cleaning, deficiencies in the cleaning of shared patient equipment and contamination of ventilation grilles. These findings highlight ongoing challenges in maintaining a safe care environment and demonstrate the need for clearer accountability between domestic, nursing and Estates teams for environmental cleanliness.

At HUTH, the cleanliness score of 96.53% fell below both the regional acute teaching peer average (97.77%) and the national average. This represents a marked deterioration from the 98.88% achieved in 2024. The principal issues identified included high-level dust accumulation, deficiencies in floor-cleaning standards, inconsistent cleaning of reusable patient equipment such as fans and commodes, and dirty ventilation grilles requiring Estates intervention. The deterioration in cleanliness occurred alongside a decline in the condition and maintenance of the estate, increasing the difficulty of achieving effective environmental decontamination. At NLaG, cleanliness performance was significantly below both peer and national averages. Key contributory factors included high levels of dust, poor floor maintenance, inconsistent cleaning of workstations on wheels and reusable patient equipment, missing ceiling tiles and environmental defects, together with corroded sink plugs, taps and sanitary fittings that could not be effectively cleaned. Performance varied considerably across sites, with Goole District Hospital performing well while DPoW and SGH demonstrated the greatest environmental challenges.

In response, both Trusts implemented local action plans and remedial measures. HUTH introduced a dedicated floor-cleaning team at Hull Royal Infirmary, whilst targeted retraining was undertaken by the cleaning contractor in areas identified during the assessment. Joint working between Infection Prevention and Control, nursing and facilities teams was established to improve compliance with equipment cleaning responsibilities. At NLaG, action plans were cascaded to all areas and standardised cleaning checklists introduced. Additional enhanced cleaning measures were implemented during the CPE outbreak response at DPoW and SGH, including the provision of a 24-hour reactive deep-cleaning service.

Condition, Appearance and Maintenance

The condition, appearance and maintenance domain represented one of the most significant concerns identified during the 2025 PLACE assessments. HUTH achieved a score of 93.61% and NLaG 85.54%, both substantially below the national average of 97.00%. Across the Partnership, ageing infrastructure, historic underinvestment

and the absence of suitable decant facilities continue to limit the ability to undertake refurbishment, deep cleaning, environmental maintenance and replacement of damaged fixtures. These constraints result in environments that are increasingly difficult to clean effectively and maintain to the standards required for safe patient care.

At HUTH, the score of 93.61% was the lowest amongst its regional peer group. Contributory factors included ageing infrastructure, particularly at Hull Royal Infirmary, deterioration of surfaces and fixtures affecting cleanability, and the lack of dedicated decant facilities to support refurbishment and maintenance programmes. The inability to vacate clinical areas for significant works restricts opportunities for redecoration, deep cleaning and environmental improvements. The lack of suitable decant capacity remains a recognised organisational risk and is recorded on the Trust risk register.

At NLaG, the score of 85.54% was also the lowest amongst comparable peer organisations. Historic underinvestment in estate infrastructure, deterioration of environmental surfaces and significant variation in estate condition across sites contributed to the poor performance. Whilst recent capital investment has delivered improvements in flooring, windows and other aspects of the building fabric, further investment is required to achieve sustainable improvement and address longstanding environmental deficiencies.

The assessments also identified wider environmental concerns affecting patient safety and experience. These included inadequate handrails, poor colour contrast and limited orientation aids for patients living with dementia or disability, unsuitable communal seating, privacy and dignity concerns arising from procedures being undertaken at the bedside due to lack of treatment space, and information governance issues where patient information was visible in clinical areas. Addressing these issues will require a long-term programme of estate improvement supported by both capital and revenue investment. The assessments reinforce the importance of developing suitable decant facilities, prioritising replacement of damaged and uncleanable infrastructure, and implementing rolling programmes of refurbishment and environmental improvement across both Trusts.

Food and Hydration

Food and hydration scores were generally stronger than the cleanliness and estate domains; however, several issues requiring improvement were identified.
At HUTH, no significant systemic food safety concerns were identified through the PLACE assessments. Nevertheless, opportunities remain to improve the patient experience through ongoing monitoring of mealtime support, ward environments and hydration provision.
At NLaG, concerns were identified regarding the consistency of support provided to patients during mealtimes. These included variable access to hand hygiene facilities

before meals, inconsistent support for protected mealtimes,
variation in assistance provided to patients requiring help with feeding, and differing standards of mealtime practice between clinical areas. These findings have been escalated to senior nursing and clinical leaders for review and action.

Summary of Mitigations, Actions and Learning
The 2025 PLACE assessments identified several recurring themes across Humber Health Partnership and provided valuable learning to inform future improvement work. Immediate actions have included implementation of local remedial plans, targeted cleaning interventions, enhanced contractor oversight, closer collaboration between Infection Prevention and Control, Estates, Facilities and clinical teams, and escalation of food service concerns through clinical governance processes.
The assessments demonstrated the close relationship between estate condition and cleanliness performance. Poorly maintained environments, damaged fixtures and ageing infrastructure reduce the effectiveness of cleaning and decontamination processes and increase the risk of environmental contamination. Long-term improvement will therefore require sustained investment in both environmental maintenance and infrastructure renewal.

The introduction of the PLACE Lite programme has demonstrated the value of more frequent monitoring and earlier identification of environmental concerns. Expansion of this approach across all sites will support a move away from reliance on annual assessments and provide greater assurance throughout the year.
The assessments also highlighted the need for clearer accountability regarding cleaning responsibilities. A formal framework defining the responsibilities of domestic services, nursing teams and Estates staff for environmental and equipment cleaning should be developed, audited and routinely monitored.

2.3.8.2 IPC Fundamental, Environmental and Enhanced Audits

Routine fundamental and environmental audits conducted by the IPCT were paused for a period by the Chief Nurse whilst organisational changes were occurring. Consequently, 81 IPC audits became overdue, creating a temporary gap in routine baseline assurance. Recognising the threat to clinical oversight, this deficit was formally escalated to the Corporate Risk Register on 5 December 2025, and the following mitigations put in place.

- **Enhanced audits during outbreaks:** IPCT dynamically pivoted resources to execute intensive, focused audits within clinical areas during all 51 declared outbreaks to guarantee acute containment. The enhanced audits were completed more than once in the HUTH outbreak areas.

- **Point prevalence surveys (PPS)**: The Practice Development Matron Team within the Chief Nurse's Directorate executed rapid point prevalence surveys across ward areas to maintain clinical oversight of core IPC standards. The PPS identified the slipping standards of IPC practices across HHP.
- **Clinical visibility and training:** The IPCT maintained physical visibility on the wards throughout FY 2025/26 to actively challenge non-compliance, provide real-time corrections and deliver targeted education to clinical teams.

To establish a more sustainable model, a comprehensive clinical review of all IPC expert audit tools and required audit footprints was completed across HHP. This review directly informed the design of a robust, modernised IPC auditing framework, which successfully launched at the start of the 2026/27 financial year. Key advancements in this new framework include digital integration on the AMAT platform, enabling real-time, fast, reliable data retrieval and an automated escalation pathway as the system is configured to allow low compliance reports into the Care group governance meetings, Operational Infection Reduction Committee (OIRC) and Strategic Infection Reduction Committee (SIRC).

The proposed annual plan is attached in Appendix X for reference. Following the successful embedding of this system, the annual IPC audit plan and the clearance of the audit backlog, the associated entry on the Corporate Risk Register will formally be closed in 2026/27.

2.3.8.3 Hand Hygiene Audits

Overview of Hand Hygiene Assessment Audits

During FY 2025/26 reporting period, clinical areas across HHP continued to undertake monthly hand hygiene assessment audits. The current methodology requires each clinical area to observe 20 staff members per month across a range of disciplines and report onto the digital AMAT system.

The data submitted via these self-assessments has demonstrated sustained excellence, with compliance scores consistently exceeding the 95% mark, refer to Figure 30, 31 and 32.

	HUTH	NLAG	HHP
Acute and Emergency Medicine Care Group	97.60%	95.20%	96.40%
Cardiovascular Care Group	98.80%	97.50%	98.15%
Community, Frailty and Therapy Care Group	98.40%	98.80%	98.60%
Digestive Diseases Care Group	99.30%	97.60%	98.45%
Family Services Care Group	95.80%	96.70%	96.25%
Head and Neck Care Group	98.20%		98.20%
Major Trauma Network Care Group	99.60%	96.20%	97.90%
Neuroscience Specialist Care Care Group	98.90%	100.00%	99.45%
Specialist Cancer and Support Services Care Group	99.50%		99.50%
Specialist Medicine Care Group	97.30%	96.90%	97.10%
Specialist Surgery Care Group	94.10%	96.10%	95.10%
Theatres, Anaesthetics and Critical Care Care Group	94.90%	97.30%	96.10%

Figure 30: HHP, HUTH and NLaG Hand Hygiene Self-Assessment Care Group Scores

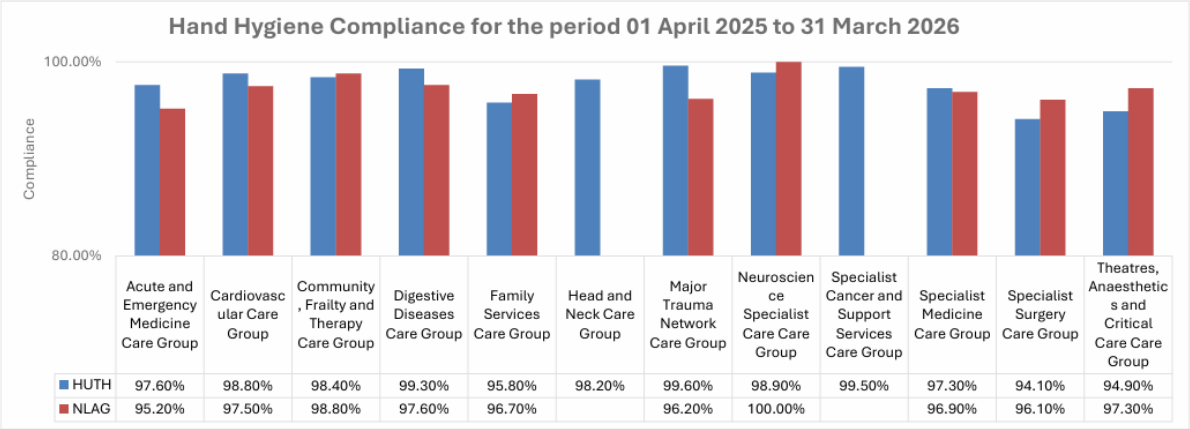


Figure 31: HUTH and NLaG Care Group Hand Hygiene Self-Assessment Scores

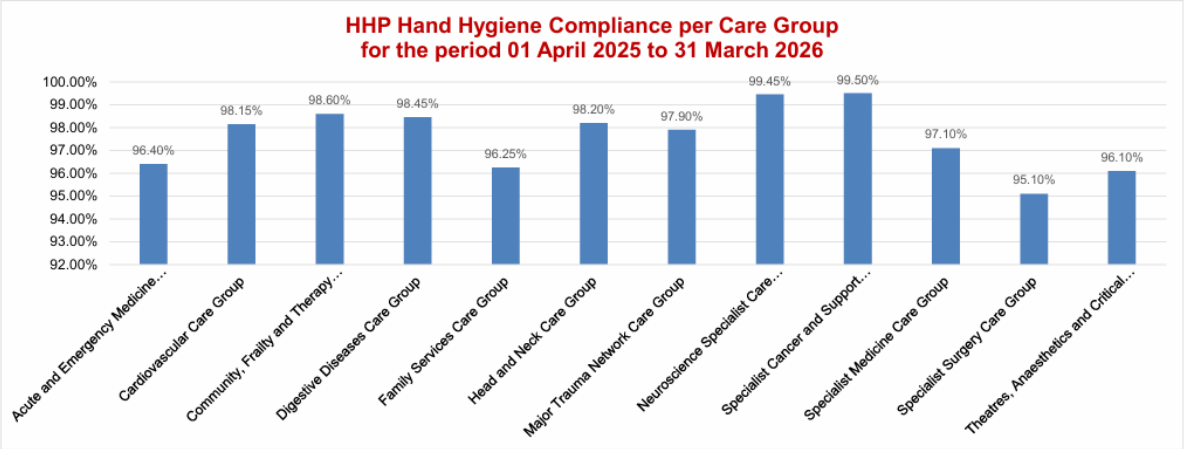


Figure 32: HHP Care Group Self-Assessment Hand Hygiene Audit Scores

While this high figure reflects a strong local culture of awareness and ownership surrounding IPC, the IPC committee maintained a degree of skepticism regarding the uniformity of these results across all clinical environments, due to the IPC expert

audits reflecting a notable variance when compared to local self-assessment data. This discrepancy is a recognised national phenomenon within healthcare auditing and can be attributed to two main factors: the Hawthorne effect and audit familiarity.

2.3.9 Education and Training

Infection Prevention and Control Education, Training and Quality Improvement Project (QIP) update

The NHS England Infection Prevention and Control Education Framework was published in March 2023. It sets out a national vision for the design and delivery of IPC education and establishes core requirements for clinical and non-clinical staff working in healthcare settings.

This section of the report highlights significant progress, including completion of an IPC education gap analysis for the IPC Team, establishment of funded IPC Practice Development Matron roles, continued delivery of face-to-face and online training, and development of a programme aligned to national IPC, antimicrobial resistance, antimicrobial stewardship, and patient safety priorities.

Core Standards

1. IPC practitioners must inform the development of IPC learning and practice development.
2. Standard Infection Control Precautions (SICPs), and evidence-based practice for preventing healthcare-associated infections associated with invasive devices and procedures, must be incorporated into all health and social care education programmes.
3. Antimicrobial resistance (AMR) and antimicrobial stewardship (AMS) must be integral components of education programmes.
4. Transmission-based precautions (TBPs), screening programmes, the hierarchy of controls and IPC risk assessment must be incorporated into relevant education programmes.
5. IPC must be incorporated appropriately into all health and social care education programmes using a contextually relevant approach, supporting safe and effective care delivery.
6. The management, maintenance and planning of the built environment must be incorporated into relevant education programmes.

National Programme Objectives

- Support system-wide improvement in IPC and AMR.
- Align practice to the national IPC manual.

- Align practice to evidence-based best practice.
- Support IPC practitioner professional development.

Organisational Commitments

- A culture of ongoing IPC learning and development.
- Strong IPC leadership at Board and Executive level, supported by visible IPC role models.
- IPC education and training developed by and with IPC experts, using multidisciplinary expertise to tailor delivery to staff needs and support behaviour change alongside knowledge and skills development.

Education, QIP and Training Delivery

A key change within the framework is the introduction of Tiers 1, 2 and 3, replacing the previous Level 1 and Level 2 terminology. Tier 1 applies to everyone working in health and social care settings. Tier 2 applies to staff working directly with, or providing care to, patients and/or working within the patient environment and Tier 3 applies to staff responsible for an area of care.

Two funded IPC Practice Development Matrons (PDMs) are now in post and are working to embed training and education effectively across the organisation.

The IPC education gap analysis has been completed for the IPC Team and is awaiting implementation across the Group in line with the NHS England IPC Education Framework. This programme will involve substantial education delivery for all staff, supporting compliance, addressing identified knowledge gaps and improving practice standards. Programme monitoring and implementation are reported through OIRC and SIRC.

Face-to-face training has included new overseas recruits, non-registered staff new to the Trust and working in clinical areas, newly qualified nurses, apprentices, doctors, ward housekeepers and hygienists. The IPC team has also continued to work with OCS (HUTH) regarding education linked to the new NHS cleaning standards, and with facilities colleagues to ensure training remains specific to staff roles.

IPC Link Champion meetings were held during the previous year. These meetings are now delivered face to face, with an option to join via Microsoft Teams where staff are unable to attend in person.

The annual ‘Bugs R Us’ event, is established at NLAG. The event attracts approximately 70–80 staff from a range of staff groups and includes local and national IPC updates and training. Previous speakers have included colleagues from NHS England and the UK Health Security Agency.

Regional and national training opportunities were offered by NHS England and UKHSA, including IPC practice, Gram-negative bloodstream infection reduction,

Carbapenemase-producing Enterobacterales and antimicrobial stewardship. Non-registered staff benefitted from a bespoke IPC course funded by the national team. Although places were limited regionally, staff who completed the course reported that the content was helpful and clinically applicable. The IPC Team were provided with the opportunity to attend 'National Sepsis and AMR Conference' in Birmingham which empowered the IPC Team to update Evidenced Based knowledge.

Development and delivery of communications to support Perfect Week activity through the promotion of "Back to Basics" IPC education and practice messages.

Development of an IPC newsletter and Care Group Governance Report was implemented for the IPC Nurses to disseminate to their respective Care Groups, increasing visibility of the IPC Team.

Priorities and Planned Work (including QIP) for 2026/27

- Refresh and strengthen the Improvement in Blood Culture Pathway task and finish group.
- Contribute to the DP Sepsis Infection Reduction Group to reduce avoidable catheter associated harm.
- Review spill kits through the cleaning and harmonisation group.
- Align post-infection reviews with PSIRF methodology.
- Continue IPC and AMS Link Champion meetings, including development of a contract for Link Champions.
- Strengthen working relationships with clinical educators, clinical staff, doctors and senior teams.
- Undertake vascular access audits with support from ICU Medical Team and BD.
- World Hand Hygiene Day celebrated on 5 May 2026.
- Progress the IPC Competency Framework, pilot to commence July 2026, followed by Group-wide roll out.
- Support Clinical Safety Day through face-to-face Tiers 1 and 2 training roll-out. Tier 3 standards will be developed for all staff who are responsible for an area of care.
- Engage with student forums and plan teaching at universities, including development of a recorded session for wider student groups such as midwives and allied health professionals.
- Ongoing support for Year 10 job fairs.
- Work with representatives and educators from external companies to support staff training on the use of relevant products.
- Review the current Tier 1 and 2 e-learning packages on the Humber Health Partnership Learning Hub.
- Plan activity for National IPC Week.

The IPC education and training programme has made important progress in aligning local delivery with the NHS England IPC Education Framework. The appointment of IPC Practice Development Matrons provides dedicated capacity to embed a structured, standardised and role-specific education programme and QIP delivery across the Group.

2.3.10 Antimicrobial Stewardship (AMS)

Antimicrobial stewardship (AMS) is fundamental to patient safety and infection prevention. Antimicrobials stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.
Effective AMS supports timely, evidence-based treatment while reducing avoidable or unnecessarily broad-spectrum antimicrobial exposure, thereby lowering the risks of adverse effects, *Clostridioides difficile* infection and the selection and spread of antimicrobial resistance. Sustained multidisciplinary leadership, surveillance, prescribing review and education are therefore essential to preserve the effectiveness of existing treatments and improve outcomes for current and future patients.

Bacterial antimicrobial resistance already causes substantial morbidity and disability and was directly attributable to an estimated 1.27 million deaths, and associated with 4.95 million deaths, globally in 2019. The estimated number of annual deaths in the UK was 3000. On current trends, modelling forecasts 1.91 million attributable deaths in 2050 and approximately 39 million cumulative attributable deaths between 2025 and 2050 globally.

National Action Plan

The UK 5-year National Action Plan (NAP) for Antimicrobial Resistance 2024 to 2029 Confronting antimicrobial resistance 2024 to 2029 was updated and published in May 2024 to be effective from April 2025. The NAP 2024/29 has 9 strategic outcomes organised under 4 themes as per summary below:

Figure 30: Summary of the UK national action plan for antimicrobial resistance, 2024 to 2029

The NAP had 5 targets, see figure X below, although the two main targets set within the action plan are:

- Reduce the total amount of antibiotics used within human healthcare by 5% compared to 2019 baseline
- Increase the proportion of ACCESS Agents to 70% within human healthcare.

Antibiotics are categorised as either ACCESS, WATCH or RESERVE. ACCESS agents are antibiotics that may have a narrow spectrum of activity and/ or a lower risk of driving resistance/ HCAI. WATCH agents are those agents that can drive resistance/ HCAI and are often broader-spectrum antibiotics. RESERVE agents are antibiotics that should be restricted for use only when clearly indicated or resistance necessitates their use.

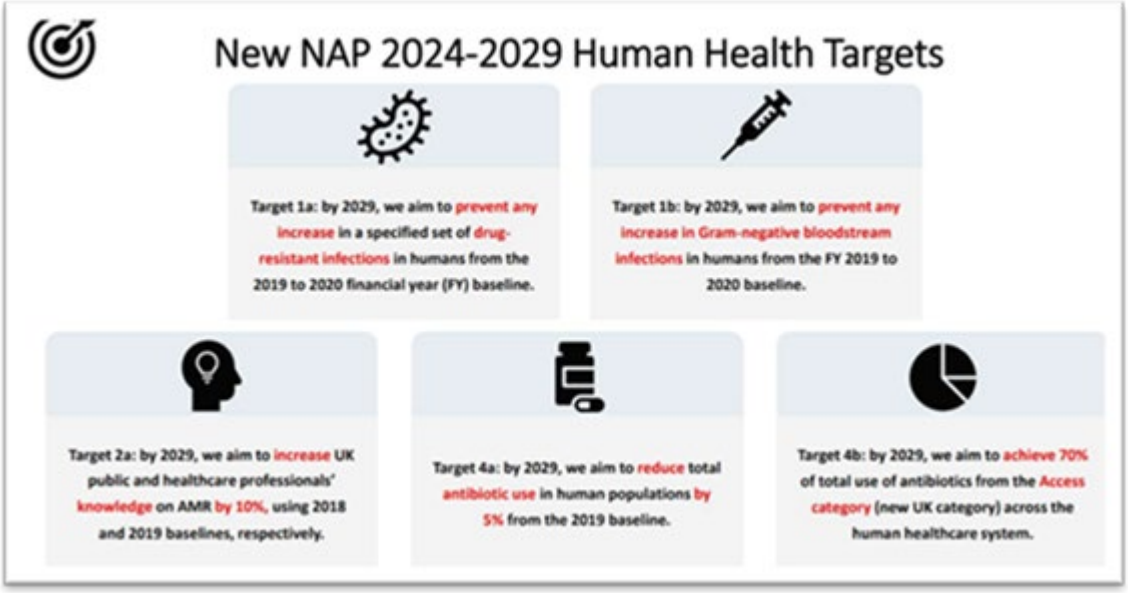


Figure 31: Human health targets in the UK national action plan for antimicrobial resistance, 2024 to 2029

HULL UNIVERSITY TEACHING HOSPITALS (HUTH) NHS TRUST

ANTIMICROBIAL STEWARDSHIP ANNUAL REPORT 2025 to 2026

Within HUTH, the antimicrobial stewardship agenda is predominately led by the Lead Antimicrobial Pharmacist (Consultant Pharmacist post), Lorraine Cullen, in conjunction with the antimicrobial stewardship clinical lead from the department of infection, who was Dr Chloe Walsh for 2025-26. There is close team working with the wider pharmacy team, the department of infection clinicians, the Infection Prevention and Control Team and microbiology biomedical scientists.

This report provides an overview of antimicrobial usage and antimicrobial stewardship work within HUTH, between April 2025 to March 2026.

Usage data is included for both local and regional use (when appropriate). Usage is calculated in Defined Daily Doses (DDDs) per 1000 bed days. DDD is a statistical measure of drug consumption as defined by the WHO that allows for usage comparisons across different clinical areas / trusts. It is the assumed average maintenance dose per day for a drug used for its main indication in adults.

The usage data listed within this report is reported as DDDs per 1000 bed days. In addition, some of the data is presented as Lorenzo ePMA administrations, which is a total value not relative to trust bed days. Both values have their limitations but give a picture of current antibiotic prescribing trends within HUTH.

TOTAL ANTIBIOTIC USE

- At the end of 25/26, HUTH was using 2.5% more antibiotics (measured as DDDs per 1000 patients) compared to the 2019 baseline. This compared to the end of 24/25, where HUTH was used 2% more antibiotics than the 2019 baseline.
- Figure 32 has the breakdown for HUTH over April 2024 to March 2026. Usage remains relatively stable with increased seasonal usage over the winter months noted in both financial years. There is a trend towards increased usage noted towards the end of 25/26 (compared to 24/25).
- Figure 33 has the regional breakdown of antibiotic (systemic) use across the region. HUTH usage remains one of the lower usage trusts for total antibiotics within the Yorkshire & Humber region, despite not making any sustained reductions in usage compared to the 2019 baseline.

Figure 32: HUTH total antibiotic use, April 2024 to March 2026 (DDDs per 1000 patients)

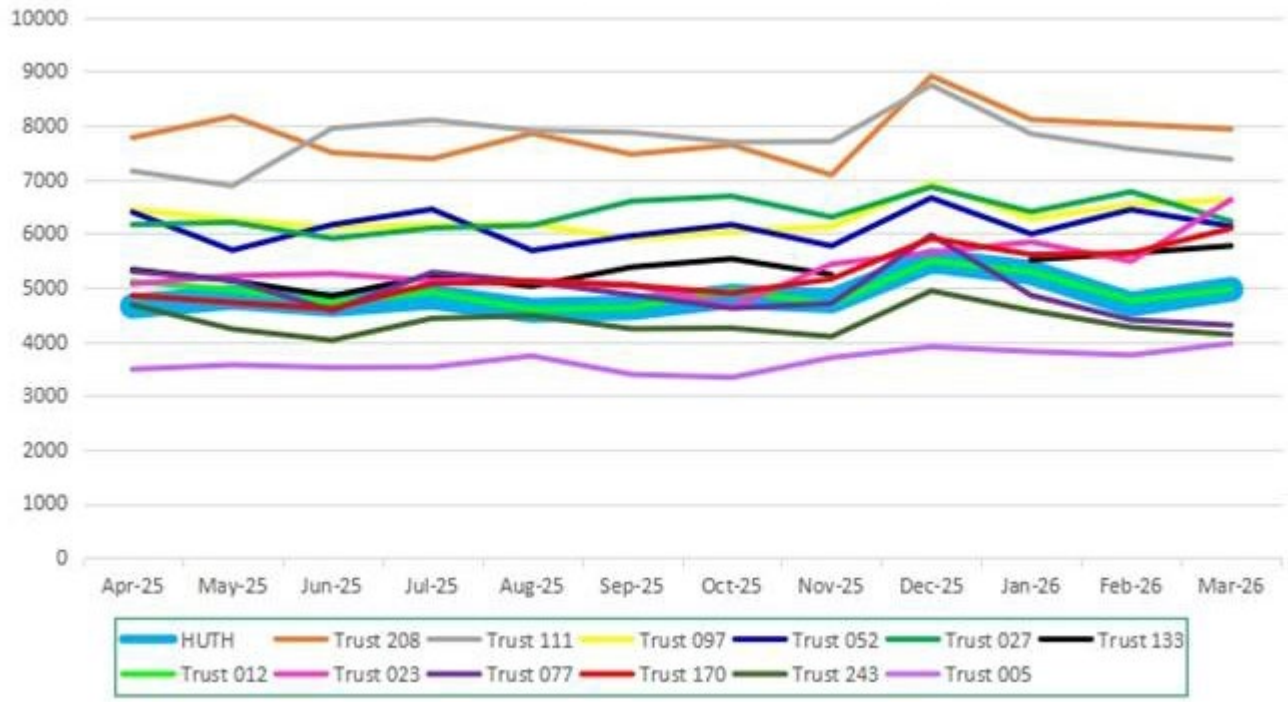


Figure 33: Regional systemic antibiotic use, April 2025 to March 2026 (DDDs per 1000 patient admissions)

AWARE ANTIBIOTIC CATEGORIES

ACCESS AGENTS

- At the end of 25/26, the proportion of ACCESS agents used in HUTH was 70% (with 26% WATCH agents and 4% RESERVE agents).
- HUTH has achieved the National Contract/ National Action Plan Target of 70% ACCESS agents at the end of 25/26 financial year. Only two other trusts have achieved this within the region (York and Harrogate). Due to increasing antimicrobial resistance rates locally, potential changes in usage/ guidance will make this target difficult to maintain.
- Figure 34 shows the proportion of ACCESS/ WATCH/ RESERVE agents used between April 2025 to March 2026 for the acute hospitals within the Yorkshire & Humber region

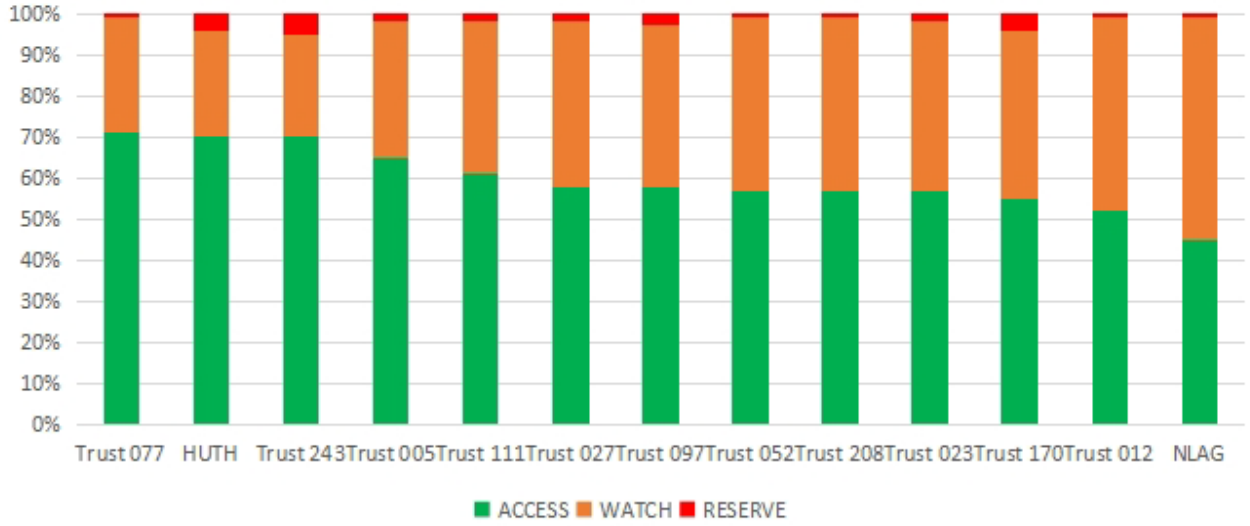


Figure 34: Regional proportion of Access, Watch and Reserve antibiotic use, April 2025 to March 2026

WATCH/RESERVE AGENTS

- At the end of 25/26, HUTH was using 22.5% less WATCH/ RESERVE agents than it was in 2019.
- Figure 35 has the breakdown for HUTH over April 2024 to March 2026. Usage remains relatively stable with increased seasonal usage of WATCH/RESERVE agents noted over the winter months in both financial years.
- Figure 36 shows the DDDs per 1000 patient admissions for WATCH/ RESERVE agents between April 2025 to March 2026 for the acute hospitals within the Yorkshire & Humber region. Regionally HUTH is one of the lowest users of WATCH/ RESERVE agents with usage comparable to York, Harrogate and Airedale Hospital.

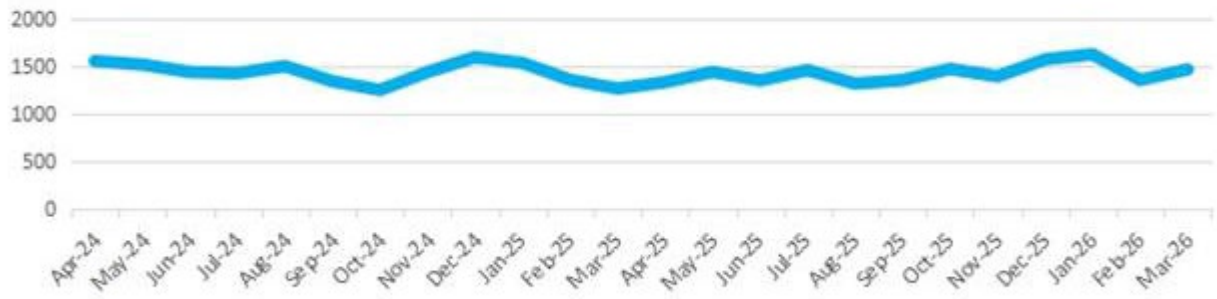


Figure 35: HUTH Watch and Reserve antibiotic use, April 2024 to March 2026

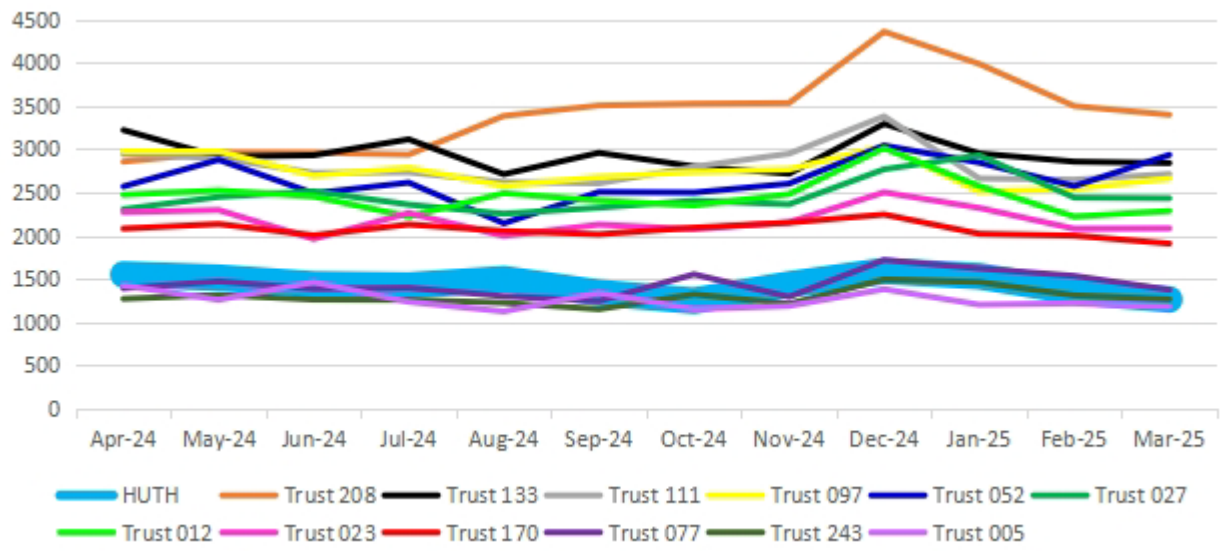


Figure 36: Regional Watch and Reserve antibiotic use, April 2025 to March 2026

KEY INDICATOR ANTIBIOTICS

A number of WATCH agents have been highlighted as agents of concern.
These are agents where overuse has been linked to driving antimicrobial resistance and/or the development of healthcare associated infections.
The agents of focus are co-amoxiclav, piperacillin/ tazobactam, carbapenems (meropenem and ertapenem in HUTH) and fluoroquinolone antibiotics (ciprofloxacin, levofloxacin, Ofloxacin and moxifloxacin).

Antibiotic	% change in 25/26 (compared to 2019) HUTH trust wide usage data
Co-amoxiclav	59.5% less than 2019
Piperacillin/ tazobactam	17.4% more than 2019
Carbapenems (Meropenem/ Ertapenem)	13.7% more than 2019
Fluoroquinolones	67% less than 2019

Table 15: Change in HUTH use of key indicator antibiotics compared with the 2019 baseline

Locally, we previously had concerns regarding the over-prescribing of co-amoxiclav with locally reported high rates of resistance in gram negative pathogens. A lot of focus in 2021/2022 was to move our empiric guidance away from co-amoxiclav based regimens and highlight to the prescribing team's our local resistance patterns. The reduction seen in the first year of the changed guidance has been maintained, with almost 60% less co-amoxiclav being used in HUTH compared to 2019.

Piperacillin/ tazobactam use has increased compared to 2019.
This is largely driven by it used in HUTH guidance for patients with suspected/ confirmed sepsis of unknown origin. Sepsis management has been an area of focus for HUTH over the last few years, and it was expected that prescribing would increase. The key point for this going forward is to encourage and support timely reviews of piperacillin/ tazobactam to minimise the risk patients are continued on this broad spectrum agent unnecessarily. Local AMS data collection has demonstrated the majority of these patients can be de-escalated within 48-72hrs of initiation.

Carbapenem use has increased compared to 2019. Local antimicrobial resistance rates are increasing. This is most notably seen in gram negative pathogens, in particular Extended Spectrum Beta-lactamase (ESBL) producing Enterobacteriaceae. Patients who require systemic treatment for these infections, will have limited options available, and carbapenem therapy will often be the preferred treatment option. Increased use was to be expected but these agents remain restricted agents within HUTH and largely require input from the Department of Infection before prescribing/ supply to ensure use is appropriate.

Fluoroquinolone agents have been linked to several serious side effects. The MHRA has issued a number of safety alerts over the last few years. Awareness sessions to high areas of use were introduced in 2024 and local guidance was reviewed. The reduction by two thirds (compared to 2019 usage) is higher than we expected, and reflects the clinical teams support to reduce the prescribing of these agents as well as the work of the Dept of Infection in the promotion of appropriate use.

CARE GROUP ACCESS/ WATCH/ RESERVE Breakdown

ACCESS agents remain the most frequently prescribed agents in HUTH for inpatient administrations in most care groups (Figure 6). Several CG used over 70% ACCESS agents in March 2026 (Acute & Emergency Medicine, Community Frailty and Neuroscience).
The use of WATCH agents was highest in critical care, specialist cancer, infectious diseases, gynaecology and C16 (head and neck). RESERVE agent use is highly variable with the highest use in March 2026 in Specialist Cancer, Critical Care and Major Trauma CG.

Care Group	ePMA wards included	% ACCESS agents (Mar26)	% WATCH agents (Mar26)	% RESERVE agents (Mar26)
Acute & Emergency Medicine	ED, H1, H36, H5, AMU, HDL, SDEC	70%	29%	1%
Cardiovascular	C26, C27, C28, CCD5, CMU, H39, H7	69%	26%	5%

Community Frailty & Therapy	C20A, EAU, FSDEC, H130E, H8, H80, H9, H90	**81%**	**18%**	**1%**
Digestive Diseases	C10, C11, C14, H100, GATH, H6, H60	**68%**	**26%**	**6%**
Family Services	H30, H34A	**54%**	**46%**	**0%**
Head and Neck	C16, H36SDEC (ENT ward)	**55%**	**45%**	**0%**
Major Trauma Network	C01A, H38 (<2025)	**65%**	**24%**	**11%**
Neuroscience	H11, H110, HASU, H4, HNHD	**72%**	**22%**	**6%**
Specialist Cancer & Support Services	C29, C30, C31, C32, C33, C7, CAU, COHD, TYAC	**53%**	**39%**	**8%**
Specialist Medicine	H10, H37A, H50, H500, H70	**61%**	**36%**	**3%**
Specialist Surgery	C12, C15, C9, H12, H120, HPLA	**68%**	**31%**	**1%**
Theatres & Critical Care	CDSC, CGI1, CICU, CSAL, HGHD, HICU, HTH	**44%**	**47%**	**9%**
Trust Total		**66%**	**30%**	**4%**

Table 16: HUTH ePMA administrations by Access, Watch and Reserve category, March 2026

IV ANTIBIOTIC USE

At the end of 2025/26, IVAB usage was 27% of all antibiotics (60% of inpatient ePMA administrations) given or supplied from HUTH. Across the Yorkshire and the Humber region, HUTH remains a high user of IV antibiotics.
Figure 37 details the use across the region as % of IV antibiotics relative to total antibiotic use (including Outpatients/ Discharges and FP10 prescriptions). HUTH is the highest user in the Y&H region of IV antibiotics when plotted as a proportion relative to PO/ enteral antibiotics.

Figure 38 shows IV antibiotic use as DDDs per 1000 patients (i.e. data that is more reflective of usage relative to patient admissions). When admission data is factored in, HUTH is no longer the highest user of IV antibiotics within the Y&H region.

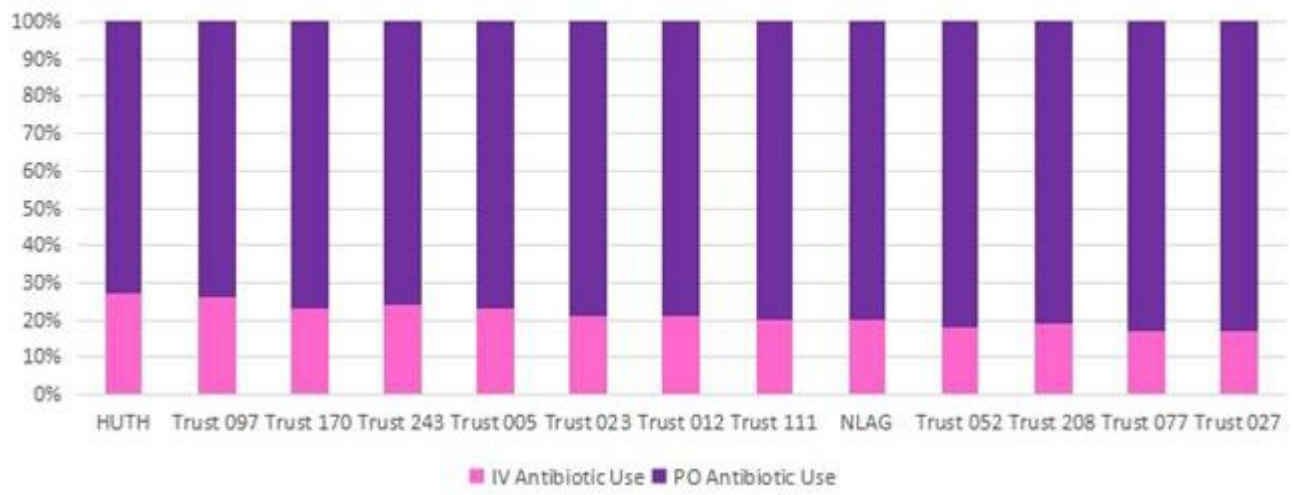


Figure 37: Regional intravenous antibiotic use as a proportion of total antibiotic use

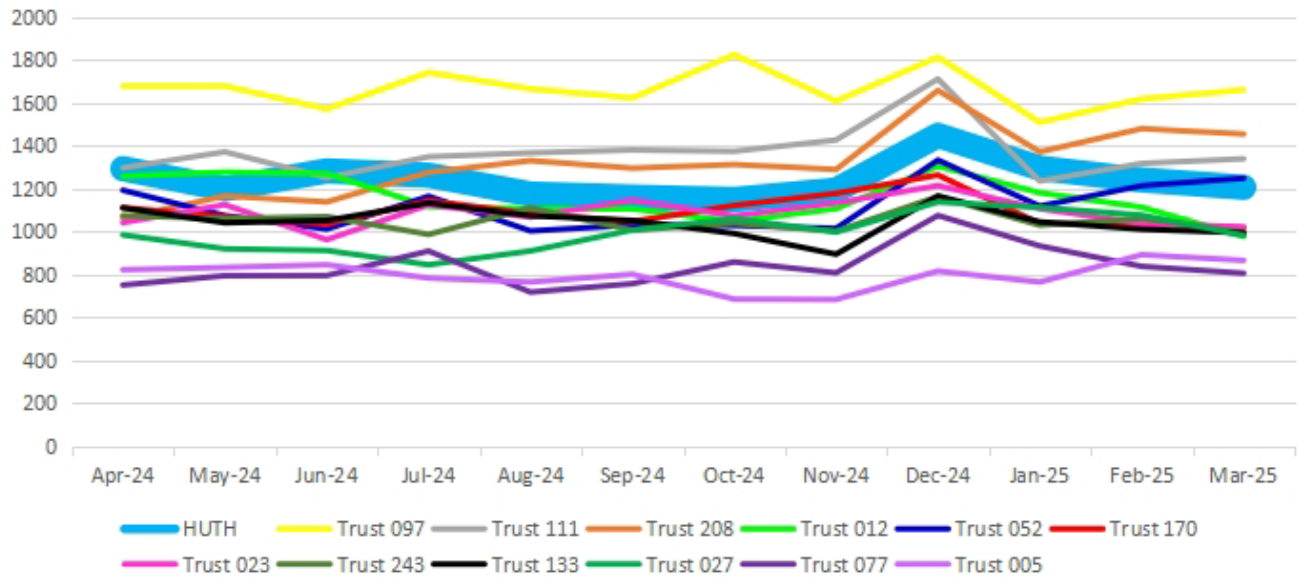


Figure 38: Regional intravenous antibiotic use per 1,000 patient admissions

CARE GROUP IV ANTIBIOTIC BREAKDOWN

There is variable IV antibiotic use across the care groups (Figure 38). High usage is seen within critical care/ theatres, acute and emergency medicine, digestive diseases (includes acute surgery), gynaecology, ENT, specialist cancer, neuroscience and specialist surgery. Higher usage within some of these areas is expected, due to the nature of the patient group.

Care Group	ePMA wards included	% IV doses (25/26)
Acute & Emergency Medicine	ED, H36, H5, AMU, SDEC	**68%**

Cardiovascular	C26, C27, C28, CCD5, CMU, CCTS, H39, H7	**44%**
Community Frailty & Therapy	C20A, EAU, H1 (≥ 2026), FSDEC, H130E, H8, H80, H9, H90	**43%**
Digestive Diseases	C10, C11, C14, H100, GATH, H6, H60	**65%**
Family Services	H30	**67%**
Head and Neck	C16, H36SDEC (ENT ward)	**71%**
Major Trauma Network	C01A, H38 (≥ 2025)	**54%**
Neuroscience	H11, H110, HASU, H4, HNHD	**65%**
Specialist Cancer & Support Services	C29, C30, C31, C32, C33, C7, CAU, COHD, CPRA, TYAC	**62%**
Specialist Medicine	H10, H37A, H50, H500, H70	**44%**
Specialist Surgery	C12, C15, C9, H12, H120, HPLA	**62%**
Theatres Anaesthetic & Critical Care	CDSC, CGI1, CICU, CSAL, HGHD, HICU, HTH	**88%**
Trust Total		**60%**

Table 17: HUTH ePMA intravenous antibiotic administrations by care group, 2025/26

CARE GROUP ANTIMICROBIAL PRESCRIBING AUDIT (Oct 2025 – March 2026)

Each ward area was reviewed on a single day. All patients on regular antimicrobial therapy were included in the audit. The following antimicrobials were excluded from the review:

- Topical antimicrobial therapy (including creams/ointments, nystatin and eye drops)
- Chemoprophylaxis regimens used in immunosuppression, HIV and Hepatitis antiviral therapy,
- STAT doses for surgical prophylaxis and
- Antimicrobial agents used for non-infection indications (e.g. erythromycin for gut motility, rifaximin in hepatic patients).

Care Group	Wards reviewed	Indication documentation on drug chart	Duration/ review date documentation on drug chart (Note: Automatic ePMA reviews excluded)	Antimicrobial prescribing as per HUTH guidance	Antimicrobial prescribing with rationale if against HUTH guidance, or no HUTH guidance available	Overall antimicrobial prescribing appropriateness (i.e. as per guidance or with clinical rationale if against guidance)	No of patient prescriptions with a planned stop date/ total AM Rx(% of Rx)	No. of pt prescriptions with an appropriate duration for the indication	% of patient prescriptions with an appropriate planned duration	% of patients on IV antimicrobial therapy	% of patients on IV therapy that meet the IVOS criteria
Specialist Medicine	H10, H37, H50, H500, H37	88%	37%	52%	78%	87%	47/84 (56%)	38/47	81%	27/66 (41%)	12/27 (44%)
Specialist Surgery	C9, C15, H12, H120, C16 (breast/plastics)	71%	26%	41%	75%	84%	16/31 (52%)	14/16	88%	13/26 (50%)	2/13 (15%)
Theatres & Critical care	GICU2, CICU1, HICU1, HICU2	91%	23%	75%	100%	100%	6/22 (27%)	4/6	67%	13/14 (93%)	Not reviewed
Neuroscience	H4, H40, H11, H110	76%	58%	61%	63%	79%	23/33 (70%)	20/23	87%	14/24 (58%)	5/14 (36%)
Family Services	H30, H31, H33, H34, H200, H20, NICU	82%	73%	89%	38%	70%	15/33 (45%)	6/15	40%	19/26 (73%)	4/13 (31%)
Major trauma	C1, H38	90%	50%	43%	57%	70%	5/ 10 (50%)	5/5	100%	3/8 (38%)	1/3 (33%)
Head & neck	C16 (ENT)	75%	50%	75%	•	75%	3/4 (75%)	2/3	67%	2/3 (67%)	1/2 (50%)
Digestive diseases	C10, C11, C14, H6, H60, H100	79%	25%	74%	70%	88%	39/97 (40%)	28/39	72%	33/57 (58%)	7/33 (21%)
Community & Frailty	FAB, H8, H80, H9, H90, H130E, H130W, C20	82%	70%	63%	44%	76%	69/97 (71%)	58/69	84%	24/72 (33%)	9/24 (38%)
Cardiovascular	H39, C26, C27,	86%	65%	65%	52%	78%	35/51 (69%)	31/35	89%	17/42 (40%)	4/17 (24%)

	C28, CMU, H7										
Acute & EM	AMU, H36, H5, ED	90%	21%	55%	29%	68%	37/128 (29%)	26/37	70%	55/82 (67%)	12/55 (22%)
Cancer & SS	C7, C29, C30, C31, C32, C33	74%	40%	43%	54%	70%	28/53 (53%)	22/28	79%	23/41 (56%)	3/23 (13%)
HUTH overall	461/1146 patients on AM therapy (40%)	**83%**	**42%**	**60%**	**56%**	**78%**	**323/643 (50%)**	**254/323**	**79%**	**243/461 (53%)**	**60/243 (25%)**
2024/25 audit results		***78%***	***41%***	***63%***	***63%***	***81%***	**Not included in 24/25 audit**				

Table 18: HUTH annual antimicrobial prescribing audit by care group, October 2025 to March 2026

Summary of annual antimicrobial prescribing audit 25/26 for HUTH:

40% of all patients reviewed were on antibiotic therapy. This compares to 35% in the 2024/25 audit.

Indication documentation on ePMA drug charts has improved (recorded in 83% of patients, compared to 78% in the 24/25 audit).

Duration/ review date documentation on drug charts was very low at 42% of prescriptions (comparable to 41% reported in the 24/25 audit).

Prescribing was in line with HUTH guidance in 60% of prescriptions. There was evident clinical rationale to prescribe 'off guidance' in 56% of remaining prescriptions. Overall, prescribing choice was assessed as appropriate in 78% prescriptions (compared to 81% in the 24/25 audit).

Planned durations were decided in 50% of patients assessed, and of those durations 79% were considered appropriate for the indication. Those durations that were not considered appropriate for the indication were generally longer than would normally be advised.

53% of antimicrobials were given via the IV route. A quarter of patients, at the point of review, met the criteria for an IV to Oral switch.

Focus Areas:

- Appropriate antibiotic choice - using Eolas for HUTH guidance choices.
- Promoting appropriate durations, in line with HUTH guidance, and documentation on ePMA to minimise unnecessarily prolonged courses.
- Timely IV to PO antibiotic switches, using ACED criteria to guide timely switches.

EOLAS LAUNCH

At the end of November 2024, the MicroGuide app, where HUTH antimicrobial guidance is viewed, moved to the Eolas Medical platform.
Since its launch almost 2,800 users have downloaded the app. Over the last 12 months there have been approximately 1,100 unique monthly users with between 12,000-16,000 total sessions each month.

SUMMARY

HUTH performs well against some of the national action plan targets.

Two years into the 2024-2029 national action plan, HUTH has achieved 70% ACCESS agent usage. This is following significant improvements since 2022 that have resulted in ~22.5% less broad spectrum use and restricted (WATCH/ RESERVE) antibiotics.

Total usage has risen in 25/26 and over the financial year, HUTH used 2.5% more antibiotics than the 2019 baseline. The target reduction is 5% less than 2019 usage and in order to achieve that target, work needs to focus on promotion of timely antibiotic reviews and appropriate treatment durations.

In addition, an additional target set within the national action plan requires increased patient and health professional knowledge and understanding of antimicrobial resistance (AMR). Throughout 25/26 the Antimicrobial Stewardship (AMS) team led several teaching sessions on appropriate antimicrobial prescribing (e.g. non-medical prescribers, Pharmacy, FY1 teaching, FY2 teaching, CT doctor teaching, Patient Safety Day, GPs). However, there is no formal education and training supported or available in HUTH and sessions are only arranged on an 'as requested' basis. Mandatory AMS training should be considered for clinical staff.

HUTH remains a high user of IV antibiotics. Ongoing work should review and support appropriate IV antibiotic use within HUTH.

The introduction of an app-based platform for trust antimicrobial guidance has been vital in improving prescribing audits and guidance accessibility and utilisation.

ANTIMICROBIAL STEWARDSHIP ACTION PLAN AND KEY PRIORITIES FOR HUTH 2025/26

The antimicrobial stewardship team request the support of the executive team to ensure the ongoing improvements continue in the use of antimicrobials. The suggested plan includes the following key points, but its success is dependent on the buy-in of clinical teams, which can be promoted by Antimicrobial Stewardship being seen as a clinical priority area.

The following recommendations form the key actions and priorities for antimicrobial stewardship at HUTH between April 2026 and March 2027

1. Reduce the amount of IV antibiotics prescribed and administered at HUTH
    a. Promote appropriate IV antibiotic initiation to ensure those who require IV therapy are initiated on IV and those who do not require IV therapy are initiated on PO treatment
    b. Promote timely IV to PO switches (IVOS) in patients who are on IV antibiotic treatment and meet the criteria for switching to oral therapy.

These switches should be encouraged as soon as the IVOS criteria is met.

c. Support improvement work within clinical areas to reduce the amount of IV antibiotic prescribing
d. Target areas of high IV antibiotic use as part of weekly AMS ward rounds

There are several benefits in reducing the amount of IV antibiotics given. The risk of blood stream infections/ local reactions is reduced, and most patients prefer oral administration of medication. Nursing time is released as the time to prepare and administer an oral antibiotic is significantly shorter than that of an IV. The organisation benefits through earlier discharges, reduced carbon footprint and reduced costs.

Target reductions:

- CQUIN target <15% of patients meet criteria for an IVOS (25/26 audit = 25%)
- Reduce overall IV usage to 25% of all AB used in HUTH (25/26 figure 27%) and 55% of all ePMA administrations (= 10% reduction)

2. Reduce total antibiotic use, aiming towards the national action plan target of a 5% reduction (compared to 2019 baseline). Reduction in overall use should focus on encouraging timely antibiotic reviews within 48-72 hours of initiation and promotion of shorter durations, in line with the recommendations in HUTH guidance.
   Target reductions:
   - Aim for 2.5% reduction annually from 2026- 2029

3. Maintain (or improve) broad spectrum/ restricted antibiotic use (WATCH/ RESERVE classification) and maximise appropriate use of these agents. At the end of 25/26, HUTH achieved the 70% ACCESS agent target.

4. In 25/26, HUTH procured ICNET. This will allow for collation of local antimicrobial resistance data. There are concerns that local resistance patterns have changed since our current guidance was developed. There is a need for local antibiogram driven guideline reviews. Once ICNET has at least 6 months of data (likely early 2027) guidance should be reviewed to ensure appropriate empiric guidelines are available to support optimal patient management / outcomes and reduce AMR burden.

5. Penicillin allergy de-labelling. ~90% of patients are incorrectly labelled as penicillin allergic. There is a number of benefits to de-label inappropriate allergies, most notably reduced AMR and improved patient safety. There is known increased mortality rates, HCAI, and ADR seen in penicillin allergic patients (who often get inferior and/ or broader spectrum agents). Currently

within HUTH there is no locally agreed guidance to support timely and appropriate allergy de-labelling pathway/ tool. Work to address this should include an initial QIP assessing Pen-Fast tool within selected pilot areas.

6. Education programme to be agreed and supported for clinical staff, including medical, nursing and pharmacy staff. This is required as per NHSEI as part of the Infection prevention and control education framework, standard 3 'Ensure antimicrobial resistance (AMR) and Antimicrobial Stewardship (AMS) is an integral part of education programmes. The National Action for AMR 2024-2029 has a target set to increase healthcare professional's knowledge on AMR by 10% (using 2019 baseline data).

7. Promotion of principles of good anti-microbial prescribing. Follow recommendations in national strategy 'Start Smart then Focus'. Detail available at: Antimicrobial stewardship: start smart then focus - GOV.UK (www.gov.uk)

8. Continued promotion and awareness of HUTH Antimicrobial Prescribing Guidance accessible via Eolas app and Bridget.

9. Promote and improve access to the OPAT (outpatient antibiotic therapy) service.
   Expansion of the treatment approaches to meet the needs of the changing patient population:
   a. Provision of IV outpatient antibiotics in an OPAT setting
   b. Expansion of the provision of education and training of patients/ carers to self-administer prolonged IV antibiotic courses at home
   c. Provision of continuous infusions (changed in the OPAT clinic or at home by appropriately trained patients/ carers)
   d. Monitoring of patients on complex oral treatments with tolerability concerns e.g. linezolid, co-trimoxazole.

10. Monitoring of prescribing practices.
    a. Utilise antimicrobial usage business intelligence report and pharmacy EMIS system to produce regular review of inpatient prescribing. The focus for 26/27 will be proportion of IV antibiotics used within clinical areas.
    b. Regular review of all inpatient prescribing areas to review indication/ duration/ adherence to HUTH guidance and if not as per guidance, review if there is justification to go against guidance. Planned frequency: every 12 months per care group.
    c. Ad hoc review(s) as per clinical need.

11. Dissemination of information.
    a. Regular production of antimicrobial reports for each care group for discussion at appropriate business/ governance meetings. Discussions should lead to individual action plans for clinical areas and care groups that can be reported back at the local Infection Reduction Committee's and Antimicrobial Stewardship committee meetings (Advisory Committee on Antimicrobial Therapy, ACAT).
    b. Monthly reports for IRC against national action plan/ national contract and any other relevant targets.

12. Restriction policies - promotion of the agents restricted for use within the trust and support pharmacy to manage appropriate supply

13. Trust wide campaign on key antimicrobial stewardship priorities to coincide with World Antimicrobial Awareness Week in November.

14. Pursue the role of antimicrobial champions within clinical specialities that can link in with the wider anti-microbial stewardship (AMS) agenda and ACAT team.

15. Quality improvement project work to support AMS. ACAT and AMS champions to work with the trust QI team to develop project work with clinical teams and identify improvement strategies.

16. Improve diagnostics in sepsis – in particular, target the improvements around the blood culture pathway as per NHSEI recommendations. Re-audit compliance and raise awareness with clinical teams, nurse educators and other appropriate colleagues.

17. Support Infection Prevention & Control work, through ongoing and outbreak-directed AMS work.

NLAG ANTIMICROBIAL STEWARDSHIP ANNUAL UPDATE 2025 to 2026

Within the NLAG Trust, the antimicrobial stewardship agenda is predominately led by the Lead Antimicrobial Pharmacist (Consultant Pharmacist post), who works closely with Pharmacy staff, the Infection Prevention and Control Team, PathLinks Microbiologists, PathLinks Microbiology Operational Manager & Laboratory Manager and clinicians; this includes working with the ePMA (electronic prescribing medication and administration) implementation team to incorporate appropriate antimicrobial stewardship into the prescribing and administration system. The AMS work is delivered by stretched teams, there are staff limitations to implement AMS

activities, gaps in audit, data and education and increased expenditure on antimicrobials.

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary. Education and training are facilitated both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses where capacity allows. The aim is to ensure appropriate antimicrobial prescribing as per 'Start smart then focus' toolkit (*Start smart then focus: antimicrobial stewardship toolkit for inpatient care settings - GOV.UK*) and optimise treatment for patients through an effective stewardship programme. The Trust antimicrobial strategy is due for review and update to incorporate the updated NAP 2024/29.

The pharmacist staffing levels continue to be challenging. The new Lead Antimicrobial Pharmacist focus has been on establishing and maintaining the NLAG Antimicrobial Stewardship Group and updating the NICE Baseline Assessment tool for AMS (NICE Medicines Practice Guideline NG15 *Overview | Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use | Guidance | NICE*) annually to evaluate if current practices at the Trust are in line with national recommendations. This helped identify gaps and challenges and informed the annual improvement action plan to meet the recommendations and give assurance to the Trust Board and commissioners of activities being undertaken to ensure best practice and compliance with current legislation. To support this, a business case to establish a pharmacy AMS team at NLAG was developed and approved by the end of the financial year. The establishment of pharmacy AMS team will strengthen capacity to deliver AMS activities to improve Trust performance.

Audit and surveillance of antimicrobial use

The following data from NHSE Antimicrobial Resistance Reporting NHS Humber and North Yorkshire ICB March 2025 report shows NLAG is in a good position with regards to antibacterial oral to IV ratio, however, the data doesn't show appropriateness. Digital tools such as ICNet have been identified as tools that would enable prioritisation of patients for AMS reviews to ensure appropriate prescribing and best outcomes for the patients. In the meantime, the AMS Champions project and recruitment of a Pharmacy AMS team will support with audit work.

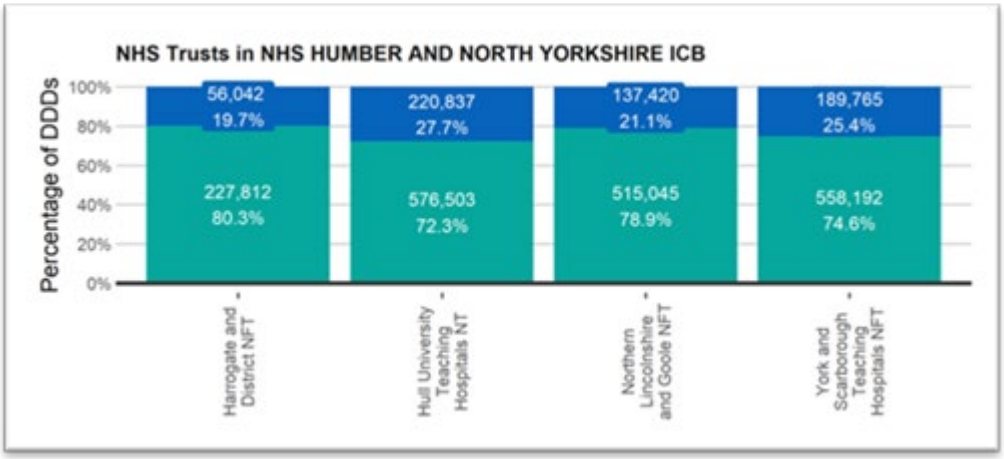


Figure 39: NLaG oral-to-intravenous antibacterial ratio in the 12 months ending April 2026

NLAG has been consistently identified as an outlier with regards to broad spectrum antimicrobial prescribing. This has been the focus of this year improvement plan for the Trust.

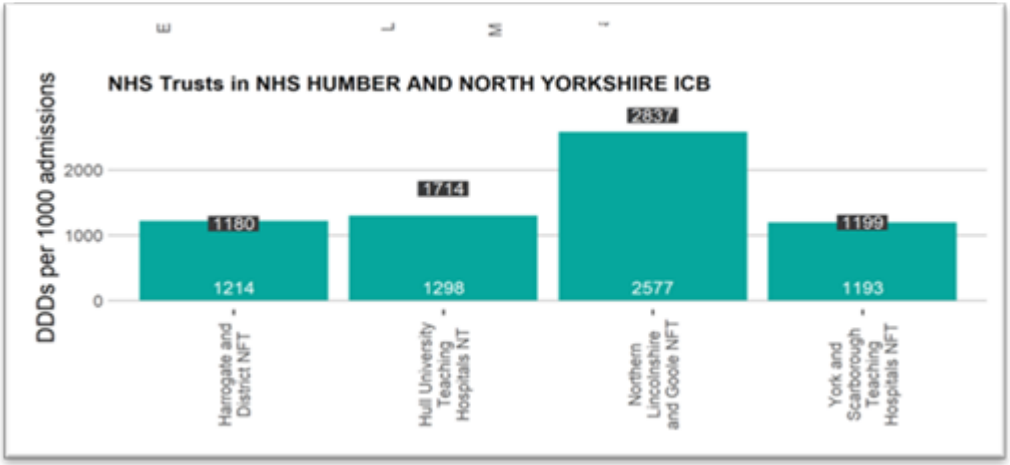


Figure 40: NLaG Watch and Reserve use per 1,000 admissions to quarter 3, 2025/26

From NHS England data report presented at local and regional meetings, it has been noted and acknowledged that the Trust is showing positive progress however, there are some areas requiring improvement:

- The total antibacterial use shows a reduction of 4.6% by Q3 2025/26. This is an improvement that must continue to achieve the national ambition of a 5% reduction by 2029.
- The use of Access agents is 45% this is of concern as remains well below the national target of 70%. We are the only Trus in Humber and North Yorkshire ICS not achieving this target.

- Infection related outcome indicators highlight higher than expected mortality for sepsis and pneumonia.

Hospital antimicrobial stewardship assurance				UK AMR NAP 2024-29 & NHS Standard Contract 2026-27						
ICB Region	Trust Code	Trust Name	NHSE IPC BAF submitted to Trust Board in 2025-26	Total AB (DDDs/1000adm) 2019-20 UKHSA	Total AB (DDDs/1000adm incl DC) 12mth	% difference in total AB vs 2019 (DDDs/1000adm incl DC) RX-info Target -5% by 2029	Trend AWaRe (last 12 months vs prev 12 months RX-info	% Access (2025 list) RX-info) - Target 70%+ by 2029	Trend	Acute sepsis pathway adheres to NICE guideline
ce				UKHSA reports to be published on I			Report - Defi	Report - Define Reports		View metric
				FY1920 baseline	to Q3 25-26	to Q3 25-26	Mar-26	12m to Mar-26	growth vs 12m to Mar 25	Nov-25
		target				-5%	-5.0%	70%+		90% of high risk get IV AB in 1hr
NHS NORTH EAST AND NORTH CUMBRI		NHS NORTH EAST AND NORTH CUMBRIA INTEGRAT		4392	4738	7.9%	1.47%	60%	2%	50%
NHS HUMBER AND NORTH YORKSHIRE I		NHS HUMBER AND NORTH YORKSHIRE INTEGRATED		4143	4176	0.8%	0.16%	64%	2%	75%
NHS WEST YORKSHIRE INTEGRATED CAR		NHS WEST YORKSHIRE INTEGRATED CARE BOARD		4552	5199	14.2%	5.65%	59%	2%	40%
NHS SOUTH YORKSHIRE INTEGRATED CA		NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD		4683	4706	0.5%	5.42%	55%	2%	20%
North East and Yorkshire		**North East and Yorkshire**		**4443**	**4722**	6.3%	3.16%	**59%**	**2%**	**50%**
England		**England**		**4519**	**4820**	6.7%	**3.6%**	**57%**	**3%**	
NHS HUMBER AND NORTH YOR	RWA	Hull University Teaching Hospitals NHS Trust		4319	4292	-0.6	2.6%	70%	2%	yes
NHS HUMBER AND NORTH YOR	RCB	York and Scarborough Teaching Hospitals NHS Foun		3647	3744	2.6	0.0%	70%	1%	no
NHS HUMBER AND NORTH YOR	RCD	Harrogate and District NHS Foundation Trust		3621	4061	12.2	-1.0%	71%	1%	yes
NHS HUMBER AND NORTH YOR	RJL	Northern Lincolnshire and Goole NHS Foundation Tr		4930	4701	-4.6	3.6%	45%	2%	no

Figure 41: NLaG total antibacterial use against the national reduction target

NLAG performance against national targets will continue to be the focus of the improvement plan for next financial year 2026/27 as this is one of the three priorities in response to NHSE “Act now: protect our present, secure our future” letter. Process Control (SPC) methodology is used within the Trust AMS reports. Despite improvements earlier in the year and achieving the 5% reduction target in overall antibacterial consumption in 2025/26 financial year, the SPC chart below shows that overall antimicrobial usage has returned to natural variance this winter which may affect this target.

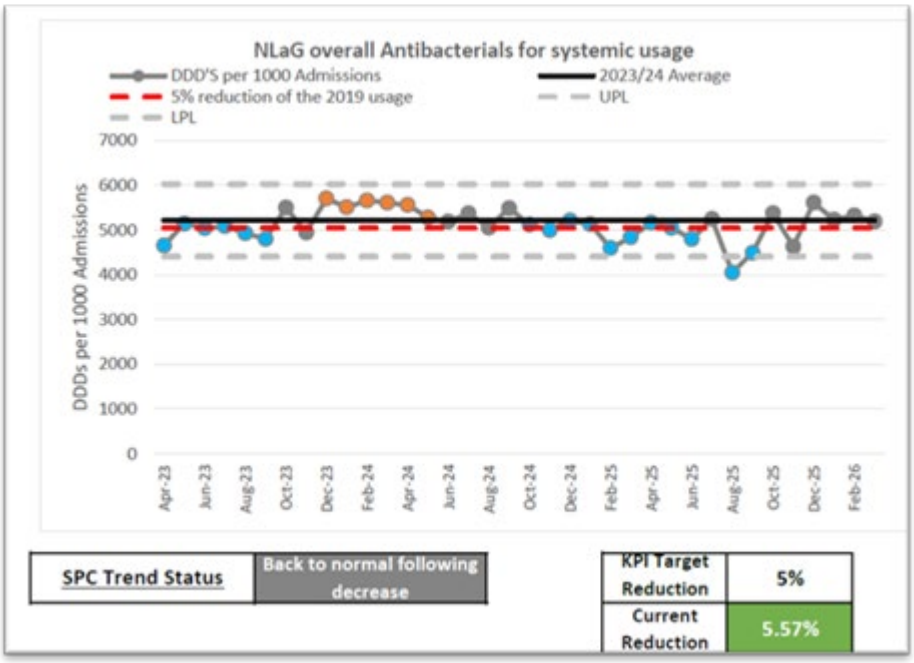


Figure 42: NLaG Access antibiotic use compared with the national target

NLaG remains the lowest-performing Trust in the region for Access UK-AWaRe category antibiotic usage, while having the highest proportion of Watch category usage in the North East and Yorkshire Region.

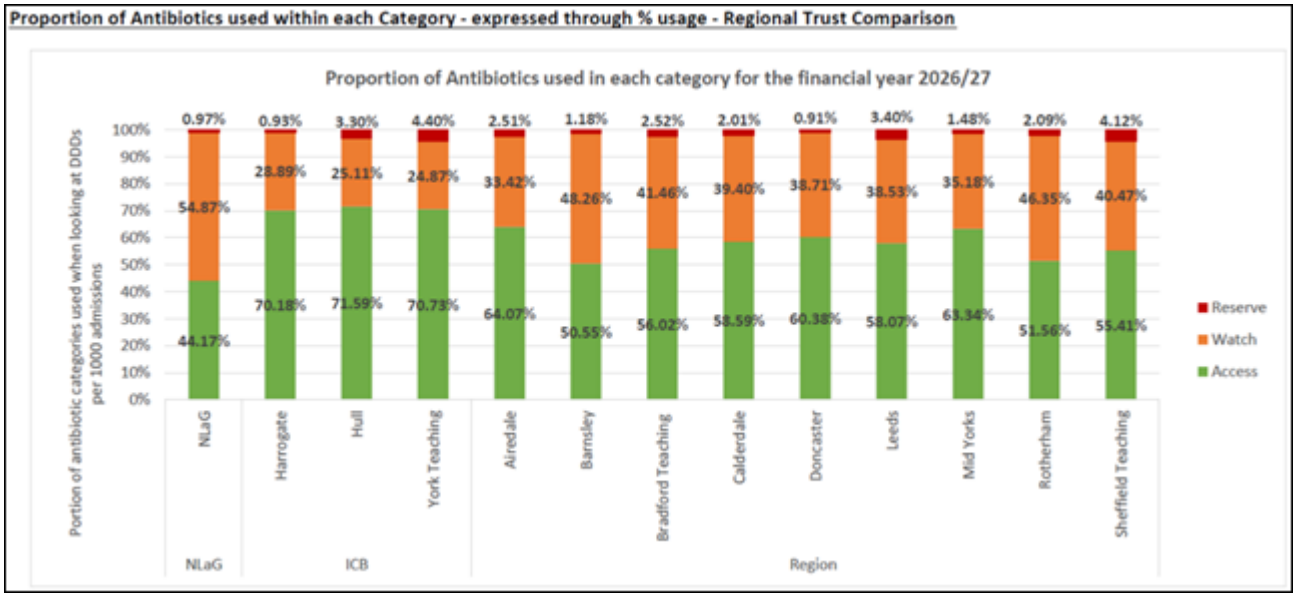


Figure 43: NLaG Access and Watch antibiotic use: regional comparison

The proportion of prescribing from the Access AWaRe category increased to 44.17%, representing improvement from the previous year but remaining substantially below the national ambition of 70% by 2029. The SPC chart below shows a sustained increase in Access antibiotic prescribing since February 2025.

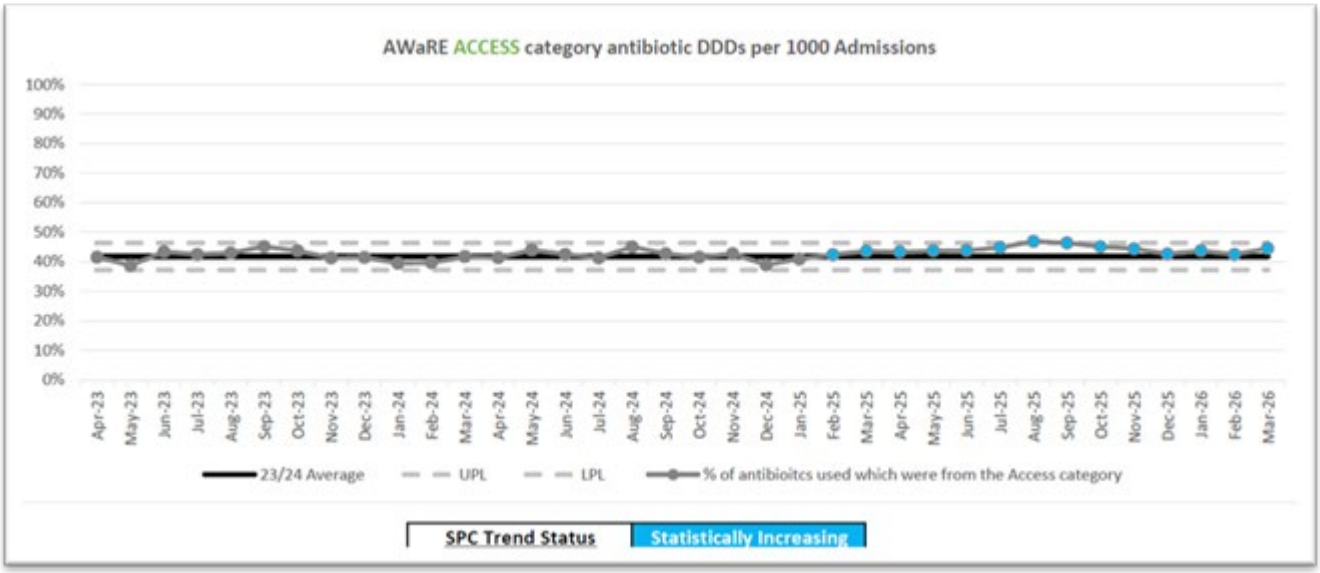


Figure 44: NLaG Access antibiotic prescribing trend

Financial impact of changes in antimicrobial formulary

The first peak we identified was in May 2025, and following investigation, this was due to the CPE (Carbapenemase Producing Enterobacterales) outbreak leading to more complex infections requiring expensive intravenous (IV) antimicrobials and increased length of stay. Changes in procurement contracts and possible inappropriate use of intravenous antibiotics instead of oral as well as overuse of ciprofloxacin, has had an impact in antimicrobial expenditure between October 2025 and March 2026.

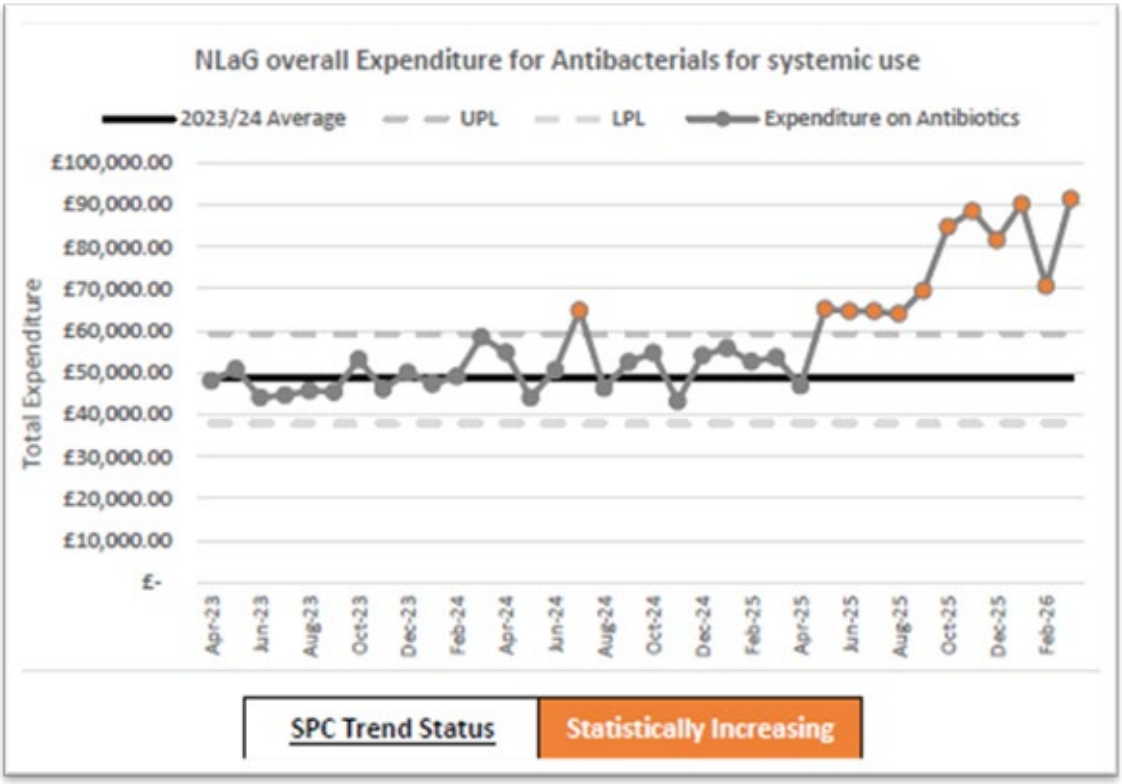


Figure 45: NLaG antimicrobial expenditure trend, 2025/26

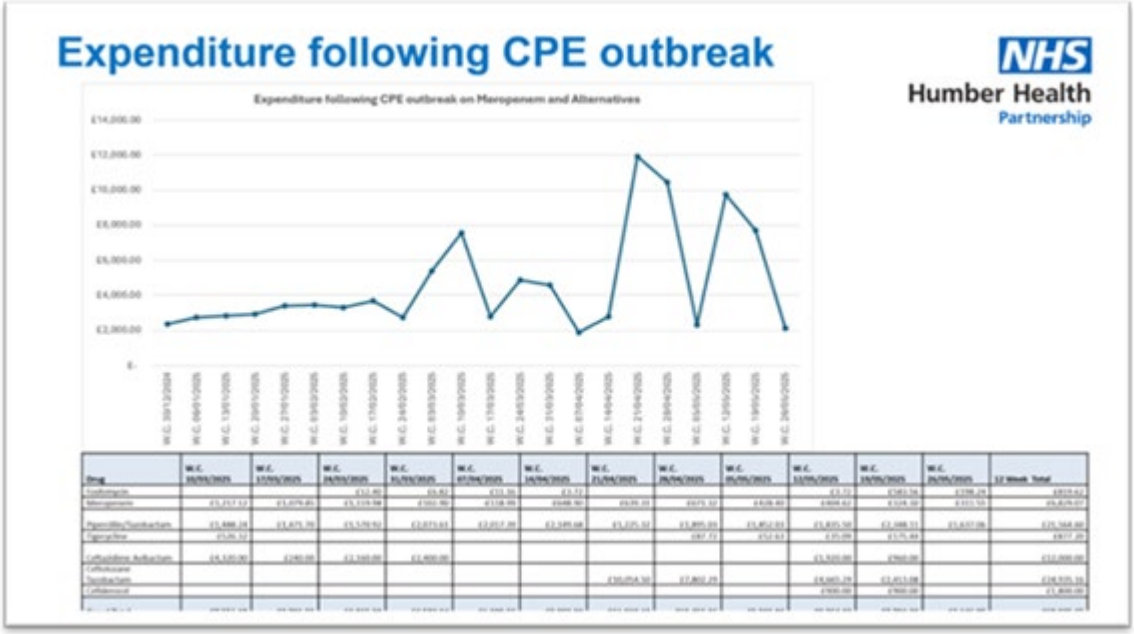


Figure 46: NLaG meropenem and piperacillin/tazobactam expenditure trends

Targeted stewardship outcomes:

The Trust antimicrobial reports include specific data of broad-spectrum antimicrobials to monitor. The data shows that continued and sustained reductions were achieved in the use of meropenem and piperacillin/tazobactam.

- **Meropenem** usage demonstrated two periods of sustained improvement and is statistically decreasing; NLaG moved from being the second highest user in 2024/25 to the lower half of regional Trusts in 2025/26. Meropenem is a broad-spectrum antimicrobial with high resistance potential. Targeted work such as prescribing review and monitoring via daily reports, trust guideline review and update, review and removal of ward stock and restriction policy and implementation has been the focus since the CPE (Carbapenemase Producing Enterobacterales) outbreak was declared in February 2025. Carbapenem prescribing remains low (no longer in the top 20).
- **Piperacillin/Tazobactam** usage has reduced, and SPC charts show sustained improvement since May 2024, with NLaG now in the lower half of regional users.
- **Ciprofloxacin** prescribing decreased during the year and is statistically decreasing following the agreement and implementation of restrictive policy, fluoroquinolone presentation at grand round, stock review and stock removal in process; however, NLaG remains the highest regional user of ciprofloxacin and fluoroquinolones overall. This is an area of focus for next year improvement plan.
- **Co-amoxiclav** remains the most frequently used antibiotic and NLaG continues to be the highest regional user. This remains a major focus for stewardship activity. Emergency departments at both sites have been identified through the data reports as highest users of co-amoxiclav and this should be considered an area to focus targeted work, however capacity to deliver the work has been a limitation. Penicillin de-labelling has also been identified as an intervention that would support the reduction of broad spectrum (Watch) agents and increase narrow spectrum (Access) ones. The Trust has expressed an interest in collaborating with East Kent Hospitals NHS Foundation Trust study: “Exploring the drivers of broad-spectrum antibiotic prescribing in emergency and acute medicine areas of acute hospitals in the UK: A mixed methods approach.”

IV-to-Oral Switch and Prescribing Quality

- IV antibiotic use accounts for 20.6% of total antibiotic use, positioning NLaG within the lower half of regional Trusts for IV antibiotic utilisation.
- A previous sustained reduction in IV antibiotic use was maintained, though no further statistically significant improvements were seen during 2025/26.

The Trust continued to collect data each quarter on Start Smart then Focus Indicators. The Antibiotic Prescribing Standards Audit is currently under review. The table below shows the data and current SPC status.

- Allergy documentation remained excellent (>96%). This is currently a mandatory field in our electronic prescribing system. However, nature of allergy documentation needs to be improved.
- Documentation of antibiotic indication remained high (>94%). This is also a mandatory field in our electronic prescribing system. However, 37.6% of the antibiotics prescribed are not in line with Trust guidelines.
- Evidence of antibiotic review within 72 hours improved substantially from 49.3% to 70.7%, demonstrating positive impact from stewardship interventions.

Antibiotic Prescribing Standards				
Key: Less than 80% / in between 80%-90% / 90% or over			*Please note 25/26 does not contain data for Q1.*	
Standard	23/24 Average	24/25 Average	25/26 Average	Current SPC Status
Standard 1. The allergy box is complete on antibiotic prescriptions	99.5%	98.8%	96.7%	No Significant Change
Standard 2. The Nature of an Allergy is recorded on all Antibiotic Prescriptions excluding NKDA	76.1%	52.7%	67.2%	No Significant Change
Standard 3. Antibiotic Prescriptions have an indication on start date	100.0%	98.2%	94.5%	No Significant Change
Standard 4. The Antibiotic choice follows Trust guidelines	66.0%	71.5%	62.4%	No Significant Change
Standard 5. Antibiotic Prescriptions have evidence of a review within 72 hours of commencing treatment	33.2%	49.3%	70.7%	Improvement

Figure 47: Antibiotic prescribing standards audit results

Result of a clinical team review 72 hours after initiating therapy	% of prescriptions FY 2025/26
Antibiotic stopped	1.45%
De- escalated antibiotic treatment with no review / stop date	0.00%
De-escalated antibiotic treatment WITH review/stop date	2.17%
Escalated antibiotic treatment WITH NO review/stop date	2.17%
Escalated antibiotic treatment WITH review/stop date	11.59%
No change with no review/stop date given	11.59%
No change WITH review/stop date given	56.52%
OPAT	0.72%
Route changed from IV to oral WITH review/stop date given	12.32%
Route changed from oral to IV WITH review/stop date given	1.45%
Route changed from IV to oral WITH NO review / stop date given	0.00%
Route changed from oral to IV WITH NO review / stop date given	0.00%

Table 19: NLaG outcomes of clinical team review 72 hours after starting antimicrobial therapy, 2025/26

Medicines Safety

- The proportion of antimicrobial incidents resulting in patient harm showed a significant reduction over the year. Most reported incidents were classified as no-harm or near-miss events.
- Administration errors remained the most frequently reported antimicrobial incidents, followed by prescribing errors. Common themes included delayed administration, omitted doses and dosing errors.
- Data in relation to omitted doses of antibiotics is included within NLAG AMS report. Current data shows that 10% of the antibiotics prescribed were not administered with avoidable omissions at 6.9%; continued work is underway through AMS and medicines safety programmes to address avoidable omissions.
- The 'Allergy Aware Project' to raise awareness and prevent incidents was completed.

Other activities undertaken not already mentioned:

- Adult antimicrobial guideline updates uploaded onto Eolas app.
- Eolas QIP in progress to improve access and usability to support safer antimicrobial prescribing and improved compliance.
- Posters displayed in clinical areas to raise awareness of AWaRe classification of antibiotics to promote the use of Access agents where appropriate.
- New doctors' corporate induction.
- Induction training for pharmacy staff.
- IV to oral switch training at additives sessions for nursing staff.
- Activities during World Antibiotics Awareness Weak (WAAW) and European Antibiotics Awareness Day (EAAD) to promote appropriate use of antimicrobials.
- Contribution to strategic planning of the NHS workforce for antimicrobial stewardship in England.
- Microbiologist substantive posts filled.
- IPC practice development Matrons with AMS element in post.

Achievements:

- Two levels of sustained improvement in the reduction of Meropenem usage (April 2024 and again in December 2024).
- Sustained improvement in the reduction of Piperacillin/Tazobactam usage since May 2024.
- Improvement noted and acknowledged by ICB DIPC and NHSE AMR Regional lead.
- AMS Business Case approved

Key challenges:

- Unable to fully meet expectations – NHS targets:
  - 5% reduction in total antibiotic use by 2029 from 2019 baseline.
  - 70% usage from Access category by 2029.
- Operational issues impacting AMS:
  - Stock shortages and alternatives.
  - Variable prescriber engagement, compliance, and documentation.
  - Workforce pressures: targeted AMS ward rounds.
  - Antibiotic use in outpatient settings (OPAT/VW/H@H).
  - Current Department of Infection arrangements affecting timeliness and alignment of AMS activity.
- Operational and system complexity impacting delivery.
- Workforce gaps: data analyst and AMS/IC Medical Lead.

Key priorities for the coming year include:

- Update and delivery of the NLAG AMS Strategy aligned to the Trust priorities in response to NHS England "Act Now" antimicrobial resistance letter.
- Increasing Access antibiotic prescribing towards the 70% national target.
- Further reduction in Watch antibiotics, particularly co-amoxiclav and ciprofloxacin.
- Continued optimisation of IV-to-oral switch processes and stewardship ward-based interventions.
- Delivery of targeted education and training on antimicrobial resistance and stewardship.
- Improve clinical engagement through AMS champions.
- OPAT service review to mitigate risks identified. The role out of the OPAT (Outpatient antimicrobial therapy) in 2023/24 financial year and job description banding for an OPAT pharmacist and OPAT pharmacy technician in 2024/25 was successful however, the recruitment process was delayed due to issues with locating the funding allocated. This issue in relation to OPAT pharmacist was resolved by the end of 2025/26 financial year.

Summary

Overall, NLaG has demonstrated good progress in antimicrobial stewardship during 2025/26, achieving the national target for reduction in total antibiotic consumption by the end of 2025/26 financial year and delivering substantial reductions in key broad-spectrum agents including meropenem and piperacillin/tazobactam supporting the management of CPE outbreak. However, further work is required to maintain the 5% reduction in total antibiotic usage whilst improving the proportion of Access antibiotic prescribing and reduce reliance on Watch category agents, particularly co-amoxiclav and ciprofloxacin, to ensure alignment with national antimicrobial resistance

objectives and to support IPC challenges in relation to HCAIs and outbreak management.

2.3.11 Laboratories

Laboratory report HUTH (SHYPS)

The microbiology and virology laboratories based at Hull Royal Infirmary are part of the Scarborough, Hull and York pathology Service and provide lab services for HUTH. The clinical service is provided by a team of clinicians from the Infection department. The microbiology laboratory service is clinically led, and Dr Debbie Wearmouth was the network clinical lead in 2025-26. The laboratories underwent their yearly UKAS assessment in January 2026 and accreditation to the ISO 15189:2022 standard was successfully maintained.

The infection department supports the delivery of the infection services, which include the clinical advisory service, AMS support, IPC, the infectious disease ward on C7, and outpatient services including the ID clinic, HIV, Hepatitis and TB clinics. During 2025-26, the major change was the introduction of a new laboratory information system (LIMS), which was a major project, although with minimal impact on end users. Otherwise, the laboratory continues to provide comprehensive services, using up to date technology to ensure timeliness and accuracy of results to best support patient pathways. The service also supports the provision of molecular respiratory point of care testing in admission areas.

In October 2025, Virology supported the implementation of Blood Borne Virus (BBV) screening at HUTH. To ensure these infections are picked up as early as possible, all patients attending adult Emergency Department, aged 16 and over are tested for hepatitis B, hepatitis C and HIV. During the 6-month trial across both HUTH and NLAG, 70% (41,506) ED attendees consented to the screening. The programme successfully identified 89 patients with hidden blood-borne viruses, who had no knowledge of their illness. The virology team worked closely with the respective blood borne virus specialist clinical teams to ensure patients are supported throughout their pathway from diagnosis to treatment.

The laboratory is working towards the introduction of new methods to ensure the new *Candidozyma auris* national screening guidance. The lab continues to hold regular meetings to ensure compliance with the UK Standards for Microbiology Investigations which are evidence based, best practice standardised operating procedures and other relevant guidance.

Changes to rota patterns and improved blood culture machine capacity have led to a sustained improvement of 90% compliance with the recommendations that blood cultures are incubated within 4 hours of being taken, see Figure 48 below. Figure 48 shows that the service is also reported over 90% of neonatal blood cultures audited at 36 hours, as per the recommendations.

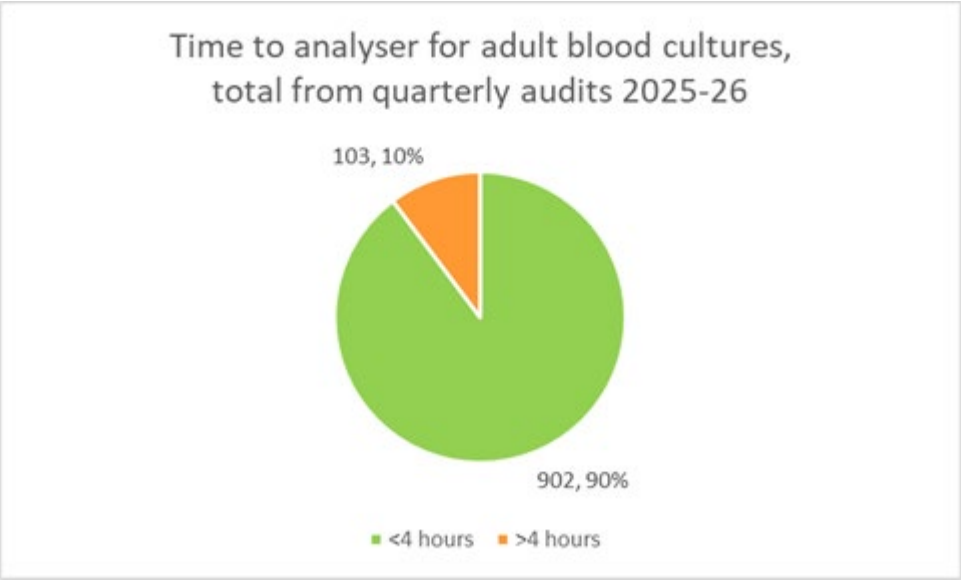


Figure 48: Adult blood cultures received in the HUTH laboratory within four hours of collection

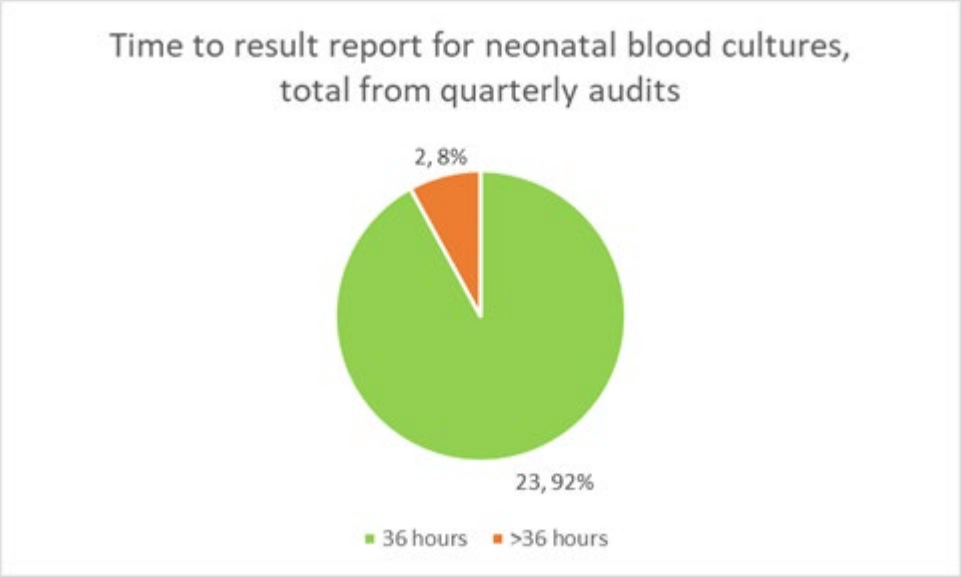


Figure 49: Neonatal blood cultures with a report released 36 hours after collection at HUTH

Laboratory report NLAG

Dr Reena Rambani has led the Microbiology Directorate since October 2024. During 2025-26 the consultant team provided the infection control lead doctor function, antimicrobial stewardship leadership and clinical microbiology and virology advice to NLaG and, under contract, to United Lincolnshire Teaching Hospitals, across six acute hospital sites. Dr Murugesh Jagadeesan, Dr Priyanka Chaskar and Dr Sawsan Awad took up post in May 2025, October 2025 and January 2026 respectively. Mr Nick Duckworth retired as Directorate Operational Manager in December 2025 and Ms Emily Kilpin has since taken up the post. A weekly antimicrobial stewardship ward round at NLaG, alternating between Diana Princess of Wales and Scunthorpe General so that one site is covered each week. Across the network the consultants authorise restricted antimicrobial agents, author and revise antimicrobial guidelines, contribute to infection prevention and control and decontamination committees, attend outbreak and incident meetings, take part in ward rounds and multidisciplinary team meetings, teach, and provide telephone and written advice to primary care and community providers.

In relation to NLAG, Path Links (the pathology service covering the Lincolnshire area) successfully retained accreditation from our Spring 2026 inspection and continues to be compliant with the United Kingdom Accreditation Service (UKAS) ISO15189:2022. Scunthorpe Hospital hosts the Microbiology and Virology laboratories and delivers a 24/7 service. While Pilgrim Hospital in Boston host a sister Microbiology laboratory. Both laboratories follow the same standard operating procedures covering two NHS Trusts (NLAG and United Lincoln H.

Path Links, as part of the East Midlands 2 (ME2) laboratory network of UKAS-accredited Microbiology laboratories, works collaboratively through an Operational Group of Microbiology Managers and Working Group of Microbiology Managers and Clinical Microbiology Leads. To enable service continuity, all ME2 Microbiology laboratories, whilst distinct entities, work together to support each other's services whenever possible to mitigate risk relating to service and/or supply disruptions. This summer, the ME2 laboratories began a phased joint procurement of new analysers with implementation to begin early next year. This will mean the majority will be standardised allowing for greater comparability of service provision and patient results. This is in addition to providing a potential opportunity to expand local testing and improve referred testing turnaround times by offering an enhanced regional based service.

Microbiology continues to work towards the Blood Culture Optimisation Pathway improvement to achieve the key pre-analytical target of blood culture collection to receipt of less than 4 hours. The ME2 analyser procurement includes analysers for Grimsby as well as other non-Microbiology sites within Lincolnshire, capacity for the current national recommendation of two sets of blood cultures per adult patient and requirement for the successful solution to be able to calculate the blood fill volume

for all adult blood cultures. The tender should be going out very shortly with analyser implementation early 2027.

In August 2025, there was implementation of molecular testing for Carbapenemase Resistant Enterobacteriaceae (CPE) by Polymerase Chain Reaction (PCR). This service supports the admission of patients to hospital and prevention of CPE outbreaks within the hospital environment.

In October 2025, Virology and Blood Sciences supported the implementation of Blood Borne Virus (BBV) screening at NLAG. During the 6-month trial across HUTH and NLaG, 70% (41,506) ED attendees consented to the screening. The programme successfully identified 89 patients with hidden blood-borne viruses, who had no knowledge of their illness. The initial trial and ongoing support from Path Links have been a huge success. This would not have been possible without the close cross-discipline collaboration of Blood Sciences and Serology departments at Scunthorpe Hospital. The NLAG Virology team work closely with Consultant Microbiologists and Nurse Specialists to ensure patients with positive results are supported.

Through our 24/7 service, we continue to support the effective flow of patients throughout the hospital by providing respiratory virus testing for COVID-19, influenza and RSV.

Path Links is currently working towards the implementation of a new laboratory information management system (LIMS). While this is having a significant impact on staffing resources, every effort is being made to minimise any impact on the processing of patient samples and maintain timely, high-quality laboratory services.

The team led the clinical and diagnostic response to carbapenemase-producing Enterobacterales at Diana Princess of Wales and Scunthorpe General Hospitals, both of which were reported as having no active outbreak by March 2026, and supported the Clostridioides difficile, norovirus and respiratory virus incidents of the year.

Escalation

The consultant microbiology establishment has remained unchanged at six whole-time equivalent posts since Path Links was formed in 2001, despite substantial growth in statutory infection prevention and control and antimicrobial stewardship duties, clinical complexity and laboratory activity, which exceeded one million specimens in 2025/26. The service now supports six acute hospitals and approximately 186 general practices across two sovereign trusts, yet has had no establishment review or additional investment; the recently approved specialty doctor post was funded by releasing 2.5 programmed activities from an already fully committed consultant pool. In March 2026, staffing fell to two available consultants for the entire network, requiring non-urgent work to be suspended and the Minimum Safe Service Delivery Model to be formally escalated to both Chief Medical Officers.

Current provision equates to 2.96 infection consultants per 1,000 acute beds—approximately 43–53% of reported national staffing levels—and no programmed activity is allocated to the infection control doctor function, despite national recommendations of 6–10 per week. The Board is therefore asked to recognise the immediate risk to service resilience, patient safety and sustained compliance with criteria 1 and 3 of the *Health and Social Care Act 2008 Code of Practice*, and to support the full service review and consultant workforce business case now in preparation.

2.3.12 Sepsis

Sepsis Team – Summary of Activity and Improvements (2025–2026)

- **Guidelines and clinical tools:** Completion of a single aligned sepsis guideline (GG017) covering all patient populations across HHP, with associated clinical assessment tools, pathways and supporting resources.
- **Performance audit:** Established a standardised adult sepsis audit aligned to GG017 to enable continuous performance monitoring across HUTH and NLaG, allowing direct comparison between sites.
- **HHP Sepsis Audit Report:** Published a Group-wide audit report in line with GG017, including analysis of performance and recommendations to inform organisational quality priorities.
- **Collaborative work with Paediatrics:** Provided specialist input to support development of bespoke paediatric screening and management tools, baseline audit, and education programme.
- **Data and case-study sharing:**
    - Established routine audit data sharing with ED in HUTH to support local quality improvement.
    - Progress is ongoing to establish similar processes in NLaG ED (dependent on identification of local audit lead).
    - Case studies identified through audit are shared with clinical areas to support learning and improvement.
- **Quality Improvement database:** Designed and implemented the Sepsis Quality Improvement database to enable the Group and individual clinical areas to monitor performance in priority indicators using automated real-time data.
- **Prevalence and mortality database:** Developed aligned databases across HUTH and NLaG to identify sepsis prevalence, mortality and patient outcomes by Health Group. Data is intended to inform mortality reviews and target quality improvement activity.

- **Staff knowledge survey:** Ongoing data collection to identify knowledge gaps and inform development of targeted in-house education.
- **E-learning development:** Drafted bespoke in-house e-learning package aligned to local guidelines, systems, audit findings and patient safety incidents. Awaiting a decision from MLOG regarding the future approach to mandated sepsis training before progress can be made.
- **ATHENS faculty support:** Ongoing contribution to faculty activities
- **Bespoke ward-based education:** Delivered multiple teaching sessions within ward team meetings across HHP in response to requests following Sepsis Team communications. Sessions well received by nursing staff.
- **EOLAS antimicrobial prescribing app development (NLaG):** Following audit findings of suboptimal prescribing practice, the NLaG EOLAS app was identified as not fit for purpose. Collaborative work with Pharmacy is ongoing to align with the HUTH version.
- **Collaborative quality improvement work:**
  - Following patient safety incidents, the Sepsis Team is supporting quality improvement work within HUTH ED/ECA to strengthen systems for sepsis recognition and response.
  - The Sepsis Team have submitted proposals to add digital changes to the CAS card (medical documentation in HUTH ED) to ensure sepsis is considered for every patient, and accurately diagnosed and documented by doctors in ED, whilst also providing a way of monitoring performance using automated data.
  - Quality Priorities – sepsis working groups have been established,
    1. Community,
    2. ED & Admission areas,
    3. Inpatient areas,
    4 Paediatric services. T
    The sepsis team have been allocated groups to be the subject matter leads.
- **PSII investigation and response:** Established process with the HUTH Safety Team for Sepsis Team involvement as expert reviewers in PSIIs, enabling identification of system learning and implementation of changes across the Group.
- **Post-sepsis support clinics:** Continued delivery of post-sepsis support clinics in HUTH, providing education about sepsis, safety-netting advice, prevention strategies (including vaccination advice), self-management guidance, and signposting for ongoing health or psychological support. Patient feedback average satisfaction rating 8/10.
- **National Sepsis Team Forum:** HHP continues to organise and chair a national forum for sepsis specialist teams to share practice, strategy, research and quality improvement learning, and to support peer networking.

- **Clinical coding improvement:** Plans finalised to improve accuracy and depth of clinical coding for patients reviewed by the Sepsis Team, to support improved data quality and outcome monitoring.

Evidence-based recommendations for future sepsis related quality priorities:

- Prioritise ensuring adequate patient monitoring (early warning assessments) throughout the organisation.
- Prioritise reducing time delays from the point of antibiotic prescribing to administration
- Prioritise improved access to reference resources for doctors and ACPs on red and amber flag criteria, to support accurate and consistent diagnosis of sepsis.
- Prioritise improved compliance with the blood culture pathway to support the microbiological confirmation of septicaemia.
- Prioritise improved antimicrobial prescribing according to guidelines in NLaG
- Ensure all doctors and nurses are given regular appropriate training in identifying, assessing and managing suspected sepsis. This should include:
    - risk stratification strategies in line with local systems
    - local protocols for early treatments, including antibiotics and intravenous fluids criteria and pathways for escalation, in line with their health care setting.

2.3.13 Occupational health

The Occupational Health Service oversees the Trust's occupational immunisation and vaccination programme, ensuring full compliance with Department of Health requirements designed to protect staff and patients from the transmission of communicable diseases. Delivery of the programme is aligned with the DIPC programme for the HHP Group. Immunisation and vaccination are undertaken at the commencement of employment, throughout employment where clinically indicated, and as part of contact tracing activity following exposure incidents.

The Occupational Health Service maintains active involvement in both the Operational and Strategic Infection Reduction Committees and collaborates closely with the Infection Reduction Team during outbreak situations, leading on staff follow-up, assessment, and intervention. Over the past year, joint working arrangements have been strengthened, supported by specialist IPC clinical guidance that has enabled the appropriate use of prophylactic treatment for staff, such as during scabies outbreaks. This enhanced approach has facilitated clearer clinical leadership and more effective management of outbreak responses.

Body fluid exposure reporting is now consistently captured across both the North and South Bank through the digital Occupational Health record system, providing a

standardised method for recording incidents and identifying exposure hotspots and associated risk patterns. This work is undertaken in conjunction with Risk Governance and Health and Safety to ensure robust oversight of emerging trends. Findings are formally reported through OIRC and SIRC, as well as to the Health and Safety Committees, supporting comprehensive governance assurance and alignment with organisational infection prevention priorities.

The 2025/26 Winter Healthcare Worker Influenza Vaccination Programme was delivered through a structured task and finish approach involving all key stakeholders, with planning commencing in April and continuing through to the October 2025 launch in accordance with national guidance to optimise winter preparedness. Delivery was supported by temporary staffing, the Occupational Health Service, and Corporate Nursing, utilising static vaccination hubs during the initial weeks followed by roving teams deployed across all sites. Peer vaccinators were enabled where operationally feasible, particularly within high throughput areas such as theatres. This coordinated model facilitated the successful implementation of the programme, as summarised in the table below.

ImmForm Staff Group - HUTH	Flu Vaccine Received	Number of Active Employees	Uptake (%)
All doctors	839	1544	54.3%
Qualified nurses, midwives and health visitors	1386	2699	51.4%
All other professionally qualified clinical staff	652	1116	58.4%
Support to clinical staff	913	2019	45.2%
Not ImmForm Staff Group	15	34	44.1%
Grand Total	**3805**	**7412**	**51.3%**

Figure 50: HHP healthcare worker influenza vaccination programme, 2025/26: uptake summary

ImmForm Staff Group - NLaG	Flu Vaccine Received	Number of Active Employees	Uptake (%)
All doctors	419	732	57.2%
Qualified nurses, midwives and health visitors	1084	2038	53.2%
All other professionally qualified clinical staff	446	784	56.9%
Support to clinical staff	1137	2447	46.5%
Not ImmForm Staff Group	3	8	37.5%
Grand Total	**3089**	**6009**	**51.4%**

Figure 51: HHP healthcare worker influenza vaccination programme, 2025/26: delivery summary

2.4 Local service improvements

- **IPC Policy harmonisation:** The 122 legacy IPC policies were reviewed and rationalised. Eight unified HHP policies were introduced, 49 obsolete policies were archived, and patient information leaflets were fully aligned across both organisations.
- **Digital IPC systems:** Electronic IPC assessments and reporting were developed through Nervecentre, alongside preparation for ICNET. These changes support earlier identification of infection risks, improved isolation prioritisation, surveillance and outbreak management.
- **CPE and multidrug-resistant organism control:** HUTH completed the rollout of CPE screening and rapidly contained a local outbreak. At NLaG, the prolonged CPE outbreak was brought to closure following universal and weekly screening, rapid PCR testing, strengthened patient tagging and isolation, a dedicated CPE ward, enhanced cleaning, HPV decontamination, environmental remediation and tighter controls on carbapenem prescribing.
- **Cleaning and decontamination:** NLaG adopted nationally compliant disinfectants and established responsive cleaning arrangements. Across HHP, deep cleaning, HPV and UV technologies, equipment decontamination, single-use items where appropriate, and commode audits were used to address environmental transmission risks.
- **CAUTI improvement:** A partnership-wide catheter-associated urinary tract infection programme established baseline surveillance, developed a dashboard, standardised policies and training, created electronic trial-without-catheter pathways and prepared for equipment standardisation and more timely catheter removal.
- **Antimicrobial stewardship:** Prescribing assurance was strengthened, carbapenem access was restricted in NLAG during the CPE response, intravenous-to-oral switching was promoted, and improvement work focused on prescribing review, alignment with guidance and executive oversight of antimicrobial resistance.
- **Outbreak management:** Coordinated multidisciplinary responses successfully controlled CPE and VRE outbreaks. The response included enhanced surveillance, admission and discharge screening, isolation or cohorting, environmental controls, deep cleaning and external partnership working.
- **Education and workforce development:** Practice Development Matrons were appointed to each Trust strengthen IPC education. Targeted education covered CPE, antimicrobial resistance, fundamental IPC practice and

competency-based donning and doffing of PPE for high-consequence infectious diseases.

- **Incident reporting and learning:** Risks and incidents were moved to the Ulysses system. Work began to improve coding, validation and alignment with national HCAI reporting, including targeted staff education and development of second-level coding.

2.5 Conclusion

During 2025–26, Humber Health Partnership made important progress in strengthening infection prevention, control and cleanliness arrangements across HUTH and NLaG, including improved governance and assurance, policy harmonisation, digital surveillance, antimicrobial stewardship and the successful control of significant outbreaks. However, performance against several healthcare-associated infection indicators remains a significant concern and requires dedicated focus organisation wide. This, taken together with continuing risks relating to the estate, isolation capacity, environmental cleanliness, audit delivery, staff compliance and winter resilience, demonstrates that sustained improvement is still required. The priority for 2026–27 is therefore to translate the learning and infrastructure developed during the year into consistent practice across every clinical area, supported by clear accountability, reliable data, targeted investment and measurable improvement trajectories. Continued Board oversight and organisational commitment will be essential to reduce avoidable infection, protect patients and staff, and provide assurance that safe, effective and equitable standards are embedded across the Partnership.

3 Recommendations

1. **Secure Board-led organisational engagement and ownership of IPC** with visible executive leadership, clear accountability from ward to Board, IPC embedded in operational and strategic decision-making, and routine scrutiny of performance, risks and improvement actions.

2. **Establish a single, measurable HHP improvement plan**
   Agree a small set of partnership-wide priorities, each with an executive owner, clinical lead, milestones, resources and outcome measures.

3. **Deliver targeted HCAI reduction programmes**

a. Treat CDI, MSSA and Gram-negative bloodstream infections as formal quality priorities.
b. Introduce standardised multidisciplinary reviews of hospital-associated CDI and selected BSIs, with actions tracked to closure and regular thematic reviews.
c. Implement the CDI improvement plan covering diagnosis, isolation, case management, antimicrobial exposure, cleaning, equipment, commodes, learning and education.
d. Fully implement the CAUTI programme at ward level, with reliable catheter indication, daily review, timely removal and outcome surveillance.
e. Prioritise vascular-access insertion and maintenance, ANTT, line necessity and specialist vascular-access support.

4. Strengthen workforce capability and accountability

a. Implement role-specific IPC competencies aligned with the NHS England education framework, supported by ward-level coaching.
b. Protect sufficient specialist IPC, microbiology, AMS, surveillance, education and data-analysis capacity.
c. Embed IPC objectives in care-group performance reviews and management processes.
d. Use supportive improvement first, but apply clear escalation where persistent non-compliance places patients or staff at risk.

5. Improve fundamental IPC reliability

a. Replace reliance on self-reported compliance with observation, competency assessment and triangulation with infection outcomes.
b. Focus on hand hygiene, PPE, bare below the elbows, ANTT, device care, isolation practice and equipment decontamination.
c. Require time-limited recovery plans for poorly performing wards, with repeat audit and care-group accountability.
d. Resolve the face-fit testing gap through a sustainable group-wide programme, clear ownership and capacity planning

6. Sustain MDRO control after outbreak closure

a. Retain proportionate CPE and VRE surveillance, rapid diagnostics, electronic patient alerts and reliable transfer communication.
b. Maintain clear triggers for escalation, enhanced screening, cohorting and incident management.

c. Complete post-outbreak reviews and confirm that temporary controls have either become sustainable business-as-usual arrangements or have a documented replacement.
d. Track delivery of environmental remediation, including sinks, drains and other identified reservoirs.

7. Strengthen antimicrobial stewardship

a. Make antimicrobial review at 48–72 hours, documented indication, duration, microbiology sampling and intravenous-to-oral switch routine assurance measures.
b. Provide specialty-level feedback on total use, Watch and Reserve agents, carbapenems and fluoroquinolones.

8. Eliminate the audit backlog and improve data quality

a. Ensure completion of the annual audit programme with protected capacity and automated escalation of overdue actions.
b. Develop one HHP dashboard covering infections, outbreaks, IPC practice, cleanliness, isolation, antimicrobial use, training, estates risks and action closure.
c. Include patient harm, bed closures and operational consequences alongside process measures.

9. Raise environmental cleanliness and decontamination standards

a. Standardise responsibilities for clinical and facilities staff, particularly for shared equipment and discharge cleaning.
b. Use technical and efficacy audits, visible star ratings and prompt corrective action for areas scoring below standard.
c. Maintain responsive deep-cleaning and enhanced decontamination capacity but use HPV and UV only within defined evidence-based protocols.
d. Establish a dedicated, protected capital fund across both trusts to directly purchase the minor environmental required to restore basic compliance with PLACE.

10. Address the built-environment and isolation risks

a. Produce an executive-prioritised IPC estates plan covering isolation capacity, ventilation, water, sinks, drainage, bed spacing and ageing clinical environments.
b. Continue to link capital decisions to infection risk and operational impact, not solely estate condition.

c. Include the requirement for ward decant facilities to allow deep cleaning, structural redecoration, and maintenance teams to systematically clear and overhaul aging clinical areas without compromising acute trust bed capacity. This area can also then be used to support winter pressures requirements.
d. Establish documented mitigations when appropriate isolation is unavailable and track each occurrence.
e. Continue to ensure IPC involvement from the earliest design stage of all capital and refurbishment projects.

11. Build winter and outbreak resilience early

a. Complete a clinically led winter IPC plan before seasonal pressure begins, with scenarios for influenza, norovirus, COVID-19, RSV and MDRO outbreaks.
b. Include isolation allocation, cohorting, testing, cleaning capacity, PPE, masking decision pathways, temporary escalation spaces and discharge arrangements.
c. Exercise the plan with NHS and social-care partners. The **NHS England winter planning expectations for 2026–27** require jointly developed, tested and Board-assured plans with named executive leadership.

12. Complete HHP standardisation

a. Finish the remaining policy harmonisation to the stated timetable and maintain one accessible source of current guidance.
b. Standardise transfer documentation, screening pathways, outbreak definitions, audit tools and patient information.
c. Test implementation through clinical audit rather than relying on publication alone.

Thanks to the following contributors
Estates and capital team

Facilities teams
AMS lead pharmacists, Lorraine Cullen and Ana Megias-Bas
Sepsis team, Donna Gotts, Laura Davis and Adele Lloyd
Microbiology team, Reena Rambani and Jo Frost
Occupational Health, Peter O'Sullivan

4. Glossary

ACAT - Advisory Committee on Antimicrobial Therapy, name for HUTH AMS committee
ACE – Accrediting Excellence – is referring to the organisation's ward quality and safety assurance scheme
AE – Authorising Engineer is an independent specialist advisor, appointed from outside the organisation who provides impartial advice on the application of statutory requirements, Healthcare Technical guidance and good practice within a defined technical area eg Water safety, Ventilation
AHPs - Allied Health Professional is a registered health professional from a range of disciplines including operating department practitioners, physiotherapists, occupational therapists, speech and language therapists, diagnostic and therapeutic radiographers, and paramedics.
AMR – Antimicrobial resistance: the ability of microorganisms, including bacteria, viruses, fungi and parasites, to survive or continue to grow despite exposure to an antimicrobial medicine that would normally inhibit or kill them. This can make infections more difficult to treat.
AMS – Antimicrobial stewardship: a coordinated approach to the responsible use of antimicrobial medicines, including selecting the appropriate agent, dose, route and duration, to optimise clinical outcomes, minimise avoidable harm and reduce the emergence and spread of antimicrobial resistance.
ANTT – Aseptic Non-Touch Technique: a standardised clinical practice framework used to protect key parts and key sites from contamination during invasive clinical procedures, thereby reducing the risk of infection. Examples include the insertion and ongoing management of vascular access devices and urinary catheters, and wound care.
BAF – Board Assurance Framework: in this report, the IPC Board Assurance Framework is a structured self-assessment and assurance tool used to evaluate organisational compliance with the ten criteria of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and its related key lines of enquiry. It identifies evidence, gaps, risks and required improvement actions for Board oversight.

BCP – Business Continuity Plan is a documented strategy outlining the specific steps an organization will take to ensure its critical functions and essential operations can continue, or be quickly resumed, during and after a disruptive event such as a natural disaster, cyberattack, or pandemic.

C. DIFF - *Clostridioides difficile* is a spore-forming bacterium that can colonise the bowel without causing symptoms. Disruption of the normal gut microbiota, commonly following antimicrobial exposure, can allow the organism to produce toxins and cause infection, typically resulting in diarrhoea and colitis and, in severe cases, toxic megacolon, sepsis or death.

CHH – Castle Hill Hospital, an acute hospital site within Hull University Teaching Hospitals.

COHA – Community onset, healthcare associated, a surveillance category for a laboratory-confirmed infection in which the specimen is taken in the community or within the early period after hospital admission, but the patient has had a recent admission to the reporting hospital within the nationally defined timeframe. The precise timeframe varies by the organism under surveillance.

CPE – Carbapenemase Producing Enterobacterales. Enterobacterales are a family of gram negative bacteria that reside within the bowels. Carbapenemase producing Enterobacterales produce carbapenemase enzymes, which can inactivate carbapenem antibiotics and often confer resistance to other antimicrobial classes. CPE may colonise the bowels or may cause serious infections that are difficult to treat.

CQC – Care Quality Commission, independent regulator of health and social care services in England.

CQUIN - Commissioning for Quality and Innovation. An NHS payment mechanism through which achievement of specified quality improvement goals may be linked to a proportion of provider income, subject to the national contractual arrangements applying in the relevant year.

CSSD - Central Sterile Services Department. The service responsible for the controlled decontamination, inspection, assembly, packaging, sterilisation and supply of reusable surgical instruments and other approved medical devices in accordance with relevant quality-management and decontamination standards.

DIPC - Director of Infection Prevention and Control (DIPC). The designated senior leader who reports directly to the Chief Executive and Board on the organisation's systems for preventing and controlling infection. The DIPC provides visible leadership, challenges inappropriate practice and ensures that the Board receives assurance on compliance, risks, incidents and improvement priorities.

DPOW – Diana Princess of Wales Hospital, an acute hospital site within Northern Lincolnshire and Goole NHS Trust.

E. coli - Escherichia coli: a species of Gram-negative bacteria commonly found in the human gastrointestinal tract. Most strains are harmless, but some can cause

infections, including urinary tract, intra-abdominal and bloodstream infections, while particular strains may cause gastrointestinal disease.

EF&D - Estates, Facilities & Development within the NHS, a department responsible for the physical infrastructure of hospitals and healthcare sites.

EHO - Environmental Health Officer protects public health by ensuring environments and workplaces are safe, healthy, and hygienic, especially in areas like food safety, housing, and noise pollution.

EOLAS - Eolas Medical is a knowledge management and communication platform for healthcare professionals that consolidates and provides instant access to critical medical information, clinical guidelines, and educational content on a single web and mobile platform.

ePMA - Electronic Prescribing and Medicines Administration in the healthcare sector, a digital system for managing prescriptions and medications to improve patient safety and efficiency.

FFP3 - Filtering Face piece 3, a European standard for disposable respirator masks that provides the highest level of protection among the FFP classes, filtering at least 99% of airborne particles such as dust, viruses, and bacteria.

FR - Functional Risk category: under the National Standards of Healthcare Cleanliness, the classification assigned to a functional area according to the nature of activity undertaken and the consequent risk to patients, staff and visitors. The category informs the required cleaning outcomes, frequencies, responsibilities and audit arrangements.

GDH - Goole District Hospital, a district hospital site within Northern Lincolnshire and Goole NHS Trust.

GNBSIs - Gram-negative bloodstream infections: bloodstream infections caused by Gram-negative bacteria. National mandatory surveillance includes Escherichia coli, Klebsiella species and Pseudomonas aeruginosa bloodstream infections.

GROUP – Group refers to both Northern Lincolnshire and Goole NHS Trust and Hull University Teaching Hospitals Trust. The Group is named Humber Health Partnership.

HCAIs – Healthcare associated infections. Infections that develop as a result of receiving healthcare, whether in hospital or another care setting. They may become apparent during care or after discharge and include infections associated with procedures, devices, treatment or transmission within the healthcare environment.

HHP - Humber Health Partnership, incorporating two Acute NHS Trusts, Northern Lincolnshire and Goole NHS Trust and Hull University Teaching Hospitals.

HOHA - infection refers to hospital-onset healthcare-associated, a classification for an infection that occurs in a hospital setting after a patient has been admitted.

HPV - Hydrogen peroxide vapour: an automated method used to decontaminate enclosed healthcare environments after appropriate cleaning, particularly following the care of patients with certain transmissible infections or during outbreak management.

HUTH – Hull University Teaching Hospitals NHS Trust, comprising Hull Royal Infirmary and Castle

HRI – Hull Royal Infirmary, an acute hospital site within Hull University Teaching Hospitals, providing tertiary services.

HTM - Health Technical Memorandum, which provides comprehensive best practice guidance on the design, installation, and operation of specialised building and engineering technology within healthcare settings. HTMs are essential for ensuring that healthcare facilities adhere to best practices, meet regulatory standards, and function safely and effectively throughout their lifecycle.

HUTH – refers to Hull University Teaching Hospitals NHS Trust, combining two sites, HRI & CHH.

ICB – Integrated Care Board: a statutory NHS organisation responsible for planning health services, managing the NHS budget and working with partner organisations to improve population health and reduce health inequalities within its integrated care system.

ICD – Infection Control Doctor: a senior doctor with specialist expertise in infection prevention and control who provides clinical, operational and strategic advice to the Trust, supports surveillance and outbreak management, and advises the Director of Infection Prevention and Control.

ICNET – a clinical surveillance software platform that supports infection prevention and control and antimicrobial stewardship through the collection, review and reporting of relevant patient and microbiology data.

INFLUENZA - Influenza – an acute respiratory infection caused by influenza viruses. It commonly causes fever, cough, headache, muscle aches and fatigue and can lead to serious complications, particularly in people at increased clinical risk.

IPCC - Infection Prevention, Control and Cleanliness: the systems and practices used to prevent and reduce the transmission of infection and to maintain a clean, safe healthcare environment for patients, staff and visitors.

IPCT - Infection Prevention and Control Team: a multidisciplinary specialist team that provides advice, surveillance, education, assurance and support for the prevention and management of infection across healthcare services.

IVOS - intravenous-to-oral switch: the clinically appropriate change from intravenous antimicrobial treatment to an oral formulation, following review against agreed criteria.

KLEBSIELLA - Klebsiella – a genus of Gram-negative bacteria within the order Enterobacterales. Some species can cause healthcare-associated infections, including urinary tract, respiratory and bloodstream infections.

KLOEs – Key Lines of Enquiry: structured questions used within the IPC Board Assurance Framework to assess evidence of compliance, identify gaps and support organisational assurance.

KPI - Key Performance Indicator: a measurable value used to assess performance and progress against a defined objective or standard.

LIMS - Laboratory Information Management System: software used to manage laboratory workflows and associated data, including specimen registration, test processing, results and reporting.

MDRO SCREENING - the collection of specimens from specified body sites to identify carriage of multidrug-resistant organisms, such as meticillin-resistant Staphylococcus aureus or carbapenemase-producing Enterobacterales. Screening is undertaken according to national guidance, local policy and the patient's clinical or epidemiological risk factors.

MEASLES - Measles – a highly infectious viral illness that typically causes fever, cough, runny nose, conjunctivitis and a characteristic rash. It can cause serious complications, including pneumonia and encephalitis.

MRSA - meticillin-resistant *Staphylococcus aureus:* a strain of S. aureus that is resistant to meticillin and related beta-lactam antibiotics. It may colonise the skin or nose without causing symptoms but can cause serious infection, particularly in vulnerable patients.

MSSA - MSSA – meticillin-susceptible *Staphylococcus aureus*: strains of S. aureus that remain susceptible to meticillin and related beta-lactam antibiotics. S. aureus commonly colonises the skin or nose without causing symptoms but can cause a range of infections, including bloodstream infection.

NAP (TARGETS) - NAP targets – the commitments and targets set out in Confronting antimicrobial resistance 2024 to 2029, the United Kingdom's second five-year national action plan for antimicrobial resistance.

NHSE - NHS England: the statutory body that leads the NHS in England, allocates resources, commissions specified services and oversees planning, performance and improvement.

NICE - National Institute for Health and Care Excellence: an independent public body that develops evidence-based guidance and quality standards for health, public health and social care in England.

NIPC FRAMEWORK - National IPC Board Assurance Framework – a self-assessment framework that supports healthcare organisations to assess and provide assurance against the infection prevention and control requirements of the Health and Social Care Act 2008 Code of Practice.

NIPCM – NIPCM – National Infection Prevention and Control Manual for England: evidence-based national guidance on infection prevention and control practice for health and care staff and organisations in England.

NLAG - NLaG – Northern Lincolnshire and Goole NHS Foundation Trust, providing acute and community services principally through Diana, Princess of Wales Hospital, Scunthorpe General Hospital and Goole and District Hospital.

NOROVIRUS - Norovirus – a highly infectious virus that commonly causes sudden-onset vomiting and diarrhoea and can lead to outbreaks in healthcare and community settings.

OCS - the facilities management provider responsible for specified services at HUTH, including healthcare cleaning.

OIRC – Operational Infection Reduction Committee: the multidisciplinary committee that monitors operational infection prevention and control performance, risks and improvement actions across Humber Health Partnership and escalates matters requiring strategic oversight.

OPAT - Outpatient Parenteral Antimicrobial Therapy: a specialist service that enables clinically suitable patients to receive intravenous antimicrobial treatment without remaining in hospital, with appropriate clinical assessment, monitoring and follow-up.

PFI - Private Finance Initiative: a procurement model under which private-sector organisations financed, designed, built and, in many cases, maintained public infrastructure through long-term contractual arrangements.

PLACE - PLACE – Patient-Led Assessments of the Care Environment: annual assessments in which patients and members of the public evaluate aspects of the healthcare environment, including cleanliness, condition, appearance, maintenance, privacy, dignity, food and support for people with dementia or a disability.

POCT - Point-of-Care Testing: diagnostic testing performed near the patient rather than in a central laboratory, enabling results to inform clinical decisions more rapidly.

PPE - Personal Protective Equipment: equipment worn to protect the user from health and safety risks. In healthcare, PPE may include gloves, aprons or gowns, masks, respirators and eye protection, selected according to the anticipated exposure and relevant risk assessment.

PPS – Point Prevalence Survey: a survey that measures the proportion of a defined population with a condition, exposure or treatment at a specified point in time. In IPC and antimicrobial stewardship, it may be used to measure healthcare-associated infections or antimicrobial use.

PSEUDOMONAS - Pseudomonas – a genus of Gram-negative bacteria. Pseudomonas aeruginosa is an opportunistic pathogen that can cause healthcare-associated infections, particularly in people who are critically ill, immunocompromised or have invasive devices.

QIP - Quality Improvement project: a structured, systematic initiative that uses defined aims, measurement and iterative change to improve patient safety, quality of care, outcomes or service efficiency.

SCABIES - Scabies – a contagious skin infestation caused by the mite Sarcoptes scabiei, which burrows into the skin and commonly causes intense itching and a characteristic rash.

SGH Scunthorpe General Hospital, an acute hospital within Northern Lincolnshire and Goole NHS Foundation Trust.

SHYPS – SHYPS – Scarborough, Hull and York Pathology Service: the networked pathology service supporting participating NHS organisations across Scarborough, Hull and York.

SICP - Standard Infection Control Precautions: the minimum infection prevention and control measures that must be used for all people receiving care, regardless of whether infection is known or suspected, to reduce the risk of transmission from recognised and unrecognised sources.

SIRC – Strategic Infection Reduction Committee: the senior multidisciplinary committee that provides strategic oversight and assurance of infection prevention and control performance, risks and improvement priorities across Humber Health Partnership, escalating significant matters through the appropriate governance route to the Trust Boards.

SOP's - Standard Operating Procedures: approved, detailed written instructions that describe how defined tasks or processes must be carried out consistently to support safety, quality, efficiency and compliance.

SSI - Surgical Site Infection: an infection occurring in the part of the body where an operation took place. It may involve the skin and subcutaneous tissue, deeper soft tissues, or organs and spaces manipulated during the procedure.

TBP's - Transmission-Based Precautions: additional infection prevention and control measures used alongside Standard Infection Control Precautions when caring for people with a known or suspected infection or colonisation that may spread by contact, droplet or airborne routes.

UKAS (LABS) - United Kingdom Accreditation Service: the national accreditation body that independently assesses laboratories against relevant recognised standards, such as ISO 15189 for medical laboratories, providing assurance of their competence, impartiality and consistent operation.

UKHSA - UK Health Security Agency: the national body responsible for protecting people from infectious diseases and environmental, chemical, radiological and other health hazards through surveillance, scientific expertise, preparedness and emergency response.

VRE - vancomycin-resistant enterococci: enterococcal bacteria that are resistant to vancomycin. They may colonise the gastrointestinal tract without causing symptoms but can cause infection, particularly in vulnerable patients.

WSG – Water Safety Group: a multidisciplinary group that oversees water safety governance, reviews risks and incidents, monitors implementation of the Water Safety Plan and provides assurance that water systems are managed in accordance with relevant national guidance.

WSP – Water Safety Plan: a documented, risk-based approach to identifying, assessing and controlling hazards associated with healthcare water systems, including defined control measures, monitoring arrangements, responsibilities and escalation processes.

5 References

WHO Guidelines on Hand Hygiene in Health Care: First Global Patient Safety Challenge Clean Care Is Safer Care [ncbi.nlm.nih.gov]

WHO global report on infection prevention and control 2024 Global report on infection prevention and control 2024

Guest JF, Keating T, Gould D*, et al* Modelling the annual NHS costs and outcomes attributable to healthcare-associated infections in England *BMJ Open* 2020; **10:** e033367. doi: 10.1136/bmjopen-2019-033367

WHO World hand hygiene day key facts and figures Key facts and figures

UKHSA Healthcare associated infections (HCAI): guidance, data and analysis Healthcare associated infections (HCAI): guidance, data and analysis - GOV.UK

6 Appendices

Appendix 1 -Definitions of health care acquired infections

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days (COHA)
- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)
- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 84 days (COCA)

Appendix 2 Infection prevention and control team structure

Amanda Stanford / Heather Mcnair were the Trust **Director of Infection Prevention and Control (DIPC)** and was responsible for leading and managing the Trust's Infection Prevention Control & Cleanliness (IPCC) plan during 2025-26, with executive responsibility for infection prevention and control during 2025-26. Wendy Millard as **Group Deputy Director for Infection Prevention and Control (Deputy DIPC),** strategically leading the Group Infection Prevention Control and Cleanliness service. Jo Ledger, Group Deputy Chief Nursing Officer, holds the Infection Prevention and Control portfolio during 2025-26. During 2025-26 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist at HUTH and Dr Shaktijit Dave, Consultant Microbiologist at NLAG.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act (2008): code of practice on the prevention and control of infections. During 2025-26, **Strategic Infection Reduction Committee (SIRC)** continued to meet. SIRC is a performance management and assurance committee, responsible for holding the Care Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. Attendance by the senior care group nursing and medical representatives has been variable.

The **Operational Infection Reduction Committee** (OIRC), continued to meet monthly. During 2025-26 this committee was chaired by the HUTH Infection Control Doctor. The Committee is a forum for the Care Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been reasonable, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the HHP Board and Care Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, the Department of Infection, Occupational Health, the Estates & Facilities Directorate, and Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding infection prevention and control activity within the Group, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Group on its statutory requirements in relation to infection prevention and control and the decontamination of medical and surgical equipment.

Other relevant committees

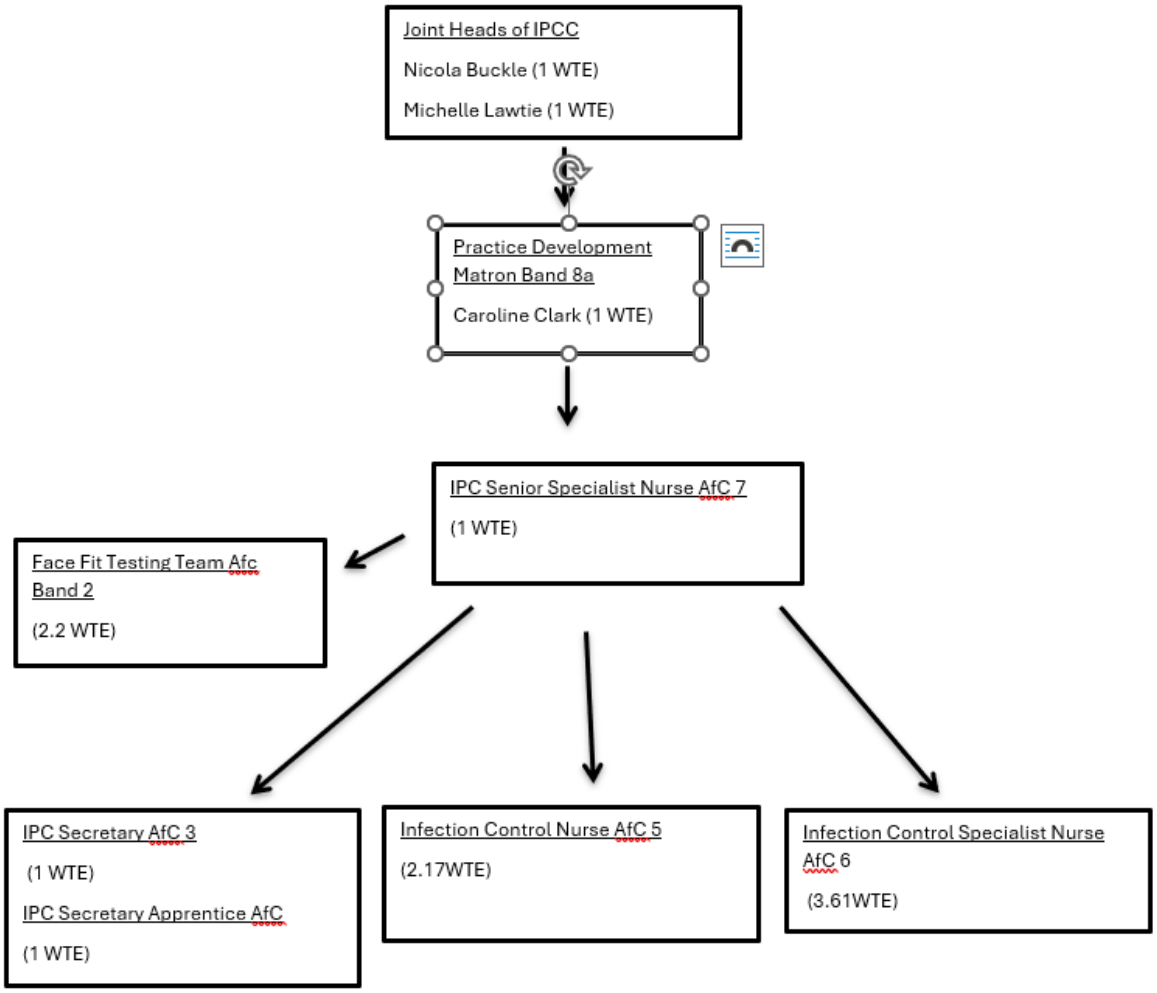
The Trust has specific committees responsible for decontamination, ventilation safety and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. Attendance by the care groups and departmental representatives has improved as the meeting as evolved across both sites.

The formation of a Command Structure to support the Partnership during peaks of infection and operational challenges with associated meetings such as operational weekend planning meetings has further supported the IPC with either the DIPC and/or ICD in attendance, to inform and advise.

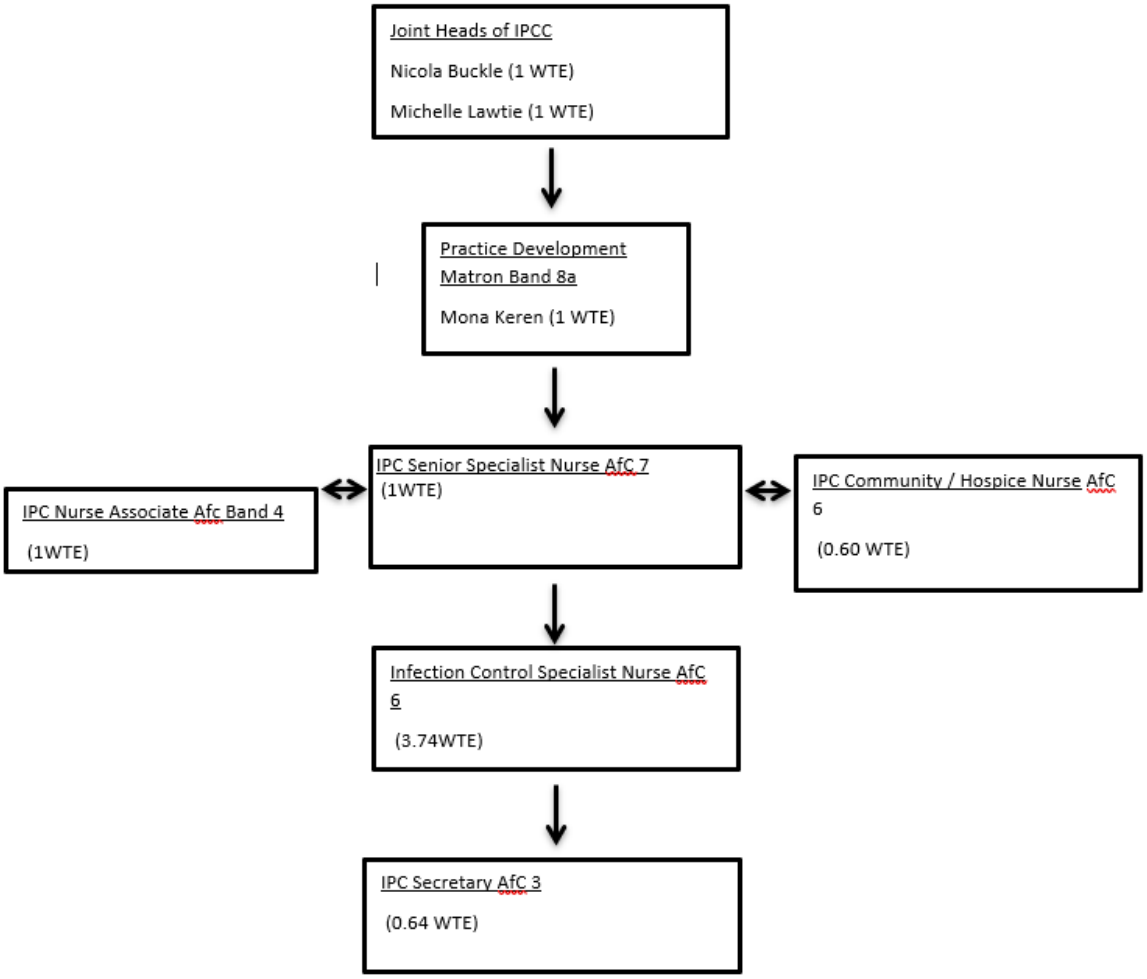
The wider infection prevention and control team

The clinical IPC team is composed of an Infection Prevention and Control Doctor for each Trust, two Heads of Infection Prevention Control and Cleanliness, covering the five hospitals and community services in the Group model, there are a team of specialist Infection Prevention and Control nurses and supporting secretarial and administrative staff for both HUTH and NLAG, as set out in the below structures for the operational IPCTs.

HUTH Infection Prevention & Control Team 2026



NLaG Infection Prevention & Control Team 2026



Humber Health Partnership

Appendix 3 - Theatre Closure Plans HUTH and NLaG

HUTH Theatre Closure Plan

Site	Theatre	Location	Start date of	Deep Clean Completed	Infection Control Plates	Hand back To Theatres
CHH	Cardio Theatre 15 (UCAS)	Block 90	Friday 9th January 2026 (16:00)	Monday 12th January 2026 (22:00)	Not Required	Tuesday 13th January 2026 (08:00)
CHH	Cardio Theatre 16 (UCAS)	Block 90	Friday 30th January 2026 (16:00)	Monday 2nd February 2026 (22:00)	Not Required	Tuesday 3rd February 2026 (08:00)
CHH	Cardio Theatre 14 (UCAS)	Block 90	Friday 20th February 2026 (16:00)	Monday 23rd February 2026 (22:00)	Not Required	Tuesday 24th February 2026 (08:00)
CHH	Cardio Theatre 11	Block 90	Friday 6th March 2026 (16:00)	Sunday 8th March 2026 (22:00)	Monday 9th March 2026 (09:00)	Wednesday 11th March 2026 (09:00)
CHH	Cardio Theatre 12 (UCAS)	Block 90	Friday 20th March 2026 (16:00)	Monday 23rd March 2026 (22:00)	Not Required	Tuesday 24th March 2026 (08:00)
2025-2026						
CHH	Theatre 10 (Urology)	Block 34	Saturday 28th March 2026 (08:00)	Tuesday 31st March 2026 (22:00)	Wednesday 1st April 2026 (09:00)	Friday 3rd April 2026 (09:00)
CHH	Theatre 9 (Gynae)					
CHH	Theatre Recoveries 9&10					
CHH	Theatre 3 (Orthopaedic) (UCAS)	Block 32	Saturday 4th April 2026 (08:00)	Monday 6th April 2026 (22:00)	Not Required	Tuesday 7th April 2026 (08:00)
W&C	Theatre 1 W&C	Womens & Childrens	Wednesday 8th April 2026 (08:00)	Sunday 12th April 2026 (16:00)	Monday 13th April 2026 (08:00)	Wednesday 15th April 2026 (12:00)
HRI	IRT 1	2nd North block.	Friday 10th April 2026 (08:00)	Saturday 11th April 2026 (16:00)	Sunday 12th April 2026 (0800)	Tuesday 14th April 2026 (08:00)
HRI	IRT2	2nd floor North Block	Friday 24th April 2026 (08:00)	Saturday 25th April 2026 (16:00)	Sunday 26th April 2026 (0800)	Tuesday 28th April 2026 (08:00)
CHH	Day Surgery Centre Theatres 1& 2	Block 75	Saturday 2nd May 2026 (08:00)	Monday 4th May 2026 (22:00)	Not Required	Tuesday 5th May
W&C	Theatre 4 W&C	Womens & Childrens	Wednesday 6th May 2026 (08:00)	Sunday 10th May 2026 (16:00)	Monday 11th May 2026 (08:00)	Wednesday 13th May 2026 (12:00)
CHH	Day Surgery Centre Recovery 1&2	Block 75	Friday 8th May 2026 (14:00)	Sunday 10th May 2026 (22:00)	Not Required	Monday 11th May 2026 (08:00)
CHH	Day Surgery Centre Theatre 6	Block 75	Friday 8th May 2026 (14:00)	Sunday 10th May 2026 (22:00)	Monday 11th May 2026 (08:00)	Wednesday 13th May 2026 (12:00)
CHH	Centenary Building Theatre 20 (2) (UCAS)	Block 52	Saturday 16th May 2026 (08:00)	Monday 18th May 2026 (22:00)	Not Required	Tuesday 19th May 2026 (08:00)
CHH	Day Surgery Centre Theatres 3, 4 & 5	Block 75	Saturday 23rd May 2026 (08:00)	Tuesday 26th May 2026 (22:00)	Theatres 3 & 4 Not Required Theatre 5 Wednesday 27th May 2026 (08:00)	Theatres 3 & 4 Wednesday 27th May 2026 (08:00) Theatre 5 Friday 29th May 2026 (12:00)
CHH	Centenary Building Theatre 19 (1) (UCAS)	Block 52	Saturday 30th May 2026 (08:00)	Monday 1st June 2026 (22:00)	Not Required	Tuesday 2nd June 2026 (08:00)
W&C	Theatre 3 W&C	Womens & Childrens	Wednesday 3rd June 2026 (08:00)	Sunday 7th June 2026 (16:00)	Monday 8th June 2026 (08:00)	Wednesday 10th June 2026 (12:00)
HRI	Eye Hospital Theatre 3	Eye Hospital	Friday 5th June 2026 (08:00)	Saturday 6th June 2026 (after 16:00)	Sunday 7th June 2026 (08:00)	Tuesday 9th June 2026 (08:00)
CHH	Theatre Recoveries Centenary	Block 52	Saturday 6th June 2026 (08:00)	Sunday 7th June 2026 (22:00)	Not Required	Monday 8th June 2026 (08:00)
CHH	Daisy Day Surgery Theatre 18 (UCAS)		Thursday 11th June 2026 (08:00)	Sunday 14th June 2026 (22:00)	Not Required	Monday 15th June 2026 (08:00)
CHH	Daisy Theatre Recoveries Daisy				Not Required	Monday 15th June 2026 (08:00)
CHH	Daisy Day Surgery Theatre 17				Monday 15th June 2026 (08:00)	Wednesday 17th June 2026 (12:00)
W&C	Theatre 2 W&C	Womens & Childrens	Wednesday 17th June 2026 (08:00)	Sunday 21st June 2026 (16:00)	Monday 22nd June 2026 (08:00)	Wednesday 24th June 2026 (12:00)
HRI	Theatre 4 & 5	3rd floor North Block	Friday 19th June 2026 (08:00)	Saturday 20th June 2026 (22:00)	Sunday 21st June 2026 (08:00)	Tuesday 23rd June 2026 (08:00)
CHH	Centenary Building Theatre 21	Block 52	Saturday 20th June 2026 (08:00)	Sunday 21st June 2026 (22:00)	Monday 22nd June 2026 (09:00)	Wednesday 24th June 2026 (09:00)
CHH	Allam Building		Monday 6th July 2026 (07:00)	Friday 10th July 2026 (22:00)	Not Required	Saturday 11th July 2026 (07:00)
HRI	Theatre 3 (UCAS)	3rd floor North Block	Thursday 3rd July 2026 (16:00)	Monday 6th July 2026 (16:00)	Not Required	Tuesday 7th July 2026 (12:00)
HRI	Eye Hospital Theatre 1	Eye Hospital	Friday 10th July 2026 (08:00)	Saturday 11th July 2026 (after 16:00)	Sunday 12th July 2026 (08:00)	Tuesday 14th July 2026 (08:00)
HRI	Eye Hospital Theatre Rec	Eye Hospital				
CHH	Cath Lab Recovery	Block 90	Saturday 11th July 2026 (08:00)	Sunday 12th July 2026 (16:00)	Not Required	Monday 13th July 2026 (08:00)
HRI	Gastro Procedure Rm 1	2nd floor South Block	Friday 16th July 2026 (08:00)	Saturday 18th July 2026 (after 16:00)	Sunday 19th July 2026 (0800)	Monday 20th July 2026 (08:00)
W&C	Gynae + Paed Recovery	Womens & Childrens	Friday 17th July 2026 (08:00)	Sunday 19th July 2026 (16:00)	Not Required	Monday 20th July 2026 (08:00)
CHH	Cath Lab 3 & 4	Block 90	Saturday 25th July 2026 (08:00)	Sunday 26th July 2026 (16:00)	Not Required	Monday 27th July 2026 (08:00)
HRI	Theatre 10 (UCAS)	2nd Floor ICU	Thursday 30th July 2026 (16:00)	Sunday 2nd August 2026 (08:00)	Not Required	Tuesday 4th August 2026 (08:00)

Site	Theatre	Location	Start date of	Deep Clean Completed	Infection Control Plates	Hand back To Theatres
CHH	GICU 1	Block 90	Monday 3rd August 2026 (08:00)	Friday 7th August 2026 (16:00)	ICU 1& 2 at discretion of staff on ICU (own clean arranged)	Saturday 8th August 2026 (08:00)
HRI	Gastro Procedure Rm 2 & 3	2rd floor South Block	Friday 7th August 2026 (08:00)	Saturday 8th August 2026 (after 16:00)	Sunday 9th August 2026 (0800)	Monday 10th August 2026 (08:00)
CHH	Cath Lab 1& 2	Block 90	Saturday 8th August 2026 (08:00)	Sunday 9th August 2026 (16:00)	Not Required	Monday 10th August 2026 (08:00)
W&C	L&D Recovery	Womens & Childrens	Saturday 8th August 2026 (08:00)	Sunday 9th August 2026 (16:00)	Not Required	Monday 10th August 2026 (08:00)
CHH	GICU 2	Block 16	Monday 10th August 2026 (08:00)	Friday 14th August 2026 (16:00)	ICU 1& 2 at discretion of staff on ICU (own clean arranged)	Saturday 15th August 2026 (08:00)
HRI	HICU 1	3rd floor South Block	Monday 7th September 2026 (08:00)	Friday 11th September 2026 (16:00)	ICU 1& 2 at discretion of staff on ICU (own clean arranged)	Saturday 15th September 2026 (08:00)
HRI	HICU2	3rd floor North Block	Monday 14th September 2026 (08:00)	Friday 18th September 2026 (16:00)	ICU 1& 2 at discretion of staff on ICU (own clean arranged)	Saturday 19th September 2026 (08:00)
HRI	Theatre 6 (UCAS)	3rd floor North Block	Thursday 20th August 2026 (16:00)	Monday 24th August 2026 (after 16:00)	Not Required	Tuesday 25th August 2026 (08:00)
HRI	Theatre 7 (UCAS)	3rd floor North Block	TBC for May 26			
CHH	Theatre 4 (UCAS)	Block 32	Saturday 22nd August 2026 (08:00)	Monday 24th August 2026 (22:00)	Not Required	Tuesday 25th August 2026 (08:00)
HRI	Theatre 2 (UCAS)	3rd floor North Block	Thursday 27th August 2026 (16:00)	Monday 31st August 2026 (after 16:00)	Not Required	Tuesday 1st September 2026 (08:00)
HRI	Eye Hospital Theatre 2	Eye Hospital	Friday 4th September 2026 (08:00)	Sat 5th September 2026 (after 16:00)	Sunday 6th September 2026 (08:00)	Tuesday 8th September 2026 (08:00)
CHH	Theatre Recoveries Surgical	Block 32	Saturday 5th September 2026 (08:00)	Sunday 6th September 2026 (22:00)	Not Required	Monday 7th September 2026 (08:00)
W&C	Theatre 5 W&C	Womens & Childrens	Monday 7th September 2026 (08:00)	Sunday 20th September 2026 (16:00)	Monday 21st September 2026 (08:00)	Wednesday 23rd Septemver (12:00)
HRI	Theatre 11 (UCAS)	2nd Floor ICU	Thursday 17th September 2026 (16:00)	Monday 21st September 2026 (after 16:00)	Not Required	Tuesday 22nd September 2026 (12:00)
CHH	Theatre 7 (Laparoscopic)	Block 32	Saturday 26th September 2026 (08:00)	Sunday 27th September 2026 (2200)	Monday 28th September 2026 (09:00)	Wednesday 30th September 2026 (09:00)
CHH	Theatre 23 Robotics	Block 17	Friday 13th November 2026 (14:00)	Monday 16th November 2026 (22:00)	Tuesday 17th November 2026 (08:00)	Thursday 19th November 2026 (12:00)
CHH	Theatre Recoveries Robotics	Block 17				
CHH	Theatre 22 Robotics	Block 17				
HRI	PACU	3rd floor North Block	Sat 25th October 2025 (after 08.00)	Sat 25th October 2025 (after 16.00)	Not Required	Sunday 25th October 2026 (08:00)
HRI	Theatre 10 & 11 Recovery	2nd Floor ICU	Friday 30th October 2026 (08:00)	Sunday 1st November 2026 (16:00)	Not Required	Monday 2nd November 2026 (08:00)
CHH	Theatre Recoveries Cardiology	Block 90	Friday 27th November 2026 (16:00)	Sunday 29th December 2026 (22:00)	Not Required	Monday November 2026 (08:00)
CHH	Day Surgery Centre Theatres 7 & 8	Block 75	Saturday 5th December 2026 (08:00)	Sunday 6th December 2026 (22:00)	Not Required for theatre 7 Monday 7th December 2026 (08:00) Theatre 8	Theatre 7 Tuesday 8th December 2026 (08:00) Theatre 8 Wednesday 9th December 2026 (12:00)
CHH	Day Surgery Centre Theatres 9 &10	Block 75	Saturday 12thDecember 2026 (08:00)	Sunday 13th December 2026 (22:00)	Not Required for theatre 10 Monday 14th December 2026 (08:00) Theatre 9	Theatre 10 Tuesday 8th December 2026 (08:00) Theatre 9 Wednesday 9th December 2026 (12:00)
CHH	Cardio Theatre 14 & 15 (UCAS)	Block 90	Friday 8th January 2027 (14:00)	Monday 11th January 2027 (22:00)	Not Required	Tuesday 12th January 2027 (08:00)
HRI	Theatre 1 (UCAS)	3th floor North Block	Friday 15th January 2027 (16:00)	Monday 18th Janaury 2027 (22:00)	Not Required	Tuesday 19th Janaury 2027
CHH	Cardio Theatre 16 (UCAS)	Block 90	Saturday 30th January 2027 (16:00)	Monday 1st February 2027 (22:00)	Not Required	Tuesday 2nd February 2027 (08:00)
HRI	IRT4		Friday 12th February	Saturday 13th February 2027 (16:00)	Sunday 14th February 2027 (08:00)	tuesdady 16th February 2027 (12:00)
CHH	Cardio Theatre 11 & 12 (UCAS)	Block 90	Friday 12th March 2027 (14:00)	Monday 15th March 2027 (22:00)	Tuesday 16th March 2027 (08:00 th12 plates at 8am	th11 Wednesday 17th March 2027 (08:00) th12 Thursday 18 12noon
Critical Area Shutdown dates						
CHH	Ward 7 Isolation Rooms	Block 19	TBA			
CHH	CHH Isolation Rooms - CICU, WD27 etc		TBA			
SSU	SSU Clean Room		Saturday 122nd August 2026 (08.00)		not required	Saturday 17th August (16:00)
CHH	Cyclotron MIRC		TBA			

Site	Theatre	Location	Start date of	Deep Clean Completed	Infection Control Plates	Hand back To Theatres
CHH	MRI Suite		TBA			
HRI	MRI Suite		TBA			
HRI	Theatre 9 (UCAS)	3rd floor North Block				
HRI	Theatre 8	3rd floor North Block				
CHH	Plastics Theatre 2 & 3 (UCAS)	Block 4	Friday 29th August 2025 (1600)			
CHH	Plastics Theatre 1 (UCAS)	Block 4	Friday 22nd January 2027 (08:00)			
CHH	Theatre Recoveries Plastics	Block 04	Saturday 4th July 2026 (08:00)			
CHH	Theatre 6 (General Surgery)	Block 32	Thursday 16th April 2026 (08:00)			
CHH	Theatre 5 (Orthopaedic) (UCAS)	Block 32	Friday 24th April 2026 (16:00)			

NLaG Theatre Closure Plan

Appendix 4 - IPC Annual Auditing Plan

HUTH IPC Expert Inpatient Audit Annual Plan

January	February	March	April	May	June	July	August	September	October	November	December
HICU1	H37		FAB	HICU1	ROWAN		H37	HICU1	FAB		ROWAN
HICU2	H10		H8	HICU2	WOODLANDS		H10	HICU2	H8		WOODLANDS
CICU1	H500		H80	CICU1	ACORN		H500	CICU1	H80		ACORN
CICU2	H70		H9	CICU2	CEDAR		H70	CICU2	H9		CEDAR
H50	AMU		H90	H50	LABOUR		AMU	H50	H90		LABOUR
MAJORS	H36		H130E	MAJORS	MAPLE		H36	MAJORS	H130E		MAPLE
ECA	H5		C20	ECA	C10		H5	ECA	C20		C10
PAEDS	H1		H7	PAEDS	C11		H1	PAEDS	H7		C11
NICU	C16		H39	NICU	C14		C16	NICU	H39		C14
PHDU	C9		C26	PHDU	H6		C9	PHDU	C26		H6
C7	C15		C27	C7	H60		C15	C7	C27		H60
C29	H12		C28	C29	H100		H12	C29	C28		H100
C30	H120		C5DU	C30	H4		H120	C30	C5DU		H4
C31			C1	C31	H110			C31	C1		H110
C32			H40	C32	H11			C32	H40		H11
C33			H38	C33				C33	H38		
HIGH-RISK				HIGH-RISK				HIGH-RISK			

NLaG IPC Expert Inpatient Audit Annual Plan

January	February	March	April	May	June	July	August	September	October	November	December
ED SGH	B6		WARD 16	ED SGH	WARD 26		B6	ED SGH	WARD 16		WARD 26
ED DPOW	WARD 27		C6	ED DPOW	DISNEY		WARD 27	ED DPOW	C6		DISNEY
ICU SGH	WARD 17		C2	ICU SGH	BLUEBELL		WARD 17	ICU SGH	C2		BLUEBELL
ITU DPOW	WARD 25		WARD 3 GDH	ITU DPOW	HOLLY		WARD 25	ITU DPOW	WARD 3 GDH		HOLLY
HDU DPOW	A1		CARDIO WARD DPOW	HDU DPOW	JASMINE		A1	HDU DPOW	CARDIO WARD DPOW		JASMINE
NICU SGH	C5		C1 GLOVER	NICU SGH	HONEYSUCKLE		C5	NICU SGH	C1 GLOVER		HONEYSUCKLE
NICU DPOW	WARD 6 GDH		WARD 4 GDH	NICU DPOW	RAINFOREST		WARD 6 GDH	NICU DPOW	WARD 4 GDH		RAINFOREST
	WARD 18		AMETHYST		CDS		WARD 18		AMETHYST		CDS
	B4		IAAU DPOW		WARD 28		B4		IAAU DPOW		WARD 28
	B7		C3		WARD 29		B7		C3		WARD 29
	STROKE UNIT SGH		WARD 5		B3		STROKE UNIT SGH		WARD 5		B3
	C7		IAAU SGH		B2		C7		IAAU SGH		B2
			WARD 22						WARD 22		
			WARD 23						WARD 23		
			IAAU SGH						IAAU SGH		
HIGH-RISK				HIGH-RISK				HIGH-RISK			

Appendix 5 - Risk Overview

Risk Number	Risk Title	Risk Overview	Risk Score Initial (I), target (T) & current (C) scores	Organisation Link	Risk position
2410	Infection Prevention & Control Hygiene Code Board Assurance Framework	There is a risk that due to the failure to have sufficient suitable environmental infrastructure to manage infectious patients in a proactive manner (in particular on the SGH site), there is an increased infection risk, which may impact on the dissemination of pathogens such as C difficile, SARS CoV-2 and winter viruses.	I - 20 T – 4 C – 8	NLAG	Risk Open
4243	Risk of long-term effects and potential harm to patients due to colonisation of VRE	A persistent healthcare-associated VRE outbreak on the 12th Floor and Ward 120 Trauma & Orthopaedics has affected 131 patients since October 2022. Environmental and infrastructure constraints, including inadequate hand hygiene facilities, poor ward design, and insufficient bed spacing, may be contributing to ongoing transmission. The outbreak has had serious consequences for patient outcomes, including wound infections, sepsis, prolonged hospital stays, fatalities, and continued risk of spread, creating significant clinical, operational, and future healthcare challenges.	I – 9 T – 6 C – 6	HUTH	Risk Open Planned closure for 2026/27 financial year
4313	Risk of TB infection due to delays in new overseas worker screening	Delays of up to eight months in TB follow up assessments for newly recruited overseas healthcare workers from high-risk countries create a low but recognised risk that latent TB infection could reactivate, or that active TB disease may go undetected for a period after employment	I – 12 T – 4 C – 8	HUTH	Risk Open Planned closure for 2026/27 financial year

		commences. While specialist clinical advice suggests the likelihood of reactivation during the waiting period is very small, delayed assessment may increase the risk of transmission, require additional infection control interventions, and expose the organisation to operational and reputational consequences. Baseline chest X-ray screening may help mitigate the risk of undetected active TB at the point of appointment.			
3945	There is a risk that patients develop a preventable Healthcare Associated Infection during an inpatient/outpatient episode	Condition: Patient and Staff safety may be compromised due to a single or multiple outbreak of Health Care Associated Infections Cause: 1. Infrastructure within the HRI Tower are not conducive to optimal IPC. HRI Tower block required in order to mitigate the risk of spread of infection (e.g. floor to ceiling partitions, ventilation). 2. Lack of recognition and timely escalation of incidences of infection 3. Movement of infectious patients between wards/departments before test results confirmed 4. bed spacing too close and allows for transmission of infections 5. Lack of digital surveillance system, all completed manually and takes up IPC resource. Consequence: Patient harm, Reduced clinical capacity, adverse media focus, damage to the trust reputation, increased complaints, potential litigation. Increased mortality and morbidity. Increased wound infections and delayed healing.	I – 20 T – 6 C – 12	HUTH	Risk Open Planned closure for 2026/27 financial year and replace with group risk with separate actions for HUTH and NLAG

3512	CPE Outbreak RISK DPOW	The primary risk is the continued transmission of CPE within healthcare settings, resulting in increasing numbers of colonised and infected patients. This could lead to avoidable patient harm, serious healthcare-associated infections, adverse outcomes and reputational damage. A comprehensive framework of surveillance, prevention, outbreak management and system-wide collaboration is therefore required to mitigate the risk. Failure to implement and sustain these measures could result in prolonged transmission, escalating operational pressures and significant impacts on patient safety, service delivery and organisational performance.	I – 20 T – 6 C – 20	NLAG	Risk Open Planned closure for 2026/27 financial year and replaced with long-term effects of CPE outbreak on patient population at NLAG
3533	There is a risk patients develop a Healthcare Associated Infection during inpatient/ outpatient episode	There is a risk that patient and staff safety will be compromised due to outbreaks of Healthcare Associated Infections, caused by estate and infrastructure limitations, delayed recognition and escalation of infection incidents, movement of infectious patients prior to confirmation of results, inadequate bed spacing, and the absence of a digital surveillance system. This could result in patient harm, increased mortality and morbidity, reduced clinical capacity, reputational damage, complaints, litigation, and financial and operational pressures on the Trust.	I – 20 T – 6 C – 12	NLAG	Risk Open Planned closure for 2026/27 financial year and replaced with Group risk with separate actions for HUTH and NLAG
4229 HUTH & 3534 NLAG	Risk of healthcare associated BSI to patients & failure of national threshold due to practice & environmental issues	Risk of healthcare associated BSI to patients & failure of national threshold due to multi-factorial practice & environment, specifically MSSA and gram negative bacteraemia. The Trust is a regional outlier for BSIs. Condition; Built environment not conducive to optimal IPC. No ventilation in clinical areas, no engineering solution. Variance of IPC practice standards. Cause: Age of building. Poor bed spacing. Poor layout of departments. Lack of storage resulting in clutter and reduce effectiveness of cleaning in healthcare	I – 20 T – 6 C – 16	HUTH & NLAG separate	Risk Open Planned closure for 2026/27 financial year and replaced with Group risk with separate actions for

		environment. Staff practices: bare below the elbow, hand hygiene and PPE usage. Increased indwelling catheters. Prolonged use of peripheral devices and no clinical needs. Consequences: increased BSI, increased mortality and morbidity. Delayed discharges, increased length of stay.			HUTH and NLAG
4617	Failure to assure IPC compliance across the group due to a significant backlog of overdue audits	There are currently 81 overdue inpatient IPC audits across all care groups, as well as majority of theatres IPC audits overdue. The absence of a robust, systematic audit and monitoring system means there is no reliable oversight or assurance that national IPC standards (Health and Social Care Act 2008, Code of Practice) are consistently met at the clinical level.	I – 12 T – 6 C – 12	Group Wide HUTH & NLAG	Risk Open
4225	Cross infection due to inadequate hygiene facilities and environment no longer fit for purpose inc. bed spacing	The Trust faces a significant strategic risk that the current estate and infrastructure are unable to fully support modern Infection Prevention and Control requirements. This increases the likelihood of healthcare-associated infections and outbreaks, potentially compromising patient and staff safety, reducing clinical capacity, affecting operational performance, and exposing the organisation to regulatory, financial, and reputational consequences. Continued investment in estate modernisation remains critical to reducing this risk.	I – 20 T – 9 C – 15	HUTH	Risk open Planned closure for 2026/27 financial year and replaced with Group risk with separate actions for HUTH and NLAG
4244	There is a risk that healthcare associated multi drug resistant organisms (MDRO) is transmitted to patients due multifaceted	Condition: National proactive screening programmes for MDRO - to adhere to national guidance on screening Cause: Not enough HWB Poor ward layout Poor bed spacing built environment not conducive to optimal IPC	I – 20 T – 6 C – 16	HUTH	Risk Open

	environmental factors	Consequence; Infected wounds and delayed healing Sepsis Increased mortality and morbidity Delayed discharged Increased length of stay Transmission to other patients			
4673	Lack of ventilation in the Tower Block at Hull Royal Infirmary resulting in significant airborne/droplet and D&V outbreaks.	There is a risk that inadequate ventilation infrastructure within the Tower Block, arising from the limitations of an ageing estate that cannot fully accommodate modern HTM-compliant air handling systems, this will increase the transmission of airborne and respiratory infections, leading to healthcare-associated outbreaks, bed and ward closures, elective activity disruption, staff absence, reduced operational performance, and adverse impacts on patient safety and quality of care.	I – 20 T – 12 C – 20	HUTH	Risk Open
3535	Patients at increased risk of developing a Surgical Site Infection (SSI) for orthopaedics as HUTH and NLAG is an outlier for SSI	Risk for patients developing SSI, NLAG and HUTH are a regional/national outlier for SSI in orthopaedics, due to multi-factorial causes, practice and environment. Cause: Stop the line in theatres, theatre environment, provides link corridor to ICU at DPOW. Built environment not conducive to optimal IPC. Ventilation within storage areas for sterile store. Layup pre/ opening of packs not under canopy - risking increased infections. Staff practices/ theatre culture etiquette, bare below elbow, not wearing appropriate overshoes, overcoats when leaving theatres to go outside theatres, staff wearing their own clothes in theatre environment. Consequence: increased SSI, increased mortality and morbidity. Delayed discharges. Increase length of stay. Increased cost (treatment for SSI).	I – 15 T – 4 C – 12	Group Wide HUTH & NLAG	Risk Open

4149	Pandemic Influenza	Condition: There is a risk of: H23 - Pandemic Influenza (Community Risk Register) - Influenza type disease (pandemic). Cause: Serious pandemic of much greater severity than the usual seasonal flu. Excess morbidity, significant increase in hospital admissions and deaths. The consequences of the risk are: the inability of the Trust to maintain business as usual, due to significantly higher hospital admissions, increased demand on critical care services, simultaneous to the staff absence rates being higher due to illness and other societal issues (carers leave etc.). This is the highest risk on both the national and community risk registers. Up to 50% of the UK population experiencing symptoms could cause capacity pressures, potentially leading to between 20,000 and 750,000 fatalities (potential excess death issues) and high levels of absence from work.	I – 16 T – 9 C - 12	HUTH	Risk Open
4672	Inadequate clarity for isolation facilities to allow appropriate isolation facilities room identification to allow infection containment and prevention of airborne/droplet pathogens transmission	Condition: There is a lack of clear, standardised identification and documented guidance for designated isolation facilities within the care environment. Cause: Absence of prominent standardised signage on isolation room doors or cubicles doors to communicate isolation facilities. Outdated patient placement protocols that do not specify which rooms meet ventilation standards for specific pathogens or neutropenic patients. The failure to identifying isolation facilities at the point of care and within policy, therefore spreading airborne/droplet pathogens to patients, staff or visitors. Inadequate staff training on the hierarchy of controls and room identification procedures during high-occupancy periods.	I – 12 T – 4 C – 12		

		Consequences: Delayed or inappropriate patient placement leading to healthcare associated infections and cross-contamination of airborne/droplet pathogens to other patients and staff. Increased ward closures or cohorting requirements due to avoidable outbreaks, resulting in reduced bed capacity.			
3532 NLAG & 4226 HUTH	NLAG and HUTH risk breaching legislative requirements, and risk infection to staff due to lack of provision for Face Fit Testing Service	Condition: There is a risk of breaching legislative requirements and risk of infection to staff due to inadequate FFT programme. Cause: No robust FFT programme in place to meet 2 year rolling programme. Increased infection risk due to possible exposure through lack of FFT. Consequence: Staff sickness/harm Additional staffing pressures as a result of staff sickness Failure to comply with legal requirements may result in improvement notice or prosecution (HSE/CQC). Inability to staff high risk areas. Inability for staff to comply with mandatory training.	I – 15 T – 6 C – 12	Group Wide HUTH & NLAG seperate	Risk Open Planned closure for 2026/27 financial year and replaced with Group risk with separate actions for HUTH and NLAG
3279	The requirement of enhanced cleaning in line with NIPCM	There is a risk due to a lack funding for enhanced decontamination equipment could have a detrimental impact on providing a safe clean environment for both staff and patients. Currently enhanced cleaning is provided by an outsourced company with a significant financial burden.	I – 15 T – 6 C - 8	NLAG	Risk Open

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)255

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Friday 09th October 2026**
Director Lead	Murray Macdonald, Vice-Chair and Chair of Performance, Estates and Finance Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common held on 1st September 2026
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Minutes from the Performance, Estates and Finance Committees-in-Common held on 29th September 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:

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Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 7th July 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Vice-Chair - Chair
Julie Beilby	Non-Executive Director (NLaG)
Jane Hawkard	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Financial Officer
Peter Sedman	Deputy Group Chief Medical Officer
Sam Peate	Group Chief Delivery Officer

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Philippa Russell	Deputy Group Chief Financial Officer
Tom Myers	Group Director of Estates, Facilities & Development
Ryan Sutton	Associate Director of Quality Improvement *(Item 4.1.1)*
Helen Horth	Care Group Operations Director *(Item 4.7)*
Aswanthi Shanker	Care Group Operations Director *(Item 4.3)*

Observers

Ian Reekie	Public Governor (NLaG)
James Cooke	NHSE regional team

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Murray Macdonald, welcomed those present to the meeting. Apologies for absence were noted for Kate Wood, Group Chief Medical Officer, and David Sharif, Group Director of Assurance.

1.2 Staff Charter and Values

Murray Macdonald noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 2nd June 2026 and the Private meeting minutes on 2nd June 2026.

The minutes of the meeting and private meeting held on 02nd June, were accepted as a true and accurate record.

Emma Sayner requested that the finance deficit for the Group was more expanded on in future minutes.

1.5 Matters Arising

No matters arising.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

MATTERS REFERRED

2

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

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework / Risk Register Report (including estates risks)

Rebecca Crashley reported that she had been meeting with Executive colleagues on a monthly basis to maintain regular oversight and keep the Board Assurance Framework (BAF) under review, despite formal BAF reporting not being required on a monthly basis. Rebecca Crashley assured that Digital risks would be included in the risk register by August's meeting.

Murray Macdonald acknowledged that a number of risks were currently scored at the highest level, making it difficult to identify where attention and resources should be prioritised. Julie Beilby agreed, and felt that the 12 score did not fully represent the Partnership's wider digital risks.

Murray Macdonald suggested that the next meeting should include an update from the digital team on the current position, including key cyber and digital risks.

Action: The digital team to bring an update to August's PEF. (Alastair Pickering)

Jane Hawkard supported the need to review how digital risks were reflected in the BAF. She noted that there was currently no reference to the Data Security and Protection Toolkit (DSPT), cyber security risks, or the potential impact these issues could have on confidence in the electronic patient record.

Jane Hawkard also raised concerns regarding the financial risk section, noting that the actions described appeared too reasonable when compared to the level of risk identified. She suggested that either the actions or the risk ratings should be reviewed to ensure they accurately reflected the level of concern. Emma Sayner acknowledged the concerns raised and explained that some actions had been rated as reasonable because the relevant processes and controls were already in place. However, she recognised that, despite these processes, the desired outcomes were not always being achieved.

Samuel Peate made a minor observation regarding the colour ratings used within the report. He noted that the colour assigned to a "limited" rating gave the impression that the position was better than it actually was.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

Murray Macdonald noted that there were currently no internal or external reports, recommendations or assurances to consider. However, he suggested that future external reports, such as those relating to maternity services or mortuary provision, could be relevant to the Committee's work as they may include operational as well as quality-related issues.

Murray Macdonald suggested that Samuel Peate and Pete Sedman bring relevant external reports and emerging issues to future meetings to help keep the Group informed of wider risks and developments.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 Group Finance Report: Month 2, including Care Group trajectories following

CIP Board Session

Emma Sayner presented the month 2 Group Finance Report and noted that the Month 2 report already felt out of date due to the pace of work taking place. She explained that the year-to-date position was not where the Partnership wanted it to be, and that spending levels had not yet reduced as needed.

Emma Sayner advised that more focused work had started with the Care Groups and clinical leaders, including shared learning sessions with other NHS organisations. A session had taken place with Maidstone and Tunbridge Wells, which showed the importance of clinical and operational teams taking ownership of financial recovery, not just finance teams.

Emma Sayner noted that further support and learning sessions were planned, including a session with NHS England colleagues on productivity and efficiency. This would use the Partnership's own data to help care groups better understand cost growth, workforce pressures and productivity opportunities.

Emma Sayner reported that care groups had been reviewed using the RIDGWAY rating approach, with the most challenged care groups being highlighted in the Month 2 report, as previously agreed.

Emma Sayner also advised that NHS England was putting additional support in place for the Partnership. This included a financial turnaround lead and support from Grant Thornton. She informed the CiC that they would have a focus on understanding why existing controls and actions were not yet having the required impact, and what needed to change quickly. Emma Sayner explained that this support would not be a short-term review, but a wider package of support over several months, funded by NHS England.

Emma Sayner noted that the Partnership remained off plan financially. She advised that, if the current position continued, the year-end position could be significantly worse than planned. She added that the level of financial risk had been highlighted during the planning process, with estimates suggesting a potential deficit of around £118 million if savings targets were not achieved. She explained that the scale of the challenge had led to increased scrutiny and the additional support being put in place.

Philippa Russell advised that the year-to-date position was mainly being driven by delays in delivering planned savings (CIP), alongside the impact of industrial action. While some progress had been made, it was not happening quickly enough and challenges remained around reducing variable pay costs and workforce numbers.

Philippa Russell reported that care groups had been asked to develop recovery plans, with a number of areas requiring significant improvement to meet their targets. She also noted that a further £30 million savings gap remained without an identified solution.

On the year-end forecast, Philippa Russell advised that the current position showed a gap of around £42 million, although this relied on delivering savings opportunities that were not yet fully developed. She noted that a more realistic risk-adjusted position could be closer to £60 million if further improvements were not achieved.

Philippa Russell also highlighted pressures on cash flow, with cash support requirements currently higher than planned. The Committees-In-Common were asked to approve a maximum revenue support request of £37.5 million for Quarter 2, noting that monthly requests would continue to be reviewed and reduced where possible.

Philippa Russell highlighted a number of risks, including the tower block cladding scheme, which could create financial pressures if it could not be moved into future years. She also noted potential delays to other capital projects and advised that work was underway to identify options to manage these risks during the second half of the year.

Murray Macdonald highlighted concerns about the year-to-date financial position, year-end forecast, delivery of CIP and progress against the variable pay reduction target. He noted that variable pay reductions were not yet progressing at the expected pace and should continue to be closely monitored. He also noted that current risks relating to cash and capital appeared manageable at this stage, although they would require ongoing oversight. He suggested that the additional support and controls being put in place, including the work with Grant Thornton, the financial recovery support, and the increased focus on care group performance, should be reflected in the Board Assurance Framework (BAF).

Tom Myers joined the meeting at 9.39am

Jane Hawkard asked for an update on whether a voluntary redundancy (VR) or MARS scheme was being considered as part of the financial recovery plans, as this had been raised previously but had not been discussed further. Emma Sayner advised that a vacancy pause had recently been introduced but has been delayed to avoid unintended consequences, such as increased spending on temporary staffing. The introduction of the Locum's Nest system on 1st July would provide greater oversight and control of variable pay costs, helping to reduce the risk of these costs increasing as vacancies were managed. Emma Sayner noted that the vacancy pause would support planned workforce reductions across Care Groups. She confirmed that voluntary redundancy remained an option, although funding for any scheme had not been identified within the current financial plan. Discussions with NHS England may take place in future if additional support was required.

Jane Hawkard asked whether a formal rating or assessment process had been considered for care groups as part of the recovery programme. She also questioned whether stronger controls on variable pay should be introduced, similar to the controls currently in place for recruitment.

Jane Hawkard sought clarification on references to business cases within recovery plans, noting that any new spending would need to demonstrate clear benefits and

value for money. Emma Sayner explained that the organisation was seeking to reduce reliance on requests for additional funding in relation to business cases. However, a small number of them remained necessary where there were a clear operational need and the potential to improve value for money or reduce costs elsewhere. She added that work was continuing to identify areas where spending was above expected levels, particularly within urgent and emergency care services, with the aim of improving efficiency and supporting financial recovery.

Philippa Russell clarified that the endoscopy business case was not a request for additional funding. The service was already incurring the cost, and the business case was intended to confirm the appropriate level of funding and budget. She noted that there may be opportunities to reduce current spending levels once this work was completed. Philippa Russell also reported that recent reviews of agency staffing requests had shown increased recruitment activity, particularly for medical staff. Many temporary staffing requests now included end dates linked to permanent recruitment, providing some assurance that action was being taken to reduce reliance on agency staff over time.

Samuel Peate provided further context on the endoscopy business case, noting that he had been working closely with the service over recent weeks. He explained that the review had identified opportunities to make better use of existing resources before additional investment was considered.

Julie Beilby noted that the discussion with Care Groups had identified a number of common themes, including the potential use of a MARS scheme and concerns that some HR processes may be slowing recruitment. She suggested that these themes should be discussed collectively to ensure any organisation-wide issues are considered and addressed. Emma Sayner advised that NHS England had also undertaken detailed reviews of workforce and HR processes with early findings reflecting many of the same themes raised by care groups, including opportunities to improve existing processes and controls.

Julie Beilby also expressed concern about the ongoing level of variable pay expenditure. While controls were reported to be in place, spending remained above target. She suggested that future reports should place greater emphasis on performance against the current year's target rather than comparisons with the previous year, to provide a clearer picture of the scale of the challenge.

Julie Beilby also noted that progress towards the 30% variable pay reduction target was significantly behind plan and that, with the organisation already in Quarter 2, achieving the target would require a substantial improvement in performance over the remainder of the year.

Emma Sayner expressed that further work was underway in areas such as medical rostering and workforce management, with updates to be provided through existing reporting arrangements.

Philippa Russell requested members of the CiC to formally approve the Quarter 2 cash drawdown request. The CiC approved the maximum revenue support request

of £37.5 million for Quarter 2, noting that monthly requests would continue to be reviewed and adjusted where possible.

The Committees-in-Common agreed limited assurance for this item and approved the Quarter 2 cash drawdown request.

Ryan Sutton joined the meeting at 9.58am

4.1.1 CIP and Transformation Programme Update

Ryan Sutton took the report as read. He reported that many of the savings' schemes were still at an early stage of development and informed the CiC that a detailed review was underway to assess whether schemes would deliver the expected benefits, need to be delayed, or were unlikely to proceed. He noted that a number of schemes had not yet been fully costed and may provide further opportunities to improve the financial position.

Ryan Sutton highlighted the introduction of the Locum's Nest system across the Group, which has digitised the management of expenditure on Speciality and Specialist (SAS) doctors and consultants. He noted that this would provide greater oversight and control of variable pay spending and improve monitoring and approval processes.

Ryan Sutton advised that recovery plans were being developed for the Care Groups identified as requiring additional support, with progress being monitored through the established performance and accountability arrangements.

Ryan Sutton also reported that discussions were taking place with NHS England regarding external support. He noted that, while current efforts were focused on addressing immediate financial challenges, external support could help the organisation develop longer-term transformation plans to deliver sustainable improvements over the next two to three years.

Jane Hawkard asked what actions were most likely to improve the financial position and also checked on the wellbeing and capacity of his team. Ryan Sutton thanked Jane for her comments and advised that his team was under pressure due to supporting both the financial recovery programme and the Integrated Improvement Plan. He noted that work was underway to prioritise workloads and that additional external support was being explored.

Ryan Sutton said that stronger financial control across care groups would be key to improving the financial position. He noted that premium pay costs remained a challenge and that a more coordinated approach to managing spending could help.

Jane Hawkard left the meeting at 10.16am

Jane Hawkard joined the meeting at 10.19am

The Committees-in-Common agreed on limited assurance.

Ryan Sutton left the meeting at 10.21am

Julie Beilby said that the report should place more focus on transformation. She noted that while controlling costs was important, long-term change would be needed to improve the financial position and support the workforce. She suggested that future reports included clearer updates on transformation work and progress. She also raised concerns about organisational capacity to deliver this work and stressed the need to maintain focus on longer-term improvement alongside immediate financial pressures.

Murray Macdonald agreed that transformation was important but said it needed a clear long-term plan. He noted that much of the current focus was on short-term challenges rather than future priorities.

Murray Macdonald also raised concerns that planning often started too late, making it harder to focus on longer-term improvements rather than short-term savings.

In closing the discussion, Murray Macdonald noted that the Committee's overall position remained one of very limited assurance, with key concerns relating to the financial position, delivery of savings plans (CIP), variable pay and cash flow. Members acknowledged that work was ongoing to address these issues and hoped to see improvement in future reports.

The Committees-in-Common agreed limited assurance for this item, due to concerns about the financial position, savings delivery, variable pay and cash flow. They noted that work was underway to address these issues.

4.2 Group Performance Report including theatre trajectory metrics

Sam Peate presented the Group Performance Report. He reported that the refreshed performance report provided a clearer overview of progress against key performance measures across the Group.

In urgent and emergency care, performance against the four-hour standard remained below plan in some areas. This was being driven by Type-3 performance delivered by CHCP and not the trust. Work was underway to review triage processes, improve patient flow and strengthen alternatives to Emergency Departments. NHS England continued to provide support, including work on ward models and urgent care pathways.

Samuel Peate noted that recent multi-agency work had helped reduce delays in discharging patients, although it was too early to assess the long-term impact. Further work was also taking place to review site management processes across the Group.

Samuel Peate updated that in elective care, performance against referral-to-treatment (RTT) standards was ahead of plan, although overall waiting lists had

increased. Work to improve waiting list management and data quality was ongoing, including the introduction of new digital tools.

Samuel Peate noted that the number of patients waiting more than 65 weeks had increased, largely due to capacity pressures within plastic surgery. Actions were being put in place to address this, including additional medical support. He advised that further work with NHS England would focus on outpatient transformation and reviews of key specialties, including ophthalmology, plastic surgery and gynaecology.

Samuel Peate reported that diagnostic performance had slightly worsened at the start of the year, although some areas remained on track. Funding had been allocated to support improvements in areas including neurophysiology and echocardiography.

Samuel Peate noted that endoscopy remained an area of concern, and work was continuing to reduce waiting times and improve performance.

Jane Hawkard asked for an update on the CHCP contract, the plans for a 24/7 UTC at Hull Royal, and the new bed management system (TeleTracking). Samuel Peate advised that CHCP was aiming for implementation in October, subject to approval. He confirmed that the issue had been raised with the ICB and remained under discussion.

Samuel Peate assured that moving the Hull Royal UTC to a 24/7 service should help improve urgent care performance, but this was dependent on ICB approval. Samuel Peate also updated that the new bed management system would help staff track patients more effectively, supporting patient flow, discharges and bed management. The first phase was expected to go live later in the summer, with further rollout to follow.

Julie Beilby queried why there wasn’t a target set for patients who were clinically ready for discharge in an inpatient bed. Samuel Peate confirmed that this related to patients with no criteria to reside. He noted that the TeleTracking system would improve how this was tracked and reported in future reports.

Samuel Peate reported that work was underway to improve care for frail patients and reduce unnecessary hospital stays. He said discussions were taking place with local authority and system partners to improve discharge arrangements and community support, with the aim of reducing the number of patients who no longer needed to be in an acute hospital bed. Samuel Peate reported that the National Frailty Collaborative Team had visited the Trust to support work on improving care for frail patients. He noted that frail patients make up a large proportion of unplanned hospital admissions, highlighting the opportunity to improve patient flow and reduce delays.

Julie Beilby asked what was being done to reduce the number of people attending A&E who could be treated elsewhere. Samuel Peate expressed that work was underway to identify patients who could use other services instead of A&E. Discussions were taking place with CHCP and the ICB to make better use of

alternative services, including Urgent Treatment Centres. He added that new Same Day Emergency Care services planned for later in the year would provide more options for patients and help reduce pressure on A&E departments.

Ashy joined the meeting at 10.42am

4.3 Cancer Performance Update

Aswathi Shanker shared a presentation on screen highlighting cancer performance.

Aswathi Shanker reported that performance had been maintained in most areas, with improvements seen in some services. She highlighted strong breast cancer performance in HUTH, supported by additional temporary capacity while longer-term workforce solutions were developed. Progress had also been made in reducing histology turnaround times through closer working between pathology services across the Group.

Aswathi Shanker noted that radiotherapy remained a challenge, although recruitment was progressing following approval of a business case. Improvements were expected over time, but the full benefit would take longer to be realised. Work was continuing to address pressures in endoscopy, diagnostic services and consultant vacancies. Recruitment was ongoing in a number of areas, and reviews were underway to ensure services had the right capacity in place.

Aswathi Shanker advised that some services continued to rely on non-recurrent funding to maintain performance, although steps had been taken to reduce long-term reliance on this approach. She assured that cancer governance arrangements had been strengthened, with dedicated groups in place to oversee performance, delivery and clinical quality.

Aswathi Shanker also reported that oversight of clinical harm had improved, with new arrangements in place to monitor risks and support timely action where concerns were identified.

Murray Macdonald asked for an assessment of likely performance against cancer standards by the end of the financial year. Samuel Peate stated he was confident that the Faster Diagnosis Standard (FDS) would be achieved and noted that revised plans showed the target being reached earlier than originally expected. Samuel Peate reported that modelling work was helping to identify where further improvements were needed across cancer pathways. While he believed the planned performance for the 62-day cancer standard could be achieved, he noted that it would remain challenging and require continued focus and effort throughout the year.

Jane Hawkard asked when improvements in the 62-day cancer standard, particularly at HUTH, were likely to be seen. Samuel Peate explained that the benefits of the radiotherapy recruitment programme were not expected to be seen until Quarter 3. He noted that there were opportunities to improve performance,

particularly within lung and urology cancer pathways, where focused work was underway.

Jane Hawkard welcomed the progress that had been made and noted that regular updates from Aswathi Shanker had helped the CiC see improvements over time.

Aswathi Shanker left the meeting at 11.12am

Murray Macdonald thanked Samuel Peate and Aswathi Shanker for the update. He welcomed the progress made and noted that the programme continued to deliver against the plans previously presented to the Committee.

The Committees-in-Common agreed Reasonable Assurance for this item.

4.4 Outpatient Transformation Deep Dive

Sam Peate took the report as read and provided an update on the Outpatient Transformation Programme. He advised that work was focusing on two main areas: the introduction of a Single Point of Access model in key specialties, and reducing delays in follow-up appointments.

Samuel Peate noted that national guidance suggested there may be opportunities to reduce the number of first outpatient appointments through improved clinical triage and new ways of working. Work was underway to assess the potential impact locally. He also reported that further work was taking place to improve follow-up processes, including the use of digital tools and patient engagement systems.

Samuel Peate advised that the programme was being developed in partnership with primary care and other system partners. He noted that progress had been made in strengthening engagement and developing clearer plans for delivery. Members noted the update and the ongoing work to improve outpatient services across the Group.

Murray Macdonald noted that the Outpatient Transformation Programme involved major changes to services and asked how confident Samuel Peate was that it could be delivered. Samuel Peate said he was confident that the first phase could be implemented, with good support from clinical teams. However, he noted that there were some risks and that the changes would take time to deliver. Work was ongoing to understand and manage the impact.

Jane Hawkard asked whether a plan was being developed to reduce the large follow-up backlog and when a trajectory for improvement would be available. Samuel Peate said that work was underway to review the backlog, including the use of the patient engagement portal and discussions with primary care about reviewing some follow-up activity. He noted that improvements had already been made in some specialties, including ophthalmology, where the number of highest-risk patients waiting had reduced significantly. Samuel Peate advised that a clearer

picture was expected after the summer as further review work was completed. He noted that the size of the backlog remained a significant risk nationally.

Jane Hawkard asked how the follow-up backlog would be monitored and reported going forward. Samuel Peate suggested including the backlog as a regular measure within the Integrated Performance Report (IPR) so that progress could be tracked over time. Murray Macdonald supported this approach and suggested that the Committee receive a further update on the Outpatient Transformation Programme in the autumn to review progress and any challenges to delivery.

Action: Samuel Peate to bring an update on the Outpatient Transformation Programme to Octobers meeting.

Julie Beilby asked for more information about the risks relating to job planning reviews, noting Workforce, Education and Culture (WEC) CiC's interest in this area. Samuel Peate explained that the risk related to changes being made through the Outpatient Transformation Programme. He explained how referrals were going to be managed differently under the new Single Point of Access model, and as a result clinical workload may change across some services. He noted that job planning reviews were being used to ensure the right staffing and resources were in place to support these changes. The full impact was not yet known and would continue to be reviewed as the programme was implemented.

The Committees-in-Common agreed limited assurance.

4.5 Directorate of Estates, Facilities and Development Update: including HRI Tower Block Update

Murray Macdonald thanked Tom for his patience and suggested that future agendas could be reordered, with digital and estates items being considered earlier in the meeting.

Action: Agenda format to be changed for next meeting; digital, estates, operations and finance.

Tom Myers provided an update on estates and facilities.

Tom Myers reported that there had been no change to the 11 high-level estate risks previously reported. Work was continuing to address these risks through a range of capital projects, including roofing and electrical infrastructure improvements.

Tom Myers reported progress on a new estates management system, which would improve asset management, maintenance planning and reporting across the Group.

Tom Myers noted that a £32 million estates programme was underway, with further projects moving through design and procurement stages.

Tom Myers advised that a diesel leak at Scunthorpe had been reported to the Environment Agency and Severn Trent. The incident was contained quickly and an investigation was underway. He also reported improvements within catering services following the introduction of a new sales system, which had improved oversight and supported efforts to reduce losses.

Tom Myers noted that occupancy surveys had identified underused office space, supporting plans to reduce estate costs and make better use of existing buildings.

Tom Myers reported that work on the Group Estates Strategy was progressing and would be presented to the CiC later in the year.

Murray Macdonald asked whether future reports could include a high-level summary of compliance checks and any overdue inspections or remedial actions, to provide assurance that key estates and health and safety requirements were being managed. Tom Myers agreed and noted that the new estates management system would make this information easier to report. He confirmed that the team would look at including this in future reports.

The CiC noted that Estates, Return, Information Collection (ERIC) data had been submitted on time and that Diana Princess of Wales Hospital had maintained its five-star patient catering rating.

Murray Macdonald noted that members had received assurance on estates, facilities and development matters. However, he highlighted the tower block funding and timescales as a key issue that would continue to require close monitoring.

The Committees-in-Common agreed they had been significantly assured. Murray concluded that the report provided assurance that estates and facilities arrangements are safe and compliant, with improvements being addressed.

4.6 Cleaning Harmonisation

Tom Myers took the report as read and provided an update on the cleaning harmonisation programme. He reported that plans remained on track to procure cleaning services through the existing HUTH contract model (Mitie). Cabinet had already approved, removing the need for a full business case process and reducing programme risk.

Tom Myers advised that work was continuing to finalise the service specification ahead of procurement. He noted that a review of functional risk (FR) ratings had identified the potential for increased costs, although further review and challenge of these ratings was still required before the full impact could be confirmed.

Members of the CiC were advised that the potential financial impact had been highlighted as an early alert and would continue to be reviewed as part of the specification process.

Tom Myers also reported that work was underway to assess whether deep cleaning services could be brought in-house. Business cases were being developed for an in-house deep cleaning team and equipment, with the aim of reducing costs currently spent on external providers while maintaining infection prevention standards.

Julie Beilby expressed she was pleased to see the Group moving forwards with a tender due to concerns around Infection Control measures being discussed it Quality and Safety CiC.

Helen Horth joined the meeting at 11.40pm

4.7 Contract Approvals

4.7.1 Contract Approval: Radiology Reporting Contract Award

Helen Horth reported that the procurement process for the new teleradiology contract had been completed successfully, with strong support from the procurement team and clinical colleagues throughout.

Helen Horth advised that the new contract would deliver significant savings without any increase in headcount. The current annual cost of teleradiology services across both Trusts was £8.2 million, and following a competitive procurement process this would reduce to £5.8 million, delivering annual savings of around £2.4 million. This represented savings of around £7.2 million over a three-year contract term.

Helen Horth highlighted that the joint procurement approach had provided a valuable opportunity to align arrangements across the Group and achieve better value for money.

Helen Horth sought approval to proceed with the contract award as outlined in the report, and the Committees-In-Common approved the contract which would now be presented to the Boards-In-Common for approval as per the scheme of delegation.

Helen Horth left the meeting at 11.50am

4.7.2 Contract Approval: Total Waste Management Service

Tom Myers apologised for the late submission of the paper, explaining that this was due to changes within the team and would be addressed for future meetings.

Tom Myers presented the proposal for the Total Waste Management contract. He explained that waste services currently operate differently across the North and South Bank sites, and that further work was needed before a single Group-wide model could be introduced. To allow time for this review, a new contract had been proposed through an existing framework arrangement. The contract would run for an initial three years, with options to extend, and would provide an estimated

annual saving of around £78,000 compared to the current arrangement.

Tom Myers noted that there was also potential for additional savings through reducing waste volumes and increasing recycling and appropriate waste segregation.

Murray Macdonald sought assurance that the proposed contract was compliant with legal and procurement requirements, aligned with organisational policies and strategy, and could be funded within existing budgets.

Tom Myers confirmed that the proposal met all legal and procurement requirements, aligned with organisational policies, and could be delivered within existing budgets. He noted that the contract had been approved through the appropriate procurement framework and would cost slightly less than the current arrangement.

The Committees-In-Common approved the contract.

4.8 Emerging Issues

None to note.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

Murray Macdonald noted that the work plan should be updated to better reflect digital matters. He advised that work would take place to incorporate digital priorities into the programme and confirmed that a comprehensive update on digital and cyber issues would be a main agenda item at the next meeting.

Action: Lauren Rowbottom and Rebecca Crashley to incorporate the digital agenda into the work plan.

5.2 Planned Care Board Meeting Minutes

This was shared for information.

5.3 Unplanned Care Board Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Nothing raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Key highlights were noted during the meeting. Any Alerts, Assurances and Advisories would be included in the Highlight Report submitted to the Board following the meeting.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

The next meeting will take place on Tuesday 4th August 2026 via Microsoft Teams.

The meeting closed at 12.03pm

Cumulative Record of Attendance at PEF CiC 26/2027

Name	Title	2026/27											
		Apr No Meeting	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Murray MacDonald	Chair / Vice Chair		D	Y	Y								
Jane Hawkard	NED (HUTH)		Y	Y	Y								
Julie Beilby	NED (NLaG)		Y	Y	Y								
Emma Sayner	Group Chief Financial Officer		Y	Y	Y								
Dr Kate Wood	Group Chief Medical Officer		N	D	D								
Sam Peate	Group Chief Delivery Officer		Y	D	Y								
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	D	Y								
David Sharif	Group Director of Assurance or deputy		N	D	D								

Philippa Russell	Deputy Group Chief Finance Officer		Y	Y	Y								
Ian Reekie	Governor Observer (NLaG)		D	Y	Y								

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)256

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 October 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 5**
Executive Summary	This report highlights the reported financial position for August 2026
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Presented at Performance, Estates & Finance Comittees-in Common 29 September 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
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: CIC(26)4.8

Name of Meeting	**Performance, Estates & Finance Committees-in-Common**
Date of the Meeting	**29 September 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	**Group Finance Report Month 5**
Executive Summary	The purpose of this report is to highlight the reported financial position for August 2026. Also attached is a highlight report from the September Cash Committee meeting. **Alert** • The Group reported a year-to-date deficit of (£50.5m), (£16.4m) adverse to plan. This position includes (£1.5m) of expenditure relating to Industrial Action cover which will have to be mitigated internally. • Whilst the Group is formally forecasting a plan compliant position, the forecast includes an unidentified and unmitigated gap of (£39.5m) and this is currently assessed to be the best-case scenario. Mid-case forecast is currently assessed to be a (£119.1m) deficit, a (£55.9m) adverse variance to plan. • Year to date adverse variance and slippage on identification of CIP is adversely impacting the cash forecast. Revenue Support PDC requested for both HUTH and NLAG up to the end of October is £11.66m higher than the planned value. • September PDC Revenue Support cash allocation was £15.9m lower than requested and this is impacting on the Group's ability to pay suppliers promptly. **Assure** A new Financial Recovery Programme (FRP) started at the beginning of September with a fortnightly FRP Board meeting, chaired by the CEO and a fortnightly FRP Delivery Group

	chaired by the Financial Improvement Director. The Delivery Group will provide structured check and challenge with Care Groups and Corporate areas, reviewing progress against financial recovery and Cost Improvement Programme (CIP) plans and agreeing the actions required to close identified gaps. Financial Recovery Plan progress: - Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD. - Weekly monitoring of variable pay where data is available - shared weekly with Care Groups. - Introduced vacancy pause – implemented 6th July. - Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – implemented 1st July 2026 - Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern (see attached report). - Business Case in-development for Voluntary Redundancy programme. - Finance training to be included in LISA programme being developed to support operational managers. - Enhanced communications strategy to support ownership of the finance agenda. - Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30th June 2026. - Strengthened CIP development & support delivery - Appointment of Grant Thornton & Keith Pringle - Financial Improvement Director. Grant Thornton are directly supporting the 8 most challenged Care Groups to deliver their CIP and financial plans. - New Non-Pay Panel set up to review all non-clinical orders over £500. This new panel will have a much wider remit than the Discretionary Spend Panel, with full oversight of non-pay governance and efficiency opportunities **Advise** • October requests for external cash support for both HUTH (£9.03m) and NLAG (3.48m) are pending approval. • Underlying deficit position of £138.98m. • The revised profile and cost for the Tower Block scheme is expected to be agreed later this month (Sept) and

	should see the reduction from £12.5m in 2026/27 to circa £2.4m with increases in 2027/28 and 2028/29. • Capital expenditure behind plan at Month 5 with delays in progressing HRI SDEC and Tower Block schemes and the ITU at DPOW.
Background Information and/or Supporting Document(s) (if applicable)	**Attached:** M5 Finance Report Cash Committee Highlight Report
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	As detailed in the report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**-**
Recommended action(s) required	☐ Approval by CiC ☐ Information ☐ Endorse for approval by Trust Board(s) ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	☐
Our People	☐
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	✓

NHS
Humber Health
Partnership

Finance Report Month 5
August – 2026/27

Finance Overview

In-month I&E Performance – page 3 to 8

(£3.1m)

The Group reported an in-month deficit for month 5 of (£8.6m), (£3.1m) adverse to plan.

Year to Date I&E Performance – page 3 to 8

(£16.4m)

The Group reported a year-to-date deficit of (£50.5m), (£16.4m) adverse to plan. The position includes (£1.5m) of expenditure relating to Industrial Action cover.

I&E Forecast Outturn & Risk – page 9 to 11

(£39.5m)

The Group is formally forecasting a plan compliant position. However, an adjusted straight-line projection would give a deficit of (£136.4m). Mitigating actions reduce the deficit leaving an unidentified gap of (£39.5m).

YTD Cost Improvement Plan – page 12 to 13

(£22.9m)

The Group has delivered £18.5m in CIP against a YTD target of £41.4m, (£22.9m) behind target.The Group are forecasting CIP delivery of £75.6m, (£43.5m) adverse to plan.

Underlying I&E – page 14

(£138.8m)

The Group's underlying position is estimated at a deficit of circa (£138.8m). In year recurrent CIP delivery will be the key driver of its underlying financial position.

System Performance – page 15

(£46.8m)

The ICS reported a YTD deficit of (£83.4m), (£46.8m) adverse to plan at month 5. The ICS is forecasting a (£63.1m) deficit for the year in line with plan.(*Values are including DSF)

Capital Expenditure – page 16

(£14.9m)

The Group has spent £8.5m on capital expenditure against a plan of £23.4m, (£14.9m) behind plan.

Balance Sheet & Cash – pages 17 to 18

£51.1m

The Group's cash balance at the end of month 5 was £51.1m. The Group continues to require additional external cash support. At the end of month 5 the Group has drawn down £24.3m in cash support.

Variable Pay – pages 19 to 25

£5.0m

The Group has spent £40.1m on variable pay, £5.0m less than the same period in 2025/26. This includes (£1.9m) of gross IA expenditure. Variable pay remains significantly behind the 30% Target reduction.

Key Risks

- High value of unidentified CIP and high-risk CIP opportunities.
- Variable Income Risk - CDC under-performance claw back.
- Inflation above Tariff assumptions.
- Further Industrial Action.
- Slippage on Capital Expenditure profile
- Requirement for additional Revenue Cash Support.

Key Actions

- Reducing cost pressures: reliance on premium variable pay; minimising escalation beds; and greater control of non-pay expenditure.
- Maximising planned care activity within core capacity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- Delivering a challenging CIP programme – conversion of non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target.

Financial Performance Summary

The Group ended month 5 with a year-to-date (YTD) deficit of (£50.5m), (£16.4m) adverse to plan.

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.9	76.5	0.6	379.0	382.0	3.0	47.0	46.9	(0.1)	234.9	233.4	(1.5)	122.9	123.5	0.5	613.8	615.4	1.5
Other Income	6.1	7.0	0.9	30.6	31.5	0.9	4.5	4.4	(0.1)	22.5	23.2	0.7	10.6	11.4	0.8	53.1	54.7	1.6
Total Operating Income	**82.0**	**83.6**	**1.5**	**409.6**	**413.5**	**3.9**	**51.5**	**51.3**	**(0.2)**	**257.3**	**256.5**	**(0.8)**	**133.5**	**134.9**	**1.3**	**667.0**	**670.1**	**3.1**
Pay Costs																		
Clinical Pay	(41.2)	(42.6)	(1.5)	(207.7)	(213.2)	(5.6)	(29.9)	(29.3)	0.6	(149.3)	(146.9)	2.4	(71.1)	(72.0)	(0.9)	(357.0)	(360.2)	(3.2)
Other Pay	(8.5)	(8.7)	(0.2)	(43.5)	(43.4)	0.1	(7.2)	(7.2)	0.1	(36.2)	(36.3)	(0.1)	(15.8)	(15.9)	(0.2)	(79.7)	(79.7)	(0.0)
Total Pay Costs	**(49.7)**	**(51.4)**	**(1.7)**	**(251.2)**	**(256.6)**	**(5.5)**	**(37.1)**	**(36.5)**	**0.6**	**(185.5)**	**(183.3)**	**2.3**	**(86.8)**	**(87.9)**	**(1.1)**	**(436.7)**	**(439.9)**	**(3.2)**
Clinical Non Pay	(19.7)	(19.7)	0.0	(99.3)	(103.8)	(4.5)	(8.1)	(8.3)	(0.1)	(40.7)	(41.9)	(1.2)	(27.8)	(27.9)	(0.1)	(140.1)	(145.7)	(5.7)
Other Non Pay	(11.6)	(14.6)	(3.0)	(59.6)	(67.9)	(8.4)	(5.7)	(6.7)	(1.0)	(29.2)	(34.3)	(5.1)	(17.4)	(21.3)	(4.0)	(88.8)	(102.2)	(13.4)
Total Non Pay Costs	**(31.3)**	**(34.3)**	**(3.0)**	**(158.9)**	**(171.8)**	**(12.9)**	**(13.9)**	**(15.0)**	**(1.1)**	**(70.0)**	**(76.2)**	**(6.2)**	**(45.2)**	**(49.3)**	**(4.1)**	**(228.9)**	**(248.0)**	**(19.1)**
Total Operating Expenditure	**(81.0)**	**(85.6)**	**(4.7)**	**(410.1)**	**(428.4)**	**(18.3)**	**(51.0)**	**(51.5)**	**(0.5)**	**(255.5)**	**(259.5)**	**(4.0)**	**(132.0)**	**(137.1)**	**(5.1)**	**(665.6)**	**(687.9)**	**(22.3)**
EBITDA	**1.1**	**(2.1)**	**(3.1)**	**(0.5)**	**(14.9)**	**(14.4)**	**0.5**	**(0.2)**	**(0.7)**	**1.8**	**(2.9)**	**(4.8)**	**1.6**	**(2.2)**	**(3.8)**	**1.4**	**(17.8)**	**(19.2)**
Depreciation	(2.7)	(2.7)	0.0	(13.5)	(13.3)	0.2	(2.4)	(1.6)	0.7	(11.7)	(8.9)	2.8	(5.0)	(4.3)	0.8	(25.2)	(22.2)	3.0
Non Operating Items	(1.5)	(1.2)	0.3	(7.7)	(7.4)	0.3	(0.7)	(0.6)	0.1	(3.4)	(2.9)	0.5	(2.2)	(1.8)	0.4	(11.1)	(10.3)	0.8
Surplus/(Deficit)	**(3.2)**	**(5.9)**	**(2.8)**	**(21.6)**	**(35.6)**	**(14.0)**	**(2.5)**	**(2.4)**	**0.1**	**(13.3)**	**(14.7)**	**(1.4)**	**(5.7)**	**(8.3)**	**(2.7)**	**(34.9)**	**(50.3)**	**(15.4)**
NHSE Allowable Adjustments	0.0	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.2	0.1	(0.1)	0.8	0.4	(0.4)	0.2	(0.3)	(0.4)	0.8	(0.2)	(1.0)
Adjusted Surplus / (Deficit)	**(3.2)**	**(6.3)**	**(3.1)**	**(21.6)**	**(36.1)**	**(14.5)**	**(2.4)**	**(2.3)**	**0.0**	**(12.5)**	**(14.3)**	**(1.8)**	**(5.5)**	**(8.6)**	**(3.1)**	**(34.1)**	**(50.5)**	**(16.4)**

- **The Group reported a (£8.6m) deficit in month, (£3.1m) adverse to plan. The Group has incurred (£1.5m) to cover Industrial Action in April.**
- The Group is behind on its CIP programme by (£22.96m). This is only partly mitigated through vacancy factors and other underspends.
- The Group cash balance increased by £3.7m in month to £51.1m (£20.0m HUTH / £31.1m NLAG), but the majority of the available cash is linked to capital creditors and slippage on the capital programme. £24.3m of additional external cash support (Revenue Support Public Dividend Capital (PDC)) has been drawn down at the end of Month 5. The Group requested £21.6m of cash support for September but has only gained approval of £5.7m putting further pressure on cash balances and timely creditor payments, resulting in an increased October request of £12.5m still awaiting NHSE approval.

See Appendix A on Page 27 to 28 for Detailed I&E Position

Financial Performance Summary: By Care Group

Directorate	Directorate 2	Care Group	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	In Month Variance £'000's	% Overspend	% CIP Identified (Forecast)	Escalate	% Overspend movement M5
Central Income			626,202	622,959	(3,242)	(1,077)	-0.5%			↓
Corporate Directorates			(106,612)	(107,504)	(892)	(842)	-0.8%	45.3%		↓
Finance Technical			(37,155)	(32,299)	4,856	2,096				
Operations	Operations North	Acute And Emergency Medicine North	(18,877)	(20,888)	(2,011)	(292)	-10.7%	48.2%	Y	↑
		Cancer Network	(3,757)	(3,743)	14	20	0.4%	7.7%	N	↑
		Cardiovascular	(22,020)	(23,197)	(1,177)	257	-5.3%	120.3%	Monitor	↑
		Chief Delivery Officer	(396)	(616)	(220)	(40)	-55.6%	0.0%	Monitor	↓
		Digestive Diseases	(29,039)	(32,141)	(3,101)	(315)	-10.7%	38.5%	Y	↑
		Head & Neck	(24,266)	(24,034)	233	337	1.0%	84.6%	N	↑
		Patient Services	(19,078)	(19,409)	(331)	(7)	-1.7%	31.7%	Monitor	↑
		Specialist Cancer And Support Services	(121,638)	(125,004)	(3,367)	(486)	-2.8%	45.7%	Y	↓
		Theatres, Anaesthetics And Critical Care	(55,826)	(57,765)	(1,939)	(261)	-3.5%	62.4%	Y	↓
	Operations North Total		(294,898)	(306,797)	(11,900)	(788)	-4.0%			
	Operations South	Acute And Emergency Medicine South	(28,848)	(29,818)	(971)	(140)	-3.4%	69.5%	N	↓
		Chief Delivery Officer	(385)	(382)	3	(24)	0.8%	0.0%	N	↓
		Community, Frailty & Therapy	(37,597)	(39,629)	(2,032)	(359)	-5.4%	45.2%	Y	↓
		Family Services	(49,620)	(51,049)	(1,430)	(81)	-2.9%	45.0%	Y	↑
		Neuroscience	(16,468)	(17,220)	(752)	(205)	-4.6%	43.4%	Monitor	↓
		Pathology Network Group	(21,744)	(21,858)	(114)	(2)	-0.5%	74.0%	N	↑
		Site Management & Discharge Teams	(3,119)	(3,214)	(95)	(15)	-3.1%	22.1%	Monitor	↓
		Specialist Medicine	(31,506)	(32,867)	(1,361)	(270)	-4.3%	22.9%	Y	↑
		Specialist Surgery	(28,286)	(29,511)	(1,225)	(358)	-4.3%	60.5%	Monitor	↓
	Operations South Total		(217,573)	(225,549)	(7,976)	(1,455)	-3.7%			
Operations Total			(512,470)	(532,346)	(19,876)	(2,243)	-3.9%			
Reserves			(4,822)	(1,079)	3,744	(587)				
Grand Total			(34,858)	(50,268)	(15,410)	(2,653)				
Adjusted Financial Performance			788	(186)	(974)	(429)				
Adjusted Financial Performance (surplus / (deficit)			(34,070)	(50,454)	(16,384)	(3,082)				

See Appendix A on Page 28 for Detailed I&E Position

Care Group Escalations: Acute & Emergency Medicine North M5 Financial Position

A&EM North and Major Trauma (Financial Position £000)	YTD (M5)
Budget Allocation	18,877
Expenditure	20,888
Variance	(2,011)

Variance made up of:

CIP non delivery	A&EM £989k ; Major Trauma £50k	(1,039)
Vacancy factor	A&EM £88k ; Major Trauma (£36k)	(52)
Medical Staff	Unfunded IA strike costs	(336)
	Unfunded Towerblock on call rota changes	(67)
	ED : unfunded deanery +6wte	(223)
	ED : additional wte worked	(212)
	Acute : vacancy premium	(127)
Major Trauma	Pay : excludes IA & CIP & VF	(13)
Nursing Pay	Emergency Dept	(135)
	AMU & wards	(6)
Drugs		124
NonPay		75
		(2,011)

A&EM : £166k CIP delivered YTD - £989k adverse ; VF variance - £88k adverse = Total £1,077k deficit

MT : £17k CIP delivered YTD - £50k adverse ; VF variance - £36k favourable = Total £14k deficit

£336k unfunded IA medical staff costs

Medical Pay cost pressures continue covering gaps with locums & agency. Acute pressures are due to vacancy cover premium. Extra Contractual Rates will reduce as substantive consultant posts started mid/late August.

ED medics continue to staff above budgeted levels & includes 6wte unfunded deanery posts.

The ED Nursing is now working at the uplifted SNCT levels. Agency & overtime has reduced but is still used to cover vacancies (15 RN & 3 HCA) & sickness (7%). Recruitment is key to mitigate this use.

There are still no plans to mitigate the external changes made to the Tower block oncall rotas. The expected annual pressure to cover Acute TG staff with locums is £160k.

Digestive Diseases – M5 Financial Position

Reason	Current Month Variance £k	Year to Date £k	Forecast £k
CIP including mitigating actions - risk adjusted forecast	-239	-1,135	-2,527
Consultant Additional Sessions before mitigations	-135	-498	-1,195
Endoscopy CHH & HRI Clinical Supplies Expense Category overspends	-67	-542	-1,301
Upper GI Clinical Supplies Expense Category overspends	22	-98	-234
Exec historically approved Allam Build Recruitment (CHH Endoscopy Unit cost centre pay)	-35	-158	-380
Bowel screening consumables	6	-25	-60
Resident Doctors - over established (rota expansion)	-94	-366	-879
JAG Accreditation nurse	-6	-30	-72
Agency GIM rota costs consultant and CT3 level - exact WTE/amount TBC, before mitigations	12	-77	-77
Nursing - maternity leave, redeploymnets due, long-term sickness, historically agreed spec nurses requiring business case due to saving consultant spend	-49	-198	-475
Nursing OT Pressure - Premium element estimate	-11	-60	-144
Industrial Action Cover	3	-168	-168
Technical issues/adjustments - insourcing/outsourcing	2	-225	
NLAG underspends across several nursing wards & Endoscopy	80	466	1,118
Business cases requiring approval			2,526
Other	195	13	
TOTAL	**-315**	**-3,101**	**-3,867**

The Care Group was forecasting a deficit of £3.9m at the end of month 5. This includes some mitigating actions totalling £3.3m, subject to further work and calculations.

37% of the year to date overspend is driven by the CIP position, which at the point of reporting had a risk-adjusted forecast variance of £2.5m under target.

Other significant cost pressures are mainly connected with waiting lists, the staffing for the new Allam building and historical resident doctor allocations, all of which require business cases to agree the run-rate expenditure and budget going forward.

Specialist Cancer and Support Services – M5 Financial Position

	(£,000s)		
	Current Month	Year-To-Date	Forecast
CIP Delivery	(579)	(3,108)	(6,093)
IRT consumables overtrade/Excluded devices	115	(302)	(559)
Medical Equipment Repair Costs	15	2	6
Medical Gasses Usage	(8)	(38)	(90)
Radiopharmacy isotopes	(65)	(173)	(454)
CT Contrast	13	(95)	(284)
OPAT drugs	(2)	(18)	(50)
MT expansion	-	-	(400)
ED CT OOH	-	-	(90)
Passthrough drugs block (over)/under trade	(421)	(899)	(2,322)
Trust Wide Maintenance Contracts	(22)	(96)	(183)
EMIS Contract	74	-	-
RT Maintenance	(43)	(136)	(270)
Industrial Action	-	(44)	(44)
Drug Wastage	-	(253)	(253)
Prior Year costs @ hihger than planned levels	-	(21)	(20)
Dr Doctor	24	(84)	(246)
Vacancies above NR VF (incl CDC)	171	1,322	1,992
Lung Cancer Screening Programme undertrade	14	104	249
Onc & Haem consumables	31	275	717
Assumed Funding/Inc MT & OOH CT			490
Other non-pay	194	195	1,235
	(487)	(3,367)	(6,666)

At the end of M5, the Care Group is forecasting a year-end deficit of £6.6m. This assumes £0.4m of technical adjustments for NHSE MT funding and £0.1m of reserves for approved schemes are released.

The main driver of the overspend is unidentified CIP (£6m). The position has deteriorated significantly in month as it no reflects the risk adjusted delivery values

Other key issues include consumable overtrade on IRT (£0.6m) linked to higher activity levels and increased cost per case.

Pass-through drugs are currently forecasting a block overtrade of £2.3m with growth above funded levels. Of this, £1.1m relates to unfunded 25/26 OT.

One-off events (£0.3m) are included in the YTD overspend related to industrial action and overspend on drug waste. No further increase is anticipated as part of the forecast.

Community, Frailty & Therapies – M5 Financial Position

	Current Month Variance £'k	Year to Date £'k	Forecast £'k
CIP non delivery	- 180	- 1,578	- 2,617
Ward Staffing pressures in Frailty	- 65	- 358	- 501
H1 and FSDEC	-	- 153	- 153
CHH C20 and Medical Cover	- 60	- 300	- 720
Industrial action	-	- 80	- 80
Medical staffing pressures incl Sickness & Goole	- 73	- 172	- 413
District Nursing Sickness Cover	- 8	- 14	- 34
Wheelchair Services	58	98	235
Non Pay/income	- 71	150	164
Additional Vacancies	41	375	457
Recovery Action Plan			119
TOTAL	-358	-2032	-3543

As at month 5, the Care Group is forecasting a deficit of £3.5m. 74% of this is driven by the CIP position, which at the point of reporting had a risk adjusted forecast variance of £2.6m.

Other significant cost pressures are connected with Medical staff cover both at CHH and Goole as well high levels of sickness. The Nursing position is equally challenged with staffing pressures on the Frailty wards and high levels of sickness within District Nursing, however in month the latter has improved considerably.

The Care Group is continuing to actively manage the sickness and reduce cover wherever safe to do so. Further CIP schemes are being developed to close the efficiency gap and a recovery action plan has been put in place.

Care Group Escalations: Family Services – M5 Financial Position

Reason	Current Month Variance £k	Year to Date £k	Forecast £k
CIP including mitigating actions	-355	-1,712	-3,520
VF	202	1,325	2,640
Med staff	-173	-788	-2,355
Nursing	-55	-348	-878
Other pay	7	0	0
Drugs	65	-30	-566
Clinical supplies	117	187	60
Other Non Pay	36	110	200
Income	74	189	320
Industrial Action Cover	0	-363	-363
TOTAL	**-82**	**-1,430**	**-4,462**

At this stage of the financial year, the Care Group was forecasting a deficit of £4.4m at the end of month 05. This excludes some mitigating plans, subject to further work and calculations.

119% of the year to date overspend is driven by the CIP position, which at the point of reporting had a forecast variance of £3.5m.

Other significant cost pressures are mainly connected with Medical staffing Extra Contractual Payments, Nursing staff bank and OT costs.

Drug costs forecast a cost pressure across Paediatrics (£469k); maternity (£76k); Neonates (£22k) & Gynae FP10s (£43k)

Care Group Escalations: Specialist Medicine M5 Financial Position

Specialist Medicine (Financial Position £000)	YTD (M5)
Budget Allocation	31,506
Expenditure	32,867
Variance	(1,361)

Variance made up of:

CIP non delivery		(1,034)
Vacancy Factor		231
Medical Staff	Unfunded IA strike costs	(73)
	HUTH Rheumatology	(83)
	NLG Respiratory + IS	(87)
Activity Pressures	Renal : CAPD Fluids / LTH tests	(110)
	Renal : Fresenius Contract	(143)
	Respiratory : Home Ventilation	73
	Respiratory : CPAP consumables	(381)
Lung Cancer Screening	IS : actual < plan	88
Nursing Wards	Pay	(68)
	NonPay	41
Drugs	non ward	43
Income		73
Misc Other		69
		(1,361)

- CIP non-delivery = 76% of YTD variance
  YTD = £224k delivered against a target of £1,258k
- Unfunded £73k IA strike medical staff costs
- HUTH Rheumatology medical staff
  1.7wte worked WTE > funded WTE
- NLG Respiratory medical staff
  4.0wte consultant vacancy premium
- Non-pay pressures
  CPAP (£381k) ; Renal fluids/LTH tests £110k)
  Renal Fresenius contract (£143k) +3% activity
- Ward Pay pressures
  (H70 £54k ; H50 £12k ; Wd25 £4k)
- NLG Lung Cancer Screening £88k IS underspent based on activity phasing. A forecast balanced variance is expected.

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£121.1m) based on a straight-line projection. Seasonal costs, planned investments, CIP delivery and other mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£39.5m) across the Group.

- The Group continues to forecast delivery of the planned deficit, but there remains a significant level of risk to delivery due to the challenging £119.1m efficiency target (6.8% including FYEs), which at the point of reporting had a risk adjusted forecast of just £57.0m, a gap of £62.1m.

- A straight-line forecast based on the YTD deficit position would leave the group with a £121.1m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent slippage in the year-to-date position, this deficit increases to £136.4m, an improvement of £3.2m versus M4.

- To bring back the forecast deficit to the planned level the Group needs to:

- **Deliver forecast improved efficiency of at least £28.5m** including currently undeveloped opportunities of c.£15m.

- **Identify further mitigations of £39.5m** to close the unidentified efficiency gap and cover other cost pressures and risks including the unplanned cost of industrial action.

- The forecast also assumes a level of mitigation through additional non recurrent income and non recurrent flexibility.

	Current Month			Previous Month			Movement		
Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m	HUTH £'m	NLAG £'m	HHP £'m
YTD deficit (M5)	(36.1)	(14.3)	(50.5)	(29.9)	(12.0)	(41.8)	(6.3)	(2.3)	(8.6)
Straight line forecast	**(86.7)**	**(34.4)**	**(121.1)**	**(89.6)**	**(36.0)**	**(125.5)**	**2.9**	**1.6**	**4.4**
Seasonality	(1.3)	(1.5)	(2.8)	(1.6)	(1.5)	(3.1)	0.3	-	0.3
Industrial Action	1.6	0.5	2.0	2.2	0.7	2.9	(0.7)	(0.2)	(0.9)
Investment Expenditure Profile	(3.3)	(2.4)	(5.7)	(3.4)	(3.1)	(6.5)	0.1	0.7	0.8
Expected changes to run-rate	(4.0)	(3.1)	(7.0)	(2.0)	(3.3)	(5.3)	(2.0)	0.2	(1.8)
Depreciation, Interest Received & PDC	-	(1.8)	(1.8)	-	(2.1)	(2.1)	-	0.3	0.3
Adjusted Run Rate	**(93.8)**	**(42.7)**	**(136.4)**	**(94.4)**	**(45.2)**	**(139.6)**	**0.6**	**2.5**	**3.2**
Forecast CIP delivery (improvement in run-rate)	21.4	7.1	28.5	25.9	9.6	35.5	(4.5)	(2.6)	(7.1)
Non recurrent mitigation		3.0	3.0		3.0	3.0	-	-	-
Additional Non Recurrent (Technical)			-			-	-	-	-
Additional Non Recurrent Income	2.4		2.4	2.0		2.0	0.4	-	0.4
Forecast deficit	**(69.9)**	**(32.6)**	**(102.6)**	**(66.5)**	**(32.6)**	**(99.1)**	**(3.5)**	**(0.1)**	**(3.5)**
Plan	**(39.4)**	**(23.7)**	**(63.1)**	**(39.4)**	**(23.7)**	**(63.1)**	**-**	**-**	**-**
Unmitigated Variance	**(30.5)**	**(9.0)**	**(39.5)**	**(27.1)**	**(8.9)**	**(36.0)**	**(3.5)**	**(0.1)**	**(3.5)**

Financial Performance – Forecast Scenarios

The Group has a significant amount of risk to its core Best Case forecast deficit of £102.6m, particularly CIP forecast delivery.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	Group £'m
Best Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.7)	(63.1)
Less Unidentified Mitigation	(30.55)	(8.96)	(39.5)
Forecast deficit	**(69.9)**	**(32.6)**	**(102.6)**
Variance	**(30.5)**	**(9.0)**	**(39.5)**
Mid Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(30.55)	(8.96)	(39.5)
CIP adjusted to reflect current risk adjusted forecast	(13.53)	(2.9)	(16.4)
Forecast deficit	**(83.5)**	**(35.5)**	**(119.0)**
Variance	**(44.1)**	**(11.9)**	**(55.9)**
Worst Case			
Reported Forecast (as per Forecast Bridge)	(39.40)	(23.67)	(63.1)
Less Unidentified Mitigation	(30.55)	(8.96)	(39.5)
No further improvement in CIP delivery vs run-rate	(21.41)	(7.1)	(28.5)
Variable Income Risk	(2.90)	(1.8)	(4.7)
Winter Pressures / Growth Risk	(0.60)	(0.4)	(1.0)
Inflationary Risks	(0.40)	(0.7)	(1.1)
Other risks			0.0
Forecast deficit	**(95.3)**	**(42.5)**	**(137.8)**
Variance	**(55.9)**	**(18.9)**	**(74.7)**

This analysis matches the scenarios included in the Provider Assurance Model (PAM).

Best case assumes all identified CIP, including opportunities that have not yet been worked up are delivered and aligns with the forecast assumptions described in the forecast bridge.

Mid case reflects the risk adjusted CIP forecast at M5.

Worst case assumes no further CIP is delivered (over and above the level already assumed in the YTD position) plus some additional risks to delivery.

Financial Performance – Recovery Plan

A new Financial Recovery Programme (FRP) started at the beginning of September with a fortnightly FRP Board meeting, chaired by the CEO and a fortnightly FRP Delivery Group chaired by the Financial Improvement Director. The Delivery Group will provide structured check and challenge with Care Groups and Corporate areas, reviewing progress against financial recovery and Cost Improvement Programme (CIP) plans and agreeing the actions required to close identified gaps.

- Agreed a targeted 30% / £30m reduction in variable pay with associated Care Group targets – the majority of Care Groups have developed plans to achieve this target, but further work required to deliver with c. 10% reduction YTD.
- Weekly monitoring of variable pay where data is available - shared with Care Groups.
- Introduced vacancy pause – **implemented 6th July.** CEO escalation process underpinned with a revised vacancy control process supported by a new form and tracker – **implemented.**
- Approved expansion of Locum's Nest digital solution which will facilitate electronic approval for variable pay including Extra Contractual Payments – **implemented 1st July 2026**
- Recovery Action Plan's escalated to Performance & Finance Committee for the Care Groups' of greatest concern.
- Business Case in-development for Voluntary Redundancy programme.
- Finance training to be included in LISA programme being developed to support operational managers.
- Enhanced communications strategy to support ownership of the finance agenda.
- Alignment with clinical priorities through the Integrated Recovery Plan – action plans signed off 30th June 2026.
- Strengthened CIP development & support delivery - Appointment of Grant Thornton & Keith Pringle - Financial Improvement Director. Grant Thornton are directly supporting the 8 most challenged Care Groups to deliver their CIP and financial plans.
- New Non-Pay Panel set up to review all non-clinical orders over £500. This new panel will have a much wider remit than the Discretionary Spend Panel, with full oversight of non-pay governance and efficiency opportunities.

Financial Performance – CIP Delivery

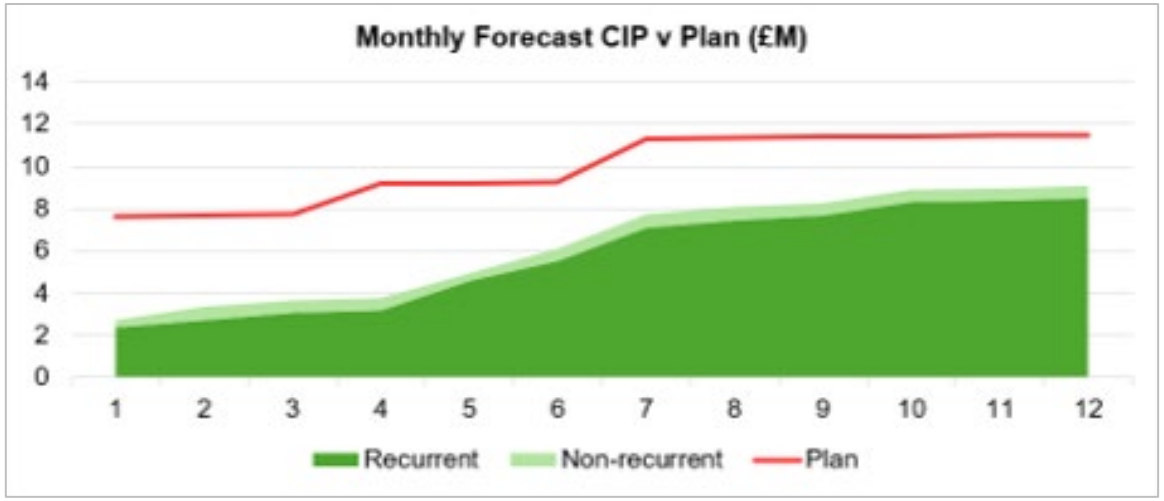
The Group has delivered £18.5m CIP year-to-date against a target of £41.4m, (£22.9m) adverse. The Group is forecasting CIP delivery of £75.6m (£43.5m) adverse to plan.

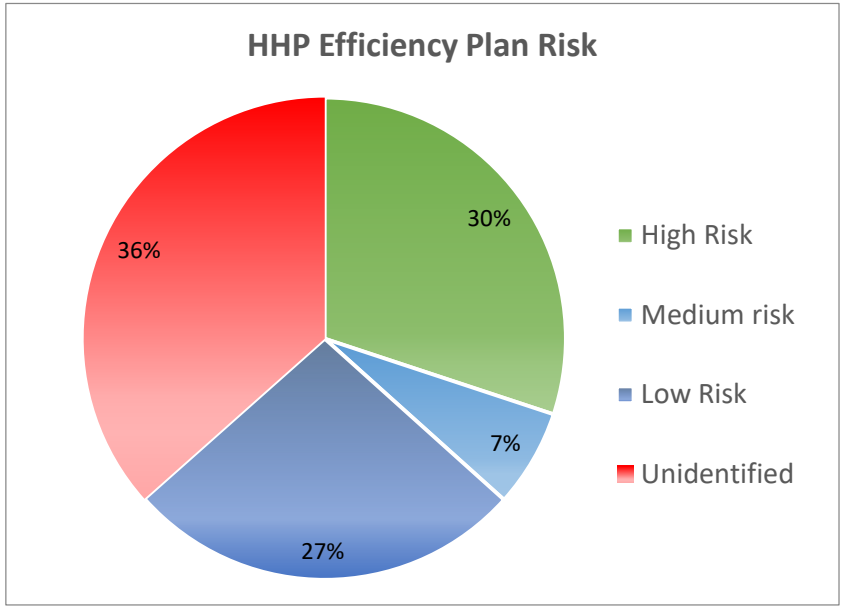
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute and Emergency Medicine North	1,155	166	(989)	2,771	1,335	(1,437)	0	0	0	0	0	0	1,155	166	(989)	2,771	1,335	(1,437)
	Acute and Emergency Medicine South	0	0	0	0	0	0	2,151	1,160	(992)	5,163	3,586	(1,577)	2,151	1,160	(992)	5,163	3,586	(1,577)
	Cancer Network	85	11	(75)	205	26	(179)	55	0	(55)	133	0	(133)	141	11	(130)	337	26	(311)
	Cardiovascular	884	157	(727)	2,122	2,870	748	224	124	(100)	538	330	(208)	1,109	281	(827)	2,661	3,200	540
	Chief Delivery Officer	22	0	(22)	54	0	(54)	24	0	(24)	58	0	(58)	47	0	(47)	112	0	(112)
	Community, Frailty & Therapy	901	251	(650)	2,163	1,107	(1,056)	1,077	146	(931)	2,586	1,040	(1,546)	1,979	398	(1,581)	4,749	2,147	(2,602)
	Digestive Diseases	748	192	(557)	1,796	883	(913)	757	179	(579)	1,818	508	(1,309)	1,506	370	(1,135)	3,614	1,391	(2,222)
	Family Services	1,257	411	(846)	3,017	1,578	(1,439)	1,275	408	(867)	3,060	1,154	(1,906)	2,532	819	(1,713)	6,076	2,732	(3,344)
	Head & Neck	825	643	(183)	1,981	1,614	(367)	533	417	(116)	1,279	1,142	(137)	1,358	1,060	(299)	3,260	2,757	(503)
	Major Trauma Network	67	17	(50)	161	43	(118)	0	0	0	0	0	0	67	17	(50)	161	43	(118)
	Neuroscience	554	211	(343)	1,331	601	(729)	261	50	(211)	628	248	(380)	816	261	(555)	1,958	849	(1,109)
	Pathology Network Group	265	276	12	635	666	31	853	276	(577)	2,048	1,319	(729)	1,118	552	(566)	2,683	1,985	(698)
	Patient Services	475	139	(336)	1,140	484	(656)	405	37	(368)	972	187	(786)	880	177	(703)	2,112	670	(1,442)
	Site Management & Discharge Teams	70	15	(55)	169	65	(103)	91	25	(66)	218	79	(140)	161	40	(121)	387	144	(243)
	Specialist Cancer And Support Services	2,300	521	(1,779)	5,521	1,954	(3,567)	1,614	286	(1,329)	3,875	2,337	(1,538)	3,915	807	(3,108)	9,396	4,291	(5,105)
	Specialist Medicine	723	74	(649)	1,736	208	(1,528)	535	149	(385)	1,283	460	(822)	1,258	223	(1,034)	3,019	668	(2,350)
	Specialist Surgery	885	184	(701)	2,123	846	(1,277)	605	481	(124)	1,452	1,319	(133)	1,490	666	(824)	3,575	2,165	(1,411)
	Theatres, Anaesthetics And Critical Care	1,613	223	(1,390)	3,871	2,400	(1,471)	1,112	379	(733)	2,668	1,682	(986)	2,724	601	(2,123)	6,539	4,082	(2,457)
Total Operations		**12,831**	**3,491**	**(9,340)**	**30,795**	**16,679**	**(14,115)**	**11,574**	**4,117**	**(7,457)**	**27,777**	**15,391**	**(12,386)**	**24,405**	**7,609**	**(16,796)**	**58,572**	**32,070**	**(26,502)**
Corporate	Chief Executive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Chief Medical Officer	300	83	(217)	721	200	(521)	84	0	(84)	201	0	(201)	384	83	(301)	922	200	(722)
	Chief Nurse	251	45	(206)	602	346	(256)	235	77	(158)	565	508	(57)	486	122	(364)	1,166	854	(312)
	Director Of Assurance	10	0	(10)	25	48	23	22	13	(9)	53	79	26	33	13	(19)	78	127	49
	Director Of People	318	0	(318)	764	316	(447)	266	0	(266)	638	375	(263)	584	0	(584)	1,402	691	(710)
	Finance - E&F	2,200	780	(1,420)	5,280	2,966	(2,314)	1,335	129	(1,205)	3,203	1,206	(1,997)	3,534	909	(2,625)	8,482	4,171	(4,311)
	Finance - Finance	120	54	(67)	289	129	(160)	99	70	(29)	239	169	(70)	220	124	(96)	527	298	(230)
	Finance - Procurement	52	0	(52)	124	0	(124)	36	0	(36)	87	0	(87)	88	0	(88)	212	0	(212)
	Finance - S & P	165	0	(165)	397	0	(397)	97	52	(45)	233	124	(109)	263	52	(211)	630	124	(506)
	Strategy, Partnerships and Digital	359	7	(352)	862	52	(810)	299	85	(214)	718	324	(394)	658	92	(566)	1,580	376	(1,204)
Total Corporate		**3,776**	**969**	**(2,807)**	**9,063**	**4,057**	**(5,006)**	**2,474**	**426**	**(2,048)**	**5,937**	**2,784**	**(3,153)**	**6,250**	**1,395**	**(4,855)**	**15,000**	**6,841**	**(8,159)**
Total Allocated CIPCore Programme		**16,607**	**4,460**	**(12,147)**	**39,857**	**20,736**	**(19,121)**	**14,048**	**4,543**	**(9,504)**	**33,714**	**18,175**	**(15,539)**	**30,655**	**9,003**	**(21,651)**	**73,572**	**38,912**	**(34,660)**
Trustwide	Reserves	0	1,501	1,501	0	2,527	2,527	0	2,119	2,119	0	4,552	4,552	0	3,620	3,620	0	7,078	7,078
	Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unallocated	4,609	0	(4,609)	22,043	15,253	(6,790)	326	0	(326)	9,486	314	(9,171)	4,935	0	(4,935)	31,528	15,567	(15,961)
	Full Year Effects	4,575	4,580	5	10,981	10,981	0	1,260	1,258	(2)	3,023	3,023	0	5,835	5,838	3	14,004	14,004	0
Total Technical & Unallocated		**9,185**	**6,081**	**(3,104)**	**33,024**	**28,761**	**(4,263)**	**1,585**	**3,377**	**1,791**	**12,509**	**7,889**	**(4,620)**	**10,770**	**9,457**	**(1,313)**	**45,532**	**36,650**	**(8,883)**
TOTAL		**25,792**	**10,540**	**(15,252)**	**72,881**	**49,497**	**(23,384)**	**15,633**	**7,920**	**(7,713)**	**46,223**	**26,065**	**(20,158)**	**41,425**	**18,461**	**(22,964)**	**119,104**	**75,561**	**(43,543)**

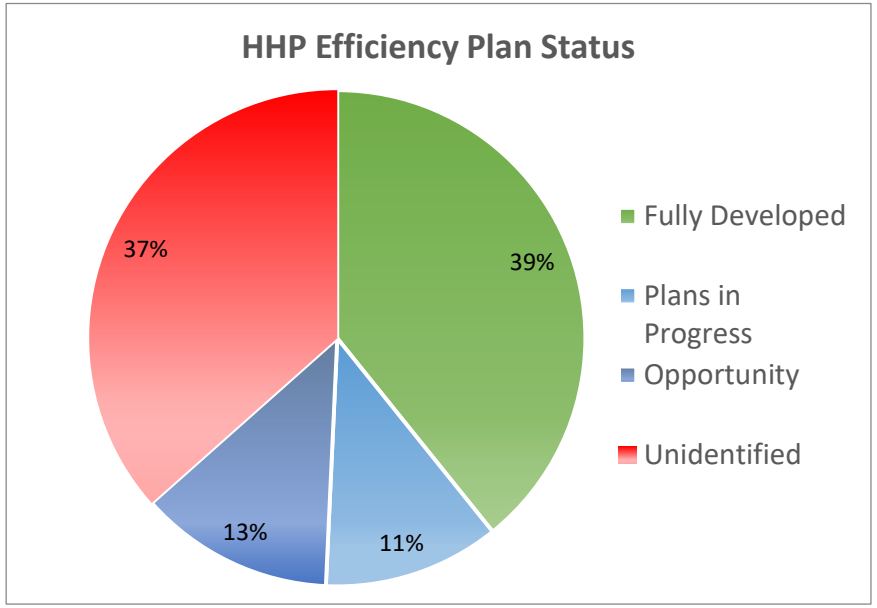
Financial Performance – CIP

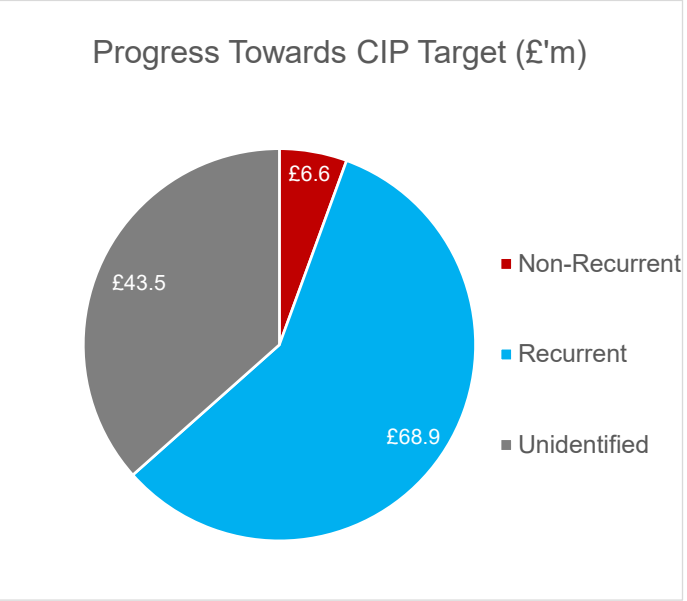
Efficiency Forecast Risk	HUTH	NLAG	HHP
High Risk	20,309	15,518	35,826
Medium risk	1,726	6,097	7,823
Low Risk	27,462	4,450	31,912
Unidentified	23,384	20,158	43,542
TOTAL	**72,881**	**46,223**	**119,104**

Efficiency Forecast Status	HUTH	NLAG	HHP
Fully Developed	26,058	20,662	46,719
Plans in Progress	8,523	5,183	13,706
Opportunity	14,916	220	15,136
Unidentified	23,384	20,158	43,542
TOTAL	**72,881**	**46,223**	**119,104**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£138.8m)

Bridging from the (£63.1m) planned deficit for 2026-27 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income and associated Expenditure totalling (£9.5m).
2. The Group currently has unidentified and non recurrent CIP of (£72.5m).
3. The in year CIP schemes have a potential FYE of £19.2m if delivered in full in year.
4. The Group has incurred £1.5m of Industrial Action costs (net of pay reductions).
5. The Groups has committed investments with a full year effect of (£8.5m).
6. The Group is forecasting to deliver £5.9m of NR Technical balance sheet support.

This position assumes that CIP opportunities including high risk schemes will be delivered recurrently and in full. Delivery of these schemes will be the key driver for the Trust's underlying financial position both in year and the potential full year effects of in year schemes.

£million	NLAG	HUTH	HHP
2026/27 - Planned Surplus/(Deficit)	**(23.7)**	**(39.4)**	**(63.1)**
Non-recurrent Adjustments			
NR Additional Income & Costs	1.3	(10.8)	(9.5)
NR CIP (Forecast incl Unidentified & Risk)	(21.8)	(50.7)	(72.5)
FYE 26/27 CIP (Risk Adjusted)	3.2	16.0	19.2
NR Industrial Action	0.3	1.1	1.5
FYE 26/27 Investments	(3.0)	(5.4)	(8.5)
NR Technical & Other	(4.6)	(1.3)	(5.9)
Underlying Deficit	**(48.2)**	**(90.6)**	**(138.8)**

System Financial Performance – Month 5, August 2026

The ICS reported a YTD deficit of (£83.4m), (£46.8m) adverse to plan. The ICS is forecasting a (£63.1m) plan compliant deficit at the year end. (Headline values include Deficit Support Funding)

			Surplus / (Deficit) Including DSF						Surplus / (Deficit) Excluding DSF					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire														
QOQ	NHS Humber and North Yorkshire ICB	ICB	0	0	0	0	0	0	(4,535)	(4,535)	0	(10,883)	(10,883)	0
RCD	Harrogate and District NHS Foundation Trust	Provider	(2,408)	(18,816)	(16,408)	0	0	0	(8,033)	(18,816)	(10,783)	(13,500)	(13,500)	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	(21,578)	(36,124)	(14,546)	(39,400)	(39,400)	0	(21,578)	(36,124)	(14,546)	(39,400)	(39,400)	0
RV9	Humber Teaching NHS Foundation Trust	Provider	0	0	0	0	0	0	0	0	0	0	0	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	(12,491)	(14,328)	(1,837)	(23,665)	(23,665)	0	(12,491)	(14,328)	(1,837)	(23,665)	(23,665)	0
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	(78)	(14,082)	(14,004)	0	0	0	(7,784)	(14,082)	(6,298)	(18,500)	(18,500)	0
Humber and North Yorkshire Provider Total		**QOQ**	**(36,555)**	**(83,350)**	**(46,795)**	**(63,065)**	**(63,065)**	**0**	**(49,886)**	**(83,350)**	**(33,464)**	**(95,065)**	**(95,065)**	**0**
Humber and North Yorkshire Total		**QOQ**	**(36,555)**	**(83,350)**	**(46,795)**	**(63,065)**	**(63,065)**	**0**	**(54,421)**	**(87,885)**	**(33,464)**	**(105,948)**	**(105,948)**	**0**

			Total Efficiencies					
Code	Name	ICB / Provider	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	FOT £000s	Variance £000s
Humber and North Yorkshire								
QOQ	NHS Humber and North Yorkshire ICB	ICB	30,231	29,869	(362)	81,468	81,467	(1)
RCD	Harrogate and District NHS Foundation Trust	Provider	11,994	5,897	(6,097)	32,000	32,000	0
RWA	Hull University Teaching Hospitals NHS Trust	Provider	25,792	10,540	(15,252)	72,881	72,881	(0)
RV9	Humber Teaching NHS Foundation Trust	Provider	5,876	6,037	161	14,353	14,353	0
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Provider	15,633	7,920	(7,713)	46,223	46,223	(0)
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Provider	26,329	19,711	(6,618)	65,787	65,786	(1)
Humber and North Yorkshire Provider Total		**QOQ**	**85,624**	**50,105**	**(35,518)**	**231,244**	**231,242**	**(2)**
Humber and North Yorkshire Total		**QOQ**	**115,855**	**79,974**	**(35,881)**	**312,712**	**312,709**	**(2)**

Note - The ICS plan has been updated following formal agreement of revised financial plans for Harrogate & York Trusts.

Capital Expenditure

The Group has spent £8.5m year to date on capital expenditure against a plan of £23.4m plan, (£14.9m) behind plan.

£million	NLAG Year to Date Plan	NLAG Year to Date Actual	NLAG Year to Date Var.	HUTH Year to Date Plan	HUTH Year to Date Actual	HUTH Year to Date Var.	HHP Year to Date Plan	HHP Year to Date Actual	HHP Year to Date Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	2.5	0.0	(2.5)	0.0	0.0	0.0	2.5	0.0	(2.5)
Constitutional Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1
Theatre upgrades and ventilation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HRI Tower Block	0.0	0.0	0.0	5.0	0.1	(4.9)	5.0	0.1	(4.9)
SDEC	0.0	0.0	0.0	4.0	0.0	(4.0)	4.0	0.0	(4.0)
Total Estates Major Schemes	**2.5**	**0.1**	**(2.4)**	**9.0**	**0.2**	**(8.8)**	**11.5**	**0.2**	**(11.3)**
Other Estates Schemes	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0
IM&T Programme	0.6	0.4	(0.2)	0.2	0.4	0.2	0.8	0.8	(0.1)
EPR	2.4	2.0	(0.4)	1.1	2.2	1.1	3.5	4.2	0.6
Equipment Renewal	0.4	0.0	(0.4)	3.0	0.1	(2.9)	3.4	0.1	(3.3)
Facilities Maintenance	0.8	0.4	(0.4)	0.5	0.5	0.1	1.3	0.9	(0.3)
Other Capital Expenditure	0.1	0.3	0.2	2.7	1.9	(0.9)	2.8	2.2	(0.6)
Total Capital Programme	**6.9**	**3.2**	**(3.7)**	**16.5**	**5.3**	**(11.3)**	**23.4**	**8.5**	**(14.9)**
Funded By:									
Internally Generated	6.2	2.5	(3.6)	7.5	5.3	(2.3)	13.7	7.8	(5.9)
PDC Funded	0.6	0.4	(0.2)	9.0	0.0	(9.0)	9.6	0.4	(9.2)
Donated	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
IFRS16	0.1	0.3	0.2	0.0	0.0	0.0	0.1	0.3	0.2
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**6.9**	**3.2**	**(3.7)**	**16.5**	**5.3**	**(11.3)**	**23.4**	**8.5**	**(14.9)**

Key areas of slippage in Month 5 continue to relate to HRI: the reconfiguration required to facilitate SDEC and the Tower Block improvements. Enabling has commenced for the Lansdown building. Building Safety Regulation (BSR) for SDEC configuration is waiting approval, this has been extended further to 28th September.

The revised profile and cost for the Tower Block scheme is expected to be agreed later this month (Sept) and should see the reduction from £12.5m in 2026/27 to circa £2.4m with increases in 2027/28 and 2028/29.

Delayed spend on new ITU at DPoW, the CCU demolition started on 11 May, phase 1 is progressing, however phase 2, old medical records has been delayed due to bitumen adhesive being found under the floor. Planned work to strip all asbestos prior to phase 2 start.

Ward C6 at DPoW is now fully live and progressing well on site.

For both Trusts, the latest UEC Business cases have been approved (£2m for NLaG DPoW SDEC and £1.5m for H36/EEMAC HUTH), MOUs have been issued and the PDC will be drawn down accordingly, as the schemes progress.

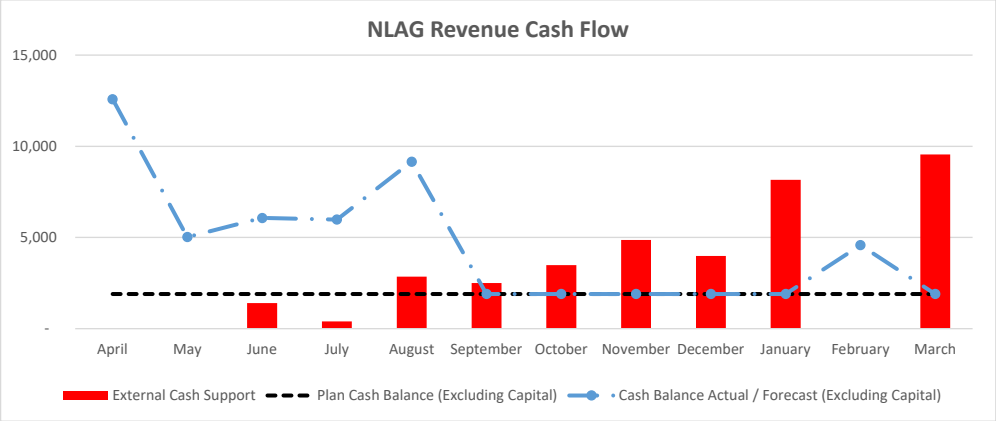
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual 31-Jul-26	Actual 31-Aug-26	In month movement	Actual 31-Jul-26	Actual 31-Aug-26	In month movement	Actual 31-Jul-26	Actual 31-Aug-26	In month movement
Fixed Assets	308.6	307.2	(1.4)	540.8	539.0	(1.8)	849.4	846.2	(3.2)
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	5.1	0.0	19.6	20.4	0.8	24.7	25.5	0.8
Trade and Other Debtors	19.4	19.3	(0.0)	44.6	45.4	0.8	64.0	64.7	0.7
Cash	27.5	31.1	3.6	20.0	20.0	0.0	47.4	51.1	3.7
Total Current Assets	**51.9**	**55.5**	**3.6**	**84.2**	**85.8**	**1.6**	**136.1**	**141.3**	**5.2**
Current Liabilities									
Trade and Other Creditors	(62.4)	(64.3)	(1.9)	(84.1)	(81.3)	2.7	(146.5)	(145.7)	0.8
Accruals	(26.1)	(27.9)	(1.8)	(39.0)	(42.9)	(3.9)	(65.1)	(70.8)	(5.7)
Other Current Liabilities	(11.8)	(9.9)	1.9	(27.6)	(26.1)	1.5	(39.4)	(36.1)	3.4
Total Current Liabilities	**(100.3)**	**(102.2)**	**(1.9)**	**(150.7)**	**(150.4)**	**0.4**	**(251.0)**	**(252.5)**	**(1.5)**
Net Current Liabilities	**(48.4)**	**(46.7)**	**1.7**	**(66.5)**	**(64.6)**	**1.9**	**(114.9)**	**(111.2)**	**3.6**
Debtors Due > 1 Year	0.7	0.7	0.0	2.0	2.0	0.0	2.7	2.7	0.0
Creditors Due > 1 Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans > 1 Year	(2.9)	(2.9)	0.0	(3.1)	(3.1)	0.0	(6.0)	(6.0)	0.0
Finance Lease Obligations > 1 Year	(6.4)	(6.3)	0.1	(69.1)	(68.6)	0.5	(75.5)	(74.9)	0.6
Provisions - Non Current	(3.3)	(3.3)	0.0	(2.2)	(2.2)	0.0	(5.5)	(5.5)	0.0
Total Assets/(Liabilities)	**248.3**	**248.7**	**0.4**	**402.4**	**403.0**	**0.6**	**650.7**	**651.7**	**1.1**
TOTAL CAPITAL & RESERVES	**248.3**	**248.7**	**0.4**	**402.4**	**403.0**	**0.6**	**650.7**	**651.7**	**1.1**

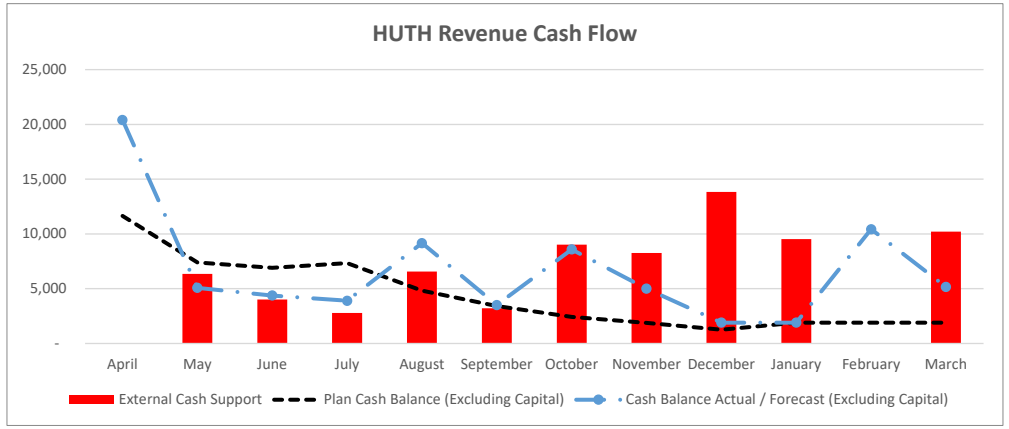
Cash Flow

The Group cash balance increased by £3.7m in month to £51.1m (£20.0m HUTH / £31.1m NLAG). £24.3m of additional external cash support (Revenue Support Public Dividend Capital (PDC)) has been drawn down at the end of Month 5. The Group requested £21.6m of cash support for September but has only gained approval of £5.7m putting further pressure on cash balances and timely creditor payments, resulting in an increased October request of £12.5m still awaiting NHSE approval.

NLAG



HUTH



2026-27 Combined ICB and Provider Summary
Month 5
BPPC Summary

			YTD					
			Percentage of bills paid within target			Percentage of bills paid within target		
			Current YTD by Number			Current YTD by Value £000s		
Code	Name	Provider Type	Non NHS %	NHS %	Total %	Non NHS %	NHS %	Total %
Humber and North Yorkshire								
RCD	Harrogate and District NHS Foundation Trust	Acute	15.1%	16.9%	15.2%	38.5%	7.7%	35.8%
RWA	Hull University Teaching Hospitals NHS Trust	Acute	68.7%	69.5%	68.7%	60.0%	76.9%	62.9%
RV9	Humber Teaching NHS Foundation Trust	Mental Health	98.9%	90.0%	98.4%	96.8%	98.9%	97.4%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	Acute	57.9%	62.2%	58.0%	77.2%	71.5%	76.5%
RCB	York and Scarborough Teaching Hospitals NHS Foundation Trust	Acute	89.5%	68.4%	88.9%	88.8%	65.9%	85.5%
Humber and North Yorkshire Total			#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!

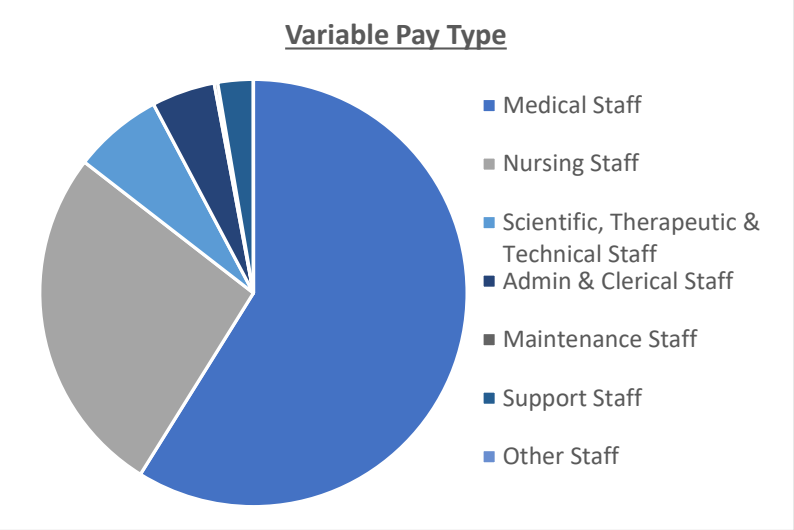
Variable Pay Summary

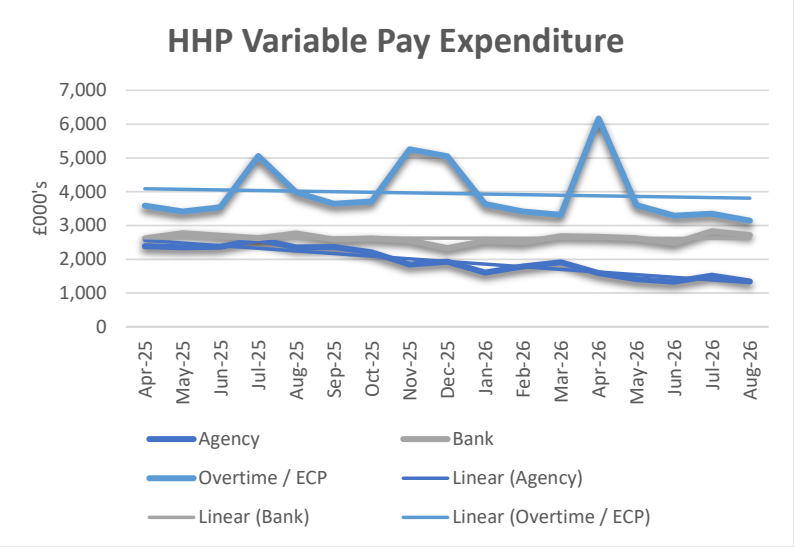
The Group has spent £40.1m on variable pay YTD. This is £5.0m less than the same period in 2025/26. The position includes £1.9m of expenditure covering Industrial Action.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Agency	Medical Staff	3,656	2,089	1,566	5,479	3,670	1,809	9,135	5,759	3,375
	Nursing Staff	591	516	75	1,452	360	1,092	2,044	876	1,168
	Scientific, Therapeutic & Technical Staff	111	102	9	719	451	267	830	553	277
	Admin & Clerical Staff	(12)	7	(18)	40	0	40	28	7	21
	Maintenance Staff	0	0	0	0	2	(2)	0	2	(2)
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	22	0	22	2	2	(0)	24	2	22
Agency Total		4,368	2,714	1,654	7,692	4,486	3,206	12,060	7,200	4,860
Bank	Medical Staff	1,934	2,177	(243)	987	968	19	2,921	3,145	(224)
	Nursing Staff	1,855	1,751	104	5,190	5,506	(316)	7,045	7,256	(212)
	Scientific, Therapeutic & Technical Staff	300	183	118	657	523	133	957	706	251
	Admin & Clerical Staff	448	459	(11)	863	921	(59)	1,310	1,381	(70)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	71	39	31	1,178	794	383	1,249	834	415
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		4,608	4,609	(1)	8,874	8,712	161	13,481	13,321	160
Overtime / ECP's	Medical Staff	7,314	7,928	(614)	6,279	6,762	(483)	13,592	14,690	(1,098)
	Nursing Staff	2,490	2,084	406	829	452	377	3,318	2,536	783
	Scientific, Therapeutic & Technical Staff	954	904	49	646	545	101	1,600	1,449	151
	Admin & Clerical Staff	500	430	70	134	106	27	633	536	97
	Maintenance Staff	84	77	7	25	28	(3)	108	105	4
	Support Staff	260	201	59	68	38	30	328	239	89
	Other Staff	0	0	0	0	0	0	0	0	0
Overtime / ECP's Total		11,601	11,624	(23)	7,980	7,931	49	19,581	19,555	26
Grand Total		20,577	18,947	1,630	24,545	21,129	3,417	45,122	40,076	5,047

Agency Spend v's Agency CAP								
Bank Spend v's Bank CAP								

	HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Subjective Sub category	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Medical Staff	12,903	12,194	709	12,744	11,400	1,345	25,647	23,594	2,054
Nursing Staff	4,936	4,351	586	7,470	6,317	1,153	12,407	10,668	1,739
Scientific, Therapeutic & Technical Staff	1,365	1,189	176	2,022	1,520	502	3,387	2,708	679
Admin & Clerical Staff	936	896	40	1,036	1,028	8	1,972	1,923	49
Maintenance Staff	84	77	7	25	30	(5)	108	107	2
Support Staff	331	241	90	1,246	832	414	1,577	1,073	504
Other Staff	22	0	22	2	2	(0)	24	2	22
Grand Total	20,577	18,947	1,630	24,545	21,129	3,417	45,122	40,076	5,047





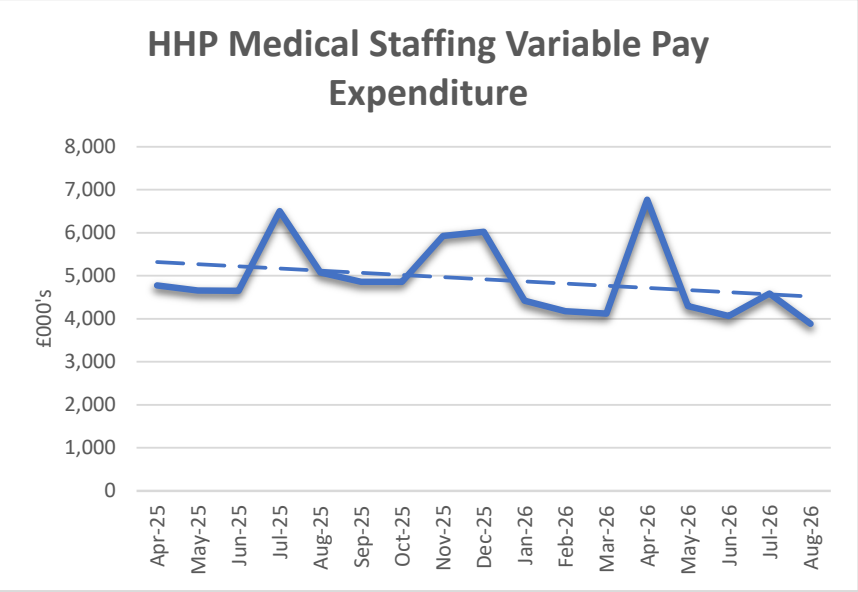
Variable Pay Summary – Directorate / Care Group

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	3,739	3,906	(167)	0	16	(16)	3,739	3,923	(184)
	Acute and Emergency Medicine (South)	0	0	0	6,471	5,928	543	6,471	5,928	543
	Cancer Network	72	16	57	37	13	24	110	29	81
	Cardiovascular	1,225	1,226	(2)	241	311	(69)	1,466	1,537	(71)
	Chief Delivery Officer	7	0	6	15	22	(7)	22	22	(0)
	Community, Frailty & Therapy	1,891	1,630	262	1,474	1,486	(12)	3,366	3,116	250
	Digestive Diseases	1,090	1,211	(120)	1,314	1,621	(307)	2,404	2,831	(428)
	Family Services	2,026	2,420	(394)	2,729	2,590	139	4,756	5,011	(255)
	Head & Neck	1,368	772	596	1,595	986	609	2,963	1,758	1,205
	Neuroscience	735	544	191	676	557	119	1,411	1,101	309
	Pathology Network Group	87	53	34	542	336	206	629	389	240
	Patient Services	661	638	23	526	494	32	1,187	1,132	55
	Site Management & Discharge teams	262	93	168	124	155	(31)	386	248	137
	Specialist Cancer and Support Services	2,173	2,238	(65)	2,035	1,657	378	4,208	3,895	313
	Specialist Medicine	730	606	123	1,533	1,144	389	2,263	1,750	512
	Specialist Surgery	1,277	1,103	175	1,310	769	541	2,587	1,872	716
	Theatres, Anaesthetics and Critical Care	2,631	1,922	709	2,414	2,023	391	5,045	3,945	1,100
Total Operations		**19,973**	**18,378**	**1,595**	**23,038**	**20,108**	**2,930**	**43,011**	**38,486**	**4,526**
Corporate	Corporate Directorates	604	569	34	1,507	1,021	486	2,111	1,590	521
Total Corporate		**604**	**569**	**34**	**1,507**	**1,021**	**486**	**2,111**	**1,590**	**521**
Grand Total		**20,577**	**18,947**	**1,630**	**24,545**	**21,129**	**3,417**	**45,122**	**40,076**	**5,047**

Variable Pay Summary – Medical Staffing

The Group has spent £23.6m on Medical Staffing variable pay YTD. This is £2.0m less than the same period in 2025/26 but does include £1.9m of Industrial Action Cover.

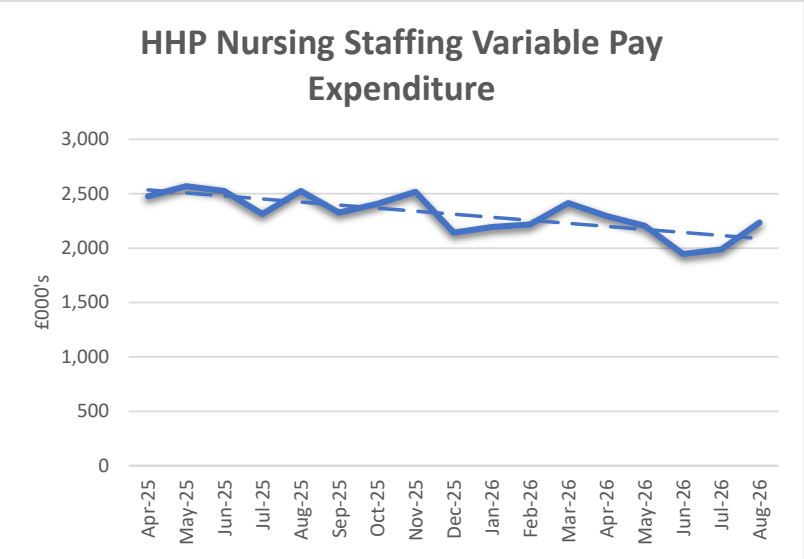
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	2,755	2,891	(136)	0	0	0	2,755	2,891	(136)
	Acute and Emergency Medicine (South)	0	0	0	4,034	3,761	274	4,034	3,761	274
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	904	860	44	67	90	(24)	970	950	20
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	993	851	143	611	603	8	1,604	1,453	151
	Digestive Diseases	640	798	(158)	743	1,062	(319)	1,383	1,860	(477)
	Family Services	1,348	1,649	(301)	1,091	1,507	(416)	2,439	3,156	(717)
	Head & Neck	1,251	684	568	1,335	767	568	2,586	1,450	1,136
	Neuroscience	452	340	112	305	259	46	757	599	158
	Pathology Network Group	74	31	43	156	110	45	230	141	89
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	961	1,117	(156)	804	567	237	1,765	1,684	81
	Specialist Medicine	483	343	140	947	651	296	1,430	993	437
	Specialist Surgery	1,046	939	107	1,061	566	495	2,106	1,505	602
	Theatres, Anaesthetics and Critical Care	1,996	1,661	335	1,587	1,456	131	3,582	3,117	465
Total Operations		**12,902**	**12,162**	**739**	**12,741**	**11,399**	**1,342**	**25,643**	**23,561**	**2,082**
Corporate	Corporate Directorates	1	32	(31)	3	1	2	5	33	(28)
Total Corporate		**1**	**32**	**(31)**	**3**	**1**	**2**	**5**	**33**	**(28)**
Grand Total		**12,903**	**12,194**	**709**	**12,744**	**11,400**	**1,345**	**25,647**	**23,594**	**2,054**



Variable Pay Summary - Nursing

The Group has spent £10.7m on Nursing variable pay YTD. This is £1.7m less than the same period in 2025/26.

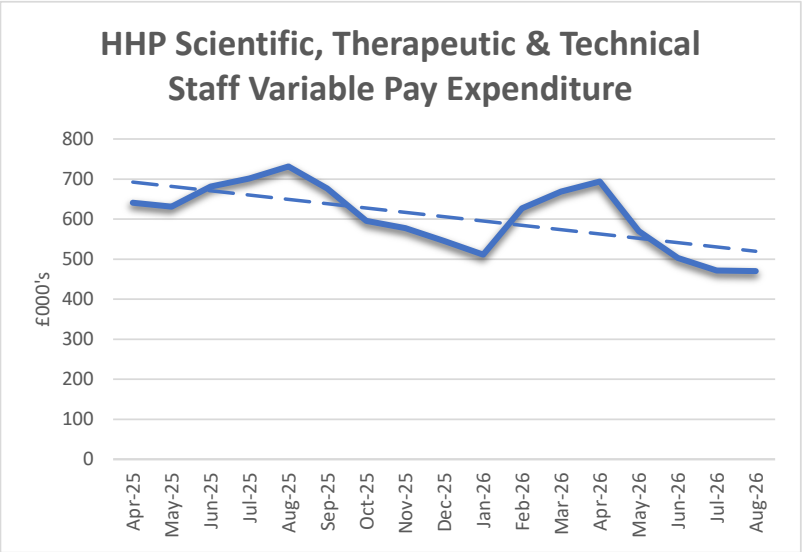
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	960	994	(35)	0	0	0	960	994	(35)
	Acute and Emergency Medicine (South)	0	0	0	2,355	2,093	262	2,355	2,093	262
	Cancer Network	2	3	(2)	3	0	3	5	4	2
	Cardiovascular	223	274	(51)	143	172	(29)	366	445	(79)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	722	659	63	654	687	(33)	1,376	1,346	30
	Digestive Diseases	428	396	32	571	558	12	998	954	44
	Family Services	674	769	(95)	1,637	1,071	566	2,311	1,840	471
	Head & Neck	60	53	7	29	48	(19)	89	101	(13)
	Neuroscience	269	202	67	331	272	59	601	474	126
	Pathology Network Group	2	1	1	0	0	(0)	2	2	0
	Patient Services	10	8	2	60	4	56	70	12	58
	Site Management & Discharge teams	249	83	166	120	150	(29)	369	232	137
	Specialist Cancer and Support Services	373	267	106	87	124	(37)	460	391	69
	Specialist Medicine	240	255	(15)	563	477	86	803	732	71
	Specialist Surgery	221	153	68	249	203	46	470	356	114
	Theatres, Anaesthetics and Critical Care	458	213	245	631	435	196	1,090	649	441
Total Operations		**4,890**	**4,330**	**560**	**7,434**	**6,296**	**1,138**	**12,324**	**10,626**	**1,698**
Corporate	Corporate Directorates	46	20	26	36	22	15	83	42	41
Total Corporate		**46**	**20**	**26**	**36**	**22**	**15**	**83**	**42**	**41**
Grand Total		**4,936**	**4,351**	**586**	**7,470**	**6,317**	**1,153**	**12,407**	**10,668**	**1,739**



Variable Pay Summary – Scientific, Therapeutic & Technical Staff

The Group has spent £2.7m on AHP variable pay YTD. This is £0.7m less than the same period in 2025/26.

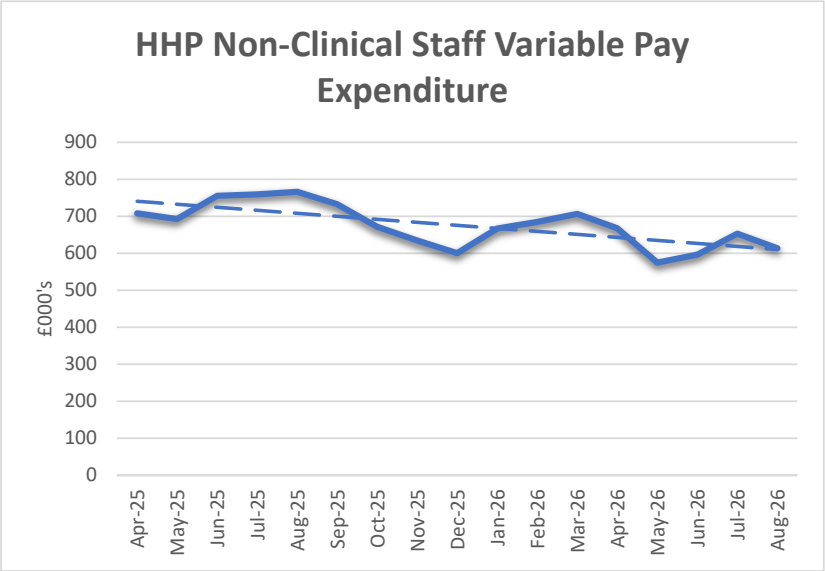
		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	0	0	0	0	0	0	0	0	0
	Acute and Emergency Medicine (South)	0	0	0	0	0	0	0	0	0
	Cancer Network	44	0	44	0	0	0	44	0	44
	Cardiovascular	95	85	10	30	48	(17)	126	133	(7)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	164	105	59	128	90	39	292	195	98
	Digestive Diseases	0	3	(3)	0	0	(0)	0	4	(3)
	Family Services	1	1	0	0	0	0	1	1	0
	Head & Neck	51	32	19	191	151	40	242	182	59
	Neuroscience	8	1	7	35	16	19	44	17	27
	Pathology Network Group	10	20	(10)	365	219	146	375	239	136
	Patient Services	0	0	(0)	0	0	0	0	0	(0)
	Site Management & Discharge teams	0	0	0	0	0	0	0	0	0
	Specialist Cancer and Support Services	760	807	(47)	1,085	855	229	1,845	1,662	183
	Specialist Medicine	6	4	2	7	3	4	13	7	5
	Specialist Surgery	8	11	(3)	0	0	0	8	11	(3)
	Theatres, Anaesthetics and Critical Care	177	48	129	165	120	45	341	167	174
Total Operations		**1,324**	**1,117**	**207**	**2,007**	**1,502**	**505**	**3,331**	**2,619**	**712**
Corporate	Corporate Directorates	41	72	(30)	15	18	(3)	56	90	(33)
Total Corporate		**41**	**72**	**(30)**	**15**	**18**	**(3)**	**56**	**90**	**(33)**
Grand Total		**1,365**	**1,189**	**176**	**2,022**	**1,520**	**502**	**3,387**	**2,708**	**679**



Variable Pay Summary – Non-Clinical Staff

The Group has spent £3.1m on Non-Clinical variable pay YTD. This is £0.6m less than the same period in 2025/26.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2025/26	2026/27	Variance	2025/26	2026/27	Variance	2025/26	2026/27	Variance
Operations	Acute and Emergency Medicine (North)	24	21	3	0	16	(16)	24	37	(13)
	Acute and Emergency Medicine (South)	0	0	0	81	74	7	81	74	7
	Cancer Network	27	12	14	34	13	21	61	25	36
	Cardiovascular	3	7	(5)	1	1	0	4	8	(4)
	Chief Delivery Officer	7	0	6	15	22	(7)	22	22	(0)
	Community, Frailty & Therapy	12	16	(3)	81	106	(25)	93	121	(28)
	Digestive Diseases	22	14	9	0	0	(0)	22	14	8
	Family Services	4	1	3	1	12	(11)	5	14	(8)
	Head & Neck	6	4	2	40	20	20	46	24	23
	Neuroscience	5	1	4	3	9	(6)	9	10	(2)
	Pathology Network Group	0	0	0	22	7	15	22	7	15
	Patient Services	652	629	22	466	489	(24)	1,117	1,119	(2)
	Site Management & Discharge teams	13	10	2	4	6	(2)	17	16	1
	Specialist Cancer and Support Services	79	47	32	59	111	(52)	139	158	(19)
	Specialist Medicine	1	5	(4)	17	13	3	18	18	(0)
	Specialist Surgery	3	0	3	0	0	0	3	0	3
	Theatres, Anaesthetics and Critical Care	0	0	0	32	12	20	32	12	20
Total Operations		**858**	**768**	**90**	**856**	**912**	**(56)**	**1,714**	**1,680**	**34**
Corporate	Corporate Directorates	514	445	69	1,453	980	472	1,967	1,425	542
Total Corporate		**514**	**445**	**69**	**1,453**	**980**	**472**	**1,967**	**1,425**	**542**
Grand Total		**1,372**	**1,213**	**159**	**2,309**	**1,892**	**417**	**3,681**	**3,105**	**576**



Variable Pay v's 30% Target Reduction

The Group has seen a marginal decrease in its variable pay expenditure once adjusting for industrial Action expenditure. However, this falls well short of the 30% targeted reduction. A straight-line projection would be (£20.9m) higher than target.

HHP Variable Pay £k (excluding IA)

Directorate / Care Group	Annual Target	Monthly Target	August	Variance to Target	YTD Target	YTD Actual (exc IA)	YTD Variance to Target	YTD Straight-line	Forecast Variance to Target
Acute And Emergency Medicine North	5,754	479	634	(154)	2,397	3,547	(1,150)	8,514	(2,760)
Acute And Emergency Medicine South	10,912	909	1,129	(219)	4,547	5,819	(1,273)	13,966	(3,054)
Cancer Network	126	10	4	7	52	29	24	69	57
Cardiovascular	2,068	172	219	(47)	861	1,358	(497)	3,260	(1,192)
Chief Delivery Officer	0	0	3	(3)	0	22	(22)	52	(52)
Community, Frailty & Therapy	5,468	456	614	(158)	2,278	2,995	(716)	7,187	(1,719)
Digestive Diseases	4,395	366	434	(67)	1,831	2,637	(806)	6,329	(1,934)
Family Services	7,552	629	963	(333)	3,147	4,605	(1,458)	11,052	(3,499)
Head & Neck	4,262	355	309	47	1,776	1,721	55	4,131	131
Neuroscience	2,222	185	172	13	926	1,057	(131)	2,536	(315)
Pathology Network Group	1,060	88	57	31	442	389	53	933	127
Patient Services	1,583	132	194	(62)	660	1,132	(472)	2,716	(1,134)
Site Management & Discharge Teams	633	53	49	4	264	248	16	596	37
Specialist Cancer And Support Services	6,621	552	630	(78)	2,759	3,814	(1,055)	9,154	(2,533)
Specialist Medicine	3,211	268	334	(66)	1,338	1,645	(307)	3,949	(738)
Specialist Surgery	3,571	298	351	(53)	1,488	1,740	(252)	4,176	(605)
Theatres, Anaesthetics And Critical Care	7,665	639	764	(126)	3,194	3,830	(637)	9,193	(1,528)
Sub Total Operations	**67,103**	**5,592**	**6,860**	**(1,268)**	**27,960**	**36,588**	**(8,629)**	**87,812**	**(20,709)**
Chief Executive	13	1	5	(4)	6	25	(19)	59	(46)
Chief Medical Officer	20	2	4	(2)	8	27	(19)	65	(44)
Chief Nurse Office	181	15	17	(2)	75	99	(24)	238	(57)
Director of Assurance	0	0	-	0	0	-	0	-	0
Director of People	227	19	10	9	95	78	17	186	41
Director of Finance, Estates & Facilities	3,038	253	299	(46)	1,266	1,269	(3)	3,046	(8)
Strategy and Partnerships	133	11	8	3	56	92	(36)	221	(87)
Sub Total Operations	**3,613**	**301**	**344**	**(42)**	**1,505**	**1,590**	**(84)**	**3,816**	**(203)**
TOTAL	**70,716**	**5,893**	**7,203**	**(1,310)**	**29,465**	**38,178**	**(8,713)**	**91,628**	**(20,912)**

Appendices

Appendix A – Trust I&E & Divisional Budgetary Performance

£million	HUTH £m						NLAG £m						HHP £m					
	CM			YTD			CM			YTD			CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income																		
Clinical Income	75.9	76.5	0.6	379.0	382.0	3.0	47.0	46.9	(0.1)	234.9	233.4	(1.5)	122.9	123.5	0.5	613.8	615.4	1.5
Other Income	6.1	7.0	0.9	30.6	31.5	0.9	4.5	4.4	(0.1)	22.5	23.2	0.7	10.6	11.4	0.8	53.1	54.7	1.6
Total Operating Income	**82.0**	**83.6**	**1.5**	**409.6**	**413.5**	**3.9**	**51.5**	**51.3**	**(0.2)**	**257.3**	**256.5**	**(0.8)**	**133.5**	**134.9**	**1.3**	**667.0**	**670.1**	**3.1**
Pay Costs																		
Medical Staff	(17.5)	(18.9)	(1.4)	(88.1)	(94.4)	(6.3)	(10.7)	(10.8)	(0.1)	(53.4)	(53.7)	(0.3)	(28.3)	(29.8)	(1.5)	(141.5)	(148.1)	(6.6)
Nursing Staff	(16.2)	(16.4)	(0.2)	(81.8)	(82.4)	(0.6)	(13.6)	(13.1)	0.5	(68.0)	(66.1)	1.9	(29.8)	(29.5)	0.3	(149.8)	(148.5)	1.3
Scientific Therapeutic & Technical Staff	(7.4)	(7.3)	0.1	(37.8)	(36.4)	1.4	(5.5)	(5.4)	0.2	(27.9)	(27.1)	0.8	(12.9)	(12.7)	0.3	(65.7)	(63.6)	2.1
Total Clincial Pay	**(41.2)**	**(42.6)**	**(1.5)**	**(207.7)**	**(213.2)**	**(5.6)**	**(29.9)**	**(29.3)**	**0.6**	**(149.3)**	**(146.9)**	**2.4**	**(71.1)**	**(72.0)**	**(0.9)**	**(357.0)**	**(360.2)**	**(3.2)**
Admin & Clerical Staff	(6.3)	(6.4)	(0.1)	(32.6)	(32.4)	0.2	(5.4)	(5.2)	0.2	(27.0)	(26.5)	0.5	(11.6)	(11.6)	0.0	(59.6)	(58.8)	0.7
Maintenance Staff	(0.3)	(0.3)	(0.0)	(1.6)	(1.6)	0.0	(0.2)	(0.2)	0.0	(0.9)	(0.9)	0.0	(0.5)	(0.5)	0.0	(2.5)	(2.4)	0.1
Support Staff	(1.8)	(1.8)	(0.1)	(8.4)	(8.4)	0.0	(1.5)	(1.7)	(0.1)	(7.5)	(8.2)	(0.7)	(3.3)	(3.5)	(0.2)	(16.0)	(16.6)	(0.7)
Other Staff	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.0
Apprentice Levy	(0.2)	(0.2)	(0.0)	(0.8)	(1.0)	(0.2)	(0.1)	(0.1)	0.0	(0.7)	(0.7)	0.0	(0.3)	(0.3)	(0.0)	(1.5)	(1.7)	(0.2)
Total Other Pay	**(8.5)**	**(8.7)**	**(0.2)**	**(43.5)**	**(43.4)**	**0.1**	**(7.2)**	**(7.2)**	**0.1**	**(36.2)**	**(36.3)**	**(0.1)**	**(15.8)**	**(15.9)**	**(0.2)**	**(79.7)**	**(79.7)**	**(0.0)**
Total Pay Costs	**(49.7)**	**(51.4)**	**(1.7)**	**(251.2)**	**(256.6)**	**(5.5)**	**(37.1)**	**(36.5)**	**0.6**	**(185.5)**	**(183.3)**	**2.3**	**(86.8)**	**(87.9)**	**(1.1)**	**(436.7)**	**(439.9)**	**(3.2)**
Drugs	(11.3)	(12.0)	(0.7)	(56.7)	(61.2)	(4.5)	(3.4)	(3.4)	(0.0)	(16.9)	(17.6)	(0.6)	(14.7)	(15.4)	(0.7)	(73.6)	(78.7)	(5.1)
Clinical Supplies & Services	(8.3)	(7.6)	0.7	(42.6)	(42.7)	(0.1)	(4.7)	(4.9)	(0.1)	(23.8)	(24.3)	(0.5)	(13.1)	(12.5)	0.6	(66.4)	(67.0)	(0.6)
Total Clinical Non Pay	**(19.7)**	**(19.7)**	**0.0**	**(99.3)**	**(103.8)**	**(4.5)**	**(8.1)**	**(8.3)**	**(0.1)**	**(40.7)**	**(41.9)**	**(1.2)**	**(27.8)**	**(27.9)**	**(0.1)**	**(140.1)**	**(145.7)**	**(5.7)**
Admin & Clerical Staff - Non Execs	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.1
General Supplies & Services	(1.8)	(2.2)	(0.4)	(9.6)	(10.5)	(0.9)	(0.7)	(0.7)	(0.0)	(3.4)	(3.5)	(0.2)	(2.4)	(2.9)	(0.4)	(13.0)	(14.1)	(1.1)
Establishment Expenses	(0.3)	(0.3)	(0.0)	(1.5)	(2.0)	(0.5)	(0.3)	(0.3)	0.0	(1.8)	(1.8)	(0.0)	(0.6)	(0.6)	0.0	(3.3)	(3.8)	(0.5)
Establishment Expenses Op Lease	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	(0.1)	0.0	(0.3)	(0.4)	(0.1)	(0.1)	(0.1)	0.0	(0.3)	(0.4)	(0.1)
Establishment Expenses Transport	(0.2)	(0.2)	(0.1)	(0.9)	(1.2)	(0.3)	(0.3)	(0.3)	(0.0)	(1.3)	(1.3)	(0.0)	(0.4)	(0.5)	(0.1)	(2.1)	(2.5)	(0.3)
Other Establishment Costs	(0.2)	(0.5)	(0.3)	(0.9)	(1.7)	(0.8)	(0.1)	(0.2)	(0.1)	(0.5)	(0.7)	(0.2)	(0.3)	(0.7)	(0.4)	(1.4)	(2.4)	(1.0)
Other Establishment Costs Clinical Negligence	(2.5)	(2.4)	0.1	(12.3)	(11.9)	0.4	(1.6)	(1.5)	0.0	(7.8)	(7.7)	0.1	(4.0)	(3.9)	0.1	(20.1)	(19.6)	0.5
Premises and Fixed Plant	(2.9)	(2.8)	0.1	(15.3)	(14.3)	1.0	(1.7)	(1.7)	0.0	(9.2)	(9.1)	0.1	(4.6)	(4.5)	0.1	(24.5)	(23.4)	1.1
Premises and Fixed Plant - Rates	(0.4)	(0.4)	(0.1)	(1.9)	(2.2)	(0.3)	(0.2)	(0.3)	(0.0)	(1.2)	(1.3)	(0.1)	(0.6)	(0.7)	(0.1)	(3.1)	(3.5)	(0.4)
Purchase of Healthcare Services NHS and other DHSC bodies	(1.9)	(2.2)	(0.3)	(9.4)	(10.3)	(0.9)	(0.3)	(0.2)	0.1	(1.6)	(1.3)	0.3	(2.2)	(2.4)	(0.2)	(11.0)	(11.6)	(0.6)
Purchase of Healthcare Services Non NHS	(0.9)	(2.0)	(1.1)	(4.5)	(9.8)	(5.3)	(0.1)	(1.0)	(0.9)	(0.6)	(5.0)	(4.4)	(1.0)	(3.1)	(2.1)	(5.1)	(14.9)	(9.8)
Miscellaneous Expenditure	(0.1)	(0.3)	(0.3)	(0.4)	(0.6)	(0.2)	(0.1)	(0.1)	0.0	(0.3)	(0.4)	(0.0)	(0.1)	(0.4)	(0.2)	(0.7)	(1.0)	(0.2)
Miscellaneous Expenditure Statutory Audit	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
Education Expenditure	(0.5)	(1.0)	(0.5)	(2.6)	(2.9)	(0.3)	(0.2)	(0.2)	0.0	(1.0)	(1.0)	0.1	(0.8)	(1.2)	(0.4)	(3.7)	(3.9)	(0.2)
Consultancy Expenditure	0.0	(0.2)	(0.2)	0.0	(0.5)	(0.5)	(0.0)	(0.2)	(0.2)	(0.1)	(0.6)	(0.5)	(0.0)	(0.4)	(0.3)	(0.1)	(1.1)	(1.0)
Fixed Assett Impairments / Revaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Other Non Pay	**(11.6)**	**(14.6)**	**(3.0)**	**(59.6)**	**(67.9)**	**(8.4)**	**(5.7)**	**(6.7)**	**(1.0)**	**(29.2)**	**(34.3)**	**(5.1)**	**(17.4)**	**(21.3)**	**(4.0)**	**(88.8)**	**(102.2)**	**(13.4)**
Total Non Pay Costs	**(31.3)**	**(34.3)**	**(3.0)**	**(158.9)**	**(171.8)**	**(12.9)**	**(13.9)**	**(15.0)**	**(1.1)**	**(70.0)**	**(76.2)**	**(6.2)**	**(45.2)**	**(49.3)**	**(4.1)**	**(228.9)**	**(248.0)**	**(19.1)**
Total Operating Expenditure	**(81.0)**	**(85.6)**	**(4.7)**	**(410.1)**	**(428.4)**	**(18.3)**	**(51.0)**	**(51.5)**	**(0.5)**	**(255.5)**	**(259.5)**	**(4.0)**	**(132.0)**	**(137.1)**	**(5.1)**	**(665.6)**	**(687.9)**	**(22.3)**
EBITDA	**1.1**	**(2.1)**	**(3.1)**	**(0.5)**	**(14.9)**	**(14.4)**	**0.5**	**(0.2)**	**(0.7)**	**1.8**	**(2.9)**	**(4.8)**	**1.6**	**(2.2)**	**(3.8)**	**1.4**	**(17.8)**	**(19.2)**
Depreciation	(2.7)	(2.7)	0.0	(13.5)	(13.3)	0.2	(2.4)	(1.6)	0.7	(11.7)	(8.9)	2.8	(5.0)	(4.3)	0.8	(25.2)	(22.2)	3.0
Non Operating Items	(1.5)	(1.2)	0.3	(7.7)	(7.4)	0.3	(0.7)	(0.6)	0.1	(3.4)	(2.9)	0.5	(2.2)	(1.8)	0.4	(11.1)	(10.3)	0.8
Surplus/(Deficit)	**(3.2)**	**(5.9)**	**(2.8)**	**(21.6)**	**(35.6)**	**(14.0)**	**(2.5)**	**(2.4)**	**0.1**	**(13.3)**	**(14.7)**	**(1.4)**	**(5.7)**	**(8.3)**	**(2.7)**	**(34.9)**	**(50.3)**	**(15.4)**
NHSE Allowable Adjustments	0.0	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.2	0.1	(0.1)	0.8	0.4	(0.4)	0.2	(0.3)	(0.4)	0.8	(0.2)	(1.0)
Adjusted Surplus / (Deficit)	**(3.2)**	**(6.3)**	**(3.1)**	**(21.6)**	**(36.1)**	**(14.5)**	**(2.4)**	**(2.3)**	**0.0**	**(12.5)**	**(14.3)**	**(1.8)**	**(5.5)**	**(8.6)**	**(3.1)**	**(34.1)**	**(50.5)**	**(16.4)**

Appendix A – Trust I&E & Divisional Budgetary Performance

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine (North)	(3.8)	(4.1)	(0.3)	(18.9)	(20.9)	(2.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(3.8)	(4.1)	(0.3)	(18.9)	(20.9)	(2.0)
	Acute and Emergency Medicine (South)	0.0	0.0	0.0	0.0	0.0	0.0	(5.8)	(5.9)	(0.1)	(28.8)	(29.8)	(1.0)	(5.8)	(5.9)	(0.1)	(28.8)	(29.8)	(1.0)
	Cancer Network	(0.5)	(0.5)	(0.0)	(2.4)	(2.4)	(0.0)	(0.3)	(0.2)	0.0	(1.4)	(1.3)	0.1	(0.8)	(0.7)	0.0	(3.8)	(3.7)	0.0
	Cardiovascular	(3.5)	(3.3)	0.2	(17.6)	(18.7)	(1.1)	(0.9)	(0.8)	0.1	(4.4)	(4.5)	(0.1)	(4.4)	(4.1)	0.3	(22.0)	(23.2)	(1.2)
	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(0.4)	(0.6)	(0.2)	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	0.0	(0.1)	(0.2)	(0.1)	(0.8)	(1.0)	(0.2)
	Community, Frailty & Therapy	(3.5)	(3.7)	(0.2)	(17.7)	(19.1)	(1.5)	(4.0)	(4.2)	(0.2)	(19.9)	(20.5)	(0.6)	(7.5)	(7.9)	(0.4)	(37.6)	(39.6)	(2.0)
	Digestive Diseases	(3.1)	(3.5)	(0.4)	(15.6)	(18.5)	(2.9)	(2.7)	(2.7)	0.1	(13.4)	(13.6)	(0.2)	(5.8)	(6.2)	(0.3)	(29.0)	(32.1)	(3.1)
	Family Services	(5.2)	(5.4)	(0.2)	(25.7)	(27.3)	(1.7)	(4.8)	(4.7)	0.1	(24.0)	(23.7)	0.3	(10.0)	(10.1)	(0.1)	(49.6)	(51.0)	(1.4)
	Head & Neck	(3.4)	(3.1)	0.3	(17.1)	(17.0)	0.1	(1.4)	(1.4)	0.0	(7.1)	(7.0)	0.1	(4.8)	(4.5)	0.3	(24.3)	(24.0)	0.2
	Neuroscience	(2.4)	(2.6)	(0.2)	(12.0)	(12.6)	(0.6)	(0.9)	(0.9)	0.0	(4.5)	(4.6)	(0.2)	(3.3)	(3.5)	(0.2)	(16.5)	(17.2)	(0.8)
	Pathology Network Group	(2.1)	(2.2)	(0.1)	(10.4)	(10.7)	(0.3)	(2.2)	(2.1)	0.1	(11.3)	(11.2)	0.1	(4.3)	(4.3)	(0.0)	(21.7)	(21.9)	(0.1)
	Patient Services	(2.2)	(2.2)	0.0	(11.0)	(11.3)	(0.2)	(1.6)	(1.6)	(0.0)	(8.1)	(8.1)	(0.1)	(3.8)	(3.8)	(0.0)	(19.1)	(19.4)	(0.3)
	Site Management & Discharge teams	(0.3)	(0.3)	(0.0)	(1.4)	(1.4)	(0.0)	(0.3)	(0.4)	(0.0)	(1.7)	(1.8)	(0.1)	(0.6)	(0.6)	(0.0)	(3.1)	(3.2)	(0.1)
	Specialist Cancer and Support Services	(18.4)	(19.0)	(0.6)	(92.3)	(95.5)	(3.2)	(5.7)	(5.5)	0.1	(29.3)	(29.5)	(0.2)	(24.1)	(24.6)	(0.5)	(121.6)	(125.0)	(3.4)
	Specialist Medicine	(4.1)	(4.4)	(0.2)	(20.6)	(21.7)	(1.1)	(2.4)	(2.5)	(0.0)	(10.9)	(11.1)	(0.2)	(6.6)	(6.8)	(0.3)	(31.5)	(32.9)	(1.4)
	Specialist Surgery	(3.7)	(3.9)	(0.2)	(18.6)	(19.5)	(0.8)	(2.1)	(2.2)	(0.2)	(9.7)	(10.1)	(0.4)	(5.8)	(6.2)	(0.4)	(28.3)	(29.5)	(1.2)
	Theatres, Anaesthetics and Critical Care	(7.0)	(7.2)	(0.2)	(35.0)	(36.6)	(1.5)	(3.8)	(3.9)	(0.1)	(19.6)	(20.0)	(0.4)	(10.8)	(11.1)	(0.3)	(54.6)	(56.6)	(1.9)
Total Operations		**(63.3)**	**(65.3)**	**(2.0)**	**(316.7)**	**(333.8)**	**(17.1)**	**(39.0)**	**(39.2)**	**(0.2)**	**(194.6)**	**(197.4)**	**(2.8)**	**(102.3)**	**(104.5)**	**(2.2)**	**(511.3)**	**(531.2)**	**(19.9)**
Corporate	Chief Executive	(0.1)	(0.1)	0.0	(0.6)	(1.0)	(0.3)	(0.1)	(0.1)	(0.0)	(0.5)	(0.9)	(0.4)	(0.2)	(0.2)	0.0	(1.1)	(1.9)	(0.7)
	Chief Medical Officer	(0.5)	(0.7)	(0.2)	(2.5)	(2.5)	(0.0)	(0.6)	(0.7)	(0.1)	(3.2)	(3.3)	(0.0)	(1.1)	(1.4)	(0.3)	(5.7)	(5.8)	(0.1)
	Chief Nurse Office	(3.2)	(3.4)	(0.2)	(16.1)	(15.6)	0.5	(2.4)	(2.6)	(0.2)	(12.1)	(11.9)	0.2	(5.6)	(6.0)	(0.4)	(28.2)	(27.5)	0.7
	Director of Assurance	(0.1)	(0.1)	(0.0)	(0.3)	(0.4)	(0.2)	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	0.0	(0.1)	(0.2)	(0.1)	(0.6)	(0.8)	(0.2)
	Director of People	(0.9)	(1.0)	(0.1)	(4.5)	(4.4)	0.1	(0.8)	(0.8)	0.0	(4.0)	(4.0)	0.1	(1.7)	(1.8)	(0.0)	(8.6)	(8.4)	0.2
	Director of Finance, Estates & Facilities	(6.8)	(6.9)	(0.2)	(33.2)	(33.2)	0.0	(4.5)	(4.3)	0.2	(21.8)	(22.6)	(0.8)	(11.2)	(11.2)	(0.0)	(55.0)	(55.8)	(0.7)
	Strategy and Partnerships	(1.0)	(1.1)	(0.1)	(4.8)	(4.7)	0.1	(0.7)	(0.7)	(0.0)	(3.7)	(3.8)	(0.2)	(1.7)	(1.8)	(0.1)	(8.5)	(8.6)	(0.0)
Total Corporate		**(12.6)**	**(13.3)**	**(0.7)**	**(62.0)**	**(61.8)**	**0.2**	**(9.2)**	**(9.3)**	**(0.1)**	**(45.8)**	**(46.9)**	**(1.1)**	**(21.8)**	**(22.6)**	**(0.8)**	**(107.8)**	**(108.7)**	**(0.9)**
Central Income, Reserves & Technical	Central Income	76.7	76.3	(0.4)	383.0	382.3	(0.7)	48.7	48.0	(0.7)	243.2	240.7	(2.5)	125.4	124.3	(1.1)	626.2	623.0	(3.2)
	Central Technical	(4.5)	(3.5)	1.0	(22.7)	(21.7)	1.0	(2.9)	(1.8)	1.1	(14.5)	(10.7)	3.9	(7.5)	(5.4)	2.1	(37.2)	(32.3)	4.8
	Reserves	0.6	(0.1)	(0.7)	(3.3)	(0.6)	2.7	(0.2)	(0.1)	0.1	(1.5)	(0.4)	1.1	0.4	(0.2)	(0.6)	(4.8)	(1.1)	3.7
Total Central Income, Reserves & Technical		**72.7**	**72.7**	**(0.0)**	**357.0**	**360.0**	**2.9**	**45.6**	**46.1**	**0.5**	**227.2**	**229.6**	**2.4**	**118.3**	**118.8**	**0.4**	**584.2**	**589.5**	**5.3**
Surplus / (Deficit)		**(3.2)**	**(5.9)**	**(2.8)**	**(21.6)**	**(35.6)**	**(14.0)**	**(2.5)**	**(2.4)**	**0.1**	**(13.3)**	**(14.7)**	**(1.4)**	**(5.7)**	**(8.3)**	**(2.7)**	**(34.9)**	**(50.3)**	**(15.4)**
Adjustments to adjusted financial performance		0.0	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.2	0.1	(0.1)	0.8	0.4	(0.4)	0.2	(0.3)	(0.4)	0.8	(0.2)	(1.0)
Adjusted financial performance Surplus / (Deficit)		**(3.2)**	**(6.3)**	**(3.1)**	**(21.6)**	**(36.1)**	**(14.5)**	**(2.4)**	**(2.3)**	**0.0**	**(12.5)**	**(14.3)**	**(1.8)**	**(5.5)**	**(8.6)**	**(3.1)**	**(34.1)**	**(50.5)**	**(16.4)**

Recovery Action Plan

Care Group:	HUTH Acute & Emerg Med & Major Trauma	£'000
Forecast Variance as at:	M5 (August-26)	(3,707)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Progress status	Recurrent / Non-Recurrent
Acute Consultant appointments (5wte) - over & above the £460k in M3 CIP plan	start dates in August	in forecast	actioned	Rec
Reduce x2 RN 24/7 covering corridor care	wef Sept	in forecast	Plans In Development	Rec
Cease In-Reach doctors (consultant & registrar)	wef Aug	in forecast	actioned	Rec
Reduce additional support into ECA = overtime (work towards safe dept. numbers c40)	wef November (£20k a month)	100	Plans In Development	Rec
re-align Wd5 resources following closure	nonpay wef Sept. Review w/c 6th July to confirm	20	Plans In Development	Rec
re-align Wd5 resources following closure	Consultant to cease wef Nov	in forecast	Plans In Development	Rec
rebanding of MT co-ordinators	to review in December	TBC	Plans In Development	Rec
Adjusted Forecast / Recovery Gap		**(3,587)**		

Recovery Action Plan

Care Group:	Digestive Diseases	£'000
Forecast Variance as at:	End of August 2026	(7,138)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
£250k Nurse Endoscopy workforce model	Consultation, agree new workforce model.	63	250	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Workforce redesign. Run rate reduction	Consultation, agree new workforce model.	(128)	130	01-Jan-27	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
WLI controls further details needed for £k calculation. RR reduction	Additional internal care group controls and process changes. Then a potentially material savings amount can be forecasted. Locum cons interview july 14th gastro north. Flexible job plan for first year to fill more vacant lists and reduce WLIs. Two endoscopy fellows north intervew 18th with flexible job plann HRI and CHH. Forecast 30pc reduction in forecast from recruitment dates. Consultant start end of August. Two registrars starting end of Sept. INcrease in number of people able to do fixed lists by funding the 6th room - this will reduce the number of vacant lists that are published i.e. fewer WLIs.	TBC	TBC	01-Sep-26	Scoping	Med	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
£34k Reduce budget WTE on wards on the south bank	Rotas and budgets permanently changed.	34	34	01-Sep-26	Plans in development	Low	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
£18k PEG service income from CHCP.	Process for capturing and rechargning costs set up.	11	18	01-Sep-26	Plans in development	Low	Tracey Davies	Recovery action - to reduce current expenditure	Rec
£40k endoscopy – switch from pre-made to loaded syringes.	Switch date confirmation. Chase lisa gadd. Emailed Lisa again June 30th	23	40	01-Aug-26	Plans in development	Med	Procurement	Recovery action - to reduce current expenditure	Rec
£9k Endoscopy on-call nursing requirements GI bleed rota.	linked to Humber GI job planning review	5	9	01-Sep-26	Scoping	Med	Sarah Clarke	Recovery action - to reduce current expenditure	Rec
Technical / budget improvements - mainly outstanding business cases requiring submission and budget award	Outstanding business cases requiring submission and budget award - mainly - consultant additional sessions, Endoscopy Allam building, resident doctor rotas.	2,526	2,526	01-Oct-26	Plans in development	Med	Several Care Group Staff	Budget transfer	Rec
UNPALATABLE - stop GIM rota agency cover. THIS HAS STOPPED.	Needs trust-wide agreement. Consultant stopped but consultant review costs 2.5 PAs per week (2 hours per day mon to fri £80 per hour). CT3 end of Aug onwards replaced by substantive.	150	300	Sep-26	Scoping	High	George Abouda, Peter Grant	Recovery action - to reduce current expenditure	Rec
Back to basics exercise – review of all job plans and long-term vacancies underway	Review of all job plans and long-term vacancies underway	TBC	TBC	01-Sep-26	Scoping	Med	Tri	Recovery action - to reduce current expenditure	Rec
Other	minor adjustments across several areas to reflect YTD run-rate / balancing figure to forecast	587	587						
NEW Sep 2026 - COW model to reduce ECPs	Details to be gathered to allow quantification	TBC	TBC	01-Oct-26	Scoping	Med	George Abouda, Peter Grant	Recovery action - to deliver CIP	Rec
NEW Sep 2026 - Monofer referrals / iron infusion costs	Details to be gathered to allow quantification. Email sent to Pharmacy 14.9.26	TBC	TBC	01-Oct-26	Plans in development	Med	George Abouda	Recovery action - to deliver CIP	Rec
NEW Sep 2026 - Peter CIP presentation 7.9.26 – extra schemes	Details to be gathered to allow quantification	TBC	TBC	01-Oct-26	Scoping	Med	Peter Grant	Recovery action - to deliver CIP	
Adjusted Forecast / Recovery Gap		(3,867)	(3,243)						

Recovery Action Plan

Care Group:	Specialsit Cancer & Support	£'000
Forecast Variance as at:	M5	(6,666)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Clinical Engineering Repairs	Ceasing repairs and support on equipment over 10 years in age - eQIA completed and supported	11	85		Agreed / Approved	Low		Recovery action - to deliver CIP	Rec
Radiation Protection Income Margin	Increase income margin of private work	10	20		Agreed / Approved	Low		Recovery action - to deliver CIP	Rec
Onc & Haem External Testing Review	Challenge the breadth of external specialist testing and review what isn't necessary and what can be downgraded to local labs instead	TBC	TBC		Scoping	Med		Recovery action - to deliver CIP	Rec
HCD Income Recovery	Embed group-wide income recovery process to align NLAG recovery with HUTH	194	388		Scoping	High		Recovery action - to deliver CIP	Rec
Biosimilar Gains Share	Negotiate gains share arrangements with ICB/NHSE around biosimilar switches	TBC	TBC		Plans in development	Med		Additional Income allocation	NR
Manufacturer review in IR	Looking to standardise/rationalise product options	20	40		Plans in development	Low		Recovery action - to reduce forecast expenditure	Rec
IRT Stock Management	Ensuring stock processes, including regular stock takes, Scan4Safety, and consignment are actively supporting the financial position	100	100		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Breast Tissue Consumables	Product switch to be reviewed for cost effectiveness and clinical appropriateness	25	50		Plans in development	Low		Recovery action - to deliver CIP	Rec
Ultrasound Probe Maintenance	Review scope of maintenance contracts and risk appetite for probe cover	18	72		Scoping	Med		Recovery action - to deliver CIP	Rec
Shadow On-Call Review		7	28		Scoping	Med		Recovery action - to deliver CIP	Rec
Implement Reporting Productivity Model	National tool now available, reviewing to identify opportunity to implement	150	360		Scoping	High		Recovery action - to deliver CIP	Rec
OPAT Drugs	Support transition to 7 day model to reduce premium drugs expenditure	50	100		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Not extending MT service beyond current hours	£1m cost avoidance on current draft staffing model/requirement	0	0		Scoping	High		Recovery action - to remove forecast risk	Rec
Variable pay reduction (Pharmacy)	Enforce cut off times for IDL	40	75		Scoping	High		Recovery action - to deliver CIP	Rec
Vacancy Hold	Support Group-wide vacancy freeze by holding non-essential vacancies which don't adversely impact variable pay - estimated at 10wte being held	300	0		Plans in development	High		Recovery action - to reduce forecast expenditure	NR
Removal of Hospital funded welfare rights officer (service commissioned from ERYC).	EQIA supported by care group, work progressing to understand contractual implications/exit arrangements	TBC	TBC		Plans in development	Med		Recovery action - to reduce forecast expenditure	Rec
CT ED Business case	Delays in recruiting additional staffing requirement	90	0		In delivery	Med		Recovery action - to reduce forecast expenditure	NR
Management of CIP schemes to ensure progression/delivery	Remove risk rating from forecast	989	989		Plans in development	Med		Recovery action - to remove forecast risk	Rec
Adjusted Forecast / Recovery Gap		(4,663)	(4,359)						

Recovery Action Plan

Care Group:	TACC	£'000
Forecast Variance as at:	Month 5	-3,046

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve						
CRES Unidentified- HUTH	Improved delivery of CIP	2,500		ASAP	Plans in Development		TACC Tri		Recurrent
Acute Latent Sessions Cease	Cease unfunded sessions	310	460	Oct-27	Plans in Development		TACC Tri		Recurrent
F2 MT Transfer - HUTH	Agree Transfer Between MT & TACC. Discussed at TACC Exec M3	260	260	Oct-26	Scoping		Hayley Briggs, Caroline Hibbert, Lorraine Laws		Recurrent
HUTH Drugs	Understand reasons for and seek control of Drugs position	250	400	Jan-27	Scoping		Rob Bourne		Recurrent
CRES Unidentified - NLAG	Improved delivery of CIP	1,000		ASAP	Plans in Development		TACC Tri		Recurrent
F2 Pressure NLAG	Do not renew	33	67	Apr-27	Plans in Development		Sophie Fisher		Recurrent
Adjusted Forecast / Recovery Gap		**1,307**	**0**						

Recovery Action Plan

Care Group:	Community, Frailty & Therapies	£'000
Forecast Variance as at:	Month 5	(3,662)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
NCTR Capacity	Exec decision on option paper submitted				Plans in development	High	Exec	Recovery action - to reduce forecast expenditure	Rec
Review of CHCP/HUTH Palliative care medical staff	Approval of Business model by CHCP	20	50	30-Sep-26	Plans in development	Med	Care Group Board	Recovery action - to deliver CIP	Rec
CHH Overnight Hospital at Night	Revert to previous model on CHH Med cover - requires Exec Approval	99	170	30-Sep-26	Plans in development	High	Exec	Recovery action - to reduce current expenditure	Rec
Active Sickness Management	Targetted actions to reduce high levels of sickness - IN FORECAST				In delivery	Low			Rec
Ward Staffing - review of levels and funding	remove additional nurse staff on rotas until funding starts in October - ACTIONED _ IN FORECAST			30-Jun-26	In delivery	Low	Care Group Board	Recovery action - to reduce current expenditure	NR
Secure deanery funding	Funding request to be approved - ACTIONED - IN FORECAST				In delivery	Low			
Increased Variable pay reductions	Further stretch challenge re variable pay reductions - IN FORECAST				In delivery	Low			
Adjusted Forecast / Recovery Gap		(3,543)	(3,442)						

Recovery Action Plan

Care Group:	Family Services Care Group	£'000
Forecast Variance as at:	Month 05	(4,467)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Expected Financial Improvement - Full Year Effect (£'000)	Action to be completed by (date)	Progress status	RAG Rating	Responsible Officer	Category	Recurrent / Non-Recurrent
		+ve	+ve		Select from drop-down	Select from drop-down		Select from drop-down	Select from drop-down
Uncosted CIP Schemes	A&G templates being rolled out to reduce acceptance of non commissioned pathways. EG Sleep. This will reduce the melatonin medication spend	100	200	01-Sep-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce forecast expenditure	Rec
ADHD Medication	Reduction in ADHD medication overspend	30	65	01-Sep-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce forecast expenditure	Rec
Cease use of Agency staff	Phase out usage of agency medical staff as we recruit to med staff expansion bus case	180	480	31-Mar-27	Plans in development	Med	Lisa Pearce	Recovery action - to deliver CIP	Rec
Paediatric Surgery Consultant Costs	Removal of cost pressure - end of Cons locum contract	50	0	01-Oct-26	Agreed / Approved	Low	Lisa Pearce	Recovery action - to reduce current expenditure	NR
Hospital at Home - NLAG	Decommission Hospital at Home service model - NLAG	230	350	01-Sep-26	Plans in development	Med	Debbie Bray	Non Recurrent benefit	Rec
Reduction of ECP	Workforce expansion will support additional ECP reduction via flexi job planning with consultant expansion across gynaecology and paed/neonates	100	360	01-Mar-26	Plans in development	Med	Clinical Leads and Clinical Director	Recovery action - to deliver CIP	Rec
Neonatal Critical Care Review	Outcome of the regional NCCR to be implemented. It is anticipated that this will reduce the status of the SGH service from LNU to a SCU leading to an HHP neonatal configuration of NICU HUTH L3, LNU DPoW L2, SCU SGH L1. At present efficiences are unknown given the large scale transformation and likely formal public consultation that will be required to deliver the change. NB The fallout of the NCCR will require reconfiguration of the matenrity pathways which may have financial efficiences, however these are unknown at this time	0	tbc	Unknown NHSE / Spec Comm / ODN led exercise	Plans in development	Med	NHSE	Recovery action - to reduce current expenditure	Rec
Site consolidation of Gynaecology services NLAG	Undertake a scoping exercise to review the options regarding gynaecolgoy elective and non elective pathways, IP and OP across NLAG	0	tbc		Scoping	High	QUAD	Recovery action - to reduce current expenditure	Rec
Paediatric Critical Care Service HUTH	Undertake a review of the service model and commissioning of critical care service model at HUTH - Income v's cost.	0	tbc	2027	Scoping	High	Debbie Bray	Recovery action - to reduce current expenditure	Rec
Paediatric Neonatal Surgery Senate	Outcome of the Neonatal Surgery Senate to be implemented. This may deliver some savings, however this will be unknown until the recommendations are received	0	tbc		Plans in development	Med		Recovery action - to reduce current expenditure	Rec
Drug Review	Undertake a further deep dive with pharmacy colleagues to explore any medication / prescribing efficiencies or standardisation of practice	20	60	01-Oct-26	Scoping	Med	QUAD	Recovery action - to reduce forecast expenditure	Rec
Reusable Bottles	Replace disposable bottles with reusable bottles - North bank (already in place south bank)	5	10	01-Oct-26	Agreed / Approved	Low	Yvonne McGrath	Recovery action - to reduce forecast expenditure	Rec
Conversion of community clinic Gynae NLAG	Convert the community based clinic on site to DPOW, this is due to the lack of efficiency and use of the community clinic. Currently pay rent and taxi fare to transport staff. Bi weekly clinic - Louth and Mablethorpe - 2 rooms, travel in work time so clinic capacity is compromised.	5	10	01-Oct-26	Scoping	High	Clinical Lead DPOW	Recovery action - to deliver CIP	Rec
Adjusted Forecast / Recovery Gap		(3,747)	(2,932)						

Recovery Action Plan

Care Group:	Specialist Medicine	£'000
Forecast Variance as at:	Month 5 (August-26)	(3,182)

Recovery Schemes	Details of actions / decisions required	Expected Forecast Improvement - Current Year (£'000)	Progress status	Recurrent / Non-Recurrent
vacancy pause	to review vacanct posts & impact on activity / waiting lists	18	Agreed / Approved	NR
reduce NLG Respiratory Agency (from 3 to 2 posts covered)	decision TBC = impact on activity/WL - (Oct-Dec)	71	Plans in development	Rec
Insulin Rebates (£15k assumed in CIP plan)	to confirm any additional rebates above forecast	50	Plans in development	NR
CPAP consumables - increase in unfunded activity (£914k forecast pressure)	escalated at exec review as funded on block.activity impact of increased sleep studies. Options? cease activity & also pursue additional block funding?	400	Escalated at Exec Review & ICB contract discussions	Rec
Review of non-commissioned (unpaid) work/activity (CNS staff) - efficiency not cost out? Divert to community				
Ward Reviews - bed reduction				
Lung Cancer Screening - review of staffing resource & pathways across HHP			Scoping	Rec
Adjusted Forecast / Recovery Gap		(2,643)		

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Cash Committee TO Performance, Estates & Finance Committees-in-Common: ADVISE, ALERT and ASSURE	
Cash Committee:	
Meeting Date:	14th September 2026
Chair:	Philippa Russell, Deputy Group Chief Finance Officer

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**
Impact on cash forecast due to limited progress in progressing CIP plans / Cash Releasing savings	At Month 5 the Group was £16.4m overspent with a risk adjusted CIP forecast that is £62.1m short of delivering the target. The financial plan for the year has still not been accepted by NHS England.	A Finance Improvement Director has been appointed and is leading on both Grip and Control and efficiency delivery. Additional support to financial recovery in the form of a team from Grant Thornton in place since the beginning of August. This team has been embedded into Care Groups to provide direct support to delivery as well as the PMO function.	The impact on cash requirements due to slippage on CIP to be highlighted to PEF and Board as a continuing significant risk.	Sep 26
Revenue Support PDC requested for both HUTH and NLAG up to the end of October is £11.66m higher	September approved cash support was £15.9m less than requested for the Group. An application for cash support	Cash allocations confirmed for - £2.50m for NLAG and £3.20m for HUTH.	Awaiting confirmation from NHSE on October PDC applications.	Confirmation of outcome / Memorandum of Understanding due 9th

than the planned value.. September cash allocation was materially lower than requested and this is impacting on the Group's ability to pay suppliers promptly.	has been submitted to NHS England as follows: Oct: £9.03m for HUTH, £3.48m for NLAG Year to date cash requirements remain within the £75.5m total envelope approved at the PEF meeting on the 1st of September.	NHSE Regional team have supported the October applications. Cash forecast reviewed daily to confirm future requirements. Prioritisation process in place to ensure critical suppliers are paid promptly. Capital cash remains higher than planned.	November requirements to be confirmed once confirmation of allocation for October has been received and applications completed in line with national deadlines. Cash support applications have been explicit about short term likely requirement to utilise capital cash to manage payroll and priority suppliers if there is a further shortfall in cash allocated.	October 26 Deadline for Nov submission is 14th October 26

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
Delays in approval and payment of intergroup recharges.	Still a significant value waiting for approval with challenges getting older invoices approved by service managers due to the age.	List of outstanding invoices has been compiled and sent to all Finance Managers to action.	Circulate to Heads of Finance to resolve as a priority.	Sep 26
Progress in reducing aged debt	Aged debt remained fairly static in August with no significant improvement. Overall biggest debtors remain linked to recharges between	Working closely with York & Scarborough to reduce level of debt on both sides and have seen some progress during August.	Confirm level of bad debt provision in place for Overseas debt.	Sep 26

	HUTH and NLAG and with York & Scarborough with which there is a similar value of outstanding payables. Areas of concern are longer standing debts with City Health Care Partnership, North Lincolnshire Council, Alliance Medical, University of Hull & HNY ICB. Overseas debt continues to make up a large proportion of debt over 360 days.		Old invoices relating to CAP (York & Scarborough) have been escalated, but not yet resolved (to chase).	Sep 26
Increasing number of threats from Suppliers to put Trusts on stop.	Growing number of suppliers have been added to the priority payment list to avoid being placed on stop or late payment charges. As payment runs will have to be reduced in September this is likely to impact on suppliers that have not yet taken this action and risks further escalation. £4k late payment fees from Restore (records storage) due to invoices not being approved.	No significant late payment charges seen due to close management of suppliers. Late payment charge notification of £460k received linked to old agency invoices at NLAG, but this has been negotiated down to £10k due to consolidation of invoices. This appears to be a national issue linked to an FOI which will require careful monitoring.	Highlighted to regional and national team as a significant risk through the latest cash support application.	
Concerns raised about the scale of accrual income.	Accrued income increase in month 5.		Communication across the finance team to ask that all income accruals are reviewed and invoiced raised wherever possible. Income and Contracting team to	Sept 26 Oct 26

			contact NHS England to ask whether payment on account for pass through drugs and devices can be increased to reflect growth in activity. £1.5m accrued for Procurement Consortium to be raised urgently.	Sep 26
ASSURE (Provide any areas of assurance that the Committee has received)				
Issue	**Update**	**Assurance received**	**Action**	**Timescale**
Communication on supplier payment prioritisation.	Information regarding the process and key contacts has been circulated to all budget holders.		Complete	
Non-Pay Panel	Non-Pay panel is now in place and Includes review and approval of all non-clinical non pay over £500.	Terms of Reference approved and panel is now meeting weekly. Communication regarding the new process has been sent to all staff who raise or approve requisitions and summary included in the weekly Group Wide email newsletter.		

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)257

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9th October 2026**
Director Lead	**Tom Myers – Group Director of Estates Facilities and Development**
Contact Officer / Author	**Bill Parkinson – Group Associate Director of Health & Safety, Fire and Security**
Title of Report	**Annual Fire Report 25/26**
Executive Summary	**The purpose of this report is share fire safety performance and issues arising during the period and to request Trust Board sign off, of the annual statements**
Background Information and/or Supporting Document(s) (if applicable)	**Attached are the detailed annual reports and overview executive summary reports as required in compliance with the HTM 05-01 and the Fire Safety (Regulatory Reform) Order 2005.**
Prior Approval Process	**The reports and overview summary have been reviewed by the Fire Safety Technical Groups and both the Security, Fire , Health and Safety Group (HUTH) and the Fire, Safety & Health Group (NLaG) and PEF**
Financial Implication(s) (if applicable)	**None with regards to this report**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**Not applicable as requirements are part of statutory guidance and regulatory requirements.**
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

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Committees-in-Common Front Sheet

Agenda Item No: CIC(26) 4.3

Name of Meeting	Performance Estates and Finance Committees-in-Common
Date of the Meeting	**1st September 2026**
Director Lead	**Tom Myers – Director of Estates, Facilities & Capital Development**
Contact Officer / Author	**Bill Parkinson – Group Associate Director of Health & Safety, Fire and Security**
Title of Report	**Annual Fire Report 25/26**
Executive Summary	The purpose of this report is to report on the fire safety performance and issues arising during the period and recommend approval to the Trust Board and signing of Annual Statements. **Alert** **Assure** The installation of the Fire Compliance Online will enable a real time accurate profile of trained fire wardens in all areas within HHP and where additional fire wardens need to be trained. **Advise** The enforcement notice in relation to the tower block at HRI entails a programme of action over a number of years but is overseen by a dedicated programme board and formal updates with Humberside Fire & Rescue Services (HFRS). Current restructure of the fire teams across the Group will over the next period will bring together a consistent approach to fire safety management as well as standardizing fire training, fire risk assessments and fire strategy. **Recommendation/s** **The report for each Trust makes the following recommendations.**

	NLaG • Recruit fire door inspection/maintenance teams to reduce expenditure in relation to fire doors (i.e. repair instead of replace where appropriate). • Implement "red box" system used within HUTH to ensure information is available in the event of a fire. **HUTH** • Continue with the HRI tower block work to comply with the HFRS Improvement Notice • Review the current Hercules interface to determine if fit for purpose or requires replacement.
Background Information and/or Supporting Document(s) (if applicable)	Attached are the detailed annual reports and overview executive summary reports as required in compliance with the HTM 05-01 and the Fire Safety (Regulatory Reform) Order 2005.
Prior Approval Process	The reports and overview summary have been reviewed by the Fire Safety Technical Groups and both the Security, Fire , Health and Safety Group (HUTH) and the Fire, Safety & Health Group (NLaG).
Financial Implication(s) (if applicable)	None with regards to this report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable as requirements are part of statutory guidance and regulatory requirements.
Recommended action(s) required	☐ Approval by CiC ☐ Information ✓ Endorse for approval by Trust Board(s) ☐ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐
Our Patients - Safety	✓
Our People	✓

Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

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Directorate of Estates, Facilities & Development

Annual Fire Reports

1st April 2025 to 31st March 2026

Combined Executive Summary

This executive summary is formulated from the two statutory reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Each partner organisation produces its own annual fire report in order to satisfy its statutory obligations.

However, to assist those working across the Group this executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to fire safety management across the Group.

Currently, the format of the reports differ in the layout but going forward subsequent reports will be in a compatible format.

Key Points

The appointment of an Authorised Engineer (AE Fire) across the Group has now been completed and this will ensure consistency in terms of approach and audit action plans for both organisations. Going forward, restructure of the EF& D is progressing and responsibilities for fire being transferred to Group Associate Director for Health & Safety, Fire and Security

The use of an Authorised Engineer (AE Fire) has been implemented at both organisations. Recommendations are identified for one of the organisations or both, and labelled as such in this combined executive summary.

HHP

1. Review revised HTM 05-02 Part A (Training) requirements and develop training programmes for HHP so training delivered is consistent across the Group.
2. Utilising Fire Compliance Online software identify gaps in fire warden coverage and increase so all areas have a suitable number of fire wardens present at any one time (including out of hours, week-ends etc.).
3. Bring the Group fire risk assessment programme back on track and “smooth out” where a high number of risk assessments are required in one month.
4. As part of the move towards a Group structure bring together the fire teams across into one team to give great flexibility and make more efficient use of available resources.
5. Continue with passive fire and compartment surveys and embed the passive fire penetration permit within normal practices.

6. Continue with capital programme to replace current fire alarm system at GDH and secure funding for replacement at HRI and CHH.
7. Continue with the development of Group Fire Strategy and policies/procedures to enable a consistent approach to be implemented throughout the Group.
8. Review the digital platforms in use and those available in the market to select a common platform across the Group.

NLaG

9. Approval to Recruit fire door inspection and repair team given and looking to recruit to positions and commence in-house inspections and repairs to negate the need to replace with brand new fire doors when they can be repaired. Currently recruitment is difficult to find appropriate candidates and further attempts to be made.
10. Implement “red box” system within organisation (currently used in HUTH) to allow documentation to be readily available.

HUTH

11. Review the current Hercules interface to determine if needs to be upgraded or replaced (this could also be part of the alarm replacement programme).

The above recommendations are made to ensure that adequate assurance can continue to be given and more detail is contained the respective reports for each partner organisation.

NB – these recommendations do not include work being undertaken within the Tower Block project as these are part of the separate project.

In addition, the work programme for fire safety for the Group is shown in Appendix 1.

Bill Parkinson

Fire Safety Manager

Appendix 1 - 2026/27 Work Plan for Fire Safety Management within HHP

Item	Area	Task / Objective	HUTH/NLAG Or HHP	Target Dates	Completed/Progress
	Review of Policies				
1.1	Review fire safety management policies and guidance with revised HTM 05 suite of documents and 24/25 AE. Potential scope for Group documents to be considered	• Review new training HTM requirements • AE Action plan arising from 26/27 audit • Update AE Audit action plan for policy requirements • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	HHP HHP HHP HHP HHP	July 2026 Oct 2026 Aug 2026 October 2026 Octoiber 2026	**Completed** **In progress** **In progress** **In progress** **In progress**
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• Arrange operational plan review visit (annual). • Fire audits with HFRS • Complete any actions arising from HFRS audits	HHP HHP HHP	May 2026 March 2027 March 2027	**Completed** **In progress** **In progress**
1.3	Review Technical Fire Safety Terms of Reference after 12 months of operational meetings	• Ensure FSTG continues to develop and review technical fire safety issues • Schedule meetings for 26/27 period • Review Group approach and overview across the Group for fire safety management	NLaG NLaG HHP	March 2027 April 2026 September 2026	**Ongoing** **Completed** **In progress**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within revised HTM • Complete draft annual report for consultation • Finalise annual report and send to CIC PEF for recommendation for Board Approval • Approval by Trust Board	HHP HHP HHP HHP	April 2026 May 2026 August 2026 October 2025	**Completed** **Completed** **In progress** **In progress**
	Fire Training				
2.1	Review annually face to face training content for delivery of fire lecture	• Revise face-to-face training presentation and content in light of new HTM & new national STAT/MAN	HHP	October 2026	**In progress**

		• Highlight reports on fire training attendance	HHP	Ongoing throughout 26/27	**In progress**
2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Increase number of fire wardens per area • Maintain register of fire wardens • Review and revise fire warden training content • Implement recruitment campaign for fire wardens	HHP HHP HHP	March 2027 August 2026 October 2026	**In progress** **Completed** **In progress**
	Fire Drills and Exercises				
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify priority areas where desktop exercises are required. • Engage with fire wardens training scenarios for clinical areas requiring desktop exercises • Implement series of desktop exercises	HHP HHP HHP	June 2026 March 2027 June 2026	**Now ongoing throughout 26/27** **In progress** **Ongoing**
	Fire Alarm Tests				
4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Review with AE (Fire) alarm testing strategy and notification processes • Review MCP testing programme to ensure all MCP undergo testing	HHP HHP	July 2026 November 2026	**Completed** **In progress**
	Fire Action Plans				
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Audit areas to ensure fire action plans are in place and updated • Fire action cards to be located in each area	HHP NLaG	March 2027 March 2027	**In progress** **In progress**
5.2	Fire safety response kits should be developed and rolled out to each area	• Identify fire response kit requirements and source supplies	NLaG NLaG	March 2027 March 2027	**In progress** **In progress**

		• Roll out response kits to all areas identified where required			
	Fire Strategy Development				
6.1	Work with HUTH to align fire safety management principles.	• Revise structure in conjunction with EFD re-structure • Review training content across both organisations to align so more transferable workforce • Review general safety management policies across both organisations and standardise where appropriate • Review fire inspection processes across the organisations to determine if single process can be applied • Review reporting process and format of reports to determine if standard report can be utilised for Group performance on fire safety management	HHP HHP HHP HHP	July 2026 October 2026 September 2026 March 2027 October 2026	**Completed** **In progress** **In progress** **In progress** **In progress**
6.2	Development of fire strategy to improve fire safety across the Trust	• Work with AE (Fire) to ensure fire safety strategy appropriate for all areas in light of new HTMs • Fire strategy drawings to be drawn up on MiCad • Undertake fire stopping surveys and ensure appropriate fire stopping in place. • Use MiCad or new CAFM system to develop appropriate “layers” of	HHP NLaG HHP HHP	March 2027 March 2027 September 2026 March 2027	**In progress** **In progress** **In progress** **In progress as new system purchased**

		information to enable fire strategy drawings to be available to all areas.			
		• Update and maintain fire risk assessments in-line with the fire safety policy	HHP	March 2027	**In progress**
		• Continue and further develop working relationship with HFRS to avoid any enforcement action	HHP	March 2027	**In progress**
	HUTH Tower Block				
7.1	Work related to Tower Block Improvement Notice	• Undertake quarterly formal and regular informal meetings with HFRS to update on progress of work	HUTH	March 2027	**In progress**
		• Complete actions identified within initial action plan	HUTH	August 2026	**In progress**
		• Appointment of Design Team to commence drawing up design options	HUTH	May 2026	**Completed**
		• Completion of HFRS Audit Actions undertaken	HUTH	September 2026	**In progress**
		• Establishment of Programme and Project Boards to oversee project	HUTH	April 2026	**Completed**

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Directorate of Estates, Facilities & Development

Annual Fire Report

1st April 2025 to 31st March 2026

Hull University Teaching Hospitals NHS Trust

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1.0 INTRODUCTION

Trust fire safety compliance is driven by the Regulatory Reform (Fire Safety) Order 2005 (FSO). The responsibility for ensuring necessary precautions to protect people and property in the event of fire rests with the Trust Board. The Department of Health Fire code (HTM 05) suite of documents provides guidance on statutory compliance and other fire safety measures that apply to healthcare premises.

HUTH's Risk Based Inspection Programme (RBIP) focuses resources to best effect across the Trust. This places the largest weighting on higher risk patient care areas (12 monthly inspections), plant and laboratory type areas are medium risks (24 months) with mainly lower risk administration areas at 36 monthly inspections. The programme is flexible, and changes can be made for areas or buildings, dependent on relevant risk factors.

The full extent of the impact on fire safety arising from Grenfell Tower fire in June 2017 in London is now more apparent and includes changes to high-rise accommodation legislation (The Building Safety Act 2022).

The Estates, Facilities and Capital Development management teams continue to maintain existing fire safety standards and work towards improvements (including the cladding, structural integrity and fire-stopping of Trust building stock) wherever this is possible and/or practicable.

Corporate risk register entries and action plans are made for any such matters which remain outstanding.

2.0 EXECUTIVE SUMMARY

This report provides assurance on fire safety management across Hull University Teaching Hospitals NHS Trust (HUTH) for 2025–2026. The Trust remains **generally compliant** with the Regulatory Reform (Fire Safety) Order 2005 and HTM guidance, supported by established governance, risk-based inspections, and ongoing engagement with Humberside Fire and Rescue Service.

Performance has improved in key areas. **Fire safety training compliance has reached 86% (above target)** and fire warden numbers have increased, strengthening local resilience. Fire alarm activations have also **reduced significantly from 165 to 97 incidents**, demonstrating improved management of unwanted fire signals

However, several challenges remain, including:

- Resource constraints impacting fire risk assessment completion and documentation updates
- Fire alarm system performance and cause-and-effect issues in parts of the estate
- Ongoing passive fire protection and compartmentation requirements, particularly in the Tower Block

- Variable fire warden coverage during off-peak periods

These risks are being actively managed through the Trust risk register, and a programme of investment (circa £1.2m in 2025/26) and improvement works. Premises Assurance Model ratings indicate areas requiring **moderate improvement**, particularly in fire risk assessments, documentation, and review processes

In summary, the Trust has a **stable and improving fire safety position**, but continued focus on resources, system improvements, and delivery of key priorities is required to achieve full compliance and maintain the safety of patients, staff, and visitors.

Fire Expenditure 2025/2026

Table 1 below indicates the statutory compliance budget for fire and how it is apportioned.

Fire Budget Expenditure 2025 - 2026	
Fire Extinguishers	£5000
Fire Dampers	£38500
BORIS System/Bolster	£16000
Fire Audit works	£28000
Passive Fire work (HUTH both sites)	£1,111,000
Total	**£1,198,500**

Table 1 - Apportion of Statutory Compliance Budget

3.0 COMPLIANCE WITH REGULATIONS AND GUIDANCE

The compliance against regulations and guidance is identified in Table 2 below. In some cases the Trust's systems and processes will be compliant, but the RAG rating may be increased where there are frequent or major failings operationally.

Requirement/ Recommendation	**Progress**	**RAG**
Regulatory Reform (Fire Safety) Order 2005		
Fire risk assessment of premises *Statutory Requirement*	Only partially compliant due to fluctuating resource issues with regards to staffing levels, training and the Tower Block being the target area due to the Tower Block cladding Enforcement Notice.	
HTM 05 – 01 managing healthcare fire safety (second edition)		
Clearly defined fire safety policy. *Mandatory*	Compliant. Policy CP034 on Trust Intranet.	
Director nominated re: Fire Safety *Mandatory*	Compliant	
Nomination of Fire Safety Manager *Mandatory*	Compliant	

Central reporting of all fire related incidents *Mandatory*	Compliant- As mandatory there is a central internal reporting system, that is monitored and logged.	
Emergency evacuation procedures *Mandatory*	Compliant – Fire Safety Information Manuals are broadly in place. A strategic building evacuation group is working up evacuation plans for major buildings	
Adequate fire alarm and detection systems *Mandatory*	Compliant, with additional systems installed or upgraded as necessary. There are issues at both HRI and CHH which have been identified and added to the risk register.	
Staff training programme appropriate to level of risk and duties *Mandatory*	Currently compliant to the Trust's mandatory training requirements and within the Trusts target of 85%.	
Annual audit of fire safety provisions and report to Board *Recommendation*	The fire AE produced an annual audit report and action plan.	
Access to a Fire Safety Adviser *Recommendation*	Compliant.	
Formation of Fire Safety Committee *Recommendation*	Compliant. Fire, Health & Safety & Security Committee reporting to the Non-Clinical Quality Committee.	
Provision of Fire Wardens *Recommendation*	Improving steadily but not always in place during 'off peak' periods.	
Liaison with External Bodies *Mandatory*	Compliant – six monthly HFRS Service level meetings	
Authorising Engineer (Fire) [External Specialist) *Recommendation*	Compliant – a suitable competent and qualified person has been appointed	
HTM 05-03 Operational Provisions *All are Recommendations*		
Monitoring and mitigation of Unwanted Fire Signals	Compliant via shared file databases	
Arson Policy	Compliant – see main fire policy CP034	
Textures and furniture purchasing policy.	Compliant – see main fire policy CP034	
Planned preventative maintenance programme	Compliant- Improved fire door completion rates and trained staff in place.	

Table 2- Compliance with Regulations/Guidance

Key – RED = Overdue Amber = In progress Green = Completed

4.0 RISK MANAGEMENT

4.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 3.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
4398		There is a risk that safe fire evacuation may be at risk due to the unresolved cause and effect fire alarm strategy.	Inspection and testing programme in place for the active modified L1 fire alarm system. Building occupied 24/7 Fire dampers inspected and tested annually. Fire extinguisher PPM system in place. Fire Door PPM in place Fire Training is mandatory Department Nominated Fire Officer (DNFO) training provided	12
4158		There is a risk that the fire structure integrity could be breached resulting in a spread of smoke or fire.	Fire damper inspection and testing programme in place, for those dampers that can be located and accessed. Annual fire risk assessments carried out in all wards and high risk departments. Estates staff told to report any fault seen in	8

			such locations during their maintenance works. Fire stopping to most 60 minute compartments carried out in 2019. Use of 3rd party accredited fire stopping companies. Modified L1 fire alarm system installed to provide early warning of fire events. The Trust offers and encourages staff to attend Fire Warden training so that there can be Fire Wardens at their place of work. There is also the Emergency Response Fire Team to react to all fire calls. Additional operative has been booked onto a Fire Safety Adviser's course to take place in December 2023. Works have been contracted out for the surveying of the fire stopping to the 12th and 13th floors the HRI Tower Block. Additional floors also surveyed.	
4399		There is a risk that there may be a delay in the initial fire response due to the fact that devices are now incorrectly labelled	Inspection and testing programme in place for the active modified L1 fire alarm system	12

4560		Risk fire compartmentation compromised due to insufficient fire dampers installed in the ventilation system, etc. to Ward H37.		12
4595		HRI Tower Block Encapsulation System - Fire Compliance		15

Table 3 - Risk Register

4.2 Fire Risk Assessments

The Regulatory Reform (Fire Safety) Order 2005 requires a suitable and sufficient fire risk assessment of all relevant Trust premises covered by the Order. Trust premises have been assessed in accordance with the regulations using the Fire code and national risk assessment standards. All assessments are reviewed periodically by the Fire Safety Team.

The Trust Fire Team web-based system (BORIS) is used for the vast majority of FRA's. A small number are currently on the shared drive in Word format. New buildings are inputted onto BORIS as a matter of course.

At peak times in certain areas, it remains an accepted practice by some staff to leave storage cages, beds etc. causing obstruction and fire loading to primary escape routes. Such breaches could lead to further enforcement action against the Trust by HFRS. The Fire Safety Team periodically carry out spot checks and advise staff and may issue internal fire action notices as necessary.

There is currently a number of overdue assessments but this is due to priority assessments relating to the Tower Block and turnover of staff and training of new staff, and the frequency of review being set at 12 months.

The frequency of reviewing risk assessments is being standardised across the Group with the following review frequencies being:

- In-patient areas and overnight stays – every 12 months
- Out-patient areas and areas closed overnight – every 24 months
- Administration areas only – every 36 months

This should allow all fire risk assessments to be reviewed within the specified periods. The workplan for 26/27 includes the review of all overdue assessments being completed.

4.3 HFRS Fire Safety Audits

During the year 2025 to 2026 HFRS carried out 11 routine compliance fire safety audits, covering 2 at CHH and 9 at HRI.

A level of minor deficiencies were noted by HFRS at both HRI and CHH. These deficiencies were forwarded to the Estates Department, PFI for action with no enforcement measures issued.
Consultation with HFRS to date have not disclosed any audit areas for 2026/2027.

4.4 Local Plans and Fire Safety Manuals

Fire Safety Information Manuals have been previously produced for all wards and departments. Ongoing department changes etc. routinely result in some new or amended Manuals. The Fire Safety Team continues to action this matter as resources permit.

Current Trust fire safety plans do not always reflect changes in wards or departments as they occur. This is due to a current resource issue and a lack of information being made available in a timely manner.

A gap in compliance remains with the nominated departmental Fire Warden arrangements. Deputies are not always nominated or trained for the warden role, particularly when staff are on annual leave or sick or they change post. Problems occasionally arise as ward/department management changes. Fire Risk Assessments identify such shortfalls, but all relevant managers should be proactive to reduce such shortfalls. The implementation of Fire Compliance Online should address this issue as there will be a nominated fire wardens list for each area.

4.5 Fire compartments

Department of Health Estates & Facilities Alert ref. DH/2014/003 identified the need to survey and audit fire compartment integrity in Trust premises. Fire stopping survey works and monitoring system updates have now recommenced. The main target area for the fire stopping has been the Tower Block due to the Enforcement notice issued in July 2025. The Tower Block surveys are complete with a few remaining areas of remediation work remaining due to restriction in access. At the time of the report being drafted these are Paediatric Resus, MRI and Max Fax Surgery. Arrangements are being put in place to undertake the remedial work over the next few weeks. This has been identified in Operational Risk Register item 4158 (see 4.1 Risk Register above).

Further passive fire surveys and remedial work will be undertaken in this financial year.

The routine programmed testing of ventilation system fire dampers continues in line with the HTM guidance.

4.6 Fire Door Maintenance

HUTH undertake the fire door inspection and maintenance of the fire doors throughout the Trust properties via the direct labour in-house estates team. The staff have been trained by an external accredited company and are qualified to the appropriate standard to check and repair minor defects to the fire doors. Figure 1 below identifies the current compliance figures for fire door inspection over a 12-month period.

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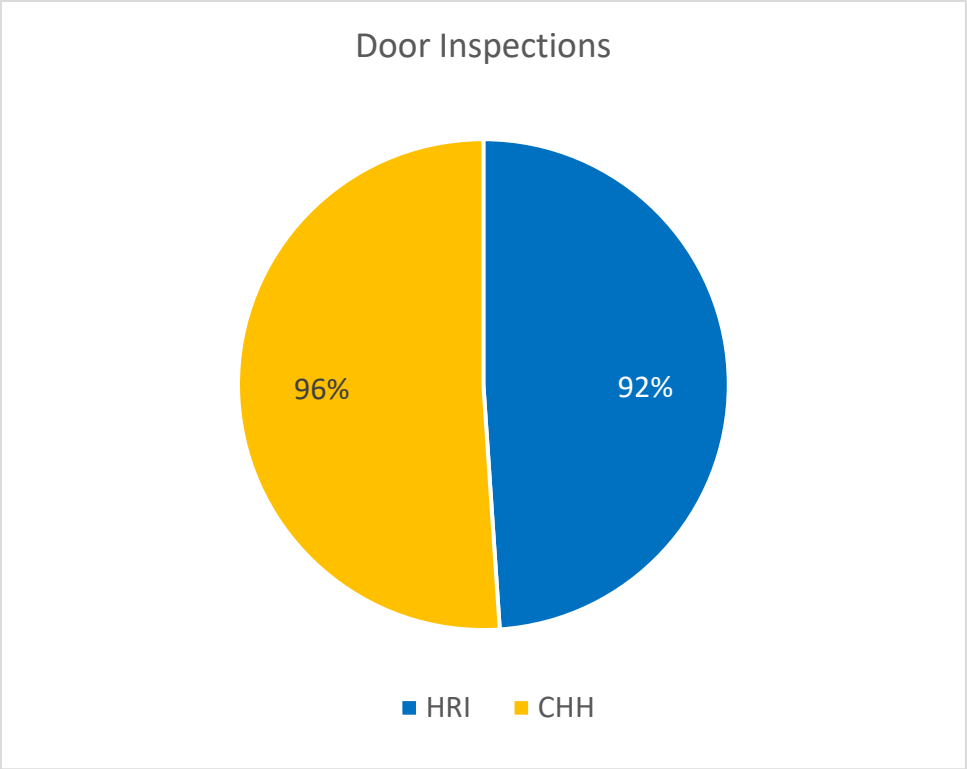


Figure 1- Fire Door Compliance Checks Completed

4.7 Fire Dampers

Fire dampers are a planned maintenance and testing programme undertaken throughout the year. As part of the new CAFM system work is ongoing to ensure that all damper locations are on the asset list and physical checks made to determine ease of access to maintain and test.

4.8 Fire Safety Committee

The Fire Safety Committee (HSFG) has met regularly during 24/25 to review the detailed technical aspects in relation to fire safety management for HUTH. It also considers and reviews compliance against the statutory provisions within the FSO and the HTM fire safety documents. The Fire Safety Committee will also consider requested derogations from HTM based on risk assessments.

The group report and escalate to the Health, Fire & Safety Group. The HFSG oversee and manage fire safety issues which may need a group decision, or further escalation.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the higher groups when the Group meeting structures are finalised to enable issues to be escalated when appropriate.

4.9 Training *(Trust figures from Education & Development)*

The table below identifies the Trust's mandatory training figures for the clinical and support services, showing the level of compliance.

The fire training comprises mandatory training delivered by the training department as well as more specific fire training targeted at specific staff. The fire team cover the initial induction first responder, tabletop evacuations and theatre fire training.

Type of fire training				
Training course	Completed	Not completed	Total	Percentage
Department nominated fire officer	2162	113	2275	95
Fire first responders	106	40	146	72.6
Clinical (mandatory training)	6689	1362	8051	83.1
Non-clinical (mandatory training)	2933	226	3159	92.8
Overall total	11,890	1,741	13,631	-

Table 4 - Fire Training Figures 2025/26

Last year there was 2106 trained Fire Wardens, this has increased to 2275 training fire wardens within the Trust, which is a positive increase of 160. As part of the actions from the Enforcement Notice issued by HFRS, there is a new on-line audit tool (On-Line Fire Compliance) which the fire wardens complete. It is currently in the early stages and will be rolled out as a Trust-Wide tool for the audits in the next few months.

5.0 Unwanted Fire Signals and Fire Incidents

The Trust report database has recently been comprehensively reviewed and updated by the EF&D administration team and the Business Information Manager.

The data below identifies the fire alarm activations to both the HUTH sites, the reason for the activation and if HFRS were in attendance.

The main areas of activation trends at HRI are accidental activation by patient or visitor,

smoking and vaping on Trust property is still a constant issue as well as accidental activation by contractors.

Additionally, the main areas of activation at CHH are staff leaving toasters and microwaves unattended, system faults and steam activation.

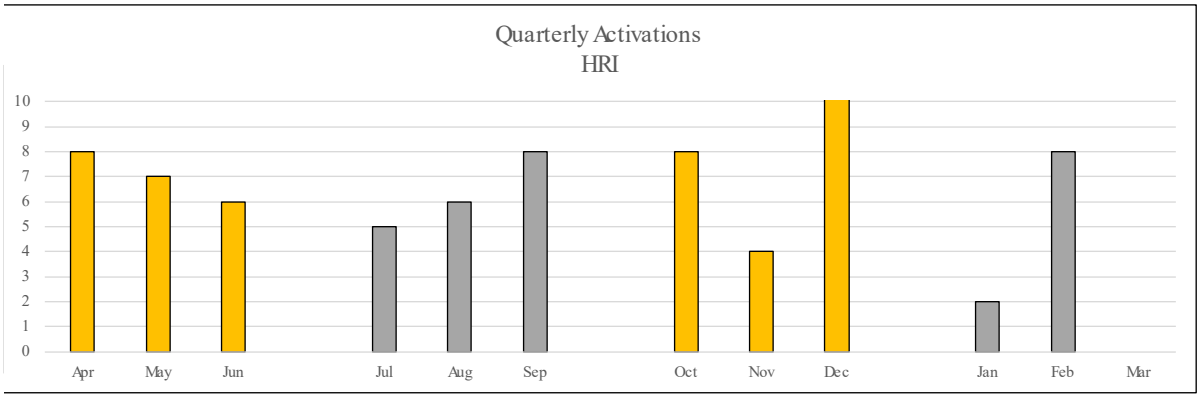
Ongoing cooperation and coordination between all stakeholders (Estates, PFI providers, contractors) is therefore essential to reduce and eliminate such largely avoidable causes.

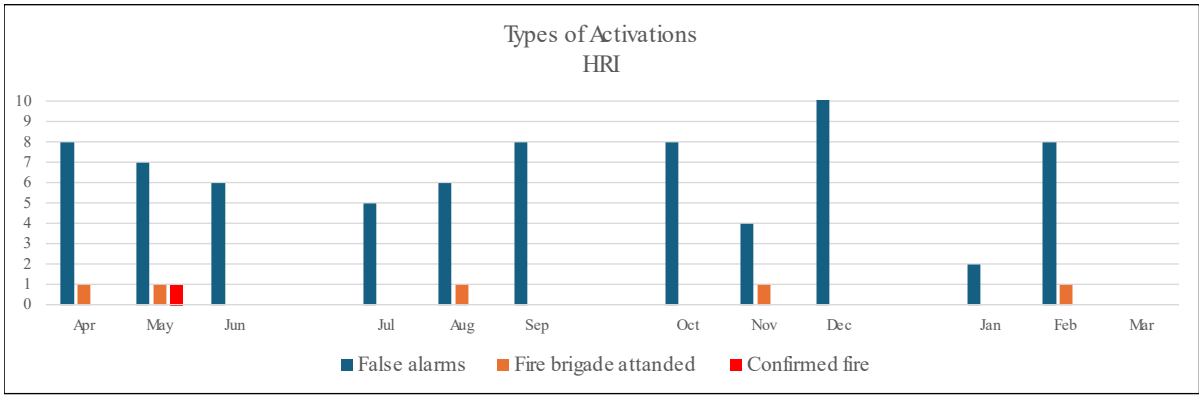
The activation causes are shown in Figure 2 below for HRI and CHH.

Hull Royal Infirmary

Cause of activation	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Accidental activation - Patient - Visitor	4	1	3	3	1	2	1	1	8	-	3	-	27
Smoking - Vaping	1	4	2	1	-	2	-	1	3	2	1	-	17
Toast - Microwave - Pan	1	-	-	-	2	1	2	1	-	-	-	-	7
Contractor	-	-	1	1	1	1	2	-	-	-	2	-	8
Accidental damage to call point	-	-	-	-	-	-	-	-	-	-	-	-	0
Milicous damage	-	-	-	-	-	1	-	-	-	-	-	-	1
Milicous activation - Patient - Visitor	-	-	-	-	-	-	-	-	-	-	-	-	0
System fault	1	-	-	-	1	-	-	-	-	-	2	-	4
Environmental - Steam etc	-	1	-	-	-	-	1	-	1	-	-	-	3
Fire	-	-	-	-	-	-	-	-	-	-	-	-	0
Good intent	-	-	-	-	-	1	-	-	-	-	-	-	1
System procedure not complied with	-	1	-	-	-	-	-	-	-	-	-	-	1
Accidental activation (arosol)	1	-	-	-	1	-	2	1	1	-	-	-	6
Monthly total:	8	7	6	5	6	8	8	4	13	2	8	-	75
Quarterly total:	21			19			25			10			

Types of alarms	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
False alarms	8	7	6	5	6	8	8	4	13	2	8	-	75
Fire brigade attanded	1	1	-	-	1	-	-	1	-	-	1	-	5
Confirmed fire	-	1	-	-	-	-	-	-	-	-	-	-	1

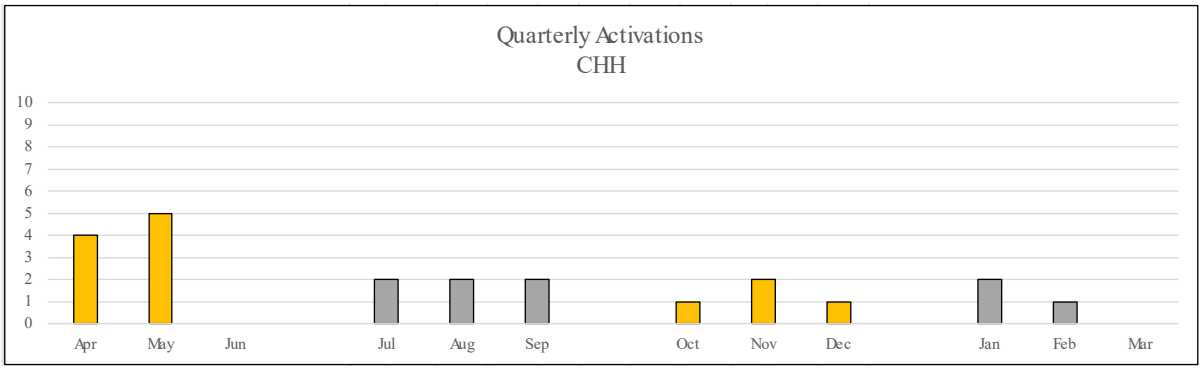




Castle Hill Hospital

Cause of activation	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Accidental activation - Patient - Visitor	-	-	-	-	-	-	-	-	-	1	-	-	1
Smoking - Vaping	-	-	-	-	-	-	-	-	-	-	-	-	0
Toast - Microwave - Pan	1	1	-	-	1	1	1	2	1	-	1	-	9
Contractor	-	-	-	1	-	-	-	-	-	-	-	-	1
Accidental damage to call point	-	-	-	-	-	-	-	-	-	-	-	-	0
Milicous damage	-	-	-	-	-	-	-	-	-	-	-	-	0
Milicous activation - Patient - Visitor	-	-	-	-	-	-	-	-	-	-	-	-	0
System fault	1	2	-	-	1	-	-	-	-	-	-	-	4
Environmental - Steam etc	1	-	-	1	-	1	-	-	-	-	-	-	3
Fire	-	1	-		-	-	-	-	-	-	-	-	1
Good intent	-	-	-	-	-	-	-	-	-	-	-	-	0
System procedure not complied with	1	-	-	-	-	-	-	-	-	-	-	-	1
Accidental arosol - deorderant	-	1	-	-	-	-	-	-	-	1	-	-	2
Monthly total:	4	5	0	2	2	2	1	2	1	2	1	-	22
Quarterly total:	9			6			4			3			

Types of alarms	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
False alarms	4	5	-	2	2	2	1	2	1	2	1	-	22
Fire brigade attended	-	1	-	1	-	-	-	1	-	-	-	-	3
Confirmed fire	-	1	-	-	-	-	-	-	-	-	-	-	1



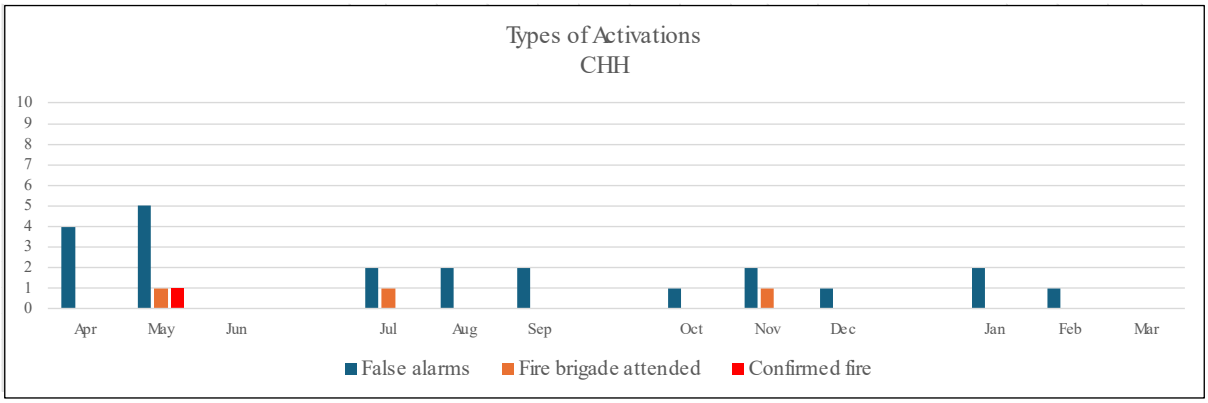


Figure 2 - Alarm Activations

Ongoing discussions with HFRS business safety managers have indicated that HFRS is extending its current policy of call challenging and charging for some attendances which are confirmed as false alarm calls.

Although there may be some dispensation for sleeping risks, especially at night, this cannot be guaranteed for all Trust sites and buildings indefinitely.

Previous charges were approximately £446.25 per appliance per call out, plus an administration figure of £63.00.

This policy is currently evolving for the wider business community. Positive six-monthly Service level liaison meetings with HFRS have continued to mitigate any significant effect of this policy on the Trust to date.

Call filtering principles are adopted to.

- Reduce calls and impact on service delivery and Key Performance Indicators (Fire) for both organisations.
- Avoid placing members of the public at risk during incidents and attendances.
- Prevent damage to the environment

6.0 Premises Assurance Model (PAM) Data - Fire Safety

The PAM assurance model for fire comprises of ten questions, based on how the Trust can evidence the fire information it holds. The following are a summary of the questions, the rating given and any subsequent actions required to strengthen the current position.

6.1 Policies and Procedures

The current rating judgement is Amber (Requires Moderate Improvement)

Actions -

The Fire Safety Manuals, protocols and documentation are to be reviewed by the fire team to strengthen assurance.

The fire safety procedures are to be developed by the fire team and to be presented for approval at the relevant committee.

6.2 Roles and Responsibilities

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions-

There needs to be a confirmed identification of the roles, with the recent reorganisation of the E, F&D re-structure, with confirmation given in writing.

There needs to be a more robust fire warden/Senior Management coverage to wards and multi-occupancy office areas.

6.3 Governance

The current rating judgement is Yellow (Requires minimal Improvement)

Actions -

A final Fire Authorising Engineers (AE) report will be distributed to the HUTH Governance & Assurance Committee, upon completion of the audit in August.

6.4 Enforcement

The current rating judgement is Red (Poor). This was due to the Trust receiving an Improvement Notice (IN) in relation to the Tower Block at HRI. This was issued after the Trust notified HFRS the results of intrusive surveys on the cladding and encapsulation materials within the Tower Block. It was discovered that materials unsuitable for heights of 18m + had been installed which needed to be addressed.

After a meeting with HFRS an IN was issued to the Trust to replace the encapsulation materials with appropriate materials suitable for use for buildings over 18m.

Actions -

There is a detailed action plan within the Tower Block Programme for the work required to satisfy the IN. This work is over the next three years due to the complexity and affects all floors on the Tower Block. HUTH are working with HFRS to comply with the IN and meet formally on a regular basis to identify progress towards completion.

In addition design consultants have now been engaged to commence the design in terms of remedial actions required and discussions are ongoing with the Building Safety Regulator in regards to application information required. A number of working boards have also been set up to oversee the project, programme and commercial aspects. Currently, awaiting formal notification of funding allocation but verbal confirmation has been attained.

6.5 Fire Risk Assessment

The current rating judgement Orange (Requires Moderate Improvement)

Actions -

The Fire AE needs to be commissioned to approve the proposed fire compartmentations at HRI from the ground to the third floor of the Tower Block and North Blocks as an addition to their fee bid for fire AE duties.

The Building fire risk assessment and Ward Risk Assessment programme is to be reviewed and developed to enable monitoring and compliance to provide the appropriate level of assurance to the E,F&D Management Committee/Trust Fire, Health & Security Committee. Regular updates will also be made to the Performance, Estates & Finance (PEF) who have sub-board oversight in relation to fire safety management.

6.6 Maintenance

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

A costed action plan for passive fire surveys and remedial works is to be developed by the fire team.

6.7 Training and Development

The current rating judgement is Yellow (Requires Minimal Improvement)

Actions -

The Trust fire team are implementing tabletop fire evacuation to High Dependency areas where the full evacuation training is impractical. The team have also formulated a power point theory and practical evacuation, as well as training for the risk of surgical fires and how to deal with them.

There remains a backlog of fire evacuation training needs throughout the Trust. This is down to a resource issue and also the practicalities of evacuating the wards. The team are going to undertake desk-top evacuation exercises to the wards to ensure partial compliance, in line with the latest HTM guidance.

The Trust training department are currently reviewing the Trust training standards, specifically the induction process. This will involve more specific and detailed fire training, which is in line with the changes to the HTM standards.

6.8 Resilience, Emergency Planning and Business Continuity

The current rating judgement is Yellow (Requires Minimal Improvement)

Action - Evacuation drills are required to be undertaken and recorded in both clinical and administration areas where possible, with the option of a “Table-Top” exercise in critical care and Theatre areas.

6.9 Review Process

The current final rating judgement is Amber (Requires Moderate Improvement)

Actions -To review the current electronic recording system for both passive fire and fire audit purposes.

6.10 Costed Action Plans

The current position is yes.

Action -There is a costed plan for the passive fire surveys and associated remedial work. Orders have been placed for the remedial work identified to date via the passive fire surveys.

7.0 Fire Safety Improvement and Development

The HUTH fire team are scheduled to be audited by the Fire AE in August 2026. The outcome of the audit will be an action plan with recommendations.

Estates/PFI agreed cyclical fire alarm system improvements remain in place for all Trust sites to help reduce false alarms/ UWFS and to improve system reliability and property protection. It is important to continue this impetus to maintain the effectiveness of the Trust fire alarm systems and to maintain suitable statutory compliance levels.

New developments and major refurbishment or extensions are prioritised as far as practicable for a new or updated Fire Risk Assessment (FRA) after appropriate consultations between the Trust Capital Development and Fire Teams, relevant Building Control Bodies and HFRS as necessary. `

The Capital Development and Fire Safety teams need to reconvene to confirm a previous scheme to consolidate the fire compartment lines for the HRI Tower Block ground to third floor inclusive, as well as the issues with the cause and effect in the ED department.

The scheme was previously agreed in principle; however, it was not ratified by the Trust's previous Authorised Engineer (Fire) [Trenton Fire Engineers].

This matter remains outstanding and is expected to be reviewed during the year with the current Authorised Engineer (Fire).

8.0 Ongoing Fire Safety Priorities For 2026-27

An annual audit has been confirmed for the week commencing August 2026 (three-day audit) with the fire Authorising Engineer (Fire safety Partnership).

Continue liaison with HFRS regarding false alarm fire calls, attendances and potential charges etc.

Promote joint working with Learning and Development, Health Groups and other stakeholders to further improve global fire training figures.

Further improve and refine the Trust Fire Safety Risk Based Inspection Programme and the BORIS database.

Maintain and further develop HFRS statutory fire safety and operational risk information site visits and Service level liaison meetings.

Increase and monitor the numbers and frequencies of local ward and department fire drills and fire plan exercises etc.

Continue with the passive fire surveys and remedial work associated with the surveys to the high-risk areas.

9.0 Conclusion

The Trust continues to demonstrate a strong commitment to maintaining and improving fire safety management arrangements across its estate, with overall compliance broadly aligned to statutory requirements under the Regulatory Reform (Fire Safety) Order 2005 and relevant HTM guidance. Progress has been made in key areas, including increased fire warden numbers, improved training compliance, enhanced fire door inspection performance, and a notable reduction in fire alarm activations compared to the previous reporting period.

However, several areas require continued focus to strengthen assurance and ensure sustained compliance. These include addressing resource constraints within the Fire Safety Team, progressing outstanding fire risk assessments, improving fire alarm system performance and cause and effect arrangements, and ensuring fire safety documentation and local plans are consistently maintained and up to date. The ongoing programme of passive fire surveys and remedial works—particularly in higher-risk areas such as the Tower Block—remains critical in mitigating risks associated with compartmentation and structural fire integrity.

The Trust's governance arrangements, risk management processes, and engagement with external stakeholders such as Humberside Fire and Rescue Service continue to provide a solid framework for oversight and improvement. The forthcoming Authorising Engineer audit will provide further independent assurance and support the development of a robust action plan.

Overall, while the Trust is operating at a level that meets many of its fire safety obligations, targeted improvements and sustained investment are required to address identified gaps, reduce residual risk, and enhance resilience. Delivery of the priorities and recommendations outlined in this report will be essential to achieving full compliance and ensuring the safety of patients, staff, and visitors.

10.0 Recommendations

The Committee is asked to note the content of this report and support the delivery of the following recommendations to strengthen fire safety compliance and assurance across the Trust:

Key Fire Safety Priorities

1. **Upgrade Fire Alarm Systems**
   Progress replacement or upgrade of the Hercules system and review of cause & effect arrangements to improve reliability, reduce unwanted fire signals, and support safe evacuation.
2. **Complete Fire Risk Assessments (FRAs)**
   Address backlog and ensure all high- and medium-risk areas are assessed and reviewed in line with statutory requirements to strengthen compliance assurance.
3. **Deliver Passive Fire Safety Programme**
   Continue and accelerate fire compartmentation surveys and remedial works, particularly within the Tower Block, supported by a clear costed plan.
4. **Strengthen Workforce and Training**
   Address Fire Safety Team capacity as part of EF&D restructure, improve evacuation training delivery, and ensure sufficient fire warden and senior management coverage across all areas and shifts.
5. **Improve Governance and Assurance**
   Enhance fire safety documentation, implement outcomes from the Authorising Engineer audit, and strengthen oversight to ensure consistent compliance and continuous improvement.
6. **Collaboration and Continuous Improvement**
   Strengthen collaboration with partner organisations (North/South Bank) to ensure a **consistent and standardised approach to fire safety management** where appropriate.

Hedley Wilson
Deputy Head of Operational Estates

June 2026

ANNUAL FIRE STATEMENT **FOR PERIOD – April 2025 – March 2026**	NHS Hull University Teaching Hospitals NHS Trust

I confirm that for the period 1st April 2025 to 31st March 2026, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)

1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment.	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A

* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk
Date: Not applicable

4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	Yes
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method. (see part 1 below)	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Lyn Simpson Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
Improvement Notice (IN) – issued on 16th July 2025 in relation to the Tower Block at HRI after the Trust approached Humberside Fire & Rescue Services (HFRS) with the results of surveys carried out on the external encapsulation of the block, cladding and internal insulation identified that material present did not meet the Class 0 or Class A1-s1; d0 (or A2-s1;d0). This was considered by HFRS to be in contravention of Article 8 (1) (a) (b) of the Regulatory Reform (Fire Safety) Order 2005. The requirement of the notice is to:- • Replace all external wall facades and/or encapsulation systems where it is not meeting the required standard. • Ensure that cavity barriers are fitted to all of the external wall system to the current standard of Building Regulations. A full intrusive survey must be carried out on all externally clad walls to confirm this. The required date to comply was set as 16th July 2026. Since the IN was issued a number of surveys have been completed and options identified to comply with the notice. A dedicated project team has been including external support and a design team is to be appointed to develop a full design and plan regarding the replacement of the encapsulation and cladding system. Mitigation measures undertaken as an interim measure include: • Complete review of all fire risk assessments and development of primary risk assessment • Review and update of fire strategy covering current status (this will be updated when detailed designs are approved) • Discussion with NHS England regarding funding for undertaking the work required to comply with the IN. • Full fire stopping survey and remedial works within the Tower Block • Implementation of Fire Compliance Online which will enable identification of Fire Wardens to be undertaken in real time and highlight areas where more are required. • Formal quarterly meetings with HFRS to update on progress made and programme updates. Given the nature of the work required the Trust is working towards requesting an extension to the compliance date to complete the work. In addition, NHS England have indicated the allocation of funding is to be granted there is currently no formal notification to confirm this.
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred, and additional costs required to comply.
None
NB Statement to be retained for external fire authority audits.

Northern Lincolnshire and Goole
NHS Foundation Trust

Directorate of Estates, Facilities & Development

Annual Fire Report

1st April 2025 to 31st March 2026

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1.0 INTRODUCTION

The responsibility for compliance with the Fire Regulatory Reform (Safety Order) referred to as the FSO rests with the "responsible person" (RP) which in the case of Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) is the Group Chief Executive Officer or in the event of remote buildings off site buildings this may be the person in control of those premises.

As the development of the Group structure develops there may be a number of staff who work across the Group with specific fire responsibilities but for the purposes of the FSO NLaG is required to produce an annual report as it's own legal entity.

However, this report together with the corresponding report for Hull University Teaching Hospitals (HUTH) will be linked with an overview summary detailing those issues planned within the Group workplan for 26/27.

In addition, to the FSO those areas within the definition of clinical activities being undertaken, the requirements of Healthcare Technical Memorandum (HTM) fire documents (called the Firecode) are also performance indicators to demonstrate compliance with fire safety. The documents related to these areas are within the HTM 05 suite and also set out responsibilities for individuals as well as groups of workers within NLaG (NB some individuals working for the Group may also have similar responsibilities for HUTH).

Under Firecode (i.e. HTM 05 suite), the primary responsibility for ensuring that there is an effective policy rests with the board-level director assisted by the Fire Safety Manager.

This report has been developed to provide information to the Trust Board of Directors concerning the management of fire safety for the period **1st April 2025 to 31st March 2026** and to also identify potential issues for the next 12 months. Included within this report is a workplan for 26/27 which is across Humber Health Partnership (HHP). Issues for a specific Trust will be stated as some differences may occur due to layout, buildings composition and activities which are being undertaken (also may take into account those areas under PFI control).

The Care Quality Commission (CQC) as part of its responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 will also consider fire safety issues as part of its "Safe" domain and generally will review issues such as:

- Active inspections – walk throughs looking at fire signage and equipment is being maintained.

- Documentation – that fire risk assessments are maintained as well as fire procedures and staff training.

- Evacuation planning – use of Personal Emergency Evacuation Plans (PEEPs), evacuation drills.

Whilst CQC will check compliance the fire authority still retains the enforcement duties.

This report will also assist with the formulation of annual statement within this report and may also assist with demonstrating performance against Regulation 15 of the Care Quality Commission (CQC) Essential Standards of Quality & Safety. This report should therefore be retained along with the workplan as the assurance to external authorities in terms of fire safety management within the Trust.

It should also be noted that the HTM 05 suite of documents have been revised and will be updated documents will be issued during the 24/25 period and relevant policies have been updated to reflect those amendments which came into force during the 25/26 period. As further updates are now being proposed in relation to the Governments acceptance of the Grenfell Inquiry recommendations in full, these will be reviewed and incorporated, where relevant, with further updates of the relevant policies.

Likewise, the Group structure across NLaG and HUTH is not yet complete and the impact on responsibilities to comply with the HTM will be reviewed when this is finalised.

2.0 EXECUTIVE SUMMARY

Within the 2024 period (this is the last period with national verified information) there were 140 recorded arson attacks against healthcare premises with 1,159 fires reported. This may seem a large figure but should be taken into account a reduction of nearly 30% within the healthcare environment.

The NLaG breakdown of reported fire related incidents is given in the sections below

Thankfully, the number of fires in healthcare settings are not an everyday occurrence and since 2010 the number of accidental fires attended by the fire brigade are reducing.

In addition, guidance specific for the healthcare sector gives more detailed information to try and prevent fires occurring or detect them at the stage where they are detected whilst small and easier to put out. This includes the expected lifetime of any detection and alarm system which currently suggests that an AFD system should be replaced approx. every 20 years.

Capital investment over the last five years of circa £12m has seen the systems nearly completely replaced at Diana, Princess of Wales Hospital and Scunthorpe General Hospital with an Advanced System which gives greater flexibility and compatibility across the two main sites.

The consideration of when to replace any AFD system is monitored by the number of system fault activation (as all alarm activations are recorded) and reporting this performance to show any deteriorating trends at an early stage. The number of system faults for the AFD system at Goole has been monitored for the past two years amid concerns regarding the number of system faults. When the alarm system at SGH was replaced a number of panels were kept to act as spares for any failures at GDH until funding could be allocated to replace the system in its entirety.

However, there is still a risk of a catastrophic failure which potentially could leave the system non-operational and then fire watchers would need to be present 24 hours per day/ seven days per week to keep the hospital operational.

On the 27th January 2026 such a catastrophic failure occurred where a number fire alarm panels including the main panel went down. It was fortuitous that predominantly the areas most affected were empty wards which were no longer in use. This did mean however, that contingency short term arrangements needed to be implemented at short notice to allow the hospital to remain operational.

Whilst these short-term measures were in operation a replacement panels needed to be constructed from scratch to bring the alarm system back onto a L1 alarm compatibility. It should be mentioned that the efforts of the EF&D teams together with the fire alarm maintenance contractor meant that the site continued with little disruption.

The capital funding for the replacement of the AFD alarm system has been subsequently brought forward and the scheme will commence in 26/27 with completion in 27/28. This will complete the replacement of all AFD alarms systems at the 3 main NLaG sites.

The breakdown of fire alarm activations, attendance by the fire brigade and actual fires are detailed within the following sections below. Generally however, the number of activations has decreased by circa 20% from the previous 12 months which reflects on the reduction of system faults that were due to the age of the systems and commissioning third party interfaces as part of the new installations.

The Group reports to the Health, Fire & Safety Group (HFSG) the escalation from the HFSG to groups above is part of the Group meeting structure which is to be finalised in 26/27 but during the interim period escalations will be made to the Performance, Estates & Finance (PEF) Committee-in-Common (CiC).

Within the detailed report below the following recommendations are made:

1. The deterioration of the GDH system should be noted and consideration given for replacement of the entire system within the next 2-3 years.
2. There are gaps in the fire warden coverage across the Group and further campaigns should be implemented to get more nominated and trained.
3. The fire risk assessments (which incorporate passive fire elements) should be reviewed in accordance with the programme and reminders generated from the electronic system.
4. Consider further capital allocations to review and compile fire stopping at NLaG as there are gaps in the inventory and some areas have not been surveyed (or there is no record) for compliance requirements.
5. Review business case for an in-house fire door inspection and repair team to reduce costs on fire doors which could be repaired but are currently replaced (at a higher cost than an approved repair).
6. Whist collaborative work across the Group is already in place there is scope for greater working together to address the common fire safety management issues in both partner organisations. This will also result in a more consistent approach to reducing the risks and protecting staff, patients, visitors alike.

Finally, acknowledgement must be made for the capital investment made to replace the aged alarm fire alarm system at SGH to increase the protection and early detection of a fire occurring before it can significantly affect patient care.

3.0 REPORT

3.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 1.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
3361	GDH	Goole District Hospital Fire Alarm Potential Failure. **There is a risk of failure due to the age of the system (40+ years) and is not compliant with HTM 05-03 and BS 5839 and the parts are obsolete. The system may give adequate or timely alerts of a**	• All system faults monitored on a monthly basis and reported to EF&D Governance and Fire Safety Technical Group.	12

		fire on site resulting in potential harm and loss of life		

Table 1 - Fire risks on Trust Risk Register

Previous risks have now been removed due to completion of work.

Operational risks that sit within the functional responsibilities of the Estates Department are identified through the E&F Operational Risk Register. These risks are separate from the Trust Risk Register and cover specific issues (rather than generalised) and enable appropriate prioritisation to be undertaken so the funding allocation is used to tackle the higher risks as a priority. This operational risk register also includes costed options which will allow any additional allocations received to be quickly utilised avoiding undue delay.

Work continues within the Coronation Block at SGH to look to achieve compliance with the statutory requirements. This will not be fully achieved whilst any clinical activity is undertaken within the building due to its construction. The ongoing work is improve the compliance and minimise the risk from fire. More work is ongoing as more areas are refurbished into admin areas but the fracture clinic continues to operate from the Coronation Block. The agreement with HFRS to allow this still stands but longer term this clinic will need to be relocated.

Due to the age and construction of some of the buildings means that they no longer meet the fire safety requirements. Under the legislation a change of use or the area not being used for a period means that to re-use or repurpose these area they have to be brought up to the fire standards of today. Areas such as the Coronation block and the Ward 2 block will not meet these new standards and they no longer can be considered for any future clinical use. The Planned Investigation Unit (PIU) will fall into this category should it be repurposed or closed down for any period but currently can be continued for use as a PIU. This will be an ongoing issue as buildings age and new fire requirements come into force in the future and so this issue should be included in any Estates strategy going forward.

3.2 Fire Safety Technical Group

The Fire Safety Technical Group (FSTG) continues to meet regularly and going forward as a Group consideration is being given as to developing an overarching similar group or extend the FSTG to include HUTH (as there is no corresponding group formally in place).

The FSTG reviews the detailed technical aspects in relation to fire safety management. It also considers and reviews compliance against the statutory provisions within the FSO and also the HTM fire safety documents. There have been a number of reviews to current HTM with part K (Fire Risk Assessments) being re-issued and this has been reviewed by the FSTG and changes made accordingly.

The FTSG will also consider requested derogations from HTM based on risk assessments. The group reports to the Health, Fire & Safety Group and allows the HFSG to oversee fire safety rather than get too detailed which could detract from other agenda items.

During the period of this report there have been topics such as the derogation process and the impact of the revised Regulation 38 requirements that have been escalated to the Health, Safety and Fire Group and to the EF& D Group Governance Group improve compliance and ensure that fire safety management is embedded within the processes operated within the Trust.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the higher groups when the Group meeting structures are finalised to enable issues to be escalated when appropriate.

3.3 Fire Safety Management Polices

The Trust has now appointed an Authorising Engineer (AE) for fire safety management and ongoing audits are now conducted on an annual basis with the last audit report raising a number of procedural issues the majority of which have been addressed. There are some issues which will be part of the Group approach to combine policies and procedures across the partnership within the 26/27 workplan.

The audit report findings and action plan are reviewed as a standing agenda item by the FTSG with the EF& D Governance Group having overview with any issues escalated.

The Authorising Engineer for Fire AE(Fire) has undertaken a further audit in 25/26 and the actions identified are monitored by the FSTG and the HSFG with no significant issues being identified. The AE(Fire) has also now been appointed for HUTH and so there will be a consistent approach in terms of the annual audit across the Group.

3.4 Management of Fire Risks

There are currently 168 active fire risk assessments covering the Trust and units which are currently being used by NLaG staff.

This represents an increase of 3% over the previous period. The increase is within normal parameters and can be due to re-aligning fire compartments or a number of areas where a change of use whereby more than one risk assessment is required. However, there are a number noted that are due for review where those areas are no longer used (e.g. leased premises whereby we have vacated). This will be rectified in the 26/27 period including a small number of outstanding reviews which have been delayed due to other priorities.

Current changes required under revised HTM or Building Safety Regulations will also bring forward some review dates and a full work programme is being implemented within the 26/27 period to address these issues.

The current review periods for assessments are:

- In-patient areas - 12 months
- Out-patient areas - 24 months
- Admin areas - 36 months

These review periods are now also aligned across the Group allowing for greater resource utilisation and flexibility across the Group.

The assessments are maintained on an electronic system which is cloud based system containing a number of assessment types (service provided by Evotix) and updated by the Fire Safety Officers (FSO) and Fire Safety Manager (FSM).

The development of a digital strategy within EFD will consider either extending this system across the Group or transferring onto a new digital platform in either the 26/27 or 27/28 period.

3.5 Structural Fire Protection

Changes made to the FSO and the introduction of the Building Safety Act, implementation of the Fire Safety (England) Regulations (2022) have strengthened fire safety requirement particular in relation to residential premises (especially those over 18m in height). This does not materially affect NLaG as no current buildings fall into the “high risk” category as it stands but it should be noted that the current references to residential dwellings is changing in new guidance and this may bring in some requirements. This situation is being monitored via the AE(Fire) and the FSTG.

Further strengthening within the Building Safety Act and new guidance has been implemented in regards to Regulation

A significant change which occurred during 24/25 period was the amendments to the Regulation 38 requirements of the Building Regulations. The requirements are such that handover of projects should not occur until the regulation requirements have been met as to do so may now constitute an offence under the statutory provisions

As part of working across the Group the CAFM system specification is to go out to tender to determine if a system can be used across the two organisations for more consistency, compatibility of data and also to allow direct performance comparison for all sites within the Group. This project is expected to be completed within the 26/27 for full implementation as the system to be used has now been confirmed. This may also include the fire risk assessment recording but this is not confirmed at this point.

3.6 Fire Doors Inspection & Maintenance

The business safety case to recruit a dedicated fire door inspection and repair team within NLaG was approved within the 25/26 period and this recruitment will be implemented within the 26/27 period. In the meantime, work is ongoing to update and implement a fire door specification for use across the Group to adopt a consistent approach to the procurement of fire doors

3.7 Fire Response Management

The FSO and HTM give requirements in relation to a response to an alarm activation require organisations to deal with the initial stages of fires and alarm activations without relying on the attendance of the fire services. There is a group wide review which will cover the 25/26 period looking to update training of fire wardens, identify gaps in provision of fire wardens and response in relation to staff roles. The method of recording the training and refresher intervals is also part of this work as well as any issues identified within the respective AE Audit Reports.

Regular drills are required to check the effectiveness of arrangements and review where further improvements can be made. However, HFRS recognise that it is extremely difficult to undertake live drills in clinical areas where patients are located (especially in those areas with overnight patients, immobile patients or those who are seriously ill). It is therefore agreed (with HFRS) that live top exercises will be undertaken areas including those areas which are subject to a different fire strategy than others (e.g. ITU areas). There will be feedback from these exercises to the Fire Safety Technical Group and any actions monitored via this group.

More details are also included in the sections below and timescales shown within the workplan attached in Appendix 2.

3.8 Fire Training

Face-to-face fire training is a requirement under the HTM and also the FSO requirements and the recently revised HTM 05-03 Part A has further emphasised that “perodic” fire safety training is required to be undertaken. The frequency and type of training is based on a Training Needs Analysis [TNA] but guidance is given within the HTM.

The HTM also identifies that face-to-face training for fire evacuation using evacuation equipment is the only appropriate method to test evacuation processes. This is difficult in a clinical environment when the area is operating on a 24/7 basis. Currently, the team is working with Organisational Development to enable training to be delivered on a practical basis regarding the use of fire evacuation equipment. In addition, local induction within a staff members work area should also be face-to-

face. In respect of e-learning the HTM acknowledges the usefulness of this type of training but stipulates that face-to face training by a competent person must be delivered every two years.

Discussions across the group has resulted in agreement that this frequency is to be adopted across the Group going into 25/26 and onwards. Also the content of fire training for all levels (i.e. fire warden, response teams, incident manager etc.) is being reviewed with induction having already been reviewed and implemented.

General fire training will also include practical fire extinguisher training (as part of the requirement to ensure that there are sufficient persons at any one time who are able to use a fire extinguisher correctly.

During the 25/26 period there has been a slight increase in the percentage of those trained as the number of sessions being delivered continues to be increased in places offered as circa 3400 places were available compared to 2800 in same period previously. In addition, a more flexible approach for ad-hoc sessions can also now be offered due to the purchase of more training equipment so now equipment is available at all three sites allowing for training to be delivered on different sites at the same time.

The number of training sessions for face-to-face training is calculated using the records of those who will come out of compliance in the next 12 months. A safety factor to allow for non-attenders has been implemented so that over 1300 additional places are available for staff to access.

The fire training compliance for the 25-26 period is included in Table 2 below.

Period	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
% staff trained	80	79	78	84	84	91*	77**	75	83	85

Table 2 - Fire Training Compliance

* - no face to face training

** face to face training reintroduced

The table above shows that over the last four years there has been an increase in the number of staff trained and with the exception of the 21/22 period (where no face-face training was provided due to covid restrictions) the level of training is the highest within the last decade. However, this still means that 15% of the workforce are not in compliance with the requirements so further work is needed.

In order to address staff not attended more follow ups with managers have been undertaken especially to address a small number of staff who have booked to

attendance on numerous occasions during the 25/26 period but have failed to attend any session in the period.

3.9 Fire Alarm Activations and Unwanted Fire Signals

The definition of an Unwanted Fire Signal (UwFS) from the Chief Fire Officers Association (CFOA) is:

where an alarm activation causes a requirement for the local fire & rescue services to attend the organisation's premises un-necessarily and which impacts on the fire cover for the local population potentially putting lives at risk.

These are not fire alarm activations which is the AFD system is triggered via a sensor or manual call point. Whilst there may a large amount of false alarms the number of UwFS should be reduced to the lowest level possible. If the Fire Authority identify that efforts are not being made to reduce this then they can take action in the form of an enforcement notice and also submit a charge for the attendance of each tender and admin costs. For NLaG this would amount to circa £1500 per attendance. However, the Trust has 24 hour "call filtering" in place where there is a six minute delay to determine if there is a significant fire or whether it is a false alarm. This means that the actual number of attendances by the brigade is reduced and therefore fire cover for the rest of the town/area is not compromised.

The Trust has to date never received an invoice for the attendance of the fire brigade.

It should also be noted that the CFOA definition of UwFS is different to that which is reported in the Estates Returns Information Collection (ERIC) which class an alarm activation as an UwFS within the information submitted in previous ERIC returns. The definition for reporting has now been modified going forward so the return to 25/26 will give the number of fires with "no call out" as well as the number of fires with "call out" this latter includes calls due to the time exceeded for checking if this was a real fire and those the fire service would classify as with "good intent" (i.e. if a person smelt smoke and activated a manual call point) etc. The definition used for this report is in line with that with the CFOA definition but also taking into account any "stop calls" (this is where it is confirmed that there is no fire but the call had already been made to to the fire brigade, and also those classed as "good intent".

The number of UwFS each year is shown in Table 3 below. These do not include any actual fire at the DPOW site which would not be classified as an UwFS. Any activation which is classed as "good intent" by HFRS is also not specified as an UwFS.

The installation of new alarms for DPOW and SGH have resulted in the number of systems faults but the deterioration of the GDH alarm system has resulted in the highest number of UwFS for the site in 11 years. The number of UwFS for SGH has increased in part due to the SGH accommodation alarm system which was not replaced when the main system was. The system is monitored by a third party and in some instances they have contact the fire brigade directly before contact the Trust.

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
SGH	7	4	3	10	10	7	7	1	2	3	4
DPOW	9	8	9	8	17	3	9	1	5	7	1
GDH	0	2	2	0	1	0	0	2*	2	1	4
Total	16	14	14	18	28	10	16	4	9	11	9

Table 3 - UwFS for NLaG

* - Classed as “good intent” but HFRS attended despite “stop” call

There were a further 4 activations that would have been classed as UwFS but stop calls by switchboard were made in time to prevent attendance.

In relation as a percentage of total activations the UwFS is 4.3% of all activations and is considerably lower than the fire authority guidelines for enforcement intervention (i.e. Fire Protection Association (FPA) guidance is no more than one UwFS per 20 detectors)

In relation to the number of alarm activations there were 208 (compared to 257 for the same period last year). This is a reduction on the previous period of nearly 20% and reflects the investment in the systems over the last 4 years. The breakdown of the alarm activations is seen in Figure 2 below for the period of this report with a comparison of the previous period shown in Figure 3.

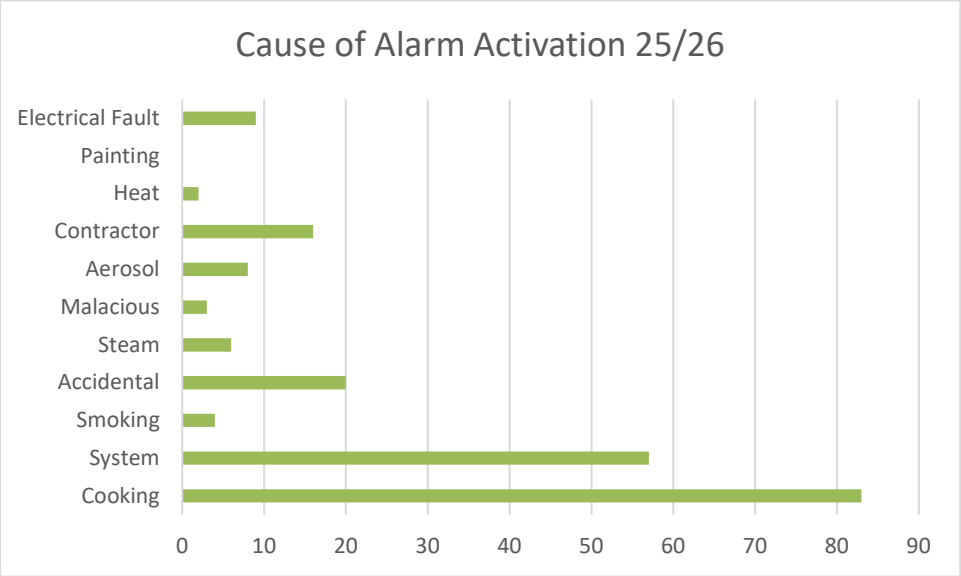


Figure 1- Breakdown of activations 25/26

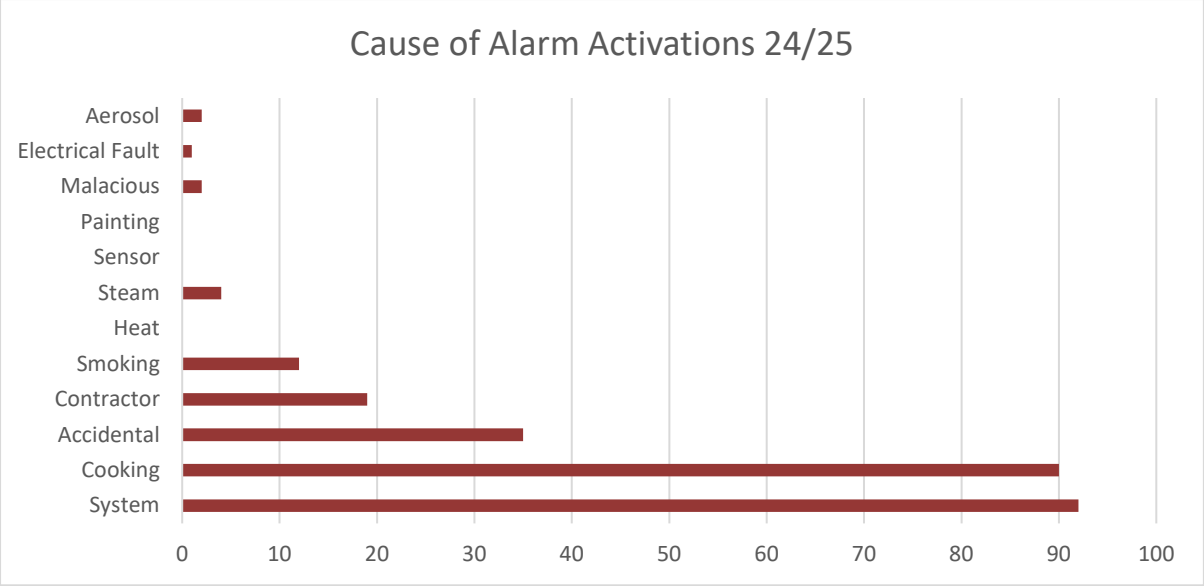


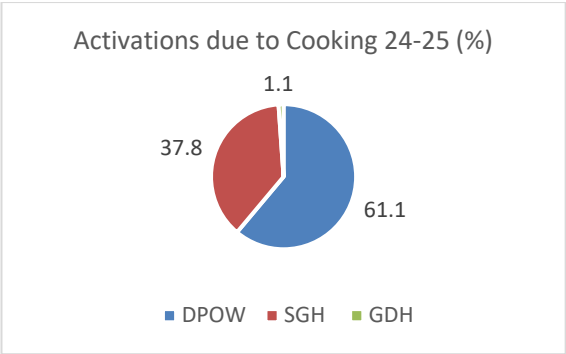
Figure 2 - Breakdown of activations 24/25

It can be seen that the most activations are caused due to cooking. In the period 24/26 this was the second most activation cause (see figure 2) but is now clearly the largest cause of alarm activations by a large margin.

The highest causes during the 24/25 period were due to system issues and cooking. In relation to cooking the majority of activations are due to staff leaving “attended appliances” (predominantly toasters) unattended. These appliances require the user to be with the machine whilst it is being used. An awareness campaign to highlight the use of “attended appliances” will be undertaken during the 25/26 period to try and reduce these activations.

In relation to system activations the ongoing work in third party interfaces should result in a reduction in the number of activations.

The comparison of “cooking” alarm activations compared to 22/23 is shown in Fig 4 which shows that the majority of activations are now at SGH unlike the previous period. A common theme in the activations for cooking is the incidents where equipment such as toasters etc. are left unattended by staff. Such equipment is classed as an “attended appliance” and should not be left unattended whilst it is being operated. More awareness of this issue is to be part of the work programme for 26/27 to reduce these type of incidents.



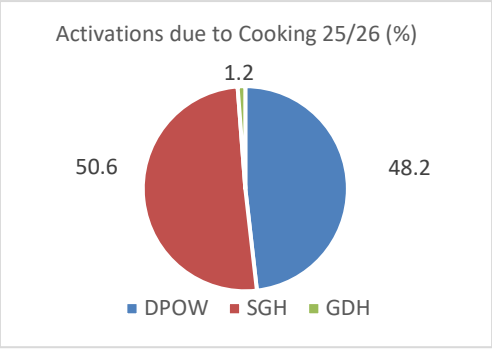


Figure 4 - Activations due to cooking

3.10 Enforcement Activities by Local Fire Authorities

There has been no enforcement action undertaken by HFRS in respect of fire safety within NLaG premises. During the period there have been a number of physical audits by the Fire Authority at all three sites with no items of concern raised. Minor issues were raised in relation signage and ensuring that risk assessments are reviewed at appropriate periods. All of the issues have either been completed or are included within the work programme.

3.11 Capital Investment

The working of a commercial AFD is between 20 – 30 years and this is dependent on the fire alarm type, availability of replacement detectors, alarm panels and the ability to reprogramme zones etc. due to changes in use.

The reduction in activations due to system faults has improved across the DPOW and SGH sites since the replacement of the alarms. The alarm system at GDH has been showing significant deterioration in its performance and at one point the main panel and 2 sub-panels failed causing a potential serious issue. Luckily, the areas affected were mainly confined to those that were not occupied and the external maintenance alarm contractor assisted in restoring operational functions to the main panel and also building and installing a new panel within a short period of time.

This prompted the Trust Board to approve to bring forward capital investment to replace the alarm system at GDH and this will take place over the 26/27 and 27/28 period.

legal requirement for a L1 fire alarm system within a hospital otherwise fire watchers would be required 24 hours per day within all areas to keep the hospital open.

Issues such as fire stopping have received limited funding but it is noted that fire authorities in other areas have identified this as an issue and given the issues identified in Grenfell regarding fire migration this is an area that needs to be addressed going forward.

3.12 Actual Fires Recorded

There were five actual fires recorded during the 25/26 period and these are briefly outlined below.

Site	Location	Details
SGH	Ward 23	Toaster seen to be smoking but no attempt to switch off led to toaster catching fire.
DPOW	Incinerator Waste bay	Lead acid batteries stored in area overheated and caught fire. Smoke damage to area and Electric Tug destroyed. NB there was no Lithium Ion batteries in the fire although adjacent to seat of fire and needed to be cooled for circa 2 weeks.
SGH	Location not identified	Blood fridge caught fire.
SGH	Accommodation	Shower electric unit caught fire.
SGH	Accommodation	Hot heater left on bed setting fire to bedding.

In relation to the incinerator waste bay fire there was a full call out where the fire brigade initially increased the number of fire tenders attending and required evacuation from Estates, Medical Records Annex, Pharmacy Aseptic Suite, Main Kitchens areas and also caused traffic diversions to be put into place. The leading fire officer thanked the Trust and response staff for their assistance and initial response in securing the affected areas which allowed the crews to tackle the fire and bring it under control sooner. This allowed a number of affected areas to be re-opened for staff to return to work.

A full investigation and report was produced and action plan developed and the actions identified have mostly been completed.

4.0 Work Plan for 26/27

The workplan for the next period (26/27) is attached in Appendix 2. It should be noted that this workplan may be further developed and added to after the next AE(Fire) audit depending on the findings and action plan developed. In addition, as the various parts of the revised HTM documents for fire are issued the action plan will be reviewed and addition items added where appropriate.

This work plan is for HHP as a group but where there are specific issues for HUTH/NLaG then these will be identified.

5.0 Conclusions & Recommendations

Management of fire safety within NLaG is an ongoing development and the workplan shown in appendix 2 gives more detail on the various elements that need to be further developed. The level of capital investment over the last 48 months has meant that circa £12m of capital investment in fire safety management has occurred. Further

capital investment of circa £2m is to be invested in the GDH alarm replacement. The Trust should be recognised for this level of investment and demonstrates how important fire safety is considered within NLaG.

The appointment of an AE(Fire) further demonstrates the Trust's approach to fire safety as currently this is not a legal requirement but is seen as a positive benefit to the Trust having an independent expert available to further develop fire safety management with the Trust.

The recommendations of this report are:-

- Review the revised HTM regarding fire training and revised training content appropriately to implement within HHP
- Increase the number of fire wardens across the Trust to ensure that there is adequate cover
- Review and update those fire risk assessments which are due to be reviewed within the 26/27 period
- Work collaboratively with the HUTH fire teams to adopt a more consistent approach to fire safety management across the group where practicable.
- Consider further capital funding to undertake a complete fire stopping survey at all NLaG sites and rectify issues especially to restore 60 min fire compartment lines.

Appendix 1 – Annual Fire Safety Statement

ANNUAL FIRE STATEMENT FOR PERIOD – April 2025 – March 2026		NHS Northern Lincolnshire and Goole NHS Foundation Trust
I confirm that for the period 1st April 2025 to 31st March 2026, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)		
1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment (see appendix 2)	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A
* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Lyn Simpson Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
None
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred and additional costs required to comply.
None
NB Statement to be retained for external fire authority audits.

As a Foundation Trust annual fire safety statements are not required to be submitted to the Department of Health & Social Care. However, the completion of an annual statement signed off by the Trust Board is seen as good practice and allows the Board to gain assurance in relation to fire safety that adequate systems and controls are in place to reduce the risk of fire within the Trust premises.

2026/27 Work Plan for Fire Safety Management within HHP

Item	Area	Task / Objective	HUTH/NLAG Or HHP	Target Dates	Completed/Progress
	Review of Policies				
1.1	Review fire safety management policies and guidance with revised HTM 05 suite of documents and 24/25 AE. Potential scope for Group documents to be considered	• Review new training HTM requirements • AE Action plan arising from 26/27 audit • Update AE Audit action plan for policy requirements • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	HHP HHP HHP HHP HHP	July 2026 Oct 2026 Aug 2026 June 2026 July 2026	**In progress** **In progress** **In progress** **In progress** **In progress**
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• Arrange operational plan review visit (annual). • Fire audits with HFRS • Complete any actions arising from HFRS audits	HHP HHP HHP	May 2026 March 2027 March 2027	**Completed** **In progress** **In progress**
1.3	Review Technical Fire Safety Terms of Reference after 12 months of operational meetings	• Ensure FSTG continues to develop and review technical fire safety issues • Schedule meetings for 26/27 period • Review Group approach and overview across the Group for fire safety management	NLaG NLaG HHP	March 2027 April 2026 September 2026	**Ongoing** **Completed** **In progress**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within revised HTM • Complete draft annual report for consultation • Finalise annual report and send to CIC PEF for recommendation for Board Approval • Approval by Trust Board	HHP HHP HHP HHP	April 2026 May 2026 August 2026 October 2025	**Completed** **Completed** **In progress**

	Fire Training				
2.1	Review annually face to face training content for delivery of fire lecture	• Revise face-to-face training presentation and content in light of new HTM & new national STAT/MAN • Highlight reports on fire training attendance	HHP HHP	June 2026 Ongoing throughout 26/27	**In progress** **In progress**
2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Increase number of fire wardens per area • Maintain register of fire wardens • Review and revise fire warden training content • Implement recruitment campaign for fire wardens	HHP HHP HHP	March 2027 July 2026 June 2026	**In progress** **In progress** **In progress**
	Fire Drills and Exercises				
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify priority areas where desktop exercises are required. • Engage with fire wardens training scenarios for clinical areas requiring desktop exercises • Implement series of desktop exercises	HHP HHP HHP	June 2026 March 2027 June 2026	**In progress** **In progress** **In progress**
	Fire Alarm Tests				
4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Review with AE (Fire) alarm testing strategy and notification processes • Review MCP testing programme to ensure all MCP undergo testing	HHP HHP	July 2026 June 2026	**In progress** **In progress**
	Fire Action Plans				
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Audit areas to ensure fire action plans are in place and updated • Fire action cards to be located in each area	HHP NLaG	March 2027 March 2027	**In progress** **In progress**
5.2	Fire safety response kits should be developed and rolled out to each area	• Identify fire response kit requirements and source supplies • Roll out response kits to all areas identified where required	NLaG NLaG	March 2026 March 2026	**In progress**
	Fire Strategy Development				
6.1	Work with HUTH to align fire safety management principles.	• Revise structure in conjunction with EFD re-structure	HHP	July 2026	**In progress** **In progress**

		• Review training content across both organisations to align so more transferable workforce • Review general safety management policies across both organisations and standardise where appropriate • Review fire inspection processes across the organisations to determine if single process can be applied • Review reporting process and format of reports to determine if standard report can be utilised for Group performance on fire safety management	HHP HHP HHP	September 2026 March 2027 July 2026	**In progress** **In progress** **In progress**
6.2	Development of fire strategy to improve fire safety across the Trust	• Work with AE (Fire) to ensure fire safety strategy appropriate for all areas in light of new HTMs • Fire strategy drawings to be drawn up on MiCad • Undertake fire stopping surveys and ensure appropriate fire stopping in place. • Use MiCad or new CAFM system to develop appropriate "layers" of information to enable fire strategy drawings to be available to all areas. • Update and maintain fire risk assessments in-line with the fire safety policy • Continue and further develop working relationship with HFRS to avoid any enforcement action	HHP NLaG HHP HHP HHP HHP	March 2027 March 2027 July 2026 March 2027 March 2027 March 2027	**In progress** **In progress** **In progress** **In progress as new system purchased** **In progress** **In progress**
	HUTH Tower Block				
7.1	Work related to Tower Block Improvement Notice	• Undertake quarterly formal and regular informal meetings with HFRS to update on progress of work	HUTH	March 2027	**In progress** **In progress**

		• Complete actions identified within initial action plan	HUTH	August 2026	**In progress**
		• Appointment of Design Team to commence drawing up design options	HUTH	May 2026	**Completed**
		• Completion of HFRS Audit Actions undertaken	HUTH	July 2026	**In progress**
		• Establishment of Programme and Project Boards to oversee project	HUTH	April 2026	**Completed**

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)258

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**9th October 2026**
Director Lead	**Tom Myers – Group Director of Estates Facilities and Development**
Contact Officer / Author	**Bill Parkinson – Group Associate Director of Health & Safety, Fire and Security**
Title of Report	**Annual Security Report – HUTH and NLaG**
Executive Summary	**The purpose of this report is share findings and updates during the period and to request Trust Board sign off**
Background Information and/or Supporting Document(s) (if applicable)	**Martyn's Law was passed in Parliament in April 2025 with a two year implementation plan. The requirement by April 2027 is to have the Vulnerability Risk Assessments undertaken and the SDI identified. There should also be a workplan for actions identified in the risks assessments.**
Prior Approval Process	**Reviewed and approved by NLaG Security Group, HUTH Fire, Security & Safety Group, NLaG Health, Safety and Fire Group; EFD Governance Group**
Financial Implication(s) (if applicable)	**None identified from these reports however, the vulnerability risk assessments will likely result in funding requirements although not known at this stage.**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**None**
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

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Committees-in-Common Front Sheet

Agenda Item No: CIC(26) 4.3

Name of Meeting	Performance, Estates & Finance Committees-in-Common
Date of the Meeting	**29th September 2026**
Director Lead	**Tom Myers**
Contact Officer / Author	**Bill Parkinson**
Title of Report	**Annual Security Report – HUTH and NLaG**
Executive Summary	The purpose of this report is to … **Alert** There has been an increase in security related incidents both in violence/assaults and anti-social behaviour. Changes to the policies is ensuring that all these incidents are reviewed and where appropriate escalated for further action whether by the Police or via the relevant Trust. Actions restricting access to hospital sites, specific times etc. have been enacted to reduce incidents and tackle perpetrators. **Assure** Security Groups have been meeting on regular basis to review incidents and review policies and further actions that can be taken in relation to target hardening and referring cases to Police. In addition, review of premises with regards to security management, CCTV coverage etc. is now ongoing and changes being enacted (e.g. lock down of buildings out of hours, upgrading of CCTV etc.) to improve security. The Violence Prevention & Reduction Standards (VPR) continue to be further strengthened across both Trusts which are **Advise** The implementation of Martyn's Law will mean significant changes to systems (and in some to the sites themselves). A working Group is now established with the Senior Designated Individual (SDI) chairing the Group (working across both Trusts) and a workshop with NHS England and Counter Terrorism has

	recently taken place to highlight areas where further work is required. **Recommendation/s** The Martyn's Law Working Group should continue to span both Trusts to tackle common issues so that the PEF CiC can be assured that a consistent approach is being adopted. The main element of the work in relation to the implementation of Martyn's Law will be the vulnerability risk assessments for each site which will identify further work required to reduce risks from terrorism related attacks (although some of these actions are already on the work programme). A check against the NHS England guidance on the Act should be undertaken when the guidance is published to ensure all points are covered.
Background Information and/or Supporting Document(s) (if applicable)	Martyn's Law was passed in Parliament in April 2025 with a two year implementation plan. The requirement by April 2027 is to have the Vulnerability Risk Assessments undertaken and the SDI identified. There should also be a workplan for actions identified in the risks assessments.
Prior Approval Process	Reviewed and approved by NLaG Security Group, HUTH Fire, Security & Safety Group, NLag Health, Safety and Fire Group; EFD Governance Group
Financial Implication(s) (if applicable)	None identified from these reports however, the vulnerability risk assessments will likely result in funding requirements although not known at this stage.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval by CiC ☐ Information ✓ Endorse for approval by Trust Board(s) ✓ Assurance ☐ Other – please detail below:

BAF to which the paper relates:	Tick all those appropriate
Our Patients - Access	☐

Our Patients - Safety	✓
Our People	✓
Our Partnerships	☐
Our Pioneers	☐
Our Public Purse	☐

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Directorate of Estates, Facilities & Development

Annual Security Reports

1st April 2025 to 31st March 2026

Combined Executive Summary

This executive summary is formulated from the two reports relating to Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Each partner organisation produces its own annual security report to satisfy their statutory obligations. Currently, the reports are in different formats and reporting on localised issues. However, going forward and with the ongoing development of a Group structure in relation to security management, reports in subsequent years will be in a consistent format and include Group security management issues along with specific localised identified.

This executive summary considers both reports to identify key points/issues and to adopt a more consistent approach to security management across the Group.

There are differences in terms of the information given and the structure of security management within the two organisations. Some recommendations are made after considering the two reports to assist in the development of a Group Strategy across both organisations.

Both partner organisations have been engaged in upgrading systems and building in resilience to ensure that systems can be operated from different locations when required. These upgrades will increase the reliability and image quality of the systems and give better opportunities to pursue perpetrators and provide evidential quality for the police and crown prosecution services for their investigations and court cases.

In addition, the move to a Group move will also assist the Group to adopt a consistent approach to implementing the

Key Points

1. The responsibilities and structure differ in that in HUTH all security management elements are within the same section whilst at NLaG operational security management sits within Facilities (as in HUTH) but the security management strategy sits within the Statutory Compliance functions through the appointment of a Local Security Management Specialist (LSMS) allowing a degree of independence and development of a security strategy, as well as an auditing function without conflicts of interest. This is proposed to be addressed as part of the 26/27 EFD senior management re-structure moving to a Group model across the two organisations and the separation of operational security from strategic security management strategy.

2. A significant number of operational resources was being committed to patient watches on the Northbank which did not offer appropriate patient care (as

security staff were not clinically trained or requirements in caring for patients with clinical conditions). This is now being modified and measures being put into place in 26/27 to ensure that security personnel are requested appropriately and relevant patient care is delivered.

3. Generally, there has been an Increase in security related incidents including violence/assault as well as anti-social behaviour. This is replicated throughout HHP at the main sites which has been compounded by different methods or work, reporting lines, roles etc. However, as the security management structure is consolidated across both organisations the work in 26/27 will be to merge policies, procedures and practices so as to be consistent across the partnership. It is recognised that in a large number of incidents no further action can be taken due to the clinical condition of the patient/perpetrator, those incidents where action can be taken and both soft and hard measures can be applied.

4. The enactment of Martyn's Law (i.e. Terrorism (Protection of Premises) Act) was in March 2025 and after awaiting guidance on how the Security Industry Authority (SIA) are looking to regulate there were a number of webinars outlining general requirements. As most of the sites within HHP will fall into the enhanced tier (800 + capacity) a significant work plan will be developed in 26/27. The detailed NHS guidance on implementing the Act within healthcare settings especially acute healthcare has not been published in 25/26 but HHP is reviewing a number of elements which will be required.

   A working group has now been established with the Designated Senior Individual (DSI) heading the group and involving security management, fire safety and emergency preparedness. The main element of the work in 26/27 will focus on the development of risk assessments for each site in regards to vulnerability of a terrorism attack and control measures in place or required. Two areas which are known to be especially relevant to HHP premises are lockdown facilities and hostile vehicle risk. Currently, a significant amount of work is review each building, any current lockdown facilities available and any additional systems or upgrades that may be required to reduce the risk of site attacks with weapons. In addition, some work has been undertaken previously and some measures at some sites to protect areas such as Emergency

Departments and this work will be expanded to other areas and potential impact on traffic flows where appropriate rated bollards etc. are required.

5. During the 26/27 the partnership will be establishing a single provision across the group for car parking and security services. Security management policies and strategy will need to be reviewed to ensure that the HHP security strategy is embedded with the operational processes of the new provider.

The above points and recommendations are made to ensure that adequate assurance can continue to be given, and more consistent detail is contained within future reports for each partner organisation and the group.

Bill Parkinson

Associate Director of Safety & Statutory Compliance

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Hull University Teaching Hospitals (HUTH) NHS Trust Annual Security Report (FY - 2025/26)

Report date	06/05/2026
Number of pages	15
Report author(s)	Billy Lax (Trust Security Manager) Ryan Longworth (Assistant Security Manager)
Director sign-off	

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1. Executive Summary

This annual report provides a comprehensive review of security provision at Hull University Teaching Hospitals NHS Trust (HUTH) for the reporting period 1st April 2025 to 31st March 2026. The purpose of the report is to outline the Trust's ongoing commitment and strategic approach to ensuring a safe, secure environment for all patients, staff, visitors, and contractors, alongside the robust protection of its premises and assets.

The report summarises the Trust's performance in key security domains, highlights significant achievements, and identifies areas requiring attention and resource.

HUTH commitment and objectives

The Trust is dedicated to maintaining a safe and secure environment for all staff, patients, and visitors, while ensuring the protection of its premises and valuable assets. This commitment is carefully balanced with the need to provide accessible clinical services and to promote an open, welcoming, and non-intimidating atmosphere across all facilities.

The key objectives underpinning the Trust's security strategy are as follows:

- To provide, so far as is reasonably practicable, a safe environment that supports staff in their work, enables effective patient care, and allows appropriate access for visitors.
- To safeguard Trust property and assets against loss, damage, theft, and vandalism.
- To minimise incidents of violence, aggression, and other criminal behaviour on Trust premises, or directed towards staff and patients, to the lowest practicable level.
- To deliver effective and resilient security support that underpins Trust operations and enables the continuous delivery of high-quality patient care.

Mission statement

Provision of a physical security presence, including a rapid reaction capability, which is strategically deployed based on risk assessments across the two main hospital sites: Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). This mission is integral to supporting the development and delivery of the Humber Health Partnership (HHP) Estates Strategy, Priorities and associated plans.

Purpose and scope of the report

This annual security report is designed to provide an operational overview of the security services provided across Hull University Teaching Hospitals NHS Trust 1st April 2025 to 31st March 2026. It outlines the multifaceted aspects of local security management and provides a detailed update on workstreams, and initiatives completed within this specific timeframe. The report aims to provide a transparent and comprehensive account of the organisation's security activities, highlighting key achievements and ongoing challenges.

Key security challenges and risks

- High-risk trends (e.g. increase in violence and aggression incidents)
- Staffing pressures within Trust
- Estate and infrastructure limitations (regards to lockdown capability)
- Increase in patient watch requests (inclusive of highest ever cost pressure)
- No formal maintenance contract (pressure on ACU batteries during generator testing, outages or lockdown processes)
- Lack of available support from local authorities with regards to homelessness around HRI

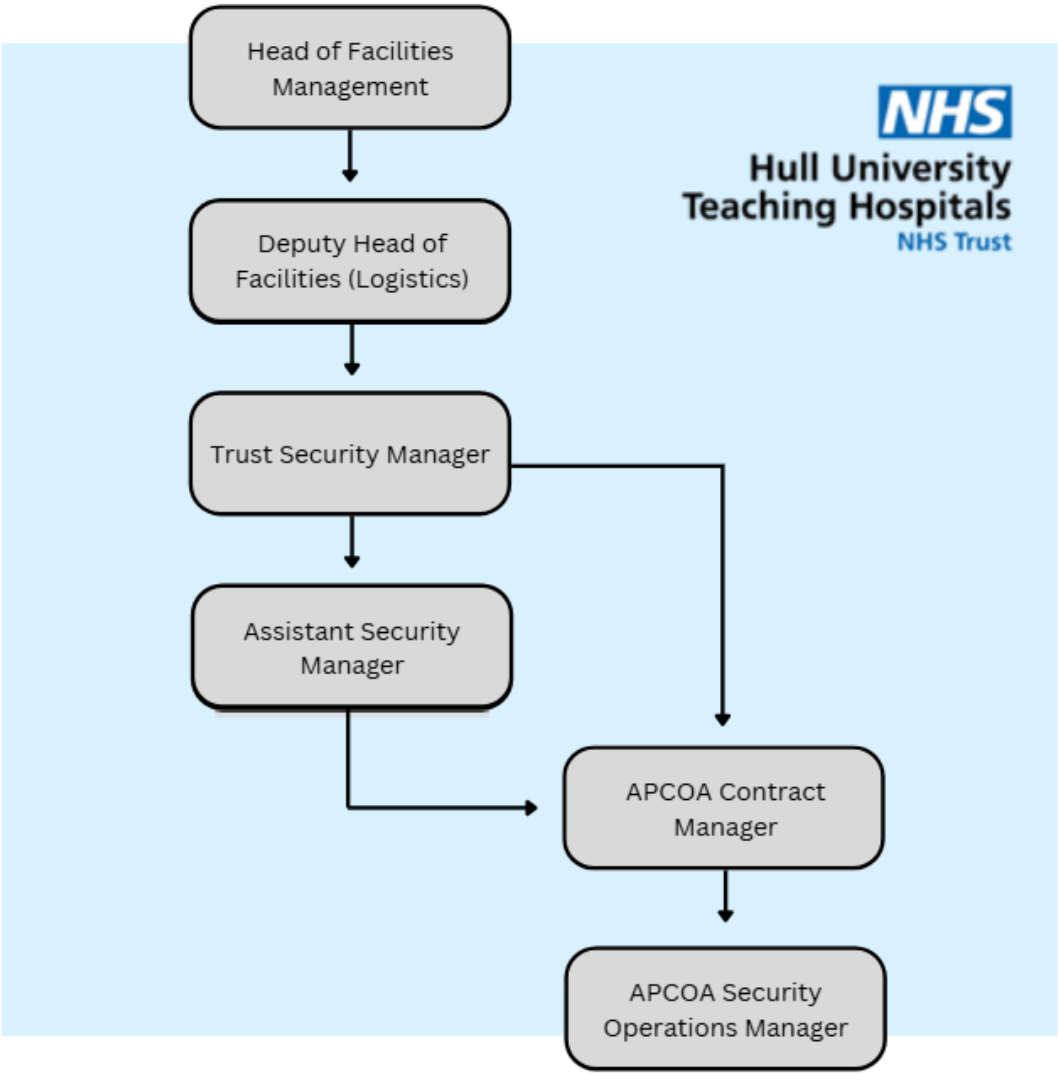
2. Structure & Security Provision

Overview of the Security Management structure in the 2025/26 FY

The Trust's Security Management structure is an integral component of the Group Directorate of Estates and Facilities. This structure is composed of key nominated roles:

- Head of Facilities Management.
- Deputy Head of Facilities (Logistics)
- Trust Security Manager.
- Assistant Security Manager

The Trust Security Manager and Assistant Security Manager have general oversight of the operational security and car parking functions, which are delivered through the Trust's contracted security provider. The security contractor from this reporting period is APCOA Parking (UK) Limited, for the provision of site security and car parking.



Contracted security and car parking provider - APCOA Parking (UK) Limited

The security and car parking provision is delivered by APCOA Parking (UK) Limited under contract HEY/19/238. The contract was originally awarded for a five-year term, with an agreed 12-month extension. The 2025/26 financial year represents the final year of this extension period. Following this, the service provision will be subject to a competitive tender process for the 2026/27 financial year as part of the planned HHP Group Car Parking and Security procurement.

HUTH's Security Department, alongside APCOA, is primarily responsible for the protection of patients, staff, visitors, and property across Trust premises. This includes a broad range of functions such as the control of access and egress points, continuous monitoring of CCTV and alarm systems, proactive and preventative patrols, staff and patient escorts, and the management, response, and investigation of incidents.

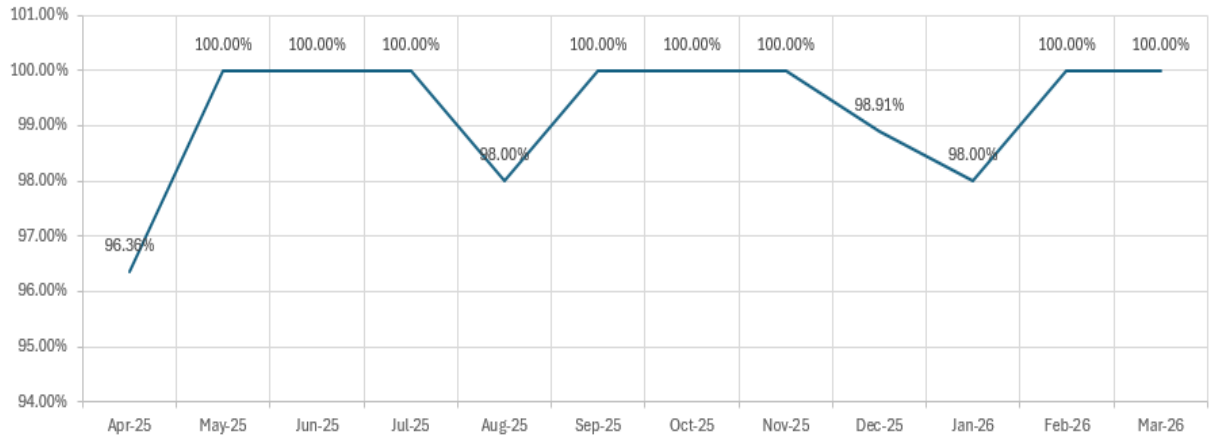
Security operations are fully integrated and delivered on a continuous basis, 24 hours a day, 365 days per year. A dedicated security control room operates at both Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). In addition, checks are provided to two satellite sites: Harrow Street (Central Decontamination Unit and Medical Records) and Sykes Street (Artificial Limb Unit).

3. Operational Performance

Performance Against Key Performance Indicators (KPIs)

The Trust monitors the services delivered by APCOA Parking (UK) Limited through a structured KPI framework. The compliance rating for KPIs is set at 90.00%, with any monthly score falling below this threshold triggering the issuance of a warning notice and the requirement for a mutually agreed improvement plan. A more significant drop below 85.00% automatically results in a financial penalty.

Persistent failure to meet the 90.00% threshold beyond three months triggers an extraordinary contract review meeting.



This shows an average year to date KPI percentage score of **99.27%**.

The KPI's recorded during this period were:

- Actual versus delivered hours (including ad-hoc and patient watch)
- Trust income report

- Paxton access card processing compliance
- Key audit compliance
- CCTV review and release compliance
- Contractor training compliance
- Car parking permit processing compliance
- PCN detail

Security provision hours fulfilled (FY - 2025/26)

The demand for security services remained high throughout the financial year. Additional security officer duties, in particular patient watches and Urgent Treatment Centre (UTC) continued to place significant pressure on the contracted service, necessitating the utilisation of sub-contracted agencies to meet the demand.

The fulfilment rates for various categories of security hours are detailed below:

Category	Requested hours	Fulfilled hours	Unfulfilled hours	Fulfilment rate %
Contracted hours	80,168.0	79,230.8	937.2	98.83%
Ad-hoc hours	5,910.5	5,905.3	5.2	99.91%
Patient watch	54,182.5	52,387.8	1,794.7	96.69%
Total	140,261.0	137,523.9	2,737.1	98.48%

Total fulfilment percentage rate is >4.98% from 2024/25 FY.

Whilst contracted and ad-hoc hours continue to demonstrate consistently high fulfilment rates, patient watch activity shows a comparatively lower fulfilment rate, with 1,794.7 hours unfulfilled. This indicates ongoing pressure within this area, albeit at a reduced level. The data suggests a continued imbalance between demand for patient watch services and available resources, which can result in reliance on supplementary staffing solutions. This has implications for both financial efficiency and the appropriate deployment of security personnel, particularly where patient watch requirements fall within clinical care responsibilities rather than security provision.

March 2026, Chief Nurse established the Enhanced Therapeutic Observations of Care (ETOC) Task and Finish working group. This working group is to support the development of a restraint and restriction training pilot and to remove the use of security of patient watch for patients assessed as level 4 or below. The Task and finish group will also work to establish a clinical band 3 ETOC team.

4. Security Governance and Compliance

Policy and procedure

The Trust has the following implemented security policies:

Reference	Policy name	Review date
CP468	Car Parking and Traffic Management policy and procedure	June 2027
CP420	Surveillance Camera policy	June 2026
CP110	Trust Security Management policy	November 2027

Security Management have updated the below internal SOPs in FY – 2025/26.

Reference	Standard Operating Procedure (SOP) name
HHP-SP-001	Bomb threat
HUTH-SP-001	Phonetic alphabet
HUTH-SP-002	Security codes
HUTH-SP-003	Fire reports
HUTH-SP-004	CCTV control room compliance
HUTH-SP-005	Secure key holding
HUTH-SP-006	Panic alarm testing
HUTH-SP-007	Access control and restricted areas
HUTH-SP-008	Security systems booking
HUTH-SP-009	Illicit substances
HUTH-SP-010	Car parking exemptions
HUTH-SP-011	CCTV data controlling
HUTH-SP-012	Identification records
HUTH-SP-012A	Asset log
HUTH-SP-012B	Asset list
HUTH-SP-012C	Asset disposal log
HUTH-SP-013	Possession of weapons
HUTH-SP-014	Press and media attendance
HUTH-SP-015	Cash handling
HUTH-SP-015A	Cash verification
HUTH-SP-016	Delivery of radioactive materials
HUTH-SP-017	Cycle lock tagging and removal (Draft)

5. Security Incidents & Trends

Total reported security incidents (FY – 2025/26)

During 2025/26, a total of 3,326 security incidents were recorded via Datix/Ulysses across the Trust, equating to an average of 277 incidents per month. This figure represents a substantial increase in reported incidents compared to the previous FY – 2024/25 (2,879 incidents).

Metric	Value
Total reported incidents	3,326
Average incidents per month	277
Increase from the 2024/25 FY	13.4%

It is important to note that the increase in reported incidents does not necessarily indicate a rise in the actual number of events. Instead, it reflects a successful improvement in the Trust's reporting culture. Security and Facilities Management have proactively engaged with care groups, encouraging increased reporting of incidents and undesirable events.

This approach has led to more comprehensive reporting, including multiple perspectives of a single event (e.g., security submitting a report, and affected staff/department also submitting a report). Every security intervention is reported on Ulysses. This enhanced data capture allows for more in-depth investigations, the development of effective action and care plans and positive outcomes. The improved data reporting provides a more transparent and accurate understanding of the security landscape across the Trust.

Violence and aggression Incidents (FY – 2025/26)

Of a total 3,326 incidents reported in 2025-26, 1,010 (30.3%) were classified as violent and/or aggressive in nature. This percentage includes incidents categorised as 'Staff on Staff' within the overall figure. Incidents pertaining to violence and aggression are investigated by the Trust Security Management team, which also endeavours to provide comprehensive support to staff throughout any subsequent investigation or criminal proceedings along with supporting police reports and intervention.

Violence and aggression Incidents by Intent (Monthly breakdown, FY – 2025/26)

In October 2025, the Trust transitioned from Datix to the Ulysses incident reporting system. At present, Ulysses does not provide the same level of detailed incident categorisation previously available within Datix. As a result, there are current limitations in the ability to analyse incidents in sufficient detail, particularly in distinguishing whether such incidents were driven by malicious intent. This constraint should be considered when interpreting incident data for the reporting period.

Month	Total violence and aggression incidents (from data)	Percentage difference from previous month
April 2025	95	
May 2025	90	-5.26%
June 2025	107	18.89%
July 2025	101	-5.61%
August 2025	98	-2.97%
September 2025	99	1.02%
October 2025	92	-7.07%
November 2025	49	-46.74%
December 2025	69	40.82%
January 2026	61	-11.59%
February 2026	78	27.87%
March 2026	71	-8.97%
Total:	1,010	

Implementation of Trust PSPO at HRI October 2025

This is an 80.03% increase in violence and aggression incidents from the 2024/25 financial year where 561 incidents of this nature were recorded.

The fluctuating proportion of incidents throughout the year highlights the complex nature of violence encountered within a hospital setting. A significant portion of these incidents are linked to medical conditions that may impact a person's capacity status. This underscores the critical need for integrated security and clinical strategies, particularly concerning de-escalation training and appropriate patient supervision, rather than relying solely on punitive measures.

Anti-Social Behaviour (ASB) letters

Since April 2023, the Trust has issued Anti-Social Behaviour (ASB) letters to individuals whose conduct is deemed inappropriate, supported by incident reporting and in collaboration with relevant departments, heads of service, and PALS (Patient Advice and Liaison Service).

Building on this approach, the Trust is now adopting a Group-wide policy and process for violence

prevention and reduction. This will introduce a structured, staged framework incorporating formal warnings and, where necessary, the implementation of site restrictions or exclusions. This enhanced approach is intended to provide a consistent, proportionate, and effective response to unacceptable behaviours across all Trust sites.

There are also ongoing joint working initiatives with partner agencies and Humberside Police. In March 2025, Hull City Council expanded the Public Space Protection Order (PSPO) in Hull City Centre, which now encompasses HRI. The PSPO forms part of 2025/26 workplan to reduce anti-social behaviours with the issuing of penalty notices by Humberside Police/ Hull City Council. These collaborative efforts continue our work to support a reduction in anti-social behaviour through joint working with the police and partner agencies.

Incidents of note (FY – 2025/26).

Month	Incident in brief
May 2025	Baby abduction drill at Hull Women and Children's Hospital (WaCH), Rowan Ward. Security successfully negated the abduction by identifying the perpetrator before they got to the ward.
October 2025	PALS team received a bomb threat via email over a weekend. Threat was made to be executed the following day if no action was taken; however, as the PALS team didn't see this until the Monday, the timeline had elapsed and luckily nothing happened. Police discovered that the email was sent to numerous recipients across the country and was a hoax. Perpetrator identified and arrested.
January 2026	Unknown female entered Poppy Suite in CHH and was located inside a general office, smoking, and found to have moved/broken items in the room. No police action due to no crime reported at the time, security attended and removed the female. Police claim that the female is known to them and has mental health and learning difficulties. They considered this incident to be "abscond risk" as opposed to a criminal event.
January 2026	Individual brought into hospital by police after being brought down from a roof in the city centre (suicide risk). When police left him in ED, the male left and climbed on to the UTC roof to jump off but was prevented from doing so by security colleagues. He was caught as he jumped, security managed to catch his legs. Male was detained and was taken to a mental health establishment by police.

6. Strategic Security Initiatives and Compliance

Violence Prevention and Reduction (VPR) standards

Hull University Teaching Hospitals NHS Trust host a quarterly Violence Prevention and Reduction (VPR) working group meeting. These meetings include key stakeholders from Safeguarding, Health & Safety, Education, and Care Groups, ensuring a coordinated and multidisciplinary approach to violence reduction across the Trust.

In line with the NHS Violence Prevention and Reduction (VPR) Standard, the Trust is working collaboratively with Safeguarding teams to strengthen its approach to managing violence and aggression. A proposal has been submitted to introduce De-escalation and Management of Incidents (DMI) training, aimed at enhancing staff capability in recognising, preventing, and safely responding to challenging behaviours. This initiative supports a proactive, prevention-focused approach, ensuring staff are equipped with the appropriate skills and knowledge to maintain a safe

environment for patients, visitors, and colleagues.

Patient watch duties undertaken by agency security

Level 4 and 5 security patient watches, which involve agency security personnel monitoring patients presenting with challenging behaviours, resulted in a cost of £1,136,654.52 (Net) to the Trust during 2025/26 (160% increase from 2024/25 of £437,020.13). This expenditure has continued to rise throughout 2025/26 which has forced reviews and ongoing work within Care Groups aims to reduce reliance on this provision.

Highest figure during 2025/26 was February 2026, costing £182,697.66 (Net)

The increase in level 5 requests is largely driven by demand at Level 4 enhanced care, which should ordinarily be delivered by clinical staff. In practice, these cases are escalating to Level 5 due to workforce pressures and the limited availability of appropriately trained clinical personnel. It should be noted that Level 5 observations are not delivered by contracted APCOA security staff, but via an external security agency.

This provision is limited in scope, with staff only authorised to undertake restraint and restriction under Common Law in emergency situations where there is an immediate risk of harm. They are not trained or authorised to provide ongoing therapeutic care or clinical interventions.

It was identified that some requests from senior clinicians for a Level 5 security patient watch was made; however, subsequent reviews confirmed that the patient's assessed requirement was Level 3 or below. This discrepancy was attributed to staffing pressures within ward areas. It is recognised that such gaps should not be mitigated through the deployment of security personnel, as this falls outside the intended scope of their role. The matter was promptly escalated and addressed to ensure appropriate processes and resource allocation were reinforced.

This model presents a risk that security personnel may become inappropriately involved in the management of complex patients, driven by gaps in clinical staffing and training. This raises significant concerns in relation to safeguarding, as well as patient privacy and dignity. Security staff are neither trained nor equipped to manage key patient care needs, including the prevention of falls or the provision of general care and supervision.

As of April 2026, NHS England had requested the removal of all security-led patient watch activity. However, immediate cessation is not considered practicable due to existing Trust-wide workforce vacancies. A phased approach is therefore being adopted, with the provision to be fully withdrawn by July 2026. This timeline aligns with the forthcoming security contract, which does not include scope for agency-supported patient watch activity.

To support safer and more appropriate care delivery, a digital Enhanced Care Supervision assessment process was redeveloped and implemented in September 2024 and continues to be updated to suit business needs. This aims to strengthen clinical decision-making and reduce the overall reliance on restrictive practices.

Lone Worker systems – Reliance Protect

The Trust currently utilises Reliance lone worker systems to support the safety of employees working in lone or higher-risk environments. The existing contract is due to expire in mid to late 2026, at which point a comprehensive review will be undertaken to assess service delivery against operational requirements and ensure the continued effectiveness and value of the provision.

Currently, x127/150 devices are currently used across the Trust (both individual and pool).

Compliance rates for Fire Safety and First Responder training (APCOA Security Team)

The APCOA security team are first responders to fire alarm activations across the HUTH estate. Compliance with mandatory training for the APCOA security team is a key aspect of operational readiness. The compliance rates for Fire Safety Training (Level 1) and Fire First Responder Training (Part One and Two) are detailed below:

Fire Safety & First Responder Training compliance (APCOA security team, FY – 2025/26)

Training Type	Compliance %
Fire Safety Training (Level 1)	97.44%
Fire First Responder training	84.70%

It's noted that APCOA have had a number of new starters in the last quarter of 2025/26 whom have not yet been booked on to the Fire First Responder training. This is a theory and practical course, with 5 APCOA staff requiring completion of the practical element of the course which is face to face training.

7. Security/Car parking Infrastructure and Technology Advancements

The Trust has made significant progress in enhancing its security infrastructure and technology during the 2025-26 financial year, focusing on CCTV surveillance systems and access control.

- HRI and CHH Paxton servers are now hosted on a cloud-based platform, reducing the risk of system disruption resulting from hardware failure.
- Paper-based forms that previously incurred resource costs have been replaced with online form integration, providing a cost-free and more efficient digital solution.
- ANPR management commenced April 2025 after extensive testing, resulting in changed driver behaviour on site. Income received from parking is reinvested to cover the security and car parking contract.

Key security/infrastructure projects and status

Below are key security/infrastructure projects ongoing or completed:

Project Name	Date	Key activities/milestones	Status
Public Spaces Protection Order (PSPO)	October 2025	HUTH NHS Trust has successfully secured a Public Spaces Protection Order (PSPO) across its sites, providing enhanced legal powers to address anti-social behaviour and protect patients, staff, and visitors.	Completed
Trust-wide lockdown – HRI/CHH	January 2026	To enable security to complete zonal lockdowns across HUTH Trust security control rooms in situations of emerging/escalating threat.	In progress
Atrium lockdown pilot	March 2026	To control footfall into the main	In progress

– Hull Royal Infirmary (HRI)		hospital building from midnight to 05:30 each day. This also ties in with violence prevention and reduction strategies.	System in place but "in progress" referring to monitoring
Access control project – Harrow Street District Medical Records	March 2026	To secure the medical records hanger and linked building(s) to prevent unauthorised access.	In progress
Access control project – HRI Pathology	March 2026	Identified gaps in access control protection during a security review. This will boost the security of the lab and its equipment.	In progress

8. Collaborative Partnerships and Joint Working

HUTH Security Management places a high priority on fostering strong working relationships with both internal stakeholders and external partners. These collaborations are crucial for addressing complex security challenges and ensuring a safe secure environment.

Internal multi-disciplinary teams (MDTs)

Security management actively contributed to multiple multi-disciplinary team (MDT) meetings throughout 2025/26. These meetings involved key internal stakeholders including Safeguarding, Health & Safety, Education, Care Groups. Community support groups include the Homeless Pathway Team. External partners such as M.E.A.M (Make Every Adult Matter), Hull City Council (HCC) Safeguarding, and HCC Emergency Accommodation.

MDT meetings discussed specific cases with patients with complex needs or challenging behaviours. The collaborative agenda aimed to create comprehensive care plans that served the best interests of the individual, staff, and the public. Security teams are sometimes the first point of contact for these individuals.

The active participation of Security Management in MDT meetings, signifies a joint and integrated approach to security. This involvement extends beyond reactive reporting of incident response, to proactive, multi-agency care planning. This collaborative model represents a best practice in healthcare security, ensuring that security interventions are aligned with patient care objectives.

Partnership working with Humberside Police

The partnership with Humberside Police is fundamental to the Trust's security framework, demonstrating joint working that extends across operational and strategic domains:

- Monthly police liaison officer meetings:
  These meetings are held monthly at both HRI and CHH. The agenda includes discussions on crime trends, security alert information and the progression of legal proceedings related to criminal activity on hospital premises, with feedback on outcomes from recent cases. A Humberside Police Liaison officer is also assigned to CHH and mirrors the successful HRI meetings. These meetings now include local Council and Trust ED Navigators.

- Public Space Protection Order (PSPO):
  Humberside Police, with Hull City Council, placed a PSPO for Hull City Centre, which has been

extended to include HRI area. This order prohibits activities such as begging, loitering, public alcohol consumption, which will reduce the “fear of crime” and will support security when dealing with frequent anti-social behaviours.

- Bicycle marking events:
  A security initiative takes place monthly at HRI, where Humberside Police set up a canopy to allow staff and the public to have their bicycles uniquely marked and added to a national database, aiding recovery if stolen.

- 'Knife Arch' project:
  Launched July 2024 at the HRI by Humberside Police, this project is a proactive approach to reassure the public, staff, visitors, and patients about site safety and to deter offences related to bladed articles. Repeat knife arches occur monthly or bi-monthly depending on the availability of the arch.

- Drug activity:
  Partnership work with Humberside Police with information sharing, has led to the successful identification of individuals suspected of involvement criminal activities on HUTH sites.

Engagement with local councils

Meetings with Hull City Council (HCC) have been set up with Trust facilities management, providing a forum to discuss recent concerns, trends, and potential issues that affect both the hospital environment and the wider community. This enables all stakeholders to proactively work together to address concerns with a focus to reduce anti-social behaviour. Hull City Council also support with litter enforcement at the HUTH Trust which is changing behaviours on site.

Paxton

Hull University Teaching Hospitals NHS Trust maintains a strong and collaborative working relationship with Paxton Access, centred on the effective use of the Net2 platform. This partnership supports the Trust in delivering a secure, reliable, and scalable access control solution across its estate. Through ongoing engagement and system optimisation, the Trust is able to manage security operations efficiently, respond to evolving requirements, and ensure that staff and patient safety remain a priority, supported by modern, integrated technology.

TESS (Total Electrical and Security Systems)

HUTH NHS Trust has developed a strong and effective working relationship with Total Electrical & Security Systems Ltd (TESS), whose local presence in Hull enables responsive and reliable support across the Trust’s estate. TESS plays a key role in the installation, maintenance, and ongoing development of security systems, working collaboratively with the Trust to ensure operational continuity and high standards of service delivery. This partnership supports the Trust in maintaining a safe and secure environment through dependable, locally delivered expertise.

TESS were complimented by Paxton regarding their installation of ACU’s across the Trust, Paxton stating during their recent HRI site visit in April 2026 that it’s the best work they have ever seen and will use that example/standard when working with other organisations across the UK and internationally.

TESS completed 179 projects at HUTH sites within the 2025/26 FY. It’s helpful to understand that a project might be fault attendance, or 1 project involving installing readers, ACU’s and more.

9. Security Risk Management & Assessments

At HUTH NHS Trust, security risk assessments form a key component of the Trust’s overall security

strategy. These assessments systematically identify and evaluate risks across sites, enabling the development of targeted mitigation plans.

The Trust works collaboratively with EPRR teams across the Group to support the development of robust risk management strategies and to identify critical works required to address identified vulnerabilities. Outcomes include recommendations for infrastructure upgrades, policy and procedural changes, and the optimisation of security systems, ensuring a proactive and intelligence-led approach to maintaining a safe environment for patients, staff, and visitors.

10. HUTH Trust physical security lockdown project

Following a review of the 2023 HUTH NHS Trust Lockdown Plan, it was identified that the Trust did not have the full operational capability to implement an effective lockdown across its sites. In response, Paxton was engaged to undertake a comprehensive physical site assessment.

The findings have informed a programme of works now underway to enhance access control infrastructure, ensuring the Trust can deliver controlled, zonal lockdowns across both sites in a safe and efficient manner. This development represents a significant step forward in strengthening the Trust's resilience and emergency preparedness.

Upon project completion, HUTH security teams will be able to implement a lockdown via the following methods:

- Utilising the Paxton Net2 system
- Tapping a "lockdown access card" on a reader installed in the security control room (each zone will have its own lockdown access card)
- Entering a code in a keypad that is associated with a zone to lock it down

Access rights can be set for specific personnel to bypass locked doors (e.g. security teams) to be able to move through the site and if required, move people from building to building in the event of a moving threat.

New SOP and policy to be created when the project approaches it's end.

11. Future Projects

The Trust's commitment to enhancing security is reflected in several anticipated projects and ongoing initiatives that extend beyond the current financial year. Addressing persistent challenges will require continued strategic focus and investment.

- Security Control Room relocation (HRI)
  The Security Control Room at HRI will be transitioning to a purpose-built facility, significantly enhancing our team's ability to manage security operations with industry-leading equipment and technology.

- CCTV upgrade on the back of recent HHP CCTV specification works
  CCTV A CCTV specification to upgrade HUTH CCTV equipment and software has been included within security and car parking contract tender, which is anticipated to be awarded in 2026 Quarter 2.

- CCTV installation on HRI temporary Discharge Lounge
  Capital team were waiting on the final awning build to complete before looking at CCTV

positioning and implementation. CCTV project work TBC.

- CCTV installation in solar car ports at HRI (Main, Brocklehurst and Argyle)
  There are construction works underway in the Argyle Street car park at HRI which will soon change the layout and efficiency of the car park. Solar car port works have concluded at HRI main car park and Brocklehurst car park, of which CCTV work will tie into this project to ensure the best possible CCTV coverage in the car parks.

12. Key data from report

- APCOA KPI average for 2025/26 is 99.27%
- APCOA hours fulfilment percentage for 2025/26 is 98.48%
- Total number of reported incidents during 2025/26 is 3,326
- Of those incidents noted above, 1,010 (30.3%) were related to violence and aggression incidents
- Cost of security patient watch during 2025/26 was £182,697.66. This is a 160% increase from the 2024/25 financial year. NHSE requested cessation of security patient watch by April 2026 which we were unable to accommodate.
- 127/150 Reliance lone worker systems are being used at HUTH.
- TESS completed 179 projects at HUTH during 2025/26.
- Paxton attended HRI in April 2026 to assist with a site review regarding a physical lockdown strategy and process.

13. Any other business to note

Information below that isn't categorised anywhere else.

- Appointment of new Trust Security Manager in December 2025.
- Assistant Security Manager being supported through formal security management training.
- Security teams nominated for a Golden star award under the "Outstanding support" category in September 2025.
- Security Supervisor for APCOA nominated for ACS Pacesetters Security Officer of Distinction award for his involvement preventing a suicide attempt from UTC roof in January 2026. Award ceremony being held in Windsor on the 20th of May, Trust Security Management will be present to support.
- Security management taking lead in Armed Forces champions (North Bank) in line with the Trust ERS gold standard re-awarded in 2026 to act as a key advocate, advisor and point of contact for the armed forces community.
- Public parking tariff now aligned across the Humber Health Partnership.

14. Summary

Workstreams from 2025/26 have made improvements to strengthen HUTH security infrastructure and provision. A Key focus in 2026/27 will be compliance with Protection of Premises (Terrorism) Act (Martyn's Law) and a HHP group Security and Car Parking model. A HHP group security model with alignment of policies and procedures will enable best practice and strengthen security for a safe and secure environment for staff, public and our patients

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates, Facilities and Development

Annual Report for Security Management 2025/26

Report Date:	
Number of Pages:	31
Report Author:	Philip Young, Security (LSMS) & Safety Compliance Officer
Director Sign-Off:	

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Executive Foreword

The NHS Constitution affirms patients' rights to care in a safe, secure, and suitable environment, alongside the Trust's legal duty to protect staff. Ensuring the safety and security of staff, patients, visitors, and property is essential to the effective delivery of healthcare services.

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to strengthen its security arrangements through a structured work programme outlined in the previous Annual Report. Key developments include a proactive approach to issuing informal and formal warning letters to individuals displaying violent or abusive behaviour, supporting compliance with the NHS Violence Prevention and Reduction Standards.

The Trust-wide Closed-Circuit Television (CCTV) system was reviewed and upgraded in 2022 across Grimsby, Scunthorpe, and Goole sites. The system now provides enhanced footage, is fit for purpose, and is subject to annual review to ensure optimal camera placement and coverage.

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) continues to maintain strong partnerships with local and regional anti-crime agencies, including Humberside Police, local authorities, and safeguarding teams. Improved sharing and analysis of crime data with Community Safety Partnerships across North and North East Lincolnshire further supports staff and site security.

Security remains a key consideration in new build and refurbishment projects, including the Community Diagnostic Centres in Grimsby and Scunthorpe, the Emergency Departments, and Same Day Emergency Care (SDEC) buildings, all of which have been fully operational for over a year.

During 2025/26, a number of criminal and Trust policy sanctions were successfully applied, including convictions for verbal and physical assaults, criminal damage, and theft. The Trust issued four informal warning letters and one formal warning letter in response to inappropriate or severe behaviour towards staff. No patient or visitor exclusions were required during this period.

The 6 Point Promise for victims of intentional physical assault at work, implemented in late 2021, continues to be upheld through the Joint Working Agreement with the Crown Prosecution Service and Humberside Police. Consideration is being given to extending this to a Group-wide agreement. The Trust also continues to operate in

line with the National Health Service (NHS) Violence Prevention and Reduction Standards (Version 2, December 2024).

1.0 Background and Introduction

This report outlines all aspects of Security Management within Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) at a local level. It provides an update on the security work streams completed during the period from 1 April 2025 to 31 March 2026.

The Trust and the Local Security Management Specialist (LSMS) remain committed to strengthening the provision of a safe and secure environment for staff, patients, and visitors, as well as safeguarding the Trust's premises and assets. This commitment is balanced with the need to maintain accessible clinical services and a welcoming, non-threatening environment. These objectives are achieved through the implementation of appropriate systems and arrangements that comply with national guidance, legislative requirements, and relevant codes of practice issued by recognised bodies.

Although the specific security requirements within the NHS Standard Contract were removed in 2021/2022, the Trust continues to meet the expectations of NHS Commissioners. In line with the standards previously established by NHS Protect, four core priority areas remain central to the Trust's approach to maintaining a secure environment:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

The Trust and LSMS now operate in accordance with the NHS Violence Prevention and Reduction Standards, published in December 2020, alongside the accompanying guidance issued in June 2022.

The Trust's Security Strategy, coordinated locally by the LSMS, focuses on seven key areas of action:

- **Creating a pro-security culture –** Promoting a culture where responsibility for security, including the timely reporting of incidents, is shared by all.
- **Deterrence and reduction –** Identifying and implementing measures to deter and reduce security incidents and breaches.
- **Prevention –** Developing and applying measures to prevent incidents and breaches from occurring.
- **Detection –** Ensuring security incidents are promptly identified and supported by effective reporting mechanisms.
- **Investigation –** Undertaking post-incident reviews and, where appropriate, conducting criminal investigations.
- **Sanctions –** Providing advice on relevant sanctions and applying Trust policies consistently.
- **Redress –** Supporting the Trust in seeking redress where appropriate and assessing the true financial and operational impact of security incidents on the NHS.

NHS Violence Prevention and Reduction Standards

Violence and abuse against NHS staff remains a significant and persistent challenge across the health system. Despite long-standing “zero tolerance” messaging, recent evidence demonstrates that levels of physical violence, harassment, and abuse towards NHS workers have risen slightly since 2023, with emergency care, mental health services, ambulance services, and primary care particularly affected. In response, NHS England and national partners have strengthened the Violence Prevention and Reduction (VPR) Programme, refreshed statutory guidance, and placed greater emphasis on system-wide, trauma-informed, and public-health approaches to violence prevention.
The publication of the refreshed Violence Prevention and Reduction Standard (Version 2, December 2024) now represents the central national framework for addressing violence against NHS staff, with implementation continuing through Integrated Care Systems (ICSs) and individual NHS organisations.

Prevalence of Violence and Abuse

Incidents disproportionately affect ambulance trusts, emergency departments, mental health services, and front-line clinical roles.
Staff from ethnic minority backgrounds and disabled staff continue to experience higher rates of abuse and discrimination.

Violence against NHS staff – latest confirmed figures (England)

Physical violence (patients / public)

- 14.5% of NHS staff experienced at least one incident of physical violence from patients, service users, relatives or the public in the last 12 months.
- Equivalent to ~217,000 staff (based on ~1.5 million NHS employees)
- Highest level since 2022

Harassment, bullying or abuse (patients / public)

- 25.3% of staff experienced harassment, bullying or abuse from patients or the public in the last year
- Equivalent to ~380,000 staff affected in 2025 alone

Highest levels recorded in three years

Role-specific risk (notable for risk assessments)

Registered nurses and midwives:

- 22.6% experienced physical violence
- 35.0% experienced harassment or abuse

Ambulance staff:

- Nearly one-third reported physical violence or unwanted sexual behaviour

Sexual harassment and sexual harm

- 9–10% of NHS staff reported unwanted sexual behaviour in 2025 (highest level recorded)
- 50,000 sexual harm incidents recorded by trusts over the three years to April 2025, indicating sustained risk entering 2025/26

Trend data relevant to 2025/26 risk profiling

- NHS trusts reported ~104,000 violent incidents in 2024/25, rising year-on-year from 2022/23
- This equates to ~285 reported violent incidents per day across England
- Under-reporting remains significant: only ~50% of staff report harassment or abuse, meaning true figures are likely higher

Independent analysis has also identified over 100,000 violent incidents per year across England, equating to approximately 285 incidents per day, reinforcing concerns that staff safety is now a workforce sustainability issue as well as a security one.

Violence Prevention and Reduction (VPR) Standard (2024)

The Violence Prevention and Reduction Standard – Version 2 (2024) is the primary national mechanism for NHS organisations. It is:

- Risk-based and evidence-led
- Aligned with health and safety legislation
- Explicitly linked to the NHS People Promise ("We are safe and healthy")

The standard requires organisations to assess themselves across seven domains:

1) Leadership and accountability
2) Governance and assurance
3) Collaboration and partnership
4) Data and intelligence
5) Workforce capability and training
6) Preventative and protective interventions
7) Evaluation and continuous improvement

A new **Red–Amber–Green (RAG)** rating system enables organisations and systems to track maturity and improvement over time.

NHS Sexual Safety Charter

Humber Health Partnership Sexual Safety Charter

Humber Health Partnership is fully committed to providing a safe, respectful, and inclusive environment that is free from sexual harassment, abuse, and misconduct. Sexual safety is fundamental to dignity, trust, equality, and high-quality care. The Partnership adopts a zero-tolerance approach to sexual harm and is committed to protecting patients, service users, staff, volunteers, contractors, students, and visitors.

The Sexual Safety Charter sets out clear expectations for behaviour, professional boundaries, and consent, and affirms the Partnership's responsibility to prevent harm, listen and respond to concerns, support those affected, and take decisive action when standards are breached. All concerns will be taken seriously and addressed promptly, sensitively, and fairly, in line with safeguarding duties, employment policies, and professional standards.

The Charter promotes a confident speaking-up culture where individuals can raise concerns without fear of blame or retaliation, supported by accessible reporting routes and trauma-informed responses. Leaders at all levels are accountable for modelling appropriate behaviour and ensuring the Charter is embedded into everyday practice, training, and governance.

By adopting this Charter, Humber Health Partnership confirms that sexual safety is everyone's responsibility and reaffirms its commitment to dignity, respect, and compassionate care in all settings.

The Humber Health Partnership has a Sexual Safety Operational Group covering both Hull University Teaching Hospitals NHS Trust (HUTH) and NLAG and a Humber Health Partnership Sexual Safety Policy GP021.

The Security Management Specialists for HUTH and NLaG are in the process of writing a Group Wide Violence Prevention and Reduction Policy which will reference the NHS Sexual Safety Charter.

https://www.england.nhs.uk/long-read/sexual-safety-charter-assurance-framework/

National NHS Security Management and NHSE Standards
The NHS Violence Prevention and Reduction Standard.

The NHS Violence Prevention and Reduction (VPR) Standards set out a clear national framework for preventing and managing violence, aggression and abuse against NHS staff, patients and others. They expect NHS organisations to take a preventative, victim-centred and learning-focused approach, embedded within strong leadership, governance and culture. Core expectations include visible board-level ownership, clear policies and procedures, staff engagement and partnership working with key agencies (such as police and local authorities). The standards emphasise risk assessment, environmental safety, de-escalation and early intervention, alongside promoting respect, dignity and inclusion to reduce the factors that can contribute to violence.
The standards also set expectations around support, reporting and learning when incidents occur. NHS organisations are required to make it easy for staff to report violence, aggression and abuse, ensure incidents are properly investigated, and provide timely support, aftercare and access to occupational health or trauma services. There is a strong focus on using data and staff feedback to identify patterns, share learning and drive continuous improvement, rather than blame. Overall, the VPR Standards position violence prevention as a core patient safety and workforce wellbeing issue, with organisations accountable for measurable progress and safer working environments across the NHS.

The NHS Violence Prevention and Reduction (VPR) Standards are not enforced through a single statutory regulator or legal penalty, but through a combination of system oversight, contractual levers, inspection alignment and organisational accountability.
Firstly, enforcement operates through NHS England oversight and commissioning mechanisms. The VPR Standards are an NHS England requirement and form part of the NHS Standard Contract and broader workforce and safety expectations. Integrated Care Boards (ICBs), regional NHS England teams and commissioners can require assurance from trusts on how the standards are being implemented, request action plans where gaps are identified, and escalate concerns through performance and quality review meetings. Compliance is therefore driven by assurance, monitoring and improvement expectations, rather than punishment.

Secondly, the standards are reinforced through inspection, governance and leadership accountability. While the Care Quality Commission (CQC) does not inspect the VPR Standards directly, it considers violence prevention, staff safety, learning from incidents and organisational culture as part of its Well-Led, Safe and Caring domains. Poor implementation can contribute to adverse inspection findings. At trust level, boards are expected to hold executives to account via regular reporting on incidents, staff experience and improvement actions. Failure to meet the standards can result in reputational risk, regulatory concern, increased scrutiny and mandated improvement support, making enforcement primarily system- and leadership-driven, focused on continuous improvement and staff safety rather than formal sanctions.

https://www.england.nhs.uk/long-read/violence-prevention-and-reduction-standard/

The Trust continues to work to these standards to ensure compliance and the work plan for Security Management for the 2025/2026 reflected this, the work plan for 2026/2027 is still in consultation as this will now be a group wide work plan for the LSMS on the North and South Bank

During 2025/2026 the LSMS planned to create a Violence Prevention and Reduction Strategy and work plan for the Trust, however due to other commitments and the current restructure as a Group, both the North and South LSMS's are looking at creating a Humber Health Partnership Violence Prevention and Reduction Strategy and work plan, this will now be created during 2026/2027.

The LSMS has completed the National Examination Board in Occupational Safety and Health (NEBOSH) Incident Investigation course to support his role as LSMS.

2.0 Security Management Structure

The Trust's security management structure sits within the Directorate of Estates and Facilities and Development, as there is to be a Group structure for security management in 2026/2027 the Security Management Structure will be confirmed and covered in the Security Management Annual report for 2026/2027.

2.1 Violence and Aggression against Staff

A total of 674 security-related incidents were reported across Trust sites. There is a significant year-on-year reduction between 2025 (508 incidents) and 2026 (166 incidents), representing an approximate 67–75% reduction, indicating improving controls, responses, or reporting maturity.
However, persistent risk remains concentrated in acute and frailty environments, particularly relating to violence against staff, patient absconding, and verbal abuse.

The number of reported security coded incidents during 2025/26 was a total of 674 incidents Trust wide, this is up from 572 in 2023/2024.

Incident Volume & Type
Overall Breakdown (Top Categories)

- **Physical contact / assault:** 158 incidents
- **Missing / absconded patients:** 139 incidents
- **Verbal abuse:** 131 incidents
- **Disruptive / antisocial behaviour:** 61 incidents
- Remaining categories include self-harm, restraint incidents, drug use, harassment, and sexual misconduct.

Together, violence, abuse, and absconding account for the majority of all incidents, highlighting frontline safety and patient containment as the primary risk themes.

Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPOWH) together account for 91% of all incidents, reflecting the high-acuity nature of services delivered at these sites.

Departmental Hotspots

Highest-incident areas include:

- Emergency Department (ED): 131 incidents

Short Stay Units:

- Ward 23 – 38
- Ward C3 – 28

IAAU (Acute Assessment Units):

- SGH – 28
- DPOWH – 20

Frailty and dementia-related wards: Ward 16, Ward C6, Ward C5
Paediatrics: Rainforest Ward (notable absconding and safeguarding risk)

Trend: Acute medicine, emergency care, and frailty wards consistently experience the highest levels of violence and absconding.

Year-on-Year Trends

All major categories show substantial reduction in 2026, including:

Physical assaults: 115 → 43
Missing / absconded patients: 107 → 32
Verbal abuse: 97 → 34
Disruptive behaviour: 43 → 18

Interpretation: Improvements in controls, reporting awareness, escalation pathways, or staffing interventions are likely contributing factors, though risk remains concentrated in similar service areas

Key Risk Themes

Patient-Related

- Dementia, delirium, mental health crisis
- Substance misuse (alcohol/drugs)
- Self-harm behaviour
- Lack of capacity requiring Deprivation of Liberty (DoLS)
- Repeated absconding from wards and ED

Staff-Related

- Physical injury (punches, kicks, bites, spit, strangulation attempts)
- Psychological harm (anxiety, distress, sickness absence)
- Bullying & harassment (including staff-on-staff)

Organisational

- Insufficient 1:1 supervision capacity
- Inconsistent capacity assessment documentation
- Communication failures (handover, escalation)
- Training gaps (breakaway/restraint, de-escalation)

Incident Response & Outcomes

Common immediate actions included:

- Security and police attendance
- Safeguarding referrals (adult & child)
- Mental Capacity Assessments and DoLS
- Multi-Disciplinary Team (MDT) escalation (NAViGO, psychiatry, safeguarding)
- Informal and formal warning letters
- Staff welfare checks and Occupational Health referral

Most incidents were resolved without serious harm, though staff injuries and emotional distress were reported in multiple cases. Some investigations (HR, safeguarding) remain ongoing.

Data Quality & Gaps

- Missing patient identifiers in some incidents
- Incomplete capacity/DOLS documentation
- Follow-up outcomes not consistently recorded
- Linked incidents not always cross-referenced

Improved reporting consistency is required to support assurance and learning.

Overall Conclusion

While incident volumes have reduced significantly, the risk profile remains unchanged: acute, frailty, and emergency services continue to face high exposure to violence, abuse, and patient absconding. Sustained focus on training, staffing, security presence, and governance is required to maintain downward trends and protect both staff and patients.

This data includes all incidents that are coded as security incidents including behaviour that is related to medical condition, absconding from wards, and is not just coded to violence and aggressive behaviour. There appears to have been a increase on the figures that was reported during 2024/25, this may be due to incidents being reported the LSMS more often due to the work the LSMS has carried out within the Trust to promote the reporting of incidents during Ward visits, Ward huddles and Communication bulletins, the LSMS continues to actively promote the reporting of incidents through the Ulysses system throughout the Trust, making staff aware of the benefits of reporting incidents which include through investigations taking place, jointly working with the Police and other partner agencies, as well as positive action being taken against offenders and the Trust identifying trends and acting upon them to make the Trust a safety place to work and visit.

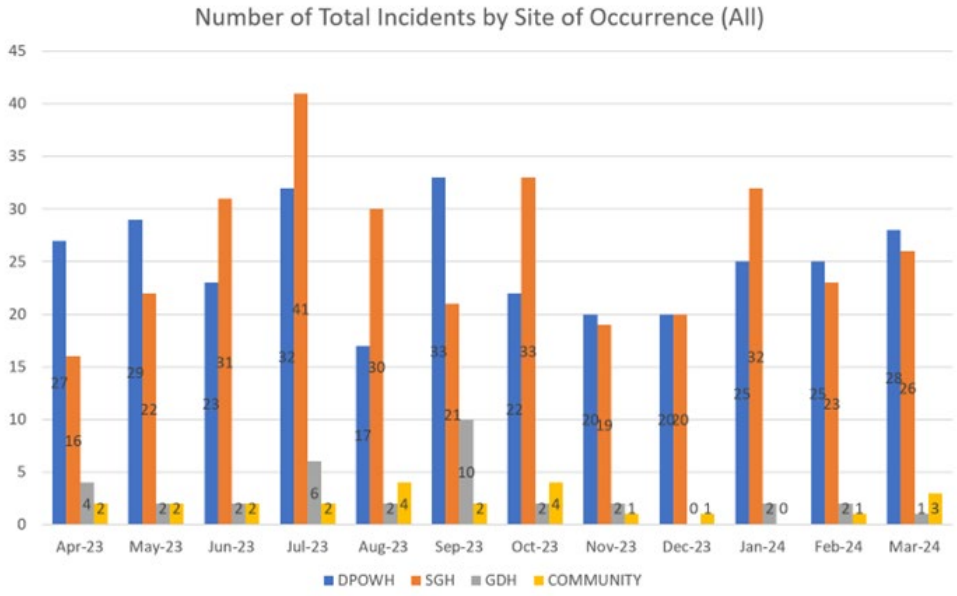
Staff have been made aware that they will be supported if they are a victim and violence and aggression and the LSMS will contact them and support them through any criminal investigation process as well as any court appearances, working closely with the Police Investigating Officer, Crown Prosecutor, and Witness Care. Through evaluation with Partner Agencies including the Police, when a rise in certain types of crime has been seen within the community, and it has been

identified that when a rise occurs within the community it is also seen within NLaG, in these circumstances the LSMS works closely with the Policing Teams to coordinate an approach.

The chart below (figure 2) shows the number of incidents per month by site. The reported numbers show that there has been a steady number of incidents reported at both DPOWH and SGH throughout the year, with September 2025 seeing the largest number of incidents reported at DPOWH, and July 2025 at SGH.
DPOW had a slight drop in numbers in November and December 2025, which was also seen in 2024 and SGH had a slight drop in numbers in November and December 2025, previously the drop in incidents at SGH were seen in July and November 2024, and January 2025.
Community figures sit in single figures each month with the highest in a month being 4 in August and October 2025. Previously the highest number of incidents with 4 were in August and November 2024.

GDH also sits in single figures apart from September 2025 when there were 10 incidents, previously the highest month was 7 in October 2024.

It is worth noting that within the Incident figures there was 1 incident in April 2025 at Scunthorpe Community Diagnostic Centre (CDC) which was verbal abuse, and there were no Incident at Grimsby CDC for 2025/2026, the LSMS is ware of this and has recently been visiting the CDC's to talk to staff and raise awareness around incident reporting as there is information that incidents are occurring but not being reported, the LSMS will continue to carry out periodic visits to speak to staff and raise awareness and discuss any concerns raised.



Calendar Month	Community	DPOWH	GDH	SGH	TOTAL
Apr - 25	2	27	4	16	49
May - 25	2	29	2	22	55
Jun - 25	2	23	2	31	58
Jul - 25	2	32	6	41	81
Aug - 25	4	17	2	30	53
Sep - 25	2	33	10	21	66
Oct - 25	4	22	2	33	61
Nov - 25	1	20	2	19	42
Dec - 25	1	20	0	20	41
Jan - 26	0	25	2	32	59
Feb -26	1	25	2	23	51
Mar - 26	3	28	1	26	58
Total	24	301	35	314	674

Figure 2 - Number of incidents per month by site.

During 2025/2026 there has been12 incidents of Verbal Abuse with Racial Content, 7 in 2025 and 5 in 2026, (a decrease from 20 in 2024/2025), and on every occasion the Trust worked closely with the Police whenever possible to provide comprehensive evidence including body camera footage that supports a prompt and effective investigation.

In relation to both Emergency Care Centres, Violence and aggression incidents are more prevalent in emergency departments (EDs) due to a combination of factors, including patient stress, the ED's environment, and communication challenges.

Patients may be in pain, anxious, or waiting long periods, which can exacerbate frustration and lead to aggressive behaviour. The ED itself can be a stressful environment with long waits, overcrowding, and potentially unclear communication, further fuelling these issues.

Consideration also needs to be given to patients who lack capacity and commit incidents against the staff, these incidents are reviewed by both the LSMS and Adult Safeguarding Team. The LSMS and the Police endeavour to take strong action to try and prevent incidents reoccurring where is this appropriate

Supporting victims is a key part of the work undertaken and to put relevant actions in place against aggressors in the hope of positive outcomes, as well as trying to prevent further reoccurrence. Details of some of the work in progress are included in other sections of this report.
During 2025/2026 period as in previous years the LSMS has continued to work closely with Humberside Police to raise the number of sanctioned detections (i.e. convictions and cautions) as it has been identified in the past these figures at times were low, in order to see more positive outcomes for offender behaviour and highlighted these outcomes to deter crime being committed within the Trust.
Due to the excellent working relationship with Humberside Police at a local level this is continually monitored and discussed.

The LSMS continues to promote to staff that they will be supported if they are a victim of violence and aggression and, also that the LSMS can be a point of contact for them throughout any investigation, or potential court appearances. The LSMS has a good working relationship with the Humberside Witness Care Programme and Crown Prosecution (CPS) Prosecutors, often talking to them directly to discuss cases and their progress.
The LSMS is Police and Criminal Evidence Act 1984 trained and qualified in criminal Investigation and securing and giving evidence.
Every report will be and is taken seriously by the Trust and the LSMS, reviewed and acted upon.

2.2 Joint Working Agreement

The Joint Working Agreement (JWA) between the Trust, Yorkshire and Humber Crown Prosecution Service (CPS), and Humberside Police is currently undergoing a full review to support the development of a single Humber Health Partnership JWA. Progress has been delayed due to organisational changes within Humberside Police and issues associated with the formation of the Partnership. Once finalised, the revised JWA will be promoted across Humberside Police, the CPS, and partner NHS organisations by the Local Security Management Specialist (LSMS).

Following completion of the Northern Lincolnshire and Goole (NLaG) review, joint work will take place with Hull University Teaching Hospitals (HUTH) to ensure inclusion within the agreement, providing a consistent framework across both Trusts and criminal justice partners.

The LSMS continues to work with Community Policing Teams and local Community Safety Partnerships to implement the principles of the JWA and embed them within frontline services.

Separate to the JWA, a 6-Point Promise agreed in 2021 between NLaG and Humberside Police remains in place and continues to provide assurance regarding the management of assaults against NHS staff. This commitment confirms that assaults are taken seriously, applies to all NHS workers (including contracted staff), ensures appropriate welfare and managerial support for victims, mandates incident reporting via Ulysses, and requires both organisations to work together to undertake robust investigations aimed at achieving positive outcomes for victims wherever possible.

Due to the Group Structure being created, during 2026/2027 the LSMS plans to update the JWA to reflect the Humber Health Partnership approach so that the JWA supports both NLaG and HUTH.

6-Point Promise

1	Assaults on NHS staif will be taken seriousiy when reported to Humberside Police.
2	The joint working agreement applies to all NHS workers. inciuding staff not directly employed by the NrtS but contracted to devver NHS senitces (e g. security staff and volunteers)
3	Victims will be offered appropriate welfare support to aid recovery.
4	Line managers will ensure a relevant senior manager is informed to provide continuity of support.
5	All incidents of violence or abuse against staff must be reported via Ulysses
6	The Trust and Humberside Police will work jointly to carry out robust investigations, secure available evidence, and pursue positive outcomes for victims wherever possible

2.3 Warning Letters for Unacceptable Behaviour

The Trust does not tolerate any acts of criminal violence or aggression towards our staff and in support of this the Trust currently has a Policy for the management of Violent, Aggressive and Intimidating Behaviour which contains an exclusion procedure. The exclusion procedure consists of four stages, verbal warning, informal warning letter, formal warning letter and then an exclusion letter, however due to the Group restructure and Group working a new Group Wide Violence Prevention and Reduction Policy is currently being drafted by both Security Management Specialists from HUTH and NLaG.

Managing Unacceptable Behaviour (Patients and Visitors)

The Local Security Management Specialist (LSMS) has maintained a proactive approach to challenging unacceptable behaviour by patients and visitors. This early-intervention approach is intended to prevent escalation, reduce recurrence, and reinforce expected standards of conduct towards staff.

During 2025/26, 20 informal warning letters were issued to patients and visitors in response to inappropriate behaviour towards staff. In addition, 4 formal warning letter was issued to a patient due to the severity of the behaviour. While this represents an increase compared to 2024/2025.

No exclusions were issued to patients or visitors during 2025/26. Behaviours that may result in informal or formal warnings include verbal aggression, threats towards staff, physical assault, and racial abuse. Informal and formal warnings may also be issued where the individual is under police investigation for criminal offences.

Overall incident levels have risen compared to previous periods; however, there is confidence that staff are now reporting incidents more often, as well as offending increasing which is a concern for the LSMS. Through discussion with staff the LSMS has identified that there is an element of staff normalisation of inappropriate behaviour, and reduced confidence that reporting will lead to meaningful outcomes, the LSMS continues to proactively promote incident reporting and reassure staff that a robust approach will be taken against offenders and staff will be supported. As the incident reporting system is reviewed to support a single reporting solution across the Group, targeted activity will be undertaken to strengthen reporting culture, improve staff confidence in the process, and demonstrate the benefits of reporting in protecting staff.

Monitoring incidents before and after the issuance of warning letters indicates that, in most cases, there is no recurrence involving the individuals concerned following receipt of a letter. A small number of repeat offenders remain. These cases are managed through collaborative working between the LSMS and Humberside Police to address repeat offending and identify appropriate community resolutions. This approach reflects evidence that individuals who repeatedly offend within NHS settings may also be involved in antisocial behaviour and crime within the wider community, making joint working beneficial for both the Trust and the Police.

Where opportunities arise, particularly where individuals contact the LSMS, constructive discussion is used to educate and deter future unacceptable behaviour.

The LSMS reviews body-worn camera footage and CCTV on a weekly basis. This provides valuable evidence to support the four-stage exclusion procedure where required, supports police reporting where appropriate, and contributes to wider police intelligence gathering.

2.4 Community Lone Working

The Peoplesafe Lone Worker devices currently in use contain the latest lone working technology, are linked to a 24/7 specialist alarm receiving centre and feature GPS locating technology that can be directly linked to the Police Command Centre Dispatchers during an emergency to ensure the quickest response possible for staff requiring help. The feedback received from staff has been positive regarding training, service provided by Peoplesafe and the device functionality.

There are approximately **617** profiles are individuals and a profile for a shared device registered on the database, this is down from **521** registered staff in 2024/2025, with **393** devices registered against a profile/user, **138** devices on the system that are not assigned to a user/profile. Currently the Trust has **531** Devices in total registered on the database, which is down from **537** devices in 2024/2025, as of 13/05/2026 there are **89** active users over the previous 30 days. that are assigned to staff with a mixture of individuals and pooled units.

The Safety and Statutory Compliance Administrator supports the management of the Peoplesafe database, including oversight of devices and users across the Trust. This involves monitoring underused units, as well as identifying devices assigned to staff who have either left the Trust or transferred to other roles. As a result, devices are regularly recalled and redeployed to ensure maximum efficiency and optimal utilisation.

As of March 2026, overall usage stands at 27%. This level of engagement is not considered acceptable by the Trust and has been escalated on multiple occasions to the relevant Divisions, with requests for improved promotion and use of the devices within teams. The issue has also been escalated to the Executive Team. A continuous review process is in place, focusing on devices that have been inactive for six months. Users are contacted to understand the reasons for inactivity, and where no reasonable explanation is provided, devices are recalled and reallocated to new users who demonstrate a need.

Additional support to improve usage has been provided by Peoplesafe, alongside promotional efforts led by the Trust's Communications Team via the intranet and social media platforms. Awareness has also been raised through Violence Against Staff workshops, and the matter has been discussed at Trust Management Board

level. While both active user numbers and overall usage have improved since 2023/2024, the Trust remains committed to achieving further progress.

The Local Security Management Specialist (LSMS), in collaboration with Peoplesafe, continues to explore opportunities to enhance device utilisation and ensure users engage with the system effectively. This effort is supported by Peoplesafe through weekly workshops and the sharing of case studies that highlight real-life incidents, demonstrating the benefits of device usage.

On 29 April 2026, the LSMS met with the Peoplesafe CEO to discuss usage challenges and potential solutions. Following this meeting, a Customer Success Manager has made contact to arrange an initial meeting to explore available support opportunities.

The LSMS has previously worked closely with the dedicated Peoplesafe Account Manager to deliver targeted engagement initiatives. These have included attending a Community Nurses' away day at Forest Pines Hotel to provide training and promote device usage, as well as hosting an open workshop at Global House for staff. Similar engagement activities are planned for 2026/2027.

The LSMS also serves as a point of contact for other NHS Trusts considering the implementation of Peoplesafe. Support is provided in the form of guidance and advice throughout their procurement and implementation processes.

Looking ahead, the LSMS plans to visit the Peoplesafe headquarters to observe the 24-hour Monitoring Centre and engage with staff regarding the management of violence and aggression incidents, as well as their handling of emergency calls.

2.5 Surveillance Systems

The Trust currently operates three Security Surveillance Systems: Closed Circuit Television (CCTV), Body Worn Video (BWV) devices, and non-recording patient cameras and monitors. In addition, Automatic Number Plate Recognition (ANPR) is used on Trust car park barriers. Although ANPR is not a security system, it is classed as a surveillance system.

The CCTV system in place across all NLaG sites is fully digital and utilises high-definition cameras. Upgrades to both the cameras and the system during 2022/2023 have delivered a significant improvement in image quality, as well as the introduction of audio recording on BWV devices. These enhancements have enabled the provision of high-quality evidence to the Police where action is taken in

response to inappropriate behaviour. The rationalisation of the system also provides assurance that the Trust has taken all reasonable steps to minimise unnecessary surveillance, in line with the Surveillance Camera Commissioner (SCC) Code of Practice.
During 2025/2026, the Local Security Management Specialist (LSMS) conducted Data Protection Privacy Risk Assessments for CCTV at the new Community Diagnostic Centres (CDC):

Grimsby CDC – 09/09/2025
Scunthorpe CDC – 09/09/2025

Feedback from partner agencies that have accessed and obtained CCTV footage has been consistently positive, with particular reference to the quality of evidence provided and its contribution to successful prosecutions.
The Trust operates a number of high-definition “fisheye” cameras, which provide a full 360-degree field of view. These can be divided into multiple zones, allowing more than one view to be monitored simultaneously. These cameras are installed within the Emergency Departments at both DPOWH and SGH, where they have proven to be highly effective.
All CCTV cameras are linked to the Security Office, which is monitored continuously, 24 hours a day, 7 days a week. Images are retained for up to 30 days; however, footage is deleted sooner where its purpose has been fulfilled, and it is no longer required for the stated purpose of the surveillance system.

Body worn Video Devices are worn by the Security officers; we currently have the following Body Worn Cameras in use which is the same as 2024/2025 -
DPOW x 7 Body Worn Cameras – All active (4 held as spares)
SGH x 3 Body Worn Cameras – All active
GDH x 1 Body Worn Camera – Active

No covert cameras were deployed during this year financial year. Covert surveillances falls within the Regulatory Investigatory Powers Act (RIPA) and can only be authorised by the police and the Secretary of State for Health & Social Care (for use on healthcare premises)

2.6 Counter Terrorism

The many terrorist incidents that have occurred in the UK over the past few years reminds us of the continued need to ensure our sites and staff are prepared to respond to an incident and to be aware of the warning signs leading to an event. The Trust continues to work closely with the National Counter Terrorism Policing: North East Counter Terrorism Unit in providing up to date advise and appropriate training sessions for Trust staff.
In 2024/2025 the Trust added the Action Counter Terrorism training (ACT Training) which incorporates SCaN (See, Check and Notify) onto Electronic Staff Record (ESR) as an E-Learning package which will become mandatory training now Martyn's Law has become legislation, currently this training is optional for staff to complete

All Trust staff have been made aware of the available ACT Training via a communication briefings sign posting them to ESR.

2.7 The Terrorism (Protection of Premises) Act 2025 (Martyn's Law / Protect Duty)

Purpose
To provide the Board with a concise update on the Protect Duty (Martyn's Law), its relevance to the NHS, and the assurance actions required during the national implementation period.

Key Messages for the Board

- Martyn's Law is enacted but not yet enforceable; compliance is expected from 2027 at the earliest.
- NHS organisations are within scope due to open access and high public footfall.
- Boards are expected to demonstrate active preparedness, not formal compliance, at this stage.
- This duty complements, but does not replace, existing Prevent arrangements.

What is the Protect Duty?

- The Terrorism (Protection of Premises) Act 2025, known as Martyn's Law.
- Introduced following the Manchester Arena attack to improve public protection.
- Requires proportionate measures to prepare for and respond to terrorist incidents.
- Regulated by the Security Industry Authority (SIA).

Current Status (May 2026)

- Royal Assent: April 2025
- Implementation period: Minimum 24 months (to at least April 2027)
- Statutory guidance published: April 2026
- Enforcement and inspection activity expected post-implementation

Impact on the NHS

- Large acute hospitals and some mental health sites are likely to fall within scope.
- NHS England confirms applicability via NHS Estates Technical Bulletin (NETB).
- Board accountability applies across the whole estate.
- Assurance will be monitored through the Premises Assurance Model (PAM).

Summary of Duties (When in Force)

Standard Duty (200–799 persons):

- Notify SIA.
- Reasonable public protection procedures (e.g. evacuation, lockdown).
- Staff awareness and training.

Enhanced Duty (800+ persons):

- All standard duties, plus:
- Documented terrorism risk assessment.
- Measures to reduce vulnerability.
- Appointed Designated Senior Individual (DSI).
- Submission of documentation to the regulator.

Approach is risk-based and proportionate, no expectation of excessive security measures.

Relationship to Prevent

- **Prevent:** safeguarding and radicalisation (Counter-Terrorism & Security Act 2015).
- **Protect Duty:** physical security and incident preparedness.
- The duties are complementary, not duplicative.

Key Risks for the Board

- Balancing security with patient access and dignity.
- Complex estates with multiple occupancy profiles.
- Resource prioritisation ahead of enforcement.
- Demonstrating clear governance and senior ownership.

Recommended Board Actions (Now)

- Note Martyn's Law as a future statutory duty.
- Confirm executive ownership and emerging DSI arrangements.
- Assure that an estate-wide scoping exercise is underway.
- Request a gap analysis against existing emergency plans and training.
- Ensure progress is visible through PAM / EPRR / security reporting.

Board Assurance Position

The organisation is expected to be planning and preparing, with evidence of proportionate readiness, ahead of formal enforcement.

The LSMS will continue attending online briefings and conferences delivered by the Home Office and Homeland Security and NHSE in relation to the current position of Terrorism (Protection of Premises) Act 2025 in preparation for the Legislation being a legal requirement and enforceable.
The LSMS is also working closely with both North Lincolnshire and North East Lincolnshire on their preparation for the Act to work alongside Local Authorities.

2.8 Joint Working

During the last 12 months the LSMS has continued to build positive working relationships within the Trust and with external partners, this has been successfully achieved with positive outcomes now being seen across trust and with all its partners.

Trust/Police working relationship.

The working relationship we have developed with both the Grimsby and Scunthorpe Neighbourhood Policing Teams has been very reassuring and continues to be extremely positive. Our joint, proactive approach has been effective in deterring and responding to unacceptable behaviour and criminal activity. A number of improved joint working practices have been implemented to better support one another.

We actively encourage and maintain a regular police presence across Trust sites as part of this partnership. Police surgeries have taken place at DPOW and SGH, providing a visible joint presence for both the public and staff. On previous occasions, North Lincolnshire Council's Safer Streets Team has also attended, delivering cycle-marking events that offered staff and members of the public the opportunity to have their bicycles security-marked free of charge.

There is clear evidence of the benefits of this collaborative approach. The partnership has contributed to positive police investigation outcomes, including secured convictions, demonstrating to Trust staff that prompt and effective action is taken and that offenders face appropriate consequences.

Historically, DPOW and SGH were among the highest crime locations within the Park Ward in Grimsby and the Town Centre Ward in Scunthorpe. However, this is no longer the case, which is both positive and reassuring. We are seeing increased crime detection rates, with offenders being dealt with appropriately through cautions or court disposals. During the 2025/2026 financial year, both sites are no longer the highest crime locations within their respective wards, and this reduction is continuing as a positive trend throughout the year.

Unison/Trust

The LSMS continues to have a very positive working relationship with Unison representatives Alex Hutchinson and Julian Corlett, in previous years the LSMS and Unison have provided joint violence at work events for staff to attend whereby the

LSMS attended the restaurants and café areas at DPOW, SGH and GDH with Alex and Julian with information to provide support and advise in relation to violence at work, these events are considered to be highly successful and worthwhile and will be taking place again during 2026/2027.

Safeguarding

The LSMS has had a close and positive working relationship with the Trust Safeguarding Teams and the Mental Health teams.

The LSMS is invited to strategy meetings and members of the team contact LSMS regarding patients that pose a risk to others to plan their visit/inpatient stay and obtain advise.

The LSMS writes management plans when required to support and protect safeguarding, ward staff, ward management, the patient, visitors and the security team, the management plan is security focused and details the risk the patient presents and how it can be managed within the Trust and with support of partner agencies when required, the plan also details routes of escalation when required.

The LSMS works closely with the adult safeguarding team when supporting Domestic Abuse victims, this includes both patients and Staff.

The joint working has been positively acknowledged by Head of Safeguarding and members of the Safeguarding Team who has positive commended during minuted Safeguarding meetings.

The LSMS supplies written reports and attends the Safeguarding and Sexual Safety meetings.

The LSMS also has direct contact with partner agencies in relation to safeguarding including the Blue Door, probation, and the Local Authorities Social Care Teams (adults and Children).

The LSMS has completed the Level 3 Children's Safeguarding and Level 3 Adults Safeguarding course and is now planning on completing the Designated Safeguarding Lead Course himself to further his knowledge and professional ability in the workplace and obtain professional qualifications in Safeguarding.

Community Safety Partnership

The LSMS is an active member of both the North East Lincolnshire Community Safety Partnership and North Lincolnshire Community Safety Partnership, and up until December 2024 chaired the North East Lincolnshire Violence Against Women

(VAWG) Working Group, only stepping down to focus on his commitment within the Trust to support staff and find ways to reduce Violence and Aggression, the LSMS also sits on the serious Violent Crime working group and serious Youth Violence working groups at both Community Safety Partnerships.

3.0 2026/2027 Work Plan for Security Management

The 2026/2027 work plan for Security Management, which outlines the key actions against each security management objective, NHS Violence Prevention and Reduction Standards and Protect Duty, is delayed allowing Group Wide working once the restructure process is completed within Estates, Facilities and Development, the work plan will be provided to the Board at a later date and will comprise of a 3 year workplan to facilitate the Protection of Premises Act 2025 and the diverse work load experienced by the LSMS .

4.0 Summary and Next Steps

In summary, significant work remains to further develop the Trust's security management arrangements in order to enhance the safety of staff, patients, and visitors, and to protect NHS property and assets. The work undertaken by the Local Security Management Specialist (LSMS), in partnership with Trust colleagues and external partners, is essential to strengthening security management arrangements and to preventing and reducing violence and criminal offences directed at staff and Trust property.

The key focus areas to be incorporated into the 2026/27 Security Management Work Plan include continuing close collaborative working with partner agencies to improve incident reporting and investigative outcomes, providing effective support for staff who are victims of crime, and progressing the introduction of new technology and improvements to surveillance systems. The Work Plan will also be aligned to support Security Management Specialists operating within a Group structure following the conclusion of the Group Estates, Facilities and Development restructuring process. This will be presented to the Board at a later date.

The national focus on reducing violence against NHS staff, particularly through the Violence Prevention and Reduction Standards, is expected to lead to the

development of updated security management standards and improved sharing of incident data and analysis across NHS organisations in the near future.

There is also a significant focus on compliance with the Terrorism (Protection of Premises) Act 2025, formally known as Martyn's Law. The LSMS will prioritise this legislation within the Work Plan due to its anticipated substantial impact on the Trust. As part of the preparatory work, efforts are underway to ensure Trust staff receive up-to-date counter-terrorism training through approved ACT training, which has been added to ESR e-learning. The LSMS will also contribute to the NHS England–supported Protection of Premises Working Group.

As part of preparations for the Protection of Premises Act 2025, the LSMS is developing an Emergency Department (ED) lockdown policy and guidance document. The ED currently has the capability to be locked down by zone via emergency activation buttons, preventing entry and exit and disabling the door access system. The LSMS undertakes monthly testing of this lockdown system. With support from Paxton, the Trust's door access system provider, a software upgrade has been identified that would provide enhanced lockdown functionality. Transitioning to the upgraded software would further support compliance with the Protection of Premises Act 2025 and accommodate potential future changes to lockdown requirements. The enhanced system would allow authorised access cards to operate during a lockdown for staff required to continue working, whereas currently access is restricted until the system is manually reset. The upgrade could also support the introduction of a progressive lockdown capability in response to a moving threat. Enquiries are ongoing with Paxton regarding this upgrade.

In addition, continued engagement with partner agencies will focus on promoting positive community outcomes, including rehabilitation and diversion from further offending for individuals who commit offences on Trust property. Where appropriate, the LSMS is keen to support restorative justice approaches, particularly in partnership with Youth Justice services.

5.0 Executive Board Action Required

The Executive Board is asked to:

- Note the contents of the report.
- Note that the Security Management Structure is delayed and not present on this report due to the restructure of Estates, Facilities and Development, the structure will be provide to the board at a later date once confirmed.
- Note the 2026/27 Work Plan for Security Management is being delayed allowing for Group wide working once the restructure process is completed within Estates, Facilities and Development, the work plan will be presented to the board at a later date.

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)259

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Friday 09th October 2026**
Director Lead	Julie Beilby, Non-Executive Director & Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-in-Common held on May 27th and July 22nd 2026
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Minutes from the Workforce, Education and Culture Committees-in-Common held on July 22nd 2026 & 29th September 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 22nd July 2026 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Julie Beilby	Non-Executive Director (NLaG) - Chair
David Sulch	Non-Executive Director (HUTH)
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement (attending for Group Chief People Officer)
Wendy Page	Care Group Nurse Director (attending for Group Chief Nurse)
Dr Peter Sedman	Deputy Chief Medical Officer (attending for Group Chief Medical Officer)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Lucy Vere	Group Director of Learning and Organisational Development *(item 4.3)*
Helen Marks	Senior interim HR Consultant
Murray Macdonald	Vice-Chair
Ellie Parker	Head of Professional Practice for Nursing – NLaG *(item 4.5)*

Observers:

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees-in-Common Chair welcomed those present to the meeting. Apologies for absence were noted for Dr Kate Wood,Group Chief MedicalOfficer, David Sharif, Group Director of Assurance, Jo Ledger, Deputy Group Chief Nurse.

1.2 **Staff Charter and Values**

Julie Beilby noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meeting held on 27th May 2026**

The minutes of the meeting held on 27th May 2026 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to raise.

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

Updates to the Action Tracker were provided within the agenda items.

1.7 **Urgent and Emerging Issues**

Paul Bunyan provided an update on industrial action and workforce changes. He reported that resident doctors' industrial action had been called off following a pay award and the introduction of a revised 10 Point Plan (Version 2).

Paul Bunyan informed the Committees-In-Common (CiC) he had attended a national meeting with the new National Medical Director, Frankie Swords, who was leading engagement work to review the 10 Point Plan. He explained that feedback suggested the original plan had not fully met the needs of resident doctors, and that the revised version would focus more closely on improving workplace experience. He noted that further information on the new framework would be shared as it became available.

Julie Beilby noted that she had recently been appointed as the Non-Executive Director lead for oversight of the 10 Point Plan through the Workforce and Education Committee (WEC). She said she would like a briefing on the development of Version 2 of the plan and requested that it be added to the action tracker for future discussion by the Committee.

Action: Lauren Rowbottom to add an update on the 10 Point Plan (Version 2) to the Workforce Plan action tracker for future consideration by the Workforce and Education Committee.

Paul Bunyan provided an update on industrial action. He reported that Specialty Associate Specialists (SAS) doctors had not met the ballot threshold required for industrial action and there were therefore no plans for action from this staff group. Paul Bunyan noted that consultants had met the ballot requirements for industrial action. However, no further information had been received, and discussions were

expected to continue nationally following the appointment of the new Health Secretary. He advised that consultants now had the option to take industrial action if negotiations did not progress.

Julie Beilby and David Sulch discussed that this wasn't a specific concern requiring escalation but suggested this should be an advisory to the Board in the escalation report.

Paul Bunyan provided an update on the Care Group Restructure Programme. He explained that Sam Peate, Chief Delivery Officer, Helen Marks, Senior Interim HR Consultant and Peter Sedman, Deputy Medical Officer had been leading an engagement programme with care groups and trade unions throughout July to gather views on what a more productive and efficient care group structure should look like.

Paul Bunyan said feedback from care groups suggested that the current structure was overly complex and could make decision-making, resource deployment and management arrangements less effective. He noted that staff had been actively involved in shaping proposals for future arrangements based on their experience of working within the existing structure.

Paul Bunyan reported that recent engagement sessions had been positive and productive. Early proposals suggested a future structure of around eight to ten care groups. He explained that options were expected to be developed by the end of July, with formal consultation planned to follow.

Peter Sedman reflected on a recent engagement event, describing it as the most engaged Care Professional Group meeting held to date. He said around 70 staff attended and had taken part in constructive discussions about the future organisation of care groups. He noted that the feedback had focused on what would work best for the organisation rather than individual interests, which he found encouraging. Peter Sedman said the discussions appeared to support a future model of around eight care groups, although no final decision had been made.

Julie Beilby asked whether staff from both the North and South Bank areas had been represented at the engagement event. Peter Sedman confirmed that there had been good representation from across both banks, including Chiefs of Service and Clinical Leads, and that participation had reflected the organisation's overall structure.

2. MATTERS REFERRED

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

None to note.

3. RISK & ASSURANCE

3.1 Board Assurance Framework including Risks

Rebecca Crashley provided an update on the Board Assurance Framework (BAF). She explained that, following a review, work was underway to refresh the BAF as

part of a wider review of governance arrangements.

Rebecca Crashley said that Value Circle had been working closely with Keith Haynes, Interim Board Secretary, and that a working group had been established to review the BAF and related governance processes. She advised that the BAF would be simplified and aligned more closely with the Integrated Improvement Plan, ensuring that actions and risks were better connected.

Rebecca Crashley noted that the BAF would undergo a significant redesign, including changes to its format and structure. She explained that Executive Leads and Non-Executive Director leads from the Committees-in-Common would be involved in the review process. In the meantime, existing risks continued to be monitored and managed while the revised framework was being developed.

David Sulch commented that, based on the current position and the work being undertaken through the People Strategy, the workforce-related risk score appeared higher than might be expected when compared with access and financial risks. He noted that this could be considered as part of the wider BAF review. Julie Beilby agreed and noted that, given the planned refresh of the BAF, it was not necessary for the CiC to spend significant time discussing the current version.

Murray Macdonald highlighted the importance of ensuring that risk, governance and audit functions worked alongside the revised BAF to provide effective oversight and assurance. He noted that there would be further discussion as the work progressed and welcomed the leadership being provided by Keith Haynes.

Julie Beilby emphasised the need for careful review of any actions, assurance ratings and risk scores carried forward into the refreshed BAF. She noted that some current ratings did not appear to reflect the level of assurance being reported elsewhere and stressed the importance of being open and realistic when assessing risks and controls. Rebecca Crashley confirmed that assurance ratings would form part of the review and would include consideration of best practice from other organisations to ensure that assurance ratings were applied consistently and accurately.

The CiC noted the progress being made on the BAF refresh and supported the proposed approach to strengthening risk and assurance arrangements.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate**

None to note.

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

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 People Strategy: Delivery Plan & Priorities – Quarter 1

Paul Bunyan took the report as read and gave key updates to the workforce priorities linked to the Integrated Improvement Plan (IIP). He explained that future reporting to the Committee would focus on the most significant workforce measures and would be closely aligned with the delivery of the IIP.

Paul Bunyan provided an update on the proposed Voluntary Redundancy Scheme. He reported that the financial assessment had been completed and the proposal was being reviewed by the Executive Team. Subject to the necessary approvals and NHS England sign-off, the scheme was expected to be introduced in early August and could support workforce changes arising from the Care Group Restructure Programme and wider headcount reductions.

Paul Bunyan also reported that agency and overtime spending had reduced during Quarter 1, although further reductions were required. A bank-first approach had been adopted, resulting in increased bank spend as a planned alternative to agency use.

Paul Bunyan advised that delivery of the Workforce Plan remained a significant risk. While NHS England had recognised some early improvements, concerns remained about the pace of progress and the organisation's ability to reduce workforce costs while maintaining safe, high-quality services. He noted that robust review processes were in place to support staffing decisions, particularly for clinical posts.

Paul Bunyan noted that extra contractual payments for doctors remained a challenge. He reported that a new digital approval system, Locums Nest, had been introduced on 1 July to strengthen oversight, improve reporting and ensure senior approval of requests. He reported that the impact of the new controls would become clearer once a full month of data was available.

Paul Bunyan reported that work was underway to align workforce, financial and operational reporting through a single reporting framework. He said this would provide one consistent source of information for internal and external reporting, while future workforce trajectories would be updated to reflect the full workforce cost position, including overtime, extra contractual payments and independent sector spending.

The CiC noted the update and the actions being taken to strengthen workforce controls, improve reporting arrangements and support delivery of the Integrated Improvement Plan.

Murray Macdonald emphasised the importance of developing a single, Board-approved reporting approach that aligned workforce, financial and operational information. He said that consistent reporting across committees and the Board would provide a clear and shared understanding of organisational performance.

Julie Beilby highlighted the need for clear reporting of variable pay performance, including progress against reduction targets. She stressed the importance of linking workforce and financial metrics to support effective oversight and decision-making.

Julie Beilby also noted that while vacancy controls were an important measure, workforce reductions could not be achieved through vacancy freezes alone. She said sustainable savings would require service transformation, workforce redesign and ensuring that staff were deployed in the right roles to support organisational priorities. Paul Bunyan agreed and reported that work was underway to explore delivering some people services, including payroll, recruitment and occupational health, at a regional level.

Paul Bunyan noted that corporate services had already experienced significant headcount reductions and that further changes would need to be carefully managed. He said the focus was on redesigning services and identifying opportunities to work differently, both across the organisation and at system level, rather than relying solely on reducing posts. He added that the Care Group Restructure Programme could support this work by simplifying organisational structures and reducing administrative complexity, creating opportunities to redesign how corporate services were delivered in the future.

David Sulch noted that vacancy freezes could sometimes lead to decisions being driven by circumstances rather than service design. He also highlighted the risk that delays in filling vacancies might increase spending on temporary staff. He suggested this should be considered as part of future workforce reporting and monitoring.

Julie Beilby noted her concern about the continued reliance on 12-month planning cycles and the challenges this created for long-term transformation.

Peter Sedman said that vacancy controls remained a necessary short-term measure but were a blunt tool. He noted that further cultural change and a greater understanding of financial responsibilities across care groups would be needed to support sustainable improvements.

The Committees-in-Common agreed limited assurance, noting that there had not been enough progress on workforce savings and headcount reduction to improve the assurance rating.

The Committees-in-Common agreed to escalate concerns to the Board regarding workforce capacity and demand management, including the need for assurance that care groups and clinical leaders were accountable for delivering workforce and financial targets.

Lucy Vere joined the meeting at 10.01am

4.2 **Workforce Integrated Performance Report (Draft Workforce Integrated Performance Report)**

Updates were captured within item 4.1, however Paul provided assurance that performance in mandatory and role-specific training had continued to improve and

was now being sustained at a high level. He also highlighted ongoing work within care groups to improve mandatory training, appraisals and job planning compliance.

Julie Beilby raised concerns about delays in parts of the recruitment process, including shortlisting and providing feedback to applicants. She emphasised the importance of effective recruitment processes to support the organisation's workforce plans and asked whether technology could be used to help manage high numbers of applications.

Julie Beilby also welcomed improvements in the handling of flexible working requests and recognised the positive progress made in this area.

Paul Bunyan explained that high application volumes were creating challenges for shortlisting, partly due to the increasing use of AI-generated applications. He reported that alternative local recruitment approaches had been trialled successfully, attracting more relevant applicants in manageable numbers.

Paul Bunyan advised that recruitment performance remained strong in relation to time-to-hire but acknowledged that shortlisting continued to be a challenge. He said work was underway to explore new technologies and processes to help reduce shortlisting workloads and improve recruitment efficiency.

4.3 **Modern Slavery Statement**

Lucy Vere presented the Annual Modern Slavery Statement. She explained that the statement followed the format previously reviewed by the Workforce and Education Committee and would need to be published before the end of September.

Lucy Vere advised that the statement remained largely unchanged from the previous year. She noted that procurement requirements were covered through the procurement collaborative's Modern Slavery Statement, while local arrangements focused on safeguarding policies, staff support policies and compliance with mandatory safeguarding training.

Lucy Vere also highlighted the organisation's commitment to inclusion, equality and zero tolerance of discrimination. She reported that the organisation continued to meet the requirements of the Modern Slavery Act and had established effective arrangements with procurement partners to support compliance.

The Committee noted the statement and was invited to submit any comments or proposed amendments before publication.

Julie Beilby asked how the organisation was gaining assurance that local suppliers were meeting modern slavery requirements. Lucy Vere explained that modern slavery requirements were now being considered as part of local procurement arrangements. She noted that while most procurement activity was covered through the procurement collaborative, checks were also being applied to local contracts where needed.

Lucy Vere highlighted a recent case where staff had identified and supported an individual affected by modern slavery. She said this demonstrated good staff awareness and confidence in recognising and responding to potential concerns.

Julie Beilby thanked Lucy Vere for the report and noted that modern slavery was ultimately about protecting people, not just having the right policies in place.

The Committees-in-Common reviewed the Modern Slavery Statement and supported its submission to the Trust Board for approval.

Lucy Vere left the meeting at 10.25am

Ellie Parker joined the meeting at 10.35am

4.5 **Nursing, Therapies and Midwifery Education Progress Report**

Ellie Parker presented the report, providing assurance on the quality of Nursing and Midwifery Education across HUTH and NLAG. She reported that around 300 nursing and midwifery students undertook placements each year and that student feedback remained positive, with no significant concerns identified through NHS England quality monitoring.

Ellie Parker highlighted a continued national decline in student numbers, which had reduced placement activity and associated tariff income. She also noted potential risks linked to proposed national changes to practice learning requirements and the planned transition to a new placement management system.

Ellie Parker reported that student feedback continued to exceed NHS England benchmarks, with students describing placements as supportive and beneficial to their learning and development. She noted that work was ongoing to improve placement feedback from midwifery students.

Ellie Parker advised that strong educator networks remained in place across both organisations, supporting high-quality learning environments for students.

Ellie Parker also highlighted several achievements, including successful school engagement activities, expansion of work experience and implementation of the Safe Learning Environment Charter.

Wendy Page highlighted concerns about a national consultation proposing a reduction in required practice learning hours for nursing students. She noted that there were concerns this could affect students' preparedness and ability to demonstrate the required competencies after qualification.

Helen Marks enquired about the arrangements in place to ensure newly qualified nurses were able to secure employment following their training. Wendy Page explained that work had been undertaken with partners to plan recruitment in advance and support students through interview preparation. Wendy Page noted that nursing vacancies had been managed carefully to help ensure opportunities were available for newly qualified nurses completing their training later in the year.

Julie Beilby thanked Ellie Parker for the report, noting the positive student feedback, successful outcomes and examples of good practice highlighted throughout. She said the report provided reassurance that students continued to have positive learning experiences across the organisation.

The CiC received the report for information and noted the positive feedback from students, strong placement experiences and successful workforce development initiatives. The CiC agreed that the Board escalation report should highlight the positive feedback and outcomes within the report, while also noting the risks associated with declining student numbers and the importance of continuing to learn from all student experiences.

Ellie Parker left the meeting at 10.49am

4.6 Guardian of Safe Working Hours Quarter Q4 - HUTH & NLaG

4.6.1 Guardian of Safe Working Hours Quarter Q4 – HUTH

Peter Sedman presented the Guardian of Safe Working Hours report. He noted that changes had been made to the reporting process in line with the Resident Doctor 10 Point Plan, which could affect comparisons with previous reports.

Peter Sedman reported that the overall position remained stable, with a similar number of exception reports to previous quarters. Most reports related to doctors finishing late due to workload pressures.

Peter Sedman highlighted an area of concern relating to fines issued for breaches of safe working hours, particularly within Family Services. He noted that this issue had been ongoing for some time and required further investigation to ensure appropriate action was being taken.

Julie Beilby asked whether there were any other significant concerns arising from the report. Peter Sedman advised that, aside from the issues identified in Family Services, he was satisfied that the arrangements for monitoring safe working hours were operating effectively and that the overall position remained stable particularly on the North bank.

Murray Macdonald queried whether comparative data was available to help assess exception reporting rates. Peter Sedman agreed that the difference between reporting rates across the organisation required further review. He noted that work was underway to review staffing arrangements and resident doctor rotas, particularly on the South Bank.

David Sulch noted that national benchmarking data for exception reporting was limited and that comparisons between organisations could be difficult, as reporting levels were influenced by factors such as staffing levels and rota arrangements.

David Sulch emphasised that the focus should be on understanding and addressing recurring issues highlighted through exception reporting, particularly in Family Services. Peter Sedman confirmed that further work was underway to review exception reporting patterns and understand the reasons for higher reporting rates in some areas. He noted that recent changes to reporting

processes may have influenced the figures and said an update would be provided at a future meeting.

Julie Beilby asked whether funds generated through fines for breaches of safe working hours could be used to support actions within the Resident Doctor 10 Point Plan. Peter Sedman advised that funding from fines could be used for initiatives that supported resident doctors. He noted that decisions on the use of these funds were made through the Junior Doctors Committee and could be aligned to priorities within the 10 Point Plan.

The Committees-in-Common agreed reasonable assurance.

4.6.2 **Guardian of Safe Working Hours Quarter Q4 – NLaG**

Peter Sedman reported that exception reporting levels at NLaG remained similar to previous periods, with most reports relating to additional hours worked, particularly in Acute and Emergency Medicine where staffing pressures were greatest. He noted that work was ongoing to review resident doctor rotas and address identified capacity gaps.

Murray Macdonald noted the high number of exception reports across several services on the South Bank and raised concerns about missed educational opportunities for junior doctors. Peter Sedman acknowledged the concerns and confirmed that staffing levels, training opportunities and rota arrangements were being reviewed as part of ongoing workforce planning.

The Committees-In-Common felt they had received reasonable assurance and were comfortable with the processes and structures in place. They highlighted the need to continue monitoring and responding to areas of pressure, particularly on the South Bank, to ensure that identified issues were addressed and improvements delivered.

4.6 **Medical Revalidation / Responsible Officer Annual Report – HUTH & NLaG**

4.6.1/ 4.6.2 **Medical Revalidation / Responsible Officer Annual Report – HUTH/ Medical Revalidation / Responsible Officer Annual Report – NlaG**

Pete Sedman took the reports as read. He advised that the medical revalidation process continued to perform well across the Group.

Peter Sedman reported that the availability of appraisers had improved significantly, helping to ensure that appraisals and revalidations were completed on time. He noted that dedicated support arrangements and the use of a Group-wide approach had strengthened the process.

Peter Sedman advised that a recent review by the Responsible Officers Liaison Officer had provided positive feedback on the arrangements in place across both organisations, recognising them as an example of good practice.

Peter Sedman confirmed that revalidation completion rates remained high and that there were no significant concerns to report.

Peter Sedman noted that the medical appraisal and revalidation process had developed significantly in recent years and was now operating effectively across both organisations. He highlighted improvements in the availability of appraisers, which had helped ensure appraisals were completed on time.

David Sulch sought assurance regarding the number of missed appraisals reported for HUTH and requested further context on the reasons for this and any actions being taken to improve completion rates. Peter Sedman agreed to review the position regarding missed appraisals at HUTH and provide further detail. He noted that appraisal completion had improved significantly over the past year and that previous difficulties in securing appraisers had largely been resolved due to increased appraisal capacity and improved processes.

Julie Beilby requested that an update on the missed appraisal position at HUTH be added to the action tracker and reported back to the Committee as part of the annual update.

Action: Peter Sedman to feedback further context on the reasons for HUTH missed appraisals.

Peter Sedman also updated the CiC that the medical appraisal process had changed in recent years, with the Responsible Officer role now operating separately from the Chief Medical Officer role. He explained that appraisal arrangements differed across the North and South Banks, reflecting historical ways of working.

David Sulch noted that he was able to take reasonable assurance from the South Bank report but had concerns about the number of missed appraisals reported at HUTH. Julie Beilby concluded that the CiC would take reasonable assurance for the South Bank and limited assurance for the North Bank, pending further clarification on the number of unauthorised missed appraisals.

5. ITEMS FOR INFORMATION

5.1 Workplan (Deep Dive additions)

The Committee agreed that a revised work plan would be developed by the Committee Chairs, Executive Team and Murray Macdonald ahead of the next meeting to ensure a more aligned and focused approach to future business.

5.2 Minutes of Workforce Transformation Group

Nothing raised.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Nothing raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note

7.1 Matters to be Referred to other Board Committees

None to note

7.2 Matters to be escalated to the Trust Boards including any proposed changes to the BAFs

The CiC alerted the Board to issues relating to the Care Group Restructure programme, potential impact of resident Doctor and Consultants industrial action, the Workforce Report, including the need for clearer links between workforce and financial performance and The Guardian of Safe Working Hours reports.

They advised to the Board potential industrial action in the future for Consultant's and recognised the full refresh of the BAF.

They gave assurance to the Modern Slavery Statement, Nursing and Midwifery Education report and the Revalidation Report.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

Wednesday 23 September 2026 at 9am till 12.30pm, Via MS Teams

The Committee Chair closed the meeting at 11.31am.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2026/2027

Name	Title	2025/26											
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y		Y		Y							
David Sulch	Non-Executive Director (HUTH) / Chair	Y		Y		Y							
Simon Nearney	Group Chief People Officer	D		D		D							
Amanda Stanford	Group Chief Nurse	D		D		D							

Jo Ledger	Interim Group Chief Nurse	D		D		D							
Kate Wood	Group Chief Medical Officer	D		D		D							
Vacant	Non-Executive Director (HUTH)	Y											
Vacant	Non-Executive Director (NLaG)												
Vacant	Non-Executive Director (HUTH)												
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y		D		D							

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 27th May 2026 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Julie Beilby	Non-Executive Director (NLaG)
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement (attending for Group Chief People Officer)
Professor Jack Kastelik	Consultant in General Medicine (attending for Interim Group Chief Medical Officer)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Lauren Rowbottom	Personal Assistant (Minute Taker)
Myles Howell	Director of Communications & Engagement
Lucy Vere	Group Director of Learning and Organisational Development
Wendy Page	Care Group Nurse Director
Helen Marks	Senior HR Consultant

Observers:

Clare Woodard	Governor Observer

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees-in-Common Chair welcomed those present to the meeting. Apologies for absence were noted for Dr Kate Wood, Group Chief Medical Officer, Simon Nearney, Group Chief People Officer, Peter Sedman, Deputy Group Chief Medical Officer (attending for Group Chief Medical Officer), David Sharif, Group Director of Assurance, Fran Moverley, Freedom to speak up champion, Jo Ledger, Deputy Group Chief Nurse.

1.2 Staff Charter and Values

David Sulch noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 25th March 2026

The minutes of the meeting held on 25th March 2026 were accepted as a true and accurate record.

1.5 Matters Arising

None to raise.

1.6 Committees-in-Common Action Tracker

Updates to the Action Tracker were provided within the agenda items.

1.7 Urgent and Emerging Issues

Paul Bunyan highlighted the upcoming closure of consultant and SES ballots in early July, noting the significant cost pressures and operational disruptions caused by previous industrial actions, and flagged this as an ongoing risk.

Julie Beilby raised concerns following the hot weather over the bank holiday week noting staff on social media pages faced confusion on the use of fans and uniform protocol. She added that guidance wasn't posted on the Group intranet until after the heatwave had passed. Wendy Page reassured the CiC that communications were being updated and proactive guidance would be issued in advance of hot weather.

Paul Bunyan committed to developing a standardised hot weather protocol to ensure timely and consistent guidance on uniforms, fan usage, and infection control.

Helen Marks inquired whether wellbeing checks were being conducted in relation to staff on the wards. Wendy Page reassured that a daily huddle is held every morning, and reminders are sent through that channel to ensure wellbeing checks and additional ward rounds are conducted.

2. MATTERS REFERRED

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

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate

None to note.

3.2 Review of Relevant External Reports, Recommendations & Assurances as appropriate

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 People Strategy Progress Report – Q4

Paul Bunyan gave an update on the People Strategy informing the CiC that a lot of the quarter 4 position was related to the planning of quarter 1.

He gave some positive insight into the performance position, such as reducing 2.4% of overall gross pay bill following significant reductions in agency usage. He reported the Group was achieving the 30% reduction from quarter 1 of agency usage.

Paul Bunyan reported that the Group met the 95% target in job planning, expressing further work was required to link capacity and demand. He updated that Sam Peate (CDO) was running training across the Group to aid in this.

Paul Bunyan updated that Health and Wellbeing target had been achieved at NLaG and was 0.2% under position at HUTH, despite the report submitted to the CiC showing this wasn't achieved. He added that the figures would be updated and recirculated to the CiC. Most pressures in this area related to burn out.

Paul Bunyan reported that the Group reported to hit the flexible working and appraisal target. The area which did not hit target fell under the culture and engagement criteria. He announced that first year turnover and turnover both met their target areas. Nationally the Group had a low turnover, but noted a decline nationally due to uncertainties within the workforce position.

Paul Bunyan explained that a lot of work had been underway to ensure the Organisation was utilising all the digital products such as Health Roster to increase productivity and efficiency positions.

Paul Bunyan reported that Wendy Page and Jo Ledger had been creating ward action cards to ensure robust processes where in place to ensure deployment of staff was efficient.

Myles Howell gave an update on the culture and engagement piece of work, as well as the Pulse survey results. He expressed the key approach to improving the culture was to improve the senior leadership visibility across the Organisation. Part

of this work was identifying areas that the Senior Leaders Team (SLT) can visit each quarter. He informed the CiC that he and Lucy Vere began these visits by visiting Rehab.

Myles Howell hopes that following the SLT visiting these areas they can identify any quick wins, any feedback or support required, any long-term issues and work with the Learning Improvement Safety Academy (LISA) to triage any issues arising. He added that the SLT are cited on what is expected of them and feel comfortable with what is expected following two briefing sessions led by Sam Peate.

Myles Howell reported that the Pulse survey had gone backwards in comparison to the staff survey, noting that the Pulse survey usually deteriorates. Myles Howell described how the staff survey feedback showed that staff didn't want to recommend the organisation as place to work or receive care/treatment, noting that the overarching effort was to make staff feel assured that the Group was focusing on patient care, safety and experience.

Lucy Vere explained how she had been working with Sue Page and Scott Fitzgerald on the LISA programme mapping out each quarter and focusing on practical delivery and aiming to get an integrated service.

Lucy Vere expressed the communications team had been helpful with creating visibility, including creating clear branding and an easy access portal on Bridget by mid-June.

Lucy Vere communicated that the team had done a surgical safety day as part of the LISA agenda, which helped the team understand the never ever events in a restorative approach which created an action plan and new learning approach.

Lucy Vere explained how the Group had created an Operational Managers Essential Programme in collaboration with 'getting it right first time' that focuses on training and capacity and demand. The programme was currently working on reducing the wait to 1st outpatient appointment over the next 8 weeks.

Julie Beilby thanked everyone for the work and updates. She questioned what was being done about the mandatory training alert as this was a red flag at two CiC's. Lucy Vere explained how NLaG and HUTH both had different ways of learning, but both trusts had a lot of people trained to train the trainer. She added that a lot of work needed to be done with nursing teams to identify barriers, and a permanent simulation nurse lead was now in place and she was working with Paul Bunyan's team around further recruitment to promote carrying out training in their own areas.

Jack Kastelik gave thanks to Lucy Vere's team for the excellent work undertaken with Gastroenterology at NLaG, adding it was very beneficial and provided assurance to post-graduates.

Julie Beilby felt disappointed to see the pulse surveys being low following the programmes of work and effort and needed to see a shift to get out of tier 5. Myles Howell agreed, however pointed out that the pulse survey does not inform the NOF rating. He explained that they were speaking to a number of Organisations who were doing well with their staff surveys to learn from them.

David Sulch praised the reduction in never events, and pointed out that fixing staff experience and survey results was also about operational experience.

Helen Marks praised the programme and the work being undertaken but asked if it would be useful to bring the KPI's to the CiC that show how the work is making a positive impact on the next staff survey.

Julie Beilby acknowledged that the staff survey did not feed into the NOF rating and was more about the staff and organisational health, but voiced that the Group would not be able to move forward unless this was controlled.

Julie Beilby informed Paul Bunyan she felt it was difficult to track the metrics around reduction in temporary spend and queried how do they pull together some key metrics around the workforce issues. David Sulch seconded this, and stated in the workforce KPI's submitted he could not see the trend lines for the key metrics being tracked for people strategy. Paul Bunyan agreed that the information needed to be consolidated into a report including a breakdown of metrics and would be something he would bring in the future.

ACTION Paul Bunyon to review KPIs to feed into IPR

The Committees-in-Common agreed limited assurance. They noted the good work ongoing, but acknowledged there was some uncertainty on effectiveness as it was too early to see positive outcomes. .

The agenda was taken out of order at this point

Pulse Survey

Myles Howell updated on the pulse survey within item 4.1 but welcomed questions.

4.4

David Sulch queried how much validity was in the low numbers of people who responded to the pulse survey, and noted the data did not show much of a difference from the staff survey and national picture and was this a cause for concern. Myles Howell reassured that this was not a cause for concern, as the majority of responses reflect office staff rather than the Organisational view. However, he explained it did reflect how support services were feeling. Julie Beilby noted some learning could be taken from this for effective communication and how the Group was deciding on efficiency savings.

David Sulch felt uneasy around the reward and recognition, worried that some people delivering excellent patient care within the Group would fly under the radar. Myles Howell reassured the CIC that nobody within the Group was disqualified, or would be exempt from receiving a shining light nomination or golden star. Julie Beilby queried whether Non-Executive Directors (NED's) would still present shining lights.
Myles Howell informed the CiC that the Group receives around 150 shining lights every month and welcomed NED visits although it was acknowledged that the NEDs would not be able to attend them all due to the numbers

Action: Julie Beilby and David Sulch to pick up shining light visits in the NED workplans at another meeting.

Julie Beilby questioned if the recruitment of the Health and Wellbeing Practitioners were permanent or fixed term. Paul Bunyan stated these was fixed term, with funding coming from a national funding model but this ended on the 31st March 2026.

The agenda returned to order from here

4.2 **Mechanisms Processes**

Wendy Page explained that the paper submitted outlined the governance arrangement about variable pay costs within clinical areas receiving investment following the SAFER care Nursing tool. She updated that governance arrangements and control measures had been implemented throughout the Organisation by strengthening governance, oversight and strict operational controls.

Wendy Page outlined the introduction of monthly meetings with nurse directors and finance leads to review run rates, roster efficiencies, and approval processes for agency, bank, and overtime spend, ensuring alignment with funded establishments.

The CiC discussed the importance of weekly forecasting meetings with matrons and ward managers to enhance grip and control, with senior nursing teams being held accountable for maintaining financial discipline and patient safety.

Wendy Page informed the CiC that the Emergency Department (ED) on the North Bank had reduced agency staffing by 50% following a reduction in temporary escalation spaces.

David Sulch questioned if the Group was doing anything different following the investment as he expected to see the controls already in place following the previously financial targets. Wendy Page agreed, stating they needed refreshing and reinforcing.

David Sulch asked where reductions in financial spend was being tracked. Paul Bunyan explained this was tracked in the IPR, WEC CiC and Performance, Estates and Finance CiC. Julie Beilby and Helen Marks raised concerns about fragmented data reporting, advocating for the workforce committee to have comprehensive oversight of all workforce KPIs, and for clear escalation pathways to the Board.

Helen Marks stated it was great that the senior nurse leadershp were conducting monthly meetings, and explored the possibility of a weekly meeting which would be a challenge and confirm meeting in order to enhance grip and control.

David Sulch and Julie Beilby thanked Wendy Page for the paper. They agreed to take the current report for information, noting the need for outcome data and metrics before providing assurance on the effectiveness of the controls, and committed to revisiting the topic at a future meeting.

4.3 **Apprenticeship Levy Update following National Guidance**

Lucy Vere apologised for the delay in receiving the report to this CiC.

Lucy Vere explained the government's shift in focus to entry-level apprenticeships for 16–24year-olds, the reduction in levy spend timeframes, and the removal of public funding for level 7 apprenticeships, which had impacted leadership and management development. The leadership and management apprenticeship spending levy had changed from 24 months to 12 months which Lucy Vere noted meant the Group was unable to bank some of the levy.

Wendy Page clarified that, due to financial constraints the number of Registered Nurse Degree Apprenticeships and Nursing Associates had been significantly reduced, with a shift towards Support Worker Apprenticeships, and that the funding model was being finalised for Board escalation. Lucy Vere explained that the Group was not limited, but would work towards over 18s to aid with unsociable working hours.

Lucy Vere gave assurance that the overall Apprenticeship position was in a good place and the Group increased their levy spend from 2.9 million to 3.9 million. She reported that there was some underspend position and Anne Burdis was working with finance teams to create a financing model.

Lucy Vere updated that there was going to be 100 apprenticeship places across three chartered degree programmes: level 3, 5 and 6. She declared these needed to be started before September 2026.

Julie Beilby raised the need for a coordinated approach to Artificial Intelligence (AI) adoption and governance across the partnership, highlighting current gaps in guidance, skills development, and the potential risks. Paul Bunyan explained this was a conversation to be had with Alistair Pickering (Interim Group Chief Digital Officer) in the digital team to explore opportunities posed by AI for workforce roles, and to explore the capabilities and strengthen the General Data Protection Regulation (GDPR) with the current AI tools in the Group. Julie Beilby noted it would be important to see this as an alert item to escalate to the board.

Julie Beilby questioned whether the Registered Midwife Apprenticeships feature in SAFER Nursing tool and whether this had any impact. Wendy Page explained due to the small numbers it would not impact in the first instance, but could impact going forward as the Group grows their own Registered Midwives. Wendy Page emphasised the importance of working with the Maternity service to improve the culture.

Break commenced at 10.30 for 15 minutes

Elizabeth Houchin joined the meeting at 10.45

4.5 Freedom to Speak Up Quarterly Report - HUTH & NLaG

4.5.1 Freedom to Speak Up Report - Q3 and Q4 Report - HUTH

Elizabeth Houchin gave a brief update in the absence of Fran Moverley.

She reported that HUTH saw 307 concerns raised in the year, a 13% increase from the previous year and the highest ever reported, with the top reasons being poor behaviours, concerns about role, and general concerns.

Elizabeth Houchin noted a significant increase in cases from admin and clerical staff at HUTH, followed by nursing and midwifery. The staff survey indicated 11 individuals reported detriment after speaking up, prompting the development of a local detriment guidance, based on national guidance and reviewed by Lindsey Harding, which was now available for staff to access on Bridget.
A feedback survey reported that 100% of staff who had reported would speak up again.

The Committees-in-Common agreed significant assurance.

4.5.2 **Freedom to Speak Up Report - Q3 and Q4 Report - NLaG**

Elizabeth Houchin took the report as read. She updated that NLaG had 388 concerns, slightly lower than the previous year at 401 concerns. Worker safety, HR process, and inappropriate behaviours as main themes. 3 concerns were raised anonymously in quarter 4, concluding 10 raised anonymously throughout the year which was below the national average. Nursing and Midwifery was the highest reporting profession.

The latest Freedom to Speak up (FTSU) survey results showed a decline in staff being able to raise concerns in clinical practice, but did see an increase in confidence that the Organisation would address the concern. The report also showed an increase in confidence to use the FTSU guardian to raise a concern.

Elizabeth concluded that both trusts (HUTH & NLaG) where below the national and regional average.

Julie Beilby expressed disappointment seeing the detriment figures and endorsed integrating detriment management into existing HR policies rather than creating a new one and clarified that issues involving board members would be escalated to the Chair of WEC, with NED involvement as needed.

Julie Beilby cited that it was important to have a radar on how the group manages staff within clerical and administration following the pulse survey reporting a higher degree of less settled staff in this area. She went on to thank Elizabeth Houchin and Fran Moverley for all their hard work through the year.

Helen Marks praised the report and wondered how they were going to close the loop on lessons learned and how they’re going to incorporate these into training programmes. Elizabeth Houchin explained that high-level stories are published monthly on the Bridget page, and themes are discussed with care group leads and medical directors, with relevant learning shared with Lucy Vere as appropriate. Helen Marks asked if it would be helpful in future reports to talk about lessons learnt and any training that has been completed.

Paul Bunyan reassured the CiC that HUTH would see an improvement in Administration staff following recruiting into vacant positions in patient experience.

David Sulch queried the difference in trends between HUTH and NLaG, and Elizabeth Houchin attributed NLaG's plateau to dedicated communications support, while HUTH's increase may reflect growing awareness of the service. She also noted that her absence in late March may have affected reporting figures.

Julie Beilby asserted that inappropriate behaviours within the Organisation are never acceptable, but felt assured by Elizabeth Houchin and Fran Moverley that these incidents related to a culture broader issue around behaviours towards colleagues.

The Committees-in-Common agreed significant assurance. The CiC recognize the challenges the Organisation is facing and continue to support the work Elizabeth Houchin and Fran Moverley do.

Elizabeth Houchin left the meeting at 11.00

4.6 **Undergraduate Medical Education Six-month Progress Report – NLaG**

Jack Kastelik provided a brief update on undergraduate medical education. He confirmed that there were no major issues reported by the outgoing clinical dean, and that recruitment for the site clinical dean at HUTH and the group undergraduate clinical dean was underway.

Julie Beilby highlighted the need for transparency in undergraduate funding at NLAG, noting historical challenges, and requested an update on when care groups would receive clarity on funding allocations to support teaching.

Julie Beilby noted that student feedback remained very positive, with 99% recommending placements, and congratulated NLaG for receiving four of the eight Hymms Teaching Excellence Awards, suggesting these achievements be escalated to the board.

David Sulch asked about the risk of not recruiting all six teaching fellows for bedside teaching. Jack Kastelik responded that, nationally, there was a shortage of training posts, making these roles attractive, and historically there had been no recruitment issues.

The Committees-in-Common agreed reasonable assurance. Julie Beilby and David Sulch agreed that while the quality of teaching and student experience was high, assurance remained 'reasonable' until funding clarity was achieved and transparently reported.

4.7 **Operational Workforce Planning Processes: including Job Planning**

Paul Bunyan took the report as read. He explained the national approach to job planning, the limitations of the 12-month business cycle, and the need to align business planning with clinical strategy, highlighting the complexity of managing 16

care groups with separate plans and the importance of identifying critical investments and potential areas for de-investment. He added that Sam Peate the Group Chief Delivery Officer was working with all the Care Groups to understand their current position.

Paul detailed the operational plan's focus on substantive, agency, and bank workforce, cost improvement targets, and the interplay between headcount reduction, variable pay, and non-pay work streams, with monthly monitoring against planned and actual baselines.

Paul Bunyan reported that HUTH's sickness rate was 4.4% (below national average), NLAG's was 5.4%, and job planning compliance was at 95% for both organisations. He described ongoing efforts to improve reporting dashboards, track team-based job planning, and manage headcount reduction through various work streams.

Paul Bunyan shared a presentation to the CiC that outlined all HHP substantive WTE changes in finer detail.

Julie Beilby expressed that she found the presentation very helpful but challenged how the metrics could be captured in a simple way to aid in understanding and give assurance to the Board. She queried what metric was the top target for workforce reduction vs variable pay. Paul Bunyan informed that the Group was underway with an operational transformation piece, and Urgent and Emergency Care (UEC) transformation was the most urgent. He voiced plans to aid in patient flow, reduce corridor care and the overall transformation of the UEC floor. Julie Beilby added it would be helpful to see the key metrics within the Integrated Performance Report (IPR). Paul Bunyan agreed that the reporting cycle needed to be increased and how often this came to the CiC for assurance.

Action: Paul Bunyan to review and simplify the current IPR to embed key workforce and financial metrics, ensuring clear and coherent reporting for committee assurance.

Helen Marks felt that it would be beneficial to see the trajectories in relation to variable pay within an IPR.

Helen Marks discussed the need for clarity on PMO versus improvement capacity, with ongoing mapping of improvement capability and plans for further discussion at board level. Julie Beilby suggested a meeting with Paul Bunyan and Helen Marks to plan a step change in reporting before the July board.

David Sulch thanked Paul Bunyan for the comprehensive information given.

Helen Marks advised that it would be helpful to be clear on the ask around capacity. Lucy Vere replied that she was looking at all the roles and a paper would be created to understand what is needed.

The Committees-in-Common agreed limited assurance due to challenges in triangulating data and the pace of transformation and recommended escalating these concerns to the board.

4.8 Target Operating Model for People Services

Paul Bunyan shared his screen to present a presentation to the CiC. He outlined the national plan to scale up transactional people services such as payroll and recruitment at regional level. He stated this had been piloted in London Trusts already. He noted the lack of clarity on rollout timelines, regional leadership, and the impact on local outsourcing plans, with KPMG invited to present to regional people services leads for further insight.

Paul Bunyan explained that People Services was an NHS England scheme which would come with a significant financial benefit of around 65-77 million per region two years of implementation.

Paul Bunyan gave an insight into the Digital First HR Strategy which would replace the current system of ESR. He reported the new system would be more user friendly for staff and managers. With the new system there would come singular policies across the NHS in the country, which would allow AI bots to answer any policy-based questions. He expressed he was unsure what the new system would look like but would be attending a meeting to get learning of what's taken place in Southern Trusts.

Helen Marks wondered whether it would be beneficial to have a board development session to understand the initiative, noting that a maturity assessment would be required and that the organisation.

Lucy Vere highlighted the need to consider local operational differences such as equipment and training when implementing regional solutions, and questioned how feedback from provider-level teams would be incorporated into the national model.

The Committees-in-Common agreed limited assurance.

Peter O'Sullivan joined the meeting at 12.00

5. ITEMS FOR INFORMATION

5.1 Occupational Health Annual Report

Peter O'Sullivan took the report as read updating that Occupational Health (OH) services had a standardised policy across the Group under 1 single leadership. He noted differences with the digital formats across the North and South Bank which would continue due to high costs to integrate the systems.

Peter O'Sullivan informed the CiC that staff turnover had impacted how the OH service was running and the team was looking at ways how the Service can invest in staff. The North bank showed mostly retirements.

Peter O'Sullivan described the Employee Assistant Programme (EAP) was a valuable, externally provided counselling and support service, with contract costs set to increase but assured it was still competitive. He added that the EAP would be a single point of access for staff and Managers. Julie Beilby emphasised the importance of maintaining EAP support, including Freedom to Speak Up Guardians, as national support had now ended.

Julie Beilby queried whether the investment into the IT services was being considered to which Peter O'Sullivan explained that the systems was already in place but the backgrounds of the systems was different, noting it would be a cost of around £1000 to merge them.

Julie Beilby queried the higher referral numbers from South Bank. Peter O'Sullivan attributed this to policy alignment and increased referrals, with ongoing work to educate managers and standardise processes. He added that higher sickness and vacancy rates at NLaG explain increased activity.

Julie Beilby voiced she was a supporter of the EAP programmes.

The Committees-in-Common agreed limited assurance.

Peter O'Sullivan left the meeting at 12.10

5.2 **Workplan (Deep Dive additions)**

This CiC agreed that future deep dives would be identified following the reports brought to the meeting in July.

5.3 **Minutes of Workforce Transformation Group**

None to note

6. ANY OTHER URGENT BUSINESS

6.1 **Any Other Urgent Business**

Julie Beilby queried whether the Workforce Transformation Group had recently met. Lucy Vere explained the last meeting was cancelled in April due to the industrial action, and the next one was due to take place the following day.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note

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

None to note

7.2 **Matters to be escalated to the Trust Boards including any proposed changes to the BAFs**

The CiC alerted to the Board issues in Staff Survey/Pulse Survey Q1, Resident doctor industrial action and financial impact, the Workforce consolidated report, AI

usage and governance arrangements, Operational Workforce Planning and Job planning.

They advised to the Board the ATHENs training, Apprenticeship Levy – national funding changes continue to constrain levy spend, and the Transforming People Services.

They gave assurance to Agency expenditure which met target, LISA, Freedom to speak up annual reports HUTH/NLAG, Undergraduate Medical Education Report, and the Occupational Health Annual Report

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 22 July 2026 at 9am till 12:30pm, Via MS Teams

The Committee Chair closed the meeting at 12.20 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2026/2027

Name	Title	2025/26											
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y		Y									
David Sulch	Non-Executive Director (HUTH) / Chair	Y		Y									
Simon Nearney	Group Chief People Officer	D		D									
Amanda Stanford	Group Chief Nurse	D		D									
Jo Ledger	Interim Group Chief Nurse	D		D									
Kate Wood	Group Chief Medical Officer	D		D									
Vacant	Non-Executive Director (HUTH)	Y											
Vacant	Non-Executive Director (NLaG)												
Vacant	Non-Executive Director (HUTH)												
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y		D									

KEY: *Y = attended* *N = did not attend* *D = nominated deputy attended*

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)263

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Keith Haynes, Interim Board Secretary
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 - V23

Hull University Teaching Hospitals NHS Trust

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**	09.10.26 **Boardroom, HRI**	12.11.26 **Boardroom, DPOW**	10.12.26 **Boardroom, DPOW**
HUTH Annual General Meeting & NLaG Council Of Governors Annual Members Meeting (Virtual Meeting)										14.10.26 (2.30 pm - 5.00 pm)		
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	06.01.26 **Virtual Meeting**	03.02.26 **Virtual meeting**	03.03.26 **Virtual Meeting**		05.05.26 **Virtual Meeting**	02.06.26 **Virtual Meeting**	07.07.26 **Virtual Meeting**	04.08.26 **Virtual Meeting**	01.09.26 **Virtual Meeting**	29.09.26 **(please note falls in September)** **Virtual Meeting**	03.11.26 **Virtual Meeting**	01.12.26 **Virtual Meeting**
Strategic Programmes & Partnerships (Thursdays - 9.00 am - 12.00 pm with exceptions as stated)						30.06.26 **Virtual Meeting**			17.09.26 **Virutal Meeting**			15.12.26 (Tuesday - 1.30 pm - 4.30 pm) **Virtual Meeting**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		26.02.26 **Virtual Meeting** (1.00 pm - 4.00 pm)	26.03.26 **Virtual Meeting**	30.04.26 **Virtual Meeting**	28.05.26 **Virtual Meeting**	25.06.26 **Virtual Meeting**	23.07.26 **Virtual Meeting**		24.09.26 **Virtual Meeting**	29.10.26 **Virtual Meeting**	26.11.26 **Virtual Meeting**	17.12.26 **Virtual Meeting**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)					26.05.26 **Cancelled**			05.08.26			19.11.26	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	28.01.26 **Virtual Meeting**		25.03.26 **Virtual Meeting**		27.05.26 **Virtual Meeting**		22.07.26 **Virtual Meeting**		23.09.26 **Virtual Meeting**		25.11.26 **Virtual Meeting**	
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	22.01.26 **Virtual Meeting**			23.04.26 (subject to NHSE Submission Deadline **Virtual Meeting**		18.06.26 HUTH & NLaG **Annual Accounts** 1.30 pm - 4.30 pm **Virtual Meeting**	30.07.26 **Virtual Meeting**			15.10.26 (1.00 pm - 4.30 pm) **Virtual Meeting**		
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	15.01.26			01.04.26			08.07.26 **Boardroom, DPOW**			07.10.26		
HUTH (9.00 am - 12.00 pm)		05.02.26			06.05.26			06.08.26			20.11.26	
Executive Team Meetings												
Group Cabinet Meeting	06.01.26 13.01.26 20.01.26 27.01.26	03.02.26 10.02.26 17.02.26 24.02.26	03.03.26 10.03.26 17.03.26 24.03.26 31.03.26	07.04.26 14.04.26 21.04.26 28.04.26	07.05.26 27.05.26	03.06.26 09.06.26 17.06.26 25.06.26	07.07.26 21.07.26	04.08.26 18.08.26	01.09.26 15.09.26 29.09.26	13.10.26 27.10.26	10.11.26 24.11.26	08.12.26 22.12.26
SLT (Tuesdays - 2.00 pm - 5.00 pm)					05.05.26 19.05.26	02.06.26 16.06.26 30.06.26	14.07.26 28.07.26	11.08.26 25.08.26	08.09.26 22.09.26	06.10.26 20.10.26	03.11.26 17.11.26	01.12.26 15.12.26
Financial Planning & Improvement Board (Mondays - 2.00 pm - 4.00 pm)	12.01.26 26.01.26	09.02.26 23.02.26	09.03.26 23.03.26	13.04.26 27.04.26	11.05.26	08.06.26 22.06.26	13.07.26 27.07.26	10.08.26 24.08.26	14.09.26 28.09.26	12.10.26 26.10.26	09.11.26 23.11.26	14.12.26
Clinical Policy Group												
Clinical Policy Group										01.10.26 9.00 am - 12.00 pm Old Canteen, GDH	05.11.26 9.00 am - 12.00 pm Old Canteen, GDH	03.12.26 9.00 am - 12.00 pm Old Canteen, GDH
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	

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)264

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in June 2026. The report includes documents sealed by Hull University Teaching Hospital (HUTH) NHS Trust during this period. Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust had no documents sealed during this period.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Use of Trust Seal – October 2026

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at HUTH has been used on the following occasions, NLaG did not have any documents sealed during this period:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
NLaG Documents Sealed			
	No documents sealed during this period		
HUTH Documents Sealed			
2026/03	HUTH and Alliance Medical Ltd Renewal lease by reference to an existing lease	Sam Peate & Peter Sedman	07.07.2026
2026/04	Hull and East Yorkshire Medical Research Centre, HUTH and Inhealth Ltd Licence for agreement for underlease	Sam Peate & Peter Sedman	07.07.2026
2026/05	Hull and East Yorkshire medical Research Centre, HUTH and Alliance Medical Ltd Licence to underlet	Sam Peate & Peter Sedman	07.07.2026
2026/06	HUTH and Alliance Medical Ltd Renewal lease by reference to an existing lease	Sam Peate & Peter Sedman	07.07.2026
2026/07	HUTH and Hull and East Yorkshire Medical Research Centre (Daisy Appeal) and University of Hull Licence to occupy relating to the 2nd floor of the Daisy Building, CHH	Lyn Simpson & Emma Sayner	19.08.2026
2026/08	HUTH and East Yorkshire Aluminium and Glass Ltd and Hobson and Porter x 3 Sub-contractor's deed of warranty in favour of a landlord relating to development at CHH	Emma Sayner	10.09.2026
2026/09	HUTH and Arrow Industrial Group Ltd and Hobson and Porter x 3 Sub-contractor's deed of warranty in favour of a landlord relating to a development at CHH	Emma Sayner	10.09.2026

2026/10	HUTH and Securerail Ltd and Hobson and Porter Ltd Sub-contractor's deed of warranty in favour of a landlord relating to a development at CHH	Emma Sayner	10.09.2026

Action Required

The Trust Boards-in-Common are asked to note the report.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)272

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	9 October 2026 (note that virtual approval was sought in order to submit the assessment to meet the 2 October deadline)
Director Lead	Keith Haynes, Group Governance Secretary
Contact Officer / Author	Keith Haynes, Group Governance Secretary
Title of Report	Provider Capability Assessment 2026
Executive Summary	The annual NHS England (NHSE) Provider Trust Capability Assessment requires Boards to undertake an evidence-based self-assessment of organisational capability across six domains aligned to the Insightful Provider Board framework. The assessment forms part of the NHSE oversight arrangements and will be considered alongside organisational performance, leadership capability and wider intelligence to inform future oversight and support arrangements. Contributions have been received and consolidated into a single return while clearly identifying any differences in capability across the two Trusts. The assessment identifies key strengths, areas for development and actions underway to address gaps. The Trust Boards-in-Common is asked to review and ratify the self-assessment, agree the final domain ratings and authorise submission to NHS England by 2 October 2026.
Background Information and/or Supporting Document(s) (if applicable)	Assessing provider capability: guidance for NHS trust boards – can be found at NHS England » Assessing provider capability: guidance for NHS trust boards The insightful provider board can be found at NHS England » The insightful provider board **Appendix A** – Provider capability self-assessment template 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:

Introduction and background

1.1 This report presents the draft annual Provider Trust Capability Assessment, which NHS England (NHSE) requires all provider organisations to complete as part of its oversight framework.

1.2 As part of its oversight approach, NHSE assesses provider capability alongside National Oversight Framework (NOF) segmentation to determine the level of support, intervention and oversight required.

1.3 Trusts are required to complete a self-assessment of their organisational capability. This self-assessment is organised around the six domains set out in the Insightful Provider Board framework:

- strategy, leadership and planning
- quality of Care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

1.4 The assessment is designed to focus Board attention on the key capabilities required for effective organisational leadership and governance, while supporting a culture of openness and transparency between providers and oversight teams.

1.5 NHSE North-East and Yorkshire (NHSE NEY) will consider the Group's self-assessment alongside its own assessment of organisational performance, leadership capability, recent delivery record and relevant third-party intelligence. A key consideration is organisational 'grip', including the Board's ability to identify challenges, maintain control and deliver sustainable improvement.

1.6 Following national moderation and NHSE Executive Board ratification, a final capability rating will be confirmed and will inform the future oversight relationship.

1.7 While the assessment draws significantly on the Insightful Provider Board Framework, it is not intended to be a compliance exercise. Its primary purpose is to encourage honest self-reflection, strengthen organisational self-awareness and provide a clear understanding of the Trust's strengths, development areas and improvement priorities.

2. Self-Assessment

2.1 The Partnership is required to complete an organisational capability self-assessment. The completed assessment must be ratified by the Boards-in-Common and submitted to the NHSE regional oversight team by **5.00pm on Friday 2 October 2026**.

2.2 The assessment framework supports Boards in evaluating organisational capability through a RAG-rated self-assessment (Green, Amber-Green, Amber-Red or Red) against the six capability domains (definitions are described in Appendix A).

2.3 The self-assessment should reflect an evidence-based and balanced view of current organisational capability, recognising both areas of strength and those requiring further development and should demonstrate the Board's understanding of the actions required to sustain improvement and address identified gaps.

2.4 The Interim Board Secretary has coordinated the self-assessment process, with all contributions now received. This intelligence has been consolidated into a single return while clearly identifying any differences in capability across the two Trusts providing a

collective assessment of current capability, identified gaps and planned actions and supporting examples of evidence.

3. Next Required Steps

3.1 All Board members are now asked to;

a) Review the self-assessment template (Appendix A) and confirm that the assessment accurately reflects the extent to which the organisation meets each capability statement.
b) Ensure that the evidence underpinning each assessment is clearly documented.
c) Confirm or challenge the four-point RAG rating system reach an agreed assessment for each capability area.
d) Formally ratify the completed self-assessment and authorise submission through endorsement by the Chair and Chief Executive Officer.

Provider capability self-assessment template 2026

Provider name:	**NHS Humber Health Partnership** (Hull University Teaching Hospitals NHS Trust & Northern Lincolnshire and Goole Hospital NHS Foundation Trust)

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to england.neyoversightregulation@nhs.net by **5pm Friday 2 October 2026**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Red
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Group continues to collaborate with a wide range of system partners within the Humber and North Yorkshire Health and Care Partnership and Integrated Care System (ICS), including: • Local authorities across six "Places" • Acute, mental health, and community NHS trusts • Voluntary and community sector organisations • GP practices over 230) and care homes • Ambulance providers The Group's strategy (2025 – 2030) reflects six domain themes – Patients, People, Population, Pioneering, Public Purse and Partnerships. These reflect our priorities of delivering outstanding patient care, having staff who are proud to work here, would recommend the organisation as a place to work and supporting the ICS goal of having our population live more years in good health. Pioneering reflects our ambition to move from analogue to digital services in line with the 10-year plan, work effectively with public and private partnerships and deliver financial balance as well as good value for public money. Supporting this is a suite of group-wide strategies covering areas such as digital, research, people, clinical services and partnerships, providing a coherent framework for the delivery of organisational priorities. The Board routinely considers forward-looking strategic matters, including three-year planning horizons, quality priorities and the implications of emerging challenges and opportunities. Further development is now required to finalise and refresh several supporting strategies, including Quality & Safety, Estates and Health Inequalities, alongside a wider review of the strategic portfolio to assess progress and ensure alignment. The recent establishment of the Clinical Policy Group and Senior Leadership Team provides a stronger mechanism to harness clinical and executive expertise in strategic discussion, planning and decision-making. The next phase of work is to strengthen delivery through clear ownership, defined plans and milestones, while ensuring routine Board oversight and robust accountability for outcomes. This work is being progressed through the Board and Executive Development workstream within the Integrated Improvement Plan (IIP). Our Digital Strategy identifies five key missions: • unlocking productivity; • building our foundations; • improving our use of data; • establishing a virtual care approach and • embedding digital inclusion in everything we do. The roadmap for these missions and the metrics against which success is measured are described and outline the key work areas for delivery. The Digital portfolio reports into our Performance, Estates and Finance (PEF) Committee in Common, with assurance reports on Information Governance, Cybersecurity and the linked CAF-DSPT audits reporting to the Audit Risk and Governance (ARG) Committee. Our Board Assurance Framework (BAF) is currently being refreshed but includes Cybersecurity, Digital Transformation capacity, Digital Foundations and system resilience and Artificial Intelligence – opportunities and threats. Cybersecurity and system resilience has always been managed through the corporate risk register, reporting into ARG.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	

	The current programme of work for digital teams has been mapped to the newly established, IIP, (which closely links to our Financial Recovery plan) to ensure that the projects and systems being delivered aligns to the critical delivery items needed for both organisations. Current programmes include; • enhancing our patient portal functionality to improve flexibility for patients and improving patient access options; • establishing a centralised patient flow coordination centre to improve patient flow through our beds and support our unplanned care pathways; • working across the outpatient transformation programme to support clinic kiosks, wayfinding, referral management, waiting list validation and; • establishing the nationally mandated single point of access approach. We continue to deliver our EPR programme, seeking to align with national plans to converge systems and support acute service delivery, reducing multiple system management, simplifying the experience for clinical staff and aligning clinical and operational services. The work across the Group to deliver a single data warehouse, integration engine, enterprise architecture, EPR and virtual care offers also includes direct integration to the Yorkshire Care Record supporting the wider ICB and regional data sharing approach. Other critical programmes of work include support for our diagnostics pathways through upgrades to our PACS and LIMS systems, implementing platforms that will be able to deliver AI supported future models of service. This has been further supported through the national DDCP 2 programme and Cancer Alliance funding. We are working closely with NHSE GIRFT programme digital partners Isla to deliver the Digital Pathway platform across four of our critical pathways as well as 8 other GIRFT identified pathways to enhance our service delivery for patients. We are actively engaged in the latest national Digital Maturity Assessment exercise with areas for improvement identified from our previous self-assessments. Our teams supported a 2026 HSJ Digital Award-winning initiative, Driving Change through AI & Automation. Working collaboratively across digital, clinical and R&D services, the vascular team developed an AI-enabled model using the TRAFIC tool to deliver tailored vascular risk assessments.
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The Group is currently navigating a period of significant organisational change following recent developments regarding the future operating model of Humber Health Partnership (HHP) and the proposed transition to separate Trust arrangements. As a result, work to strengthen Board and Executive effectiveness remains at an early stage of mobilisation and is being reviewed to ensure it aligns with the emerging governance, leadership and organisational requirements of the individual Trusts. Prior to these recent developments, plans were in place to strengthen leadership stability and capacity through substantive Executive and Non-Executive Director appointments. However, these plans will require further consideration in light of the proposed separation, which is expected to necessitate decisions on future Board structures, membership, leadership development priorities, succession planning and governance arrangements. In the interim, the Board and Executive Development workstream remains in place responding to recommendations arising from external reviews and wider leadership improvement priorities. Key early actions have been completed, including the establishment of clearer executive accountability through the review and alignment of executive portfolios and job descriptions, alongside work to clarify Non-Executive Director responsibilities and portfolio ownership. A refreshed communications and engagement approach has also been implemented to strengthen leadership visibility, staff engagement and feedback mechanisms. In parallel, a structured programme of Board and Executive development is being designed with external support, complemented by initiatives remaining in progress, including the development of a behavioural framework that will define expected leadership behaviours, strengthen accountability and improve reporting standards across the organisation. Although these initiatives provide a foundation for strengthening leadership capability, the scope and future direction of development activity will need to evolve as the organisational model becomes clearer.

The immediate focus is therefore on maintaining clear accountability, effective governance and leadership stability throughout the transition period, while developing a clearer understanding of the future capability, capacity and development requirements needed to support independent Boards and Executive teams. This approach will help ensure that leadership arrangements remain fit for purpose both during the transition and within the future operating model.

NHSE Undertakings letter to both Trusts dated February 2026 stated that “the Trusts had both failed to comply with the following conditions of licence: NHS2.5(a), (b), (d), (e), (f) and (g); NHS2.6(a) to (f) and NHS2.2 and 2.4." There are encouraging early signs of improvement, including strengthened corporate governance arrangements, enhanced Board leadership and governance structures, and a continued commitment to working collaboratively and constructively with colleagues supporting the organisation’s improvement journey. These developments demonstrate increasing organisational maturity and a stronger foundation for sustained improvement. However, the Board recognises that both organisations remain in breach of elements of their Provider Licence, including requirements to consistently meet healthcare standards and deliver against operational and strategic planning expectations. While progress is being made, significant work remains to address areas of non-compliance, embed improvements and demonstrate sustainable delivery of required standards and outcomes. The Group remains fully engaged with NHS England and regional colleagues in delivering the actions associated with the NHSE Undertakings.

Board Governance 1.1 Apply principles, systems and standards of good corporate governance. 1.2 Review board leadership and governance arrangements. 1.3 Develop an action plan in response to the findings and recommendations for the review set out in 1.2.
Operational Recovery 1.1 Ensure compliance with health care standards including those set out in operational and strategic planning guidance. 1.2 Co-operate and work with any improvement directors and colleagues supporting approved by NHSE in support of action outlined in 2.1. 1.3 Submit a recovery plan setting out the steps it will take to achieve the actions outlined in 2.1. 1.4 The Recovery Plan must assess senior clinical and operational leadership, operational culture (including the normalisation of emergency department overcrowding), and the required actions. 1.5 The Recovery Plan must specify timescales for completion of identified actions. 1.6 Periodically review and revise the Recovery Plan as required to ensure deliverability and alignment with section 2.1, subject to NHSE approval. 1.7 Deliver the Recovery Plan in accordance with the timescales specified in the Recovery Plan. 1.8 Provide a report demonstrating how the board is assured that the objectives in 2.1 have been met.
Financial Recovery 3.1 Take all reasonable steps to ensure it is applying systems and/or processes to ensure compliance with its duty to operate efficiently, economically and effectively. 3.2 Submit a Financial Recovery Plan to NHSE setting out actions to deliver the objectives in section 3.1, including optimising financial delivery in 25/26, aligning sustainability plans with wider recovery actions, and specifying timescales for delivery. 3.3 Take all reasonable steps to improve its financial position and minimise its external funding requirements both within the 25/26 financial year and on a recurrent basis. 3.4 Deliver services on a financially sustainable basis taking into account; 3.4.1 Alignment with local system service and sustainability plans and strategies including workforce. 3.4.2 – Impact on delivery of other licence conditions including those pertaining to the quality and safety of services.

Funding conditions and spending approvals
4.1 Where interim support financing or planned term support financing is provided, comply with any terms and conditions which attach to the financing. 4.2 Comply with any reporting requests made by NHSE in relation to any financing. 4.3 Comply with any spending approvals processes that are deemed necessary by NHSE.
Delivery of Undertakings
5.1 Implement sufficient governance arrangements to enable delivery of these undertakings. Such governance arrangements must enable the board to: 5.1.1 – Obtain clear oversight over the process in delivering these undertakings; 5.1.2 – Obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and 5.1.3 – Hold individuals to account for the delivery of the undertakings.
Meetings and Reports
6.1 Attend meetings or, if NHSE stipulates, conference or on-line calls, at such times and places, and with such attendees, as may be required by NHSE. 6.2 Provide reports in relation to the matters covered by these undertakings as NHSE may require.

Positively, the CQC Section 31 for Maternity at HUTH was removed in March 2026. However, both organisations subsequently received CQC Section 29A Warning Notices in July 2026 relating to the regulated activity of treatment of disease, disorder and injury, following a Well-Led inspection undertaken between 23 and 25 June 2026. A detailed gap analysis was completed following the Extraordinary Board 05 August 2026, confirming strong alignment between the 4 principal themes identified by the CQC and the existing IIP domains and workstreams. Key priority workstreams have been identified as central to delivering the required improvements before 31 March 2027. The analysis also identified areas where existing plans require further strengthening to fully address the expectations and outcomes of the CQC notices. Dedicated stakeholder sessions were held in September 2026 led by the Group Patient Safety Officer and Chief Nursing Officer, to review these gaps, enhance delivery plans and agree any additional actions required to support compliance, deliver sustainable improvement and strengthen assurance. These actions are progressing supported by the central PMO and the Group continues to maintain regular engagement with the CQC to provide assurance on progress.

Progress continues to be made against the requirements for exiting the highest level of regional and national oversight, with improvement activity being monitored through established governance and assurance arrangements;

Highest-level of oversight transition criteria	Supporting Evidence
Demonstrate continual and sustainable progress against regulatory undertakings. Address findings from previous and current diagnostics and regulatory assessments. Establish a credible and realistic integrated improvement plan.	Integrated Improvement Plan (IIP) ('Listening to Clinicians, Learning from Patients') is now established and the delivery phase is mobilised. The IIP incorporates key workstreams and deliverables to evidence completion for the NOF, regulatory undertakings, CQC 29A, Value Circle and NPIP recommendations into a single framework for prioritised improvement activity through accountable executive SROs. Implementation of robust programme management to drive delivery and oversee the IIP. Operational Plan submission.

	Continued engagement with NHSE Intensive Recovery Support (IRS) and Carnell Farrer Group Model review.
Demonstrate continual and sustainable progress across all areas of the Medium-Term Plan submitted by the Partnership (in quality, finance and performance).	Financial Plan - the Partnership submitted a financial combined deficit of £63 million (HUTH £39.4m / NLAG £23.7m), driven in part by reductions in income, and is required to deliver recurrent savings of at least £105 million during 2026/27. Funding conditions and spending approvals process in place. Financial Recovery Plan (FRP) in place to improve the Partnership's financial recovery plans through establishing new controls to workforce recruitment, variable pay costs and non-pay costs, while also taking further steps to improving the mandated Grip & Control measures as currently being applied across the organisation. In addition, significant changes are enacted to the operation and structure of the PMO, governance meetings, communications, and reporting of CIPs. Implementation of adequate programme management to deliver the FRP via both internal PMO and Grant Thorton support.
Provide sufficient assurance to NHS England North-East and Yorkshire (NHSE NEY) that improvements are robust and will be maintained beyond the period of intensive scrutiny.	Attendance at (NHSE) meetings and provision of reports as and when required.

The Group has fully engaged with the previously known National Provider Improvement Programme (NPIP) following both Trust's move Segment 5 of the National Oversight Framework (NOF) and worked alongside the Improvement Director to enable the mobilisation and assessment phase to be undertaken and shared with the Trust Boards-in-Common July 2026. From April 2026 Partnership has fully engaged with NHSE IRP and Carnell Farrer Group Model review demonstrating a proactive commitment to addressing identified challenges, strengthening organisational performance and supporting sustainable improvement.

<u>Examples of Evidence to Support Domain Response:</u>

- Group and supporting strategies
- Digital and data strategy – linked to the ICS strategy and underpinned by a sustainable financial plan.
- Examples of effective partnership, such as working to deliver data sharing, joint care records, remote consultations.
- Digital maturity self-assessment ratings/standards under What Good Looks Like framework, digital inclusion.
- System wide meeting minutes/forums on digital.
- Digital exemplar status/awards.
- Performance indicators relating to the use of digital services.
- Evidence of compliance with national digital standards.
- Integrated Improvement Plan – Board & Executive Development workstream plans and highlight reports
- CQC 29A gap analysis and actions
- Working with Value Circle to develop robust gap analysis of board skill set

	• Leadership defined portfolios • Board effectiveness reviews • The outputs of board effectiveness reviews from Value Circle and NPIP • Action and mitigation plans in relation to key risks and regulatory requirement – Integrated Improvement Plan • Draft refreshed Board Assurance Framework

II. Quality of care

Capability statements	Proposed domain rating
	Amber-Red
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Trust Boards-in-Common routinely considers a broad range of intelligence, including NHS England guidance, CQC findings, patient safety incidents, mortality and infection prevention indicators, quality priorities and National Oversight Framework measures. This intelligence is used to provide focused scrutiny, identify areas requiring improvement, challenge performance and monitor the delivery and impact of corrective actions. Through strengthened governance arrangements and targeted oversight, the Group is increasingly able to focus on areas of greatest risk, ensuring improvement activity is prioritised and progress is subject to robust challenge and assurance. The Board acknowledges that the CQC Section 29A Warning Notices highlighted significant areas requiring improvement. Many of these risks had already been identified through Board oversight, internal assurance processes and external reviews, with improvement actions already underway. The CQC findings provided additional validation of the concerns identified and reinforced the need to accelerate delivery. In response, the Board is overseeing improvement through the IIP with executive accountability across governance, infection prevention and control, incidents and risks and complaints and PALS. The Board receives regular assurance on quality and safety through the Quality Committee and Board reporting arrangements. The introduction of the IIP governance structure has further strengthened oversight, accountability and pace of delivery against key quality priorities. In addition, the Ward Accreditation Programme is supporting the delivery of consistent standards of care, reducing variation and promoting the adoption of best practice across clinical services. Quality priorities are overseen through the annual Quality Account process and executive-led delivery plans, providing clear accountability and assurance regarding the delivery of improvement objectives. There is evidence of progress across several quality indicators, including improvements in sepsis performance, reductions in MRSA bacteraemia, strengthened Never Event governance resulting in the Group no longer being a national outlier and the successful removal of the Section 31 maternity restrictions at HUTH. These improvements demonstrate the impact of focused board and executive leadership, strengthened governance and targeted improvement activity. However, the Group recognises that performance remains variable in some quality areas e.g. complaints (Group-wide) and PALS (HUTH) continue to experience backlogs and timeliness challenges and further work is required to strengthen the systematic capture, analysis and utilisation of patient experience and feedback. Addressing these issues remains a priority within the IIP and for the Board to ensure that patient feedback is consistently used to drive learning, service improvement and quality assurance. The Board receives assurance through a combination of the Safety and Quality Report, the Integrated Performance Report (IPR), targeted deep-dive reviews in areas of concern and established ward-to-board escalation processes. Complaints and PALS themes, patient safety incidents, mortality reviews and quality metrics are routinely reviewed through formal
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	
8. Systems are in place to	

monitor patient experience and there are clear paths to relay safety concerns to the board	governance arrangements, providing clear escalation routes from frontline services to the Board. The Group recognises, however, that opportunities remain to strengthen the triangulation of intelligence across these sources to improve the identification of emerging themes, enhance organisational learning and provide greater assurance that learning is consistently translated into measurable improvement actions. This has been identified as a priority. Whilst the current IPR provides valuable oversight, the Board acknowledges that it does not yet function as a fully integrated assurance tool. Work is therefore underway to strengthen the IPR by bringing together quality, safety, workforce, and performance intelligence into a more cohesive reporting framework. This will improve the Board's ability to identify relationships between indicators, support risk-informed decision-making and provide a more comprehensive view of organisational performance and quality improvement. Patient experience and safety concerns are visible to the Board through both quantitative and qualitative intelligence. Monthly patient stories provide direct insight into patient and carer experiences and help inform Board discussions. Executive Directors undertake regular visibility visits within clinical areas and Non-Executive Directors are safety champions in key areas and participate in programmes such as Ward Accreditation and PLACE assessments to gain direct feedback from patients and staff. The Group is also reflective about areas where assurance is not yet fully complete. The Learning, Improvement and Safety Academy (LISA) is aiming to provide an improved organisational learning framework with acknowledgement this remains under development. Aspects of organisational culture require further improvement to fully embed a culture of continuous learning and improvement across quality indicators. In addition, the Board recognises that the Board Assurance Framework (BAF) requires strengthening to provide greater visibility of strategic quality risks and stronger integration between risk management, committee oversight and Board decision-making which is currently under review. The Group corporate risk register will be reviewed once the refreshed BAF is complete. Overall, the Group considers itself reasonably assured but not fully assured against these requirements. Continuing to strengthen governance, visible executive leadership, clinically led improvement and active patient engagement provides a solid foundation for improvement. However, further work is required to eliminate performance variation across quality standards, strengthen patient feedback mechanisms, embed organisational learning, improve triangulation of quality intelligence and enhance risk management which will all demonstrate sustained improvement in outcomes for patients. The Board is satisfied that appropriate plans are in place to address these gaps and remains committed to continuous improvement and transparent oversight of quality and patient safety. <u>Examples of Evidence to Support Domain Response:</u> • Quality Accounts • Quality Committee papers and minutes • Quality report to Trust Board-in-Common • IIP workstreams from Quality & Safety / Clinical Governance domain • Maternity Assurance Reports • Ward Accreditation Programme and improvement plans • Draft refreshed Board Assurance Framework • Quality & delivery metrics • Draft refreshed Board Assurance Framework • Board patient stories • NED champion in maternity • Complaints / PALs data reports • Integrated Performance Report

	• Deep dives e.g. IPC

III. People and culture

Capability statements	Proposed domain rating
	Amber-Red
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Group recognises that staff experience and engagement remain central to delivering safe, effective and sustainable care. The 2025 NHS Staff Survey showed encouraging progress compared with 2024: NLAG improved significantly on 22 comparable questions, with no significant deterioration, while HUTH improved on 15 questions, although four questions deteriorated. At theme level, NLAG improved in seven of the nine key areas and HUTH improved in four. NLAG's overall positive-score ranking also rose from 55th to 44th among comparable Picker organisations. These results demonstrate that improvement is possible, while also confirming that both trusts remain below the Picker average for overall engagement and that advocacy—whether colleagues would recommend the organisation as a place to work or receive care—requires sustained attention. During 2026/27, the response is being taken forward through the Staff Culture, Leadership and Experience workstream within the IIP. The National Staff Survey action plan has been approved by the Trust Boards-in-Common and is focused on safety culture, civility and respect, staff voice, equality and inclusion and advocacy. Progress is being supported by stronger clinical engagement through the Senior Leadership Team (SLT) and Clinical Policy Group, Freedom to Speak Up (FTSU) focus groups, active staff networks and the development of a single culture and workforce assurance framework that brings together staff survey results, pulse surveys, workforce indicators, concerns and local intelligence. This will enable emerging risks to be identified earlier, targeted support to be directed to teams and progress to be tracked more systematically from ward and service level through to the Board. The Your Voice Matters programme is a key part of this approach. Each quarter, 64 senior leaders, including executive directors, are expected to visit a team or service for a structured listening conversation or walkaround. Sessions focus on 3 questions: • what is working well; • what is getting in the way of delivering the service colleagues want to provide; and • which three changes would make the greatest positive difference. The aim is to improve leadership visibility, understand working life directly from teams and turn feedback into practical action. Quick wins are progressed wherever possible, while more complex issues can become locally led improvement projects supported by Organisational Development, Communications, the Programme Management Office and the LISA. Actions are recorded, assigned and followed up so that colleagues can see what has changed as a result of speaking up. Board and executive engagement with staff continue through a wider range of routes. Non-Executive and Executive Directors maintain links with the Group's staff networks, including LGBTQIA+, BAME and Disability networks. The Chief Medical Officer and Chief People Officer engage with medical staff-side representatives, and the Chief People Officer meets with the Joint Negotiation and Consultative Committee. Executives also engage with Care Groups through performance reviews, the fortnightly Senior Leadership Team and service visits. The priority in 2026/27 is to connect these routes into a consistent listening-to-action model, with clear ownership, feedback to staff and oversight of themes, actions and impact.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	
11. Staff can express concerns in an open and constructive environment.	

	Learning, development and leadership capability remain important foundations for cultural improvement. The HHP Learning Hub was introduced across the Group in April 2026, providing a single system through which colleagues can book and record learning. Managers and staff continue to use the harmonised appraisal process for development conversations, and the Mandatory Learning Oversight Group is reviewing locally mandated and role-specific training so that requirements remain relevant and proportionate. During 2026/27, the Group will strengthen its assessment of current and future skills needs, align development activity with workforce plans and improve assurance that teams have the capability needed to deliver service transformation. Creating a safe reporting culture also remains a priority. Staff can raise concerns through line management, incident reporting, Freedom to Speak Up Guardians and Champions, staff-side representatives, networks and direct engagement with leaders. Work during 2026/27 will establish a clearer and more transparent 'raising concerns to action' framework, improve the quality and timeliness of responses, strengthen executive oversight and make learning and action more visible. This will be supported by a Group-wide civility and respect framework, clearer reporting and resolution pathways, targeted support for areas of concern and regular assurance to the Workforce, Education and Culture Committee and the Boards. Examples of Evidence to Support Domain Response: • Draft refreshed Board Assurance Framework • Annual Staff Survey results • Freedom to Speak up Guardian Board Reports • Regular staff and staff representatives' engagement

IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Red
12. Plans are in place to improve performance against the relevant access and waiting times standards	The Group does not meet currently the national standards set out in the NHS planning guidance and its year-end projections do not meet the Faster Diagnosis Standard, DM01, or Referral To Treatment (RTT) targets. However clear plans for improvement and trajectories throughout the year have been agreed for the current financial year. The Group continues to actively participate in Tier 1 meetings and has seen some early signs of improvement. UEC measures at HUTH have shown improvement in the last 6 months with an agreed plan of work for the following 6 months and beyond. There is a clear understanding of the service gaps effecting UEC performance across NLAG with a programme of work for improvement in the process of being established along with support from system partners. The Group has been in receipt of support and oversight by NHSE, ECIST and GIRFT. The Group has shared system roles in place supporting improvements in NCTR in both HUTH and NLAG and has held a number of perfect weeks and MADE events in the last 6 months with plans for further initiatives through the winter of 26/27. Plans have been agreed with the ICB to open the UTC at the HRI site 24/7 from October 2026 to support improvements in patient flows, Medical SDEC and Surgical SDEC's are due to open in the next 6 months at HRI along with an EMAC facility. Additionally, funding has been provided to enable establishment of a UTC at DPoW and EEMAC facilities. Plans to improve elective performance continue to develop. Detailed demand and capacity analysis has been undertaken across all elective care specialities in the last 3 months. A
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	
14. Appropriate population health targets	

have been agreed with the ICB.	full refresh of the Outpatient Transformation Board has been delivered in the last 6 months with plans to significantly change patient flows due to come into place in the latter half of the current financial year. Theatre utilisation is showing signs of improvement with engagement with GiRFT programmes and surgical hub accreditation has been received at DPoW and Goole in the last 3 months. The Group does not currently have an underlying plan or workforce to substantively deliver access waiting times. Diagnostic activity is showing some improvements in some modalities and use of the CDC's is increasing but shows room for improvement and need to work more closely with the wider system to reduce demand. The Board continues to receive a range of Executive-led reports detailing the reasons for below-par performance of the constitutional standards. Deep dives across all key domains have been received into the PEF Committee-in-Common with a plan for these to be received as part of a rolling cycle of business. The IPR has also been further developed, and the improved performance overview will be in place for board meetings from September 26 onwards. In addition, the Group does not yet have a sufficiently mature understanding of the extent to which its activities are improving the overall health and wellbeing of the population it serves. While the Group Strategy identifies a range of health inequalities and population health challenges associated with the region's deprivation and poorer health outcomes, further work is required to translate these strategic ambitions into targeted, measurable and outcome-focused plans as previously described. The Board receives quarterly updates on delivery of the Population Strategy, with ongoing work to define priorities and agree the approach for the next 12 to 18 months. The Board has agreed that this programme will focus on reducing health inequalities, strengthening prevention and addressing the wider determinants of health in partnership with system colleagues. At present, the organisation has established mechanisms to monitor unwarranted variation in access to, and delivery of services and can identify and respond to areas of operational variation through targeted improvement plans. However, its population health intelligence and ability to measure the wider impact of services on long-term health outcomes remains less developed. Strengthening population health analytics, outcome measurement and system-wide insight will therefore be an important next step in demonstrating the Group's contribution to improving the health and wellbeing of local communities. <u>Examples of Evidence to Support Domain Response:</u> • Integrated Performance Report including performance against NOF • PEF Committee-in-Common Reports • Operational Plans • Draft refreshed Board Assurance Framework

V. Productivity and value for money

Capability statements	**Proposed domain rating**
	Amber-Red
15. Plans are in place to deliver productivity improvements	The Group can demonstrate an established understanding of productivity and value-for-money opportunities and has developed a range of programmes to address identified opportunities. The Group makes use of national benchmarking, including Corporate Benchmarking, Model Hospital and GIRFT, to identify unwarranted variation and inform

as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	service and workforce improvement. There is evidence of some productivity improvement, but this still remains lower than 2019/20 activity levels. Evidence of a consistent and sustained record of delivering productivity improvements is less mature. The scale of the Group's efficiency requirement, together with the level of high-risk and unidentified savings within the 2026/27 programme, indicates that delivery remains a material challenge. Continuing variation against relevant benchmarks also indicates that identified productivity opportunities have not yet been fully converted into sustained improvements. The principal capability gap is therefore not the identification of productivity opportunities, but the consistent conversion of those opportunities into recurrent and sustainable improvements in productivity and value for money. Examples of Evidence to Support Domain Response: • National and local benchmarking data, including Model Hospital and GIRFT benchmarking data sets.

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Red
16. The trust has a robust financial governance framework and appropriate contract management arrangements.	The Group has established financial governance arrangements, Board and committee oversight, financial reporting processes and a substantial programme of financial recovery and productivity improvement providing an established mechanism for joint financial planning and system-level working. However, both Trusts are currently in NOF Segment 5, the highest level of oversight and therefore evidence indicates that the effectiveness and sustainability of financial recovery remain the principal areas of concern. The Partnership submitted a financial combined deficit of £63 million (HUTH £39.4m / NLAG £23.7m). At the time of this return the submitted plan has not been accepted by NHSE. The self-assessment rating therefore reflects: • a significant underlying financial challenge; • continuing reliance on non-recurrent measures and system support; • material CIP delivery and identification risk; • evidence that financial grip and control have required further strengthening; and; • insufficient evidence, at the point of this assessment, that the underlying recurrent financial position has been sustainably resolved. This is balanced however by evidence of strong Board awareness of the problem, established governance arrangements, active recovery programmes and increasing integration with system partners. Examples of Evidence to Support Domain Response: • Draft refreshed Board Assurance Framework • Financial recovery plan in place and regular oversight by Performance, Estates and Finance Committee and Board reporting
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	
18. The trust engages with its system partners on the optimal	

use of NHS resources and supports the overall system in delivering its planned financial outturn	• Year-to-date performance against plan, and risks and mitigations to the reported financial position.

Signed on behalf of the Board of Directors

Chair: ___**Alan Downey, Group Chair**_____

Signature: _____ Date: ___**1st October 2026**_____

Signed on behalf of the Board of Directors

Chief Executive: ____**Lyn Simpson, Group Chief Executive Officer**_____

Signature: Date: __**1st October 2026**_____

Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

Leadership and strategy	
Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.	
Capability statements	**Indicative evidence**
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. **If in breach:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • **If in breach:** all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered. • Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded. **Amber-Green** • Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery. • **If in breach:** On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed.

	• Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand **Amber-Red** • Strategy unclear, outdated, or inconsistently applied. • **If in breach:** Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led 'requires improvement' • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. **Red** • No credible strategy; board direction fragmented. • **If in breach:** persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led 'Inadequate' • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
Quality oversight	
Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.	
Capability statements	**Indicative evidence**
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical • Patient experience embedded in discussions around quality; concerns reach board quickly.

and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Amber-Green** • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. **Amber-Red** • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. **Red** • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
People and culture	
Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.	
Capability statements	**Indicative evidence**
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green:** • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. **Amber-Green** • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. **Amber-Red**

	• Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey **Red** • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.	
Capability statements	**Indicative evidence**
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). **Amber-Green** • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. **Amber-Red** • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it;

	• Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. **Red** • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
Productivity and value for money	
Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.	
Capability statement	**Indicative evidence**
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing **Amber-green** • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months **Amber-red** • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months **Red** • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers

Financial performance and oversight	
Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.	
Capability statements	**Indicative evidence**
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	*The following are indicative aspects of each level of capability but should not be seen as exhaustive:* **Green** • Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised **Amber-Green** • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans **Amber-Red** • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. **Red**

	• Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff • Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment