NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 12 February 2026 at 9.00 am to 1.00 pm in the Main Boardroom, Diana, Princess of Wales Hospital

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** Murray Macdonald, Interim Group Chair	Verbal	Information	**09:00**
1.2	**Staff Charter and Values** Murray Macdonald, Interim Group Chair	Attached	Information	
1.3	**Patient Story** Heather McNair, Interim Group Chief Nurse	Verbal	Assurance	**09:05**
1.4	**Questions from the Public and Governors** Murray Macdonald, Interim Group Chair	Verbal	Discussion	**09:25**
1.5	**Declarations of Interest** Murray Macdonald, Interim Group Chair	Attached	Assurance	**09:35**
1.6	**Minutes of the Meeting held on Thursday, 11 December 2025** Murray Macdonald, Interim Group Chair	BIC(26)001 Attached	Approval	
1.7	**Matters Arising** Murray Macdonald, Interim Group Chair	Verbal	Assurance	
1.8	**Action Tracker** - **Public** Murray Macdonald, Interim Group Chair	BIC(26)002 Attached	Assurance	
2.	**CHIEF EXECUTIVE & CHAIR REPORTS**			
2.1	**Interim Group Chair's Report** Murray Macdonald, Interim Group Chair	BIC(26)003 Attached	Assurance	**09:45**
2.2	**Interim Group Chief Executive's Briefing** Lyn Simpson, Interim Group Chief Executive	BIC(26)004 Attached	Assurance	**09:55**
3.	**STRATEGIC PROGRESS**			
3.1	**Patients – Safety (including Assurance Committee update)** Dr Kate Wood, Group Chief Medical Officer & Heather McNair, Interim Group Chief Nurse Dr David Sulch, NED Committee Chair	BIC(26)005 Attached	Assurance	**10:05**
3.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Dr David Sulch, NED Maternity & Neonatal Safety Champion	BIC(26)006 Attached	Assurance	
3.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Heather McNair, Interim Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(26)007 Attached	Assurance	
BREAK – 10:45 – 11:00				

3.2	**Patients – Performance (including Assurance Committee update)** • **Cancer** • **Urgent & Emergency Care** • **Referral to Treatment** • **Diagnostics** Matt Powls, Interim Group Chief Delivery Officer Gill Ponder, NED Committee Chair	BIC(26)008 Attached	Assurance	**11:00**
3.3	**People (including Assurance Committee update)** Simon Nearney, Group Chief People Officer Julie Beilby & Tony Curry, NED Committee Chairs	BIC(26)009 Attached	Assurance	**11:15**
3.3.1	**Freedom to Speak Up Guardian (FTSUG) Quarter Three Report (NLaG & HUTH)** Liz Houchin & Fran Moverley, FTSUGs	BIC(26)010 Attached	Assurance	**11:25**
3.4	**Population** Heather McNair, Interim Group Chief Nurse	BIC(26)011 Attached	Assurance	**11:35**
3.5	**Public Purse (including Assurance Committee update)** Emma Sayner, Group Chief Financial Officer Gill Ponder, NED Committee Chair	BIC(26)012 Attached	Assurance	**11:40**
3.6	**Partnerships (including Assurance Committee Update)** Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer Gill Ponder, NED Committee Chair	BIC(26)013 Attached	Assurance	**11:50**
4.	**OTHER ITEMS FOR ASSURANCE**			
4.1	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report** Jane Hawkard, NED Committee Chair	BIC(26)014 Attached	Assurance	**12:00**
4.1.1	**Annual Accounts – Delegation of Authority to the Audit, Risk & Governance Committees-in-Common** Emma Sayner, Group Chief Financial Officer	BIC(26)015 Attached	Approval	
5.	**OTHER ITEMS FOR APPROVAL**			
5.1	**Nursing Establishment Business Case** Heather McNair, Interim Group Chief Nurse	BIC(26)016 Attached	Approval	**12:15**
5.2	**Group Improvement Plan** Lyn Simpson, Interim Group Chief Executive	BIC(26)017 Attached	Approval	**12:25**
5.3	**Audit, Risk & Governance Committees-in-Common Terms of Reference – NLaG & HUTH** Jane Hawkard, NED Committee Chair	BIC(26)039 Attached	Approval	**12:50**
6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Murray Macdonald, Interim Group Chair	Verbal	Information / Assurance	
7.	**ANY OTHER URGENT BUSINESS**			
7.1	**Any Other Urgent Business** Murray Macdonald, Interim Group Chair / All	Verbal		**12:55**
8.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
8.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Murray Macdonald, Interim Group Chair / All	Verbal	Discussion	

9.	DATE OF THE NEXT MEETING
9.1	**The next meeting of the Boards-in-Common will be held on Thursday, 12 March 2026**

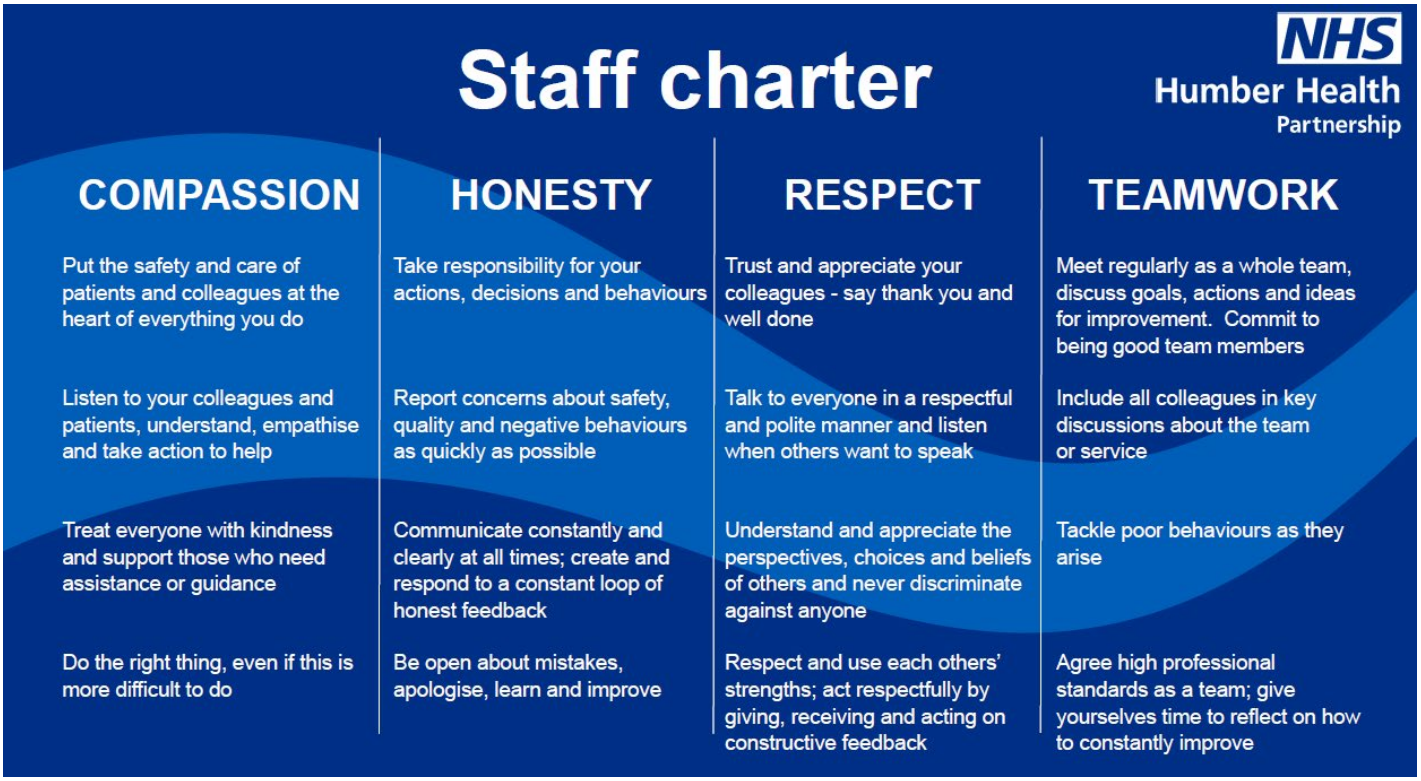
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – October 2025** Dr David Sulch, Non-Executive Directors Committee Chair	BIC(26)018 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Performance, Estates & Finance Committees-in-Common Minutes – December 2025 & January 2026** Gill Ponder, Non-Executive Directors Committee Chair	BIC(26)020 Attached
6.2.2	**Finance Report – Month 9** Emma Sayner, Group Chief Financial Officer	BIC(26)021 Attached
6.3	**Workforce, Education & Culture Committees-in-Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – November & December 2025** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(26)022 Attached
6.4	**Audit, Risk & Governance Committees-in-Common**	
6.4.1	**Audit, Risk & Governance Committees-in-Common Minutes – November 2025** Jane Hawkard, Non-Executive Directors Committee Chair	BIC(26)023 Attached
6.4.2	**Audit, Risk & Governance Committees-in-Common Self-Assessment Exercise 2026** Jane Hawkard, Non-Executive Directors Committee Chair	BIC(26)019 Attached
6.5	**Capital & Major Projects Committees-in-Common**	
6.5.1	**None**	
6.6	**Other**	
6.6.1	**Group Performance Report – NLaG and HUTH** Adam Creeggan, Group Director of Performance	BIC(26)025 Attached
6.6.2	**Board Assurance Framework (BAF)** David Sharif, Group Director of Assurance	BIC(26)027 Attached
6.6.3	**Health Tree Foundation Trustees' Committee Highlight Report** Chair Health Tree Foundation Trustees' Committee	BIC(26)024 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

DRAFT
TRUST BOARDS-IN-COMMON MEETING IN PUBLIC
Minutes of the meeting held on Thursday, 11 December 2025 at 9.00 am
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Jane Hawkard	Non-Executive Director (HUTH) (Chair of Meeting)
Lyn Simpson	Interim Group Chief Executive
Heather McNair	Interim Group Chief Nurse
Matt Powls	Interim Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Dr Kate Wood	Group Chief Medical Officer
Julie Beilby	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG) (attended virtually)
Gill Ponder	Non-Executive Director (NLaG)
Dr David Sulch	Non-Executive Director (HUTH)
Prof Laura Treadgold	Non-Executive Director (HUTH) (attended virtually)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Mark Blakeman	NHS England
Cllr Linda Bayram	Public Governor (attended virtually)
Ian Hall	The Value Circle
Andy Haywood	Group Chief Strategy, Partnership & Digital Officer
Cameron Henser	XYLA Services (attended virtually – member of the public)
Myles Howell	Group Director of Communications
Yvonne McGrath	Midwifery Director (For item 3.1.2) (attended virtually)
Simon Nearney	Group Chief People Officer
John Palmer	Member of the Public
Ian Reekie	Lead Governor (attended virtually)
Lesley Saunders	Member of the Public
David Sharif	Group Director of Assurance
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

Jane Hawkard welcomed Board members and observers to the meeting and

declared it open at 9.10 am, she advised that she was representing Murray Macdonald as Chair of the meeting due to him being on annual leave.

The following apologies for absence were noted:

Murray Macdonald Interim Group Chair

1.2 **Staff Charter and Values**

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

1.3 **Patient Story**

Dr Kate Wood advised the story being shared would be uncomfortable to hear. She highlighted that the organisation had already started to learn from this with immediate actions being put in place. She added that Jo Ledger would be sharing the story with the Boards.

Jo Ledger referred to the story and explained that this was in respect of the Emergency Department (ED) pressures that had occurred over a recent weekend at Hull Royal Infirmary (HRI). She explained the extremely high number of attendances to ED, that this had raised immediate concerns regarding patient safety including fire risks due to where patients had been situated in corridors waiting to be cared for. There had also been environmental issues due to low temperatures in some of the areas. Over that period certain mitigations had been put in place with staff redeployed to ED from other areas of the hospital. The strategic on call team and site matrons had maintained on site presence to provide additional support. Executive on call had been updated regarding the severity of the situation and the associated safety concerns. Support had also been required from neighbouring Trusts where patients had had to be redirected. The Integrated Care Board (ICB) on call had been briefed, however, no additional support was available due to regional pressures. At the peak the number of patients with a Decision to Admit (DTAs) had been 80. The situation had unfortunately resulted in one particular patient being in ED for 30 hours where care had not been as it should be due to the extreme number of patients and them being cared for on a trolley within that area.

The situation had also caused distress to staff due to the ongoing pressures over that period. Staff had, therefore, been offered support. It was highlighted that patient flow remained an issue within ED and it was an issue for the whole organisation. Heather McNair recognised that this was a time where staff needed to be supported as well as ensuring patients were safe.

It was noted that following this episode, work had already been undertaken to address the concerns raised. The public had been advised not to attend ED unless they really needed to due to the extreme pressures, instead they were being asked to use alternative services.

Lyn Simpson recognised the hard work of the staff over that period and noted it was obviously an unacceptable situation for patients to be in. She, therefore, wanted to personally apologise to patients who may have received harm over

that period. She added that this was one of the fundamental reasons for the organisation becoming more clinically led to understand what was needed in respect of patient care. It was recognised that the organisation could not accept the current situation and that improvements needed to be made.

Matt Powls agreed with the points made and advised that both clinical and nursing colleagues needed to support improvements moving forward. He explained that the organisation would be implementing a rapid ward and board round improvement programme to ensure patients were identified as early as possible in the day for discharge. This would be supported by the clinicians and nursing teams to ensure there were improvements. It was noted that the length of stay also needed to be considered in respect of supporting this work as flow was a contributory factor. As of that day there had been a change in bed meetings, these had previously been undertaken by care groups, this would now be split to the north bank and south bank to drive immediate improvements. Ambulance handovers would also be reviewed as part of this work as some patients were being brought to ED when they did not need to be. It was recognised that there also needed to be improvements in respect of partnership working in the system.

Tony Curry felt that this had been a distressing story to listen to, he was aware that flow continued to be an issue. He queried how well prepared the organisation was in respect of such surges in attendances. Dr David Sulch appreciated the work being undertaken around early discharge. However, he felt that the fundamental issue for this occurring was due to there not being sufficient beds and this needed to be resolved. Dr Kate Wood explained that the teams had reflected on immediate learning which had been put in place. In respect of operational actions and the issues raised it was noted that these would be reviewed through the Quality & Safety Committees-in-Common which would then be highlighted to the Trust Boards-in-Common for ongoing assurance. Sue Liburd agreed as Joint Chair of the Quality & Safety Committees-in-Common that this would be included in the next agenda.

Julie Beilby was concerned that there may not be sufficient senior cover to support the winter plan over the weekend and holiday period particularly in respect of the surge in flu cases requiring treatment. She added that there was a need to continue to highlight the wellbeing of staff over this period to ensure that they were supported. She was also concerned as to whether there was sufficient capacity to focus on what was to be achieved to ensure the appropriate services were available. Dr Kate Wood explained that there were high level immediate interventions in place and that the story had been highlighted to show the current situation. She felt that providing further detail that day may not provide the required assurance as this was still being worked through. She felt that holding a further meeting to discuss specific areas for quality and safety may provide further detail for the Boards.

In response to Tony Curry's query, Matt Powls advised that there were surge plans in place and that the organisation did hold bed meetings to ensure teams on the ground could enact as required. In respect of the system, it was felt that there had been improvements as the organisation were working with them daily to ensure there was integrated working.

Simon Parkes felt that a line had to be drawn in respect of highlighting what support was required from the Boards to ensure that there were differences made.

Lyn Simpson noted the points made and explained that the Boards needed to accept the improvement plan as this showed changes that would be made, it was recognised this was still in the stabilising phase during the winter period. She agreed that a Boards session should be held in respect of the quality and safety issues as all members should be held to account for this, she proposed that a meeting should be held in the new year.

Action: David Sharif to arrange an additional Trust Boards-in-Common session to address quality and safety concerns raised

Helen Wright referred to the partnerships query, she felt there was a need to be clearer on what the required outcomes were to ensure that they were achieved in respect of system working.

Gill Ponder raised the issue that there had been work by the system and hospital to reduce patients waiting for discharge and that the work had resulted in a clear reduction in the number of DTA patients, she queried whether this was still the case given the patient story.

Jane Hawkard agreed this had been a difficult story to listen to and that it was important this did not reoccur in the future. She was in agreement that the plans should be adhered to rather than continually changing plans and not executing them.

Jane Hawkard thanked Jo Ledger for attending and sharing the story.

1.4 **Questions from the Public and Governors**

David Sharif advised that two questions had been received the previous day after the required deadline. It was, therefore advised that they would be addressed and communicated to the member of the public following the meeting to allow sufficient time for them to be addressed. Jane Hawkard thanked John Palmer for the questions that had been received and advised that a response would be provided within the week.

1.5 **Declarations of Interest**

Jane Hawkard sought declarations of interest from Board members, none were received.

1.6 **To approve the minutes of the Trust Boards-in-Common meeting held on Thursday, 9 October 2025 – BIC(25)215**

The minutes of the meetings held on the 9 October 2025 were accepted as a true and accurate record and would be duly signed by the Chair.

1.7 **To approve the minutes of the HUTH Annual General Meeting (AGM) held on Wednesday, 22 October 2025 – BIC(25)216**

The minutes of the meetings held on the 22 October 2025 were accepted as a true and accurate record and would be duly signed by the Chair.

1.8 **Matters Arising**

Jane Hawkard invited board members to raise any matters requiring discussion not captured on the agenda.

1.9 **Action Tracker – Public – BIC(25)217**

The following updates to the Action Tracker were noted:

- Item 3.1, 9 October 2025 – Patients - Safety - Implementation of Martha's Rule across the organisation. Dr Kate Wood confirmed that the organisation was in the second implementation and roll out phase of Martha's Rule. She wanted to assure colleagues that escalation processes were in place for both staff, patients and families to request a second opinion. Standard Operating Procedures (SOP) were currently being worked through as part of the implementation. Dr Kate Wood advised of a briefing paper that would be shared with Board colleagues after the meeting.

  Post Meeting Note: A briefing note was shared with Board colleagues via email following the meeting.

- Item 3.1, 9 October 2025 – Patients - Safety - Improvements to the Patient Safety reporting. Sue Liburd thanked Gill Ponder and Julie Beilby for their feedback received. Discussions had been undertaken in respect of this to ensure there were improvements. It was agreed this action would be closed.

Jane Hawkard referred to the closed actions on the tracker and asked if Board colleagues were happy that they were closed. It was agreed that board members were happy with this.

2. GROUP CHIEF EXECUTIVE & CHAIR REPORT

2.1 **Group Chair's Report – BIC(25)218**

Jane Hawkard shared the report on behalf of Murray Macdonald.

Jane Hawkard referred to the report and highlighted key points including those in respect of the governance review being undertaken. She welcomed Matt Powls, Interim Group Chief Delivery Officer and Heather McNair, Interim Group Chief Nurse to the organisation. Thanks were noted to Sarah Tedford who had now left the organisation and to Amanda Stanford who was currently on a secondment with the ICB. It was acknowledged that Simon Parkes would be leaving the organisation at the end of January 2026. She thanked him for his dedication and hard work during his time as a Non-Executive Director (NED).

Jane Hawkard noted the new NLaG Governor updates within the report and noted that Mike Bateson had been appointed as Deputy Lead Governor.

2.2 **Group Chief Executive's Briefing – BIC(25)219**

Lyn Simpson referred to the report and highlighted key points.

She referred to the clinical led improvement and advised that a discussion had been held with the City Health Care Partnership (CHCP) in respect of working more closely with the organisation. She noted that the organisation remained challenged in the Urgent & Emergency Care (UEC) pathway. The recent Care Quality Commission (CQC) report received had highlighted what was required to ensure there were improvements, however, there was a need to understand where the organisation needed to be to progress. In respect of adult and social care there were still issues with no criteria to reside (NCTR) within the hospitals. This needed to be further reviewed to highlight what changes need to be. It was recognised that the previous industrial action had been well managed with an expectation that this would be undertaken in the same way for the pending action the following week.

Lyn Simpson advised that in respect of elective recovery and outpatient transformation there had been clear discussions with executives to ensure there was focus with outpatients to ensure that there was accelerated delivery.

Lyn Simpson thanked Myles Howell for his support during the recent internal engagement with staff. The events had proved helpful in pulling together themes that had been heard from staff.

Lyn Simpson referred to the dashboard within the report and added that going forward this would be implemented further amongst Committees-in-Common as previously requested.

Dr David Sulch referred to NCTR as it was recognised that these numbers had started to increase. Lyn Simpson agreed with the point made and advised that Ward H130W had been closed. She wondered whether this needed to be further reflected on and whether the rationale of this should be provided in more detail through undertaking audits on outcomes since this was closed. Gill Ponder felt that an audit in respect of NCTR would be very helpful to highlight any issues. She explained that this had been discussed at the Performance, Estates & Finance Committees-in-Common and that it was felt that the system partner work had not delivered as quickly as it was planned to have. She added that having a greater understanding of this may be helpful to consider whether those beds should have been closed although it was acknowledged that there had been a reduction of NCTR patients at the time that this may now have slipped back up.

At this point Dr Kate Wood left the meeting for a prearranged call with NHSE and then she would return.

Sue Liburd queried whether partners considered that NCTR was a system issue or if they saw this as an organisational challenge to be faced without their support. Lyn Simpson felt they did share the challenge and that they were also in the same position due to capacity challenges. She added that she would be happy to discuss this further with them.

Julie Beilby felt that there also needed to be more awareness during discussions with local authorities to ensure that they were aware of the challenges faced within

the system. This would then improve the political engagement. One suggestion would be to invite elected members key local politicians for them to visit ED over the weekend period to show them the issues within that service.

Jane Hawkard referred to Ward H130W as the NCTR had not increased when this had first closed. She added that a surge in patients during particular times also needed to be considered. In respect of the 'A Commitment to Excellence' (ACE) programme, she queried when this would restart for Board members to be part of, as further sessions had been cancelled in January 2026. She felt that this programme had improved ward to Board focus and provided an added 'eyes on' safety and quality standard adherence. Heather McNair advised this had been paused due to some discrepancies with the data. Some areas had scored high, however, on triangulation they had had some incidents within those areas which did not reflect the scoring. It had, therefore, been agreed to review the criteria for that program. She added that visits were being undertaken on a Friday, however, the focus had been around respect forms, falls risk assessments to highlight the fundamentals of nursing care. Following on from this it had been felt that the ACE criteria needed to be redefined further. In the meantime, a much wider programme was being considered which would be discussed further. It was agreed this should be discussed further through the Quality & Safety Committees-in-Common, this would then be escalated to the Trust Boards-in-Common.

Jane Hawkard was concerned that this programme had been paused to be further redeveloped, therefore, meaning no accreditation was in place for ward areas to be assessed against. Sue Liburd noted that the request for a change had been due to the scheduled review, however, she was also concerned that there were further delays being proposed. She, therefore, asked if the ACE programme, or the 15 steps previously undertaken, could be resumed until the issues had been resolved. Heather McNair noted the points made and advised this would be discussed further by the senior team.

Gill Ponder felt that there were benefits with a structed programme of people visiting wards areas. She felt that there should be an overlay of triangulation against important metrics that the organisation needed to be focussed on and that this should be included within the scoring. She was, however, concerned that the visits were paused altogether whilst this was resolved. Heather McNair advised that ward areas were still being visited on a Friday it was just that this was not being undertaken under the accreditation programme. Gill Ponder was concerned that the structured programme had now paused for the second time over the past year. After further discussion it was agreed this would be discussed further and reported to the Quality & Safety Committees-in-Common which would then be escalated to the Trust Boards-in-Common.

Simon Parkes raised the issue that yet again a major decision not to involve Board members had been made without Board agreement which was unacceptable particularly given the safety issues that were occurring.

Action: **Heather McNair agreed to review the programme with the relevant senior nursing team and report this to the Quality & Safety Committees-in-Common, a further update would then be shared with the Trust Boards-in-Common**

3. STRATEGIC PROGRESS

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

3.1.1 Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG & HUTH – BIC(25)221

Sue Liburd referred to the paper and highlighted key points. She noted that in respect of learning lessons that data quality issues had been identified across some metrics, these specifically related to tests not being uploaded in a timely manner to Badgernet. There had also been issues with patients struggling to access required reading material. It was reported that this was now being addressed.

She added that there had been concern in respect of clinical staff not being able to be sighted in a timely manner in traumatic births. It was noted that the service user feedback remained positive. Sue Liburd advised that Venous Thromboembolism (VTE) assessments remained low, however, the team were sighted on this, and improvement actions were being undertaken. She added that morale had improved due to the recent business cases being approved for staffing. Sue Liburd highlighted that there was significant confidence in the maternity leadership and the teams in that area.

3.1.2 Maternity Reporting – BIC(25)222:

- **Maternity & Neonatal Safety Assurance Reports – NLaG & HUTH**
- **Maternity Safety: Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)**

Yvonne McGrath referred to the report and noted key points. She reported that for HUTH full compliance was being declared in respect of the Clinical Negligence for Trusts (CNST). In respect of NLaG, full compliance could not be declared due to an obstetric clinician not completing all their mandatory training by the submission date of the 30 November 2025, due to annual leave. Until the training had been completed, they had not undertaken any clinical duties within that area. This had been raised with NHS Resolution (NHSR) due to the mitigation that had been put in place, however, they had advised that non-compliance must be declared. It was hoped that they may reconsider this decision. It was noted that safety had not been compromised during this time due to the mitigations in place.

At this point Dr Kate Wood returned to the meeting.

Yvonne McGrath confirmed that there were no further mitigations that required declaration.

Yvonne McGrath advised that the quarter two reports and updated workforce action plans were included within the paper shared. Attached were also the combined staffing reports for information. It was reported that HUTH had over recruited midwives and that roles had been offered the previous week. Yvonne McGrath referred to the detail in respect of Saving Babies' Lives. It was reported that the NED Safety Champions and Maternity & Neonatal Voices Partnership (MNVP) had met during this quarter. It was noted that the Improvement Plan continued to be updated on a regular basis and had been included within the paper shared. All duty of candour were in place as required. It was noted that there had been several

maternity & newborn safety investigations (MNSI) undertaken, however, there were no themes highlighted during the review, and no concerns had been raised.

In respect of the Maternity Incentive Scheme (MIS), Yvonne McGrath advised that the organisation was in an improved position in respect of responding to complaints. It was noted that the vacancy rates had improved. It was highlighted that there had been some data quality issues at NLaG which would be presented in more detail going forward including a deeper dive into those issues.

Yvonne McGrath advised that there was various work being undertaken to support improvements in culture including walkarounds within that area. There had been some positive news regarding a review and reset in respect of the maternity support programme. Due to changes in the programme from January 2026, the organisation would, therefore, be writing to request a review of the removal of the Section 31 for HUTH.

Jane Hawkard thanked Yvonne McGrath for all the hard work undertaken by the team to reach the improved position. Gill Ponder also noted thanks to Sue Liburd and Dr David Sulch in supporting the team as Safety Champions to reach this point.

Heather McNair highlighted that the recent visit had received positive feedback in recognising the journey the service had been on noting that this needed to continue. It was felt that this should be celebrated.

Jane Hawkard referred to the fetal monitoring data within the report as this remained a concern. Yvonne McGrath noted the point made and highlighted that this may always be a concern due to the technology that was used. The team did continue to reflect on the National Institute for Health and Care Excellence (NICE) guidelines which had recently been updated. There was also a midwife at NLaG that had been selected to go on the required training to support this.

Sue Liburd wanted the Boards to acknowledge that maternity services would continue to be a service of a sensitive nature due to the reporting at the moment. It was recognised that there had been a high number of recommendations over previous years. Heather McNair highlighted that the MNVP was currently hosted through the ICB, however, in the new model it was being proposed that there would be no Local Maternity & Neonatal System (LMNS). This would be considered through consultation. Jane Hawkard raised this as a concern and after further discussion it was agreed that Heather McNair would write to the ICB.

Action: Heather McNair to write to the ICB to raise concern regarding the proposed removal of LMNS as this was something that the Joint Boards did not support and would ask the ICB to reconsider as part of the consultation.

Yvonne McGrath highlighted that there were various workstreams that were managed through the LMNS service which she would not want to lose. She added that some of those issues were being worked through as a back-up should that occur.

At this point Laura Treadgold left the meeting.

3.1 **Patients – Safety (including Assurance Committee Update) – BIC(25)220**

Dr Kate Wood referred to the report and apologised that the paper shared had not provided the assurance the Boards required as highlighted prior to the Board by Sue Liburd, moving forward this would provide all required information. Heather McNair added that this would also include information in respect of carbapenemase-producing Enterobacteriaceae (CPE), infection control and other key issues around falls. Dr Kate Wood highlighted that the organisation was aware of the Aubrey Report into breast care services (at the County Durham and Darlington NHS Foundation Trust) which would be worthy of a review. It was noted there were lessons within that report around corporate and clinical governance that the executive team would be reflecting on to highlight to the Boards.

Dr Kate Wood referred to the number of incidents and never events that had occurred which were of course unacceptable, this had been recognised by staff and work was being undertaken to raise awareness and consider any themes. A meeting was due to be held the following day with the multi-disciplinary teams (MDT) to discuss events that had occurred within the organisation and how work could be undertaken differently. This would be supported by holding a Patient Safety Summit towards the end of quarter four across the group. It was noted that the Patient Experience Annual Report was included as an item for information.

Dr Kate Wood explained that teams were aware that they needed to work differently within the organisation, this included reporting and including medical staff as part of the ACE programmes. The organisation was also looking into a development and learning improvement academy which would fit into the improvement plan.

Tony Curry queried if on reviewing never events it highlighted that they had been due to human error, as this was not detailed within the report. Dr Kate Wood explained that when they occurred it was understood why this had happened. Unfortunately, this had not stopped them happening again. She went on to explain that there was always an immediate reflection by the team on what could have been done differently which was captured in the never event meetings. It was recognised that there should always be 100% focus on patients when they were being cared for. However, it was felt that when those incidents did occur, the learning was only shared within the direct team instead of this being shared more widely.

Sue Liburd appreciated infection prevention and control (IPC) being included within the report going forward and asked if Heather McNair could please share an update with the Boards that day. Heather McNair advised that CPE had settled, however, there were still ten positive cases being reported on the South Bank and that there were also cases within the community. It was noted that Clostridioides Difficile (C. diff) would exceed the trajectory set. It was highlighted that this would of course overlay with the flu period which had already seen increased cases with the peak expected within the next two weeks. It was expected that the numbers of methicillin-resistant Staphylococcus aureus (MRSA) would also exceed its trajectory due to the three cases already reported. After further discussion it was agreed a more detailed infection control report would be shared with the Boards in the future.

Action: Heather McNair to provide more detailed infection control reporting to the Trust Boards-in-Common through the Patient – Safety report

Gill Ponder referred to the never events and queried whether near miss data was recorded to ensure this was learned from. Dr Kate Wood advised that near misses were encouraged to be reported, however, she was aware this was not always the case. It was agreed that further work around this could be undertaken as learning from near misses could support teams in working better.

Jane Hawkard recognised that the level of assurance provided within this report was low and noted that this would be improved for the report being provided at the next meeting.

At this point the meeting reverted to the agenda sequence.

3.2 **Patients – Performance (including Assurance Committee Update) – BIC(25)224**
Cancer / Urgent & Emergency Care / Referral to Treatment / Diagnostics

Matt Powls referred to the paper and highlighted key data as detailed within the report. It was noted that in respect of referral to treatment (RTT) the waiting list growth had stabilised which was positive news. The waiting list at NLaG had reduced by 6,295 patients which was 13.8% since April 2024, HUTH had shown marginal growth of 1%. RTT performance did remain challenged as detailed within the report. It was recognised that long waits had unfortunately increased year on year. There were in place recovery trajectories for the organisation to improve this position. To support those improvements the care groups had undertaken daily meetings to manage this more closely. This has meant the teams were more open and transparent in dealing with issues more quickly and addressing concerns more efficiently. Key risks in respect of RTT were increased because of urgent care and cancer diagnostic demand which would potentially reduce outpatient and diagnostic capacity for RTT pathways.

In respect of cancer, the organisation remained an outlier in respect of waiting times, this was driven by delays in diagnostics. Matt Powls explained that in respect of the faster diagnostics standard there had been some significant improvements since April 2025. Thanks were noted to the teams for driving those improvements. In respect of the 60-day treatment standard there had been improvements for the organisation. There were pressures within the cancer service as referrals had risen across the organisation which the Boards needed to be aware of, this had increased the 14-day referral appointments and diagnosis.

The organisation was an outlier in respect of diagnostics and the six-week standard, Matt Powls advised he had met with the ICB to discuss issues around improvement plans with further meetings planned to discuss solutions. He added that at HUTH it was at 31.3% for patients waiting six weeks for an appointment and at NLaG the current position was 35.3%, the national expectation was 5% which of course meant that the group had considerable work to undertake to improve this position. The drivers for the underperformance were due to the high number of daily diagnostics and the emergency and cancer diagnostic demand was constraining capacity for the core activity.

Matt Powls referred to the report and highlighted the data around the four and twelve-hour standard which was lower than the required standard due to high

demand, there were several improvements that would be put in place to support this.

Matt Powls explained that although areas remained challenged there were some improvements being seen. Delivery risk was high, however, there were plans in place to ensure there were improvements.

Tony Curry referred to diagnostic testing and queried how the Community Diagnostic Centres (CDC) were supporting that challenge. Matt Powls explained that the activity being referred through the CDCs was not at the level it should be, improvement plans would be implemented to support this. Tony Curry further queried what the issues were in respect of referrals. Matt Powls added that part of the issue was around staff resource. He agreed that there could be improvements made to resolve those issues.

Jane Hawkard noted that a package of measures had previously been agreed across the Boards to improve performance which included a funding package. She queried whether it was expected this would be delivered as previous assurance had been provided by the previous Director of Operations. Matt Powls agreed this was on plan, for example in respect of the 65-week elective target, the Boards had agreed funding for insourcing and outsourcing which was being executed to meet performance targets. He agreed to bring back a highlight report to detail how this was being delivered.

Action: **Matt Powls to provide a report to the Trust Boards-in-Common on the current position of the elective improvement plan and delivery against the agreed package of measures that the Board agreed would improve performance**

Lyn Simpson highlighted that the organisation had to deliver the RTT 65-week wait by the 22 December 2025, she queried whether this was expected to be achieved. Matt Powls confirmed this was close to being achieved, it was recognised this would not have been the case without the investment, it was felt that this would be achieved within a week of the specified date, and it was noted that NHS England (NHSE) had been advised of progress.

Gill Ponder explained that the Performance, Estates & Finance Committees-in-Common had discussed the 65-week position and it had been indicated that this would not be achieved until mid-January 2026. Matt Powls advised that the expectation was the end of December 2025 and it was expected that it would be achieved within a week of that date and that this had been agreed with NHSE. He added that this was monitored on a daily basis. Gill Ponder was pleased to see there was grip and control in place to ensure this was achieved. From a committees-in-common perspective further detail had been requested as to whether the plans were correct and if they were expected to be delivered. Helen Wright agreed with the points made and explained that improvements were seen when the transformation teams supported the work. It appeared that managing those actions as business as usual within the current teams did not see the progress that was required. Matt Powls recognised immediate requirements had to be dealt with through grip and control, and that an improvement plan was in place as part of the transformational work being progressed. Emma Sayner added that in respect of the £4.5 million, £500,000 of this was linked with the UEC, the remainder was for achieving the constitutional performance around elective. She added that this was

tightly monitored in respect of the resource being released. £1 million had been released after the agreement of the Boards decision, the remaining resource was in line with several insourcing and external sourcing providers which had started to be mobilised.

David Sharif explained that the Performance, Estates & Finance Committees-in-Common had considered a change to the risk appetite around the risk for patient access, creating a greater distance between the current score of 20 and its tolerable score. This was also reflective of discussions undertaken at the group executive meeting. David Sharif sought approval from the Boards. Gill Ponder advised that the reason the score was where it was had been due to the description of the risk as this referred to the organisation being in the top quartile for performance. The risk of not achieving the top quartile was considered to be lower than the risk of not achieving our constitutional standards as this was high due to the risk to patients.

The Trust Boards-in-Common approved this change and minor change to the risk description through chairs of the Committees-in-Common.

3.3 **People (including Assurance Committee Update) – BIC(25)225**

Simon Nearney referred to the report and noted key points. It was reported that the national staff survey had now completed, NLaG had been at 40% completion and HUTH at 46%. He explained that the Golden Stars would be held on the 3 July 2026, and that the event was sponsored and funded through the staff lottery. It was reported that discussions were being held in respect of the cancer alliance service, this was currently overseen by the ICB, however, there were discussions for this service to be taken over by the organisation. There was a headcount of 24 people and a budget to support the service. Discussions were ongoing in respect of underwriting liability in case the funding was no longer available. It was reported that the ICBs were looking to transfer this service to a provider. Lyn Simpson explained there was caution around this whilst discussions were undertaken.

Simon Nearney reported that the consultant pay dispute had now been resolved at NLaG. In respect of the resident doctors' report there was in place a ten-point plan in place with identified leads.

Simon Nearney reported on the pending strike action due to take place the following week. It was hoped that the offer made to the resident doctors would be accepted, however, this had not been agreed to as yet. Assurance was provided to the Boards that plans were in place should the strike action go ahead. The organisation was working to maintain 95% of the elective activity. The pressures areas would be ED at HUTH ensuring this was covered and general medicine at NLaG, any risks to this would be reported as required.

Simon Nearney referred to the Sexual Misconduct Safety Policy, he assured Board members that the charter had been accepted, and that the policy would be implemented. A Steering Group was in place and relevant communications would be circulated to staff, training had also been undertaken as required.

Julie Beilby reported as Chair of the Workforce, Education & Cultures Committees-in-Common that there had been concern due to the number of times that the CQC actions had been shared and lack of traction in respect of aspects such as training.

It had been queried whether discussions had been held with the CQC as to whether the achievable level could be reviewed due to the other priorities within the organisation. The committees-in-common had been pleased with the progress around job planning, noting that there was still progress to be made. It had been recognised that there needed to be more reflection in respect of reporting in terms of senior cover around holiday periods that impacted on safety. In respect of the wellbeing work for staff there was a need to ensure that this was communicated and used effectively by staff.

There had also been discussion around the risks in respect of the instability within the senior team. It was queried whether this had been adequately reflected in respect of the risk rating, and it was agreed this would be reviewed. There had been observations that there had been a cultural shift that needed to be made, it was recognised that staff needed to be working differently rather than increasing the numbers of staff within some areas. Julie Beilby added that reports did not highlight consequences for those that had not achieved targets. Equally it did not show who was accountable for those aspects which could have a consequence for patients and staff. Tony Curry added as Co-Chair of the committees that the whole theme of consequences for leaders continued to be raised as a theme.

Julie Beilby referred to the cancer alliance point. She felt that they did undertake positive work, however, there was a need to understand the benefits that could be gained for the organisation for overseeing this service.

In respect of the Golden Stars event Julie Beilby felt that from a personal view she would like to see some categories that were linked to the constitutional standards that also linked into the improvement plan.

Simon Nearney referred to the issue raised around consequences and accountability and explained that this was due to be discussed with the senior leaders. There were frameworks in place to address individuals, but it was noted that performance management took time to implement. It was agreed this may need reviewing further to ensure there were improvements. Once this had been discussed with the wider senior leadership team, Simon Nearney agreed to share an update with the Workforce, Education & Culture Committees-in-Common.

Gill Ponder was pleased to see that the consultant dispute at NLaG had been settled as this had impacted on performance. She queried what the cost implication had been in respect of the settlement. Emma Sayner advised that there had been some financial modelling undertaken on different options and that she was confident that this option was within the budget. She added that the on-call would also now mean some efficiency savings.

Sue Liburd supported the Golden Stars being held in July 2026, she referred to the points raised by Julie Beilby in respect of considering some changes to the awards and requested that this was undertaken in consultation with the staff networks. Simon Nearney agreed to the points raised. Helen Wright referred to the referral between the committees and the Performance, Estates and Finance Committees-in-Common in respect of the 24/7 capability in terms of resource. She explained that this had been considered at the previous meeting, and that it had been recognised. Matt Powls had, therefore, agreed to consider where there were weaknesses and gaps in respect of this cover and what could be put in place. The committees could then highlight those issues between them.

Action: Matt Powls agreed to consider where there were weaknesses and gaps in respect of 24/7 senior cover and what could be put in place.

3.3.1 **Freedom to Speak Up Guardian (FTSUG) Quarter Two Report (NLaG & HUTH) – BIC(25)226**

Fran Moverley referred to the HUTH quarter two report and highlighted key points. She added that the National Guardian Office was being disbanded and would be overseen by NHSE, it had been confirmed that the FTSUG role would continue until March 2027.

Liz Houchin referred to the NLaG quarter two report and highlighted key points.

Jane Hawkard referred to behavioural issues detailed in the report, she felt it was not positive that they were still occurring. She queried whether it was felt that this needed communicating on a wider scale to highlight that this was not acceptable. Liz Houchin explained that inappropriate behaviours were very much an individual perception as referred to in the guidance. She added that this could include staff members eye rolling and that being perceived differently. Julie Beilby explained that she had also discussed this as the NED FTSUG Champion to identify what this had meant, she had been reassured that there were no extreme concerns.

Simon Nearney added that the human resources business partners were involved in every incident and that these were then formally addressed. Following such issues being raised, the teams try and work with those individuals to improve relationships. Fran Moverley highlighted that bullying and harassment, and racism was a separate category.

Jane Hawkard requested that when the Boards' communications update was circulated that it included a statement to say that such behaviours would not be tolerated.

Action: Communications message in respect of the Trust Boards-in-Common update to include statement that poor behaviours would not be tolerated

Sue Liburd referred to the data analysis, she queried whether the concerns raised by younger colleagues were different to older colleagues. Liz Houchin felt this was not the case at NLaG. Fran Moverley advised that at HUTH it appeared that younger staff were more willing to make changes and raise issues.

3.4 **Population – BIC(25)227**

Heather McNair referred to the report and took it as read. Helen Wright advised she would like to see some actions in respect of what the quick wins could be, this would then ensure there were improvements.

3.5 **Public Purse (including Assurance Committee Update) – BIC(25)228**

Emma Sayner referred to the report and highlighted key points advising that the organisation was currently off plan of around £4.8 million in month seven. She

added that month eight was now being closed and that the position remained challenged. The report shared did show some of the system wide context and that the organisation must live within its means. It was noted that there would be no deficit support received in quarter four which would equate to around £7 million across the organisation. This would affect both the revenue and cash position for the organisation, it was noted that this was not reflected in the financial position. The report did detail the enhanced control mechanisms in place to control the financial constraints. There was in place a stringent vacancy control process.

Although there had been some reductions in agency spend, which was positive, there had unfortunately been pressures in other areas. Discussions were being undertaken with regional colleagues as the organisation moved into the last quarter of the financial year. The organisation had been issued with the forecast outturn protocol process which would support discussion around where the organisation would be at the year-end position.

Emma Sayner reported that in respect of the capital position the team continued to work hard to deliver the significant programme for the year. From the Electronic Patient Record (EPR) perspective it had been recognised nationally the exemplary way the organisation had worked in handling the brokerage piece.

Gill Ponder reported as Chair of the Performance, Estates & Finance Committees-in-Common that there had been some improvements that had unfortunately now deteriorated. Therefore, the committees had asked for a report that included actions on closing the gap for the year to show where there would be improvements. Helen Wright added that the organisation was off plan and that although it was reported that this was £4.8 million the underline position was £25 million due to the flexibility being offered. She wanted to endorse the controls for reducing agency spend and the robust control in respect of this. Emma Sayner highlighted that what was delivered in 2025/26 from a non-recurrent and recurrent perspective mattered as the organisation moved into 2026/27.

3.6 **Partnerships (including Assurance Committee Update) – BIC(25)229**

Andy Haywood referred to the report and highlighted its key areas. One was in respect of the restructure consultation within the ICB which may impact on engagement. It was noted that there would also be a local government reorganisation in March 2026, this may slightly impact the South Bank. Lyn Simpson had written to the local authority to advise that the organisation would continue to work with them. Andy Haywood referred to neighbourhood working as detailed within the report. It was noted that North East Lincolnshire had been selected for a national neighbourhood implementation programme that would be reviewing how it could establish new providers and commissioning frameworks within multi-neighbourhood teams.

Dr Kate Wood referred to the neighbourhood health point in North East Lincolnshire and advised that they would focus on a cohort of patients within our area. This would highlight where they could make the most impact on certain areas of our population, the organisation would also be part of those discussions. Andy Haywood explained this would be linked into the existing activity.

Andy Haywood referred to the Partnerships Strategy being shared at the meeting for approval. The Strategy Programme & Partnerships Committees-in-Common had

recommended that the Trust Boards-in-Common approve the Strategy, however, they had asked for more detailed plans around partnership working.

Andy Haywood referred to the Partnerships Strategy and provided an update. He advised this had been reviewed by the relevant groups where support had been confirmed. He added that this would be updated when issues progressed as required. He added that one of the key deliverables was a stakeholder panel which would be finalised in January 2026. This would then be shared with the Trust Boards-in-Common.

Julie Beilby referred to the Partnerships Strategy which she had found a thoughtful read with helpful references. She queried the geography of the four local authority areas which fall into the local ICB footprint. However, NLaG also fell within the East and West Lindsey as it was located within Lincolnshire. She felt it should be appropriate to reference this in the overarching Strategy to ensure this was acknowledged. Secondly, in respect of resourcing she felt that there should be discussions at a strategic level with those who influenced where the money was spent.

Sue Liburd felt there was still some work to be undertaken around the public and patient voice as an equitable partner as it still felt it was organisational led as opposed to being more collaborative for population needs. Andy Haywood referred to the point made in respect of resources and advised that this was limited, however, it was recognised that this was seen differently than it had been previously due to the group entity. It was noted that this may need to be undertaken in a different way.

The Trust Boards-in-Common approved the Partnerships Strategy on the basis that there would be some inclusion in respect of the Lincolnshire Authorities. There would also be the inclusion of the patient and public voice as a partner. It was acknowledged that it was the local authorities that influenced the spend.

Helen Wright as Chair of the Strategy Programme & Partnerships Committees-in-Common explained that the EPR had been discussed during the meeting with the Business Case due to be approved. She added that the committees would be responsible for the governance around this and that regular updates would be received. She further added that the committees would also receive updates on the CDCs and the performance of them. It had been referenced previously that they would also have the oversight of the post project evaluation to ensure delivery had been in line with expectations.

Action: The Strategic Programme and Partnership Committee agenda to include governance around partnerships; updates on the CDCs and the performance of them; oversight of the post project evaluation to ensure delivery had been in line with expectations

4. OTHER ITEMS FOR ASSURANCE

4.1 Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report – BIC(25)231

Simon Parkes referred to the report and took it as read. He highlighted that the Committees-in-Common had noted good progress in respect of the Emergency

Preparedness, Resilience & Response (EPRR) Regulatory Report and had recommended this for Trust Boards-in-Common approval. In respect of the Board Assurance Framework (BAF) and Risk Register there had been limited assurance as it had been felt it was still not where it should be in terms of effectiveness. He queried whether as a collective the Boards and the senior team had the same vision for the BAF. He requested additional time be allocated as a Board to improve this. There had been significant concern in respect of the risk register as there had been no progress in respect of this. It had, therefore, been concluded that the committees could not take any further assurance on this.

Jane Hawkard agreed with the points made as Co-Chair as this did of course refer to patient safety and clinical governance. There was a need to ensure that risks within the risk register were reviewed as part of a piece of work around quality. Helen Wright felt that there was no ownership, she agreed that the Boards needed to spend some time on reviewing this to identify key mitigations whilst this was being undertaken. She added that Board members were aware of the key risks that would support this work being undertaken. Lyn Simpson agreed with the points made and felt that the top 25 risks should be considered in the first instance with Board members. It was felt it would be helpful to share this prior to the Christmas period.

Simon Parkes agreed that it was a substantial risk register, he did also feel that there was a need to tackle the culture around risk to ensure there was more ownership through the organisation. Helen Wright felt that there was a need to understand the terminology of what the risks were as some of the risks were issues being managed on a day-to-day basis rather than risks. Jane Hawkard agreed that there should be a separate board session to discuss the risk register as the Audit Committee had consistently highlighted the lack of improvement in this area over a number of months.

Action: David Sharif to arrange a separate Boards session to review the risk register

Action: Lyn Simpson agreed to share a list of the top 25 risks as viewed by the Executives with Board members prior to the Christmas period to provide an overview

5. OTHER ITEMS FOR APPROVAL

5.1 Emergency Preparedness, Resilience & Response (EPRR) Regulatory Report – BIC(25)232

Jane Hawkard referred to the report which had been shared for approval, she noted that the Audit, Risk & Governance Committees-in-Common had recommended this for approval. Simon Parkes thanked the team for producing the report which had been a great piece of work.

The Trust Boards-in-Common approved the Emergency Preparedness, Resilience & Response (EPRR) Regulatory Report.

5.2 Partnerships Strategy – BIC(25)233

This item was approved at item number 3.6.

5.3 Terms of Reference – BIC(25)234

- Performance, Estates & Finance
- Quality & Safety
- Workforce, Education & Culture
- Strategic Programme & Partnerships

David Sharif referred to the report and sought approval, he highlighted that all Terms of Reference had been endorsed by the individual Committees-in-Common. He advised that there was one minor amendment concerning draft paper turnaround times that would be made to the Quality & Safety Committees-in-Common Terms of Reference to align them to the other Terms of Reference. Jane Hawkard went through each individual Terms of Reference to seek Boards approval; each one was approved.

The Trust Boards-in-Common approved all Terms of Reference.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 **Items for Information / Supporting Papers**

The following items for information were shared.

- Quality & Safety CiC Minutes – September 2025
- Safeguarding & Vulnerabilities Annual Report
- Patient Experience Annual Report
- PSIRF / Serious Incident Annual Report
- Performance, Estates & Finance CiC Minutes – 30 September & October 2025
- Finance Report – Month 7
- Workforce, Education & Culture CiC Minutes – September & October 2025
- Guardian of Safe Working Hours – Quarter Two Report
- Audit, Risk & Governance CiC Minutes – July 2025
- Capital & Major Projects CiC Minutes – July 2025
- Group Performance Report (GPR)
- Trust Boards & Committees Meeting Cycle 2026
- Board Assurance Framework (BAF)

7. ANY OTHER URGENT BUSINESS

Jane Hawkard sought any other urgent business items; none were received.

8. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

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

9. DATE AND TIME OF THE NEXT MEETING

9.1 Date and Time of the next Boards in Common meeting:

Thursday, 12 February 2026 at 9.00 am in the Main Boardroom, Diana Princess of Wales Hospital in Grimsby.

The meeting closed at 12:21 hrs.

Cumulative Record of Board Director's Attendance 2025/26

Name	Possible	Actual	Name	Possible	Actual
Murray Macdonald	5	4	Simon Parkes	5	5
Sean Lyons	4	4	Gill Ponder	5	5
Jonathan Lofthouse	0	0	Matt Powls	1	1
Lyn Simpson	3	2	Emma Sayner	5	5
Julie Beilby	5	5	David Sharif	5	5
Tony Curry	5	4	Amanda Stanford	4	4
Linda Jackson	3	2	David Sulch	5	5
Jane Hawkard	5	5	Sarah Tedford	4	4
Sue Liburd	5	5	Laura Treadgold	5	3
Ivan McConnell	2	2	Clive Walsh	2	2
Heather McNair	2	2	Kate Wood	5	5
Simon Nearney	5	4	Helen Wright	5	5

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(26)002

BOARDS-IN-COMMON - PUBLIC ACTION TRACKER

2025 / 26

ACTION TRACKER - CURRENT ACTIONS - 12 FEBRUARY 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									
3.1	09.10.25	Patients - Safety - Implementation of Martha's Rule across the organisation		Dr Kate Wood and Lyn Simpson to provide an update on adopting Martha's Rule across the organisation following discussion outside of the meeting	Dr Kate Wood	December 2025	Further update to be provided at the December 2025 meeting. Updated received with Martha's Rule Briefing circulated to Board members		11 December 2025 meeting notes
3.1	09.10.25	Patients - Safety - Improvements to the Patient Safety reporting		Board colleagues to feedback on what they would like included in patient safety reports in the future to Dr David Sulch and Sue Liburd on behalf of the committees	All Board Members	December 2025	Further update to be provided at the December 2025 meeting.		11 December 2025 meeting notes
1.3	11.12.25	Patient Story - Safety Summit		David Sharif to arrange an additional Trust Boards-in-Common session to address quality and safety concerns raised	David Sharif	February 2026	Session arranged for 5 February 2026		Email invite sent 22 December 2025
2.2	11.12.25	Group Chief Executive's Briefing - ACE Programme review		Heather McNair agreed to review the ACE programme with the relevant senior nursing team and report this to the Quality & Safety Committees-in-Common, a further update would then be shared with the Trust Boards-in-Common	Heather McNair	February 2026	Further update to be provided at February 2026 meeting.		Quality & Safety CiC received paper on 18 December 2025 regarding the Accreditation Programme. Board members are invited to review the item on team engine (4.4).
3.1.2	11.12.25	Maternity Reporting - concern raised in respect of the removal of LMNS		Heather McNair to write to the ICB to raise concern regarding the proposed removal of LMNS as this was something that the Joint Boards did not support and would ask the ICB to reconsider as part of the consultation.	Heather McNair	February 2026	Further update to be provided at February 2026 meeting.		Heather McNair has written to the ICB and they are considering this.
3.1	11.12.25	Patients - Safety		Heather McNair to provide more detailed infection control reporting to the Trust Boards-in-Common through the Patient – Safety report	Heather McNair	February 2026	Further update to be provided at February 2026 meeting.		More detail included within the Group Performance Report, going forward the Patient Safety Report will include this.
3.2	11.12.25	Patients - Performance - Improvement Plan		Matt Powls to provide a report to the Trust Boards-in-Common on the current position of the elective improvement plan and delivery against the agreed package of measures that the Board agreed would improve performance	Matt Powls	February 2026	Further update to be provided at February 2026 meeting.		
3.3	11.12.25	People - 24/7 Senior Cover		Matt Powls agreed to consider where there were weaknesses and gaps in respect of 24/7 senior cover and what could be put in place.	Matt Powls	February 2026	Further update to be provided at February 2026 meeting.		
3.3.1	11.12.25	Freedom to Speak Up Guardian - Quarter Two Report - communications regarding non-acceptance of poor behaviour		Communications message in respect of the Trust Boards-in-Common update to include statement that poor behaviours would not be tolerated	Myles Howell	February 2026	Further update to be provided at February 2026 meeting.		Comms have circulated videos on social media and posters have been displayed in wards and patient facing areas.
3.6	11.12.25	Partnerships - Additions to Agenda		The Strategic Programme and Partnership Committee agenda to include; governance around partnerships; updates on the CDCs and the performance of them; oversight of the post project evaluation to ensure delivery had been in line with expectations	David Sharif	February 2026	Further update to be provided at February 2026 meeting.		Terms of Reference have been updated and will be circulated for approval for the next review.
4.1	11.12.25	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge - risk register review		David Sharif to arrange a separate Boards session to review the risk register	David Sharif	February 2026	March Board development session includes item on risk management and appetite (12/3/26)		
4.1	11.12.25	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge - top 25 risks to be shared		Lyn Simpson agreed to share a list of the top 25 risks with Board members prior to the Christmas period to provide an overview	Lyn Simpson	February 2026	A list was circulated to Board members prior to the Christmas period		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
3.1.3	13.02.25	Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports - Consideration for Maternity Sub-Board to be introduced		Consideration for Maternity Sub-Board to be introduced	Amanda Stanford	June 2025	Update to be shared at the June 2025 meeting.		June 2025 minutes
3.2	13.02.25	Performance, Estates & Finance Committees-in-Common Highlight Report - Audit, Risk & Governance Committees-in-Common to review risks		Simon Parkes and Jane Hawkard as NED Chairs of Audit, Risk & Governance Committees-in-Common to review that risks that related to performance were being referred through to the Quality & Safety Committees-in-Common appropriately	Simon Parkes / Jane Hawkard	April 2025	Update to be shared at the June 2025 meeting.		June 2025 minutes
3.5	12.06.25	Capital & Major Projects Committees-in-Common Highlight Report - BAF Risks against each Committees-in-Common		David Sharif to review this further in respect of the BAF risk against each Committees-in-Common	David Sharif	August 2025	Review complete with digital BAF Risk being assigned to Strategic, Programmes & Partnerships CiC.		Pioneer Board Item Update including BAF.
5.1	12.06.25	Green Plan - more detail to be added in respect of trajectories		Emma Sayner to add more detail within the report on what would be put in place including trajectories	Emma Sayner	August 2025	Subsequent discussions concluded that enhanced trajectories would be considered for future reports.		Discussions have taken place with the Finance & Estates team
3.1.2	12.06.25	Maternity & Neonatal Safety Assurance Reports - Low fill rate for unregistered neonatal staff at HUTH		Yvonne McGrath to review the reason for the low fill rate for unregistered neonatal staff at HUTH	Yvonne McGrath	August 2025	Update to be shared at the August 2025 meeting.		August 2025 minutes
4.2	14.08.25	Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge - Internal Audit Recommendations		David Sharif to progress the cleansing of internal audit recommendations that were low priority	David Sharif	October 2025	Update to be shared at the October 2025 meeting: advised at the September Executive Group Risk and Assurance meeting		KPMG internal audit action log
5.4	14.08.25	Strategic Programmes & Partnerships Committees-in-Common Terms of Reference - clarification in respect of research		David Sharif to arrange a chairs meeting to resolve research in the new Strategic Programmes & Partnerships Committees-in-Common terms of reference prior to Chair's action to approve.	David Sharif	October 2025	Update to be shared at the October 2025 meeting.		2 October 2025 meeting notes
3.1.2	09.10.25	Maternity & Neonatal Safety Assurance Reports - information in respect of trends in maternity attitudes		Yvonne McGrath to share with Board members information previously shared with Sean Lyons on trends in maternity attitudes	Yvonne McGrath	October 2025	Information circulated to Board members		
5.5	09.10.25	Group Lottery Bank Account		Myles Howell to provide a report on the proposals for the Group Lottery to the Workforce, Education & Cultures Committees-in-Common following NED concern that integrating two small charities would become subject to heavier regulation from the Gambling Commission.	Myles Howell	November 2025	Myles Howell provided an email to NEDs that raised the query, confirming current arrangements, preparations and existing licence progress. With Workforce, Education & Culture Chairs and Interim Group Chair agreement, it was agreed this information closed the action.		

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)003

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 February 2026**
Director Lead	Murray Macdonald, Interim Group Chair
Contact Officer / Author	Murray Macdonald, Interim Group Chair
Title of Report	Interim Group Chair's Report
Executive Summary	Report on Policy, Regulation and wider activities
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Interim Group Chair's Update

Introduction

Priority Actions

As the Interim Group Chair I was tasked by regional NHS England (NHSE) with a number of priority actions to deliver during the interim appointment. I am pleased to say that other than the appointment of a substantive Group Chief Executive all the other actions are now completed or well underway.

In particular a key milestone for the Group is the completion of the draft Governance Review commissioned from ValueCircle. The working draft is being presented to the Boards in Private session this afternoon prior to coming to Public Boards for debate and adoption later this year.

Colleagues will be aware that the substantive position of Group Chair is currently being advertised with the appointment expected before the end of this month. After that I would expect that the substantive Group Chair will move quickly to fill the substantive Group Chief Executive position.

Performance Scrutiny

With both Trusts being in segment four of the National Oversight Framework we continue to be under detailed scrutiny.

In particular the Regional Team have been working with us to support our Operational Plan submission. Emma Sayner and I attended a review meeting with the Regional Director and her team at which we set out our current position. We emphasised the importance of viewing the Operational plan as an extension of the Group's Improvement Plan and that together they set out our trajectory to recovery. We also spent some time with them exploring the Board's understanding and ownership of the plan alongside the key issues, especially Safety but also viability.

I am pleased to report that we received support for our approach and an understanding that recovery will take some time. However, we took away a clear message that the Safety issues need to be addressed immediately and that the trajectory against all domains must show improvement.

In addition to the regional scrutiny and support we are also now benefiting from the National Provider Improvement Programme (NPIP) team working directly with the Trusts. The NPIP team is moving into the next phase of its work, which will take place over the coming weeks and into early Spring. This phase will focus on four broad areas:

- Board effectiveness
- Governance
- People and culture
- Improvement capability

This work is intended to provide additional insight and support, helping us build on the progress already being made and strengthen the foundations for sustainable improvement.

Partnerships

A good deal of the Group Chair's role is spent building and developing partnership working across the NHS system and more widely. Over the past two months I have met with the following organisations:

Integrated Care Board (ICB). One of our most important partners, and at times one of our commissioners. I now meet with the Chair, Jason Stamp, regularly to coordinate and prioritise our joint approach to key challenges. The ICB has now appointed a substantive Chief Executive, Teresa Fenech and I wish her well in her new role.

City Health Care Partnership (CHCP). As the provider of Community Health services on the North Bank CHCP is a key partner both strategically and operationally. I met the Chief Executive, Andrew Burnell, and agreed we would hold regular meetings.

Yorkshire Ambulance Trust (YAS). I met with the Chair, Martin Havenhand, who reported a very positive working relationship with the Group. We agreed to continue to work together bi-laterally but probably more importantly to coordinate through the Yorkshire NHS Chairs forum.

Humber and North Yorkshire Collaboration of Acute Providers (H&NY CAP). The CAP brings together the Chairs and Chief Executives from each of the acute hospital trusts York and Scarborough, Harrogate, Hull and NLaG to coordinate and support each other. The most recent meeting focused on the Operational Planning round.

Humber and North Yorkshire Chairs Forum. A more NED Chair focused meeting supported by the Regional Director that picks up on national and regional policy issues. Whilst there is an element of coordination and joint working the emphasis is more educational and developmental.

Group Chairs Forum. This is a national group that brings together Chairs who work across multiple Trusts in a Group or alliance structure. The group offers insight and learning both from lived experience but also from structured presentations and analysis. I attended the latest meeting which focused on how to understand productivity, model hospital data and using this to provoke Board debate and insight.

Governance

Non-Executive Directors (NEDs)

Since the last meeting of the Boards I have received resignations from Non-Executive Directors Sue Liburd (NLaG), Helen Wright (HUTH) and Laura Treadgold (HUTH) who with Simon Parkes (NLaG) all left on the 30 January 2026.

I would like to pass on my thanks to each of them for their service to their respective Trusts and to the Group as a whole and wish them well for the future.

As mentioned earlier in my report the Boards are receiving a draft report from ValueCircle this afternoon which I expect will make far reaching recommendations into the future governance of the Trusts and the Group. Considering this I have sought agreement from our Governors and Regional NHS to delay recruiting to the current vacancies until a future structure is agreed.

Whilst we are currently operating with fewer Non-Executive Directors I have sought and been given Governor and Boards agreement to a number of pragmatic changes including;

- Board meeting each month
- Committees meeting via Teams
- Moving Workforce, Education and Culture Committees-in-Common to bi-monthly
- Suspending further meetings of the Strategic Programmes and Partnership Committees-in-Common
- Non-Executive reporting to the Council of Governors to be brief and undertaken by the Chair for those committees where the NLaG post is vacant.

The details of these changes are set out in a paper later on the agenda and I am sure will be reviewed by the Substantive Group Chair once they are appointed.

Governors

The Council of Governors met on the 8 January 2026 virtually using Teams.

Murray Macdonald
Interim Group Chair

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)004

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2026
Director Lead	Lyn Simpson, Interim Group Chief Executive
Contact Officer / Author	Lyn Simpson, Interim Group Chief Executive
Title of Report	Interim Group Chief Executive's Update
Executive Summary	This paper provides an update on key elements of the Group's improvement and planning agenda. It notes the publication of the Group's clinically led Improvement Plan, which sets out a structured, timebound programme of work owned by clinical and operational leaders and overseen through the Senior Leadership Team. The update also covers implementation of the NHS England Maternal Care Bundle, progress with medium-term planning for 2026/27 onwards, and the phased implementation of Martha's Rule as part of the Group's deteriorating patient and sepsis priorities.
Background Information and/or Supporting Document(s) (if applicable)	Improvement Plan: *Listening to clinicans, learning for patients*
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ✓ Assurance ☐ Information ☐ Other – please detail below:

Interim Group Chief Executive's Update

1. Clinically led Group Improvement Plan

In January, the Group published its first clinically led Improvement Plan, *Listening to Clinicians, Learning for Patients*. This is the single, overarching improvement plan for Humber Health Partnership and has been developed directly through extensive engagement with Chiefs of Service, clinical teams and triangulated intelligence from internal reporting and external regulatory feedback. The plan is owned by clinicians and operational teams and sets out a clear, structured route to improvement across the Group.

The plan is organised into three phases:

- ***Stabilise***: addressing immediate safety, operational and governance risks.
- ***Develop:*** creating sustainable clinical, workforce and patient flow models.
- ***Connect:*** delivering a rolling programme of clinically led specialty reviews across pathways and sites.

All actions within the plan are timebound and have clearly identified Group-level Senior Responsible Owners. Delivery is overseen through the Senior Leadership Team, ensuring alignment between clinical priorities, workforce, finance and operational planning The has been Group PMO to develop a single, integrated reporting function so that progress against the plan can be tracked consistently through SLT, Board committees and with regulators.

The improvement plan is included with this paper for Board information and approval.

2. Learning, Improvement and Safety Academy (LISA)

As set out in the Group's Improvement Plan, work continues to establish the Learning, Improvement and Safety Academy, bringing together organisational development, quality improvement, education and training support. The Academy will support delivery of the Plan by targeting learning and support, and strengthening the capacity of teams to deliver safe care.

3. CQC

A CQC assessment of Urgent and Emergency Care services at Diana Princess of Wales Hospital and Scunthorpe General Hospital took place on 20-21 January 2026. This work forms part of the CQC's inspection arrangements under the updated Single Assessment Framework, which scores at quality-statement level and rates at key-question level across the Safe, Effective, Caring, Responsive and Well-led domains.

Heather McNair, Interim Chief Nurse, is the executive lead for the inspection. during this assessment. A draft inspection report will be submitted to the Group in due course and the Board will be kept updated as the assessment progresses.

4. Clinical Policy Group

The Clinical Policy Group is now established as a key clinically led recommending forum, bringing together senior clinical leaders to advise the Senior Leadership Team on quality, safety and service standards.

Current work includes development of Internal Professional Standards, initially focused on emergency care and patient flow, with the aim of reducing variation and supporting safe practice at times of escalation.

5. Medium-term Planning (2026/27)

Alongside improvement activity, the Group continues to develop its medium-term plans for 2026/27, in line with NHS England's Medium Term Planning Framework (2026/27–2028/29). This work is focused on delivering sustainable improvement in safety and access, while supporting clinically and financially viable care over the medium term, within the context of historical structural challenges, system constraints and commissioning expectations.

6. Maternal Care Bundle

In January, NHS England published the Maternal Care Bundle, setting out best-practice standards across five key areas of maternity care with the aim of reducing maternal mortality and morbidity. The bundle is intended for implementation by NHS providers and commissioners and provides a consistent national framework for improvement. The Interim Chief Nurse is the executive lead for implementation of the Maternal Care Bundle.

7. Patient Safety and Hospital Flow

Patient safety remains the Group's overriding priority, with a particular focus on patient flow and congestion at the front door of our hospitals. Recent Senior Leadership Team discussions have considered feedback from deep dives into key safety risks, including the increasing use of corridors for patient care, most acutely at Hull Royal Infirmary.

The Group is taking a structured, solution-focused approach to addressing these issues, led by Chiefs of Service and supported by weekly SLT review. Key areas of focus include reducing avoidable emergency admissions, improving discharge processes, and working with system partners to ensure patients are cared for in the most appropriate setting. This includes maximizing the use of Urgent Treatment Centres and community capacity, supporting safer and timelier discharge and reducing pressure on Emergency Departments.

8. Goole Hospital

The Board is asked to note exceptional performance at Goole Hospital, where recent improvements have resulted in capped theatre utilisation consistently placing the hospital as the best performer in Humber and North Yorkshire, and among the top elective hubs nationally. This achievement reflects strong clinical leadership, effective systems and a clear focus on patient experience.

9. CEO Dashboard

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

CEO DASHBOARD

February 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**

Patient safety remains the overriding priority, with a particular focus on hospital flow and congestion at the front door of services. A CQC assessment of urgent and emergency care has taken place at Diana Princess of Wales Hospital and Scunthorpe General Hospital.

- **People**

The Group has published its first clinically led Improvement Plan, Listening to Clinicians, Learning for Patients. This provides a single, framework for improvement across Humber Health Partnership, owned by clinical and operational leaders and overseen through the Senior Leadership Team..

- **Population**

The Group continues to work with system partners to support patients to receive care in the most appropriate setting for their needs, with a focus on reducing avoidable emergency admissions and improving patient flow across hospital, social care and community pathways. This includes maximising the use of Urgent Treatment Centres, reducing discharge delays, and working collaboratively to ensure capacity is aligned to population need..

MONTHLY TREND KEY

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

SAFETY AND QUALITY PRIORITIES

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

OPERATIONAL PERFORMANCE (DEC 25)

IPR

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

HUTH

A&E 4hr wait (73.6% by March 2026)	**60.1%**	↑↓ 55.8% in Oct
62-day cancer (58.7% in March 2026)	***57.4.%**	↑↓ 50.1% in Oct
28-day FDS (77% in March 2026)	***59.8%**	↑↓ 50.8% in Oct
18-week RTT (60.3% in March 2026)	**55.6%**	↓↓ 56.7% in Oct
6 week wait (93% by March 2026)	**59.8%**	↓↑ 68.7% in Oct

*November 2025

NLAG

A&E 4hr wait (76.8% by March 2026)	**64.8%**	↓↓ 69.5% in Oct
62-day cancer (62.6% in March 2026)	***70.4%**	↑↑ 57.4% in Oct
28-day FDS (77% in March 2026)	***75.6%**	↑↑ 66.7% in Oct
18-week RTT (62.1% in March 2026)	**59.2%**	↓↑ 59.7% in Oct
6 week wait (95% by March 2026)	**53.5%**	↓↑ 61.6% in Oct

*November 2025

PATIENT AND STAFF EXPERIENCE

PATIENT EXPERIENCE

- Friends and Family results: community 99.4%, inpatient 97.4%, outpatient 96.4%, and postnatal community 100% all exceeded target. A&E scored 75.6%, antenatal 76.2%, and birth 87.5% - below target.
- Improving patient experience continues to be a central focus of the Group's improvement work, closely linked to safety, flow and timely access to care.
- Positive practice continues to be seen in specific areas, including Goole and District Hospital, where clinical leadership and effective systems have delivered high levels of elective performance for patients.

STAFF EXPERIENCE

- The NHS National Staff Survey fieldwork concluded on 29 November 2025, with a predicted completion rate of 47% at Hull University Teaching Hospitals NHS Trust and 42% at Northern Lincolnshire and Goole NHS Foundation Trust. The NHS Staff Survey results are expected to be published nationally in the coming weeks.
- Development of the Learning, Improvement and Safety Academy (LISA) is progressing, bringing together organisational development, quality improvement, education and training and to support delivery of the clinically led Improvement Plan. LISA will strengthen capability, and target learning & support to deliver safe, high-quality care across the Group.

PEOPLE (DEC 25)

IPR

Group sickness absence	**4.8%**	↔	4.8% in Oct
Appraisal rate (AfC)	**82.1%**	↓	80.3% in Oct
Turnover rate (12 months)	**7.0%**	↑	7.4% in Oct
Agency spend as % Total Pay	**2.8%**	↑	2.9% in Oct
Mandatory training	**88.6%**	↑	87.4% in Oct
Role specific training	**81.0%**	↓	82.9% in Oct
Job planning	**79.4%**	↑	77% in Oct

GROUP FINANCIAL POSITION (M8)

Finance. rep

Indicator	£M
YTD I&E Performance	(£7.9m)
I&E Forecast Outturn	(0.0m)
Capital Expenditure	(£27.0m)
CIP YTD	(£26.7m)
Balance Sheet & Cash	£39.2m

DISCHARGE (JAN 26)

MH

HUTH

Bed occupancy classed as clinically ready for discharge (lower is better)

27.8% ↑↓ 27.9% in Nov

NLAG

Bed occupancy classed as clinically ready for discharge (lower is better)

18.6% ↓↓ 18.5% in Oct

THEATRE UTILISATION

IPR

HUTH touch-time capped utilisation (Elective 85% standard)	**79.5%**	↑↓	79.4% in Nov
NLAG touch-time capped utilisation (Elective 85% standard)	**82.2%**	↑↑	79.4% in Nov

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)005

Name of the Meeting	**Trust Boards-in-Common (Public)**
Date of the Meeting	12 February 2026
Director Lead	Dr Kate Wood, Group Chief Medical Officer Heather McNair, Interim Group Chief Nurse
Contact Officer/Author	Tracy Campbell, Patient Safety and Director of Quality Governance Richard Dickinson, Associate Director of Quality Governance Michela Littlewood, Associate Director of Quality Governance
Title of the Report	**Patients – Safety (including Assurance Committee update)**

Executive Summary	This report provides the Quality and Safety Committees-in-Common (Q&S CiC) escalation report from the meeting held on 18 December, and the Board Assurance Framework (BAF) for Quality.
	
	<u>Q&S CiC</u>
	• Operational Pressures: The organisation continues to face patient-flow challenges, especially in ED, compounded by rising flu cases.
	• Complaints & PALS: Response times remain too slow due to multiple factors, including team vacancies.
	• Maternity & Neonatal:
	  ○ NLAG will declare within the MIS standard following a technical failure of one measure, with mitigation to be submitted.
	  ○ National Maternity Outcomes Signal System (MOSS) system implemented.
	  ○ HUTH Neonate pseudomonas issues are being managed.
	• Paediatric Emergency Nursing: Service remains non-compliant with CQC actions. Reliant on fragile staffing arrangements dependent on ward acuity.
	• Quality Priorities: A major refresh is needed (consultation underway)
	• Ophthalmology: Service faces supply–demand pressures, limited primary care support, workforce ageing, and recruitment problems. Action plans are in place, and feedback from the new Freshney Place provision is positive.
	• A Commitment to Excellence (ACE) program has been paused with development of a new accreditation process, to improve ward to board effectiveness.
	• Further assurance is sought on:
	  ○ Never Events
	  ○ Emergency Department crowding and flow
	  ○ Pressure ulcer validation

	○ Sepsis and Fractured Neck of Femur SHMI improvement plans. ○ Clinical Harm Review processes for waiting lists. ○ IPC improvement plans A time out session for Q&S CiC members took place on 23/1/2026. <u>BAF</u> The number of controls and assurances without an indication of their strength continues to reduce with each review. There are actions underway addressing all the listed BAF risks. The boards are asked to note the following: • There has been one Never Event in December 2025 and none in January 2026. A safety summit is planned for April 2026 supporting improvements in patient safety and culture. Workstreams continue in the surgical services to improve, including the Pause Campaign and professional standard setting. • Infection control is being integrated into the revised Quality report intended for Q&S CiC in February, led by the Group Chief Nurse. • Hilda Gwilliams in her role as Group Chief Patient Safety Governance Officer will be supporting colleagues and teams to continually put patient safety first, learn from experience, and keep improving.
Background Information and/or Supporting Document(s) (if applicable)	The Integrated Performance Report in Appendix A, item 6.6.1 provides further quality metric details, including Infection control data.
Prior Approval Process	Quality and Safety Committees-in-Common
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

CiC ESCALATION REPORT

QUALITY AND SAFETY COMMITTEES-IN-COMMON – 18 December 2025

Humber Health Partnership

1.Matters for Reporting

Organisational challenges are flow through the organisation, in particular ED which is challenging for staff and patients and the rising flu numbers. Staff will now wear masks in admission and respiratory areas.

Complaints and PALS – Turnaround of responses is too slow and the reasons behind this are multi-faceted, including vacancies in the team.

Maternity and Neonatal Assurance Report – NLAG will be declaring within the MIS standard due to a technical failure of one standard. This has been clarified with NHSR and mitigation will be submitted for consideration. The new Maternity Obstetrics Signalling System was now in place and tight governance procedures would be required. HUTH Pseudomonas were being manged within the neonatal team. The CIC gave reasonable assurance.

Paediatric Emergency Nursing Service –The service remains non-compliant with CQC actions. Fragile arrangements are in place using RCN from the paediatric ward to mitigate the risk but this is dependent on ward acuity. The CIC gave limited assurance due to the fragility of the service.

Quality Priorities – a significant refresh was required of all the Quality Priorities. The CIC were not assured.

Ophthalmology – Challenges to the service include supply and demand mismatch, lack of primary care provision, an aging workforce and recruitment issues. There were action plans in place to address the issues. There had been positive feedback regarding the provision opening at Freshney Place in Grimsby.

2. Positive assurances

Industrial Action – there were no operational issues raised.

SHMI and HSMR were showing positive results for both organisations.

The **Maternity business case** relating to workforce had been approved by the Boards-in-Common. Phasing was in development and recruitment would commence soon.

Children and Young People – CQC Actions - Medical training performance had improved and the CYP Board would commence in January 2026.

Audiology (NLAG)– Following the ICB review October 2025, action plans were almost complete, and the service was now meeting the standard requirements. A further review of earlier patients that could have been impacted would be undertaken.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	IPC BAF	3	20	Assurance	Limited
2	Never Events/Emerging Concerns	3	20	Information	N/a
3	Integrated Performance Report	N/a	N/a	Information	N/a
4	Quality Priorities – End of Life	3	20	Assurance	Not assured
5	CQC Improvement Plan	3	20	Assurance	Reasonable
6	A Commitment to Excellence (ACE)	3	20	Infomation	N/a
6	Maternity and Neonatal Assurance Report	3	20	Assurance	Reasonable
7	Children and Young People Assurance Report	3	20	Assurance	Limited
8	Quarterly Quality Theme Triangulation, Learning and Improvement Report	3	20	Assurance	Reasonable
9	Learning from Deaths Q2	3	20	Assurance	Significant
10	EQIA	3	20	Assurance	Reasonable
11	Safeguarding including MCA/DOLs	3	20	Assurance	Reasonable
12	Deep Dive – Audiology and Ophthalmology	3	20	Information	N/a
13	Elective Waiting List Harm Review	3	20	Information	N/a
14	Patient Experience Report Q2	3	20	Assurance	deferred
15	Clinical Effectiveness Report Q2	3	20	Assurance	deferred
16	Research, Innovation and Development Quarterly Update Q2	3	20	Assurance	deferred

CiC ESCALATION REPORT

QUALITY AND SAFETY COMMITTEES-IN-COMMON – 18 December 2025

NHS
Humber Health
Partnership

3. Matters on which the committees have requested additional assurance

Never Events – The CIC requested further assurance regarding the learning following Never Events. Culture was raised as a key issue.

Emerging Concerns – NHS E had visited ED last week. The bed meetings had been split into North and South. The Group was receiving additional operational support from NHS E, to help work differently and more strategically. A highlight report from Unplanned Care Board would be presented to the Q&S CIC.

Integrated Performance Report - More assurance was requested regarding Pressure Ulcers and Cdifficile.

EQIA – The CIC gave reasonable assurance to this item and further assurance would be gained by any risks to Quality and Safety being highlighted in future reports.

Learning from deaths – There was currently a focus on Sepsis and Fractured Neck of Femur to improve the KPIs.

Clinical Harm Review process – There were no systematic harm reviews for elective waiting lists in place across the Group. Existing policies were being reviewed, meetings set up across the Group and NHS E had offered help. Once approved, SOPs would be developed. The interim steps in place included a review of longest waits, clinical reviews and would be picked up within Care Group performance meetings.

4. Decisions made

IPC Assurance paper to be presented the CIC, to include completion dates and key issues. The CIC gave Limited assurance due to the deliverables, but members were positive about the processes and the team in place.

5. Escalation to Trust Boards

(ACE) A Commitment to Excellence – The process had been paused and a point prevalence study triangulating key metrics with real time observation for all wards was being carried out (1700 audits). Dashboards would be developed. Further assurance was required to ensure the replacement process (ward to board) was effective and also the timescales for implementation. NED support would be required. A proposal briefing paper to be provided.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	IPC BAF	3	20	Assurance	Limited
2	Never Events/Emerging Concerns	3	20	Information	N/a
3	Integrated Performance Report	N/a	N/a	Information	N/a
4	Quality Priorities – End of Life	3	20	Assurance	Not assured
5	CQC Improvement Plan	3	20	Assurance	Reasonable
6	A Commitment to Excellence (ACE)	3	20	Infomation	N/a
6	Maternity and Neonatal Assurance Report	3	20	Assurance	Reasonable
7	Children and Young People Assurance Report	3	20	Assurance	Limited
8	Quarterly Quality Theme Triangulation, Learning and Improvement Report	3	20	Assurance	Reasonable
9	Learning from Deaths Q2	3	20	Assurance	Significant
10	EQIA	3	20	Assurance	Reasonable
11	Safeguarding including MCA/DOLs	3	20	Assurance	Reasonable
12	Deep Dive – Audiology and Ophthalmology	3	20	Information	N/a
13	Elective Waiting List Harm Review	3	20	Information	N/a
14	Patient Experience Report Q2	3	20	Assurance	deferred
15	Clinical Effectiveness Report Q2	3	20	Assurance	deferred
16	Research, Innovation and Development Quarterly Update Q2	3	20	Assurance	deferred

6. Comments on the effectiveness of the meeting

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

7. Escalation to CiCs

8. Attendance record

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

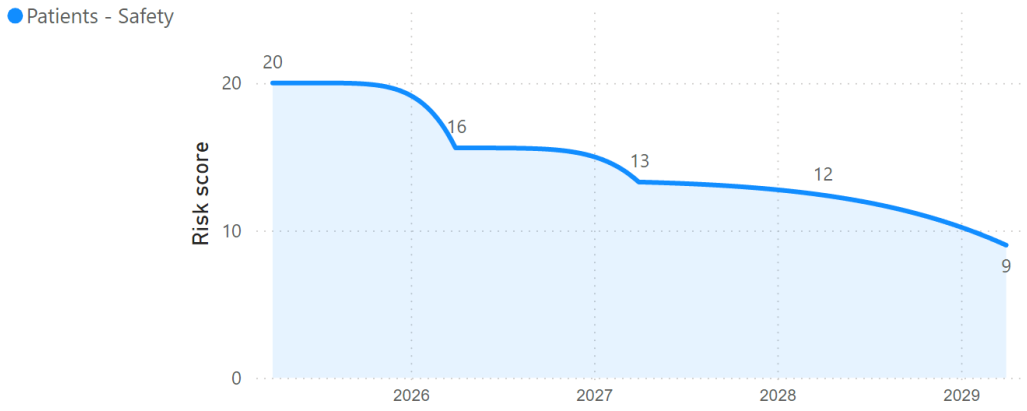
3. Patients - Safety

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

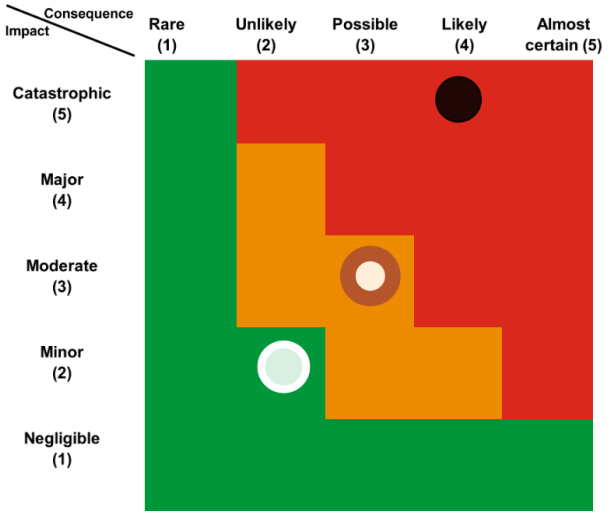
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

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

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

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

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

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

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

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

3. Patients - Safety

NHS Humber Health Partnership

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

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

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NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)006

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th February 2026
Director Lead	Sue Liburd Non-Executive Director Maternity & Neonatal Safety Champion David Sulch Non-Executive Director Maternity & Neonatal Safety Champion
Contact Officer / Author	Sue Liburd David Sulch
Title of Report	Maternity & Neonatal Safety Champion's Report
Executive Summary	Executive Summary for Trust Boards in Common
Background Information and/or Supporting Document(s) (if applicable)	This report provides assurance from the Non-Executive Director (NED) Maternity & Neonatal Safety Champions for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust for the period 01 December 2025 to 31 January 2026. The Safety Champions can provide reasonable assurance, noting continued improvement in clinical quality, governance, workforce planning and service user engagement, including HUTH's exit from the Maternity Safety Support Programme, improvement in the ATAIN rate to below 5%, progress with group-wide workforce recruitment, and the appointment of Bereavement Specialist Midwives at NLaG. Positive service user and staff feedback has been received through MNVP activity, quality improvement programmes and enhanced training initiatives; however, challenges remain with digital maternity records (BadgerNet). Key risks requiring escalation relate to workforce resilience due to sickness, maternity leave and supernumerary periods, the absence of a Neonatal Data Clerk at HUTH, and infection prevention and control

	concerns within the HUTH Neonatal Unit, which will continue to be monitored and escalated through established governance arrangements.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Safe and equitable maternity and neonatal services crucial for addressing health inequalities
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

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

Executive summary:

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

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

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

Activities undertaken this month:

The Maternity & Neonatal Safety Champion's activities undertaken between 01 December 2025 and 31 January 2026 have included a standard programme of walk rounds, meetings with service executive leads, plus attendance at maternity and neonatal assurance and service meetings as follows:

Hull University Teaching Hospitals (HUTH)

- 18 December Maternity & Neonatal Assurance Group (MNAG)
- 23 January QSC Development – Maternity & Neonatal reporting and papers review.

Northern Lincolnshire and Goole (NLaG)

- 1 December Midlands NED Safety Champions Network Meeting
- 2 December HNY LMNS Delivery Board
- 4 December NNEL MNVP quarterly meeting
- 18 December Maternity & Neonatal Assurance (MNAG)
- 22 January NHSE Armed Forces Maternity Pathway
- 23 January QSC Development – Maternity & Neonatal reporting and papers review.

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
The Safety Champions are please to note that the ATAIN rate at HUTH has now returned to <5% and are please to note a planned Pan-Group QI project to improve skin-to-skin following caesarean births.	The Safety Champions are aware that a positive 15 Steps has taken place at DPOW by the MNVP Leads and look forward to the full report. Badgernotes continues to be a challenge, however, the Safety Champions are pleased to note the launch of the Mama Academy Pregnancy Passports in early February.	Birth in Focus: Midwifery Unit Network Project launched continues with positive feedback from staff who have attended. Training Days launched to upskill Midwifery Support Workers with positive feedback.

Good practice, improvements & innovation to share:

- **Maternity Safety Support Programme:** The Safety Champions are delighted to note the confirmation that HUTH Maternity Services has now exited the Maternity Safety Support Programme.

- **Workforce Business Case (Group):** Recruitment commenced across the Group following agreement of the Workforce Business Case.
- **Bereavement Midwives:** The Safety Champions are pleased that 1.5 WTE Bereavement Specialist Midwives appointed at NLAG and will shortly commence in post addressing a gap that has existed for some time.
- **Governance Team:** The Safety Champions positively note the increase support for Governance across Maternity and Neonatal Services with appointments of a Neonatal Governance Lead ad Deputy Governance Lead at NLAG.
- **Uterine Artery Doppler:** The Safety Champions are pleased to note that this issue has progressed at NLAG and that UADs will commence at DPOW at the end of February.

Risks & concerns to escalate:

- **Data Clerk:** Currently no data Clerk in post at HUTH Neonatal Unit and unable to recruit due to freeze on non-clinical roles.
- **Infection Control:** Concerns regarding infection control at HUTH Neonatal Unit.
- **Staffing levels:** Maternity and neonatal departments are still facing staffing challenges because of staff illness, high rates of maternity leave, and newly qualified midwives and nurses who are completing their scheduled supernumerary periods.

Activities planned next month:

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

- LMNS Delivery Board
- Maternity & Neonatal Assurance Group

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

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

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)007

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th of February 2026
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	Maternity & Neonatal Assurance Report including · Perinatal Mortality Review Tool Quarterly Reports and Scorecards HUTH **BIC(26)007a** · Perinatal Mortality Review Tool Quarterly Reports and Scorecards NLAG **BIC(26)007b** · HUTH & NLAG MIS Year 7 declarations
Executive Summary	Maternity and neonatal services across Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire & Goole (NLAG) continue to deliver safe care with positive user experience, while navigating ongoing workforce, training, and data quality challenges. Both organisations remain aligned to the NHS England Three-Year Delivery Plan, with key risks focused around workforce, CNST compliance, and implementation of core safety bundles. **Quality, Safety & Outcomes** · Perinatal deaths (Dec 2025): o HUTH: 2 antenatal stillbirths (24+2, 34+5), 1 neonatal death (25+0). o NLAG: 0 antenatal stillbirths, 0 neonatal death. · Reviews: Active PMRT and MNSI investigations highlight key themes: risk assessment missed, non-adherence to GAP pathway and documentation gaps. · Term admission rates: HUTH and DPOW remain within the national <6% benchmark, with SGH having an increase in December. Respiratory distress remaining a leading cause for separation. · National Prevention of Future Deaths (Manchester Homebirth case) This case is a sentinel learning event for maternity services nationally. It underscores that women's choice of birthplace must be supported by safe systems, competent staff, and robust risk governance. Immediate assurance and sustained cultural and operational reform are required to support the safety of women and birthing people, babies and midwives. Immediate actions in place and updates will be provided via the Maternity & Neonatal Assurance Group and report. **CNST MIS Year 7 Compliance** · HUTH: full compliance to be declared for all 10 safety actions. · NLAG: compliance to be declared for 9/10 safety actions. SA8 non-complaint due to one staff group being below 90% due to unforeseen circumstances, mitigation to be provided in board declaration. **Workforce & Staffing**

	· Vacancy rates: Midwifery ~7% across both organisations; neonatal nursing pressures most notable at HUTH, with fill rates as low as 61–70% on some shifts. · Training compliance (SA8): o Midwives: generally >90% across most areas. o Medical staff: below the 90% target in several domains, particularly at NLAG. · Red flags (Dec 2025): o HUTH: 58 (mostly induction delays) o NLAG: 14 (similar themes plus delayed recognition or action on abnormal vital signs). **Service User Experience** · Feedback remains positive, with users frequently highlighting compassionate staff, community midwifery, Ask-a-Midwife, and C-section care. · Areas needing improvement: BadgerNet usability, communication and listening and discharge processes. · FFT: NLAG – 92% positive for maternity and 100% for neonatal care. HUTH – new poster launched December, awaiting data. **Operational Performance** · BSOTS compliance: HUTH- under target of 80%. NLAG compliance >80%. · Saving Babies' Lives v3: Both Trusts are progressing but remain below LMNS trajectories in several elements, particularly preterm birth interventions. Best endeavours met for MIS Year 7. · VTE performance: Variable, with some sites requiring improvement at 6- and 14-hour assessment windows. **Culture, Leadership & Staff Voice** · Multiple initiatives underway including Tea Trolleys and T2 workshops for Matrons. Perinatal Workforce Culture Group due to shortly be established. · Key themes from walkarounds: concerns about triage timeliness, space constraints, support for newly qualified midwives, and need for consistent medical presence. **Key Risks** · Workforce shortages and skill mix in maternity and neonatal units. · Training compliance gaps affecting CNST readiness. · Neonatal cot capacity and infrastructure limitations. · Data quality issues across BadgerNet, BSOTS, and SBL reporting. · Delays in induction of labour at HUTH. · Inadequate estate for community midwifery teams (NLAG).
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities	

(if applicable)		
Recommended action(s) required	☐ Approval ü Assurance	☐ Information ☐ Other – please detail below:

NHS
Humber Health
Partnership

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

January 2026

Contents

AAA Performance, Challenges, Risks	3
Section 1: Maternity Dashboard Overview	4
DPOW dashboard	4
SGH dashboard	5
HUTH dashboard	6
Section 2: Key Performance Metrics	7
2.1 NHS Resolution Maternity Incentive Scheme Update	7
2.2 CQC Progress Update	8
2.3 Ockenden: Progress of Essential Actions	9
2.4 Saving Babies' Lives Care Bundle (v.3)	9
2.5 Maternity & Neonatal Safety Improvement Plan – Progress	10
2.6 VTE Risk Assessment Performance	11
2.7 BSOTS performance	11
2.8 Baby Friendly Initiative	12
Section 3: Perinatal Mortality	13
3.1 Perinatal Mortality Summary for the period	13
3.2 Details of PMRT Review Outcomes	13
Section 4: Maternity Mandatory Training Compliance	15
Section 5: Safer Staffing	16
5.1 Maternity & Neonatal Fill rates – planned versus actual	16
5.2 Red flags, Actions and Mitigations	17
5.3 Vacancy Rates	18
Section 6: Listening to Our Staff	18
Section 7: Learning Lessons	19
7.1 MNSI cases (ongoing) – HUTH	19
7.1 MNSI cases (ongoing) – NLAG	21
7.2 Incidents graded moderate or above and rapid reviews – HUTH	21
7.2 Incidents graded moderate or above and rapid reviews – NLAG	22
7.3 Maternity Risk Register	23
Section 8: Service User Feedback	24
8.1 MNVP/Service user feedback	24
8.2 Complaints received	25
8.3 Friends and family test feedback	25
Section 9: Perinatal Quality Overview Model	27

Performance, challenges, risks and interventions

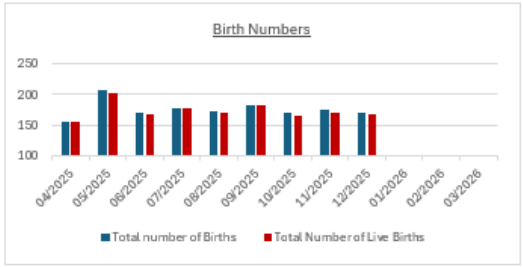
Information	Maternal Care Bundle and Improving Postnatal Care Toolkits were launched by NHS England on the 6th of January.
Alert	
Advise	National Prevention of Future Deaths (Manchester Homebirth case A letter was received from the Chief Midwife following the publication of the 'Prevention of Future Deaths Report' in January 2026 which was published following the urgent review of homebirth services. The report raises several concerns and requests Maternity Services to urgently review the safety and quality of homebirth services. This case is a sentinel learning event for maternity services nationally. It underscores that women's choice of birthplace must be supported by safe systems, competent staff, and robust risk governance. Immediate assurance and sustained cultural and operational reform are required to support the safety of women and birthing people, babies and midwives. Immediate actions in place and updates will be provided via the Maternity & Neonatal Assurance Group and report.
Assure	CNST MIS Board Declaration form to be submitted to Trust Board in February 2026 before submitting to CEO and LMNS.

1.MATERNITY DASHBOARD OVERVIEW

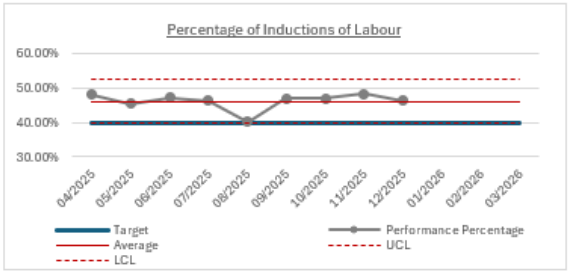
Maternity Overview - Diana Princess of Wales (DPOW)

Latest Month: December 2025

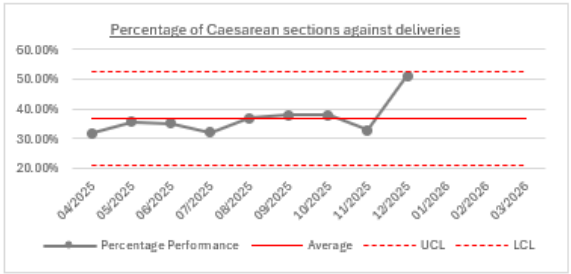
Number of Births / Live Births



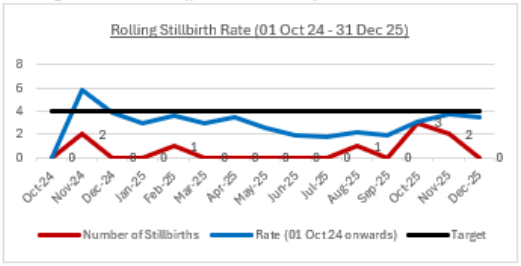
Induction of Labour Rate



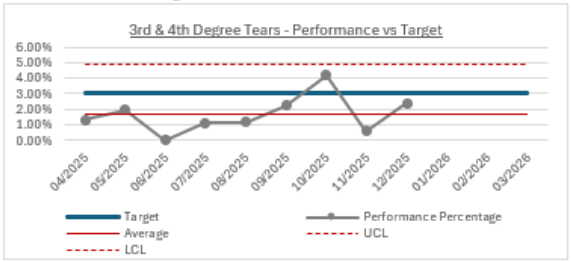
Caesarean Section Rate



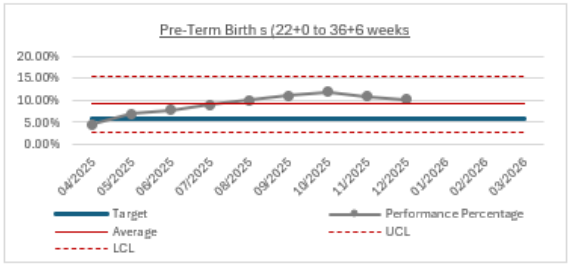
Rolling Stillbirth Rate (per 1000 births)



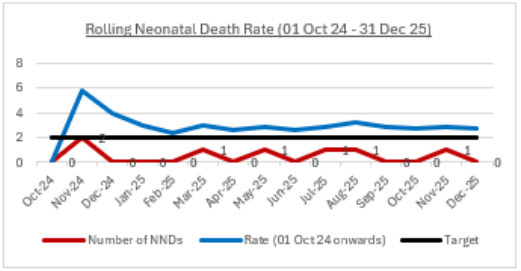
Third and Fourth Degree Tear Rate



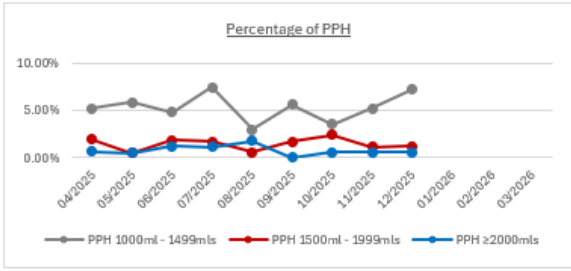
Preterm Birth Rate



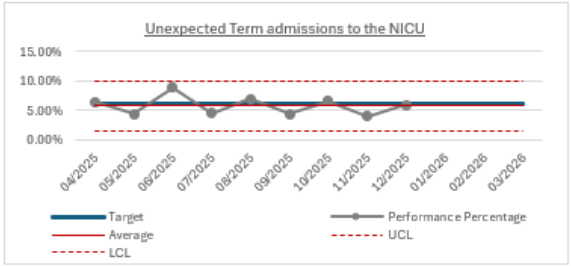
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



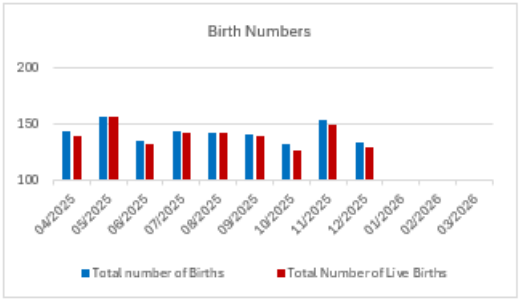
Unexpected Admission to NICU



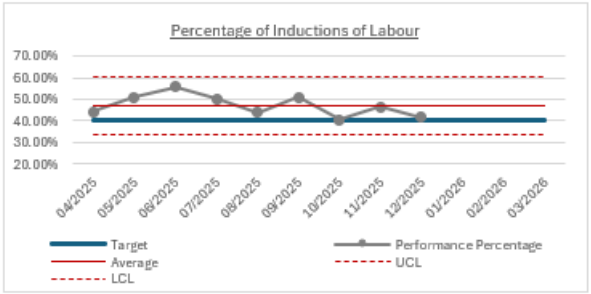
Maternity Overview - Scunthorpe General Hospital (SGH) & Goole District Hospital

Latest Month: December 2025

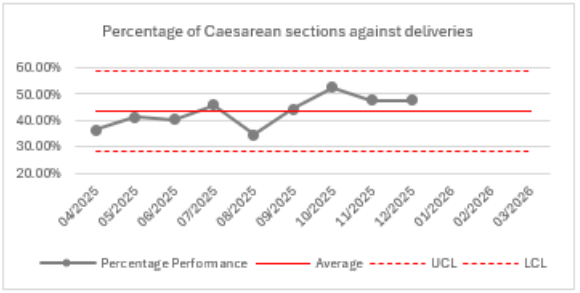
Number of Births / Live Births



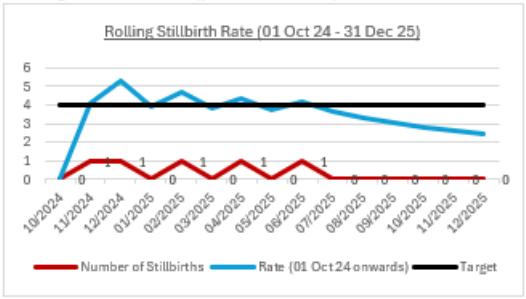
Induction of Labour Rate



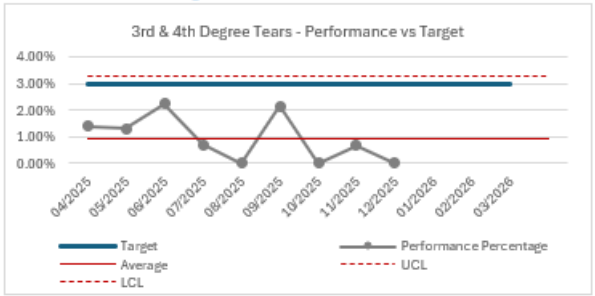
Caesarean Section Rate



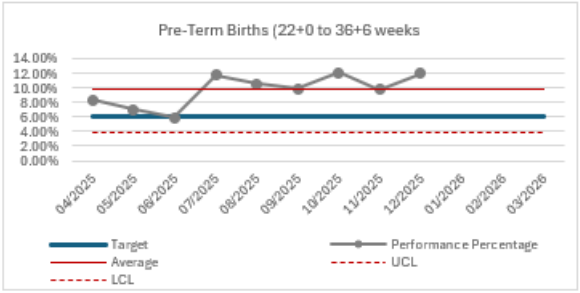
Rolling Stillbirth Rate (per 1000 births)



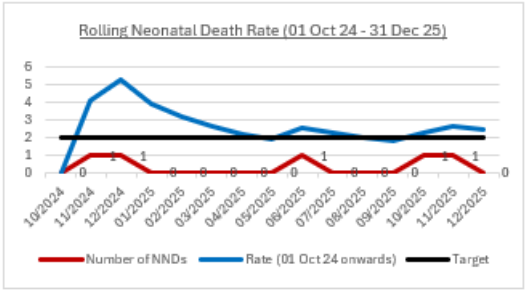
Third and Fourth Degree Tear Rate



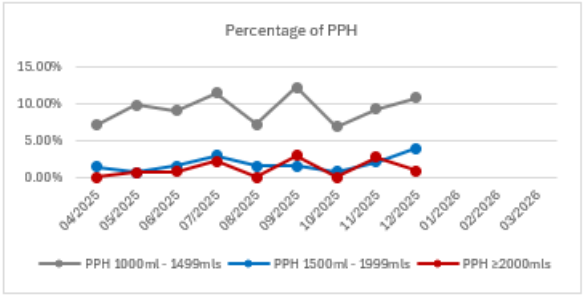
Preterm Birth Rate



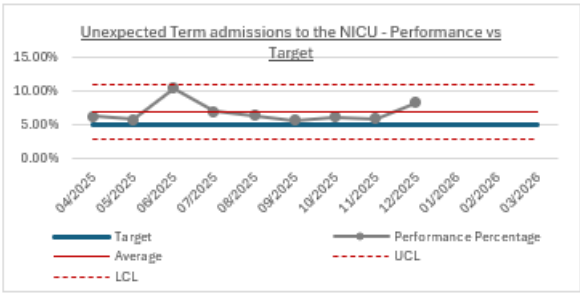
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU

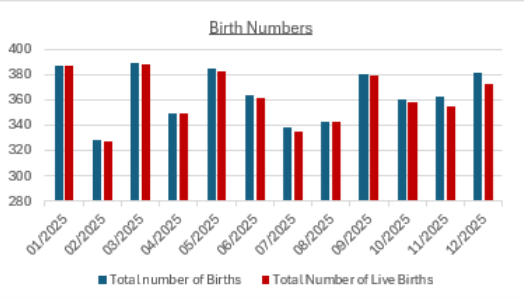


** The rolling stillbirth / neonatal death rates are based on data extracted from Badgernet. Issues noted in reporting when comparing to Power BI sourced data.*

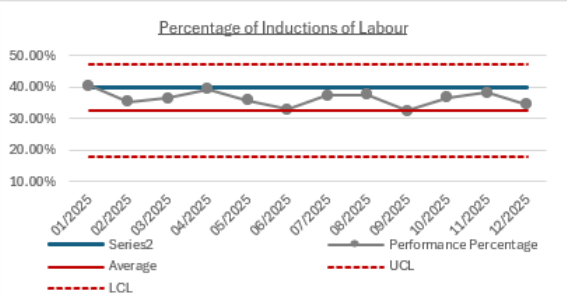
Maternity Overview - Hull University Teaching Hospitals (HUTH)

Latest month: December 2025

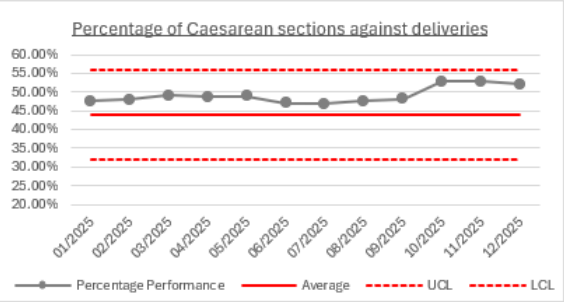
Number of Births / Live Births



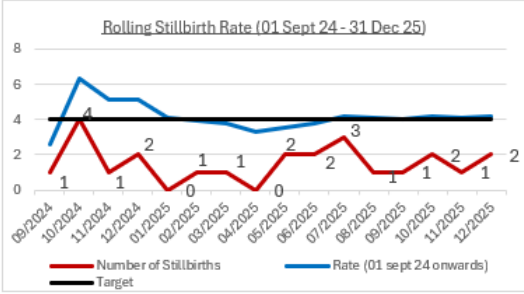
Induction of Labour Rate



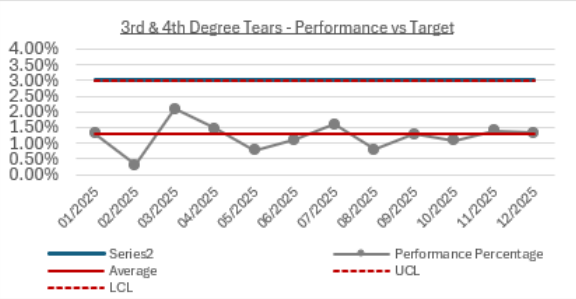
Caesarean Section Rate



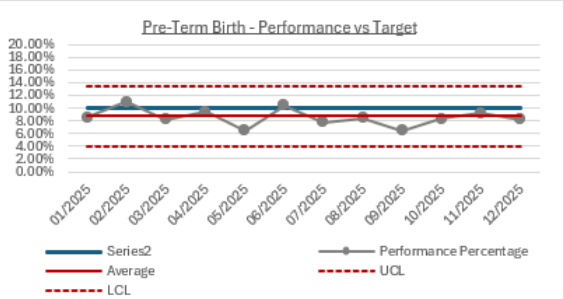
Rolling Stillbirth Rate (per 1000 births)



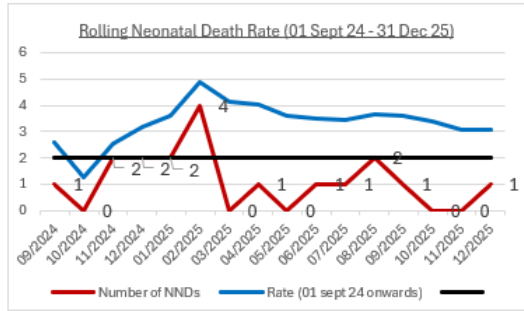
Third and Fourth Degree Tear Rate



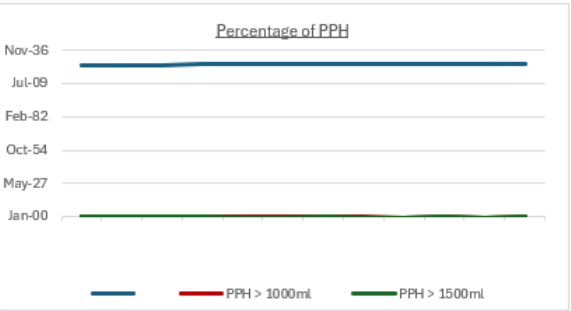
Preterm Birth Rate



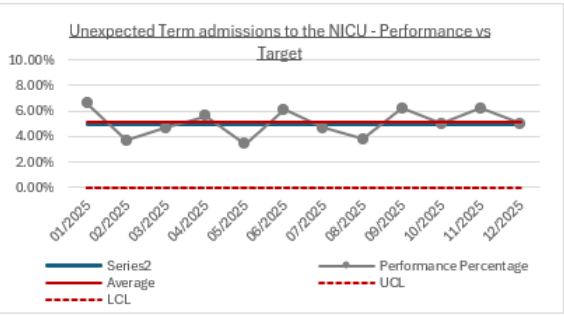
Rolling Neonatal Death Rate (per 1000 births)



Post-partum Haemorrhage Rate



Unexpected Admission to NICU



2. PERFORMANCE METRICS

2.1 NHS Resolution Maternity Incentive Scheme Update

MIS Year seven guidance was published in April 2025. The Board Declaration has been completed and will be submitted to Trust Board in February 2026 for both HUTH and NLAG.

HUTH will be declaring full compliance for all ten safety actions. NLAG will be declaring non-compliance overall following advice received from NHS Resolution due to Fetal Monitoring training compliance for one staff group being below the 90% target (Safety Action 8). Mitigation has been added to the Board Declaration Form for consideration.

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

Safety action	HUTH				NLAG			
	Red	Amber	Green	Blue	Red	Amber	Green	Blue
1 National Perinatal Mortality Review Tool								
2 Maternity Services Data Set (MSDS)								
3 Transitional Care Services								
4 Clinical Workforce Planning								
5 Midwifery Workforce Planning								
6 SBLCB V3								
7 Service User Feedback / Co-produced Services								
8 Training								
9 Floor to Board								
10 MNSI / Early Notification Scheme								
Total	**0**	**0**	**0**	**10**	**1**	**0**	**0**	**9**

2.2 CQC Progress Update

Northern Lincolnshire and Goole NHS Foundation Trust

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

Hull University Teaching Hospitals NHS Trusts

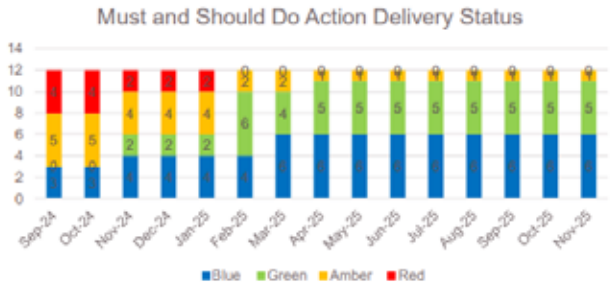
The overarching Maternity Service CQC action plan contains 37 sub actions from the ‘9 Must’ and ‘3 Should’ (12) do actions detailed in the inspection report published in August 2023.

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

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

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

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



2.3 Ockenden: Progress of Essential Actions

The final Ockenden report was published in 2022 which identified 15 areas of care where there are opportunities for learning and improving the quality of care. A total of 92 sub actions are detailed within the report. Of those, 8 are the responsibility of national teams to implement and therefore no further action is required. The remaining 84 have been assessed, the status of each sub action is detailed in the table below for both HUTH and NLAG.

Actions that are not on track predominantly relate to workforce capacity, the introduction of key leadership roles and standalone clinics. +

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

Status	NLAG	HUTH
Blue	70	20
Green	1	28
Amber	2	26
Red	11	3
Grey (National/Regional)	8	8

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

Improvement work continues at both HUTH and NLAG with the overall aim of being fully compliant with the Saving Babies Lives Care Bundle Version 3.2. Current compliance is detailed in the table below and data collection is currently taking place for Q3 25/26. The key risks across the group relate to smoking in pregnancy and pre-term birth / optimisation.

Quarter 2 25/26 – Performance	**HUTH**	**NLAG**
Element	**Current Compliance**	**Current Compliance**
Element 1: Smoking in pregnancy	70%	90%
Element 2: Fetal growth restriction	100%	90%
Element 3: Reduced fetal movements	100%	100%
Element 4: Fetal monitoring in labour	100%	100%
Element 5: Preterm birth	85%	69%
Element 6: Diabetes	100%	83%
Total	**90%**	**83%**

2.5 Maternity & Neonatal Safety Improvement Plan – Progress

The Maternity and Neonatal Improvement plan continues to be monitored by the Maternity and Neonatal Improvement Group. A total 394 actions are now complete. The table below provides a breakdown of progress for the remaining open actions within each workstream. A meeting is due to take place early February to review the open/off track actions.

Workstream	**Number of Actions HUTH**	**Number of Actions NLAG**
Culture		
Signed off and evidenced	**11**	**21**
Complete	9	-
In progress	8	7
Delays/issues	1	1

Safety

Signed off and evidenced	**16**	**14**
Complete	21	4
In progress	11	4
Delays/issues	4	2

Experience

Signed off and evidenced	**17**	**11**
Complete	6	-
In progress	7	3
Delays/issues	6	2

Assurance

Signed off and evidenced	**61**	**113**
Complete	56	34
In progress	21	16
Delays/issues	23	34

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

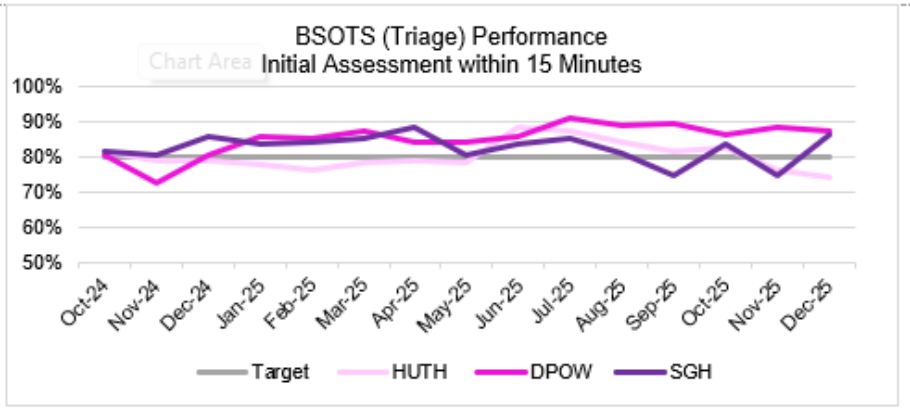
2.6 VTE Risk Assessment Performance

The table below details the performance for each hospital site for **December 2025**. Compliance is sourced from Badgernet reporting, further ward breakdown can be accessed from Power BI reporting, however, caution should be applied as the lag in data import from the data warehouse means that data is not updated in 'real time' which results in lower compliance reported for the current month.

	VTE risk assessment completed (6 hours)	VTE risk assessment completed (14 hours)	VTE risk assessment completed (24 hours)	VTE risk assessment completed (postnatal)
HUTH	79%	90%	95%	99%
DPOW	80%	85%	90%	87%
SGH	59%	74%	81%	96%

2.7 BSOTS Performance

The chart and table below demonstrates ongoing performance with regards to women/birthing people being seen for initial assessment in Triage within 15 minutes of arrival for each hospital site and whether those categorised as red are seen within 15 minutes. Data quality issues have been identified whereby the time of assessment was recorded prior to the time of arrival on Badgernet and falsely reported as not meeting the target. This has been escalated and monitoring continues to take place across all sites. Targeted work is ongoing at HUTH.



Seen within 15 minutes - Level of urgency: RED				
Month	**Target**	**HUTH**	**DPOW**	**SGH**
Oct 25	100%	96% (16/17)	75% (3/4)	100% (2/2)
Nov 25	100%	89% (16/18)	100% (6/6)	66% (2/3)
Dec 25	100%	100% (12/12)	100% (3/3)	100% (2/2)

2.8 Baby Friendly Initiative

Hull University Teaching Hospitals NHS Trusts

HUTH reached stage 3 and achieved the first reassessment in 2019. Reassessment was booked in 2023, however this was subsequently cancelled due to the staffing issues and the CQC section 31. As a result, the accreditation has been on hold with UNICEF BFI since.

The following work has recently taken place:

- Providing a full day update in 2025 for maternity staff without them being cancelled for unavoidable reasons as previously, ensuring we are compliant.
- The implementation of day 3 breastfeeding assessment/support and weight check visits has been launched across Hull & East Riding, which has been well received by service users and will support breastfeeding longevity.
- Major guideline revisions and updates.
- 2025 BFI Mother audits have shown improvements in care.
- Ongoing specialist infant feeding clinic provision as a priority, including the midwife-led frenotomy service.
- Planned expansion of the infant feeding team, and our BFI Guardian is appointed, supporting to ensure that the UNICEF BFI standards can be met.

Following a meeting with UNICEF in December, HUTH are hoping to be able to move forward with an assessment this summer. The level of which will depend on our CQC status and our BFI audit results, which are underway. Ultimately, the goal is to progress to achieving sustainability, to ensure our service supports families so that all babies get the best start in life.

Northern Lincolnshire and Goole NHS Foundation Trust

The Gold Award accreditation is due for renewal. It is vital that there is the funding made available and the support in place to maintain this valuable status that NLAG is proud of achieving and ensure that BFI standards remain in place to ensure women receive a high level of care and support in relation to feeding.

Key risks identified:

- Possible issues for the future if there is no further funding from the Family Hubs to support the increased Peer Support team for home visiting and increased presence in the Support Groups.
- Peer supporters in Lincolnshire not having their funding renewed.
- Feeding Co-ordinator role may not be funded which would impact on the joint training that is provided with the IFL.

3. PERINATAL MORTALITY

3.1 Perinatal Mortality Summary for the period

Perinatal deaths within month (December 2025)					
	Antepartum Stillbirth	Indeterminate stillbirth	Intrapartum stillbirth	Neonatal death	Infant death/post-neonatal
HUTH	2 (24+2, 34+5)	0	0	1 (25+0)	0
NLAG	0	0	0	0	0

3.2 Details of PMRT Review Outcomes (November 2025)

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

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

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

The tables below provide an overview of the cases discussed at PMRT meetings during November 2025 including the overall grading assigned to each case and the outcome / learning identified.

Hull University Teaching Hospital NHS Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
99689	B/A	N/A	N/A	Move to report writing. Arranging debrief
99180	A/A	N/A	N/A	Move to report writing. Arranging debrief
100134	B/B/B	N/A	N/A	Move to report writing. Arranging debrief
100192	A/A	N/A	N/A	Move to report writing. Arranging debrief

Northern Lincolnshire and Goole NHS Foundation Trust

PMRT Reference	Grading of care (mother / baby)	Reviewed at Learning Response Panel	Date Reviewed at Learning Response Panel	Outcome
100659	A / C	Yes	26/11/25	Fetal demise was identified at Fetal medicine clinic appointment at 22+1. Baby was known extremely growth restricted with pre-terminal dopplers and a very reduced estimated fetal weight. Mifepristone was not given. Admitted to CDS the next day to continue the cherished care pathway intrapartum care where 8x 100mcg misoprostol pv were given. 1x mifepristone 200mg po was given. 3x misoprostol 100mcg pv were given then 3x misoprostol 200mcg pv were given. The baby was delivered at 23+0. Summary of learning points: · Midwife should have had professional discussion with obstetricians regarding giving of meds and not with the woman and her family before getting all the facts in order. Not prescribed medications using the EPMA process set up digitally for these patients.

1. MATERNITY TRAINING COMPLIANCE

Hull University Teaching Hospitals NHS Trust

Month: Dec 25	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetist Consultant	Anaesthetist (other)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	99%	N/A	100%	100% (prior 01/07) 81% (after 01/07)	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	96%	100%	100% (prior 01/07) 88% (after 01/07)	100%	100% (prior 01/07) 100% (after 01/07)	N/A	N/A	N/A	N/A
Neonatal Resus (1 year MIS)	99%	N/A	N/A	N/A	N/A	N/A	92%	100%	91%	100%
NLS (4 year MIS)	N/A	N/A	N/A	N/A	N/A	N/A	94%		N/A	N/A
Personalised Care	98%	98%	85%	87%	N/A	N/A	N/A		N/A	N/A

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Dec 25	Midwives	MSWs	Obstetricians (Consultants)	Obstetricians (Other doctors)	Anaesthetists (Consultants)	Anaesthetists (other doctors)	Neonatal Consultants	Neonatal (Other doctors)	Neonatal Nurses	ANNP
Fetal Monitoring (MIS)	97%	N/A	100%	Before Jul 25 100% After Jul 25 55%	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT (MIS)	98%	99%	100%	Before Jul 25 100% After Jul 25 55%	96%	Before Jul 25 100% After Jul 25 100%	N/A	N/A	N/A	N/A
Personalised Care (SBLCB)	95%	98%	87%	Before Jul 25 80% After Jul 25 32%	N/A	N/A	N/A	N/A	N/A	N/A
Care during Labour & PN	97%	N/A	73%	Before Jul 25 40% After Jul 25 100%	N/A	N/A	N/A	N/A	N/A	N/A
Neonatal Resus (1 year) (MIS)	98%	N/A	N/A	N/A	N/A	N/A	94%	Before Jul 25 100% After Jul 25 69%	100%	100%
NLS (4 year) (MIS)	N/A	N/A	N/A	N/A	N/A	N/A	100%	Before Jul 25 100% After Jul 25 76%	N/A	N/A

2. SAFER STAFFING

5.1 Maternity & Neonatal Fill rates – planned versus actual

Northern Lincolnshire and Goole NHS Foundation Trust

Month: Nov 25	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	3204.3	2811.3	87.7%	3194.1	2913.7	91.2%	1620.0	1537.4	94.9%	1380.0	1370.0	99.3%
SGH	2484.3	2311.0	93.0%	2484.3	2222.0	89.4%	690.0	639.0	92.6%	915.0	774.5	84.6%

Month: Nov 25	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
DPOW	3105.0	2.692.4	86.7%	2760.0	2622.5	95.0%	1380.0	1244.0	90.1%	1035.0	947.6	91.6%
SGH	2070.0	1852.3	89.5%	1725.0	1754.1	101.7%	1380.0	1145.5	80.8%	1035.0	1059.3	102.4%

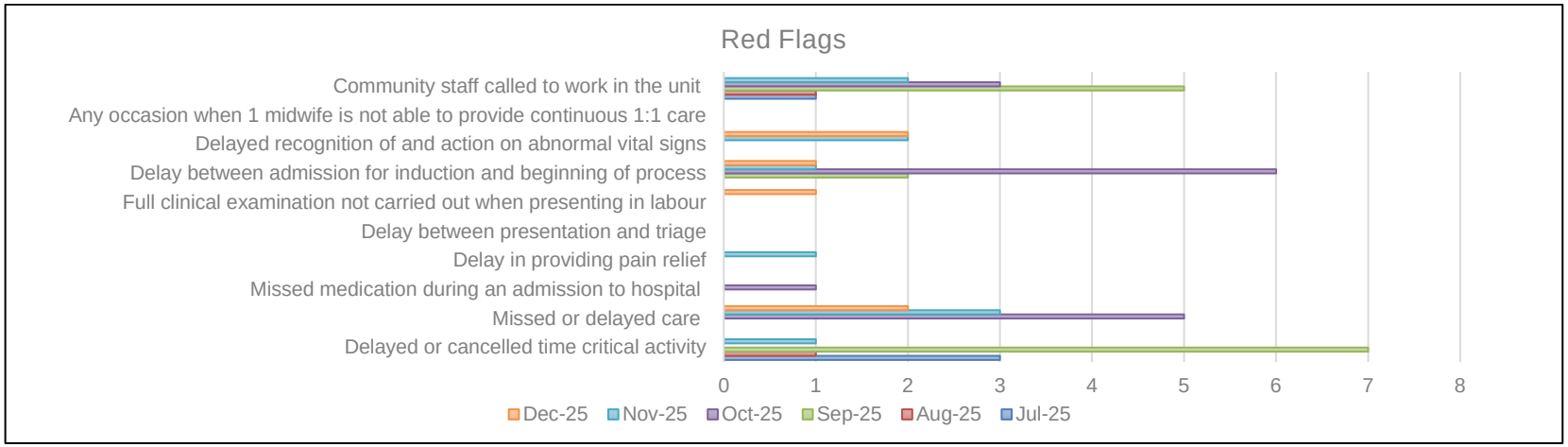
Hull University Teaching Hospitals (HUTH)

Month: Nov 25	Midwives						Midwifery Support Workers					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	10381.5	9278.45	89.37%	6283.00	5096.75	81.12%	3543.68	2911.68	82.17%	2966.50	2128.17	71.7%

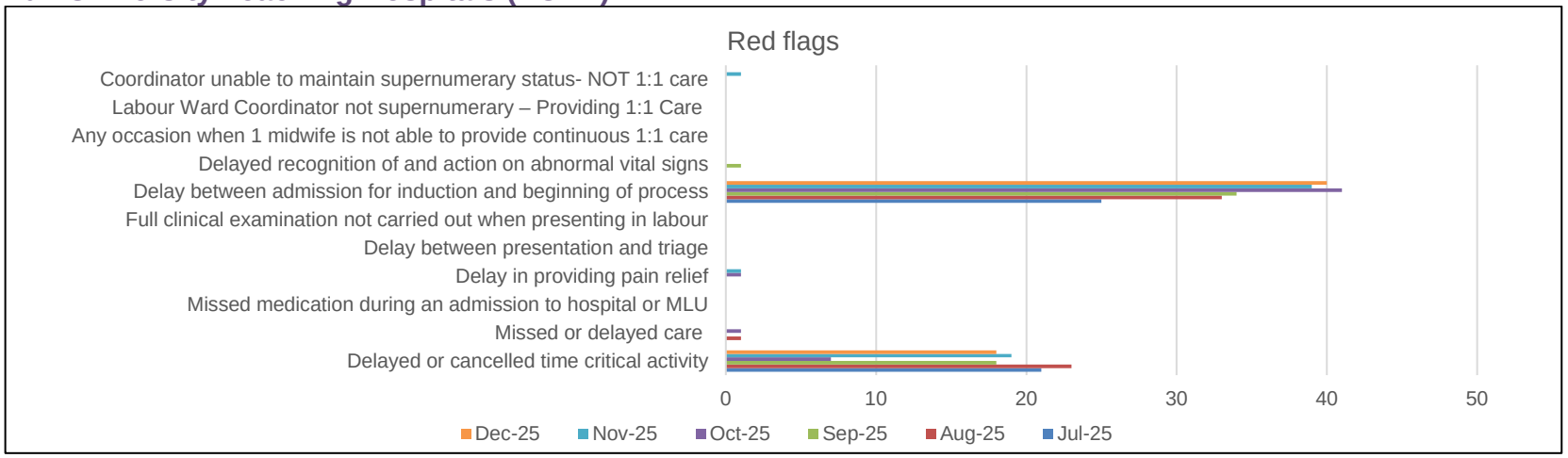
Month: Nov 25	Neonatal Nurses						Care Staff					
	Day			Night			Day			Night		
Site:	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %	Planned	Actual	Fill Rate %
HUTH	9808.25	6032.33	61.5%	6656.00	4534.92	68.13%	568.00	378.50	66.64%	330.00	232.00	70.30%

5.2 Red flags, Actions and Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust



Hull University Teaching Hospitals (HUTH)



5.3 Midwifery Staffing Vacancy Rates (November 2025)

Staff group	Vacancy rate HUTH	Vacancy rate adjusted HUTH	Vacancy rate NLAG	Vacancy rate adjusted NLAG
Midwifery	7.5%	4.2%	1.6%	-8.5%
Midwifery Support workers	9.8%	8.7%	-10.2%	-24.4%

3. LISTENING TO OUR STAFF

General Staff Feedback

- Communication survey sent to staff
- Staff consultation relaunched at DPOW following staff concerns around the previous rotation
- Listening Event for Scunthorpe and Goole Midwives- further workshops planned with Community Midwives across the Group following the Prevention of Futures Death order issued by the Manchester Coroner
- Launch of new Perinatal Culture Workstream
- Tea Trolleys continue at HUTH and are commencing at NLAG
- Midwifery Supporting Training Days have now commenced

4. LEARNING LESSONS

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

Hull University Teaching Hospitals (HUTH)

MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN/referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-042322	White British – IMDD 9	Yes	Yes	Yes	Yes	Yes	Planned homebirth (transfer in for delivery) and cooled baby. Doula supporting family. Staff interview stage. MIRM review completed. ENS referral. DoC compliant. Awaiting draft report. Report accepted. Staff debrief planned. **Action plan to follow pan-group pathway.**
MI-048159	White British – IMDD 1	No	Yes	Yes	Yes	Yes	37+6 MOH 5500ml and hysterectomy. Consent gained. Information being uploaded to Portal. MDT including anaesthetic and theatre MDT planned 07/11/2025. For uplift to LRP. **Interviews being conducted.**
MI–049911	BA – IMDD 8	No	Yes	Yes	Verbal completed	N/A	Maternal death approx. 9/40 pregnant. Found unresponsive at home and transferred to A&E. No care provided at HUTH. PM via coroner as no MCDD). **Rejected by MNSI as unable to contact family. LRP escalated to. Coroner found CoD – ruptured ectopic. YAS informed and logged on DATIX. Legal also informed**

MI-050092	BA – IMDD 1	No	Yes	Yes	Yes	Yes	39+2 Intrapartum SB. BA booked ELLSCS for previous. Attended ? labour and baby believed to be alive. Delivered via CS. Nuchal cord and thick meconium seen. USS rejection pathway discussed. Regional exploration of USS pathways for triple anti-retroviral therapy in progress. Local non-adherence to GAP pathway. **Interviews being conducted.**
MI-049569	WB – IMDD 8	Yes	Yes	Yes	Yes	Yes	41+3. MLC. Well managed. Pre-birth optimisation including terbutaline. Delivered 31mins from decision (x2 theatres open and requiring a third). MAS and PPHN. MRI – NAD. **MNSI have declined this investigation. PSIRF panel being updated. No family or organisational concerns. Debrief offered to family.**
MI-048987	WB – IMDD 8	Yes	Yes	Yes	Yes	Yes	37+6 actively cooled. Pre-terminal CTG. MLC (Seizure in pregnancy). Not risk assessed in ANC. Equipment shortage of sonicaid (did not affect outcome). MRI – HIE 3 (first since December 2023). **Interviews being conducted.**
MI-045011	WB – IMDD 5	Yes	Yes	Yes	Yes	Yes	Term baby cooled. Transfer from HUTH to NLAG for continuation of IOL. **Draft report received for factual accuracy. Sent to HUTH staff involved.**

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MNSI number	IMD/Ethnicity	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN/referral?	Did the family require and received information in a format/language that was accessible for them?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-045011	White British	Yes M25CT600/007	Yes	Yes	Yes	Yes	Draft MNSI received by the Trust for factual accuracy. Awaiting final report.
MI-049981	White British	No	Yes	Yes	Yes	Yes	Accepted by MNSI for investigation 28/11/25. Rapid review undertaken and good team working was identified. Delayed engagement of patient with MNSI.

7.2 Detail of incidents graded moderate or above and rapid reviews (December 2025)

Hull University Teaching Hospitals

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
394970 – 34+5 AN still birth. Attended CMW appointment but no heartbeat.	7/WB	Obstetric	Moderate – PMRT 101816	MIRM completed. To remain moderate. Non-adherence to PLGF pathway (educational review with ADU/Triage underway). No Obstetric review with raised PCR. Discussion around CTG being ?required due to raised PCR but local and national guidance state only upon diagnosis of PET/Gestational hypertension.
395835 - Now P1 NVD at 01:03am (DOP 1st & 2nd stage, delivered DOA, Involuntary pushing 40+ min, active pushing 1	1/WB	Obstetric	Moderate – downgraded following LMR to low	· Well managed. Hands on. Adherence to OASI bundle. To be included in thematic review. No delay in repair. Risk factors: 19, short perineum <2.5cm.

hour) 4th Degree tear, total EBL 400ml.				

Northern Lincolnshire and Goole NHS Foundation Trust

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
395784 - Major obstetric haemorrhage, hysterectomy and ICU admission.	Kurdish Iranian	Obstetrics	Moderate	Downgraded following rapid review to low harm.

7.3 Maternity Risk Register

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

Hull University Teaching Hospitals NHS Trust

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

Northern Lincolnshire and Goole NHS Foundation Trust

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

5. SERVICE USER FEEDBACK

8.1 MNVP/Service User Feedback

Hull University Teaching Hospitals NHS Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production (December 25 update)	
Going well • Caring midwives, going the extra mile • C-Sections (planned and emergency) • Community midwifery • Ask a Midwife service • MLU (if able to use) • Charitable partners support • Grand round receiving good feedback from parents on NICU • Focusing on neurodivergent service users and teenagers.	**Not going so well** • Badger notes app • Feeling dismissed/not listened to • Rowan ward discharges – often delayed and discharged in the evening. • Women not understanding/being fully informed of the reasons for IOL / Caesarean section. • Medication – unsure of the reason why they are taking medication • Women unsure why they are attending appointments.

Northern Lincolnshire and Goole NHS Foundation Trust

Insights from service users and Maternity & Neonatal Voices Partnership Co-production (December 25 update)

Going well – Maternity • Praise for Smoking cessation support (one mother 10 months postnatal and still stopped)Consistent feedback that midwives are very caring and supportive. • Nest & Nurture Fair – partners reporting positive feedback **Going well – Neonatal** · MH midwifery support for those with history of pre-term birth. Partners able to access support if needed. · Staff really supportive and taking time to build confidence. · PTBC - Feel supported by the midwives/consultants and understand the reasons for being under their care.	**Not going so well – Maternity** • Badger notes app is inaccessible due to network issues • Registering pregnancy - worry if the referral has gone through • Wait times in clinic – comments around how long the wait times are or being there for hours and not knowing why. • Debriefs following caesarean or assisted birth - women reporting not fully understanding why things happened also long wait list for Birth Reflections • Flippant comments from Dr's leaving negative impacts on women **Not going so well – Neonatal** · Self-discharge from postnatal ward (SGH). · Lack of information on signs of PTL, NICU information, ward tours.

8.2 Complaints Received

The number of complaints received in maternity during **December 2025** are detailed in the tables below along with any themes identified.

NLAG		**HUTH**	
No received:	4	No received:	3
The 4 complaints related to concerns regarding: Delays in action / treatment, loss of late term pregnancy Clinical treatment and communication (not provided with required information regarding baby's health following birth and retained products) No communication from Sonographer during scan, patient felt rushed during procedure Concerns raised regarding Caesarean section and bleeding following discharge		The 3 complaints related to concerns regarding: Patient unhappy with care and treatment in late pregnancy and birth experience Family member unhappy with communication and support following Caesarean section Concerns raised regarding birthing experience and care of baby following delivery. Did not feel listened to.	

8.3 Friends and Family Test Feedback

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HUTH's contract with Health Care Communications ended at the end of July. In December, the patient experience team launched and distributed a new Friends & Family poster with a QR code included. Upcoming data will be ward/department specific and awareness will be raised to increase submissions in Maternity.

The Bereavement team received feedback in November from 1 family, with 100% positive feedback.

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For November 2025 a total of 7 responses were received for NICU. 100% of the feedback was positive. For Maternity, 24 responses were received with 92% positive feedback, 4% reported neither good nor poor and 1 (4%) service user rated their care as 'very poor'.

6. PERINATAL QUALITY OVERSIGHT MODEL

Hull University Teaching Hospitals NHS Trust

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

Data measure	November 2025	
Findings of reviews of all perinatal deaths using the real time data monitoring tool	PMRT reviews: 4. 26th November - External reviewers present. MNVP attendance. 99689: 32+ AN SB. Care graded B/A. IUD (coil) pathway live on Bridget. No OGTT performed when an inpatient. HbA1C performed. 99180: 25+5 AN SB. Care graded A/A. 100134: Joint with NLaG. Care graded B/B/B. 100192: 34+3 AN SB. Care graded A/A.	
Number of cases referred to MNSI/ENS	3 (details can be found on page 19)	
Findings of review of all cases eligible for referral to MNSI	Please refer to body of report for ongoing update of investigation.	
Number of incidents graded as moderate or above and what action is being taken	Please refer to body of report.	
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report.	
Service User Voice feedback	Please refer to body of report.	
Staff feedback from frontline champions and walk-abouts	Concerns regarding changes to payments for medical colleagues.	
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No	
Coroner Reg 28 made directly to the Trust	0	
Progress in achievement of CNST 10	Please refer to body of report – to declare full compliance.	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Place to work – 22% Receive treatment - 31%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)		91% - response rate 79% - within IQR

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

Data measure	November 2025	
Findings of review of all perinatal deaths using the real time data monitoring tool	1 PMRT MDT meeting took place. External reviewer present. A fetal demise identified at Fetal medicine clinic at 22+1 (delivered 23+0). Baby was known growth restricted with pre-terminal dopplers and a very reduced estimated fetal weight. Graded A/C.	
Number of cases referred to MNSI/ENS	1 (details can be found on page 21)	
Findings of review of all cases eligible for referral to MNSI	Please refer to body of report for ongoing update of investigation.	
Number of patient safety incidents logged and what actions are being taken	177 maternity (3 moderate) / 28 neonatal (1 moderate) 358674 (neonatal) Discussed at LRP on 13/11/25 and 04/12/25, decision made for MDT review. 359060 (maternity) Rapid review undertaken with the MDT. Learning lessons identified and action plan devised. 360460 (maternity) Rapid review undertaken with the MDT. Learning lessons identified and action plan devised. 361514 (maternity) missed opportunity to identify AFLP.	
Training compliance for all staff groups in maternity related to the core competency framework	Please refer to body of report	
Service User Voice – themes	Please refer to body of report	
Staff feedback from frontline champions and walk-abouts - themes	New staff rotation launched at DPOW.	
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No	
Coroner Reg 28 made directly to the Trust	0	
Progress in achievement of CNST 10 safety actions	Please refer to body of report	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Place to work – 47% Receive treatment - 58.6%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually) 2025		DPOW - 85% - response rate 54% - within IQR SGH – 84% - response rate 100% - within IQR

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)007a

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th of February 2026
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	Perinatal Mortality Review Tool Quarterly Reports and Scorecards HUTH
Executive Summary	
Background Information and/or Supporting Document(s) (if applicable)	The aim of this report is to provide assurance to the Trust Board and Maternity & Neonatal Board level Safety Champions that every eligible perinatal death is reported to MBRRACE-UK via the Perinatal Mortality Review Tool (PMRT) and that a robust review of the quality of care is undertaken. There 42 incidents reported to MBRRACE-UK via the PMRT between the 1st December 2024 and the 30th November All cases fall within the Maternity Incentive Scheme (MIS) reporting period, 33 eligible for review and full assessment against the MIS Safety Action 1 standards. There are 4 babies that are not eligible because the baby is still alive due to a twin pregnancy, 1 baby whose birthweight was under 200g (excluded due to this) and 7 post-neonatal deaths that are not eligible. 2 cases met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI). There have been 8 incidents reviewed through PMRT in quarter 3, 4 of these were conducted with partner organisations where care was provided prior to either in utero/ ex-utero transfer of care. There have been reports published for 6 of these. 2 are yet to receive final gradings following final review by the neonatal team. This was impacted by the junior doctor strikes in December. They were graded in January 2026 and will be included in the quarter 4 report. Grading of Care At the conclusion of the multidisciplinary review the team agree the grading of care, the categories and outcome following review of the 4 cases are as follows: <u>Grading of care provided to the mother before the death of the baby</u> · 3 cases had no issues identified that would have had an impact on the outcome. · 3 case had issues identified that would have had no impact on the outcome. · 1 case had issues identified that may have impacted the outcome · 1 case had issues that have impacted the outcome

	Grading of care provided to the mother after the death of the baby · 5 cases had no issues identified that would have had an impact on the outcome. · 2 case had issues identified that would have had no impact on the outcome. · 1 case had issues identified that may have impacted the outcome Scorecard Quarter 3 · Term NNU Admissions top incident by volume · 7 new complaints · Emergency buzzer QI completed · Continued quarterly reviews of PPH >1500ml, perineal trauma and shoulder dystocia · QI Project on hypertension and PLGF commenced
Prior Approval Process	
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 3 2025/26)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

January 2026

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

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

1.1 MBRRACE-UK reporting requirements and PMRT support:

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

2. STANDARDS

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

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

3. SUMMARY

3.1 Eligible Incidents in MIS Year Seven (Appendix A)

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

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive	Not eligible
December 2024	3	1	0	2 (post-neonatal)
Q4 (01 Jan – 31 Mar 25)	8	0	1	0
Q1 (01 Apr – 30 Jun 25)	3	1	1	1 (BW<200g)
Q2 (01 Jul – 30 Sept 25)	10	2	1	4 (post-neonatal)
Q3 (01 Oct – 31 Dec 25)	7 (4 in MIS Y7)	1	1	1 (post-neonatal)
Total	**31**	**5**	**4**	**8**

33 cases are eligible for notification only or review and full assessment against CNST standards. Of these, 100% were notified to MBRRACE within seven days. There are **5** notifications only which are due to reasons such as a MTOP, which meet the criteria as above. There are **4** babies that are not eligible because the baby is still alive due to a twin pregnancy, **1** baby whose birthweight was under 200g (excluded due to this) and **7** post-neonatal deaths that are not eligible. **2** cases met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

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

3.2 Summary of all incidents reviewed through PMRT in Quarter 3 2025/26 (Appendix B)

There have been **8** incidents reviewed through the PMRT process in quarter 3; **4** of these were conducted with partner organisations where care was provided prior to either in utero/ ex-utero transfer of care. There have been reports published for **6** of these. **2** are yet to receive final gradings following final review by the neonatal team. This was impacted by the junior doctor strikes in December. They were graded in January 2026 and will be included in the quarter 4 report.

MNSI were also invited and attended as part of our review process.

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

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

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

Grading of care provided to the mother after the death of the baby

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

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

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

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

3. Saving Babies' Lives (Appendix E)

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

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

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

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

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	Notified < 7 days	Review started < 2mth	Review Publish < 6mth	External rep present at review
Dec 24	**96445**	Neonatal death	27+2	13.10.24	11.12.24	650g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96455	Antepartum stillbirth	38+3	13.12.24	13.12.24	2810g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 11/06/25)	Yes – LMNS
	96467	Neonatal death	37+1	13.06.24	15.12.24	3096g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96528	Neonatal death	26+2	02.08.24	09.12.24	890g	HUTH	HUTH	HUTH	Yes	No	NA	NA	NA	NA
	96596	Antepartum stillbirth	39+4	23.12.24	23.12.24	2860g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 23/06/25)	Not yet discussed at PMRT
	96662	Neonatal death	23+2	25.12.24	27.12.24	360G	HUTH	HUTH	HUTH	Yes	No	Met	Met	Not yet published (deadline 27/06/25)	MNVP
	96397	MTOP	21+2	06.12.24	06.12.24	410g	HUTH	HUTH	HUTH	NA	No	NA	NA	NA	NA

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

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

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

Q2 25/26	100143	Early NND	3 days	01.09.25	04.09.25	3302g	Rotherham	Rotherham	HUTH	Yes	Yes	Yes	Yes	On track	Planned February
	100134	Late NND	54 days	12.07.25	04.09.25	480g	DPOW	DPOW	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100192	Antenatal stillbirth	34+3 days	08.09.25	08.09.25	2300g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Yes	Yes
	100249	Late NND	34 days	24.08.25	11.09.25	550g	Doncaster	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned January
	100360	Late NND	5 months	21.04.25	18.09.25	660g	Pinders	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned February
	100449	NND	21+2	26.09.25	26.09.25	410g	HUTH	HUTH	HUTH	N/A	No	Yes	‘Not suitable for R/V’	‘Not suitable for R/V’	‘Not suitable for R/V’
	100467	Late NND	66 days	28.07.25	27.09.25	2710g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On Track	January Planned
	100766	Antenatal stillbirth	26+3	16.10.25	16.10.25	780g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	January Planned
	100869	Intrapartum stillbirth	37+6	21.10.25	21.10.25	2825g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	On Track	Yes

Q3 25/26	101373	Intrapartum stillbirth	39+2	26.11.25	26.11.25	3420g	HUTH	HUTH	HUTH	Yes	Yes	Yes	Yes	On track	Planned March
	101427	Early NND	37+1	30.11.25	30.11.25	2815g	DPOW	DPOW	HUTH	Yes	Yes	No	Yes	On track	Planned March
	101629	Antenatal stillbirth	22+6	13.12.25	13.12.25	495g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	Planned March
	101631	Post-neonatal death	25+4	15.11.25	16.12.25	910g	HUTH	HUTH	HUTH	Yes	No	Yes	N/A	On track	Planned April
	101730	Early NND	25+0	20.12.25	22.12.25	755g	UHLT	UHLT	HUTH	Yes	No	Yes	Yes	On track	Planned April
	101816	Antenatal stillbirth	35+0	23.12.25	23.12.25	2435g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	May Planned
	101817	Antenatal stillbirth	25+0	23.12.25	23.12.25	597g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	On track	April Planned

Appendix B – Summary of all incidents reviewed through PMRT and reviews completed/moved to report writing in Q3 2025-2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?
99246	A – Cardiac fauluire, impaired contractility B – DIC, Prematurity (27 weeks) C – HELLP syndrome D – Emergency C-section, not fully optimised	C(Barnsley)/ B/A	· No HUTH Issues · Barnsley Issues	· For review of neonatal mortality toolkit to make sure all appropriate information is captured. · Barnsley actions	Yes
100027	1a - Bilateral grave 4 IVH 1b - Extreme prematurity 1c - Spontaneous labour/previous cervical treatment	C/B/B	· Late booking and not following local guidance · No IVABXs · No DCC · Arrived cold to neonatal unit	· Organizational learning regarding booking process shared · Pre-term optimization education continues · Thermoregulation in extreme gestations · DCC not performed with placenta delivered with baby (evidence being gained by NICU lead)	Yes
99594	Fetal vasular malperfusion Known Truncus Arteriosus	A/A	· No HUTH Issues	No Actions	Yes
99689	Unknown asymmetrical IUGR	B/A	· Baby transferred for PM · Partially completed partogram · IUGR at delivery but scans not detected prior	No Actions	Yes
99180	Abnormal dopplers IUGR 171g	A/A	· Baby transferred for PM	No Actions	Yes
100134	Extreme prematurity	B/B/B	· NLAG issues	NLAG actions	Yes
100192	Velamentous cord insertion	A/A	· Partially completed partogram (midwife providing analgesic)	No Actions	Yes
100869	Placental abruption SGA <10th centile	D/C	· DNA process not followed · Hypertension not managed appropriately · Abruption and delay going to theatre	· DNA and non-attendance pathway · Hypertension management · Delay in management of abruption	Yes

Grading of care

Stillbirth:

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

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

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

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

Neonatal death:

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

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

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

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

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

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

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

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – 30 Nov 25	Total
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	**100%**	4/4 (100%)	8/8 (100%)	5/5 (100%)	12/12 (100%)	4/4 (100%)	**33/33 (100%)**
Cases applicable for PMRT review are applicable to the following standards (n=29)							
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	3/3 (100%)	8/8 (100%)	4/4 (100%)	9/10 (90% - 1 on going, joint case)	3/4 (75% - 1 ongoing, joint case)	**27/29 (93%)** **2 ongoing – no timeframe**
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	**95%**	3/3 (100%)	8/8 (100%)	3/4 (75%)	8/8 (100% - 2 allocated to different trust)	3/3 (100% - 1 allocated to different trust)	**25/26 (96%)**
Multi-disciplinary reviews should be published within six months of the death.	**75%**	3/3 (100%)	8/8 (100%)	4/4 (100%)	0 applicable in timeframe. 5/8 at present.	0/3 (3 cases ongoing, in timeframe)	**On Target**
An external member should be present at the multi-disciplinary review panel meeting, and this should be documented within the PMRT. (from 02/04/2025)	**50%**	N/A	N/A	4/4 (100%)	0 applicable to deadline. 7/8 at present, within timeframe.	0 applicable to deadline. 1/3 ongoing and in timeframe.	**100%**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted January 2025	Submitted April 2025	Submitted July 2025	Submitted October 2025	Submitted January 2025	**100%**

Appendix D: Learning Points and Key Themes:

Key themes and/or learning identified from **Q3** cases PMRT or continued from previous quarterly reviews are as follows:

- Hypertension management and the use of PLGF
- DNA management
- Transfer of baby for PM (Organisational)
- Pre-term optimisation with IVABXs
- DCC when placenta is delivered simultaneously (neonatal review of literature and best practice ongoing)

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

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/10 (0%)	0/6 (0%)	0/10 (0%)	0/8 (0%)	**0%**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	0/10 (0%)	0/6 (0%)	1/10 (10%)	0/8 (0%)	**2.9%**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/10 (0%)	0/6 (0%)	0/10 (0%)	0/8 (0%)	**0%**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/10 (0%)	1/6 (16.6%)	0/10 (0%)	1/8 (12.5%)	**5.88%**

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 3 2025/26

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

Humber Health Partnership

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

Claims Breakdown Q3 25/26

Unable to report due to the NHSR changing to a new system – data is not available to extract. Currently transitioning to data being accessible through Ulysses.

Incidents Q3 25/26

Top 5 incident by volume:

- Term NNU admissions **(59)**
- Post partum haemorrhage (PPH) >1500mls **(21)**
- In-utero delay in IOL/NICU Cots/Delay in IOL **(19)**
- Shoulder Dystocia **(13)**
- Perineal trauma - 3rd and 4th degree **(9)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **412**

Complaints Q3 25/26

There have been 7 new complaints received relating to the following

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

Clinical Audits Registered Q3 25/26

- Spot Check WHO Checklist Audit
- Spot Check Consent Aduit

Deep Dive Reviews Q3 25/26

- Emergency buzzer QI completed
- Continued quarterly reviews of PPH >1500ml, perineal trauma and Shoulder dystocia
- Low cord gases thematic review of Q3 (2% admission rate due to low gases). Confirmed SOP being adhered to.

Learning Q3 25/26	Themes Q3 25/26
• Hypertension and PLGF trend of not being undertaken. • HIE grade 3 diagnosed (1st since December 2023) • VTE assessment • Make every contact count	• Continued ATAIN Q3 <6% (5.3%) and late-preterm Q3 2.19% • Improved CTG classification • Increased MNSI investigations (5) • PPH >1500ml 1.2% (national average 3.41%) • Neonatal unit cot availability remains highest risk on risk register • Premature shoulder dystocia diagnosis

Action Plan Q3 25/26	Not started / In progress / Complete	
Induction of Labour Deep Dive	Aug 2025	
Thematic review of postnatal readmissions	Sept 2025	
Quality Improvement project to be registered regarding Hypertension and PLGF	April 2026	

NHS
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)007b

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th of February 2026
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer / Author	Yvonne McGrath, Group Director of Midwifery
Title of Report	Perinatal Mortality Review Tool Quarterly Reports and Scorecards NLAG
Executive Summary	<u>PMRT Report</u> The aim of this report is to provide assurance to the Trust Board and Maternity & Neonatal Board level Safety Champions that every eligible perinatal death is reported to MBRRACE-UK via the Perinatal Mortality Review Tool (PMRT) and that a robust review of the quality of care is undertaken. There 20 incidents reported to MBRRACE-UK via the PMRT between the 1st December 2024 and the 31st December 2025. All cases fall within the Maternity Incentive Scheme (MIS) reporting period, 15 eligible for review and full assessment against the MIS Safety Action 1 standards. 2 babies were still alive (triplets of a reportable cases) and 3 were reported for notification only (2 termination of pregnancy, 1 neonatal death at 21 weeks) and therefore not eligible for full assessment. 3 deaths met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) and have been reported accordingly. There have been 5 incidents reviewed through the PMRT process, in quarter 2 2025/26 4 where the death occurred at NLAG (2 antepartum stillbirths and 2 neonatal deaths) and 1 where the death occurred in another Trust but the care/PMRT review was joint with NLAG. Grading of Care At the conclusion of the multidisciplinary review the team agree the grading of care, the categories and outcome following review of the 4 cases are as follows: <u>Grading of care provided to the mother before the death of the baby</u> · 4 case had no issues identified that would have had an impact on the outcome · 0 cases had issues identified that would have had no impact on the outcome · 1 case had issues that may have had a difference to the outcome. <u>Grading of care of the baby from birth up to the death of the baby:</u> · 3 cases had no issues identified that would have had an impact on the outcome · 1 case had issues identified that would have had no impact on the outcome

	· 1 cases had issues identified that were likely to have made a difference to the · outcome for the baby. <u>Grading of care provided to the mother following confirmation of the death of the baby</u> · 1 case had no issues identified that would have had an impact on the outcome · 1 case had issues identified that would not have had an impact on the outcome · 1 cases had issues identified that may have had a difference to the outcome. Relevant actions have been put in place for each case to address any learning. <u>Scorecard Quarter 3</u> · Vast majority of incidents related to maternity/perinatal care (266/484 reported) · 7 new complaints · X3 Deep dives in progress · Bereavement Midwife WTE expanded and will shortly both be in post · Ongoing working to improve number of babies admitted to the neonatal unit that receive early breastmilk · QI work ongoing on scan capacity and growth scan appointment times.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 3 2025/26)

Yvonne McGrath
Group Director of Midwifery – Family Services Care Group

January 2026

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

United by Compassion:
Driving for Excellence

1. INTRODUCTION

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

1.1 MBRRACE-UK reporting requirements and PMRT support:

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

2. STANDARDS

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

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

3. SUMMARY

3.1 Eligible Incidents in MIS Year Seven (Appendix A)

There has been a total of 20 incidents reported to MBRRACE-UK via the PMRT between the 01 December 2024 and the 31st December 2025:

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
December 2024	1	0	0
Q4 (01 Jan – 31 Mar 25)	2	0	0
Q1 (01 Apr – 30 Jun 25)	4	0	0
Q2 (01 Jul – 30 Sept 25)	1	1	0
Q3 (01 Oct – 31 Dec 25)	7	2	2
Total	**15**	**3**	**2**

All 20 cases fall within the MIS year seven period (end date: 30/11/25). 15 cases were eligible for review and full assessment against CNST standards, 2 babies were still alive (triplets of a reportable case) and 3 cases were reported to MBRRACE but were for notification only (2 termination of pregnancy, 1 neonatal death at 21 weeks) and therefore not eligible for full assessment against CNST standards or review.

Of the 18 perinatal deaths, 3 met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI) and have been reported accordingly. 2 babies passed away at NLAG, 1 case was accepted and an investigation is complete, 1 case was rejected due to no consent obtained from the family and has therefore been reviewed internally by the Learning Response Panel and via a rapid review to identify any learning. 1 baby passed away at HUTH following transfer for neonatal care from NLAG, referral to MNSI was completed by NLAG, the death was reported to MBRRACE by HUTH and is being investigated by MNSI as well as being jointly reviewed via the PMRT process.

In addition, please note there are 7 further cases registered with MBRRACE where the deaths occurred at other Trusts but NLAG contributed to the care provided. It is the responsibility of the other Trusts to complete the PMRT process with joint input from NLAG. These cases do not appear on the MIS Year 7 case list but can be monitored by the yearly case list.

3.2 Summary of all incidents reviewed through PMRT in Quarter 3 2025/26 (Appendix B)

There have been 5 incidents reviewed through the PMRT process, 4 where the death occurred at NLAG (2 antepartum stillbirths and 2 neonatal deaths) and 1 where the death occurred in another Trust but the care/PMRT review was joint with NLAG. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby.

3.3. Grading of Care

At the conclusion of the multidisciplinary review the team agree the grading of care, the categories and outcome following review of the 4 cases are as follows:

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

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

- 1 case had issues that may have had a difference to the outcome.

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

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

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

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

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

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

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

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

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

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

Appendix A – Summary of eligible incidents for full PMRT

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

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

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

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

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

Appendix B – Summary of all incidents reviewed through PMRT in Q3 of 2025/2026

Case	Cause of Death	Grading of Care	Issues Identified	Actions	External representative present at MDT PMRT?	Discussed at Learning Response Panel?
98741	Neonatal Death	A / A / B	This mother had a risk factor(s) for having a growth restricted baby but the plan to carry out serials scans was not followed. This mother had a risk factor(s) for having a growth restricted baby, but serial scans were not performed at correct times/intervals. Estimated fetal weights from scans had not been plotted on a chart. It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out. The opportunity to discuss postmortem with the parents prior to their baby's death as part of end of life care was not taken as it was felt that post-mortem would not add anything to the understanding of the baby's condition. The parents were not offered a hospital post-mortem. The review team felt confident about the cause of death even though a post-mortem had not been offered. Although indicated this mother was not offered chromosome analysis for her baby. Although indicated this mother was not offered further postnatal investigations for herself and/or her baby. It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available.	Lessons Learned to be disseminated to all staff via the PMRT Newsletter and to be shared at Perinatal M&M Meeting. Secured finance to increase Bereavement Midwife establishment and have now appointed 2 Bereavement Midwives (1 for DPOW / 1 for SGH).	Yes	N/A

			It is not possible to tell from the notes if this mother and her partner were offered the opportunity to take photos and make memories with their baby. It is not possible to tell from the notes if the parents were told where their baby was being taken to and why when he/she was taken to the mortuary. It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home. It is not possible to tell from the notes if the relevant professionals involved in the ongoing care of the parents were informed about the death of their baby. It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital. It is not possible to tell from the notes if the parents were provided with written information about practical issues following the death e.g. funeral options and benefits. A completed bereavement checklist was not in the notes.			
99969	Antepartum Stillbirth	C / A	This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis. This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines. Following Triage, the patient was not invited in for review and no documentation of the call on Badger.	For reflective and supportive discussion with midwife involved and provide further training as required. Reminder on Huddle that BSOTS triage forms to be used for all calls. Plan moving forward for all Triage calls to be recorded.	Yes	Yes

100797	Neonatal Death	A / A / A	This mother lives with family members who smoke but they were not offered referral to smoking cessation services. There was evidence that the baby was already unwell when he/she was admitted for transitional care. The baby did not have his/her temperature measured on admission for transitional care or within an hour of arrival.	Reminder to be included on PMRT Newsletter.	Yes	N/A
100659	Late Fetal Loss	A / C	This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out. This mother was induced but the method and/or process of induction was not appropriate. The baby had to be transferred elsewhere for the post-mortem. This mother and her partner were not able to be cared for in either a sound proofed room or a room away from other mothers and crying babies because the designated room/suite was already in use. This mother and her partner were not able to be cared for in a designated room/suite where her partner was able to stay overnight with her because the designated room/suite was already in use.	Induction of Labour guideline currently under review including dosage and frequency. The most appropriate room was offered with private facilities and quieter on the ward.	Yes	Yes
99027 (Death reported by Manchester, care provided by NLAG (joint PMRT)	Neonatal Death	A / D / C	It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone. It is not possible to assess from the notes whether the decision to transfer the baby to another unit was timely. It is not possible to assess from the notes whether the time from the request for neonatal transfer to the transport arriving was within the expected timescale.	PMRT is not yet finalised, actions are yet to be agreed.	Yes	Yes

			It is not possible to assess from the notes whether the time taken to stabilise the baby before transfer was appropriate. It is not possible to assess from the notes whether the baby was stable enough to be transferred when staff started the transfer. It is not possible to assess from the notes whether the baby's thermal management was appropriate during transfer to another unit. It is not possible to assess from the notes whether the baby's airway was appropriately secured during the transfer to another unit. It is not possible to assess from the notes whether respiratory support for the baby was managed appropriately during the transfer to another unit. It is not possible to assess from the notes whether cardiovascular support for the baby was managed appropriately during the transfer to another unit. It is not possible to assess from the notes whether appropriate fluids were given to the baby during the transfer to another unit. It is not possible to assess from the notes whether appropriate drugs were given to the baby during the transfer to another unit It is not possible to assess from the notes whether the baby was monitored appropriately whilst being transferred to another neonatal/specialist unit. It is not possible to assess from the notes whether appropriately trained staff were involved in transferring the baby to another neonatal/specialist unit. It is not possible to assess from the notes whether all the equipment needed to transfer the baby to another neonatal/specialist unit was available.			

			It is not possible to assess from the notes whether there were any problems encountered during the transfer and whether they were managed appropriately. It is not possible to assess from the notes whether the baby was transferred to a unit which was able to provide the appropriate level and type of neonatal care.			

Grading of care

Stillbirth:

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

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

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

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

Neonatal death:

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

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

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

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

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

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

Appendix C – Summary of CNST

Compliance as per MIS Year 7 standards (01/12/24 – 30/11/25)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Dec 24	Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	100%	1/1 (100%)	2/2 (100%)	4/4 (100%)	2/2 (100%)	7/7 (100%)
Cases applicable for PMRT review are applicable to the following standards (n=15)						
For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	95%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death?	95%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)
Multi-disciplinary reviews should be published within six months of the death.	75%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	7/7 (100%)
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	50%	1/1 (100%)	2/2 (100%)	4/4 (100%)	1/1 (100%)	2/2 (100%) **5 not yet met**
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted Jan 2025	Submitted Apr 2025	Submitted Aug 2025	Submitted Oct 2025	To be submitted Feb 26

Appendix D: Learning Points and Key Themes:

Key themes and or learning identified from **Q3** cases PMRT or continued from previous quarterly reviews are as follows:

- Guidance for the undertaking appropriate growth surveillance had not been carried out for babies that were small for gestational age or had fetal growth restriction.
- Documentation of bereavement care requires improvement as it is not always possible to tell from the notes whether the bereavement pathway was followed or the required information was offered/provided.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified (PMRT review completed)				
		Q4 Jan – Mar 25	Q1 Apr – Jun 25	Q2 Jul – Sep 25	Q3 Oct – Dec 25	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/5 (20%)	1/5 (20%)	1/4 (25%)	2/4 (50%)	5/18 (28%)
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	3/5 (60%)	0/5 (0%)	2/4 (50%)	0/4 (0%)	5/18 (28%)
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/5 (20%)	0/5 (0%)	0/4 (0%)	0/4 (0%)	1/18 (6%)
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	1/5 (20%)	0/5 (0%)	0/4 (0%)	0/4 (0%)	1/18 (6%)

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 3

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

NHS Humber Health Partnership

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

Claims Breakdown Q3 25/26

Claims can no longer be obtained from NHS Resolution. Awaiting data to be uploaded to Ulysses for reporting (anticipated in Q4 25/26).

Incidents Q3 25/26

Top 5 incidents by volume:

- Maternity/perinatal care (266)
- Staffing resources (53)
- Documentation/health records/ID bands (24)
- Communication (19)
- Appointments/admissions/transfer/discharge/referrals (15)

Number of incidents reported on Ulysses for Obstetrics / Maternity: **484**

Complaints Q3 25/26

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

- Concerns raised regarding care during labour and
- Concerns raised regarding monitoring following delivery.
- 2 x delay in treatment / action
- Clinical treatment and communication
- No communication from Sonographer during scan, patient felt rushed during procedure
- Concerns raised regarding LSCS and bleeding following discharge.

Clinical Audits Registered Q3 25/26

- Saving Babies' Lives Q3 (Elements 1 – 6)
- National Neonatal Audit Programme (25/26)
- Delayed Cord Clamping
- Maternity Anaesthetic Reviews in Badgernet
- Snapshot of Maternity Anaesthetic Records
- Medical Documentation Audit

Deep Dive Reviews Q3 25/26

In progress:

Induction of labour (SGH / DPOW)

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

ATAIN (TWD)

Learning Q3 25/26	Themes Q3 25/26
• Badgernet documentation for anaesthetic assessments in the antenatal period not completely appropriately at SGH. Paper records/WEB V still being utilised for documentation. • Guidance for the undertaking appropriate growth surveillance had not been carried out for babies that were small for gestational age or had fetal growth restriction. • Documentation of bereavement care requires improvement as it is not always possible to tell from the notes whether the bereavement pathway was followed or the required information was offered/provided. • NICU documentation regarding provision of breastmilk given in the first 2 days of life and temperature on admission to be improved.	• Bereavement pathway documentation not always completed in its entirety. • Incomplete documentation on Badgernet (maternity and neonates). • Guidance for the undertaking appropriate growth surveillance had not been carried out for babies that were small for gestational age or had fetal growth restriction. • Women attending with RRFM not scanned in line with Saving Babies' Lives standard (by next working day) due to scan capacity issues.

Action Plan Q3 25/26	Not started / In progress / Complete	
Bereavement Midwife to commence in post (Trustwide)	April 2026	
Communication to be sent to all midwives (Trustwide) to request the appropriate bereavement documentation is completed in its entirety and to ask for support in ensuring that parents who have sadly experienced a pregnancy or baby loss are provided with the appropriate information and given the opportunity to provide feedback.	February 2026	
Parent workshop teaching material to be updated to include a section on when a baby is admitted to NICU and the importance of giving breastmilk.	March 2026	
Community Managers to discuss the requirement for CO levels to be recorded at booking appointment with community midwifery teams.	October 2025	
Current ongoing QI Project investigating scan capacity and growth scan appointment times.	July 2026	
Newsletter/staff training information regarding documentation on NICU Badgernet regarding early breastmilk / temperature in the first hour of admission to be shared with all neonatal staff.	March 2026	

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Hull University Teaching Hospitals NHS Trust**
Trust Code	**T559**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.

Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Return to Guidance Sheet

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Return to Guidance Sheet

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

Return to Guidance Sheet

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	N/A
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	No
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
12	Was the above action plan shared with the LMNS?	Yes
13	Was the above action plan shared with the Neonatal ODN?	Yes
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

Return to Guidance Sheet

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	No
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	Yes
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	Yes
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Return to Guidance Sheet

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

Return to Guidance Sheet

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

Return to Guidance Sheet

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	N/A
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Return to Guidance Sheet

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Return to Guidance Sheet

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	Yes
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

Return to Guidance Sheet

NHS Resolution

Section A : Maternity safety actions - Hull University Teaching Hospitals NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

NHS Resolution

Section B - Action plan details for Hull University Teaching Hospitals NHS Trust

An action plan should be completed for each safety action that has not been met.
Please refer to the guidance when to develop a local action into the action plan. Return to Summary form

Action plan 1

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 2

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 3

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 4

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 5

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 6

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 7

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 8

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 9

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Action plan 10

Safety action	
Word to meet action	Brief description of the work planned to meet the required progress.
Have this action plan been signed off	Action plan agreed by head of midwifery/divisional director?
Action plan owner	
Lead executive director	
Amount requested from the trust/nhs resolution, if required	
Reason for non-meeting action	Where applicable only the main reason why the safety action
Materials	Where applicable only the action plan will ensure the trust meets the safety action
Benefits	Where compliance the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure of how. Any Delivery
How determined	How and the date of risk depicting the safety action?

Monitoring	Action	Who?	When?

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Hull University Teaching Hospitals NHS Trust**
Trust code	**T559**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Hull University Teaching Hospitals NHS Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Hull University Teaching Hospitals NHS Trust
Name:	
Position:	
Date:	

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Northern Lincolnshire and Goole Hospitals NHS Foundation Trust**
Trust Code	**T600**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.
Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Return to Guidance Sheet

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Return to Guidance Sheet

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

Return to Guidance Sheet

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	No
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	No
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
12	Was the above action plan shared with the LMNS?	Yes
13	Was the above action plan shared with the Neonatal ODN?	Yes
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

Return to Guidance Sheet

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	No
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	Yes
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	Yes
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Return to Guidance Sheet

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

Return to Guidance Sheet

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

Return to Guidance Sheet

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	No
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	N/A
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Return to Guidance Sheet

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Return to Guidance Sheet

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	Yes
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

Return to Guidance Sheet

NHS Resolution

Section A : Maternity safety actions - Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	No
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

NHS Resolution

Section B - Action plan details for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

An action plan should be completed for each safety action that has not been met
Please refer to the guidance sheet to assess known actions into the action plan Show or Address here

Action plan 1

Safety action	Mandatory training
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Mrs Jackson is not allowed to take Mandatory Training for Consultant Obstetricians at our Hospital site.
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?
	Mrs Jackson Consultant Obstetrician Mandatory Training Coordinator	Date of action plan Date of Update	Maternity Unit Training Department Maternity Unit Training Department

Action plan 2

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 3

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 4

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 5

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 6

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 7

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 8

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 9

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Action plan 10

Safety action	
Words to meet action	Full documentation of the work planned to meet the required progress.
Have this action plan been executed	Yes/No
Action plan agreed by head of obstetrics/clinical director?	Yes/No
Action plan owner	
Lead executive director	
Amount requested from the Incentive fund, if required	
Reason for non-meeting action	Please explain why this non-attend dept risk safety action
Rationale	Please explain why this action plan will ensure the non-meets the safety action
Benefits	Please complete in the key benefits that will be delivered by this action plan and how. Have will deliver the required progress against the safety action. Measure when these are delivered.
How determined	How are the risks of not meeting the safety action?

Monitoring	Who?	When?	Where?

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Northern Lincolnshire and Goole Hospitals NHS Foundation Trust**
Trust code	**T600**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	-	You have missing data in your action plan for this unmet safety action, please check
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**9**	**1**		**You have a validation on 1 safety action. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Name:	
Position:	
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)008

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th February 2026
Director Lead	Matt Powls, Interim Group Chief Delivery Officer
Contact Officer / Author	Adam Creeggan, Group Director of Performance Louise Topliss, Head of Performance
Title of Report	**Patients – Performance**
Executive Summary	Key messages: • Significant challenges relating to patient access • Group Trusts are in national **Tier 1 oversight** for UEC, Cancer, Diagnostics and RTT (NLAG only) • An Operational Improvement Plan and associated in year recovery trajectories have been developed by the outgoing Interim Chief Delivery Officer, Sarah Tedford. • Delivery against both original 25/26 Operating Plan and in-year recovery trajectories for UEC and RTT are detailed in the paper. Summary Compliance:
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common Business Assurance Framework report included within this paper.
Prior Approval Process	
Financial Implication(s) (if applicable)	Report references delivery of activity versus plan with inherent links to income generation via block contract or Elective Recovery Fund
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Report references the delivery of access targets, with inherent risks to equity of access across the Group's geography

DOMAIN	GROUP	HUTH Performance	NLAG Performance
RTT Long Waits	Dec-25	Dec-25	Dec-25
104 Weeks	0	0	0
78 Weeks	0	0	0
65 Weeks	154	112	42
52 Weeks	3987	3072	915
% 52 Weeks	3.30%	3.80%	2.30%
(target =<1.3% March '26)			
Diagnostics (DM01)	Dec-25	Dec-25	Dec-25
% greater than 6 weeks	43.70%	40.20%	46.50%
Cancer	Nov-25	Nov-25	Nov-25
% FDS with 28 days	65.80%	60.20%	75.60%
% Treated within 62 days	61.00%	57.40%	70.40%
UEC	Dec-25	Dec-25	Dec-25
ED 4-hour standard	62.60%	60.10%	64.80%
(target 78% March '26)			
ED 12-hour standard	24.30%	19.70%	29.00%

Recommended action(s) required	☐ Approval ✓ Assurance	☐ Information ☐ Other – please detail below:

Board Assurance Report – Patients

Key messages

Referral to Treatment (RTT)

Waiting list (PTL) growth has been arrested at NLAG and grown at HUTH, but below the previous four years of c8% annual waiting list growth. This is a direct result of:

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

At NLAG these actions have resulted a reduction in the total volume of patients waiting from 46,541 in April 2024 to 39,254 in December 2025 (-7,287 patients, -15.7%). At HUTH the waiting list of 81,643 reflects growth of 3,653 patients (+4.9%) in year.

Stabilisation of the waiting list has yet to translate into uniform improvement in RTT compliance i.e. the percentage of patients waiting <18 weeks on an RTT pathway. NLAG is behind of the in-year recovery plan at 59.2% (plan 63.0%), HUTH is notably behind recovery expectation at 55.6% (plan 61.0%).

This relates to growth in long waiting patients with 3072 patients waiting more than 52 weeks at HUTH and 915 at NLAG. This is broadly double the volume of patients waiting >52 weeks in October 2024. In year recovery plans and associated in-year recover trajectories have been developed to reduce these volumes to 1108 and 411 respective by March 2026 to achieve the expectation that >52 weeks make up no more than 1% of the waiting list. As an interim step in the delivery of this expectation the Group was working to the elimination of >65 week waits by 31st December 2025, however, this was not achieved. At the end of December HUTH reported 112 >65 week waits and NLAG with 42.

Cancer Access

The Group is a negative national outlier for Cancer standards, with notable delays in outpatient and/or diagnostic stages of treatment in key tumour sites. The 28-day Faster Diagnosis Standard (FDS) is a critical determinant of the ability to deliver treatment with 62 days and has been significant challenged in the latter stages of 2024/25 and into 2025/26.

Extensive recovery actions have been introduced in year, through which compliance for 28-day FDS has improved from 56.5% in April 2025 to 75.6% at NLAG and 55.6% to 60.2% at HUTH in December 2025. In turn this is driving improvement in completion of cancer treatment within 62 days, with NLAG achieving 70.4% versus 46.3% and HUTH improving to 57.4% from a low of 46.3%. These positions are ahead of agreed in-year recovery trajectories.

Improvement is set against significant demand growth above planned levels on both sites, up 4.1% HUTH and 6.7% NLAG over the last year. In contrast, the volume of conversions from referral with suspected malignancy to cancer treatment remains unchanged, thereby driving a lowering of our percentage conversion over time. Given the requirement to see cancer patients within a 14-day window and associated requirement for urgent diagnostic support, this change in referral profile has a higher associated resource absorption.

Diagnostic Access

The Group is a national outlier for Diagnostic 6-week waits, with December data showing deterioration on both sites to 40.2% at HUTH and 46.5% at NLAG. National expectation is no greater than 5% of patients waiting more than 6 weeks. In-year recovery trajectories shared with NHSE have committed to 5.0% delivery at NLAG and 11.0% delivery at HUTH by March 2026.

Compliance is set against significant demand above plan. The diagnostic activity plan has been

exceeded in aggregation at both Trusts. However, increases in emergency, planned care and surveillance pathways are constricting waiting list (DM01) activity leading to associated waiting list growth.

Operational Improvement Plan launched creating enhanced capacity in key modalities such as Neurophysiology, Echocardiography, Sleep Studies, Imaging, etc. alongside utilisation efficacy to deliver year end commitments.

Unplanned & Emergency Care (UEC)

HUTH A&E 4 Hour standard (all types) was 60.1% in December 2025 (recovery trajectory 67.8%). Type 1 performance of 47.1% was below the 25/26 operating plan target of 63.3%. Type 3 performance (HRI UTC) was 91.6% against the 95% target. Type 1 attendance volumes were above plan whilst Type 3 attendances were below planned levels.

NLAG combined type 1 and 3 performance was 64.8% against a recovery trajectory of 76.0%. Type 1 performance = 41.5% (Target 61.9%) and Type 3 performance = 99.4% (Target 99%). Type 1 attendances were below the planned levels and Type 3 attendances were above planned levels for December 2025.

Critical Actions in place:

- HUTH: Working closely with Place partners aiming to increase UTC operating hours until 2am during winter to increase capacity.
- HUTH: Work ongoing with Yorkshire Ambulance Service to develop a falls care home pathway to avoid ED attendance where appropriate.
- HUTH: Plan to utilise H1 during winter pressures to reduce non admitted breaches.
- NLAG: Expanding CDU pathways to increase utilisation of area.
- NLAG: Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC.

The Group has reiterated its commitment to 78% delivery by March 2025 for both sites via the action programme agreed via national Tiering.

Regulatory oversight:

- **UEC** - remains in Tier 1 oversight for both Trusts.
- **RTT:** Tier 1 oversight for RTT for NLAG to be extended to include HUTH from December 2025
- **Cancer and Diagnostics:** remain in Tier 1 oversight for both Trusts.

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 6 January 2026

Humber Health Partnership

1. Matters for Reporting

The **Group finance** report at month 8 had seen further deterioration to the year-to-date position, which was now £7.9m away from plan. The Group was seeing positive reductions in extra contractual pay due to enhanced controls and although the cash position was stable it was being managed closely via a Cash Committee newly established.. The Capital Plan was challenging but still on track to deliver. An extra £1m pressure was reported due to the recent industrial action.

The challenging financial position had led to the protocol regarding amending the financial forecast to be commenced. Under delegated authority from the Board the CIC reviewed the amended forecast and financial impact statement which would be submitted to NHS England on 8 January. The Board would be fully briefed on the change, the resulting impacts and the commitment to deliver the recovery plan. The Group was in Double Lock with the ICS and this would be aligned with the discretionary spend panel.

The CIC gave Reasonable assurance based on the confidence of achieving the recovery plan.

The **Transformation Programme was** £17.4m behind plan at month 8. The key issue was having the right resources in the right places to deliver the plan. The CIC gave Limited assurance was given due to resourcing issues.

On **Performance**, the Group was reporting improvements to the 65 week waits although the trajectory of zero had not been met. There was also a risk around 52 week waits and further assurance was required to determine how the £4.2m was being spent to alleviate these issues.

The Group was still experiencing **UEC** pressures due to high attendances and flu cases. The CIC gave limited assurance as there was no sustained improvements and targets were not being met. The CIC asked for further information regarding the CDC capacity and the resources required to manage RTT.

Theatre Capacity/Utilisation Deep Dive – Care Group/service meetings were in place to review theatre performance. The main issues were around medical workforce vacancies but job planning action plans and expectations were in place.

Cancer Deep Dive – The presentation highlighted a number of issues such as breast, radiology, histopathology, endoscopy capacity, consultant vacancies (lung) and core capacity gaps. Improvements included a new Cancer Governance Structure, service improvement programmes in place and the clinical harm review process was being harmonised across the Group. Although there were improvements in place the CIC gave limited assurance due to the lack of sustained positive outcomes.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Group Finance Report – Month 8	6	16	Assurance/Approval	Reasonable
2	Transformation Programme	6	16	Assurance	Limited
3	Group Performance Report	2	20	Assurance	Limited
4	Theatre Capacity	2	20	Assurance	Reasonable
5	Deep Dive: Cancer Performance	2	20	Assurance	Limited
6	Estates Update (including HRI Tower Block update)	6	16	Assurance	Significant
7	ERIC	6	16	Assurance	Significant
8	Capital Programme Summary	6	16	Assurance	Reasonable
9	Contract Approvals • HRI Theatres 8, 9 and Plant Room • Lansdowne Block • SGH Theatres B and C	6	16	Approval	Extra-ordinary meeting
10	ME2 Pathology Update	2	20	Information	Extra-ordinary meeting

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 6 January 2026

Estates Update – Following the quarterly review of HRI Tower Block there were no new additional risks and potential support funding was available for replacing the cladding.

The ERIC review had been submitted and there was an action plan in place that would be regularly monitored at the CIC.

2. Positive assurances

3. Matters on which the committees have requested additional assurance

Care Group risk and opportunities to be presented to the CIC.

CDC performance and benefits appraisal to be presented to the CIC.

More assurance was required regarding the performance at the HUTH Urgent Treatment Centre.

4. Decisions made

The Group Anti-ligature policy was being developed and updates would be received as part of the Estates update reports.

The CIC were asked to give delegated approval to enter into contract discussions and appointment of contractors for the HRI Theatres 8, 9 and Plant Room, the Lansdowne Block and SGH Theatres B and C. The CIC requested an extra-ordinary meeting to discuss these in more detail.

5. Escalation to Trust Boards

Revision of forecast outturn position protocol to be commenced.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Group Finance Report – Month 8	6	16	Assurance/Approval	Reasonable
2	Transformation Programme	6	16	Assurance	Limited
3	Group Performance Report	2	20	Assurance	Limited
4	Theatre Capacity	2	20	Assurance	Reasonable
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10	ME2 Pathology Update	2	20	Information	Extra-ordinary meeting

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 3 February 2026

Humber Health Partnership

1. Matters for Reporting

CQC Actions – All outstanding previous actions are now closed. The recent visit to DPOW and SGH had raised issues at DPOW relating to triage waiting times and fire doors. There were no issues raised at SGH. The report would be reviewed further upon receipt.

Financial Plan 2026/27 – The Committee were presented with the options being worked through ready for submission and in advance of the discussion with Board on 10 February 2026. Key issues to highlight are significant reduction in income over and above that anticipated through the planning guidance, the cost base is continuing to not reduce and, in some cases, continues to increase. This was not being offset by the "recurrent" efficiency improvements. Discussion focused on deliverability of efficiency ambitions and grip and control mechanisms. It was highlighted that the updated income schedule from the ICB had still not yet been received.

Month 9 – Month 9 position had deteriorated further, despite grip and control measures in place. The revised forecast outturn position for the group is £35.3m and with the receipt of £6.2m funding for the Industrial Action the position improves to c£29m variance to plan (excluding the impact of the loss of Q4 DSF). Limited assurance was agreed by the Committee.

Operational Plan 2026/27 – UEC, Cancer and Diagnostics were the key focus and the RTT target would be a static waiting list (not increasing) as a realistic view of stretching but achievable performance. At least a 2% productivity increase was required in elective as well as increased discharges from a UEC performance perspective.

Performance – Limited Assurance. 65-week waits are increasing, due to 52 week wait 'tip-ons'. The required governance framework was now in place and plans are being enacted.

CDC performance was improving and best practice was being shared across the Group. As the CDC's performance progressed, further efficiencies would be sought within the current budget including the use of CDCs to support Diagnostics and the Faster Diagnosis Standard, which is improving at NLAG. Both HUTH and NLAG 62-day Cancer performance had improved.

Deep Dive, Urgent Care – ED performance remained off track, with the exception of Ambulance handovers at HUTH where there had been sustained reductions in breaches over 60 minutes. A number of actions were planned, including a Perfect Week with system partners, new Group-wide ways of working to reduce patient safety risks in ED and a Risk Summit on 5-2-26.

2. Positive Assurances

The Committees received Significant Assurance on Estates and Facilities risks and capital.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions	N/a	N/a	Information	N/a
2	Operational and Financial Plan including CIP	6	20	Information	N/a
3	Group Finance Report – Month 9	6	20	Assurance/ Endorsed for Boards-in-Common	Limited
4	Transformation – Financial Discipline and Communications plan	6	20	Assurance	Limited
5	Performance Recovery Trajectories – Elective and Cancer	2	20	Assurance	Limited
6	Targets for Diagnostics and faster cancer pathways – CDC update	2	20	Assurance	Limited
7	24/7 working in ED	2	20	Assurance	Reasonable
8	Deep Dive – Urgent Care	2	20	Assurance	Limited
9	Estates – Risks and Third-Party properties update	6	20	Assurance	Significant
10	Contract – HRI Surgical SDEC Level 3	6	20	Delegated authority	Approved

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 3 February 2026

Humber Health Partnership

3. Matters on which the Committees have requested more assurance

Transformation – Transformation improvement plans were questioned as were the resources required to deliver transformational change.

4. Decisions made

The CIC approved the Terms of Reference for the new Group Cash Committee.

HRI Surgical SDEC Level 3 –Tender responses had been received and 2 tenders were going through the final stages of evaluation. Due to the urgency of the work, delegated authority was requested and approved for a Contractor to be appointed within the range of £3.2m to 3.4m, with the final evaluation to return to PEF in March for assurance.

5. Escalation to Trust Boards

Revenue cash PDC support is likely to be required in Q4 due to under-delivery of the CIP, overspending against budgets and the loss of the DSF. Efforts continued to reduce the extent of support needed and the picture was being reviewed daily in the light of income, expenditure and capital programme cash availability due to delayed spend. The worst-case scenario would be a requirement for £29m, which would have a PDC revenue cost of £1m to the Group, if it was approved. Approval is also required to use capital cash which may be an alternative to PDC support. The Committee endorsed the proposal for the Board to approve the submission of a request for the minimum amount of support needed to maintain the recommended minimum cash balances of £2m for each Trust.

The 2026/27 Cost Improvement Plan was received, and the CIC requested a re-calibration to ensure the plan was challenging, but also realistically achievable.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions	N/a	N/a	Information	N/a
2	Operational and Financial Plan including CIP	6	20	Information	N/a
3	Group Finance Report – Month 9	6	20	Assurance/ Endorsed for Boards-in-Common	Limited
4	Transformation – Financial Discipline and Communications plan	6	20	Assurance	Limited
5	Performance Recovery Trajectories – Elective and Cancer	2	20	Assurance	Limited
6	Targets for Diagnostics and faster cancer pathways – CDC update	2	20	Assurance	Limited
7	24/7 working in ED	2	20	Assurance	Reasonable
8	Deep Dive – Urgent Care	2	20	Assurance	Limited
9	Estates – Risks and Third-Party properties update	6	20	Assurance	Significant
10	Contract – HRI Surgical SDEC Level 3	6	20	Delegated authority	Approved

6. Comments on the effectiveness of the meetings

7. Escalation to CiCs

Humber Health Partnership

8. Attendance record

Members / Attendees		A	M	J	J	A	S	S	N	D	J	F	M
Gill Ponder	NED (Chair)	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	
Helen Wright	NED (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	
David Sharif	Group Director of Assurance	✓	✓	RT	✓	✓	✓	✓	✓	✓	x	✓	
Emma Sayner	Group Chief Finance Officer	✓	✓	✓	✓	✓	PR	✓	✓	✓	✓	✓	
Matt Powls	Group Chief Delivery Officer	-	-	-	-	-	-	-	MP	MP	MP	✓	
Philippa Russell	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Andy Haywood	Chief of Strategy, Partnerships and Digital	-	-	-	✓	x	x	x	x	x	x	x	
Tom Myers	Group Chief of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Simon Parkes	Non Executive Director	✓	✓	✓	✓	✓	x	✓	x	✓	x	-	
Jane Hawkard	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	
Kate Wood	Group Chief Medical Officer	✓	✓	✓	✓	✓	✓	PS	✓	✓	✓	✓	

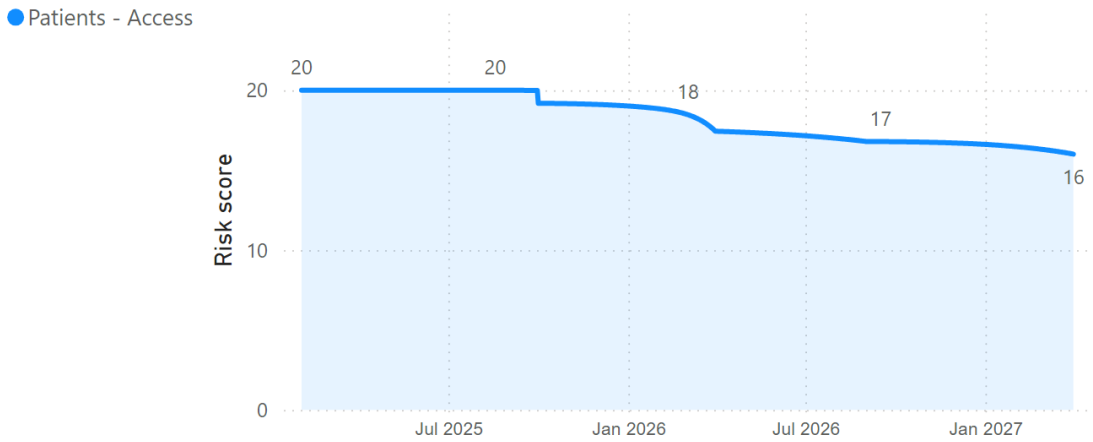
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Matt Powls, Interim Group Chief Delivery Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Patients - Access, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 18 December 2025. In full, the risk is:

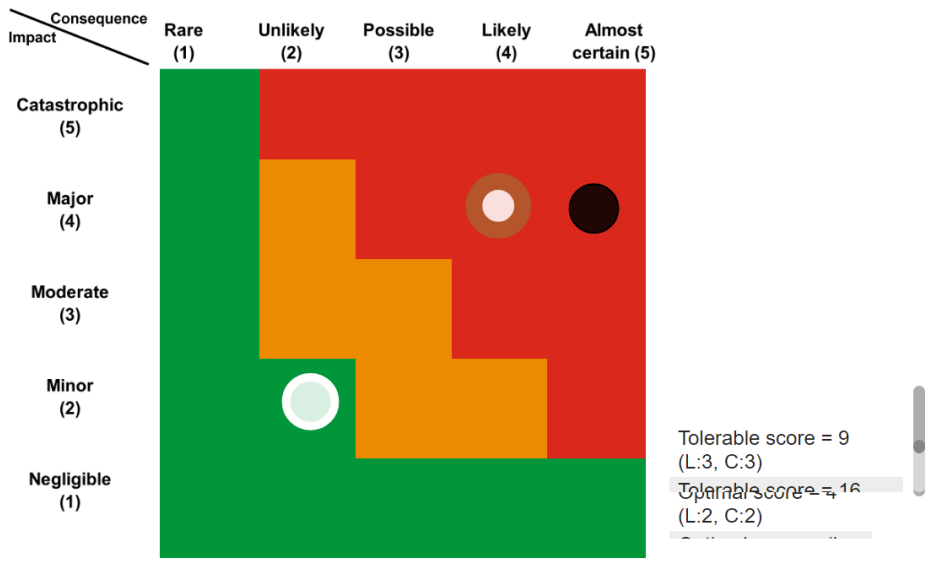
We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.

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

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



Current score and risk appetite



Risk appetite statement (Cautious)

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

2. Patients - Access

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

Control	Rating
Care Group Performance and Accountability	Limited
Daily / weekly PTL meetings (cancer and elective)	Significant
Financial Planning Improvement Board	Limited
Flow programme	Limited
National performance framework for support and scrutiny	Reasonable
Operating plan 2025-26	Limited
Planned Care Board	Limited
Tier 1 review processes - UEC, Cancer, Elective and Diagnostics	Reasonable
Unplanned Care Board	Limited

Gaps in control (and Action ID)	37	68	Total
Challenge in resolving numerous national expectations / targets with available finance, space and resources, degrading or overriding control	✓		1
Inert behaviour towards addressing system solutions by ICB	✓		1
Lack of positive medical engagment in delivery	✓		1
Lack of sufficient capacity to identify and implement service improvement gains from exemplar sites or best practice	✓		1
Weak culture of improvement/change management and siloed working	✓	✓	2
Total	3	2	1	6

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

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

Assurance gaps (and Action ID)	20	42	53	Total
Absence of a sophisticated demand and capacity (bed) model that supports scenario analysis and planning	✓		✓	2
Absence of routine data quality monitoring and patient record validation		✓		1
Total	1	1	1	3

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

2. Patients - Access

NHS Humber Health Partnership

The table below details the 5 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
20	Strategic Bed Review (based on optimum LoS)	31/01/25	01/09/26	Being developed by BI team in conjunction with clinical and operational colleagues	18/12/25	Adam Creeggan, Group Director of Performance, Matt Powls, Interim Group Chief Delivery Officer	Reasonable
37	Developing skills and capability of Care Group leadership to support D&C planning and associated operational tasks	31/03/26	01/04/27	B7 to 8b ops courses made available but yet to identify recurrent resources to support	18/12/25	Simon Nearney, Group Chief People Officer, Matt Powls, Interim Group Chief Delivery Officer	Limited
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised	30/09/25	01/10/25	Lunar Rover being implemented and benefits still to be realised	18/12/25	Adam Creeggan, Group Director of Performance	Limited
53	Develop and embed Care Group integrated plans aligning expendture, activity and workforce	31/05/25	31/03/26	Set clear and individual objectives across domains of finance, activity and workforce	18/12/25	Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	Reasonable
68	Separation and clarification of north and south operations where structural change is not required e.g. bed meetings	31/12/25	31/03/26	Weekly PTL meetings in place and reinvigorated	18/12/25	Matt Powls, Interim Group Chief Delivery Officer	Reasonable

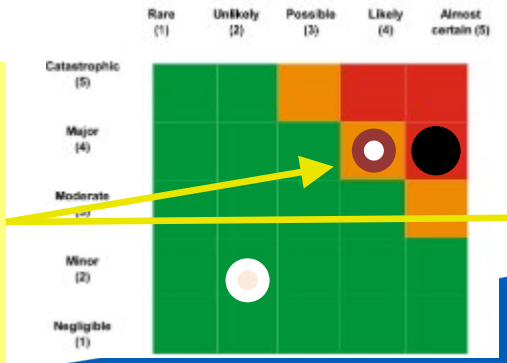
Appendix 1: Patient – Access

On 12 December, Boards-in-Common approved the change of the risk appetite for the Patient Access risk from being open (16) to becoming cautious (9) as shown below. This means that the tolerable score is 11 points below the actual risk score.

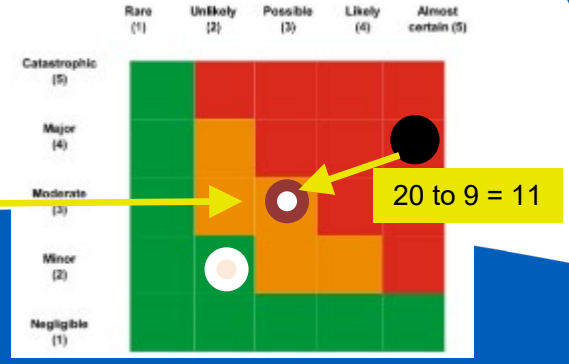
Patients – Access risk: The Chairs of Performance, Estates and Finance CIC also requested a change to the risk description as they believe that achieving the upper quartile in the current climate is unrealistic.
The following was proposed: *We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.*

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

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



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



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NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)009

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	12th February, 2026
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Simon Nearney, Group Chief People Officer
Title of Report	**Our People**
Executive Summary	This report provides an overview of the key People issues that have arisen since the last Boards-in-Common meeting and covers workforce matters discussed at Workforce, Education and Culture Committees-in-Common, which we are seeking to address and improve so our people feel engaged, valued and motivated to provide the best care possible to our patients.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce, Education and Culture Committees-in-Common December 2025 and January 2026 highlight reports and People Board Assurance Framework are included within the report.
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Humber Health Partnership

Trust Boards-in-Common

12th February 2026

Our People

1. Purpose

The purpose of this report is to provide an overview of the key People issues that have arisen since the last Boards-in-Common meeting and workforce matters discussed at Workforce, Education and Culture Committees-in-Common, which we are seeking to address and improve so our people feel engaged, valued and motivated to provide the best care possible to our patients.

2. Background

NLaG and HUTH remain in the National Operating Framework (NOF) segment 4 (at the time of writing this report). The group remains challenged with regard to its quality and safety standards, performance against constitutional standards, meeting its financial target and people measures. As a result, we are subject to a high level of scrutiny from national teams and regulators. We are required to make immediate improvements in our ED performance, reduce the size of our waiting lists and improve the timeliness of patients being diagnosed and if required, treated for cancer. Conversations are continuing with teams and individuals to focus our efforts on those key constitutional standards to make those improvements.

As well as patient access targets and financial performance, the NOF uses the national staff survey response and engagement scores to determine our position as well as sickness absence in the national league tables. This makes it even more important that managers and teams are having conversations about how we can improve the working environment; what we are doing and how we are doing it, to ensure our people enjoy coming to work, that their basic motivational needs are met, that staff are engaged and feel valued which is turn will improve performance and ultimately patient outcomes.

3. People Strategy 2025-28

The Group People Strategy (2025– 2028) was launched in April 2025 and aims to transform the workforce experience of our people through five strategic themes: People and Partnerships, Workforce Systems Transformation, Health and Wellbeing, Leadership, Learning and Talent Development, and Culture and Engagement. In the first year, the strategy is focusing on foundational priorities, including workforce planning, digital tools, wellbeing initiatives, leadership development, and anti- discrimination frameworks. The work programme and deliverables are presented to the Workforce, Education and Culture Committees-in-Common at the end of each quarter. Quarter 4 will be presented in May 2026. The strategy is aligned with the NHS Long Term Workforce Plan and the NHS People Promise.

4. Culture & Engagement

4.1 Putting People First - Cultural Transformation Programme

The Putting People First programme is in the final quarter of the year now with a focus on asking managers to put the basic essentials in place for their teams. The CARE package for staff, which is an online resource pack, including links to essential support services and benefits is almost complete. Feedback for this has to date been positive, and a virtual ‘handbook’ is in production for managers which will help to promote the CARE package on an ongoing basis.

The Group Culture group is reviewing the cultural programme for 2026/2027 with a view to ensuring it aligns with our improvement plan objectives and the patient safety agenda.

4.2 National Staff Survey

The National Staff Survey 2025 preliminary results have been received. HUTH response rate was 47%, NLaG’s response rate was 42%.

Across the nine key themes which make up the survey performance has been maintained or improved. Only the staff engagement score at HUTH has deteriorated.

The full results are embargoed until March.

4.3 Group Lottery

The Group Lottery has been awarded a national Gambling Association license. The scheme is managed by a third-party provider, Sterling, which is an experienced national organisation supporting corporate lotteries across the UK.

The 'Humber Health Jackpot' was launched to staff on Monday 2 February, with the first weekly draw taking place in April.

A Group Lottery Committee, with representation from finance, communications and governance has been established to oversee income and expenditure. Staff members are also committee members and will help to ensure funds – other than prize draw funds - are spent in accordance with members wishes.

4.4 Corporate communications activity for Q3

- 181 media stories about the group, of which 85% were positive
- 313,324 opens of corporate emails, including Chief Executive bulletin
- 890 staff attendances at Ask the Executives
- 2670 Shining Lights nominations
- 435 Freedom of Information requests received
- 189 Freedom to Speak Up concerns raised
- 520,000 website users
- 129,608 social media followers
- 14402 unique users per month on Bridget (staff intranet)

5. Health & Wellbeing

5.1 Flu Vaccination

The HHP (HUTH and NLAG) staff influenza vaccination campaign commenced on the 1st of October. During October the group had static hubs one on each of the main sites open for staff to attend and have the vaccination. From November onwards the group moved to roving teams to attend specific areas across all hospital sites. Wards and services have been able to request a roving vaccinator to attend to their team to administer vaccinations. Currently NLaG and HUTH vaccination take up is 52% for both trusts. The Group has delivered NHS England's requirement to improve take up rates by 5% from last year. The roving teams have now been stood down, but staff can still receive the vaccination via Occupational Health offices

5.2 HIV Confident

The Group achieved national HIV accreditation in December 2026 following a long campaign of work led by Dr Katie Hodgson, Principal Clinical Psychologist and our Group Health & Well-being MDT. This is a great achievement and supports both staff and patients with education and access to support and guidance where required.

5.3 WISHH Rest Areas

Working in partnership with WISHH Charity, the Health & Well-Being MDT secured £290k to upgrade staff rooms within HUTH (HRI). Work commenced in November 2025 seeing the completion of ward 100 and ward 60 with 7 more staff room renovations to be completed before 31st March 2026. This is a very local and tangible health and wellbeing improvement / outcome for our staff aligned to our core ambition to improve the working environment for our people and specifically improve, rest, hydration and nutrition as a key driver from the 2024 national staff survey. The Health Tree Foundation supported by our Wellbeing service has submitted a bid for similar funding to improve NLaG rest facilities.

6. People & Partnerships

6.1 Agency, Bank and Temporary Staffing

In the 24/25 financial year the Group reduced agency spend by £11.5m. For 25/26 NHSE required the Group to reduce agency spend by a further 30% as compared to agency usage in 24/25 i.e. £8.1m. For 25/26 the year to date spend at end Month 9 was £20.7m. At the end Month 9 agency spend is £6.2m off target. M9 agency has increased by 400k when compared with the previous month but is typical of the period as a result of significantly increased operational pressures.

Executive Directors continue to approve all agency requests over 1 week. Care Group and Site Management Teams have the responsibility to approve less than 1 week as well as overtime, bank, locum and extra contractual payments. Care Groups are working hard to reduce variable pay spend and standard placement contracts have reduced from 24 to 2 saving c20% VAT on each assignment.

6.2 Operational Planning for 26/27 and beyond

A core focus is on the development of a robust and deliverable operating plan for the financial year 26/27. This includes a five-year workforce plan narrative and a three-year numerical submission. Core metrics include sickness reduction, agency and bank reduction and an increase in job planning.

Group targets in year 1:
26% - Agency reduction
5% - Bank reduction
95% - Job planning achievement (TBC)
5.4% Y1 NLaG sickness target
4.1% Y1 HUTH sickness target

7. Workforce System Transformation

7.1 Key workforce metrics – current position

Metric	Group current Position	Target
Sickness	4.8%	4%
AFC Appraisals	81%	85%
Vacancy Rate	4.3%	7%
Turnover	7.0%	10%
Core Mandatory Training	88.5%	85%
Role Specific Training	81.7%	85%
Job Planning	83.8%	100%
Medical Appraisals	92.1%	90%

7.2 Non-clinical vacancy freeze

Given the group's current financial position, a non-clinical vacancy freeze was implemented in December 2025 for the remainder of the financial year. This decision was taken at the group's senior leadership team meeting which included Chiefs of Service, senior clinicians and managers. Services can appeal the freeze if they believe and can evidence that the 'stop' will have an adverse impact upon services and patients. Posts are presented to a weekly Executive Discretionary Pay panel for consideration and approval. Corporate posts will also need ICB approval prior to advertising. The group's current process will be reviewed in March 2026. The vacancy freeze is having an impact upon teams and staff morale.

7.3 Resident Doctor 10 Point Plan

We continue to work with our Resident Doctor Peer Leads to address key actions from the 10 Point Plan. This has included the introduction of a process to allow Resident Doctors to claim study leave expenses e.g. course fees prior to attending the event with mileage and subsistence being claimed after the event. In December 2025 management worked with Resident Doctor leads to complete a national survey to monitor progress against the 10 Point Plan which showed a 17% increase to 71% in completed actions for HUTH and a 17% increase to 69% for NLAG. Key points of focus include a review of systems and processes to ensure that Rotation Resident Doctors do not have to unnecessarily repeat mandatory training when joining the Group and a Health and Wellbeing Survey to further understand key issues experienced by Resident Doctors and help shape future actions.

8. Leadership, Learning & Talent Development

8.1 Learning, Improvement and Safety Academy (LISA)

The Organisational Development, Quality Improvement and Learning teams have been heavily involved in the development of LISA during quarter 3 as part of our wider Improvement plan and methodology. The development of LISA, will bring together functions that support clinical education, medical education and organizational development, learning, quality improvement and simulation into one coherent learning and improvement system.

LISA will provide an integrated programme of leadership development, team effectiveness, safety training and improvement support across the Humber Health Partnership. Bringing together clinical education, medical education and organisational development, the Academy becomes the central place where teams access the skills, tools and support needed to deliver safe, high-quality, reliable care.

Together, the Leadership Improvement & Safety Academy will create a consistent, partnership-wide approach to leadership, improvement and safety - ensuring that staff, teams and services are supported to continuously improve care for patients and families.

The teams that will directly support the LISA model are now coming together weekly to ensure that we can operationalise the academy model to directly support the Stabilise Improvement Plan priorities. While we work to bring LISA together the Learning and OD teams are bringing any non-priority pieces of work to a close to ensure we free up capacity as soon as possible.

8.2 Organisational Development

8.2.1 Leadership Development

The 5-day Medical Leadership programme has two cohorts currently running, cohort 4 is due to complete in May and Cohort 5 commenced in January (day 1 completed on 26th January) which has received good feedback. Below is an extract from the feedback of a candidate.

"The day helped me think about my personality/leadership style. In many ways, I wasn't surprised with the results of my Insights Personal Profile – It sounded just like me. I was actually surprised how much it seemed to "know", just based on my answers to a questionnaire. It also surprised me how much I could relate to the 4 colours in the Colour Dynamics section, used to describe broad types of leadership."

Our leadership development programme for staff with a disability (Leading Without Limits) started this month with 15 candidates, either new to leadership or aspiring leaders. This is co-designed with T2. Early feedback is positive. Below is an extract from a participant's feedback:

"I really want to run with this and get involved and assist in implementing and facilitating positive change, within the trust. "

8.2.3 Bespoke OD Work:

- **OD input within Family Services:**
  A Care Group led workforce culture group is now in place with support from OD. There were great examples of good practice from across the group shared. Maternity services are adopting a clinical micro-systems approach to cultural change focussing on the patient journey. This will align well with the LISA approach and embed patient safety and experience as the main goal and good culture as a key enabler.
- **OD Input into Cardiovascular:**
  OD are supporting the leadership development in TAVI service and Cath Labs. Incivility reporting tool is still in place, which is highlighting issues with relationships amongst a small group of people. Senior leadership team in cardiology will be working with Bravest Path to enhance skills in managing challenging situations ensuring they have the embedded skills to support internally challenged relationships.
- **OD input into TACC:**
  Aesthetic leadership team are working with Bravest Path to support the work with the Consultant Anaesthetists at NLAG transition into Group working. The Bravest Path focus on ensuring leaders have the confidence and skills to have brave, clear and kind conversations. This will support staff to embed the skills to embed open and safe conversations, give feedback and set clear expectations for behaviours.

8.3 Apprenticeship Levy

Between April and December 2025, both NLAG and HUTH demonstrated clear growth in apprenticeship investment and participation when compared with the same period in 2024. NLAG increased its apprenticeship spend from £1,122,512 to £1,316,054, a rise of 17%, while HUTH reported a more modest but still positive 7% increase from £1,615,897 to £1,721,732. This sustained upward trend highlights both Trust's continued commitment to workforce development and to maximising the value of the apprenticeship levies across the Humber Health Partnership.

Apprenticeship starts also saw strong year-on-year growth. NLAG increased its starts from 107 to 135 (26% growth), while HUTH grew from 135 to 168 (24% growth). Higher-level programmes continued to dominate activity, particularly the Level 7 Senior Leader apprenticeship, which saw significant expansion at NLAG (from 21 to 50 starts) ahead of the standard being revoked for learners aged over 25 from January 2026. Strong engagement also continued across Operations Manager, Team Leader, Nursing Associate, and Coaching Professional pathways. While participation in nursing apprenticeships remained steady overall, both Trusts noted a decline in uptake of the Level 3 Senior Healthcare Support Worker apprenticeship as a CPD route for existing health care colleagues. Plans are in place to address this in Q4 through a refreshed offer, including both online and face-to-face options, supported by targeted promotion during National Apprenticeship Week starting on 9 February.

8.4 Mediation Service

Since the last report to the Board the Mediation Service has been in high demand receiving a total of 24 new referrals, 14 from the North Bank and 10 from the South Bank. The recruitment, training and induction of 6 new Volunteer Trust Mediators (VTMs) in August 2025 has ensured the HHP Group Mediation Service has been able to meet the demands placed upon it and all referrals have been allocated in a timely manner. All 6 of the new VTMs have taken cases and are now practicing Mediators.

8.5 Learning

8.5.1 Learning Management System (LMS) – A unified approach

The new LMS for Group will be launched on 1st April 2026, this will mean that the whole group will access their learning records through the same system. Not only will this provide a consistent intuitive learning experience for all staff, but it will improve access to training resources and booking onto training sessions. It will enable unified tracking of compliance, appraisals and development activities.

8.5.2 Learning and Innovation Centre Open Day 2026

Plans are currently being finalised to extend a warm welcome to HHP staff to the Learning and Innovation Centre, CHH, to celebrate the 1-year anniversary since opening. The event will take place on 19th March 2026, all staff are invited to drop in and view the facilities, the rooms will be filled with Learning and Organisational Development professionals from across the organisation showcasing a wide range of different learning activities and opportunities. A marketplace event will also be running for those who want to drop in for a coffee and a chat about the different teams and services in place to support staff continuing professional development. We have also arranged a visit from the East Riding of Yorkshire County Council Adult Education skills bus who will be advising staff on what Key Skills training they can provide for topics including maths, English and IT. We look forward to welcoming colleagues to the celebration event.

8.6 Simulation

The Hull Institute of Learning and Simulation will be leading the SPARK – Simulation Partnership for Advancing Regional Knowledge 10th anniversary conference in York in June 2026. The event will be a celebration for 10 years of the network! “Simulation meets sustainability” will include interactive workshops and escape room style sessions. The programme is currently being finalised amongst the SPARK group members and bookings will open via Eventbrite on 16th February 2026.

8.7 GMC Survey update

The 2025 GMC National Training Survey has highlighted significant challenges requiring urgent action, particularly at Scunthorpe General Hospital (SGH), which reported 12 “red” outliers, compared to 7 at Diana Princess of Wales Hospital. The survey identified concerns regarding patient safety across several specialties, including Gastroenterology, Cardiology, Respiratory, Anaesthetics, and Diabetes and Endocrinology, as well as broader cultural issues within the Trust. Action plans have been developed, implemented and are being closely monitored.

The Trust is awaiting the results of the NHSE Education and Training survey, with the expectation that recent improvements will be recognised and reflected in the outcomes.

9. Recommendation

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

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 17 December 2025

Humber Health Partnership

1.Matters for Reporting

Effectiveness Review – Transformation was discussed, particularly around medical productivity and outpatients redesign. It was agreed that the transformation piece sat with Performance, Estates and Finance CIC and WECC would review any staffing issues following. This would be clarified through the Terms of Reference.

Flu update – vaccination rates were at 50% for both organisations. Facemasks were not yet mandated.

The **Resident Doctors industrial action** started today and plans were in place to maintain 95% of planned activity. The matter would be kept under review for the 5 days.

The 2026/27 Operational Workforce Plan was received which detailed the key criteria set by NHS England and the CIP expectations. Delivery of the plan was expected to start from 1st April 2026.

Medical and Dental Job Planning update – a marginal increase in compliance had been seen (81% compliance). Work was ongoing with the Care Groups to support them to reach the 95% target by the end of March 2026. The next report would give granular breakdown regarding challenged areas.

2. Positive assurances

Significant assurance was given to the **Nurse Staffing** processes following an external visit by NHS England. A number of recommendations relating to gaps and controls were being worked through.

Resident Doctor 10 point plan was underway and the working group was progressing the joint action plan with resident doctor leads.

3. Matters on which the committees have requested additional assurance

GMC National Training Survey - enhanced monitoring for Gastroenterology specific to Grimsby and Scunthorpe had commenced. Quarterly updates were required by the CIC.

Nursing and Midwifery Staffing – HUTH establishment risks were discussed and turnover in the first year of employment was raised as an issue. Culture and pay were the main factors and both were being addressed.

4. Decisions made

Equality and Diversity – The importance of Executive and NED involvement was discussed. NED champion support would be formalised.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Registered Nursing and Midwifery Staffing – HUTH/NLAG	1	20	Assurance	Reasonable
2	Workforce Integrated Performance Report	1	20	Assurance	Reasonable
3	2026/27 Operational Workforce Plan – Draft 1	1	20	Information	N/a
4	Equality, Diversity and Inclusion Annual Report 2024/25	1	20	Information	N/a
5	Medical and Dental Job Planning – Monthly Update	1	20	Information	N/a
6	Outcome of External Visit – Nurse Staffing	1	20	Assurance	Reasonable
7	Resident Doctor 10 Point Plan	1	20	Information	N/a

5. Escalation to Trust Boards

6. Comments on the effectiveness of the meeting

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

7. Escalation to CiCs

8. Attendance record

Members/Attendees		A	M	J	J	A	S	O	N	D	J	F	M
Julie Beilby	Non-Executive Director (NLAG) Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Tony Curry	Non-Executive Director (HUTH) Chair	x	✓	MMc	✓	✓	✓	✓	✓	✓			
Simon Nearney	Group Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Heather McNair	Interim Group Chief Nurse	✓	HMc	HMc	HMc	JL	✓	JL	HMc	✓			
Kate Wood	Group Chief Medical Officer	✓	PS	✓	✓	✓	PS	✓	AG	✓			
David Sulch	Non-Executive Director (HUTH)	x	✓	✓	✓	✓	✓	✓	x	✓			
Sue Liburd	Non-Executive Director (NLAG)	x	✓	✓	✓	✓	x	✓	✓	✓			
Laura Treadgold	Non-Executive Director (HUTH)	✓	✓	✓	✓	x	x	✓	✓	✓			
David Sharif	Group Director of Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓			

CiC ESCALATION REPORT

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON – 28 January 2026

Humber Health Partnership

1. Matters for Reporting

Resident Doctors Industrial Action – A pay increase of 9% had been agreed in Scotland for Resident Doctors and thus ended their Industrial Action. Doctors in England were being balloted for further strike action.

People Strategy – 68.4% of the plan had been delivered year-to-date and was on track. The CIC gave reasonable assurance for the actions completed compared to plan, but did not give assurance regarding the outcomes until further staff survey results could be analysed.

Agency Spend – The top 5 Care Groups with high agency spend were being supported by corporate services to help reduce their spend.

A **Learning Improvement & Safety Academy (LISA)** was being developed and will be launched across the Group. A Programme Board will be established to manage the support to Care Group requirements.

Operational Workforce Plan – The CIC received the draft that highlighted the content of the workforce elements that would be in the operating plan, but there was more work to do. The final plan would be received at the Boards-in-Common in February 2026.

2. Positive assurances

The Flu Vaccination programme – As required by NHSE, the Group had seen a 5% increase in staff taking up the flu vaccination.

3. Matters on which the committees have requested additional assurance

CQC Actions - There had been a substantial improvement regarding the remaining actions, but the CIC asked for further assurance around the process to complete them and how any actions would be managed as part of business as usual and remove them from the action plan.

Medical and Dental Job Planning – The CIC gave reasonable assurance due to the current compliance level of 83.8% against a target of 95% and with an explanation of the actions proposed to achieve compliance.

Safer Nurse Staffing Establishment Review – The CIC were reasonable assured regarding the clarity the paper provided but did not have oversight of where the funding as well as the relative priority against other funding demands. This would be discussed at the Boards-in-Common in February 2026.

4. Decisions made

5. Escalation to Trust Boards

Resident Doctors – There had been adverse media coverage around the GMC survey, particularly relating to Gastroenterology being placed in enhanced monitoring. An update to be received at the March 2026 meeting.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions Group Progress Report	N/a	N/a	Assurance	Reasonable
2	People Strategy Progress Report – Q2	1	20	Assurance	Reasonable
3	Operational Workforce Planning Summary	1	20	Assurance	Reasonable
4	Medical and Dental Job Planning	1	20	Assurance	Reasonable
5	Placement Tariff Funding and Nurse Educator costs	1	20	Assurance	Reasonable
6	Safer Nurse Staffing Establishment Review	1	20	Endorse-ment	Endorsed
7	National Staff Survey Preliminary Results	1	20	Information	N/a

6. Comments on the effectiveness of the meeting

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

7. Escalation to CiCs

N/a

8. Attendance record

Members / Attendees		A	M	J	J	A	S	O	N	D	J	F	M
Julie Beilby	Non-Executive Director (NLAG) Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Tony Curry	Non-Executive Director (HUTH) Chair	x	✓	MMc	✓	✓	✓	✓	✓	✓	✓		
Simon Nearney	Group Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Amanda Stanford	Group Chief Nurse	✓	HMc	HMc	HMc	JL	✓	JL	HMc	HMc	HMc		
Kate Wood	Group Chief Medical Officer	✓	PS	✓	✓	✓	PS	✓	AG	✓	✓		
David Sulch	Non-Executive Director (HUTH)	x	✓	✓	✓	✓	✓	✓	x	✓	x		
Sue Liburd	Non-Executive Director (NLAG)	x	✓	✓	✓	✓	x	✓	✓	✓	✓		
Laura Treadgold	Non-Executive Director (HUTH)	✓	✓	✓	✓	x	x	✓	✓	✓	x		
David Sharif	Group Director of Assurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		

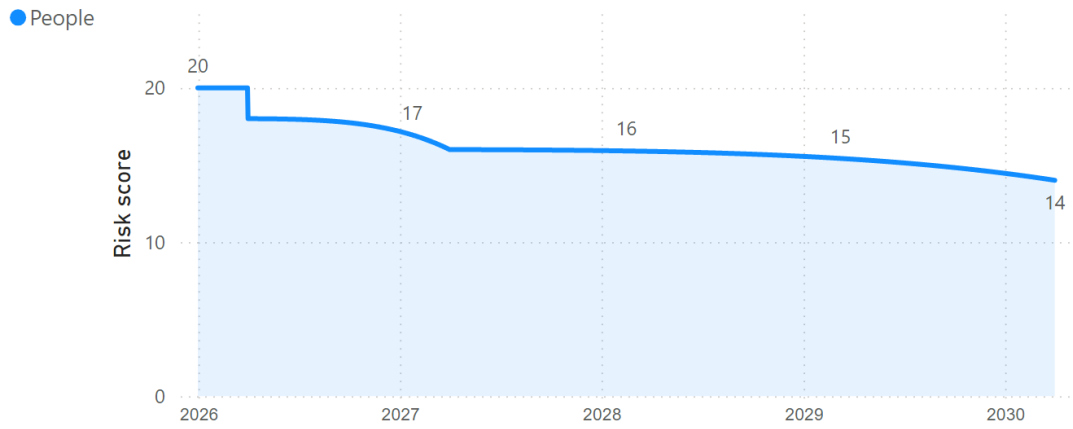
1. People

The strategic risk affecting our objective, 'People' is led by Simon Nearney, Group Chief People Officer and reported to the Workforce, Education and Culture Committees-in-Common. Under the risk category of People, the risk's current score is 20 and its score last changed on 23/09/2025. The actions were last reviewed on 21 January 2026. In full, the risk is:

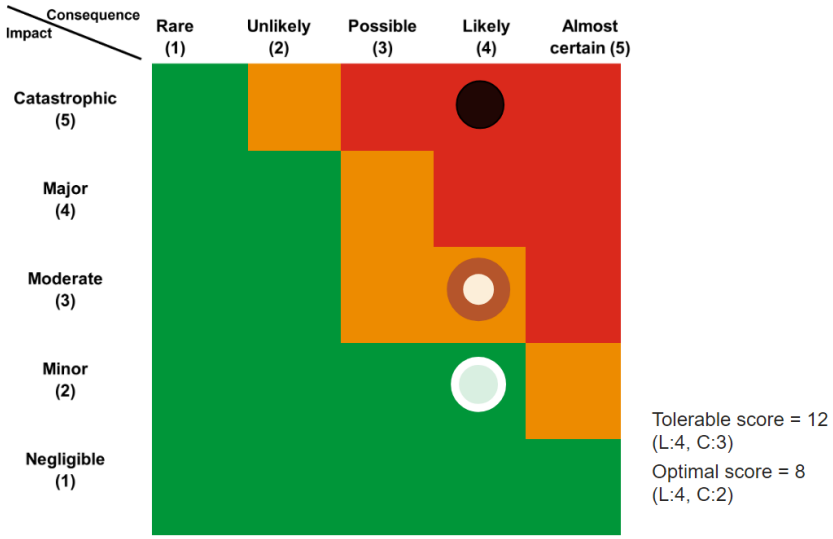
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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

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



Current score and risk appetite



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

Optimal score = 8 (L:4, C:2)

Risk appetite statement (Balanced)

Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

1. People

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

Control	Rating
Annual Care Group Workforce plans	Limited
Care Group Performance and Accountability	Limited
CESR Programme	Significant
Clinical Poiicy Group (CPG)	Limited
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Executive Team	Limited
Group Leadership Strategy	Limited
Group People Strategy 2025-28	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Reasonable
Resident Doctor 10 Point Plan Oversight Delivery Group	Reasonable
Senior Leadership Team (SLT)	Limited
Talent management team for international recruitment	Limited
Vacancy Control Panel	Reasonable
Workforce Transformation Group	Reasonable

Gaps in control (and Action ID)	6	7	8	69	Total
Hard to recruit roles in medical specialities		✓	✓		2
Instability among Board-level leadership					1
Low clinical engagement across specialities and Group					1
Management and Leadership consistency in delivering the People Promise to staff			✓		1
Sufficient attraction, to recruit and retain staff to work in the area		✓	✓	✓	3
Total	1	2	2	2	1	8

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
External	External Safer Staffing report on application of model	Reasonable
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Never events	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequent culture and staff experience measures	✓	1
Lack of assurance re short term additional hours / overtime from Care Groups	✓	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	✓	1
Plans to address ageing workforce profile	✓	1
Poor levels of mandatory training compliance		1
Total	4	1	5

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

1. People

NHS Humber Health Partnership

The table below details the 4 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
6	Recruitment drives using the Group values to attract high calibre candidates - focussed on medical staff and other key areas	31/03/26	01/04/26	Focus currently on medical staff.	21/01/26	Simon Nearney, Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	People First programme to evolve and support Safety agenda	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable
8	Group Leadership network and training programme	30/12/25	01/04/27	New leadership programme for the Group ongoing (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable
69	Development of Executive Team programme of development	31/03/27	31/03/27	Draft plan agreed	21/01/26	Simon Nearney, Group Chief People Officer	Limited

NHS
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NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)010

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12th February 2026
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Elizabeth Houchin – NLAG Freedom to Speak Up Guardian Fran Moverley – HUTH Freedom to Speak Up Guardian
Title of Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3) – NLAG & HUTH**
Executive Summary	The Q3 FTSU reports present an overview of number of concerns raised, national and regional updates and the proactive work undertaken by the NLAG and HUTH FTSU Guardians, along with future plans for FTSU. **Key points to note for NLAG:** • Number of concerns received in Q3 has increased (107) compared to the previous reporting year (85). • Low number of anonymous concerns and below the national average for the size and type of organisation. • Common themes included worker safety, patient safety, HR processes and inappropriate behaviours. **Key points to note for HUTH:** • 82 concerns were recorded; same figure as Q2 and 4% increase compared to Q3 in the previous reporting period. • No concerns were raised anonymously to the FTSUG. • Common themes included inappropriate behaviours, role and general concerns. • Individuals asking the FTSUG to protect their identity decreased to 10%, and the individuals requesting the FTSUG support directly with escalation decreased to 26%. • 100% of individuals reported they would speak up again to the FTSUG, and 82% to the wider Trust.
Background Information and/or Supporting Document(s) (if applicable)	This report is of routine nature and presented quarterly to the Workforce Transformation Group and the Workforce, Culture and Education Committees-in-Common. No supporting documents are applicable.
Prior Approval Process	Not applicable
Financial Implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 3 Report October to December 2025

Liz Houchin
7th January 2025

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 3 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Freedom to Speak Up Guardian (FTSUG) activity during quarter 3 (Q3) of the 2025/2026 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper satisfies the Trust Strategic Objective of ‘Being a good employer’ and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are several processes at NLAG in place that allow staff to raise concerns, including, dependent on the situation including, but not limited to:

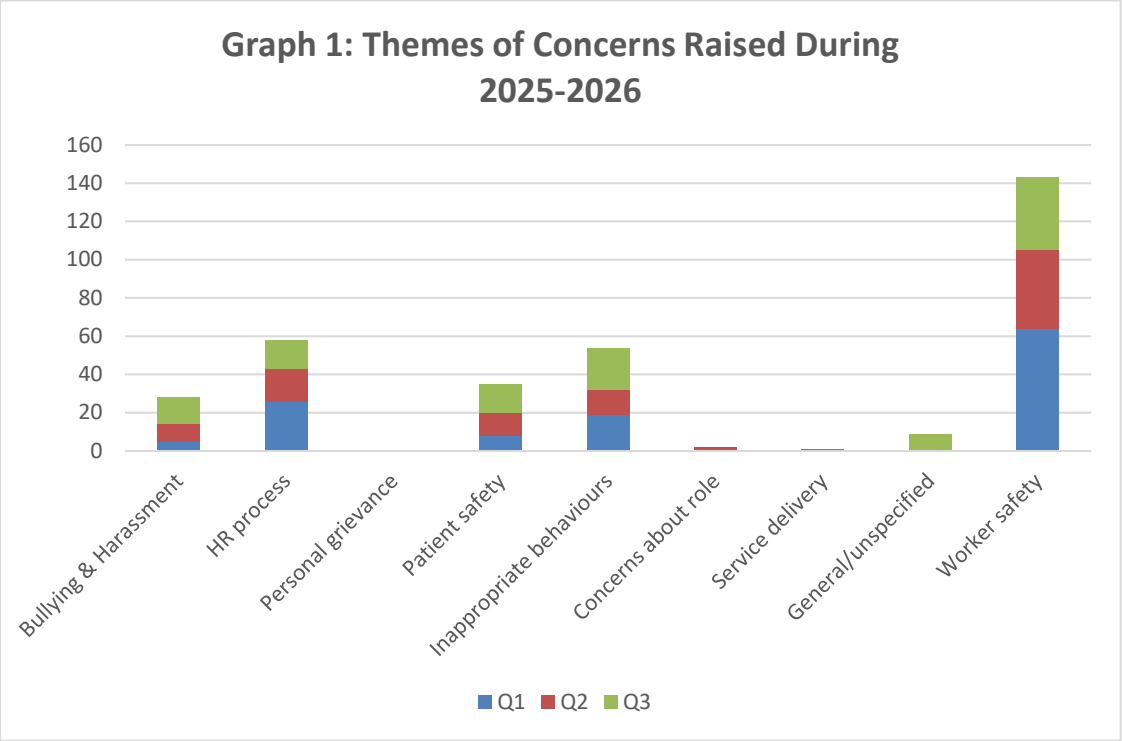
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Group Grievance Policy and Procedure (GP024)
- Group Conflict Resolution Policy (GP026)
- Ulysses Incident Management System

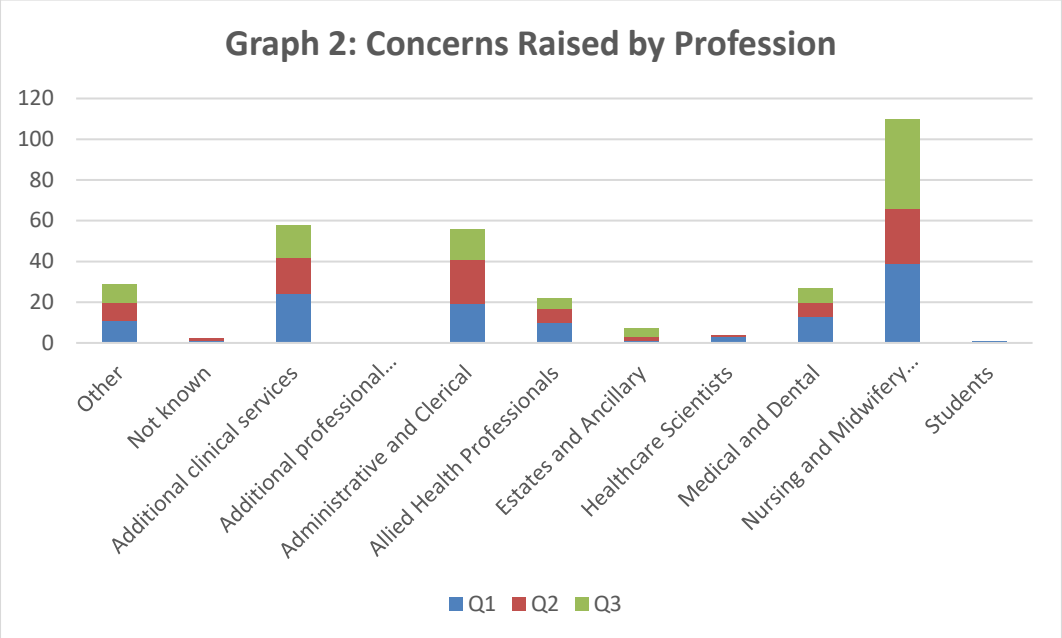
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st October 2025 to 31st December 2025 (Q3) – data, comments and assessment

4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1 and 2 summarises the Q3 data:





4.3 In Q3 2025-26, 107 concerns were received. 6% of these were closed on the same day after giving advice or signposting.

- 4 concerns were raised anonymously in Q3 using the staff app. This is below the national average although an increase from Q2.
- In Q3 15 concerns involved an element of patient safety. This puts the Trust in the highest quartile nationally. Figures accessed from Model Hospital in December 2025 - data relates to q1 25.
- In Q3 38 concerns involved an element of worker safety which puts the Trust in the highest quartile nationally. Figures accessed from Model Hospital in December 2025 - data relates to q1 25.
- In Q3 22 concerns involved an element of inappropriate behaviours which puts the Trust in the Mid-high Quartile nationally. Figures accessed from the Model Hospital December 2025 - data relates to q1 25/26.
- In Q3 14 concerns involved an element of bullying and harassment which puts the Trust in the highest quartile nationally. Data relates to q1 25/26 and accessed from the Model Hospital in December 2025
- Model Hospital data indicates that for 'Raising Concerns' the median score puts the Trust in the Mid Quartile. This is from the National Staff Survey results from 2024.

The Q3 figure of 107 is higher than Q3 for 2024-25 which was 85. The main themes raised were around worker safety, patient safety, HR process and inappropriate behaviours. Looking at the worker safety concerns, 52% related to either not feeling psychologically safe to speak up, or the impact the working environment was having on wellbeing. 36% related to working conditions and 12% related to staffing levels.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed.

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.

4.5 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q3	7	7

Data analysis of the completed evaluation forms indicate colleagues aged between 25-64 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British, Black or Black British and White backgrounds accessed the FTSUG in Q3.

Within the feedback received, the following are extracts of qualitative feedback received:

Liz has been thorough throughout the whole process, checking in on me every few weeks, updating me when and where she could. I couldn't be happier with the process.

Liz explained that everything she would have suggested to resolve my situation, I had already tried, but she still gave me suggestions on how to further chase and approach people involved which was helpful.
Liz is so helpful, knowledgeable and empathetic as to the situation I was going through, even just talking to her and sending her the initial email made me feel much better, knowing that somebody was there to listen.
Her role in the Trust is so valuable and she genuinely cares.

A lovely woman who gave me assurances and actually heard me. She was empathetic with my plight, and I was assured complete confidentiality.

4.6 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

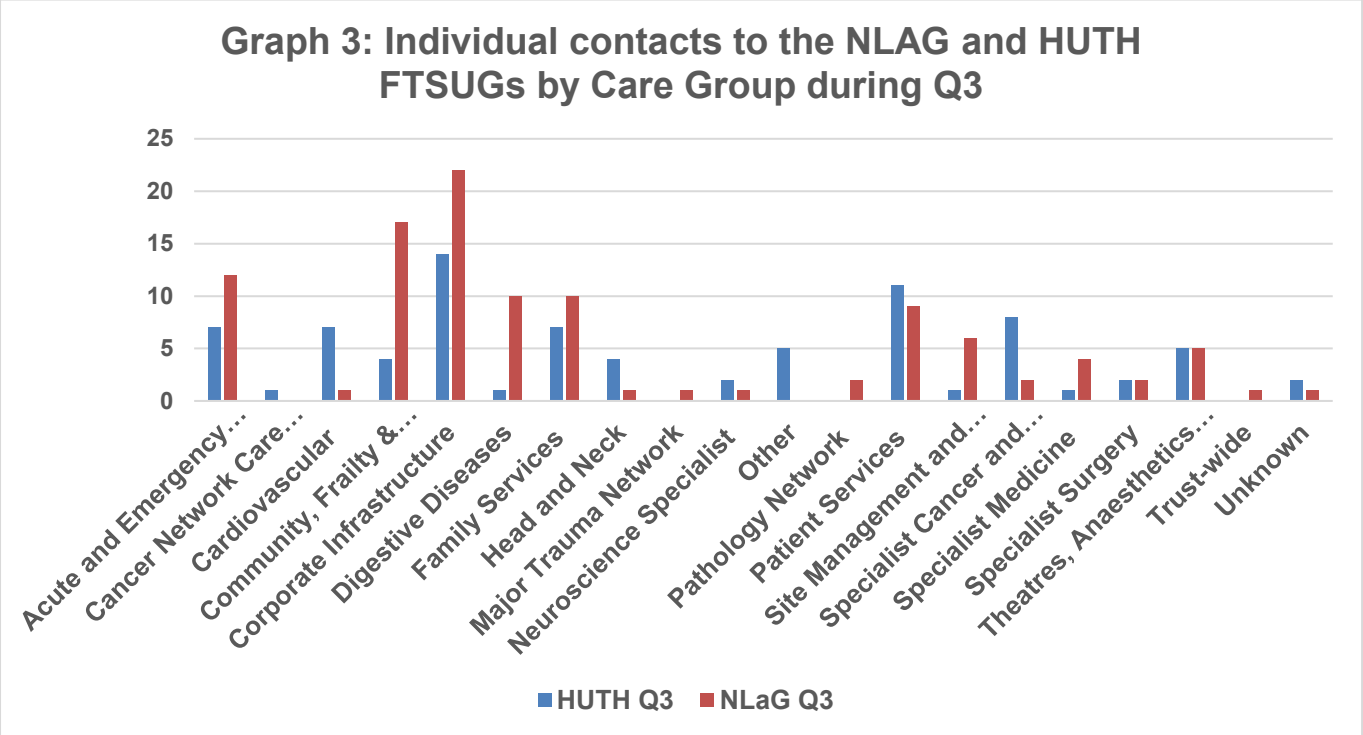
The FTSUG received several concerns from colleagues about staffing levels, on call system and impact of both on patient safety and the impact on colleagues' health and wellbeing in an area

The FTSUG contacted the management team and Nurse Director for the care group to share the details of the concerns. The management team were already aware of the issues and work had already started to address them. The Director offered to meet colleagues on a 1:1 confidential basis if they wanted to. The management team also decided to put on a listening event so everyone would be able to speak up and raise their concerns and worries.

The FTSUG shared this with the colleagues who were very grateful for the support and help the FTSUG had provided, saying they would definitely contact the FTSUG again if needed

4.7 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 Q3

5.1 A high-level summary of the activities are detailed below:

- Monthly 1to1s with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Trust inductions
- Attendance at Regional NGO meeting
- Walk rounds with OD team

5.2 Future plans:

- Continue to work with HUTH FTSUG to deliver the FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- Attendance at all relevant meetings

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings to discuss and share best practice. In October 2025, the regional network held a virtual leadership conference with national speakers and opportunity for group working and networking. This included a discussion about how organisations can truly learn from FTSU concerns and what systems and processes are in place to facilitate this.
During December 2025 the region held a supportive peer support meeting where topics included the NGO changes and training and escalation routes available to FTSUGs.

6.2 National update

There has been confirmation that the National Guardian Office will now close on 30th June 2026 with their responsibilities transferring into NHSE. The extension allows for an engagement process with NGO staff, guardians, NHS leaders and other Stakeholders about the future of the Freedom To Speak Up programme, its functions and ensures continued support of guardians during the transition.

The requirement to have a FTSUG has been included as part of the NHS standard contract up to 2027.

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom To Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Liz Houchin
7th January 2026

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 3 Report October to December 2025

Fran Moverley
January 2026

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 3 2025/2026

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during 1st October 2025 to 31st December 2025 - quarter 3 (Q3) 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 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 (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:

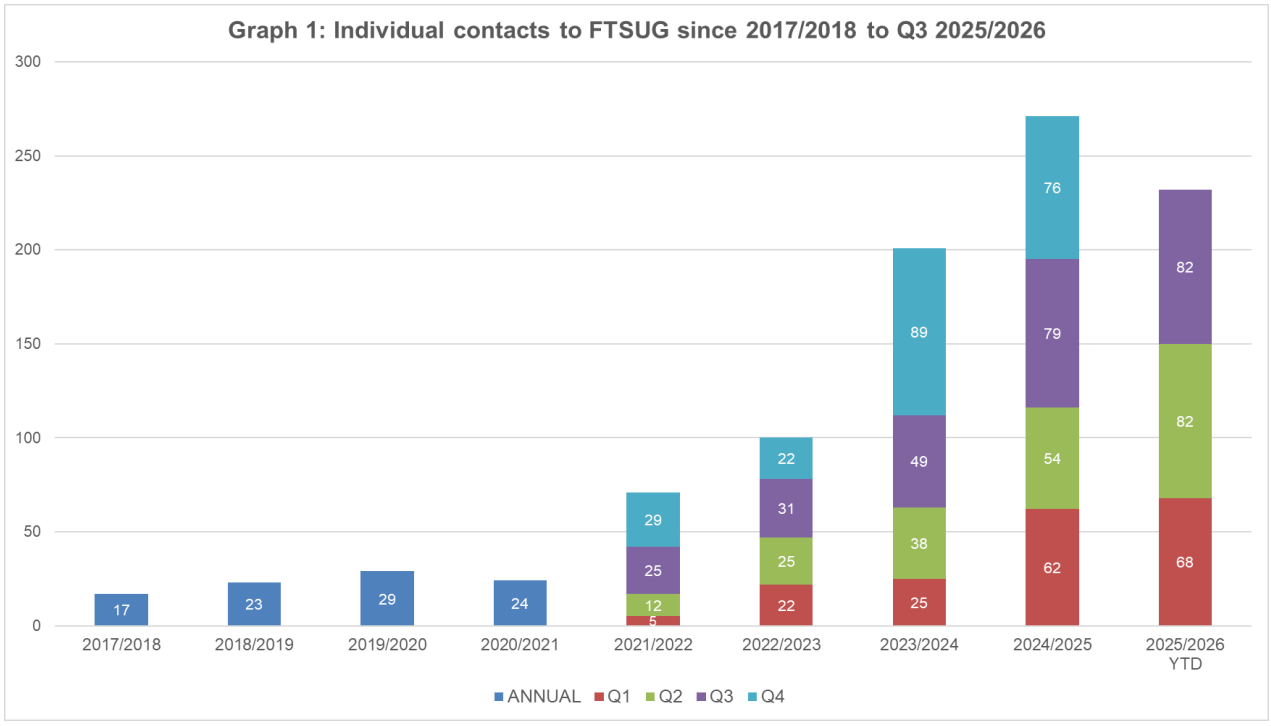
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Group Conflict Resolution Policy (GP026)
- Group Grievance Policy and Procedure (GP024)
- Ulysses incident management system

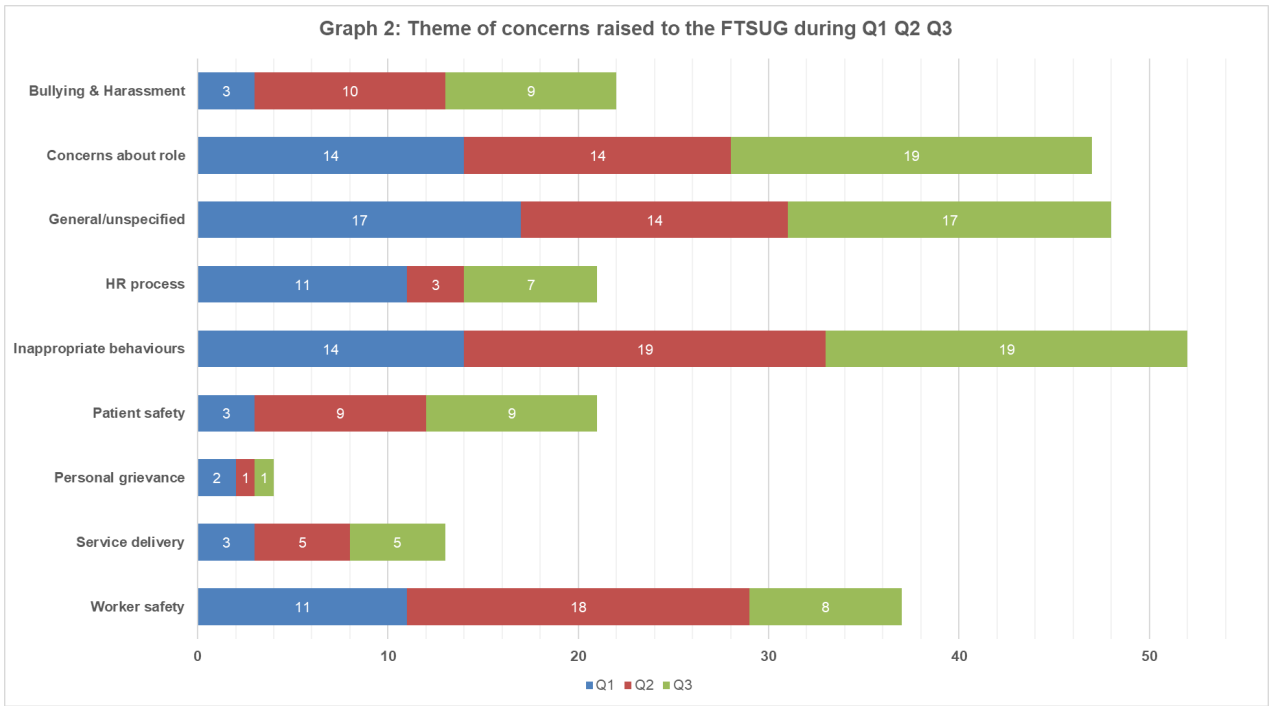
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st October 2025 to 31st December 2025 (Q3) – data, comments and assessment

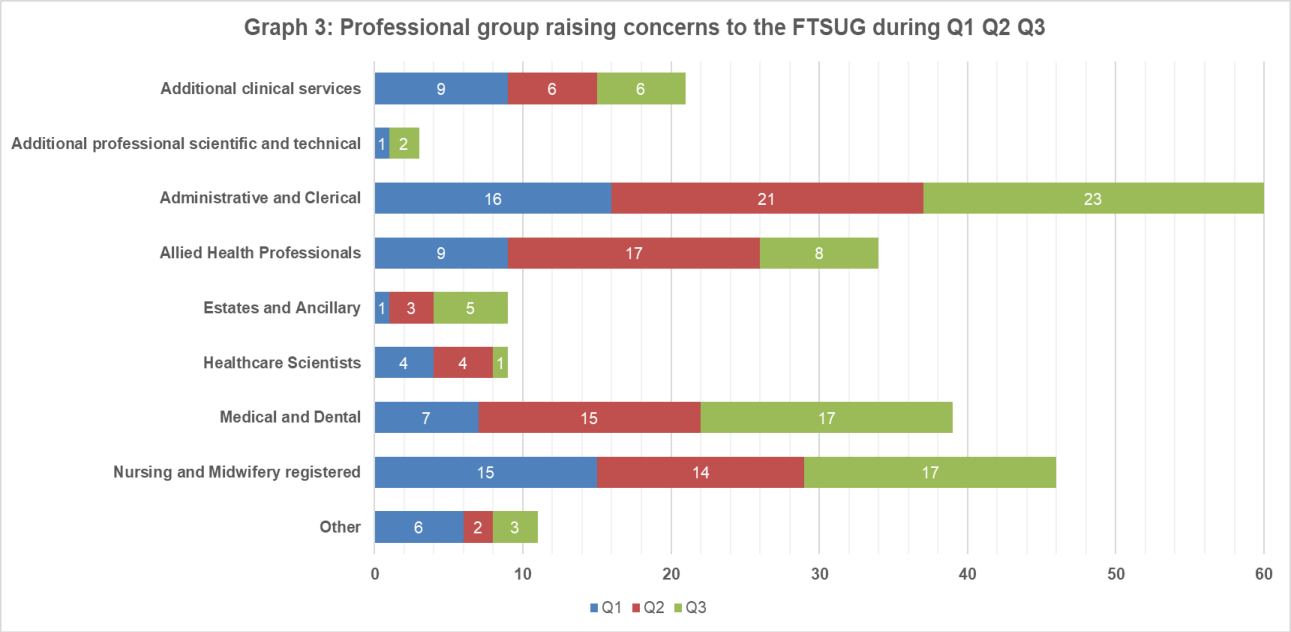
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office (NGO).

4.2 Graphs 1, 2 and 3 summarise the Q3 data:





NB. Please note some concerns may have more than one element



4.3 Observation and comments during Q3:

- The number of concerns remained the same as Q2 (82) and represented a 4% increase from the previous Q3 reporting period in 2024/2025 (79).
- No concerns were raised anonymously for a consecutive quarter. Initially one individual was anonymous but later identified themselves to the FTSUG.
- 78% (63) of concerns were either within the remit of a line manager to be resolved or about the line manager, of which 76% (48) individuals had already spoken up to their line manager, before approaching the FTSUG; an increase from Q2. Positively, there was a decrease from 30% in Q2 to 12% (10) in Q3 where individuals asked the FTSUG to protect their identity throughout the speaking up process.
- The FTSUG directly escalated 26% (21) of concerns via an appropriate route, for example to a senior manager. Positively this has decreased since Q2 (51%), and the FTSUG observed more staff members feeling confident to raise their concerns themselves.
- Concerns with an element of inappropriate behaviours and role were most frequently raised and continue to feature in the top three most common reasons for concerns. The main themes of poor behaviours were personal comments and feeling singled out or targeted. Role concerns included themes about role changes without communication and the flexible working process.
- General concerns (17) also featured within the top three, and the themes for these concerns were varied but some minor topics included unfair allocation of leave and potential information governance breaches. Each of these cases were escalated for consideration of the circumstances.
- The most common groups raising concerns were administrative and clerical workers (23) followed jointly by medical and dental (17) and nursing and midwifery (17) – all three groups slightly increased from Q2.

- Examples of learning points from cases included staff not being aware of the exit interview process when leaving the Trust as a way to raise concerns, and the flexible working policy not being followed. In both cases, the FTSUG has contacted the HR team to discuss where learning can be applied to improve processes. Furthermore, the Managers Update email, sent to all line managers at the Group, has been used to promote key learning about ensuring a psychologically safe culture to support speaking up, and promoting the national Listen Up e-learning.

4.4 FTSU Guardian Feedback/Evaluation:

The FTSUG offers a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. The FTSUG is split into two parts – firstly the worker's experience of the HUTH FTSUG, and secondly, their experience of speaking up to the wider Trust. During Q3, 17 responses to the survey were received and the key results are detailed below. Part 1 results:

	Very easy	**Fairly easy**	**Not easy**	**Difficult**
How easy was it to make contact with the FTSUG?	88% (15)	6% (1)	0%	6% (1)
	Excellent	**Good**	**Fair**	**Poor**
How was your experience of the FTSUG?	82% (14)	18% (3)	0%	0%
	Yes	**No**	**Not sure**	
Did you feel supported when speaking up to the FTSUG?	100% (17)	0%	0%	
Given your experience, would you speak up again to the FTSUG?*	100% (17)	0%	0%	
Did you feel your concerns were listened to and taken seriously?	100% (17)	0%	0%	
	Highly likely	**Likely**	**Unlikely**	**Highly unlikely**
How likely are you to recommend to a work colleague to contact the FTSUG?	100% (17)	0%	0%	0%

Comments and observations:

- *The NGO guidance only requires one mandatory question to be included in the survey – '*Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'.* At HUTH, 100% of staff answered yes to this question and this figure will be reported back to the NGO as part of the quarterly reporting.
- The most common way respondents found out about the FTSUG role was either through recommendation from a colleague (5) or previously contacting the FTSUG (5).

Examples of feedback about why the individual would speak up again and what went well with the FTSUG included:

- There was a strong theme that the FTSUG listened, supported the staff member and was understanding.

- Example included: "*I felt supported, valued and heard", "Being able speak up about the problem without feeling under pressure and someone actually listening to me without any judgement"* and *"Fran listened to my concerns and gave me really appropriate advice, she also was able to signpost me to other services I was unaware of which was really helpful".*

Individuals were asked what could improve the speaking up process:

- No areas of improvement were identified.
- *"Nothing, it was first class".*

Part 2 asked questions about the staff members' experience of speaking up to the wider Trust:

	Yes	No	Not sure	I chose not to raise my concern	In part
Did you feel your concern was treated confidentially?	71% (12)	12% (2)	12% (2)	6% (1)	
Did you feel your concerns were listened to and taken seriously?	76% (13)	12% (2)	6% (1)	6% (1)	
Given your experience, would you speak up again?	82% (14)	0%	18% (3)		
Has your concern been addressed?	47% (8)	12% (2)	0%	6% (1)	35% (6)
Have you experienced any detriment, disadvantageous and/or demeaning treatment, or any negative impact, as a direct result of speaking up?	29% (5)	65% (11)	6% (1)		

Comments and observations:

- Staff stated they had gone onto speak up to their line manager, senior manager, manager outside of their own department or the Human Resources department.
- The NGO mandatory question was also asked in respect of the individual's experience of speaking up to the wider Trust – *'Give your experience, would you speak up again?'.* In comparison, this was lower than the FTSUG with 82% (14) confirming they would but has increased in comparison to previous survey results which is positive.
- Worryingly five individuals stated they had received negative treatment or detriment as a result of speaking up – examples given included being moved around, not having any contact from their manager, colleagues breaking confidence and being seen as difficult. Whilst the survey is completed anonymously, information is provided to staff offering a further discussion with the FTSUG.

Examples of feedback about what went well with speaking up to the wider Trust, included:

- *"My concerns were hard and taken seriously", "My then [manager] was excellent she understood the issues that were going on"* and *"Higher staffing levels were approved, and we don't see as many staff being moved when we already feel short".*

Examples of feedback to improve speaking up to the wider Trust included:

- There was a general theme of staff needing to be listened to and speaking up concerns actioned quickly.
- Example quotes included: *"Nothing [went well]. It was brushed under the carpet"* and *"More engagement of diverse groups of staff during policy making process. People who speak up and challenge 'usual ways of doing things' should not be seen as difficult, but rather as creative, brave and innovative because they think outside the box".*

Planned action from the survey results:

- Key learning points from the feedback to be included in a Managers Update, to all line managers.

4.5 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, learning for the Trust, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience. The below case study demonstrates an example where a staff member was reassured about patient care, and the senior manager responded quickly to the speaking up concern.

The FTSUG was contacted by a staff member who had worked in a clinical area and become concerned about the care of a patient. The staff member wanted to ensure that the patient was receiving appropriate care and had escalated the concerns to the nurse in charge on the day. The staff member remained concerned about the patient and contacted the FTSUG, who supported the staff member by raising the concerns to the ward manager for review.

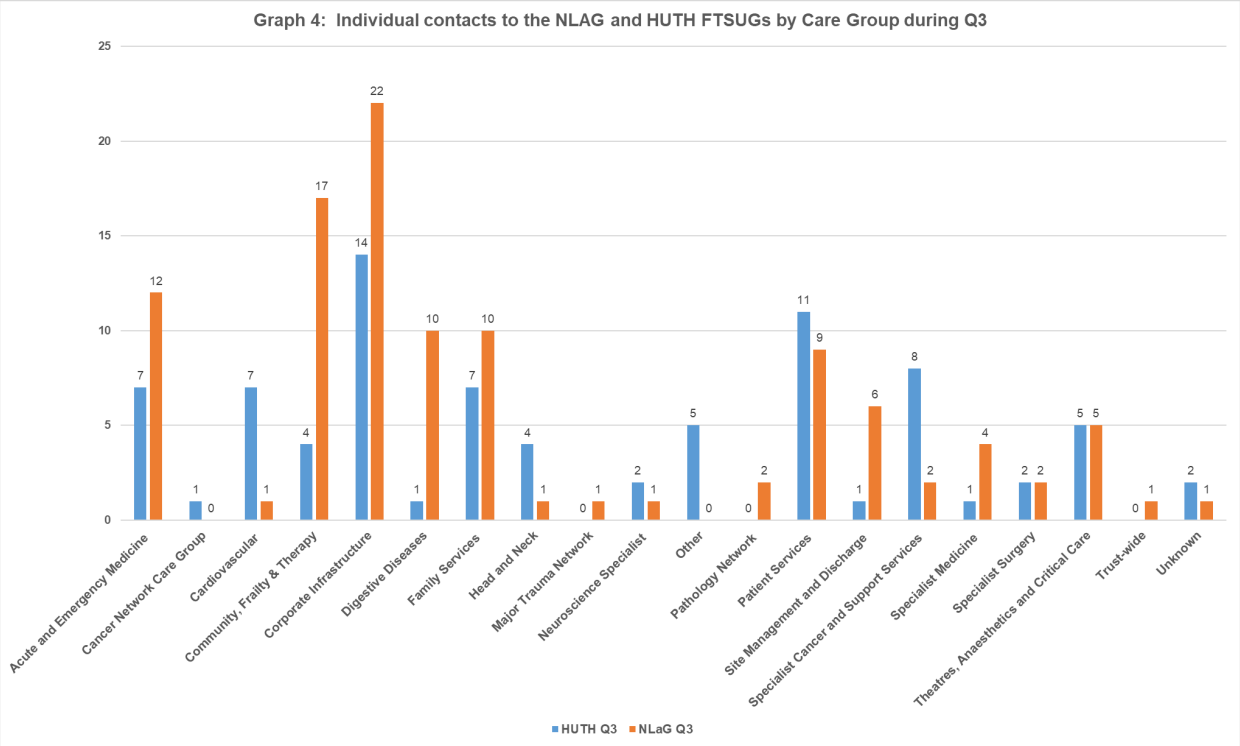
The ward manager quickly gave assurance about the patient's care, they had been well cared for and encouraged the staff member to escalate any concerns directly to them in the future for support.

The staff member confirmed they were happy with this as an outcome and were reassured by the feedback and were glad the concerns had been addressed. The staff member also thanked the FTSUG for their involvement and help.

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 Q3 to the sovereign HUTH and NLAG FTSUGs combined. At HUTH, the highest number of concerns were received about Corporate Infrastructure (14) followed by Patient Services (11) and Specialist Cancer and Support Services (8).

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 Q3

5.1 A high level summary of the FTSUG activities are detailed below:

- Ongoing 2026 monthly face to face drop-in sessions arranged for Hull Royal Infirmary, Castle Hill Hospital and MS Teams to promote visibility and accessibility to the FTSUG. The Speak Up Champions have been assisting with promoting the drop ins within their teams.
- In support of national Speak Up week increased communications to promote speaking up and offered a specific line manager session with both FTSUGs at the Group and
- For new starters, continued to present at each Group induction and supported the Let's Get Started induction and training process, presenting to over 140 newly qualified and new nurses and to the newly qualified Nursing Associates induction.
- For learners, attended Hull University to teach on the first-year midwifery programme as part of prepare to practice, and also presented the role of FTSUG to the second-year student midwives.
- Invited to attend and present at a Care Group senior nursing time out.
- Supported the International Medical Graduate induction and the Nursing, Midwifery and Allied Health Professionals conference with promotional market stalls.
- Established working arrangements with the new Local Counter Fraud Specialist.
- A further two cohorts of Speak Up Champions were trained, increasing the total number of Champions in the HUTH Speak Up Champion Network to 57.

5.2 Future plans:

- Partnership work to support the first Allied Health Professionals learners forum, to promote freedom to speak up.

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. In October 2025, the regional network held a virtual leadership conference with national speakers and opportunity for group working and networking. This included a discussion about how organisations can truly learn from FTSU concerns and what systems and processes are in place to facilitate this.

During December 2025 the region held a supportive peer support meeting where topics included the NGO changes and training and escalation routes available to FTSUGs.

6.2 National update

The closure of the NGO and transfer of responsibilities into NHS England has now been extended to 30th June 2026. This has allowed time for engagement with NGO staff, FTSUGs, NHS leaders and broader stakeholders about the future of the speaking up functions. Views are being sought as to what responsibilities should stop, start or continue and what functions might become the responsibility of employers. The engagement pack and details of the focus groups and survey are available from NHSE: click here

FTSUGs will remain in post and are recognised as having integrated into the wider NHS system. Dr Jayne Chudley-Clark has formally stood down from the National Freedom to Speak Up Guardian position and an Interim Director is currently in place at the NGO to support the transition to NHSE.

7. Conclusion

7.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up. Individuals at HUTH continue to contact the FTSUG for support in speaking up.

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The FTSUG role has been recognised as integrated into NHS Providers and will continue 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.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)011

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 February 2026**
Director Lead	**Heather McNair, (Interim) Group Chief Nurse**
Contact Officer / Author	Linsay Cunningham, Group Director of Strategy and Partnerships
Title of Report	**Population**
Executive Summary	Key messages: • There are significant health inequalities in the population our hospitals serve. Poor underlying health of the population drives increased demand for healthcare services and often lead to poorer outcomes for those from more deprived communities for a variety of complex reasons. • Our Group Strategy sets out our commitment to doing more to tackle inequity and improve population health. • Work to develop an action plan to tackle health inequalities is at a very early stage with some initial scoping work undertaken. There is no dedicated programme resource to undertake this work at the current time.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	None at this time
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	This work will support the Group to deliver our core strategic ambition – our Population live more years in good health.
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Population

Key messages

There are significant health inequalities in the population our hospitals serve. Poor underlying health of the population drives increased demand for healthcare services and often lead to poorer outcomes for those from more deprived communities for a variety of complex reasons. Our Group Strategy sets out our commitment to doing more to tackle inequity and improve population health.

Work to develop an action plan to tackle health inequalities is at a very early stage with some initial scoping work undertaken. There is no dedicated programme resource to undertake this work at the current time.

Key developments – scoping work and self-assessment

Using the Reducing health inequalities: a guide for NHS trust board members resources, work is underway to complete a self-assessment of Humber Health Partnership to build an understanding of where the organisation currently stands in its work to reduce health inequalities.

This practical guide, produced by NHS Providers, supports NHS trust board members to address health inequalities as part of their core business. It outlines why trusts should act on health inequalities, includes a vision for what good looks like, a self-assessment tool for trusts to use to determine where they are in their journey and a list of suggested objectives for board members. It covers a wide range of trust work, from operational and clinical delivery of services to the trust's role as an anchor institution and as an employer of NHS staff. The suggested objectives are drawn from NHS England (NHSE) policy, guidance, and good practice from the sector.

The self-assessment outcomes and recommendations will be reviewed by the Quality and Safety Committee in Common and will help to shape the action plan going forward.

Key developments – deprivation and maternity services

One of the discrete areas for improvement identified in the initial scoping work was missed appointments in Hull maternity services amongst service-users from the most deprived communities. Community midwifery teams, working with our local Maternity Voices Partnership and other key stakeholders are undertaking the work to understand the root causes of the issue identified and seek to co-design solutions with service-users. The remit of this group has expanded beyond missed appointments to look at vulnerability more broadly and its links to deprivation.

Key risks

The current organisational change process underway within the Integrated Care Board (ICB) may impact on the capacity of the ICB – either in the short or longer term – to support the Group in developing and implementing its Health Inequity Action Plan. It is unclear at this stage to what extent the current capabilities and functions within the ICB's population health team will be retained and what their work programme will look like from next year – the outcome of the ICB operating model consultation is expected within the coming week.

The lack of dedicated resource internally to develop this work is continuing to impact on the speed at which plans can be developed and actions put into place.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)012

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Emma Sayner, Group Chief Financial Officer
Title of Report	**Public Purse (including Assurance Committee update)**
Executive Summary	The financial position for the Humber Health Partnership Group at Month 9 is included in detail for information at agenda 6.2.2 and has been discussed extensively through the most recent PEF on 3 February 2026 as well as extra ordinary virtual Board consideration and an extended PEF on 6 January 2026. 2025/26 remains significantly challenging across a range of areas within the partnership and there is an acknowledgement that the group across both trusts is spending more than the income it receives especially from a recurrent and underlying perspective. This is not acceptable and the Executive team and wider Board are working hard to understand the areas where this is a habitual problem, and the culture / controls that need to be in place to address this. The group has been working hard to deliver the financial plan for the year and as previously reported has established mechanisms to drive improved value for money through enhanced grip and control as well as considering how the more intractable and difficult decisions are addressed and this has to be set in the challenging context of significant concerns in relation to patient safety and with a year of leadership instability. In 2025/26 the Group had a challenging efficiency requirement of £130m (8% operating expenditure) and is on track to deliver c£98m (broadly 60% recurrently and 40% non-recurrently). As a result of the shortfall in forecast delivery of the efficiency programme and other cost pressures, a decision was taken in early January to trigger the forecast outturn change protocol with NHS England as part of the Month 9 closedown process which was completed to the national team on 8 January 2026. Against a Group turnover of c£1.6bn a request was made to vary the forecast outturn to a c£35.7m deficit against what had been a breakeven plan (after receipt of £28m deficit support funding). This revised forecast continues to require the Group and Trusts to deliver on financial recovery actions and maintain absolute grip and control through to the 31 March 2026. Shortly following this request, the Group received funding in

	relation to Industrial Action and so the eventual deficit requested was c£29.5m (excluding the impact of Q4 DSF of £7m). At the time of writing this request remains subject to review and has not been formally confirmed as accepted. In terms of capital, the team have worked really hard on a multi-disciplinary basis and with system partners on a plan to manage the EPR allocation across 25/26 into 26/27. Expenditure is quite heavily backloaded to the end of the financial year and the estates and digital team are working hard to ensure we deliver the plan, there is risk linked to delivering the ground floor reconfiguration at HRI for which constitutional standards allocation has been received.
Background Information and/or Supporting Document(s) (if applicable)	BAF extract PEF Highlight Reports Month 9 Financial Position included for information at 6.2.2
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Financial considerations are an integral element of the update provided so no further updates in this section.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	It is important as we are considering changes and plans for the use of resources these considerations are taken into account through a robust EQIA process.
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 6 January 2026

Humber Health Partnership

1. Matters for Reporting

The **Group finance** report at month 8 had seen further deterioration to the year-to-date position, which was now £7.9m away from plan. The Group was seeing positive reductions in extra contractual pay due to enhanced controls and although the cash position was stable it was being managed closely via a Cash Committee newly established.. The Capital Plan was challenging but still on track to deliver. An extra £1m pressure was reported due to the recent industrial action.

The challenging financial position had led to the protocol regarding amending the financial forecast to be commenced. Under delegated authority from the Board the CIC reviewed the amended forecast and financial impact statement which would be submitted to NHS England on 8 January. The Board would be fully briefed on the change, the resulting impacts and the commitment to deliver the recovery plan. The Group was in Double Lock with the ICS and this would be aligned with the discretionary spend panel.

The CIC gave Reasonable assurance based on the confidence of achieving the recovery plan.

The **Transformation Programme was** £17.4m behind plan at month 8. The key issue was having the right resources in the right places to deliver the plan. The CIC gave Limited assurance was given due to resourcing issues.

On **Performance**, the Group was reporting improvements to the 65 week waits although the trajectory of zero had not been met. There was also a risk around 52 week waits and further assurance was required to determine how the £4.2m was being spent to alleviate these issues.

The Group was still experiencing **UEC** pressures due to high attendances and flu cases. The CIC gave limited assurance as there was no sustained improvements and targets were not being met. The CIC asked for further information regarding the CDC capacity and the resources required to manage RTT.

Theatre Capacity/Utilisation Deep Dive – Care Group/service meetings were in place to review theatre performance. The main issues were around medical workforce vacancies but job planning action plans and expectations were in place.

Cancer Deep Dive – The presentation highlighted a number of issues such as breast, radiology, histopathology, endoscopy capacity, consultant vacancies (lung) and core capacity gaps. Improvements included a new Cancer Governance Structure, service improvement programmes in place and the clinical harm review process was being harmonised across the Group. Although there were improvements in place the CIC gave limited assurance due to the lack of sustained positive outcomes.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Group Finance Report – Month 8	6	16	Assurance/Approval	Reasonable
2	Transformation Programme	6	16	Assurance	Limited
3	Group Performance Report	2	20	Assurance	Limited
4	Theatre Capacity	2	20	Assurance	Reasonable
5	Deep Dive: Cancer Performance	2	20	Assurance	Limited
6	Estates Update (including HRI Tower Block update)	6	16	Assurance	Significant
7	ERIC	6	16	Assurance	Significant
8	Capital Programme Summary	6	16	Assurance	Reasonable
9	Contract Approvals • HRI Theatres 8, 9 and Plant Room • Lansdowne Block • SGH Theatres B and C	6	16	Approval	Extra-ordinary meeting
10	ME2 Pathology Update	2	20	Information	Extra-ordinary meeting

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 6 January 2026

Estates Update – Following the quarterly review of HRI Tower Block there were no new additional risks and potential support funding was available for replacing the cladding.

The ERIC review had been submitted and there was an action plan in place that would be regularly monitored at the CIC.

2. Positive assurances

3. Matters on which the committees have requested additional assurance

Care Group risk and opportunities to be presented to the CIC.

CDC performance and benefits appraisal to be presented to the CIC.

More assurance was required regarding the performance at the HUTH Urgent Treatment Centre.

4. Decisions made

The Group Anti-ligature policy was being developed and updates would be received as part of the Estates update reports.

The CIC were asked to give delegated approval to enter into contract discussions and appointment of contractors for the HRI Theatres 8, 9 and Plant Room, the Lansdowne Block and SGH Theatres B and C. The CIC requested an extra-ordinary meeting to discuss these in more detail.

5. Escalation to Trust Boards

Revision of forecast outturn position protocol to be commenced.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	Group Finance Report – Month 8	6	16	Assurance/Approval	Reasonable
2	Transformation Programme	6	16	Assurance	Limited
3	Group Performance Report	2	20	Assurance	Limited
4	Theatre Capacity	2	20	Assurance	Reasonable
5	Deep Dive: Cancer Performance	2	20	Assurance	Limited
6	Estates Update (including HRI Tower Block update)	6	16	Assurance	Significant
7	ERIC	6	16	Assurance	Significant
8	Capital Programme Summary	6	16	Assurance	Reasonable
9	Contract Approvals • HRI Theatres 8, 9 and Plant Room • Lansdowne Block • SGH Theatres B and C	6	16	Approval	Extra-ordinary meeting
10	ME2 Pathology Update	2	20	Information	Extra-ordinary meeting

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 3 February 2026

Humber Health Partnership

1. Matters for Reporting

CQC Actions – All outstanding previous actions are now closed. The recent visit to DPOW and SGH had raised issues at DPOW relating to triage waiting times and fire doors. There were no issues raised at SGH. The report would be reviewed further upon receipt.

Financial Plan 2026/27 – The Committee were presented with the options being worked through ready for submission and in advance of the discussion with Board on 10 February 2026. Key issues to highlight are significant reduction in income over and above that anticipated through the planning guidance, the cost base is continuing to not reduce and, in some cases, continues to increase. This was not being offset by the "recurrent" efficiency improvements. Discussion focused on deliverability of efficiency ambitions and grip and control mechanisms. It was highlighted that the updated income schedule from the ICB had still not yet been received.

Month 9 – Month 9 position had deteriorated further, despite grip and control measures in place. The revised forecast outturn position for the group is £35.3m and with the receipt of £6.2m funding for the Industrial Action the position improves to c£29m variance to plan (excluding the impact of the loss of Q4 DSF). Limited assurance was agreed by the Committee.

Operational Plan 2026/27 – UEC, Cancer and Diagnostics were the key focus and the RTT target would be a static waiting list (not increasing) as a realistic view of stretching but achievable performance. At least a 2% productivity increase was required in elective as well as increased discharges from a UEC performance perspective.

Performance – Limited Assurance. 65-week waits are increasing, due to 52 week wait 'tip-ons'. The required governance framework was now in place and plans are being enacted.

CDC performance was improving and best practice was being shared across the Group. As the CDC's performance progressed, further efficiencies would be sought within the current budget including the use of CDCs to support Diagnostics and the Faster Diagnosis Standard, which is improving at NLAG. Both HUTH and NLAG 62-day Cancer performance had improved.

Deep Dive, Urgent Care – ED performance remained off track, with the exception of Ambulance handovers at HUTH where there had been sustained reductions in breaches over 60 minutes. A number of actions were planned, including a Perfect Week with system partners, new Group-wide ways of working to reduce patient safety risks in ED and a Risk Summit on 5-2-26.

2. Positive Assurances

The Committees received Significant Assurance on Estates and Facilities risks and capital.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions	N/a	N/a	Information	N/a
2	Operational and Financial Plan including CIP	6	20	Information	N/a
3	Group Finance Report – Month 9	6	20	Assurance/ Endorsed for Boards-in-Common	Limited
4	Transformation – Financial Discipline and Communications plan	6	20	Assurance	Limited
5	Performance Recovery Trajectories – Elective and Cancer	2	20	Assurance	Limited
6	Targets for Diagnostics and faster cancer pathways – CDC update	2	20	Assurance	Limited
7	24/7 working in ED	2	20	Assurance	Reasonable
8	Deep Dive – Urgent Care	2	20	Assurance	Limited
9	Estates – Risks and Third-Party properties update	6	20	Assurance	Significant
10	Contract – HRI Surgical SDEC Level 3	6	20	Delegated authority	Approved

CiC ESCALATION REPORT

PERFORMANCE, ESTATES AND FINANCE COMMITTEES-IN-COMMON – 3 February 2026

Humber Health Partnership

3. Matters on which the Committees have requested more assurance

Transformation – Transformation improvement plans were questioned as were the resources required to deliver transformational change.

4. Decisions made

The CIC approved the Terms of Reference for the new Group Cash Committee.

HRI Surgical SDEC Level 3 –Tender responses had been received and 2 tenders were going through the final stages of evaluation. Due to the urgency of the work, delegated authority was requested and approved for a Contractor to be appointed within the range of £3.2m to 3.4m, with the final evaluation to return to PEF in March for assurance.

5. Escalation to Trust Boards

Revenue cash PDC support is likely to be required in Q4 due to under-delivery of the CIP, overspending against budgets and the loss of the DSF. Efforts continued to reduce the extent of support needed and the picture was being reviewed daily in the light of income, expenditure and capital programme cash availability due to delayed spend. The worst-case scenario would be a requirement for £29m, which would have a PDC revenue cost of £1m to the Group, if it was approved. Approval is also required to use capital cash which may be an alternative to PDC support. The Committee endorsed the proposal for the Board to approve the submission of a request for the minimum amount of support needed to maintain the recommended minimum cash balances of £2m for each Trust.

The 2026/27 Cost Improvement Plan was received, and the CIC requested a re-calibration to ensure the plan was challenging, but also realistically achievable.

#	Agenda item	BAF mapping		Purpose	Assurance given
		#	Score		
1	CQC Actions	N/a	N/a	Information	N/a
2	Operational and Financial Plan including CIP	6	20	Information	N/a
3	Group Finance Report – Month 9	6	20	Assurance/ Endorsed for Boards-in-Common	Limited
4	Transformation – Financial Discipline and Communications plan	6	20	Assurance	Limited
5	Performance Recovery Trajectories – Elective and Cancer	2	20	Assurance	Limited
6	Targets for Diagnostics and faster cancer pathways – CDC update	2	20	Assurance	Limited
7	24/7 working in ED	2	20	Assurance	Reasonable
8	Deep Dive – Urgent Care	2	20	Assurance	Limited
9	Estates – Risks and Third-Party properties update	6	20	Assurance	Significant
10	Contract – HRI Surgical SDEC Level 3	6	20	Delegated authority	Approved

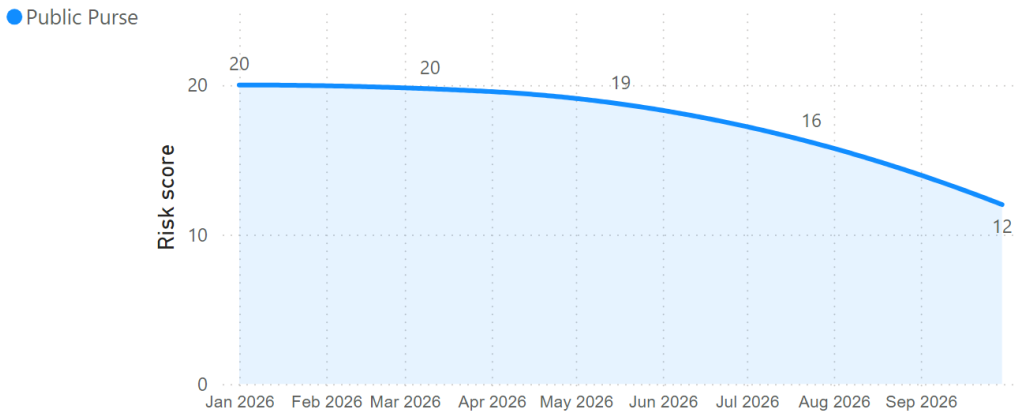
6. Public Purse

The strategic risk affecting our objective, 'Public purse' is led by Emma Sayner, Group Chief Financial Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Public Purse, the risk's current score is 16 and its score last changed on 27/01/2026. The actions were last reviewed on 27 January 2026. In full, the risk is:

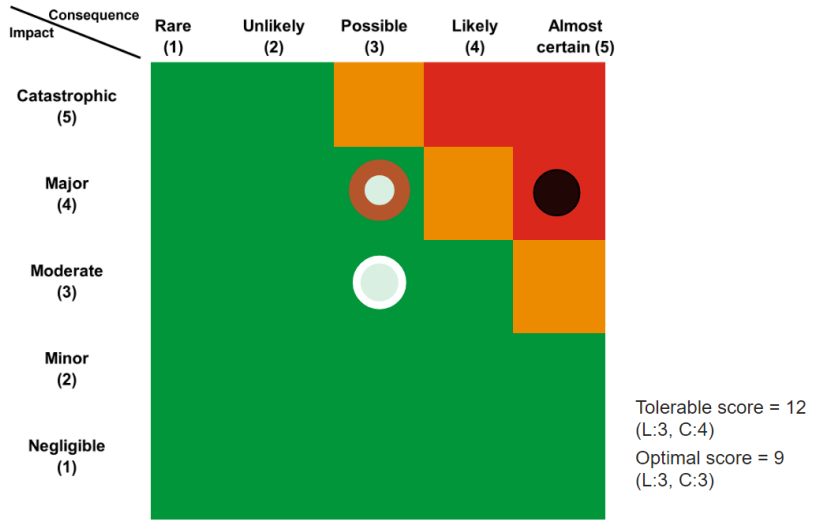
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Open)

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

6. Public Purse

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

Control	Rating
Agency Approval Panel	Reasonable
Board capability and education	Reasonable
Budgetary control system	Reasonable
Business cases for investment / disinvestment decisions	Limited
Care Group Performance and Accountability	Limited
Cash management controls	Significant
Cost Improvement Programme	Limited
Financial management education for directors and budget holders	Reasonable
Financial Planning Improvement Board	Limited
Financial Strategy	Limited
High functioning Finance department advice and guidance	Reasonable
ICS finance model	Reasonable
Long term Financial Model	Limited

Gaps in control (and Action ID)	22	33	35	36	Total
Absence of comprehensive Estates Strategy / 10-year plan	✓				1
Absence of Group Clinical Strategy	✓				1
Absence of Group Finance Strategy founded on clinical and estates strategies		✓			1
Fragmented systems and processes for financial control, planning and safety					1
Instability among Board-level leadership					1
Lack of accountability and consequence for non-delivery					1
Lack of understanding of current financial pressure and need to live within means			✓	✓	2
Out of date Long Term Financial Model inc investments		✓			1
Sustainable PMO / CIP Engine room capability to deliver transformation and financial savings	✓				1
Weak culture of improvement/change management and siloed working			✓	✓	2
Total	6	1	1	2	2	12

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

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	Limited
Internal	Budget control reports	Reasonable
Internal	Exception reporting on Standing Financial Instructions and Standing Orders compliance	Reasonable
Internal	FPIB and PMO reporting on transformation and run-rate	Limited
External	Internal audit review of key financial systems	Reasonable
Internal	In-year operational plan progress	Limited
External	NHSE external assurance reviews	Reasonable
Internal	Service Line Reporting	Limited
Internal	Vacancy control and Discretionary Spend Panel	Reasonable
Internal	Workforce planning updates	Reasonable

Assurance gaps (and Action ID)	Total
SLR not fully developed and embedded	✓	1
Total	1	1

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

6. Public Purse

NHS Humber Health Partnership

The table below details the 6 actions underway to reduce the current risk score of 16. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
22	Develop a five-year long term financial model and strategy	31/03/27	31/03/27	Linked to Operational Plan (three-year plan provides financial model) and Finance strategy development. Planning to form part of the Stabilisation / Transitional Plan development.	27/01/26	Emma Sayner, Group Chief Financial Officer	Reasonable
33	Business Case Compliance and Recommending Groups to engage and prioritise clinical and operational future developments	31/12/25	30/09/26	Both now fully operational. Review of progress to be undertaken in six months	27/01/26	Emma Sayner, Group Chief Financial Officer	Significant
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation and accountability	31/03/26	31/03/27	Pending ValueCircle assessment, likely area to strengthen	27/01/26	Matt Powls, Interim Group Chief Delivery Officer	Limited
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need add value	31/03/26	30/09/26	Directorate team meeting used to feedback issues and take group-wide actions	27/01/26	Emma Sayner, Group Chief Financial Officer	Reasonable
62	Workforce pay and agency control programme	31/03/26	31/03/26	Triple lock in place plus internal arrangements established to approve pay spend.	27/01/26	Emma Sayner, Group Chief Financial Officer, Simon Nearney, Group Chief People Officer	Limited
63	Corporate services efficiency programme	31/03/26	31/03/26	Progress becoming more complex and lengthy. People Services reducing staff (thereby giving leaders less capacity to transform)	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)013

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**12 February 2026**
Director Lead	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer
Contact Officer / Author	Linsay Cunningham, Director of Strategy & Partnerships
Title of Report	**Partnerships (including Assurance Committee Update)**
Executive Summary	Key messages: • There is a significant amount of change taking place in the system governance and decision-making arrangements across each of our Places. Continued engagement across all places and forums should remain a key priority. • The new ICB operating model will be shared in the coming weeks – many of the existing functions ICBs carry out (e.g., system convening role, programme management functions) will disappear or be significantly reduced in the new model. Update on BAF and mitigating actions: • Both mitigating actions are now complete • A review of the strategic risk and mitigations should now be undertaken Additional actions underway: • Stakeholder mapping review – will report to SLT/Executives in February • Group policy for clinical service change to support delivery of Transformation plan for 2026/27 and beyond – will be completed by end of March 2026
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	None at this time
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None at this time
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below:

Board Assurance Report – Partnerships

1. Key Messages

Good partnership working across the system is needed to underpin our group improvement journey and will be a core enabler to delivery of the HHP Improvement Plan and group clinical strategy.

There is a significant amount of change taking place in the system governance and decision-making arrangements across each of our Places. In each area, place partners are reviewing existing arrangements in response to key policy changes – specifically, implementing new Neighbourhood Health models – and changes to the role and capacity of Integrated Care Boards. Continued engagement across all places and forums should continue to be a key priority.

2. Key Developments – Neighbourhood Health

Neighbourhood Health is a core component of the government's plan for the future of the NHS and is developing at pace across the country and in our region. The work within each of our Places to develop Neighbourhood Health is continuing at pace, in spite of the forthcoming ICB changes.

This work is being led by local authorities and the ICB, who are required to jointly plan a neighbourhood health and care model for their local populations. Neighbourhood Health plans must be completed and approved by the respective Health and Wellbeing Boards by April 2026. The national framework for Neighbourhood Health Plans, setting out what is required, is expected to be published in February 2026.

There are several key areas where secondary care providers must align into emerging neighbourhood health delivery; these include:

- supporting continuity of care in the community for people under the care of a specialist hospital team, e.g., by providing specialist input to neighbourhood MDTs.
- ensuring that frailty services are joined up in all settings, supporting delivery of integrated end-to-end frailty pathways.
- supporting the development of virtual wards and community diagnostic centres as key elements of neighbourhood health provision.

The development of neighbourhood health models presents both opportunities and challenges for HHP. Work that will support developments in each of these areas features within the HHP Improvement Plan and/or wider transformation plan that is in development.

3. ICB Organisational Change

In line with national changes and implementation of the new operating model set out in the 10 Year Health Plan, our Integrated Care Board is undertaking organisational change to align to its new role and core function as a strategic commissioner.

Staff consultation on the ICB's proposed new operating model closed on 9 January 2026. The final organisational structure, taking into account consultation feedback and confirm and challenge meetings, was due to be shared with staff by the end of January 2026. This has been delayed slightly due to the volume of feedback. It is anticipated that this will be completed within the next two weeks and the future operating model, governance structures and engagement mechanisms will then be shared with providers and other key stakeholders.

Additionally, all four ICB's in the North East and Yorkshire Region have resumed the development work around potential shared services on a wider footprint which will be collectively led by the ICB Chief Executives.

The pace and scale of change present a potential risk to delivery of our Partnerships Strategy. This risk is being mitigated through ongoing management of key relationships at system and at Place.

4. Update on BAF risks and actions

Risk description

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

Key actions

A number of key actions are underway to mitigate this risk and ensure delivery of our partnership ambitions:

32. Develop and publish partnerships strategy – **COMPLETE**

- The Strategy has now been approved by the Board.
- Updates on delivery of the strategy will be provided to Strategy Partnerships and Programmes Committee

59. Align partnership reporting to governance arrangements – **COMPLETE**

- Changes to Committees in Common arrangements now in place via Strategic Partnerships and Programmes Committee in Common.

Update on other key work and actions underway:

- Review of representation on place and partnership forums has been completed – this will be taken to SLT for review and decision. An update can be provided to SPP Committee.
- Clinical service change policy review undertaken. This will be finalised by the end of the financial year so there is an aligned policy in place to support the Transformation programme for 2026/27 and beyond.

Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer
Linsay Cunningham, Director of Strategy & Partnerships – Feb 2026

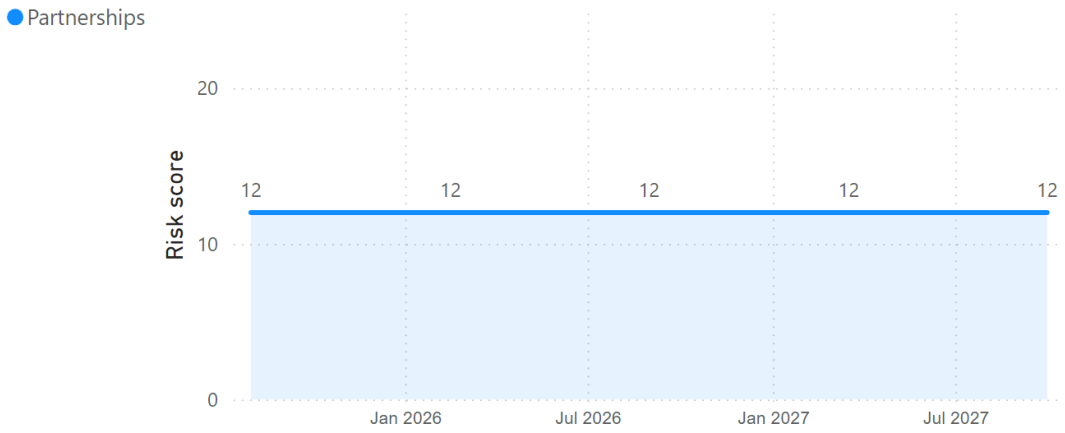
5. Partnerships

The strategic risk affecting our objective, 'Partners' is led by Lyn Simpson, Interim Group Chief Executive Officer; Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer and reported to the Strategic Programmes and Partnerships Committees-in-Common. Under the risk category of Partnerships, the risk's current score is 12 and its score last changed on 28/04/2025. The actions were last reviewed on 09 October 2025. In full, the risk is:

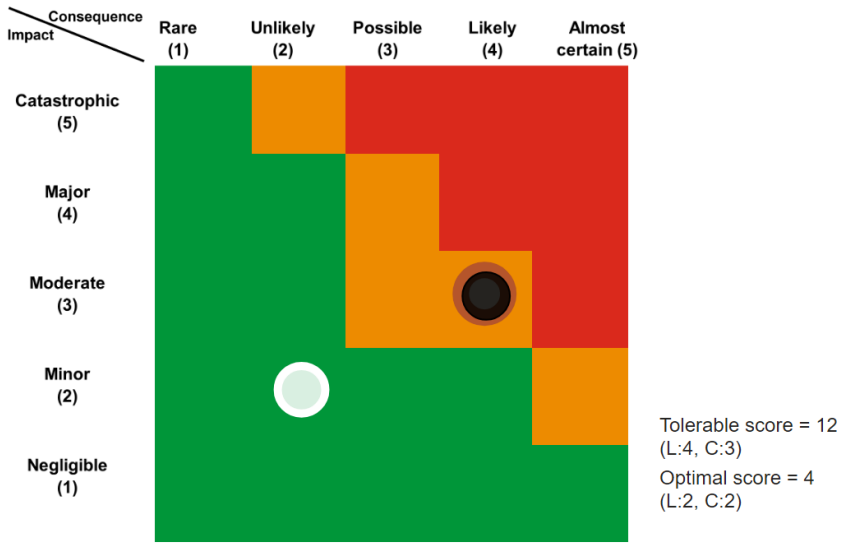
We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

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

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



Current score and risk appetite



Risk appetite statement (Balanced)

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

5. Partnerships

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

Control	Rating
Goole service review	Reasonable
Health and Overview Scrutiny Committees	Reasonable
Humber and North Yorkshire Collaboration of Acute Providers	Limited
Integrated Care Board	Limited
Place Boards	Limited

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	✓	1
Lack of continuous leadership plus inconsistent engagement across region	✓	1
Lack of ICB partnership strategy and identification of common opportunities and priorities	✓	1
Lack of integrated CAP strategy despite workplan (limited progress)	✓	1
Low system wide infrastructure to implement Goole plan	✓	1
Variable quality of engagement with Place Boards	✓	1
Total	**4**	**2** **6**

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

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

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	✓	1
Weak partnership approach embedded in Group strategies	✓	1
Total	**2**	**2**

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

5. Partnerships

NHS Humber Health Partnership

The table below details the 2 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
32	Develop and publish partnership strategy	31/07/25	30/09/27	On course for completion, undergoing futher review to ensure alignment with the Ten Year Plan	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Significant
59	Align partership reporting to governance arrangements internally	30/09/25	31/03/26	Changes to Committees in Common, Capital and Major Projects to become Strategic Partnerships and Programmes - will ensure greater visibility of partnerships working going forward	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, David Sharif, Group Director of Assurance	Reasonable

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)014

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 February 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – January 2026 - Public**
Executive Summary	The attached highlight / escalation report summarises the key matters presented to and discussed by the meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting on 22 January 2026. The Trust Boards-in-Common are asked to: • Note the public highlight report from the January 2026 ARC CiC meeting and consider as necessary.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 22 January 2026
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Assurance ☐ Other – please detail below: For noting and consideration as necessary

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

Report for meeting of the Trust Boards to be held on:	12 February 2026 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	22 January 2026
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 22 January 2026 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- HUTH Inventory Management Update
- HHP Risk Management Strategy – Summary Document for Staff
- NLAG Audit Planning Report 2025/26 / Audit Completion Certificate 2024/25
- HUTH External Audit Routine Update
- Group Internal Audit Progress Report 2025/26 & Status of Management Actions
- Internal Audit Plan Long List 2026/27
- Group LCFS Update
- Annual Review of NLAG and HUTH Arrangements for Raising Concerns / FTSU
- Group EPRR Highlight Report
- Group Board Assurance Framework
- Group Risk Register
- Charitable Funds Governance Arrangements
- Annual Review of Group Policy for Engagement of External Auditor for Non-Audit Work
- Results of ARG CiC Annual Self-Assessment Exercise 2026
- Annual Review of NLAG and HUTH ARG CiC Terms of Reference*
- Annual Review of ARG CiC Aligned Work Plan 2026/27
- Highlight Reports and Actions Logs from other Trust Board Sub-Committees-in-Common
- EPR Asset Accounting Update
- Group Data Protection and IG Report (Private Item)
- NLAG & HUTH External Audit Service – Extension / Tender Options (Private Item)

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

3.0 Matters for reporting / escalation to the Trust Boards

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

a) **Internal Audit Progress Report / Status of Management Actions** – KPMG are making good progress with the 2025/26 Internal Audit Plan, and expect to finish all work by the end of the financial year. In terms of overdue management actions, 25 actions had been implemented since the November 2025 meeting, leaving 32 actions in the tracker of which 15 actions were overdue for implementation (one 'high', 12 'medium' and two 'low' priority). The Committees discussed overdue recommendations in detail and asked what more could be done to ensure that focus was placed on actioning those that were of critical importance to improving the Group's performance, whilst potentially deferring any others. The issue of agreeing realistic implementation dates at the outset was also discussed, to avoid requests for extensions being necessary at a later date. Following discussion, it was agreed that KPMG would continue to follow-up routinely each month with action owners and they would also be more robust in their closing meetings when agreeing actions and associated timescales for implementation. In addition, a piece of work will be undertaken by the Group to review all overdue recommendations and determine, with those responsible for the actions, as to whether they still considered each of the overdue actions appropriate, necessary and important to the performance of the Group. Specific actions relating to this incorporated into the ARG CiC Self-Assessment Exercise 2026 (Question 4.5 refers).

b) **Group Board Assurance Framework** – The Group Director of Assurance reported that the BAF is yet to reflect the outcome of the Value Circle governance review. It was noted that since the report had been produced, the People risk had been updated and additional controls applied, although the score had not changed. The Patient Access risk had also been updated to reflect risk appetite changes. The ARG CiC noted that the action plans did not seem to reflect the current issues with quality and safety and actions necessary to reduce Never Events and to improve the safety culture. The Group Director of Assurance confirmed that actions and changes had been included since the report had been produced for the ARG CiC meeting. The Committees accepted the report and asked that the Patient Access action plan be updated to reflect current issues and risks.

c) **Group Risk Register** – The Group Director of Patient Safety and Quality Governance advised the ARG CiC that progress was now being made in terms of managing risk, meeting with Care Groups and progress around risk management training which had received positive evaluations by those who had undertaken the training. The Committees were informed that further progress had been made since the report had been produced. It was acknowledged that there was more work to be done in terms of cultural changes and simplifying risk management for staff to understand. The Group Director of Assurance advised that in terms of the highest risk around emergency Department flow, that this continued to be an important topic which is receiving lots of scrutiny and discussion around how things can be improved. The ARG CiC stated that they would like to see more mitigations around risks set out in the risk registers with timescales and information on what had changed since last month. Following discussion it concluded that the dial was

starting to shift in the right direction, albeit slowly, and that risk management was getting the focus it needed. Assurance remained low at present as there is still much more work to do with Care Groups, on the content of in the register and in training. It was acknowledged that the actions being taken are the right ones.

d) **Results of ARG CiC Self-Assessment Exercise 2026** – Following discussion of the latest annual self-assessment exercise results, the Committees approved the document as it currently stood. However, any feedback received in due course from the Value Circle and NHS England (in attendance at the meeting) to improve the effectiveness of the ARG CiC will be duly considered and implemented as appropriate. The results of the self-assessment exercise are presented to the Group Trust Boards-in-common as a separate document for information.

e) **Annual Review of ARG CiC Terms of Reference** – Minor amendments to the existing ToR were agreed by the Committees. These are presented to the Group Trust Boards-in-Common as separate agenda items for final approval.

4.0 Matters on which the committees have requested additional assurance:

4.1 The ARG CiC requested additional assurance in relation to items as detailed above; Risk Management, updates to the BAF in terms of action to improve patient access and quality risks.

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

5.1 The ARG CiC received its routine item on the Board Assurance Framework (BAF). Please refer to section 3 for escalation regarding this.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to note the highlight / escalation report from the Audit, Risk and Governance Committees-in-Common.

Jane Hawkard
HUTH ARG CiC Chair / NED
22 January 2026

Simon Parkes
NLAG ARG CiC Chair / NED

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)015

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 February 2026
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**NLAG and HUTH Annual Accounts and Reports 2025/26 – Delegation of Authority**
Executive Summary	In order to ensure the timely sign off of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) audited accounts and reports by the Acting Group Chief Executive and the respective External Auditors, prior to submission to NHS England on 26 June 2026, the Trust Boards-in-Common is requested to delegate formal authority to the Audit, Risk and Governance Committees-in-Common at its meeting on Thursday 18 June 2026 to sign off the audited accounts and reports on its behalf. The Trust Boards-in-Common is asked to: • Note the key dates in the final accounts process. • Delegate formal authority to the Audit, Risk and Governance Committees-in-Common to sign off the NLAG and HUTH 2025/26 audited accounts and reports on behalf of the Trust Boards-in-Common.
Background Information and/or Supporting Document(s) (if applicable)	NHS England 2025/26 Accounts Timetable
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:

Report to Trust Boards-in-Common – February 2026

ANNUAL ACCOUNTS and REPORTS 2025/26 - DELEGATION OF AUTHORITY

1. Introduction

The Audit, Risk and Governance Committees-in-Common (ARG CiC), under their delegated powers (Group Standing Financial Instruction's ref: 3.1.3 b), review the draft accounts and associated reports for Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) on behalf of the Trust Boards-in-Common, before they are submitted to NHS England (NHSE) and the respective External Auditors. This review will take place at the ARG CiC meeting scheduled for Thursday 23 April 2026, prior to submission to NHSE and the External Auditors on Monday 27 April 2026.

The ARG CiC also review the audited accounts and reports, including each Trust's Annual Governance Statements (AGS) and Annual Reports, before they are submitted to the Trust Boards-in-Common for approval, prior to the final submission to NHSE in line with the national deadline. The key dates for the 2025/26 audited accounts and reports, as confirmed by NHSE are as follows:-

Thursday 11 June 2026	Trust Boards-in-Common meeting.
Thursday 18 June 2026	ARG CiC meeting where the final audited accounts and associated reports for both Trusts in the Group will be reviewed in detail. The Interim Group Chief Executive and Interim Group Chair are invited to attend this meeting.
W/C 22 June 2026 – exact date to be confirmed	Interim Group Chief Executive sign off date for both Trusts audited accounts and reports. Once signed by the Interim Group CEO, will be passed to the respective External Auditor for formal sign off prior to return and submission to NHSE.
Friday 26 June 2026	Final audited accounts and reports for both Trusts to be formally submitted to NHSE by noon.

The audited accounts and reports for NLAG and HUTH will not be ready for final review by the time of the June 2026 Trust Boards-in-Common meeting, given that it falls early in the month. The Trust Boards-in-Common can therefore, as in previous years, delegate formal authority to the ARG CiC to approve the audited accounts and reports on their behalf before submission to NHSE by the deadline of noon on 26 June 2026.

2. Recommendation

The Trust Boards-in-Common are asked to note the key dates in the final accounts process and are requested to delegate formal authority to the Audit, Risk and Governance Committees-in-Common at its meeting on 18 June 2026 to sign off the NLAG and HUTH 2025/26 audited accounts and reports on behalf of the Trust Boards-in-Common, prior to formal signing by the Acting Group Chief Executive and the External Auditors and submission to NHSE.

Emma Sayner
Group Chief Financial Officer
February 2026

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)016

Name of the Meeting	**Trust Boards-in-Common**
Date of the Meeting	Thursday 12 February 2026
Director Lead	Heather McNair, Interim Group Chief Nurse
Contact Officer/Author	Jo Ledger, Deputy Chief Nurse and Tracy Campbell, Director of Patient Safety and Quality Governance
Title of the Report	**Safer Nurse Staffing Establishment Review Paper**
Executive Summary	There is an approximate £9m gap between what is currently in base line establishments, specifically across inpatient areas predominantly on the Hull Royal site, the HHP Emergency departments and NLAG Community Nursing when assessed using the Safer Nursing Care Tools available. This places HUTH in the bottom quartile nationally for CHPPD. Some areas are excluded where the tool is not appropriate for use such as outpatients, theatres, specialist nurses and Allied Health Professionals. Applying professional judgement and triangulation with patient outcomes areas have been RAG rated in terms of priority for investment. To fund the red areas would require an investment of £5.122M. We currently use security bed watch staff to support patients who require one to one support and supervision, although this is recognised as sometimes inappropriate, this workforce is used due to reduced non-registered nurses in several of the clinical areas at the North Bank. Additional investment in non- registered nursing workforce will support the reduction of inappropriate use of this workforce and enhance patient experience. The financial impact of this will need to be evaluated. All patients who require security bed watch are assessed every 24hrs by a specialist registered nurse 7 days a week, and support provided to the clinical area to ensure our patients are cared for in the most appropriate way.

(RED only) Financial Summary of 25.26 Nursing reviews

		26/27	FYE	In Runrate (ie shifts are in currently place, above budgeted rotas)
SNCT	HUTH	(1,685)	(3,169)	(201)
	NLAG	(97)	(194)	0
		(1,782)	**(3,363)**	**(201)**
ED	HUTH	(1,167)	(1,280)	(1,055)
	NLAG	(217)	(217)	(217)
		(1,384)	**(1,497)**	**(1,272)**
Paed ED	HUTH	0	0	0
	NLAG	(131)	(262)	0
		(131)	**(262)**	**0**
	Total Group	**(3,297)**	**(5,122)**	**(1,473)**

This equates to 123.82 WTE

The attached papers outline the rationale for the recommendations and the further work required and recognises that even with this substantial investment the organisation will remain non-compliant with certain standards going forward such as: -

- Facing the future for Paediatrics
- GPIC standards (General Intensive Care Standards)
- Critical Care Peer review recommendations at both HUTH and NLAG
- Royal College of Emergency Medicine and Royal College of Nursing, Nursing Workforce Standards (2020)
- Risk of deterioration in the Annual Staff Survey in relation to the questions of "Would *you recommend my organisation as a place of work*?" and "*if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation?*"

The financial implications of this paper is extensive and multiyear in nature, the route to affordability will be multi-factorial.

Across Humber Health Partnership there remains a financial gap and risk to the overall plan in 2025/26 as well as an underlying challenge that suggests there will be limited or no opportunity to invest without taking mitigating action to reduce spend in other ways in the medium term either.

We do, however, know that the plans we have for multi-year CIP, transformation and improvement have opportunities that will reduce waste, streamline systems and processes, scale back the size of our bed base, rationalize and modernize how we deliver services.

Examples of some of these actions include: continuous flow/bed management system, e-rostering, job planning, reducing sickness levels, reviewing medical rotas overall, working with partner organisations to share workforce etc.

Given the quality and safety challenges the Group is facing on a day-to-day basis we can also see in the run rate that some of the premium spend "bad cost" we are incurring could and should be diverted to support the substantive recruitment of at least some of the ask within these papers.

The recommendation from a financial perspective is to firmly align to the EQIA; the Board

	should assess and support the minimum required to meet the quality and safety concerns, support recruitment of substantive WTE where we know we are incurring premium expenditure and then build the impact of the consensus view of the future year requirements into the medium-term financial plan, accepting this will be an iterative process as the months progress and decisions about the future shape and size of HHP develop in line with the 10 year plan.
Background Information and/or Supporting Document(s) (if applicable)	Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time: Safe Sustainable and productive staffing (National Quality Board 2016) Developing Workforce Safeguards (NHSI 2018) Nursing Workforce Standards (Royal College of Nursing 2021) Safer Nursing Care Tool – the Shelford Group Professional Judgement Framework: A guide to applying professional judgement in nurse staffing reviews (2023)
Prior Approval Process	
Financial implication(s) (if applicable)	Listed above.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	✓ Approval by CiC ✓ Assurance ✓ Endorse for approval by ☐ Information Trust Board(s) ☐ Other – please detail below:

The 2024/25 full establishment review paper has been presented to the Workforce Committee in Common and Trust Board in common on several occasions without progression therefore there is limited assurance regarding safe staffing levels.

A further full review has been undertaken in September 2025 with results demonstrating consistency and supporting the suggested recommendations for uplift, particularly across several wards at HUTH.

A safe staffing assurance site visit was conducted by the Regional NHS England team at HRI in November 2025 who were assured by the safe staffing processes undertaken to identify the staffing requirement and the recommendations made. (appendix 1)

Paper 1 In-Patient Safe Staffing Establishment Review

Acuity and dependency data was collected for every patient for the 30-day Safer Nursing Care Tool (SNCT) census period on in-patient wards throughout September 2025. The SNCT data has captured the daily use of temporary escalation spaces on the wards with bed occupancy over 100% daily on many wards. This is putting additional pressure on staff and moral injury is evident regarding care of these patients without any additional resources, even when below established staffing numbers.

Concerns were raised by Ward Managers about sickness absence levels, particularly on some of the frailty wards at HRI, with some of this linked to work-related stress. Ward managers reported regular redeployment of staff when staffing levels were at the established levels, which is having an impact on morale.

Recommendations have been prioritised and it is recommended that as a minimum, consideration is given to funding the red areas due to patient safety concerns, and recent point prevalence audits (Appendix 2) demonstrate gaps in the delivery of the fundamental standards of care and risks recorded that are associated with staffing levels on the wards at HRI.

Paper 2 - HHP Emergency Departments

The EDs across the Group continue to see an increase in attendances, as per the national picture. This is across both ambulance arrivals and self-presenters. Overcrowding is a challenge that all departments face, and this is adding additional challenge and risk in providing care for patients when the footprint of the ED grows to accommodate the demand.

Temporary escalation spaces are frequently used in HRI ED resulting in trying to provide care delivery in the corridors which is having an impact on patient safety and experience, and staff morale. Within the South Bank ED's due environmental design the impact of overcrowding leads to delays in ambulance handovers resulting in a risk to the community we serve.

It is recommended that investment is made to safely manage the overcrowding in the departments. Currently the departments have been using temporary staff to maintain safety of the departments, however this is a very expensive model with concerns regarding the quality of care being delivered from temporary staffing

Even with some investment in this area, we will still not be fully compliant with the recommendations from the Royal College of Emergency Medicine and Royal College of Nursing, Nursing Workforce Standards (2020).

We are requesting executive support to establish substantively in these areas.
When the current challenges subside, this requirement will be reviewed, and staff will be redeployed to vacancies across the Group.

Paper 3 NLAG Paediatric Emergency Nursing (PEN) team

The Registered Sick Children's Nursing (RSCN) workforce in the Emergency Departments at both Scunthorpe General Hospital and Diana, Princess of Wales Hospital does not meet regulatory requirements (RCPCH 2018, CQC Inspection 2019, CQC 2020), which poses both a regulatory, reputational, and patient safety risk. The current RSCN workforce model does not cover the 24-hour period and regularly has vacancies leading to intermittent shifts with no or limited cover.

A programme of investment and recruitment that would allow the PEN service to strengthen to a 24/7 model by 2026 and progress to a fully complaint model by 2029, offering a high level of assurance against quality, safety, patient experience and reputational and regulatory risks is recommended.

The Executives are requested to agree to further investment to work towards having two RSCN's 24/7 across Scunthorpe Hospital and Diana Princess of Wales hospital phased from Q4 2026/2027.

This paper recommends a review of the paediatric model in the south bank.

Phased Costing Proposal

A phased costing proposal PY 25/26 (£131,000) and FY 26/27 (£262,000) would achieve one 24/7 RSCN cover by 2026 and full regulatory requirements by 2028.

NLAG Community Nursing

The Community Nursing Safer Staffing Tool (CNSST) has been used for the first time in 2025, to help determine the community nursing team's appropriate staffing levels to meet patient care need safely and effectively. Acuity and dependency data was collected over a 14-day census data collection period. Further data collection with seasonal variation will be required.

Referrals have increased over the last two years and visits are regularly deferred or cancelled due to capacity within the team, with nurses regularly working over their contracted hours. The development of a community nursing dashboard is being constructive to understand the impact on patient safety and experience. A three-year programme of investment is recommended, with ongoing collation of the CNSST data twice a year to confirm required investment prior to release of funding in years 2 and 3. An independent review of the Adult Community Nursing Service will be commissioned in 2026/2027.

There is no request for further investment currently into NLAG Adult Community Nursing currently.

Critical Care

The ODN Peer Review of Critical Care Services in June 2025 stated that they had serious concerns about nurse staffing at both HUTH and NLAG. Peer Reviewers found an overreliance on band 5 nurses. The Peer Reviewers suggested that nursing establishments should be reviewed. We are also not fully compliant with the General Intensive Care Standards – Guidelines for the Provision of Intensive Care (GPIC) Services by the Faculty of Intensive Care Medicine, version 2.1 (2022).

Patient safety concerns are less within critical care and temporary staffing is used to support safety on occasions when activity and acuity increase, and the units are out of footprint.

There is no further request for investment currently into Critical Care at NLAG and HUTH.

We recognise the inability to have full compliance with GPIC standards and the concerns from the ODN peer review. We will continue to review the planned twice yearly SNCT data collection.

This paper also recommends a process that provides greater oversight of the Group Nurse staffing and realign establishments as opportunities arise and we explore services potentially to be provided in alternative models. Further opportunity could be explored in relation to the numbers of patients we care for with no criteria to reside in conjunction with bed modelling and system partnership working.

Summary:

It is recommended that the Executives consider funding the red recommendations for the inpatient areas at HRI, due to the increased incidents, patient safety concerns and risks recorded that are associated with staffing levels on the wards at HRI.

Additionally, the priority recommendations for the three EDs should be funded given that this spend is already in the run rate and given the current demand and acuity.

Failure to fund the PEN service between 23.00 and 07.00 hours at NLAG means there will be a continued reliance on a response from the children's wards, which is not always possible due to staffing and acuity and activity levels. However, paediatric attendance in ED is lower overnight and there is some mitigation in place to reduce the risks.

(RED only) Financial Summary of 25.26 Nursing reviews

		26/27	FYE	In Runrate	(ie shifts are in currently place, above budgeted rotas)
SNCT	HUTH	(1,685)	(3,169)	(201)	
	NLAG	(97)	(194)	0	
		(1,782)	**(3,363)**	**(201)**	
ED	HUTH	(1,167)	(1,280)	(1,055)	
	NLAG	(217)	(217)	(217)	
		(1,384)	**(1,497)**	**(1,272)**	
PEN Team	HUTH	0	0	0	
	NLAG	(131)	(262)	0	
		(131)	**(262)**	**0**	
Total Group		**(3,297)**	**(5,122)**	**(1,473)**	

The CNSST data identified that although community nursing visits were deferred, they were rearranged and none were outstanding.

Although the Peer Reviewers who visited adult critical care suggested that nursing establishments should be reviewed, patient safety concerns are less in critical care and temporary staffing is used to support safety on occasions when activity and acuity increases, and the units are out of footprint.

To demonstrate compliance with the NQB guidance, HUTH and NLAG are required to include a specific workforce statement in their annual governance statement to confirm their staffing governance processes are safe and sustainable. As part of the safe staffing review, the Chief Nurse and Chief Medical Officer must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe effective, and sustainable, this remains outstanding The Executive Directors are requested to endorse this paper for consideration and approval by Trusts Boards.

Requests for investment per clinical area; -

HUTH						
Care Group	**Site**	**Group**	**Ward**	**Rationale**	**RAG**	**RAG Action**
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	1. RN 24/7 (LD)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	1. RN 24/7 (LN)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	2. HCA 24/7 (LD)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	2. HCA 24/7 (LN)
AEM	**HRI**	HUTH	**ED**	Standard (RCEM)	**Amber**	RCEM Standard RN 24/7 (long Day)
AEM	**HRI**	HUTH	**ED**	Standard (RCEM)	**Amber**	RCEM Standard RN 24/7 (Night)
AEM	**HRI**	HUTH	**ED Paeds**	SNCT	**Green**	3pm-12mn B4 NA
AEM	**HRI**	HUTH	**H5**	SNCT	**Red**	1. HCA LN to provide 3 for 27 beds
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Red**	1. HCA Late 7 days for HOBS (to give 2 HCAs for 34 beds)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Red**	1. HCA night 7 days for HOBS (to give 2 HCAs for 34 beds)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Yellow**	2. HCA late for ward 7 days (to give 3 HCAs for 34 beds if above funded as well)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Yellow**	2. HCA night for ward 7 days (to give 3 HCAs for 34 beds if above funded as well)
Cardiovascular	**HRI**	HUTH	**H39**	SNCT	**Red**	1 Fund HCA LN - used for SDECbut not funded.
Cardiovascular	**HRI**	HUTH	**H39**	SNCT	**Amber**	2. RN LD (21 beds open with SDECand TES)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Red**	1. HCA LN 7 days (will provide 2 HCA for 30 pts)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Red**	2. Fund B3 1 WTE M-F (in run rate)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Amber**	3. RN 7.5 hours Mon-Fri (2 days already in run rate but unfunded)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Yellow**	4. HCA LN for HOBS
CF&T	**CHH**	HUTH	**C20**	SNCT	**Red**	1. RN early 7 days
CF&T	**CHH**	HUTH	**H9**	SNCT	**Red**	1. HCA LN
CF&T	**HRI**	HUTH	**FAU**	SNCT	**Amber**	1. RN Band 6 co-ordinator night
CF&T	**HRI**	HUTH	**FAU**	SNCT	**Yellow**	2. HCA LN
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	2. Band 2 HCA 24/7 (LD)
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	2. Band 2 HCA 24/7 (LN)
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	Run rate but not established 3+2 + co-ord, 3+3, 2+3 (RN Early)
CF&T	**HRI**	HUTH	**H8**	SNCT	**Red**	1. HCA night
CF&T	**HRI**	HUTH	**H8**	SNCT	**Yellow**	2. HCA LD
CF&T	**HRI**	HUTH	**H80**	SNCT	**Red**	1. Fund 4th RN LD - in run rate
CF&T	**HRI**	HUTH	**H80**	SNCT	**Amber**	2. HCA LN
CF&T	**HRI**	HUTH	**H90**	SNCT	**Red**	1. HCA LN
Digestive Diseases	**CHH**	HUTH	**C10**	SNCT	**Yellow**	1. HCA LD Sunday plus
Digestive Diseases	**CHH**	HUTH	**C10**	SNCT	**Yellow**	1. HCA N 7 days
Digestive Diseases	**CHH**	HUTH	**C11**	SNCT	**Amber**	1. HCA LD Sunday plus
Digestive Diseases	**CHH**	HUTH	**C11**	SNCT	**Amber**	1. HCA N 7 days
Digestive Diseases	**CHH**	HUTH	**C14**	SNCT	**Red**	1.RN N 7 days
Digestive Diseases	**CHH**	HUTH	**C14**	SNCT	**Red**	1. HCA N 7 days plus
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Red**	1. HCA night
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Amber**	2. Fund B6 Co-ordinator role (9:00 to 21:00)
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Yellow**	3. RN 12-12mn
Family Services	**HRI**	HUTH	**H20Woodland**	SNCT	**Green**	Uplift B5 to B7 (3 Days) (B5 Reduction - 3 days)
Family Services	**HRI**	HUTH	**H20Woodland**	SNCT	**Green**	B7 5 days (3 days offset by above B5 Reduction)
Family Services	**HRI**	HUTH	**H20Woodland**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H20Woodland**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Family Services	**HRI**	HUTH	**H200**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H200**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Family Services	**HRI**	HUTH	**H34 Acorn**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H34 Acorn**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Red**	1. HCA LD Sunday +
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Red**	1. HCA LN Fri - Sun to give 2nd HCA
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Green**	2. RN LD Sat and Sun
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Green**	3. RN LN Fri - Sun
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Red**	1. 1 HCA night
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Red**	1. 2 HCA early &
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Amber**	2. 1 HCA Late
Neurosciences	**HRI**	HUTH	**H110**	SNCT	**Red**	1. HCA LD for HASU (8 beds)
Neurosciences	**HRI**	HUTH	**H110**	SNCT	**Yellow**	2. HCA for ward for LN
Neurosciences	**HRI**	HUTH	**H4**	SNCT	**Amber**	1. HCA increase HCA Early to LD
Neurosciences	**HRI**	HUTH	**H4**	SNCT	**Amber**	1. HCA LN &
Neurosciences	**HRI**	HUTH	**H40**	SNCT	**Yellow**	2. RN 7-3 Mon-Fri for SAL (3-9 pts per day not in SNCT data)
Specialised Cancer	**CHH**	HUTH	**C29**	SNCT	**Red**	HCA Night (Mon- Sun)
Specialised Cancer	**CHH**	HUTH	**C30**	SNCT	**Amber**	HCA LD for 7 days
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Amber**	1. Increase RN E to a LD Mon - Fri
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Amber**	B3 Night 7 days
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Green**	2. B3 LD 7 days
Specialised Cancer	**CHH**	HUTH	**C32**	SNCT	**Amber**	1. HCA N (Mon- Sun)
Specialised Cancer	**CHH**	HUTH	**C32**	SNCT	**Green**	2 - Increase RN E to a LD Mon-Fri
Specialised Cancer	**CHH**	HUTH	**C33**	SNCT	**Red**	TYA B5 1 WTE to cover chemo M-F for TYA day unit.
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Amber**	Keeping HCA LD - mod
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Yellow**	Keeping RN LD - low
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Yellow**	Keeping HCA N - low
Specialised Surgery	**CHH**	HUTH	**C9**	SNCT	**Green**	HCA night 7 days due to acuity and dependency, posts ops overnight 3+3
Specialised Surgery	**HRI**	HUTH	**H12**	SNCT	**Red**	HCA night to take to 3 HCAs for 28 trauma pts.
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Red**	2. RN late
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Red**	1. Don't reduce RN on night at weekend (RN Sat & Sun Night)
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Amber**	3. HCA 24/7 (LD)
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Amber**	3. HCA 24/7 (LN)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Red**	1. RN 24/7 for RSU (LN)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Amber**	1. RN 24/7 for RSU (LD)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Yellow**	2. HCA LN (ward activity doesn't reduce at night)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Green**	2. HCA LD
Speciality Medicine	**HRI**	HUTH	**H50**	SNCT	**Red**	HCA night to give 2nd HCA for 20 beds.
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	1. RN LN
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	2. HCA 24/7 (activity doesn't reduce at night) (LD)
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	2. HCA 24/7 (activity doesn't reduce at night) (LN)
TACC	**CHH**	HUTH	**HICU1**	Standard (GPICS)	**Red**	GPICS Standard Additional B 6 supernumary 247 (LD)
TACC	**CHH**	HUTH	**HICU1**	Standard (GPICS)	**Red**	GPICS Standard Additional B 6 supernumary 247 (Night)
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	1. Increase B2 establishment to cover rota
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Mon - 5 RN E
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Mon - 3 RN late
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 2 RN E
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 2RN L
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 3RN N
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sun - 3 RN LD
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sun - 5 RN LN
TACC	**HRI**	HUTH	**HICU1**	SNCT	**Amber**	1. HCA 24/7 to enable one to be allocated per unit. (LD)
TACC	**HRI**	HUTH	**HICU1**	SNCT	**Amber**	1. HCA 24/7 to enable one to be allocated per unit. (LN)
TACC	**HRI**	HUTH	**HICU1**	Standard (GPICS)	**Amber**	GPICS Standard Additional B 6 supernumary 247 (LD)
TACC	**HRI**	HUTH	**HICU1**	Standard (GPICS)	**Amber**	GPICS Standard Additional B 6 supernumary 247 (Night)

NLAG						
Care Group	**Site**	**Group**	**Ward**	**Rationale**	**RAG**	**RAG Action**
AEM	**DPOW**	NLaG	**A1**	SNCT	**Red**	1. Transfer 2.71WTE HCA vacancy to new A1 (From Amethyst) and reduce to 4+3 on LN. (No cost)
CF&T	**DPOW**	NLaG	**C6**	SNCT	**Yellow**	HCA night
CF&T	**Goole**	NLaG	**Ward 3**	SNCT	**Green**	1. Extend early HCA to LD 7 days
CF&T	**SGH**	NLaG	**16**	SNCT	**Yellow**	1. Required for 1:1 supportive care (Level 1C) B2 24/7 (LD)
CF&T	**SGH**	NLaG	**16**	SNCT	**Yellow**	1. Required for 1:1 supportive care (Level 1C) B2 24/7 (LN)
CF&T	**SGH**	NLaG	**22**	SNCT	**Amber**	B4 RNA LN 7 days
Digestive Diseases	**DPOW**	NLaG	**B7**	SNCT	**Red**	(blank)
Digestive Diseases	**DPOW**	NLaG	**B7**	SNCT	**Red**	Reduce HCA by 1 on LD Sat and Sun.
Digestive Diseases	**SGH**	NLaG	**28**	SNCT	**Red**	Skill mix for HOBS - 3+1 LD to 2+2 (Remove RN LD)
Digestive Diseases	**SGH**	NLaG	**28**	SNCT	**Red**	Skill mix for HOBS - 3+1 LD to 2+2 (Add HCA LD)
Digestive Diseases	**SGH**	NLaG	**29**	SNCT	**Red**	(blank)
Digestive Diseases	**SGH**	NLaG	**29**	SNCT	**Red**	Increase skill mix to 60:40 - 4+4 LD to 5+3 (Remove HCA LD)
Digestive Diseases	**SGH**	NLaG	**29**	SNCT	**Red**	Increase skill mix to 60:40 - 4+4 LD to 5+3 (Add RN LD)
Digestive Diseases	**SGH**	NLaG	**29**	SNCT	**Red**	Increase skill mix to 60:40 3+3 LN to 4+2 (Remove HCA LN)
Digestive Diseases	**SGH**	NLaG	**29**	SNCT	**Red**	Increase skill mix to 60:40 3+3 LN to 4+2 (Add RN LN)
Family Services	**DPOW**	NLaG	**Rainfores**	SNCT	**Yellow**	B4 Reg NA LD 7 days
Family Services	**DPOW**	NLaG	**Rainfores**	SNCT	**Yellow**	B4 Reg NA Night 7 days
Family Services	**DPOW**	NLaG	**Rainfores**	Standard	**Red**	1. RN LN to cover ward and ED (supports 24/7 PEN service)
Family Services	**SGH**	NLaG	**Disney**	SNCT	**Yellow**	B4 Reg NA LD 7 days
Family Services	**SGH**	NLaG	**Disney**	SNCT	**Yellow**	B4 Reg NA Night 7 days
Family Services	**SGH**	NLaG	**Disney**	Standard	**Red**	1. RN LN to cover ward and ED (supports 24/7 PEN service)
Neurosciences	**DPOW**	NLaG	**Stroke un**	SNCT	**Red**	Band 4 Reg NA LN 7 days
Specialised Surgery	**DPOW**	NLaG	**B6**	SNCT	**Red**	Remove 0.5WTE B3 Care Navigator(not in use on B7)
Specialised Surgery	**SGH**	NLaG	**Ward 27**	SNCT	**Amber**	1. HCA LN 7 days
Speciality Medicine	**SGH**	NLaG	**25**	SNCT	**Red**	1. Increase RN early to LD
TACC	**DPOW**	NLaG	**HDU**	SNCT	**Red**	Uplift 3 B5s to Band 6 (Remove 3 WTE B5)
TACC	**DPOW**	NLaG	**HDU**	SNCT	**Red**	Uplift 3 B5s to Band 6 (Add 3 WTE B6)
TACC	**DPOW**	NLaG	**ITU**	Standard	**Red**	Supernumerary ward manager in line with GPICS standard (currently 2 days for 8 months and 1 day for 4 months funded)
TACC	**SGH**	NLaG	**ICU**	SNCT	**Yellow**	1. HCA LN 7 days
TACC	**SGH**	NLaG	**ICU**	Standard	**Red**	Supernumerary ward manager in line with GPICS standard (currently 2 days for 8 months and 1 day for 4 months funded)

HUTH						
Care Group	**Site**	**Group**	**Ward**	**Rationale**	**RAG**	**RAG Action**
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	1. RN 24/7 (LD)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	1. RN 24/7 (LN)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	2. HCA 24/7 (LD)
AEM	**HRI**	HUTH	**AMU**	SNCT	**Amber**	2. HCA 24/7 (LN)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	2. 2xRN 24/7 to cover ECA (in run rate) (LD)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	2. 2xRN 24/7 to cover ECA (in run rate) (LN)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	2. 2xRN 24/7 to cover atrium (8 TES) (in run rate) (LD)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	2. 2xRN 24/7 to cover atrium (8 TES) (in run rate) (LN)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	1. 2 HCA 24/7 of which 3.8 WTE HCA already (in run rate) (LD)
AEM	**HRI**	HUTH	**ED**	SNCT	**Red**	1. 2 HCA 24/7 (LN)
AEM	**HRI**	HUTH	**ED**	SNCT	**Amber**	3. HCA 24/7 for majors to take to 3 HCA for 24 majors (LD)
AEM	**HRI**	HUTH	**ED**	SNCT	**Amber**	3. HCA 24/7 for majors to take to 3 HCA for 24 majors (LN)
AEM	**HRI**	HUTH	**ED**	Standard (RCEM)	**Amber**	RCEM Standard RN 24/7 (long Day)
AEM	**HRI**	HUTH	**ED**	Standard (RCEM)	**Amber**	RCEM Standard RN 24/7 (Night)
AEM	**HRI**	HUTH	**ED Paeds**	SNCT	**Green**	3pm-12mn B4 NA
AEM	**HRI**	HUTH	**H5**	SNCT	**Red**	1. HCA LN to provide 3 for 27 beds
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Red**	1. HCA Late 7 days for HOBS (to give 2 HCAs for 34 beds)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Red**	1. HCA night 7 days for HOBS (to give 2 HCAs for 34 beds)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Yellow**	2. HCA late for ward 7 days (to give 3 HCAs for 34 beds if above funded as well)
Cardiovascular	**CHH**	HUTH	**C27**	SNCT	**Yellow**	2. HCA night for ward 7 days (to give 3 HCAs for 34 beds if above funded as well)
Cardiovascular	**HRI**	HUTH	**H39**	SNCT	**Red**	1 Fund HCA LN - used for SDECbut not funded.
Cardiovascular	**HRI**	HUTH	**H39**	SNCT	**Amber**	2. RN LD (21 beds open with SDECand TES)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Red**	1. HCA LN 7 days (will provide 2 HCA for 30 pts)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Red**	2. Fund B3 1 WTE M-F (in run rate)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Amber**	3. RN 7.5 hours Mon-Fri (2 days already in run rate but unfunded)
Cardiovascular	**HRI**	HUTH	**H7**	SNCT	**Yellow**	4. HCA LN for HOBS
CF&T	**CHH**	HUTH	**C20**	SNCT	**Red**	1. RN early 7 days
CF&T	**CHH**	HUTH	**H9**	SNCT	**Red**	1. HCA LN
CF&T	**HRI**	HUTH	**FAU**	SNCT	**Amber**	1. RN Band 6 co-ordinator night
CF&T	**HRI**	HUTH	**FAU**	SNCT	**Yellow**	2. HCA LN
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	2. Band 2 HCA 24/7 (LD)
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	2. Band 2 HCA 24/7 (LN)
CF&T	**HRI**	HUTH	**H130E**	SNCT	**Red**	Run rate but not established 3+2 + co-ord, 3+3, 2+3 (RN Early)
CF&T	**HRI**	HUTH	**H8**	SNCT	**Red**	1. HCA night
CF&T	**HRI**	HUTH	**H8**	SNCT	**Yellow**	2. HCA LD
CF&T	**HRI**	HUTH	**H80**	SNCT	**Red**	1. Fund 4th RN LD - in run rate
CF&T	**HRI**	HUTH	**H80**	SNCT	**Amber**	2. HCA LN
CF&T	**HRI**	HUTH	**H90**	SNCT	**Red**	1. HCA LN
Digestive Diseases	**CHH**	HUTH	**C10**	SNCT	**Yellow**	1. HCA LD Sunday plus
Digestive Diseases	**CHH**	HUTH	**C10**	SNCT	**Yellow**	1. HCA N 7 days
Digestive Diseases	**CHH**	HUTH	**C11**	SNCT	**Amber**	1. HCA LD Sunday plus
Digestive Diseases	**CHH**	HUTH	**C11**	SNCT	**Amber**	1. HCA N 7 days
Digestive Diseases	**CHH**	HUTH	**C14**	SNCT	**Red**	1.RN N 7 days
Digestive Diseases	**CHH**	HUTH	**C14**	SNCT	**Red**	1. HCA N 7 days plus
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Red**	1. HCA night
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Amber**	2. Fund B6 Co-ordinator role (9:00 to 21:00)
Digestive Diseases	**HRI**	HUTH	**H100**	SNCT	**Yellow**	3. RN 12-12mn
Family Services	**HRI**	HUTH	**H20Woodland**	SNCT	**Green**	Uplift B5 to B7 (3 Days) (B5 Reduction - 3 days)
Family Services	**HRI**	HUTH	**H20Woodland**	SNCT	**Green**	B7 5 days (3 days offset by above B5 Reduction)
Family Services	**HRI**	HUTH	**H20Woodland**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H20Woodland**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Family Services	**HRI**	HUTH	**H200**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H200**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Family Services	**HRI**	HUTH	**H34 Acorn**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Remove 6 x WTE B5)
Family Services	**HRI**	HUTH	**H34 Acorn**	Standard (RCN, CQC)	**Red**	To Create B6 Coordinator (Add 6 x WTE B6)
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Red**	1. HCA LD Sunday +
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Red**	1. HCA LN Fri - Sun to give 2nd HCA
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Green**	2. RN LD Sat and Sun
Head & Neck	**CHH**	HUTH	**C16**	SNCT	**Green**	3. RN LN Fri - Sun
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Red**	1. 1 HCA night
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Red**	1. 2 HCA early &
Neurosciences	**HRI**	HUTH	**H11**	SNCT	**Amber**	2. 1 HCA Late
Neurosciences	**HRI**	HUTH	**H110**	SNCT	**Red**	1. HCA LD for HASU (8 beds)
Neurosciences	**HRI**	HUTH	**H110**	SNCT	**Yellow**	2. HCA for ward for LN
Neurosciences	**HRI**	HUTH	**H4**	SNCT	**Amber**	1. HCA increase HCA Early to LD
Neurosciences	**HRI**	HUTH	**H4**	SNCT	**Amber**	1. HCA LN &
Neurosciences	**HRI**	HUTH	**H40**	SNCT	**Yellow**	2. RN 7-3 Mon-Fri for SAL (3-9 pts per day not in SNCT data)
Specialised Cancer	**CHH**	HUTH	**C29**	SNCT	**Red**	HCA Night (Mon- Sun)
Specialised Cancer	**CHH**	HUTH	**C30**	SNCT	**Amber**	HCA LD for 7 days
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Amber**	1. Increase RN E to a LD Mon - Fri
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Amber**	B3 Night 7 days
Specialised Cancer	**CHH**	HUTH	**C31**	SNCT	**Green**	2. B3 LD 7 days
Specialised Cancer	**CHH**	HUTH	**C32**	SNCT	**Amber**	1. HCA N (Mon- Sun)
Specialised Cancer	**CHH**	HUTH	**C32**	SNCT	**Green**	2 - Increase RN E to a LD Mon-Fri
Specialised Cancer	**CHH**	HUTH	**C33**	SNCT	**Red**	TYA B5 1 WTE to cover chemo M-F for TYA day unit.
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Amber**	Keeping HCA LD - mod
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Yellow**	Keeping RN LD - low
Specialised Surgery	**CHH**	HUTH	**C15**	SNCT	**Yellow**	Keeping HCA N - low
Specialised Surgery	**CHH**	HUTH	**C9**	SNCT	**Green**	HCA night 7 days due to acuity and dependency, posts ops overnight 3+3
Specialised Surgery	**HRI**	HUTH	**H12**	SNCT	**Red**	HCA night to take to 3 HCAs for 28 trauma pts.
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Red**	2. RN late
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Red**	1. Don't reduce RN on night at weekend (RN Sat & Sun Night)
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Amber**	3. HCA 24/7 (LD)
Specialised Surgery	**HRI**	HUTH	**H120**	SNCT	**Amber**	3. HCA 24/7 (LN)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Red**	1. RN 24/7 for RSU (LN)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Amber**	1. RN 24/7 for RSU (LD)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Yellow**	2. HCA LN (ward activity doesn't reduce at night)
Speciality Medicine	**HRI**	HUTH	**H37**	SNCT	**Green**	2. HCA LD
Speciality Medicine	**HRI**	HUTH	**H50**	SNCT	**Red**	HCA night to give 2nd HCA for 20 beds.
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	1. RN LN
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	2. HCA 24/7 (activity doesn't reduce at night) (LD)
Speciality Medicine	**HRI**	HUTH	**H70**	SNCT	**Red**	2. HCA 24/7 (activity doesn't reduce at night) (LN)
TACC	**CHH**	HUTH	**HICU1**	Standard (GPICS)	**Red**	GPICS Standard Additional B 6 supernumary 247 (LD)
TACC	**CHH**	HUTH	**HICU1**	Standard (GPICS)	**Red**	GPICS Standard Additional B 6 supernumary 247 (Night)
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	1. Increase B2 establishment to cover rota
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Mon - 5 RN E
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Mon - 3 RN late
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 2 RN E
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 2RN L
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sat - 3RN N
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sun - 3 RN LD
TACC	**CHH**	HUTH	**CICU**	SNCT	**Amber**	Sun - 5 RN LN
TACC	**HRI**	HUTH	**HICU1**	SNCT	**Amber**	1. HCA 24/7 to enable one to be allocated per unit. (LD)
TACC	**HRI**	HUTH	**HICU1**	SNCT	**Amber**	1. HCA 24/7 to enable one to be allocated per unit. (LN)
TACC	**HRI**	HUTH	**HICU1**	Standard (GPICS)	**Amber**	GPICS Standard Additional B 6 supernumary 247 (LD)
TACC	**HRI**	HUTH	**HICU1**	Standard (GPICS)	**Amber**	GPICS Standard Additional B 6 supernumary 247 (Night)

Care Group	Site	Gr	Ward	Specialty	Rationale	RAG	RAG Action
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	2. 2xRN 24/7 to cover ECA (in run rate) (LD)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	2. 2xRN 24/7 to cover ECA (in run rate) (LN)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	1. 2 HCA 24/7 of which 3.8 WTE HCA already (in run rate) (LD)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	1. 2 HCA 24/7 (LN)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	2. 2xRN 24/7 to cover atrium (8 TES) (in run rate) (LD)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Red	2. 2xRN 24/7 to cover atrium (8 TES) (in run rate) (LN)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Amber	3. HCA 24/7 for majors to take to 3 HCA for 24 majors (LD)
AEM	HRI	HUTH	ED	Emerg Med	SNCT	Amber	3. HCA 24/7 for majors to take to 3 HCA for 24 majors (LN)
AEM	HRI	HUTH	ED Paeds	Emergency Med	SNCT	Green	3pm-12mn B4 NA
AEM	SGH	NLaG	ED	Emerg Med	SNCT	Red	1. Fund RN LD 7 days - in run rate
AEM	DPOW	NLaG	ED	Emerg Med	SNCT	Red	1. Fund unfunded RN LN for CDU (in run rate)
AEM	DPOW	NLaG	ED	Emerg Med	SNCT	Amber	2. Fund 2nd clinical educator post (funded until 31.03.26 from CPD money) - reduced NQN attrition seen.
AEM	DPOW	NLaG	ED	Emerg Med	SNCT	Yellow	3. Extend B2 Porter 7am - 12 noon (currently 12 noon - 10pm).

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)017

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2026
Director Lead	Lyn Simpson, Interim Group Chief Executive
Contact Officer / Author	Lyn Simpson, Interim Group Chief Executive
Title of Report	Group Improvement Plan
Executive Summary	This paper contains the Group's clinically led 'Improvement Plan, Listening to Clinicians, Learning for Patients', which sets out a structured, timebound programme of work owned by clinical and operational leaders and overseen through the Senior Leadership Team. It seeks formal approval prior to broader circulation. This is the single, overarching improvement plan for Humber Health Partnership and has been developed directly through extensive engagement with Chiefs of Service, clinical teams and triangulated intelligence from internal reporting and external regulatory feedback. The plan is owned by clinicians and operational teams and sets out a clear, structured route to improvement across the Group. The plan is organised into three phases: • **Stabilise**: addressing immediate safety, operational and governance risks. • **Develop**: creating sustainable clinical, workforce and patient flow models. • **Connect**: delivering a rolling programme of clinically led specialty reviews across pathways and sites. All actions within the plan are timebound and have clearly identified Group-level Senior Responsible Owners. Delivery is overseen through the Senior Leadership Team, ensuring alignment between clinical priorities, workforce, finance and operational planning. Group PMO has developed a single, integrated reporting function so that progress against the plan can be tracked consistently by SLT, Board committees and regulators.
Background Information and/or Supporting Document(s) (if applicable)	National Oversight Framework HHP Strategy and supporting strategies 10-Year Plan
Prior Approval Process	Senior Leadership Group Group Executives
Financial Implication(s) (if applicable)	Contained within the Operating Plan submission in February 2026
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	✓ Approval ☐ Information ☐ Assurance ☐ Other – please detail below:

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Listening to Clinicians, Learning for Patients

Humber Health Partnership Improvement Plan

December 2025

Introduction

NHS Humber Health Partnership

This document provides an overarching Improvement Plan for the NHS Humber Health Partnership (the Group). The plan describes three phases of work that will provide stability to services that require additional support, develop community, acute, surgical and tertiary services, and connect care across primary, secondary and tertiary services through a rolling programme of clinically-led specialty reviews.

The Group was created to bring Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust together to strengthen resilience, support challenged services and make better use of collective expertise in the interests of patients and service users.

Both trusts are currently rated Requires Improvement overall by the Care Quality Commission. At Hull, caring is rated as Good, but urgent and emergency care and other core services including medicine and surgery are rated Requires Improvement.

Northern Lincolnshire and Goole also has an overall Requires Improvement rating, with caring rated Good, but safety, effectiveness, responsiveness and leadership all requiring further improvement. Within NLAG, Goole Hospital is rated Good, while Scunthorpe General and Diana, Princess of Wales hospitals are rated Requires Improvement.

In early 2025/26, both trusts were placed in Segment 4 under the NHS Oversight Framework, reflecting long-standing challenges in quality, performance, workforce and finance.

These issues are echoed in the NHS Staff Survey, which shows consistently low numbers of colleagues citing patient care as the trusts' top priority or recommending them as places to work.

The Group has undergone a number of significant changes since August 2025. We are now working to strengthen and improve the services we deliver by empowering our clinicians to make more of the decisions about how we allocate our resources and deliver care across our hospitals and services.

As a first step, we are fixing the immediate problems by listening to clinicians and learning for patients.

For example, we have some of the most experienced surgeons and physicians in the country, but too many have not always felt properly involved in discussions about changes to our services.

To strengthen clinical decision-making, our new Senior Leadership Team now includes our Care Group's clinical Chiefs of Service alongside - some of our most experienced clinicians - alongside our executive team. This means clinical leaders are at the table, influencing decisions in real time.

We have also created a Clinical Policy Group, bringing together clinicians from across specialties and services to make collective decisions about where we invest, innovate, and prioritise.

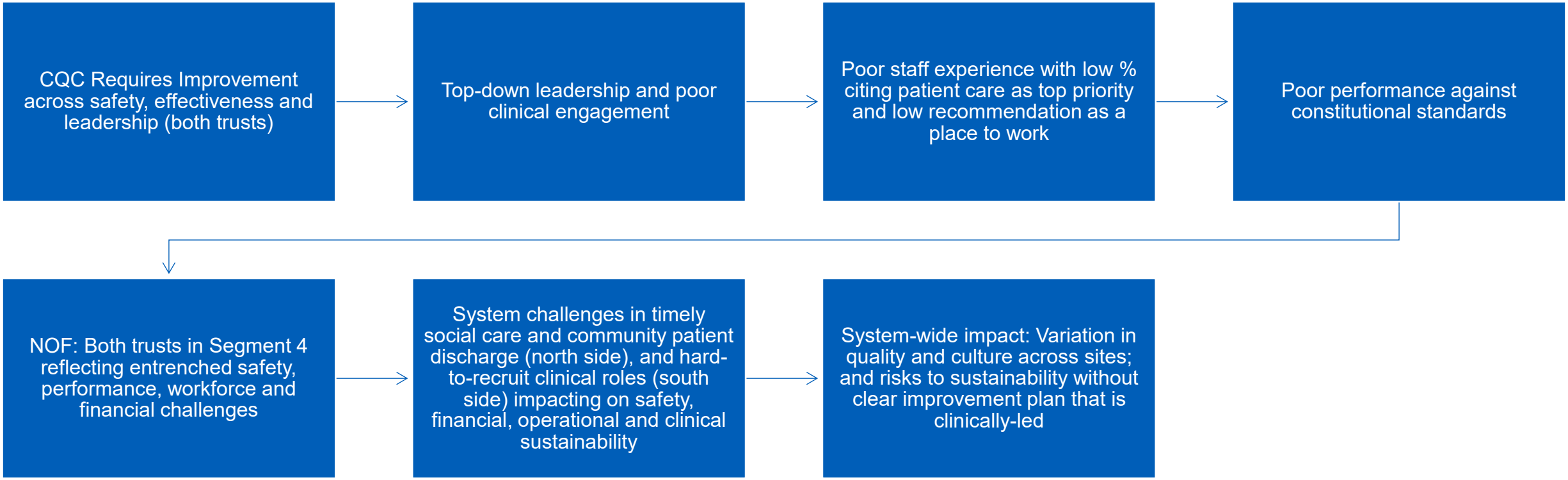
To support delivery of the plan, a significant degree of operational, cultural, learning and performance support will be provided over the coming months and years to enhance existing teams to deliver a range of early and measurable improvements.

The Group is also developing a robust set of governance arrangements which will provide scrutiny, oversight and challenge to the organisation's progress.

A key aspect of the Group's governance arrangements will be the central role of the Board in shaping a healthy culture for the organisation, while at the same time supporting collaboration and closer working across Humber to deliver, sustainable high-quality services.

CQC, Staff Survey and NOF Context

Humber Health Partnership



Improvement Plan Overview

Humber Health Partnership

Stabalise

Fix critical operational delivery and governance

The Stabalise phase focuses on identifying and addressing a range of critical issues that will have an immediate, positive impact on the delivery of safe care.

This includes addressing CQC, regulatory and professional standards action plans, organisational governance and supporting individual specialities, services and cross-cutting safety and quality issues that require significant and timely interventions.

Develop

Develop a 12–18-month clinical plan to strengthen community, acute, surgical and tertiary services

The Develop phase will see the development of a 12-18 months clinical plan, centred on four priorities: unlocking community services to reduce admissions and support discharge; strengthening acute medicine through improved flow, ward right-sizing and workforce review; maximising surgical and elective capacity across all our hospitals; and safeguarding Humber's specialist tertiary services to meet enduring population needs.

Connect

Establish clinically-led reviews to join up primary, secondary and tertiary care pathways

The Connect phase will focus on a rolling programme of specialty reviews designed to bring clinicians together across primary, secondary and tertiary care. These clinically-led reviews will use best-practice evidence, research and patient insights to strengthen integration, reduce variation and ensure patients experience safe, seamless and high-quality care across the Group and with our system partners.

Improvement Plan on a Page

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A learning organisation

Presentation last modified: 5h ago

Our people, and best use of resources

Education and Research

Safety and quality

Stabilise

Prioritise and resolve key service issues:

- Theatres – safer surgery, use of theatres and pre-operative assessment
- Anaesthetics – three departments
- Emergency care (ED 4-hr and 12-hr site-specific models and plans)
- Mixed surgical SDEC (24/7 assessment)
- Family Services (NICU, Paediatrics, Obstetrics, Maternity – incl. Midwifery)
- Flow through ITU / critical care standards
- Cancer pathways for each tumour site – MDTs
- Hyperacute stroke
- Ophthalmology (demand & capacity)
- Endoscopy / decontamination
- Radiotherapy capacity
- Interventional radiology & mechanical thrombectomy
- Emergency/urgent vascular surgery
- Breast surgery (capacity & recruitment)
- Audiology
- ENT
- Dermatology
- Pathology / Histopathology
- Cath labs (DPoW)
- Community dental
- Plastics (theatre move, trauma & cancer)

Prioritise and resolve key group wide safety & quality issues:

- Safety & Quality priorities: End of Life, Deteriorating Patient & Sepsis, Medication Safety, Mental Capacity)
- CQC 'Must Do' and Should Do' actions
- PSIRF and Never Events
- Clinical governance
- Clinically-led accreditation of wards and departments
- Frailty, therapies, palliative care/end-of-life, patient flow & discharge processes (incl. the full use of community partners' capacity)
- CDC use
- Infection prevention and control
- Trajectories to meet constitutional standards
- Effective use of space / fit for purpose clinical estate
- Humber Acute Services Review outcome
- Outpatient improvements (incl. follow-ups post-3 months)
- PACS
- Bed modelling and demand & capacity by speciality
- Group-wide job planning framework
- Resident doctor training
- Bespoke OD/improvement support for services/specialities
- Staff experience and development
- Safe staffing / skill-mix
- Operational & financial planning

Clinical leadership development and culture

Develop

Unlocking community services:

- Unlocking our community services' ambition, enthusiasm, leadership and potential to prevent avoidable admissions, support timely discharge, frailty, and overcome the fragmented service models and access currently in place across the group footprint.

Acute medicine:

- Flow through acute and emergency medicine.
- Discharge and assessment units.
- Right-sizing the medical bed base.
- General medicine workforce and rotas.

Every hospital, a strength in surgery:

- Enabling each hospital to have its own unique place in the Group by making every theatre count for patients, colleagues, teaching and training – decongesting HRI and growing the elective care delivered from Castle Hill, DPoW, SGH and Goole.

Thriving Tertiary Care:

- Enable tertiary services to thrive by safeguarding the services created in Humber to meet the population's enduring need for high-level care (eg: plastics, ophthalmology, cardiac surgery and cardiology, thoracic surgery, cardiac ICU, haematology, vascular, OMFS, oncology & radiotherapy, major trauma, neurosciences, rehab medicine etc).

Digital and EPR

Connect

'Together Together' and 'Together Apart': A Rolling Programme of Clinically-led Specialty Reviews:

A clinically-led rolling programme of specialty reviews - enabling clinicians to come together with the latest research, evidence and patient experience to review care pathways:

- **Tertiary & secondary care:** Urology, Neurology, Critical Care, Neuro-rehab, Gastro, Paediatrics, Stroke, Cardiology, Orthopaedics, Urology, ENT, Endocrinology, Upper GI and Colorectal Surgery, Neurosurgery (spinal), Hepatology, Renal etc
- **Secondary & Primary Care:** Diabetology, Ophthalmology, Audiology, Elderly Medicine, Palliative, Frailty, Respiratory, Rheumatology, Dermatology, Community Diagnostics, heart failure etc

Approach to Delivery

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This plan brings together actions that are significant to delivering sustained improvement. It is an ambitious plan and will require new systems and processes that will embed a culture of continuous quality improvement. This plan also aims to strengthen leadership in the Group to deliver safe and sustainable clinical services.

We will approach our Improvement Plan through:

- ✓ visible and responsive leadership to drive clinically-led improvement
- ✓ focused Board oversight and scrutiny
- ✓ building strong clinical leadership at all levels within the Group
- ✓ extensive staff engagement to drive improvement and innovation
- ✓ embedding a rigorous Quality Improvement approach throughout the organisation
- ✓ management support to deliver programmes of work
- ✓ a single reporting structure that will inform the Board, Regulators and Commissioners
- ✓ engagement and involvement from staff-side and Medical Staff Committees
- ✓ support and involvement from patients, service users and communities
- ✓ external support from independent experts to address capacity and capability
- ✓ working and collaborating with partners across Humber

Strengthening Clinically-Led Leadership and Decision-Making

Humber Health Partnership

Senior Leadership Team (SLT)

The Senior Leadership Team brings together the Executive Directors and senior operational, medical and nursing leaders who are collectively responsible for the overall delivery of safe, high-quality and financially sustainable care across the Humber Health Partnership.

SLT provides the organisational anchor for the Improvement Plan: setting direction, removing barriers, enabling teams, and ensuring that clinical priorities, workforce, finance and operational planning are aligned.

The SLT's role is not simply oversight—it is to create the conditions in which clinical leaders can lead, in which the Group model can thrive, and in which the structures, behaviours and culture needed for improvement are consistently reinforced. SLT ensures that decisions are transparent, grounded in evidence, and shaped by the clinical voice.

Clinical Policy Group (CPG)

The Clinical Policy Group is the Partnership's clinically-led recommending body, made up of Chiefs of Service, senior clinicians from across sites and services, and members of the senior leadership team.

It exists because safe, sustainable care can only be achieved when decisions are shaped by those who deliver care every day. The CPG strengthens the clinical voice in the organisation, ensuring that clinical insight, operational reality and patient experience drive the direction of change. The purpose of the CPG is to:

- Ensure high quality and safety of our services - for our patients and our staff - recognising this is what colleagues and communities value most.
- Oversee the delivery of the clinically-led Improvement Plan, and through it, contribute to the development of the Partnership's wider strategy.
- Inform and shape debate and decision-making, offering clinical advice, early thinking and perspective on current and future service needs.
- Guide annual planning (activity, capital, equipment, digital, and CIP plans) and advise on business cases and prioritisation.
- Promote shared learning to improve patient care, using evidence, data intelligence and examples of high-quality practice from within and outside the Partnership.
- Strengthen clinical governance, fostering a participative culture in which education, research, training and the sharing of good practice - including for resident doctors - is valued and expected.

Learning, Improvement & Safety Academy (LISA)

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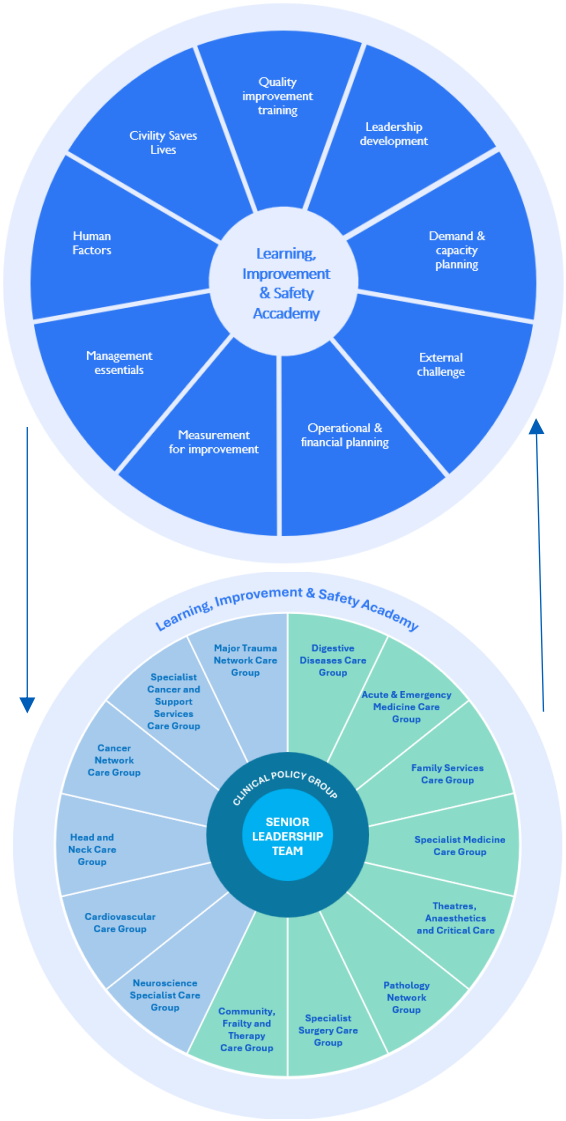
The development of a Learning, Improvement & Safety Academy (LISA) will bring together the currently dispersed functions that support clinical education, medical education and organisational development into one coherent improvement system.

The Learning, Improvement & Safety Academy (LISA) will provide an integrated programme of leadership development, team effectiveness, safety training and improvement support across the Humber Health Partnership.

Bringing together clinical education, medical education and organisational development, the Academy becomes the central place where teams access the skills, tools and support needed to deliver safe, high-quality, reliable care. LISA will:

- Develop leadership at every level, enabling staff to have the skills, confidence and behaviours to shape and improve their services.
- Build capability in quality improvement, supporting teams to use data, evidence and learning to drive safe and sustainable change.
- Strengthen team culture, offering structured team-development support and diagnostics to help teams reflect, learn and improve together.
- Provide targeted support for services, tailored to local needs and aligned to the priorities of the Clinical Policy Group.
- Promote continuous learning, connecting incident learning, safety insights, and improvement activity across directorates.
- Support the development of current and future clinical leaders, providing a coordinated offer for leadership pathways and talent development.
- Act as a coordinating hub, aligning internal and external training, national programmes and improvement resources, and ensuring staff can access the support they need within available resources.

Together, the Leadership Improvement & Safety Academy will create a consistent, partnership-wide approach to leadership, improvement and safety - ensuring that staff, teams and services are supported to continuously improve care for patients and families.



Stabilise

Stabilise (support for urgent issues)

Humber Health Partnership

The Stabalise phase focuses on addressing a range of service issues that require continued support. Through this, these service areas have been prioritised by our experienced clinicians:

- Theatres – safer surgery, use of theatres and pre-operative assessment
- Anaesthetics – three departments
- Emergency care (ED 4-hr and 12-hr site-specific models and plans)
- Surgical SDEC
- Flow through ITU
- Cancer pathways for each tumour site – MDTs
- Hyperacute stroke
- Interventional radiology & mechanical thrombectomy
- Endoscopy / decontamination
- Radiotherapy capacity
- Emergency/urgent vascular surgery
- Breast surgery (capacity & recruitment)
- ENT
- Ophthalmology
- Family Services (NICU, Paediatrics, Obstetrics, Maternity – incl. Midwifery)
- Audiology
- Dermatology
- Histopathology

Clinicians will lead the development and delivery of action plans that will have an immediate and positive impact on quality and safety – receiving intensive and bespoke support. Following the intensive support, each service will be subject to a Peer Review to assure the Group's Clinical Policy Group that the intensive support has had the required effect.

Phase 1 will also address a number of key Group-wide issues including:

- Patient Safety priorities: End of Life, Deteriorating Patient & Sepsis, Medication Safety, Mental Capacity
- CQC 'Must Do' and Should Do' actions
- PSIRF and Never Events
- Trajectories to meet constitutional standards
- Clinically-led accreditation of wards and departments
- Patient flow and discharge processes (incl. the full use of community partners' capacity)
- Infection prevention and control
- Staff experience
- Safe staffing / skill-mix
- Bed modelling and demand & capacity by speciality
- Group-wide job planning framework
- Outpatient improvements (incl. follow-ups post-3 months)
- Resident doctor training
- Effective use of space
- PACS
- Bespoke OD/improvement support for services/specialities

In addition to work in these areas commencing or underway, we will review our Governance and Performance Frameworks to ensure there is transparent reporting and clear accountability from ward to board.

We will also develop a learning organisation and a culture of continuous improvement by giving colleagues throughout the Group, the tools and skills to deliver consistently excellent care - thereby creating a culture of openness, transparency and candour. This will be achieved through the development of an Academy for learning, improvement and safety.

Stabilise (support for urgent service issues)

Key
Urgent
Important
Ongoing

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Family Services (NICU, Paediatrics, Obstetrics, Maternity – incl. Midwifery)	• Sustain 24/7 maternity triage model (HUTH). • Separate obstetrics and gynaecology rotas at HUTH. • Initiate paediatric virtual ward and escalation review. • Begin neonatal/paediatric capacity review (including PHDU).	Preeti Gandhi / Yvonne Mcgrath	Group Chief Nurse / Group Chief Medical Officer	From December 2026
Theatres - safer surgery, use of theatres and pre-operative assessment	• Launch Safety Reset half-day for theatres/anaesthetics. • Reinforce 5-steps to safer surgery in every theatre and for every session • Standardise pre-operative assessment and optimisation processes • 6-4-2 principles. • Reinforce start time and finish times discipline • Make every theatre count by consistently meeting and exceeding GIRFT standards	Richard Owen-Smith / Hayley Briggs / surgical Care Groups' Chiefs of Service	Chief Medical Officer / Chief Delivery Officer	December 2025-February 2026
Anaesthetics - three departments	• Implement job plan stabilisation and standardisation for consultant colleagues. • Introduce flexible cover models to reduce rota fragility. • Strengthen daily safety huddles and escalation discipline.	Richard Owen-Smith / Associate Medical Director	Chief Medical Officer / Group Chief People Officer	Jan–Apr 2026
Patient flow through ITU	• Review ring-fencing for surgical programme support. • Strengthen ICU escalation protocols and daily operational arrangements.	Richard Owen-Smith / Hayley Briggs	Group Chief Nurse / Group Chief Medical Officer / Group Chief Delivery Officer	February-September 2026
Ophthalmology	• Conduct demand and capacity review.	Colin Vize	Chief Medical Officer / Group Chief Delivery Officer	May 2026
Community dental	• Request ICB review of south side community dental service provision.	Colin Vize	Chief Delivery Officer / Chief Financial Officer	Dec–Apr 2026

Stabilise (support for urgent service issues)

Key
Urgent
Important
Ongoing

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
ENT	• Clarify acute bed access and escalation for north and south banks. • Start implementing ENT top-10 referral criteria (phase 1 pilot prep).	Colin Vize	Site Medical Directors / Group Chief Delivery Officer	Feb–Jun 2026
Audiology	• Phased implementation of audiology review recommendations.	Colin Vize	Chief Medical Officer / Director of Estates / Emma Sayner	Feb–Dec 2026
Breast surgery (capacity & recruitment)	• Recruit substantive consultants and breast radiologists to reduce dependency on agency and locum cover. • Strengthen one-stop breast diagnostic pathways and align with national cancer standards. • Introduce joint planning between breast, pathology and radiology to improve reporting times. • Request Specialised Commissioning review of gender affirmation surgery provision.	Mat Thomas / James Bailey / James Maclean	Chief Medical Officer / Chief People Officer / Emma Sayner	Workforce complete Q3 2026
Plastics (theatre move, trauma & cancer)	• Develop agreed internal plan for acute elective pathway including regional hand unit • Address elective and trauma balance through improved scheduling and protected elective capacity. • Recruit to vacant consultant posts and strengthen MDTs to improve throughput and morale.	Mat Thomas / Richard Owen-Smith	Chief Medical Officer / Chief Delivery Officer / Director of Estates / Group Chief Financial Officer	Jan–Jun 2026
Endoscopy / decontamination	• Work with TACC to improve scoping turnaround times by review of decontamination model and workforce alignment • Development of sustainable endoscopy capacity - phased plan for consideration in capital planning – based on NHSE demand and capacity review outcomes and GIRFT standards	George Abouda / Richard Owen-Smith George Abouda	Group Chief Delivery Officer / Group Director of Estates	NHSE Review Dec 2025; decontamination review Feb 20226

Stabilise (support for urgent service issues)

Key
Urgent
Important
Ongoing

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Dermatology	• Request ICB review of community dermatology model (north bank) • Maintain urgent cancer performance while preparing for service redesign and community pathway testing.	Mat Thomas	Chief Medical Officer / Group Chief Delivery Officer	Q4 2025/26
Emergency care (ED 4-hr and 12-hr site-specific models and plans)	• Implement front-door streaming enhancements (walk-ins + GP referrals) • Clarify specialty ownership for patients in/returning to ED. • Start refresh of Continuous Flow model • Enhance real-time escalation. • Progress ESDEC development for same-day discharge.	Ben Rayner / Anwer Qureshi / Chiefs of Service	Site Medical Directors	Dec-Mar 2026
Acute Surgical SDEC	• Develop and approve Surgical SDEC SOPs covering admission criteria, diagnostics flow, and transfer pathways • Develop and implement Castle Hill criteria-led discharge SOP to reduce length of stay and standardise discharge practice • Establish Surgical SDEC at HUTH by April 2026 to reduce ED general surgical admissions by 30%; reduce admissions to general surgical beds by 30%; and increase direct GP referrals to SSDEC by 30%	George Abouda & CoS George Abouda George Abouda	Site Medical Directors	• January 2025 • 7am-7pm - April 2026 • 7am-midnight – May 2026 • 24/7 – June 2026 (fully operational)
Emergency/urgent vascular surgery	• Implement MDT vascular hybrid theatre model • Review urgent vascular bed capacity.	Simon Thackray / Jill Mill / Wendy Magee /	Group Chief Delivery Officer	Jan–Jul 2026 (bed base review Jul)

Stabilise (support for urgent service issues)

Key
Urgent
Important
Ongoing

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Cath labs (DPoW)	• Complete DPoW Cath Lab equipment replacement and ensure replacement lab capacity is in place.	Simon Thackray	Site Medical Director / Chief Delivery Officer / Director of Estates	Dec-Feb 2026
Radiotherapy capacity	• External demand and capacity assessments completed and awaiting radiotherapy workforce capacity prioritisation (aligned to clinically informed Group financial prioritisation and Specialised Commissioning discussions).	James Bailey	Chief Medical Officer / Chief Financial Officer	Workforce prioritisation process commencing Dec 2025
Cancer pathways for each tumour site - MDTs	• Implement MDT referral gatekeeping and criteria. • Resolve cancer/MDT admin/tracker workforce model. • Fix MDT IT platform availability issues across sites.	Andrew Myatt /	Chief Medical Officer / Site Medical Directors	Dec 2025–Nov 2026 (MDT framework Mar 2026)
Interventional radiology & mechanical thrombectomy	• Develop sustainable path to 7-day service with NHSE	James Bailey	Chief Medical Officer	Jan-Apr 2026
Hyperacute stroke	• System completion of north side stroke service review and implementation of recommended changes. • Begin early supported discharge model alignment.	Ben Davison / Carole Joyce / Natalie Griffiths	Chief Medical Officer	From March 2026
Histopathology/Pathology	• Address delays in diagnostic reporting through improved governance, tracking and escalation processes. • Complete review of provision.	James Maclean	Chief Medical Officer / Chief Delivery Officer	Q4-2025/26

Stabilise (support for urgent Group-wide issues)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Safety & Quality priorities: End of Life, Deteriorating Patient & Sepsis, Medication Safety, Mental Capacity	• Increase visibility and oversight of key Safety & Quality priorities - End of Life care, deteriorating patient & sepsis, medication safety, and Mental Capacity - ensuring risks, compliance gaps and immediate actions are clearly owned and monitored. • Strengthen medication safety by embedding a Group-wide programme covering insulin safety, IV-to-oral switch, time-critical medication reliability and safer discharge processes. Improve IDL turnaround times by scaling one-stop dispensing pilots, addressing variation between north and south, and reducing delays that impact patient flow and length of stay.	Chief Nurse / Associate Chief Medical Officer Chief Pharmacist	Chief Nurse / Chief Medical Officer	Dec–Jun 2026
CQC ‘Must Do’ and Should Do’ actions	• Review all outstanding CQC actions and ensure they are clearly owned, updated, and actioned.	Director of Quality Governance	Chief Nurse / Chief Medical Officer	Dec–Mar 2026
PSIRF and Never Events	• Increase visibility and rapid learning from PSIRF investigations and Never Events, ensuring themes and actions are fed back into daily clinical practice through a simple, repeatable learning cycle across sites. • Use Safety reset session to support standards and reduce variation in critical processes. • Develop and launch the Learning, Improvement & Safety Academy as the Group-wide mechanism for embedding good practice and driving consistent learning.	Director of Quality Governance / Clinical Medical Officer	Chief Nurse / Chief Medical Officer	Dec-2025 onwards
Peer reviews / legal and coronial	• Ensure immediate visibility and follow-through of peer review, legal and coronial actions, with clear ownership and rapid escalation of risks • Incorporate peer review, legal and coronial learning into the developing Learning, Improvement & Safety Academy so this becomes a consistent, shared mechanism for embedding learning and good practice	Director of Quality Governance / Associate Chief Medical Officer	Chief Nurse / Chief Medical Officer	Dec-2025 onwards
Infection prevention and control	• Increase IPC oversight in high-risk areas (oncology, NICU, critical care, ED, endoscopy) - including consideration of cross-site clinical cover, laboratory resilience and IPC alignment. • Increase visibility of IPC priorities across sites and run focused campaigns to strengthen compliance and reduce variation.	IPC lead / Director of Comms	Chief Nurse	Ongoing development 2025/26
Clinically-led accreditation of wards and departments	• Establish a clinically-owned quality accreditation programme for wards, theatres and outpatients across sites, providing visible standards, consistent assurance, and a clear method for identifying risks and good practice.	Director of Quality Governance	Chief Nurse	Pilot areas – Q4-2025/26; rollout 2026/27

Stabilise (support for urgent Group-wide issues)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Patient experience	• Increase visibility of patient experience themes and ensure immediate actions from complaints, PALS and FFT feedback are owned and acted on across services. • Establish Patient Experience Group, reporting to Quality & Safety CIC • Conduct review of complaints process.	Head of Patient Experience & Engagement	Chief Nurse / Director of Assurance	Dec-Mar 2026
Patient flow and discharge processes (incl. the full use of local authority and community partners' capacity)	• By site: ○ Agree target with system (local authority & community) for rapid pathway 1,2 and 3 no criteria to reside delays. ○ Undertake a per-site flow review focusing on discharge coordination and intermediate care utilisation. ○ Implement frailty front-door pilots and maximise therapy availability for assessment and discharge planning. ○ Introduce criteria-led discharge with therapy and nursing sign-off. ○ Integrate community partner capacity (local authority reablement, voluntary sector, and mental health outreach) into discharge planning. ○ Embed weekly multidisciplinary discharge huddles by site with community partners and SPA representation. ○ Ensure that the Transfer of Care Board is supported to deliver this agenda by having one clear programme of work to include systems work and HPP actions clearly identified, including processes and leads internal to HHP, daily escalation is in place maximising and utilising all provider capacity in a timely way. Introducing winter solutions. ○ Rapidly test new ways of working and embed if successful. The Flow and ECIST plans ○ Clarify without delay the dashboards to be used across the systems at ward and department level including use of OPTICA.. Further expand system 1 where required. ○ Include pharmacy as a key enabler of discharge improvement through expansion of one-stop dispensing, improved IDL turnaround processes and embedding of OPTICA to reduce avoidable delays in medicines supply. ○ Maximise use of Community Diagnostic Centre capacity (echo, 24-hr ECG, diagnostics) to reduce avoidable acute attendances and diagnostic delays - currently significantly under-utilised. ○ Explore introduction portable X-ray solutions to avoid unnecessary conveyance/admission from Virtual Ward and community pathways.	Nick Cross / Naveen Samuel	Group Chief Delivery Officer/ Site Medical Directors / Group Chief Nurse	Dec–Mar 2026

Stabilise (support for urgent Group-wide issues)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Trajectories to meet constitutional standards	• Review trajectories for ED, RTT and cancer standards to ensure they are realistic, clinically owned and aligned to speciality-level planning	Director of Performance / Chiefs of Service / Chief Delivery Officer	Senior Leadership Team	Jan 2026 (for 2026/27)
Outpatient improvements (incl. follow-ups post-3 months)	• Increase use of digital outpatient tools (Dr Doctor, digital letters, wayfinding) and strengthen referral optimisation to stabilise demand. • Implement specialty-specific PIFU pathways at scale to deliver a significant, safe reduction in follow-ups, supported effective discharge and by demand/capacity insight. • Review and reset accumulated follow-ups over 3 months, prioritising high-volume specialties and discharging where appropriate • Embed safer medicines follow-up models, allowing pharmacists and CNS teams to support PIFU pathways in long-term condition management where appropriate.	Jackie France / Scott Fitzgerald	Group Chief Delivery Officer	Dec–Nov 2026
Effective use of space	• Review under-used estate that can be re-purposed or relinquished to support safe, efficient and timely care.	Director of Estates	Senior Leadership Team	Dec–Nov 2026
PACS	• Ensure PACS has clear Executive Director ownership for replacement and implementation.	James Bailey	Group Financial Director / Digital Director	Dec 2025-Q1 2026/27
Bed modelling and demand & capacity by speciality	• Implement a consistent specialty-level demand and capacity process with targeted training using national best-practice, starting with specialties identified and prioritised by SLT. • Review elective and urgent bed capacity to enable future ring-fencing of elective bed base, supporting sustainability and waiting time reduction, alongside specialty-level demand and capacity modelling and training.	Director of Performance / Chief Delivery Officer		Dec–Aug 2026
Group-wide job planning framework	• Review job planning processes to establish a consistent Group-wide framework that improves transparency, capacity utilisation and rota stability.	Associate Medical Director	Chief Medical Officer / Chief People Officer	Dec-Apr 2026
Resident doctor training	• Review resident doctor training experience in high-pressure areas and address immediate issues affecting rota stability, supervision and quality of training.	Director of postgraduate Medical Education	Chief Medical Officer / Chief Delivery Officer / SLT	Dec–Sep 2026

Stabilise (support for urgent Group-wide issues)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Operational & financial planning	• Ensure operational planning and financial planning are aligned by reviewing key activity, capacity and cost drivers across services, with clinical oversight, and clear ownership of immediate risks.	Chief Delivery Officer / Chief Financial Officer / Director of Performance	Chief Financial Officer / Chief Delivery Officer / Chief Financial Officer	Dec-Apr 2026
Bespoke OD/improvement support for services/specialities	• Provide targeted/bespoke OD and improvement support through the development of the Leadership, Safety & Improvement Hub to strengthen leadership, culture and operational reliability. • Support a shift of workforce capacity into community pathways in line with left shift	Director of OD / Clinical Medical Officer	Chief People Officer / Chief Medical Officer	Jan 2026 - ongoing
Staff experience, learning and development	• Establish Leadership Improvement & Safety Academy	Director of OD	Chief People Officer / Chief Medical Officer / Chief Nurse	Dec–Mar 2026
Safe staffing / skill-mix	• Review how staff and skill-mix are deployed to strengthen direct patient care capacity and ensure risks are visible and managed.	Deputy Chief Nurse	Chief Nurse	Dec-Aug 2026

Develop

Develop (12-18 months clinical plan)

Humber Health Partnership

The Develop phase focuses on developing a sustainable clinical plan to:

- Unlock community services – supporting a reduction admissions and safe and timely discharge - fully developing care at home, supporting a reduction in admissions and safe and timely discharge
- Strengthen acute medicine through improved flow, ward right-sizing and workforce review
- Maximise surgical and elective capacity across all our hospitals
- Safeguard Humber's specialist tertiary services to meet enduring population needs.

The Phase 2 focus will be on sustaining tertiary services, by ensuring they are able to work as stand-alone services whilst maximising the benefits created from being co-located within a large Group - enabling these services to thrive and grow. These specialities include:

- Plastics
- Ophthalmology
- Cardiac surgery and cardiology
- Thoracic surgery
- Cardiac ICU
- Haematology
- Vascular
- OMFS
- Oncology & radiotherapy
- Major trauma
- Neurosciences
- Rehab medicine

In addition, the Develop phase will focus enabling each hospital to have its own unique place in the Group by making every theatre count for patients, colleagues, teaching and training – decongesting HRI and growing the elective care delivered from Castle Hill, DPoW, SGH and Goole.

Also, as part of the Develop phase, work will focus on improving flow through acute and emergency medicine, strengthening discharge and assessment units, right-sizing the medical bed base, and optimising the general medicine workforce and rotas.

Finally, the Develop Phase will concentrate at pace on unlocking our community services' ambition, enthusiasm, leadership and potential to prevent avoidable admissions, support timely discharge, frailty and overcome the fragmented service models and access currently in place across the group footprint.

Develop (Community Strategic Narrative)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Strategic narrative
Unlocking community services	Unlocking the potential of community services is essential to reducing avoidable admissions, improving discharge, and enabling a sustainable shift in care closer to home. Across Humber, there is strong clinical ambition, committed partners, and several high-impact services already in place - yet fragmentation, inconsistent access, and variable commissioning arrangements mean this potential is not being fully realised. This phase of work will formalise a shared model with community providers, local authorities, PCNs, voluntary sector partners and the ICB, ensuring that services are aligned, scalable and capable of meaningfully reducing demand on acute hospitals & supporting people at home. On the north bank, the existing Jean Bishop Centre, Virtual Ward, and trusted assessor arrangements demonstrate what integrated community/acute working can achieve, and these approaches will be strengthened and extended. Opportunities include expanding virtual wards to meet acute demand, extending UTC operating hours, and developing consistent overnight reablement through the 'Be at Home'' model. A stronger information-sharing agreement across partners will support safety, governance and timely decision-making. Local authority and community delays - particularly access to care homes and packages of care and rehabilitation - remain a major constraint on the north side with significant lost bed days each month (Pathway 1 ~1,925; Pathway 2 ~1,559; Pathway 3 ~800; Pathway 0 ~581) and addressing these will require a single cross-partner discharge plan, aligned clinical leadership, and consistent escalation routes. This is a third of beds on daily basis on north side (and 18% on the south bank). Even after closure of one ward where NCTR patients were cared for, four further wards on the north bank and one on the south are occupied with NCTR patients. The impact of this is significant on our local population. Patients are being harmed through long corridor waits to enter the emergency department. In addition, patients experience longer LOS in secondary care leading to deconditioning as well as perpetuating a cycle of secondary care dependency when this is not the care a patient needs. Ultimately, this further impacts on waiting lists and ability to provide timely and best practice tertiary care. Strengthened hospital-avoidance work with community partners, including care homes, housing, voluntary sector organisations and mental health services, is a priority. We will strengthen joint working with Place Directors, GP Federations, CHCP and other community providers to coordinate admission avoidance, urgent community response and intermediate care - ensuring community capacity actively supports safe discharge and reduces avoidable ED attendances. Neighbourhood care models will be developed with PCNs and community partners, including re-commissioning opportunities for services that should shift out of hospital. This includes expanding intermediate care, developing care navigation centres, increasing digital and mobile diagnostics, and improving access to GP advice lines and alternative pathways for paramedics. The national frailty collaborative will be used as a vehicle for shared change, enabling comprehensive frailty assessment, front-door frailty models, and improved therapy-led discharge preparation. A more coherent, Group-wide approach is needed to consolidate community service models (north and south), reduce variation, and establish consistent rehabilitation pathways - including stroke, falls, deconditioning and post-acute rehabilitation. A refreshed partnership approach at Place level will ensure aligned priorities with local authorities, community providers and ICBs, including the use of Section 75 agreements to support pooled resources. Overall, the focus is to unify community ambition, remove fragmentation, and create a consistent offer that reduces avoidable admissions, accelerates discharge and builds resilient neighbourhood-based care. This work will set the foundation for a long-term left shift in care, underpinned by shared metrics, accountability across partners, and a clear, measurable plan for shifting activity and investment into community services over the next decade.

Develop (Community)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Unlocking community services	• Create a unified community services model across Humber to reduce fragmentation and variation between north and south providers. • Strengthen partnership working with local authorities, PCNs, community providers and the voluntary sector to improve hospital avoidance and discharge pathways. • Reduce significant discharge delays by jointly addressing major lost bed day volumes on Pathways 1, 2 and 3, and improving Trust-led Pathway 0 processes. • Expand and standardise community rehabilitation and reablement models, including stroke, falls, deconditioning and post-acute rehab pathways. Early discussion with community providers and commissioners. • Scale effective models, including virtual wards, trusted assessor arrangements, urgent community response and frailty community services. • An extension of opening hours and performance of UTCs on north side. • Develop neighbourhood care models with Federations and PCNs, including digital/mobile diagnostics, care navigation and early intervention pathways. • Improve access and consistency across community interfaces, including GP streaming, ambulance alternative pathways and community therapy. • Strengthen governance, data sharing and escalation frameworks across partners to support safe and timely discharge. • Align commissioning and planning with ICBs and local authorities to shift activity, investment and capability into community settings. • Identifying cohorts of high intensity users of emergency service, including frail patients along with other cohorts so that actions and services can be tailored accordingly. (eg: patients with a frailty score 6 and above, those with mental health needs). This will better focus on the ED 4/12 targets. • Explore opportunities to sustainably expand AHP-led models (e.g. physio-led fracture clinics, extended AHP roles) to support admission avoidance and release acute capacity. • Develop a strengthened Single Point of Access linking primary care, ambulance service, social care and community teams, enabling a “community first” approach. • Explore opportunities to Expand digital and equipment support (e.g. bladder scanners, electronic temperature monitoring, electronic keys) to prevent avoidable admissions and speed discharge.	Naveen Samue / Nick Cross	Chief Medical Officer / Chief Nurse / Chief Delivery Officer	Q1–Q4 2026

Develop (Community)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Unlocking community services	• Strengthening End-of-Life & Palliative Care ○ Undertake a full review of EOL/palliative care policy, model and workforce, recognising current under-resourcing and inconsistent provision across north and south banks. ○ Introduce Trust-wide education and practice-development support, enabling generic services to deliver high-quality care and allowing specialist teams to focus on complex need. ○ Establish an identified Clinical Lead for Palliative/EOL care and bring forward proposals through the Clinical Policy Group (CPG). ○ Improve pathway integration across hospital, community, hospice and primary care, including digital interoperability and shared care records. ○ Review late referrals, 7-day cover and in-reach models, ensuring alternatives to hospital admission are maximised.	Naveen Samuel	Chief Medical Officer / Chief Nurse / Chief Delivery Officer	Q1–Q4 2026

Phase 2: Develop (Medicine)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Acute medicine	• Develop a unified Acute & Emergency medicine model per site, including SDEC, frailty, CDU, AMU and ward transfer rules. • Implement standardised discharge & assessment unit models with agreed criteria-led discharge, early speciality involvement and same-day turnaround processes – including local authority best-practice assessment timescales. • Right-size general medicine bed bases using specialty-level demand & capacity insights (respiratory, rheumatology, endocrine, stroke, GI, renal etc). • Embed consistent medical rota principles to stabilise staffing and strengthen senior decision-making at the front door. • Develop rehabilitation-in-acute pathways to reduce delay, support flow, and reduce length of stay for frailty, stroke and trauma patients. • Use OPTICA routinely to identify, escalate and unblock discharge constraints, ensuring real-time visibility of delays across all pathways (0–3). • Share with system partners the safety impact and cost of delayed discharges across, aligning improvement effort with system performance and efficiency.	Chiefs of Service	Site Medical Directors	Jan–Sep 2026

Develop (Surgery)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	Group Lead	Timescale
Every hospital, a strength in surgery	• Develop site-based surgical service models so each hospital has a clear, sustainable surgical role (Castle Hill = tertiary and specialist surgery/elective hub; HRI = urgent complex surgery & major trauma front-door; DPoW/SGH = focused elective & HASR emergency mix; Goole = low-complexity elective hub). • Develop 'Every Theatre Counts' into a Group-wide theatre efficiency framework, including pre-op capacity optimisation, scheduling discipline, turnaround improvements and protected elective lists, leading to theatre accreditation programme. • To maximise use of resources, streamline and strengthen surgical admission processes, perioperative patient flow, enhanced recovery, and critical care step-down. • Use of diagnostics in surgical and treatment pathway planning – ensuring diagnostics are done in the correct part of the pathway.	Chiefs of Service	Chief Medical Officer / Site Medical Directors / Chief Delivery Officer	Q1–Q4 2026

Develop (Tertiary)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Lead	CMO/MD Lead	Timescale
Thriving Tertiary Care	• Develop a unified tertiary-care strategy across cardiology, cardiac surgery, thoracic neurosciences, radiotherapy/oncology, plastics, ophthalmology, vascular, haematology, OMFS, and rehab medicine. • Review all Specialised Commissiong services to ensure full cost recovery. • Standardise tertiary MDT processes (neuro, cancer, cardiology, vascular, plastics) with faster diagnostics, reliable image/report transfer, fully embedded CDC capacity and protected MDT preparation time. • Progress clinically-led service reviews for tertiary care to ensure national and international best-practice, supported by research and education. • Improve cross-site clinical pathways for radiotherapy, chemotherapy, neurology, major trauma, interventional radiology and stroke, reducing variation and time to definitive treatment. • Develop sustainable workforce models for tertiary services (radiotherapy workforce stabilisation; radiology reporting; neurology; specialist nursing; cardiac physiology; neuro-rehab workforce). • Strengthen diagnostic and therapeutic infrastructure planning, including radiotherapy capacity, hybrid theatre utilisation, Cath Lab resilience, PET-CT, endoscopy and pathology turnaround.	Chiefs of Service	Chief Medical Officer / Chief Delivery Officer	Q1–Q4 2026

Connect

Connect (Develop clinically-led speciality reviews)

NHS Humber Health Partnership

The Connect phase will focus on a programme of clinically-led specialty reviews, bringing together clinicians across tertiary, secondary and primary care to ensure services are shaped by the latest research, best practice evidence and real patient experience.

This rolling programme of one or two specialities at a time will allow teams to look systematically at care pathways across the Group, identifying opportunities for improving outcomes, strengthening integration across care settings and addressing variation in quality.

On the tertiary and secondary care side, reviews will include key specialties such as:

- Gastroenterology.
- Paediatrics.
- Stroke.
- Cardiology,
- Cardiac surgery.
- Orthopaedics.
- Urology.
- ENT.
- Endocrinology.
- Upper GI.
- Colorectal surgery.
- Hepatology.
- Renal medicine.
- Pathology

At the same time, the programme will extend into secondary, community and primary care pathways, with a focus on areas such as:

- Diabetology.
- Respiratory medicine.
- Rheumatology.
- Dermatology.
- Community diagnostics.
- Heart failure.

These specialties will be reviewed in the context of population health needs, integration with community and primary care, and the ambition to deliver more care closer to home.

Taken together, this clinically-led process will create a structured approach for redesigning services, aligning them to national and international best-practice, reducing unwarranted variation, and embedding patient experience and outcomes at the heart of future service models.

It will also provide the platform for clinicians from different settings to work together in shaping pathways that are both clinically sustainable and responsive to the changing needs of the population.

In addition, each specialty review will include a medicines optimisation assessment, focusing on missed doses, safe prescribing, antimicrobial stewardship and opportunities to improve flow through reduced medicines-related delays.

Connect (Clinically-led speciality/service reviews)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Programme oversight (SLT)	Clinical Leads (Specialty Leads)	Review Pace (Sequenced; 1–2 at a time; duration varies by complexity
Urology	Review Urology pathways to improve access, cancer performance, theatre productivity and sustainable cross-site service models.	Deliver a rolling programme of clinically-led specialty reviews, sequencing one or two at a time and pacing each review according to complexity. This will enable services to redesign pathways using evidence, research and patient experience, supporting sustainable models of care – supporting recruitment and optimising the Group model.		
Neurology	Review Neurology pathways to stabilise outpatient waits, strengthen acute/ED responsiveness and improve access to diagnostics.			
Critical Care	Review Critical Care capacity, staffing models and interdependencies to ensure sustainable compliance with standards and flow.			
Neuro-rehab	Review Neuro-rehab capacity, pathways and community linkages to improve flow from acute services and outcomes.			
Gastroenterology / Endoscopy	Review Gastroenterology/ Endoscopy pathways, endoscopy dependencies and follow-up models to improve performance and sustainability.			
Paediatrics	Review Paediatrics pathways to support safer staffing, reduce variation across sites and improve urgent and elective flow.			
Stroke	Review Stroke pathway performance, imaging, thrombolysis/thrombectomy dependencies and rehab capacity.			
Cardiology	Review Cardiology pathways, SDEC, echo access, cath lab utilisation and cross-site configuration to improve responsiveness.			
Orthopaedics	Review Orthopaedic elective and trauma models to optimise theatre use, reduce variation and improve urgent/elective balance.			
ENT	Review ENT access, follow-ups, theatre efficiency and community interface to improve access and sustainability.			
Endocrinology	Review endocrine pathways, D&C assumptions, inpatient consults and OP follow-ups to support sustainable activity levels.			
Cardiac Surgery	Review cardiac surgery pathways and critical care dependencies.			
Pathology	Review cell path, blood sciences & microbiology model to standardise quality and turnaround times			

Connect (Clinically-led speciality/service reviews)

Key
Urgent
Important
Ongoing development

Service/enabler/issue	Summary Actions	Programme oversight (SLT)	Clinical Leads (Specialty Leads)	Review Pace (Sequenced; 1–2 at a time; duration varies by complexity
Upper GI & Colorectal surgery	Review Upper GI and Colorectal pathways (elective and cancer), diagnostics, endoscopy capacity and surgical flow.	Deliver a rolling programme of clinically-led specialty reviews, sequencing one or two at a time and pacing each review according to complexity. This will enable services to redesign pathways using evidence, research and patient experience, supporting sustainable models of care – supporting recruitment and optimising the Group model.		
Neurosurgery (spinal)	Review spinal surgery pathways, imaging, access, and interdependencies with MSK/orthopaedics for sustainable delivery.			
Hepatology	Review Hepatology pathways and diagnostics to improve access, reduce variation and support earlier intervention.			
Renal medicine	Review Renal pathways, dialysis configuration, acute kidney injury processes and cross-site models of care.			
Ophthalmology	Review Ophthalmology pathways, imaging, theatres and follow-ups (including PIFU) to reduce delays and variation.			
Diabetology	Review diabetology pathways with primary care to improve outpatient flow, education models and inpatient consult responsiveness.			
Respiratory medicine	Review Respiratory pathways with primary care to support admission avoidance and earlier discharge, D&C alignment, and diagnostics			
Rheumatology	Review Rheumatology pathways with primary care, follow-ups and treatment models to reduce variation and support sustainable activity.			
Dermatology	Review Dermatology pathways with primary care, triage models and community interface to support cancer performance and access.			
Community diagnostics	Review community diagnostics capacity and demand to improve access, reporting times and pathway flow.			
Heart failure	Review Heart Failure pathways, diagnostics (echo, bloods), community links and inpatient management to improve outcomes.			
End-of-Life & Palliative Care	Review referral criteria, workforce, integration with community and hospice services, and opportunities for shared digital pathways.			

Aligned **Care Group Plans**

Community, Frailty and Therapies Care Group

NHS
Humber Health
Partnership

Plans and key deliverables:

- Implement a unified frailty model focused on early intervention, hospital avoidance, and rapid assessment at the front door.
- Establish multi-professional frailty teams with therapy and geriatric input seven days a week.
- Expand intermediate care provision and strengthen medical oversight, ensuring parity between north and south.
- Standardise community nursing service specifications across the Group, addressing outdated models and gaps in paediatric continence and inclusion services.
- Develop and embed a Group-wide 'Deconditioning, Nutrition and Discharge Preparation' programme involving therapies, nursing, and volunteers.
- Implement digital and mobile diagnostics to reduce ambulance conveyance and support housebound patients.
- Roll out advice and guidance pathways for community teams to access specialist input and prevent avoidable admissions.
- Strengthen cultural alignment and partnership working between north and south through shared leadership forums and integrated improvement meetings.
- Align north and south discharge improvement work under one shared governance structure with system partners (Transfer of Care Board, Place Directors).Include pharmacy as a core enabler through one-stop dispensing, improved IDL turnaround, and embedding OPTICA in discharge processes.

Outcome measures:

- Reduction in avoidable admissions and delayed discharges from frailty cohorts.
- Increased same-day discharge rates through criteria-led therapy-supported processes.
- Improved functional outcomes and reduced deconditioning rates.
- Improved utilisation of intermediate care and community partner capacity.
- Consistent access and response times for community nursing and urgent community response services across the Group.
- Increased patient and family satisfaction with discharge and end-of-life care.
- Improved staff survey results for teamwork, communication, and empowerment across north and south.

Key milestones:

- Unified frailty model approved and launched - Q1 2026
- Therapy-led deconditioning improvement group established - Q1 2026
- Revised community nursing specifications implemented - Q2 2026
- Expanded intermediate care and board-round model operational across north and south - Q2 2026
- Digital and mobile diagnostics pilot launched - Q3 2026
- Advice and guidance pathways live across all community teams - Q3 2026
- Evaluation of frailty and flow impact completed and reported to Clinical Policy Group - Q4 2026

Connecting programmes:

- Urgent and Emergency Care / Acute Medicine: Alignment through frailty front-door model, therapy input, and discharge readiness.
- Digital Transformation: Mobile diagnostics and direct referral pathways.
- Workforce and OD: Role development for community therapists and specialist nurses; culture and leadership improvement north/south.
- Integrated Care Partnerships: Collaboration with local authorities, voluntary sector, and ICB place teams for intermediate care and flow.
- Quality and Patient Experience: Alignment with deconditioning and end-of-life improvement workstreams.
- Elective Recovery and Flow: Therapy and discharge support to reduce length of stay and enable day-of-surgery discharge where appropriate.

Family Services Care Group

NHS
Humber Health
Partnership

Plans and key deliverables:

- Strengthen maternity governance and oversight at both sites, closing gaps in Ockenden-related perinatal meeting compliance and data assurance.
- Implement a robust 24-hour maternity triage service to meet national standards and improve timeliness of assessment.
- Resolve obstetrics and gynaecology rota management issues by separating the rota at Hull and introducing consistent consultant job planning and HR support.
- Standardise maternity and neonatal dashboards, linking data quality improvements to the corporate BI programme.
- Address workforce fragility through targeted recruitment, retention, and innovative role development (e.g. ACP pilots).
- Tackle cultural and behavioural concerns through strengthened OD support, visible leadership, and cross-site peer learning.
- Stabilise paediatric flow and escalation, including review of the virtual ward model and emergency department CYP coverage.
- Review paediatric and neonatal capacity, including PHDU provision and critical care step-down arrangements.
- Establish a Group-wide Family Services governance framework to standardise maternity, gynaecology, and CYP oversight across sites.
- Implement a rotational workforce model across obstetrics, gynaecology, and paediatrics to build flexibility and resilience.
- Deliver a Paediatric SDEC model to improve same-day access and reduce inpatient admissions.
- Develop a maternity and gynaecology site consolidation plan, ensuring sustainable coverage and alignment with workforce availability.
- Redesign CYP pathways including demand and capacity modelling for tertiary step-down services.
- Integrate digital workforce and job planning tools across the Group, ensuring transparency and equity.
- Expand leadership and culture development programmes focused on professional behaviour, inclusion, and team cohesion.

Outcome measures:

- Full compliance with Ockenden recommendations and closure of all Section 31 conditions.
- Maternity triage 24-hour response standard achieved.
- Reduction in obstetrics and gynaecology agency spend by 20%.
- Improved staff survey results in “team working” and “speaking up” domains.
- CYP ED service operating 24/7 with improved access and safety compliance
- Paediatric SDEC model established and operational.

Key milestones:

- Maternity triage model sustained (north bank) 24/7 - Feb 2026
- Split obstetrics and gynaecology rota live (north bank) - Mar 2026
- Paediatric virtual ward and escalation review completed Apr 2026
- Group-wide Family Services governance framework approved - Jun 2026
- Paediatric SDEC model implemented - Sep 2026
- Maternity and gynaecology site consolidation plan agreed - Dec 2026

Connecting programmes:

- Quality & Safety: Alignment with Ockenden and Kirkup recommendations and maternity improvement plan.
- Workforce & OD: Recruitment, rotation and leadership development across Family Services.
- Digital Transformation: Unified dashboards and digital job planning.
- Acute Flow: Paediatric SDEC and escalation alignment with emergency and medical pathways.
- Culture & Leadership: Targeted OD support and behavioural standards framework.
- Clinical Strategy: Site consolidation and rotational workforce planning integrated with partnership-wide modelling.

Theatre, Anaesthetics and Critical Care Group

Humber Health Partnership

Plans and key deliverables:

- Introduce a monthly Safety Reset half-day, converting one scheduled admin half-day per for all theatre, surgical, anaesthetic, and recovery teams to focus on safety re-set, incident review, and improvement learning.
- Implement a Group-wide theatre utilisation and productivity plan, embedding start-time discipline, list management, and turnaround standards linked to daily safety huddles.
- Standardise pre-operative assessment and patient optimisation pathways to reduce day-of-surgery cancellations and clinical risk.
- Embed perioperative care bundles for high-risk and major surgery patients to improve recovery outcomes and reduce complications.
- Address anaesthetic workforce fragility through job planning, flexible cover models, and enhanced professional development support.
- Deliver a Critical Care capacity and escalation plan, ensuring alignment with GIRFT standards and the Emergency Preparedness framework.
- Develop post-operative learning loops, ensuring themes from incidents, audit and safety reset days are fed back into daily practice.
- Align with the elective recovery programme to ensure safety and efficiency improvements directly support RTT performance and patient experience.
- Review ring-fencing of critical care capacity to support surgical programme.

Outcome measures:

- ≥85% average theatre utilisation across all sites.
- ≥95% compliance with WHO safety checklist and safety brief/debrief completion.
- 100% delivery of Safety Reset half-day with documented actions.
- Reduction in same-day cancellations to <5%.
- Full compliance with GIRFT recommendations for critical care capacity.
- Reduced anaesthetic agency usage by 20% and increased consultant satisfaction in job planning survey.
- Reduction in avoidable perioperative incidents and near-misses.

Key milestones:

- Safety Reset half-day programme launched- Jan 2026
- 2026/17 Group-wide theatre productivity plan approved - Mar 2026
- Standardised pre-op assessment and optimisation pathway implemented - Apr 2026
- Critical Care capacity and ring-fencing review completed - Feb 2026
- Theatre performance dashboard live - Jul 2026
- WHO audit compliance sustained >95% - Aug 2026
- Anaesthetic workforce plan approved - Sep 2026

Connecting programmes:

- Quality & Safety: Safety Reset programme, incident learning loops, and WHO audit governance.
- Workforce & OD: Anaesthetic workforce, and theatre team training.
- Elective Recovery: RTT delivery supported through productivity and pre-op optimisation.
- Critical Care Network: Capacity, escalation, and GIRFT alignment.
- Culture & Leadership: Safety culture, civility, and team leadership reinforcement through Safety Reset session.

Specialist Surgical Care Group

Humber Health Partnership

Plans and key deliverables:

- **Urology:**
  - Stabilise workforce and reduce reliance on premium pay through a targeted recruitment plan (including robotic surgery expertise).Improve cancer and diagnostic pathway performance to meet national standards.
  - Continue GIRFT-aligned pathway redesigns, including prostate biopsy access and outpatient flow improvements.
  - Develop process for clinically-led integration

- **Plastic Surgery:**
  - Refresh and accelerate business case for a regional hand trauma and reconstructive unit, aligning with ICB commissioning.
  - Address elective and trauma balance through improved scheduling and protected elective capacity.
  - Recruit to vacant consultant posts and strengthen MDTs to improve throughput and morale.

- **Dermatology (Skin):**
  - Undertake a region-wide review of dermatology pathways and commissioning.
  - Pilot community-based dermatology models using digital triage and teledermatology tools.
  - Reduce backlog and agency reliance through insourcing and partnership working.

- **Orthopaedics & Trauma:**
  - Embed hip fracture improvement programme and expand to additional trauma specialities.
  - Progress the regional revision surgery centre at Castle Hill through refreshed business case and capital prioritisation.
  - Improve trauma and elective flow through dedicated ward organisation and bed ring-fencing.

- **Breast Surgery:**
  - Stabilise workforce through substantive consultant and radiologist recruitment.
  - Strengthen one-stop diagnostic and treatment pathways and reduce reliance on agency staff.
  - Expand use of community diagnostic centres for routine follow-up and surveillance.

Outcome measures:

- Reduction in surgical cancer backlog and improved compliance with national cancer standards.
- 20% reduction in agency and premium pay usage across specialist surgical services.
- Shorter inpatient stays and reduced elective cancellations through protected elective capacity.
- Increased theatre utilisation and improved start-time efficiency.
- Improved consultant and radiologist fill rates to 90% establishment.
- Established, commissioned regional centres for hand trauma and orthopaedic revision services.
- Reduction in booking and diagnostic errors affecting patient care pathways.

Key milestones:

- Workforce stabilisation plan approved - Q1 2026
- Regional dermatology pathway review complete - Q1 2026
- Plastic surgery regional hand unit business case refreshed - Q2 2026
- Orthopaedic revision centre business case approved - Q2 2026
- Breast surgery workforce fully recruited - Q3 2026
- Digital dermatology and community diagnostic pilots launched - Q3 2026
- Pathology and administrative improvement actions implemented - Q3 2026
- Peer review of specialty service improvements by Clinical Policy Group - Q4 2026

Connecting programmes:

- Theatres and Anaesthetics: Alignment of safe surgery standards, theatre utilisation and elective ring-fencing.
- Elective Recovery and Flow: Improved flow, surgical SDEC and pre-operative assessment alignment.
- Diagnostics and Digital Transformation: Modernisation of booking, PACS and diagnostic reporting pathways.
- Cancer Pathways: Urology, breast and skin cancer pathway optimisation and integration with community diagnostics.
- Workforce and Job Planning: Cross-site job planning and recruitment strategy for surgical consultants and radiologists.
- ICB and Commissioning Partnerships: Co-development of business cases for hand unit, dermatology and orthopaedic services.
- Quality and Governance: Learning loops for booking and diagnostic governance improvement.

Head and Neck Care Group

NHS Humber Health Partnership

Plans and key deliverables:

- Strengthen safety and risk mitigation across Head & Neck services by addressing the elevated risk profile, including learning from recent Never Events and targeted actions to reduce harm associated with clinical backlogs.
- Strengthen acute pathways and flow, including a sustainable base for surgical SDEC and improved access to acute ENT beds on the north bank.
- Improve site-to-site flow for ENT on the south bank and clarify escalation and bed access processes.
- Progress referral management improvements, including Primary Care referral criteria for the top 10 ENT conditions through the Clinical Practice Interface Meeting; explore piloting pathways with selected practices.
- Stabilise audiology services by reviewing roles, responsibilities, workforce, and physical facilities across sites, including redesign of age-based pathways and demand management.
- Review Ophthalmology demand and capacity, ensuring optimal use of north bank facilities and addressing waiting list risks; explore local glaucoma monitoring models in partnership with ICB and local practitioners.
- Support OMFS sustainability by addressing sub-specialty pressures, reviewing two-site working, and considering a north/south configuration for complex vs routine cases.
- Work with the organisation and ICB to identify a sustainable model for community dentistry, reflecting the departure of the single-handed Consultant and current interim arrangements.
- Improve theatre and clinic utilisation, strengthening Group-wide expectations around job planning, scheduling and patient safety.
- Ensure risks in planned care are captured.

Outcome measures:

- Reduced acute flow variation and fewer delays for ENT admissions on both banks.
- Decrease in inappropriate ENT referrals and improved referral quality from primary care.
- More balanced audiology capacity, with safer paediatric and adult pathways and improved access to suitable facilities.
- Reduced ophthalmology waiting list risk and clearer demand/capacity profiles.
- Improved sustainability of OMFS service delivery, with reduced 65-week risks in cancer and community dentistry pathways.
- More consistent theatre and clinic utilisation.
- Increased visibility of Head & Neck risks.

Key milestones:

- ENT top-10 referral criteria agreed with primary care - Feb 2026
- Surgical SDEC model considered, including location and specialty access - Mar 2026
- Audiology workforce, pathway and facility review completed - Apr 2026
- Ophthalmology demand/capacity review completed (incl. glaucoma model considerations) - Mar 2026
- OMFS sustainability options developed (north/south configuration) - Jun 2026
- Community dentistry service model options agreed with ICB - Jul 2026
- Reduced Head & Neck safety risks through targeted Never Event learning, backlog-related harm mitigation and strengthened clinical governance across pathways.

Connecting programmes:

- Unplanned Care: ENT referrals, ophthalmology transformation, OMFS waiting list risks, community dentistry model.
- Planned Care: Surgical SDEC and acute ENT bed access.
- Workforce & OD: ENT consultant vacancies, audiology workforce, OMFS vacancies, community dentistry workforce risk.
- Diagnostics & Digital: Audiology equipment/facility needs; digital support for referral models.
- Financial Prioritisation: Facility issues, pathway redesign and key risks fed into clinically informed prioritisation processes.
- Ophthalmology and OMFS service configuration opportunities.
- ICB Partnership: Referral criteria pilots; glaucoma model; community dentistry re-provision.

Acute and Emergency Care Group Plan (incl. MTNCG)

Humber Health Partnership

Plans and key deliverables:

- Reinforce site leadership and accountability through a revised triumvirate model and consistent presence of a Director of the Day.
- Prepare for Major Trauma peer review (Jan 2026), addressing TARN data quality, governance, and documentation of mortality reviews.
- Review acute trauma medical cover, ensuring appropriate PA allocation and cross-site rota resilience.
- Separate rehabilitation from the trauma service and establish a clear improvement plan covering inpatient flow, therapy input, and discharge coordination.
- Improve front-door flow by strengthening streaming of GP referrals and walk-ins, with optimal utilisation of UTCs and ED focus on non-admitted patients review.
- Optimise acute medicine and AMU processes, reducing time between ED and specialty transfer and improving escalation discipline.
- Implement Continuous Flow refresh, clarifying roles, triggers, and real-time coordination across specialties.
- Progress to a CDU or ESDEC model on all sites (dependent on sustainability) delivering an estimated 8–10% improvement in ED 4 hr performance
- Progress the Clinical Decision Unit (CDU) development at Hull, enabling same-day discharge for non-admitted patients and delivering an estimated 8–10% improvement in ED performance.
- Review and align frailty and SDEC capacity, ensuring expansion plans for the Frailty Assessment Beds (FAB) and Team (FIT) are supported through community pathways.
- Strengthen winter and business continuity planning, confirming bed configuration, escalation protocols, and the role of Ward 5 in CDU and seasonal surge capacity.
- Support the data-focused UEC leadership session (GIRFT/UEC) as part of the wider improvement programme, highlighting system-wide collective leadership and delivery.
- Prepare for Major Trauma peer review (Jan 2026), addressing TARN data quality,
- governance, and documentation of mortality reviews, acute trauma cross site cover and rota resilience.
- Consider separation of rehabilitation from the trauma service and establish a clear improvement plan covering inpatient flow, therapy input, and discharge coordination.
- Work with GIRFT UEC team on paediatric 4 hr performance for all types at HUTH and for type 1 admitted patients with NLAG Paediatrics.
- Improve AMU and ED in -each and work to meet RCP consultant (expert decision maker) review standards of 6hrs in day and 14hrs overnight.
- Introduce direct SDM review following ED referral and remove need for repeat resident review, reducing admissions and clinical time overuse, improving flow and early reviews.
- Introduce criteria to admit on ED referrals for clear admissions.

Outcome measures:

- Improved Ambulance handover times 100% below 60 min and 80% below 45min by continuous flow model along with improving safety in ED TES.
- Maintained flow and all constitutional standards with least use of TES spaces eventually
- ED 4-hour performance improved by ≥8% following CDU implementation.
- Reduced non-admitted breach rates and shorter average ED length of stay.
- 100% compliance with TARN data submission and peer review standards.
- Reduction in avoidable re-attendance from care homes through improved frailty and rehab flow.
- Shorter time from ED arrival to specialty ward transfer.
- Positive staff survey movement in ‘communication’ and ‘leadership visibility.’
- Improved 12 hr total stay in ED by improved / continuous flow
- AIM/GIM-all patients seen by consultant (expert decision maker) within 6hrs during day and within 14 hrs overnight.
- 7-day 12hr SDEC for all major specialties on all sites.

Key milestones:

- Trauma peer review preparation complete - Dec 2025
- Revised site triumvirate and Director of the Day model operational - Jan 2026
- CDU development and staffing plan approved - Feb 2026
- Continuous Flow model refresh implemented - Mar 2026
- Frailty/SDEC expansion business case approved - Apr 2026
- GP referral and advice process redesign launched - May 2026
- Rehabilitation improvement plan implemented - Jun 2026
- Unified Acute & Emergency model agreed across sites - Sep 2026

Connecting programmes:

- Redesign acute pathways so ED and Acute Medicine operate on a financially sustainable footing - creating dedicated specialty assessment capacity (both banks), standardising referral/IPS processes, and ensuring timely specialty ownership of patients in a way that improves flow without simply displacing workload elsewhere.
- Flow & Discharge: Links with Frailty, Community, SDEC, and Rehabilitation pathways.
- Trauma Network: Alignment with Major Trauma Board and peer review standards.
- Rehabilitation Programme: Inpatient rehab redesign to support trauma, medical, and surgical flow.
- Workforce & OD: Acute medicine and trauma rota redesign and site leadership development.
- Digital & Data: Real-time flow dashboards and support for the UEC/GIRFT-led data session.
- Winter Planning: Bed configuration and escalation framework.
- Clinical Governance: TARN data quality, mortality review processes, and specialty accountability against GIRFT UEC standards.

Specialist Medicine Care Group

NHS
Humber Health
Partnership

Plans and key deliverables:

Respiratory Medicine
- South Bank consultant cover to maintain acute, urgent and cancer pathways.
- Reflect respiratory virtual ward learning (north bank) within south bank flow and discharge planning.
- Include the HRI respiratory bed base in the Group bed-base review.

Renal Medicine
- Reflect increasing dialysis demand and medical staffing pressure within future operational and workforce planning alongside opportunities for home dialysis expansion.
- Maintain involvement in the procurement transition for dialysis services.

Rheumatology
- Address north bank consultant vacancy pressures impacting waiting times.
- Include Ward 70 within the HRI bed-base review due to shared general medical use.
- Reflect DEXA staffing within diagnostics and workforce planning.

Diabetes/Endocrinology
- Maintain RTT and inpatient pathways under increasing outpatient demand.
- Note seven-day Nurse Specialist cover may require alternative models from April 2026.
- Include diabetes/endocrinology bed bases across HRI, DPOWH and SGH in the Group bed-base review.

Thoracic Surgery
- Reflect increasing resectable lung cancer activity and linked consultant workforce requirements within Group planning.
- Note alignment issues between thoracic surgery and Cardiovascular services for future Group configuration.

Medical Day Unit (HRI)/Planned Intervention Units (SGH & DPOWH)
- Address under-utilised capacity.
- Consider siting within outpatient/planned care pathways to maximise usage for medical and surgical specialties and support CDC, SDEC and RTT flows.

Outcome measures:

- Improved management of follow-up demand through appropriate use of PIFU models.
- RTT stability maintained across rheumatology, diabetes/endocrinology and respiratory services.
- Better utilisation of Medical Day Unit / PIU capacity through alternative models of care.
- Reduced delays linked to dialysis and DEXA pressures.
- Service models adapted where seven-day specialist cover is not sustainable

Key milestones:

- Opportunities for PIFU use across specialist medicine pathways scoped - Mar 2026
- Respiratory and diabetes/endocrinology bed-base considerations included in Group review – Mar - May 2026
- Renal workforce and dialysis demand and capacity reflected in planning cycle - Apr 2026
- Rheumatology vacancy mitigation options scoped - Apr 2026
- DEXA staffing pressure noted in diagnostics planning - Jun 2026
- Options for maintaining sustainable specialist cover - Jun 2026
- Thoracic surgery Care Group alignment reviewed - Jan 2026
- Medical Day Unit / PIU utilisation options developed - Feb 2026

Connecting programmes:

- Outpatient Transformation: Inclusion of PIFU approaches within specialist medicine pathways.
- Bed-base Review: Respiratory, rheumatology and diabetes/endocrinology bed bases included.
- Workforce & OD: Workforce sustainability reflected in planning, including alternative approaches to seven-day specialist cover.
- Diagnostics: DEXA and echo capacity included in diagnostics planning.
- Neighbourhood Care: Virtual ward learning, supported discharge and chronic disease management aligned to neighbourhood models.
- Planned Care: Medical Day Unit and PIU utilisation aligned with elective and SDEC planning.
- Financial Prioritisation: All identified needs reflected within clinically informed Group financial prioritisation.

Digestive Diseases Care Group

Humber Health Partnership

Plans and key deliverables:

- Develop and approve Surgical SDEC SOPs (admission criteria, diagnostics flow, transfer pathways)
- Develop and implement Castle Hill criteria-led discharge SOP to reduce length of stay and standardise discharge practice
- Establish Surgical SDEC at HRI by April 2026 (24/7 by June 2026 to reduce surgical attendance to ED by 30%, reduce admissions by 30% and increase GP direct referrals by 30%)
- Implement advice and referral model for gastroenterology outpatients (pilot Nov–Dec 2025)
- Work with TACC to improve scope turnaround times through review of decontamination processes
- Support NHSE-led endoscopy demand and capacity review
- Develop sustainable endoscopy capacity (6th room 2026/27; 10 rooms by 2030) plans for consideration as part of 2026/27 capital planning – needs to be based on service model review and capacity and demand work with external support)
- Work with TACC to expand Upper GI, Lower GI and colorectal day case procedures at CHH
- Confirm regional GI bleed rota for 24/7 cover from January 2026
- Job plan changes – day case lists, outpatient
- Research, teaching & education positioned as a core strength underpinning service quality and recruitment.

Outcome measures:

- Reduction in surgical admissions via ED (target 30%); reduce admissions to general surgical beds by 30%; and increase direct GP referrals to SSDEC by 30%
- Agreed and implemented SSDEC and discharge SOPs
- Shorter inpatient length of stay through criteria-led discharge
- Increased proportion of day case procedures
- Improved endoscopy throughput and reduced scope decontamination turnaround times
- Reduced outpatient waits via advice & referral model
- Enhanced patient flow and cross-site consistency
- Move to PIFU as standard outcome in long-term disease pathway management

Key milestones:

- Draft SSDEC and discharge SOPs complete - Nov 2025
- SDEC Model finalised and approved - Dec 2025
- Advice & referral pilot complete - Dec 2025
- Regional GI bleed rota live - Jan 2026
- Review of decontamination processes – November 2026
- NHSE endoscopy review report received – December 2025
- Day case surgery expansion plan agreed – December 2025 and review 2026-27 for other specialty opportunities
- Endoscopy Room 6 considered in 2026/27 capital planning and revenue in operational plan 2026-27 (or confirm revenue is cost-neutral from productivity gains)
- Achievement of JAG accreditation for Allam Digestive Disease endoscopy service June 2026

Connecting programmes:

- Theatres and Anaesthetics Elective Recovery and Flow
- Community Diagnostics (CDC)
- Workforce and Job Planning
- Specialist Nurse workforce reviews

Specialist Cancer and Support Services Care Group

Humber Health Partnership

Plans and key deliverables:

- Address radiotherapy capacity constraints by aligning workforce planning with clinically informed Group financial planning prioritisation.
- Improve visibility of radiotherapy safety governance through sharing outputs of oversight of prioritisation, waiting list validation, and clinical harm review.
- Improve oncology and chemotherapy flow through clearer admission criteria, protected day-case activity, and better use of step-down pathways.
- Review oncology ward and chemotherapy staffing models to achieve equitable nurse-to-patient ratios and consistent acuity monitoring across sites.
- Establish executive accountability for PACS implementation, ensuring digital imaging reliability and Group-wide model for diagnostic capability including reporting capacity.
- Reinforce infection prevention and microbiology service resilience, including sustainable consultant and laboratory cover.
- Clarify governance support and leadership accountabilities across imaging, radiotherapy, haematology, oncology, pharmacy, and pathology interfaces.
- Work with Specialised Commissioning to define a long-term radiotherapy service model, including workforce investment and regional access planning.
- Redesign emergency oncology and palliative pathways for timely and compassionate care closer to home.
- Underpin Microbiology and Infectious Diseases service model across both banks to underpin IPC, optimise diagnostics, and stabilise and laboratory resilience.

Outcome measures:

- Sustained reduction in radiotherapy waiting time breaches with zero harm reviews outstanding.
- 31-day subsequent treatment compliance >70%.
- Full operational PACS system.
- Consistent nurse-to-patient ratios across oncology wards.
- Improvement in safety and morale in staff survey domains.

Key milestones:

- Partnership and Spec Comm engagement on radiotherapy capacity – commence by December 2025
- Radiotherapy workforce planning with clinically informed Group financial planning prioritisation for 2025/26 and 2026/27
- Oncology admission and flow SOP agreed - Jan 2026
- Chemotherapy and ward staffing review completed Mar 2026
- PACS accountability and delivery plan approved – Dec 2025

Connecting programmes:

- Clinical Strategy & Planning: Prioritisation through the partnership's clinically informed planning process.
- Specialised Commissioning: Joint engagement in radiotherapy service model and workforce sustainability.
- Quality & Safety: Radiotherapy governance and harm review oversight.
- Digital Transformation: PACS executive accountability.
- Workforce & OD: Radiotherapy and oncology workforce planning and development.
- Culture & Leadership: Clinician-led planning and governance structures.

Cancer Network Care Group

Humber Health Partnership

Plans and key deliverables:

- Improve MDT efficiency and consistency, reducing undifferentiated referrals through clearer criteria, gatekeeping, and agreed MDT frameworks.
- Strengthen clinical engagement and secure cross-specialty alignment through CPG endorsement of MDT changes.
- Address IT and infrastructure barriers affecting MDT coordination, with digital colleagues supporting a pathway to stable cross-site MDT functionality.
- Stabilise administrative structures (MDT coordinators, cancer trackers), addressing the legacy of previous restructures and reducing variation between North and South.
- Progress CNS workforce alignment, using the tumour-site workforce tool to guide flexible deployment and support cross-site working where possible.
- Improve demand and capacity planning, enabling realistic trajectories and pathway-level performance plans.
- Include radiotherapy, histopathology and endoscopy risks within Group-level clinically informed prioritisation, reflecting safety and performance impacts.
- Support standardisation of follow-up models, including broader use of CNS-led and PIFU-style follow-up where appropriate.

Outcome measures:

- Reduction in inappropriate MDT referrals and improved MDT meeting flow.
- Consistent MDT processes and criteria across North and South.
- Improved MDT reliability through better digital functionality.
- More stable MDT admin and tracker support, improving data quality and timeliness.
- Greater CNS workforce flexibility and more consistent tumour-site coverage.
- Improved accuracy and feasibility of cancer performance trajectories.
- Reduced variation in radiotherapy, endoscopy and histopathology turnaround times.

Key milestones:

- CPG endorsement of MDT framework and referral model – Dec 2025
- MDT referral criteria and gatekeeping framework rolled out and compliant across all tumour sites - Feb 2026
- Structured MDT admin/tracker review completed, with improvement actions agreed - Apr 2026
- CNS workforce alignment options presented using tumour-site workforce tool - May 2026
- Digital requirements for MDT functionality incorporated into Group digital plan - Jan 2026
- Updated demand/capacity planning approach applied to major tumour sites - Mar 2026
- Radiotherapy, histopathology and endoscopy risks addressed - Mar 2026

Connecting programmes:

- Digital: MDT IT/infrastructure fixes, platform reliability, cross-site functionality.
- Digestive Diseases Care Group: NHSE endoscopy review report and actions.
- Diagnostics: Histopathology variation included in network planning.
- Radiotherapy & System Partnerships: Radiotherapy performance risks captured in Group prioritisation.
- Workforce & OD: Cancer admin, tracker and CNS workforce issues reflected in planning cycles.
- Outpatient Transformation: CNS-led follow-up and PIFU approaches incorporated into cancer pathways.
- Tumour-site configuration opportunities within the wider clinical review.
- Financial Prioritisation: All identified capacity and safety issues included in clinically informed Group financial prioritisation.

Neurosciences Care Group

NHS
Humber Health
Partnership

Plans and key deliverables:

- Standardise stroke pathways across Humber, ensuring equitable access and consistent clinical standards.
- Strengthen consultant leadership and governance for stroke, neurology, neurosurgery, and neurophysiology.
- Improve inpatient flow and early supported discharge to reduce length of stay.
- Restore outpatient performance in neurology through job plan review and balanced clinic capacity.
- Reinstate timely diagnostic reporting in neurophysiology through re-sequenced activity and local validation.
- Recover RTT performance in neurosurgery and improve theatre utilisation.
- Develop a regional model of excellence covering stroke, surgery, and neuro-rehabilitation.
- Strengthen rehabilitation pathways linking acute and community services.
- Expand digital and technology-enabled care, including navigation and tele-neuro systems.
- Embed research, education, and innovation in everyday practice.

Outcome measures:

- SSNAP rating ≥ Band B and compliance with national stroke standards.
- Reduction in neurology and neurosurgery RTT breaches to national median.
- Neurophysiology turnaround times within 6-week standard.
- Shorter average length of stay across all neurosciences pathways.

Key milestones:

- Standardised stroke pathway operational Mar 2026
- Consistent early supported discharge model live - Apr 2026
- Neurology job plan and outpatient review complete - May 2026
- Neurophysiology turnaround restored to standard - Jun 2026
- Neurosurgery RTT recovery achieved - Jul 2026
- Regional Neurosciences Service Model approved - Oct 2026

Connecting programmes:

- Community & Rehabilitation: Integrated neuro-rehab and ESD pathways.
- Workforce & OD: Shared medical and AHP workforce model to reduce locum dependency.
- Digital Transformation: Diagnostic, navigation, and tele-neuro systems.
- Research & Innovation: Collaborative projects with academic and regional partners.

Cardiovascular Care Group

Humber Health Partnership

Plans and key deliverables:

Vascular:

- Ensure vascular hybrid theatre considerations sit within the Group's clinically informed financial planning approach.
- Embed multidisciplinary working with Radiology, Specialist Cancer, and Clinical Support for integrated vascular theatre operations.
- Review the vascular bed base and skill mix to optimise patient flow and safety.
- Strengthen recruitment to attract vascular consultants.
- Engage with the ICB on regional vascular capacity and sub-specialty flows to mitigate duplication with York's planned theatre.

Cardiology:

- inpatient echo access through a pilot echo hot clinic on the north bank, reducing discharge delays.
- Re-establish a functioning Cardiology SDEC at HRI to improve acute assessment and reduce unnecessary admissions.
- Review Cath Lab operational hours and develop a seven-day working model at Castle Hill.
- Undertake a medical model review to rebalance consultant-heavy services and expand specialist nurse roles.
- Scale the Connected Health Network model (reverse in-reach from primary care) across both banks, supporting early management of risk factor and stable cardiology cases.
- Review cardiology bed base at HRI and south bank to align with actual acute medical flow and SDEC utilisation.
- Implement Risk Factor outpatient clinics at Goole to strengthen neighbourhood health capacity.

Cardiac Surgery:

- Sustain current performance and mortality review standards at the Castle Hill regional centre.
- Address intermittent ICU pressure through capacity alignment with critical care and elective planning.
- Participate in clinically-led specialty review.

Outcome measures:

- Reduction in length of stay for vascular patients through hybrid model and bed reconfiguration.
- 50% reduction in inpatient echo-related discharge delays by Q3 2026.
- ≥85% utilisation of Cath Labs, with a defined and sustainable seven-day operating model.
- Reduction in same-day cancellations linked to echo or pre-op issues.
- Sustained low cardiac surgery mortality and improved ICU resilience.
- Increased proportion of cardiology outpatients managed through Connected Health pathways.

Key milestones:

- Vascular hybrid theatre need reflected in Group financial prioritisation process – Jan 2026
- Echo hot clinic pilot design completed - Feb 2026
- Cardiology SDEC options reviewed - Mar 2026
- Seven-day Cath Lab model explored - Apr 2026
- Risk Factor clinic approach agreed in principle - May 2026
- Vascular bed base review completed - Jul 2026

Connecting programmes:

- Theatres & Productivity: Vascular and cardiac activity reflected in theatre improvement programme.
- Workforce & OD: Workforce needs considered in Group planning.
- Elective Recovery: Cardiac and vascular activity aligned with elective priorities.
- Diagnostics & Digital: Echo and Cath Lab needs noted in digital/diagnostic planning.
- Neighbourhood Health: Cardiology risk-factor work noted in neighbourhood planning.
- Critical Care & Anaesthetics: ICU links noted in critical care planning.

Pathology Network Care Group

NHS
Humber Health
Partnership

Plans and key deliverables:

- Strengthen network governance, including clearer oversight of SHYPS and Path Links operating models, escalation routes and shared decision-making.
- Address variation between SHYPS and Path Links in staffing, processes, digital systems and turnaround times through agreed standardisation priorities.
- Reflect workforce pressures (including consultant cover, biomedical scientists and single-handed sub-specialty roles across SHYPS and Path Links) within Group workforce planning.
- Support safe operation of both services by improving cross-site resilience, including back-up cover arrangements and shared on-call models where appropriate.
- Improve quality and QMS consistency, particularly where SHYPS and Path Links differ in documentation, audit cycles and incident management.
- Ensure LIMS functionality, connectivity and validation challenges affecting both organisations are addressed through joint actions with the digital team.
- Reduce turnaround time variation between SHYPS and Path Links through shared demand management, batching reviews and aligned workflows.
- Include all major capital, digital and workforce risks across SHYPS and Path Links within the Group's clinically informed financial prioritisation process.
- Establish a Group-wide pathology productivity dashboard, providing daily visibility of turnaround, staffing, and error rates.
- Review and update mortuary and post-mortem service pathways to ensure compliance with HTA standards and improved cross-site resilience.

Outcome measures:

- Reduced variation in turnaround times between SHYPS and Path Links.
- More consistent staffing and rota resilience across both services.
- Improved alignment of quality management processes (SOPs, audits, incident management).
- Fewer LIMS-related workflow disruptions affecting SHYPS and Path Links.
- Clearer network governance structure with transparent escalation routes.
- Better cross-site support for key sub-specialties with recruitment challenges.

Key milestones:

- Network governance model including SHYPS/Path Links roles outlined - Mar 2026
- Priorities for reducing variation between SHYPS and Path Links agreed - Apr 2026
- Turnaround time variation baseline across both services completed - Jun 2026
- LIMS stabilisation and validation issues incorporated into digital plan - Jul 2026
- Network quality reporting framework established - Sep 2026

Connecting programmes:

- Digital & Diagnostics: Joint LIMS, analyser interfaces and reporting issues across SHYPS and Path Links.
- Quality & Safety: QMS alignment, shared audit programme and harmonised incident learning across both organisations.
- Workforce & OD: Rota resilience and specialist cover pressures reflected in Group planning.
- Financial Prioritisation: SHYPS and Path Links risks included within the clinically informed financial prioritisation approach.
- Acute & Specialist Links: Engagement with oncology, haematology, emergency care and theatres to address the impact of SHYPS/Path Links variation on turnaround times.
- Clinical Strategy: Pathology network positioning to inform the Group's Phase 3 clinical review.

Enabling **Strategies & Plans**

Safety & Quality Strategy

Humber Health Partnership

Safety & quality priorities:

- Deteriorating patient, sepsis and septicaemia
- End of life and palliative care
- Medicines safety and optimisation
- Mental Capacity Act and DoLS
- Safer surgery and peri-operative care
- Falls, tissue viability and deconditioning
- Nutrition and hydration
- Infection prevention and control

} Quality Account priorities

Our plans:

- Deliver a Group-wide medicines safety improvement programme aligned to patient safety priorities, incorporating safe prescribing, insulin safety, antimicrobial stewardship and time-critical medicines reliability.
- Implement safer surgery and peri-operative improvement programmes.
- Standardise falls, tissue viability, nutrition and hydration prevention bundles.
- Strengthen early recognition and response to deterioration and sepsis.
- Improve MCA and DoLS compliance and assurance.
- Implement a strengthened IPC delivery model with named IPC nurse leadership by area, a Gram-negative bloodstream infection action plan (including Catheter QIP), antimicrobial stewardship and IV-to-oral switch, supported by Practice Development Matrons, a Group-wide IPC competency framework and targeted communications campaigns
- Develop a Quality & Safety accreditation programme for wards, theatres and departments - starting with 25% of wards across the Group, with concurrent audit and education until standards are embedded and sustained
- Establish the Learning, Improvement & Safety Academy to embed learning and improvement at scale.
- Engage with CQC on Must Do and Should Do actions, transitioning historic actions into Business as Usual (BAU) and monitoring through existing governance
- Implement a formal process for managing and escalating non-compliance with mandatory training

Key enablers:

- Learning, Improvement & Safety Academy
- Strong safety culture, alerts and campaigns
- Clinically-led quality & safety accreditation
- Group-wide standards and pathways
- Data-driven learning from harm (PSIRF)
- Multidisciplinary education and OD support
- Monthly Quality Surveillance meetings, chaired by the Chief Nurse, to share Group-wide themes, learning and provide assurance
- Systematic capture and review of learning from peer reviews, legal claims and coronial inquests through the clinical governance review

Outcome measures:

- Reduction in serious harm and avoidable patient safety incidents
- Improved sepsis, medicines safety and safer surgery compliance
- Reduced falls, pressure damage and inpatient deconditioning
- Improved end-of-life care quality and experience
- Stronger safety culture and staff engagement scores
- Consistent accreditation outcomes and assurance across sites
- Group-wide learning from patient experience themes, monitored monthly through Quality Surveillance and Patient Experience governance

Nursing & Midwifery & AHP Strategy

Humber Health Partnership

Our plans:

- **Stabilising services through strong professional leadership and standards**

Supporting immediate improvement in safety, quality, flow and experience in priority services, aligned to CQC requirements, regulatory expectations and the Group Improvement Plan.

- **Embedding clinically-led, collective leadership and decision-making**

Strengthening shared governance and multidisciplinary leadership so professional teams are actively involved in shaping priorities, pathways and investment decisions across the Group.

- **Developing a sustainable and resilient workforce model across Humber**

Enabling modern roles, safe and sustainable staffing and flexible deployment across acute, community, neighbourhood and specialist services to improve resilience, retention and service continuity.

- **Supporting neighbourhood health, flow and discharge improvement**

Aligning professional practice to the Improvement Plan focus on frailty, deconditioning, end-of-life care and timely discharge, reducing avoidable admissions and length of stay.

- **Building improvement capability and a learning culture at scale**

Embedding continuous learning, quality improvement and safety leadership as core expectations, supporting services through structured development and improvement support.

- **Enabling digitally supported and data-informed care delivery**

Supporting effective use of digital tools, virtual care models and real-time information to improve productivity, safety, coordination and patient experience.

We will:

- Introduce ourselves to patients, hello my name is……
- Address our patients by their preferred name.
- The nurse, midwife or AHP in charge in a clinical area will speak to every patient on a shift and ask them, tell me about your care today?
- Keep our patients and their loved ones informed of the plan of their care in a way they can understand.
- Our patients or loved ones will be able to tell us ‘what is wrong with me, what needs to happen to get me better, what needs to happen for me to go home and when can I go home’.
- Show patients and their loved one's respect, kindness, compassion and always maintain dignity.
- Ensure discharge plans and expected date of discharge are discussed on admission to patients and their loved ones and explain what this means.
- Ensure patients have access to appropriate nutrition and fluids.
- Respectfully challenge any colleagues who are not doing the right thing.

Outcome measures:

- Improved safety, experience and outcomes in services identified in the Improvement Plan
- Stronger leadership visibility, engagement and accountability across sites and care groups
- Improved workforce stability, wellbeing and retention, with reduced reliance on temporary staffing
- More effective patient flow, reduced deconditioning and safer transitions of care
- Consistent standards of professional practice and quality across the Group
- A stronger learning and improvement culture, reflected in staff feedback and regulatory assurance

Financial Strategy

Humber Health Partnership

Principles:

- Complementary to the organisation's overarching strategy.
- Developed with strong clinical engagement.
- Sustainable capital programme – built in principles established through SLT and CPG.
- Establishing equity of funding.
- Improving efficiency and productivity.
- Data quality and clinical coding.
- Safe and effective patient care.
- Delivery of efficiency savings recurrently and safely.

Financial and capital planning approach:

- Prioritisation criteria aligned to overarching strategy
- Estate grown >10% in 5 years
- Optimise utilisation of estate
- Work with system partners on left shift and utilisation of out of hospital estate

Governance:

- Scheme of delegation including SLT, Exec's, PEF and Board Committee's in Common
- Established prioritisation criteria
- Business Case Review Group
- Business Case Decision Group
- Clinical Policy Group

Key milestones:

- Annual Accounts 2025/26
- Operational and financial planning 2026/27 & 2027/28 – 17 December 2025
- Operational and financial planning 3 years – February 2026
- Refreshed financial strategy Q1 2026/27

People Strategy

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Principles:

- High quality workforce intelligence at all levels to enable Care Groups and services to manage effectively
- Bottom-up workforce planning aligned with Care Group and Corporate plans, performance and finance
- Development of a robust recruitment strategy with intensive support to hard-to-recruit roles
- Efficient and effective workforce controls to address variable pay
- Modern, value for money functions and processes
- Consistent and aligned policies (eg: job planning framework)
- Consistent behaviours and standards (the way we do things around here) supported by high quality and timely HR practices and support

Objectives:

- Deliver year 2 of the People Strategy 2025-28
- Focussed recruitment campaigns to fill substantive roles, particularly 'hard to recruit too' medical and clinical roles.
- Work with services to report and manage variable pay to deliver NHSE 30% agency reduction and 10% bank.
- Ensure wellbeing services are promoted and available to support staff to remain at and return to work and enhance break and rest facilities
- Develop and launch the Group's Learning, Improvement and Safety Academy (LISA) to offer a comprehensive range of support to enable services to continuously learn, grow and improve.
- Review the impact of the Group's cultural transformation programme – Putting People First and launch year two programme
- Review the Groups leadership programme to ensure our offering supports and develops aspiring, new, middle and senior leaders to lead with vision, courage and kindness
- Harmonise and develop people systems, policies and procedures across the Group to enable leaders to manage their people better

- Establish 26/27 speciality / corporate workforce plans aligned to operational plan, CIP and NHS 10 Year Plan expectations
- Launch Y1 LISA programme alongside clinical leadership at a Group level, targeting areas of known risk
- Align all workforce policy, procedure and systems in readiness for the new workforce solution (replacing ESR nationally) in 2027
- Continue to develop the Group Health & Well-being offer, targeting prevention to reduce known drivers of sickness
- Review National Staff Survey feedback to adapt cultural intervention at a local and Group level working towards the national average
- Achieve job plan KPI's whilst ensuring core activity is prioritised.
- Utilise the full extent of workforce deployment system functionality available to maximise efficiencies, including E-roster and Locums Nest.
- Continue to reduce variable pay usage and rate in line with NHSE 30% Agency & 10% bank expectations.

Outcome measures:

- Reduce agency spend by 30%
- Reduce bank spend by 10%
- Reduce sickness levels to 4.1%
- Increase signed-off job plans to 95%
- NSS We are Safe & Healthy Score of 6
- NSS We Work Flexibly Score of 6
- NSS Engagement Score – sustain current performance

Digital Improvement Plan

Humber Health Partnership

Objectives (From Digital Strategy)

- We unlock productivity with everything we do.
- We will build robust digital foundations that are secure, resilient and interoperable
- We will improve the way we use data to drive decision-making in real time and plan more effectively for the future.
- We will build a virtual hospital, which will work alongside our physical sites and be fully integrated into our existing service offer.
- We will keep digital inclusion at the heart of what we do.

Roadmap – Next 12 months

- EPR contract signature and implementation
- £2 million Laptop and PC refresh
- Network link upgrades
- PACS options assessment
- Completion of DrDoctor rollout in HUTH / NLAG
- Self check-in and wayfinding rollout
- Data Warehouse replatforming
- Interim Web V v3 upgrade
- Single Sign On (sso) optimisation
- Digital Strategy Refresh
- ICNET – Infection Prevention and Control system rollout
- ISLA
- Robotic Process Automation (RPA) for Outpatients
- Multiple clinical system upgrades
- Electronic Document Management Business Case
- LUNA Rova

Key actions

- Reprioritise list of current digital projects – Proposal ready for SLT on 13 January.
- Follow with link to Clinical Policy Group for digital prioritisation.
- Support acceleration of the virtual hospital conversation.
- Revise the digital project initiation process and separate from digital innovation / continuous improvement.
- Develop an engagement plan for the revised digital strategy and commence design of operating model for Phases 2 and 3 of improvement plan.

Outcome measures

- Outlined in Digital Strategy – Integrate into IPR
- Engage around revision for future

Communications & Engagement Strategy

Humber Health Partnership

safer patients

- Clinical Governance model
- Deconditioning – nutrition and hydration
- Infection prevention and control – sepsis and septicaemia
- Falls
- Tissue viability
- Safer surgery

healthier people

- Care is top priority
- Pride in our safety improvement
- Pride in the patient experience
- Would recommend the service
- Improved morale
- Better engagement

brighter future

- Financial efficiency achieved through:
  - Reduced LoS
  - Fewer safety incidents
  - More efficient pathways
- Less focus on money per se
- More freedom
- Reduced oversight and scrutiny

- Communications heavily focused on safety, learning and sharing
- Safety and 4 business objectives improvements celebrated and shared
- Corporate communications channels and Care Group cascade mechanisms shored up

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safer patients healthier people brighter future

Estates Strategy

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Our plans:

- **Stabilising a safe, compliant and resilient estate**

Prioritising statutory compliance, backlog maintenance and critical infrastructure risks to support safe care delivery in priority services.

- **Removing estate-related constraints to service delivery**

Targeted estate interventions to address service-limiting constraints.

- **Aligning estate investment to clinical priorities and service models**

Ensuring estate programmes directly support the Improvement Plan.

- **Clinically informed prioritisation and decision-making**

Linking estate programmes and capital investment to clinically led decision-making and priorities through the Senior Leadership Team and Clinical Policy Group, ensuring transparent, evidence-based decisions

- **Enabling neighbourhood health and system estate utilisation**

Working with system partners to optimise use of community and out-of-hospital estate in support of left-shift, prevention and care closer to home.

- **Delivering a sustainable and efficient estate**

Improving utilisation, reducing inefficiency and embedding sustainability principles across estate planning and investment.

- **Optimising use of space and fit-for-purpose clinical environments**

Ensuring clinical and non-clinical space is appropriately configured, utilised and aligned to service models, supporting safe care delivery, positive patient experience, productivity, flow, staff experience and efficiency.

- **Digitisation of the Estate**

Improve the Estates Digital Maturity by implementing systems such as a group wide CAFM system to enable greater utilisation, room booking and estates management as well as monitoring utilisation and energy use..

Outcome measures:

- Improved statutory compliance and reduced estate-related risk
- Clear alignment between clinical priorities, service plans and estate investment & prioritisation
- Removal of estate constraints impacting priority clinical services
- More effective use of the estate through repurposing, rationalisation or release of non-clinical space, prioritising fit-for-purpose clinical environments
- Estate solutions that support flow and discharge

Research & Innovation Strategy

Humber Health Partnership

Our plans:

1. We will build the infrastructure we need to deliver excellent clinical research and innovation

- We will support all clinicians, including early career researchers, to make the most of opportunities to contribute to research and innovation.
- We will support NMAHPs to undertake research by providing time and resources to increase research participation.
- We will build patient confidence and health literacy to support informed participation in research, making it more inclusive and improving population health.
- We will work with academic and industry partners to develop the facilities, data, and digital infrastructure needed for high-quality research and innovation.

2. We will align our research efforts to the big challenges facing our population

- We will use our scientific expertise to tackle the major challenges facing our population and workforce.
- We will work with industry to lead research in sustainable healthcare and support economic growth in the Humber region.

3. We will equip our people to innovate and transform

- We will work with training providers to embed research skills into training, helping staff lead innovation and improve services.
- We will foster creativity by giving teams more freedom to deliver goals within a clear framework.
- We will involve communities in research and innovation, giving them a voice in shaping solutions.

Outcome measures:

- Increase in the number of clinical academic and honorary academic consultants, working towards the aspiration that 20% of consultants have 20% protected research and innovation time.
- A dedicated NMAHP research and innovation taskforce to shape the next three years of activity, focusing on research awareness, ambition, and training needs.
- Secure one new international strategic commercial partnership and two new regional partnerships in addition to two multi-programme industry data-sharing partnerships.
- Membership of and access to the regional Secure Data Environment.
- Establish academic–industry partnerships focused on shared carbon-neutral goals
- A Group Innovation Portal, with tailored support from an established Humber Innovation Hub.
- Research and innovation career development and training opportunities will be part of all clinical job plans, appraisals, and development reviews.
- We will also increase participation in commercial research trials by 50%, strengthening our region’s role as a hub for cutting-edge innovation and increasing income year-on-year.
- Established AI-driven data analytics supporting our activity through a digital innovation pathway.
- Achievement of national 150/90 days clinical trials set-up timelines.

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Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)018

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12 February 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 – October 2025
Executive Summary	Quality & Safety Committees in Common minutes from the meeting held on 30 October 2025
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 18/12/25
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 30 October 2025 at 9.15am to 12.30pm in the Executive Meeting Room, SGH or via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (HUTH) - Chair
Sue Liburd	Non-Executive Director (NLaG)
Tony Curry	Non-Executive Director (HUTH)
Julie Beilby	Non-Executive Director (NLaG)
Amanda Stanford	Group Chief Nurse
Dr Kate Wood	Group Chief Medical Officer (virtual)

In Attendance:

David Sharif	Group Director of Assurance
Rebecca Crashley	Group Deputy Director of Assurance
Michela Littlewood	Associate Director of Quality Governance (HUTH)
Richard Dickinson	Associate Director of Quality Governance (NLaG)
Matt Powls	Interim Group Chief Delivery Officer
Murray MacDonald	Interim Group Chairman
Nicky Foster	Head of Midwifery
Corrin Manaley	Governor Observor
Kelly Northcott-Orr	Head of Continuous Quality Improvement
David Welburn	Named Nurse – Mental Capacity & DOLS
Wendy Millard	Assistant Chief Nurse/Deputy Director of IP&C
Jo Palmer	PA (Minutes)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Sue Liburd, in the absence of the Chair, David Sulch, welcomed those present to the meeting, particularly Matt Powls, Interim Group Chief Delivery Officer, to his first meeting. Apologies for absence were noted from Yvonne McGrath, Group Midwifery Director and Tracy Campbell, Interim Group Director of Patient Safety and Quality Governance.

1.2 **Staff Charter and Values**

Sue Liburd reminded attendees the meeting was to be conducted in line with the above, with particular consideration to teamwork.

1.3 **Declarations of Interest**

The following declaration was noted:

Amanda Stanford shared that she would soon be commencing her secondment as Chief Nurse for the ICB.

1.4 **To approve the minutes of the meetings held on 25 September 2025**

The minutes of the meetings held on 25 September 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

Sue Liburd invited Committee members to raise any matters requiring discussion not captured on the agenda. There were no items raised.

1.6 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

Item 2 29/5/25 – Dr Kate Wood advised colleagues that the NLaG consultants had now agreed the offer that was put forward, and this offer would now be extended to the HUTH LNC to reach unanimity for extra contractual pay rates across the Group.
Item 7.1 26/6/25 – Michela Littlewood advised that there were four people interested in attending the meeting and asked for guidance as to when this should commence. This was decided for January 2026.
Item 6.1 24/7/25 – Dr Kate Wood advised this action could now be closed
Item 3.5 25/9/25 – standing agenda item until at least the end of the year, therefore action to be closed
Item 4.3 25/9/25 – Amanda Stanford advised this action can be closed
Item 4.8 25/9/25 – further update to be provided in December
Item 4.9a 25/9/25 - TAVI to be added to the workplan and then action to be closed
Item 4.9b 25/9/25 – Richard Dickinson updated that all reviews had been completed, and no significant harm was identified. These would be discussed at the Patient Safety & Learning Group (PSLG) meetings along with, as Amanda Stanford suggested, a cardiology review in general. David Sharif shared that the cardiology governance review was out of the market so clear timelines would become known. Action to be closed.
Item 4.10a 25/9/25 – Amanda Stanford advised item will be discussed under Item 4.1 therefore action can be closed
Item 5.1 25/9/25 – action can be closed
Item 3.1 25/9/25 – action can be closed

David Sulch joined the meeting at 9.30am

1.7 **Operational Pressures Update**

Dr Kate Wood advised that Hull had been on Opel 4, but with a good deal of focussed attention, had moved up to Opel 3, but remaining in Tier 1 for UEC. There were no significant additional emerging concerns at present. Amanda Stanford pointed out that there had been some new concerns raised to her from nursing staff on the temporary escalation spaces around staffing levels, particularly in Specialist Medicine where some newly identified risks had been highlighted.

Matt Powls agreed that the teams were currently under extreme pressures, and at the recent Tier 1 meeting on UEC, assurances had been given to the ICB and NHSE that plans were in place. Matt shared that he was due to have a meeting with the ICB on several topics, and it was agreed that the organisation and the ICB would jointly report to the NHSE in terms of what those plans were. He added that he had already been out and about meeting the operational teams, supporting them in ensuring they were able to cope with the pressures and what was being asked of them.

David Sulch took over the chairing of the meeting and thanked Sue Liburd for standing-in in his absence

1.8 **Committee Review of Effectiveness**

David Sharif gave a verbal reminder for colleagues to participate in the review that would be circulated following the meeting, the outcome of which would be presented to the December meeting.

2. MATTERS REFERRED

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

The committee Chair reported that there were no matters referred.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif outlined the BAF, with particular attention to the patient safety risk and the distance between the current position and the desired position and that it was the largest difference within the framework and highlighted the ongoing concerns about delays within ED. The CQC preparatory work continued to be on hold for the foreseeable future, whilst focus remained on delivering constitutional standards. David updated that the response from the overall strategy was going to the Board Development session on 13 November 2025 and that the Quality Strategy was still being finalised, butwould enable high-level actions to be addressed in more detail and gaps to be closed.

Kelly Northcott-Orr and David Welburn joined the meeting

David Sulch noted one of the biggest concerns was around delays in ED but that there was no specific action related to this. Amanda Stanford responded that thought was now being given on how performance was triangulated through patients and suggested looking at this further by way of a deep dive in the PSLG meetings and feedback with assurance to the Committee. David Sharif added that

a summary of the high-level risks from the single risk register would feature within future BAFs, supported by executive leadership.

David Sulch questioned the inclusion of Martha's Rule within the action list and reflected that attention should be given to how to effectively deal with deteriorating patients well before the family sought to enforce Martha's Rule. Richard Dickinson added that for the last couple of months, this was being supported by way of patient interaction and staff asking for patients' thoughts on their care. Staff were being encouraged to escalate concerns rather than delay. Amanda Stanford added that deteriorating patients remained a Quality Priority and should continue as such as there had not been sufficient improvement to date.

3.2 **Risk Register Report Q1 & 2**

Michela Littlewood updated that the risk register had moved to the Ulysses system and ongoing staff training was causing some delay in risk reviews resulting in more risks being open. Along with the ED concerns, it was clear that Estates & Facilities does impact on patient care. It was important that Care Groups were challenged on their risk mitigations and who would take ownership. Amanda Stanford added there was clearly work to do in understanding risk and enabling staff to raise concerns and act upon it. The Risk & Compliance meetings were proving helpful but how the Risk Register triangulated with the BAF needed some work. Matt Powls added that he would endeavour to ensure that this work was embedded via the regular tri meetings.

Tony Curry was concerned that many of the risks lacked clear ownership and asked for more assurance that actions were being taken. Amanda Stanford reflected that this new approach was still very new to Care Groups and the Risk & Compliance Group needed to be strengthened with some Executive involvement.

David Sulch pointed out that the role of this Committee was to be assured that there was a process in place to identify, mitigate and manage risk effectively.

David Sharif appreciated that the Risk & Compliance Group had worked well with ensuring the Care Groups were rightly involved in this work but had noted a slight drop was recorded and wondered whether this was due to the new reporting system. Michela Littlewood responded that it was related to the timing of meetings versus when the report was run and because of the training position.

David Sulch noted that there was a high number of risks relating to vascular surgery and questioned whether this service should be reviewed by the Committee. Dr Kate Wood responded that the team were indeed vocal about the challenges they were facing and used the Risk Register appropriately. She pointed out that across the country, most of the vascular units had a hybrid theatre and indeed this organisation had one but without the staff to run it. She suggested a conversation with Matt Powls on picking this up within the Performance & Accountability (P&A) reviews, as a lot of the issues were operational and should be dealt with accordingly.

Murray MacDonald agreed with Dr Kate Wood, in that some of the risks came under the Care Groups and they needed to know how to deal with those risks. Some needed higher intervention and there was a need to see which ones needed

some strategic support within the Risk Register, along with clarity on the risks that would be sorted purely by clinical leadership.

It was agreed that the vascular service would be reviewed within the PSLG meeting and an action added to their action tracker to update the Committee at a future point.

ACTION: Vascular service to be reviewed by the PSLG and an update provided to this Committee

David Sulch asked on the latest position on mechanical thrombectomy, as he recalled some time ago that the Chief Executive had confirmed the matter was in hand, and had therefore dropped off the Risk Register, but now it had reappeared in September. Dr Kate Wood replied that there had been challenges with the funding flows from NHSE, where the original stance was that funding would come through to the organisation to support a 24/7 service, but now the organisation had been advised there was no funding. The organisation now had appropriate radiologists and posts could be appointed to but only to extend the service, and not 24/7, but with no accompanying increase in stroke physicians. This position had been acknowledged by the national team for this organisation as well as all regional centres and a meeting was due to be held with the national team as to how a 24/7 regional service would be managed.

Assurance was agreed as reasonable, aspiring to be significant on effective management of risk.

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

There were no external or internal audit report & recommendations to note.

3.4 **Review of Relevant External Report, Recommendations & Assurances**

There were no external reports, recommendations or assurances to note.

3.5 **Never Events/Emerging Concerns**

Richard Dickinson updated colleagues on the current position relating to the Never Events workstream, and the team were starting to engage with staff by way of specific roadshows and presentations during audit sessions. Dr Pete Sedman had circulated a summary to the Chiefs of Service to share amongst their teams to promote ownership and learning. Work was underway to align the policy, and it was becoming clear that the culture of reporting was changing.

Amanda Stanford recognised that the safety culture still needed to improve; checks should be normal practice, with no reason for doubt. External support was required to enable the change and ensure capability and capacity was available. Staff needed to be skilled to promote that change. She was of the view that there was insufficient engagement with families around patient safety and this also needed to be included within the improvement plan.

Dr Kate Wood added that this should be a multi-professional response and ownership and if this was managed effectively, Never Events would no longer occur,

providing a strong foundation on which to build improvement in safety across the Group.

Sue Liburd asked how immediate the response meetings were, who they were led by and whether they were well received. Richard Dickinson explained the process that following an investigation, and if appropriate, they usually took place within a week of the incident and should be led by the site medical director or Dr Pete Sedman. Because the staff were directly involved, there were often elements of distress, and the aim was to be supportive of them and use it as a learning exercise rather than an opportunity for blame. There was evidence of some positive engagement with staff and patients.

Murray MacDonald gave feedback from the mid-year review with NHSE that he had attended, where it was recognised that Never Events was an organisational issue and an indicator as to how well the organisation was performing and of harm to patients.

The meeting was paused due to a fire alarm and re-convened at 10.13am, when Nicky Foster also joined the meeting

Murray was concerned about the timing of the engagement sessions considering this was such a high-profile topic and Richard Dickinson accepted this point.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

The running order of the meeting was changed to enable David Welburn and Kelly Northcott-Orr to present Item 4.2

Quality & Safety

4.2 **Quality Priorities –**

- **Mental Capacity**

David Welburn introduced himself and invited Kelly Northcott-Orr to share a short overview with the Committee. The aim was to empower Care Groups to implement the improvements needed to enhance the care and protect patients in line with the Mental Capacity Act. A task and finish group had been set up, and check and challenge meetings were ongoing to help support this improvement work and highlight any challenges. The main change was the digitisation of the mental capacity assessment, best interests and DoLS forms and these had been built into the Lorenzo system on the North bank, and a pilot was underway. The South bank was already digitalised. A Business Intelligence dashboard was being developed to track activity and timeliness with a full rollout planned for November 2025, accompanied by a Comms campaign to encourage staff to move over from paper to digital. Feedback so far was positive. It was envisaged that this would assist the MCA leads in terms of assurance levels as it had been limited in the past due to being a manual process. A review of the new process was planned for review in January 2026.

The benefits of e-learning were recognised as it could be accessed 24/7 and compliance was currently 85% but there was a gap between applying the theory to practice. Following the use of confidence surveys, it was clear this was not sufficient, and workshops were planned to assist staff in improving this, however

staff resource was limited across the organisation. To overcome this, some Train the Trainer sessions were being put together where the MCA leads would work with ward/department leaders to train them, and this then be filtered down to the staff. However, it was acknowledged that staff struggled to be released from their duties to be able to complete the training and this had been escalated by Dr Nick Cross, Medical Director (South) to the Care Groups.

Amanda Stanford accepted this was an important piece of work, but it was necessary to understand what mental capacity and deprivation of liberty meant, and this would need full support across Care Groups. There was also a regulatory risk as the organisation was monitored on this.

Sue Liburd thanked David and Kelly for a comprehensive report and presentation. She asked them to clarify what leadership support specifically was required and David responded that the gap was in medical leadership.

Julie Beilby also thanked them for the quality of the report and presentation and was pleased to note the improvements in the completion of RESPECT forms and the digitisation and sharing of referrals. This was very important in terms of service quality.

Kelly Northcott-Orr thanked the Committee for the positive comments and highlighted that the team were passionate about this work, but there was a sense from the feedback received so far that staff were concerned that they would do something wrong and it be a risk to their accreditation. She hoped that through the workshops and the Train the Trainer sessions, their confidence would increase, and accountability would be rightly shared across the organisation.

David Sulch agreed with Amanda Stanford that the digital process would help but staff did need to know the basics and Kelly replied that the digitised form was the same as the paper version and safeguards had been included to support staff. Feedback from local authorities was also positive.

David Sulch questioned how effective the training was, and David Welburn responded that the training was required every three years. It was apparent that face to face training and via MS Teams was preferable to e-learning in terms of staff engagement.

Assurance was noted as reasonable.

Murray MacDonald left the meeting

4.3 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)

Nicky Foster highlighted the ongoing risks due to the workforce business case not being approved at the last Board meeting, which would impact compliance, patient safety and service user experience. Staffing challenges, particularly in recruitment and community caseloads, mainly on the North bank, remained significant. The induction of labour process was under review with a task and finish group in operation. There were ongoing maintenance and capacity issues in NICU, particularly in Hull. Positive feedback had been received following the recent events for perinatal mental health. A new risk in the variable uptake of steroids

across the Trust had been identified and a Quality Improvement project beginning. Nicky was pleased to advise that the new training support clerk had been appointed for HUTH.

Amanda Stanford added that along with the staffing concerns, high DNA rates amongst vulnerable patients were being seen in Hull and considered that a deep dive on maternity red flags was initiated, including delays between admission and induction, with the aim to assure the Committee at a future point.

ACTION: A deep dive to be undertaken on Maternity red flags and the outcome to be presented to the CiC at a future point

Tony Curry left the meeting

Dr Kate Wood asked what the next steps were for the approval of the workforce business case and Amanda clarified that the business case was scheduled to come back to Board for approval in November 2025. Dr Kate Wood asked to see the paper before it was submitted.

ACTION: Dr Kate Wood to be sighted of the business case paper before submission to Board

Sue Liburd shared that herself and David Sulch, on the last maternity walkaround, became aware that staffing numbers were being met but the skill mix was proving to be an issue. Nicky Foster agreed that there were many Band 5 midwives, and there was actually a strong support package in place for them to be able to move to a Band 6. Amanda Stanford added that an interim solution may be possible for some more external staff support. This was indeed a risk nationally and staff needed to feel able to speak up. Nicky Foster added that she was working closely with local universities in speaking with students on the importance of speaking up and building confidence that this would be supported by service leads.

Sue Liburd also asked for the latest position on the concerns raised by internationally educated midwives and was pleased to hear that this was now resolved on both sides.

David Sharif referred to the table relating to the progress and achievements on MIS and asked for clarification on why an action was coded as amber if the action was sufficient. Amanda Stanford confirmed that these actions were on track, and David asked if an explanation to the coding could be provided for future updates.

Sue Liburd also pointed out that the report did not have a front cover and Amanda Stanford agreed to pick this up.

Assurance was noted as reasonable as the plan was to present again at Board.

There was a break at 11.10am for 10 mins

The meeting reverted to Item 4.1

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

Richard Dickinson outlined the report, noting a continued reduction in the mortality index for HUTH and a sustained position for NLaG. All NLaG patient safety alerts were up to date and complete. Ongoing challenges were highlighted, especially in response times for complaints and infection control processes. In relation to Duty of Candour, the incident reports were now embedded into Ulysses, which provided a more reliable method of capturing it.

Amanda Stanford emphasised there was still a lot of work to do in reducing complaints, and the response times, whilst improving, were still high. It was evident that communication continued to be an issue across the organisation, and if this was managed better, would surely result in a decrease in the number of complaints received. This included how to better manage engagement with families. Triangulation with the incident reporting was now much better.

Michela Littlewood stressed that there had been challenges within PALS in terms of IT provision for shared learning and a need to release operational people so that face-to-face improvement work could commence.

Amand Stanford added that there had been nine severe harms which were to be followed up in the PSLG.

Dr Kate Wood drew attention to the fact that NLaG had been in the expected SHMI range for several years and HUTH had been in the expected range since the mortality improvement programme had been put into place. She noted that there is continued need for focus which would be covered within the next deep dive on the Deteriorating Patient & Sepsis in September 2026.

David Sulch referred to the colour-coded alert flags within the report and asked that the team relook at this to avoid confusion in terms of positive and negative performance and trajectory, as currently this was misleading.

ACTION: Richard Dickinson's team to re-look at the IPR colour-coded flag alerts

Tony Curry rejoined the meeting at 11.40am

David Sulch asked if the issue of CPE acquisitions causing moderate harm had been resolved and Michela Littlewood responded that this had been raised in the PSLG as an action because the Care Groups could not manage it and was for the IPC team to manage.

Dr Kate Wood asked if there was an improvement trajectory for Duty of Candour and Richard Dickinson replied that there was and significant improvements were expected over the next few months with the use of Ulysses, which was encouraging.

Wendy Millard joined the meeting at 11.42am

The running order was amended to enable discussion of Item 4.5 and then Item 4.4

4.5

Infection, Prevention & Control update

Amanda Stanford acknowledged the large amount of work that Wendy Millard and her team were doing in reducing the rates of CPE and in ensuring that the team had the right skills and qualifications to manage this work.

Wendy Millard shared a presentation on the update relating to CPE cases on both sites and most cases were colonisations identified through increased screening with few clinical infections. Admission screening had improved early identification and isolation, reducing bay closures and bed losses. There were improvements in deep cleaning schedules and mattress decontamination processes were under review. The IPC team had been restructured with the nurses now aligned to Care Groups for improvement engagement. Two practice development matrons had been appointed, and staff education was ongoing.

Matt Powls rejoined the meeting

Wendy was pleased to update that the AMS rounds had been introduced on the South bank, but there was a need for more resource, including nursing posts and a business case had been created to support the team.

There had been some focussed work with ED to address compliance gaps in CQC inspection and working towards IPC being embedded as part of direct patient care and overall, with declining infection rates, the team was planning a transition back to standard processes but being mindful of the upcoming winter period.

An assurance level was not considered appropriate for this item.

Wendy Millard left the meeting at 11.56am

4.4 **EQIA**

Dr Kate Wood was temporarily unavailable at this point, therefore Amanda Stanford presented the item

Amanda Stanford updated that this was still a developing process, with a policy in place but needing further improvement and a wider application. It was understood that there was inconsistency in how risks were assessed across Care Groups and there was a need to strengthen the process to consider impacts overall, not just in isolation. There appeared to be some reluctance among staff to complete the EQIAs and the Project Management Office frequently had to chase completion. It was being considered whether to include EQIA training into the risk management sessions or have bespoke workshops. Amanda added that with the arrival of Matt Powls, now was a pertinent time to refresh Comms across the Group and review the process in general. It needed digitising, the skill set needed improving and looking at how it was managed across Care Groups.

Amanda Stanford referred to three that were deemed high risk; NLaG endoscopy productivity and considered that the process relating to the closure of 130 West and the decision to work with the ICB and community partners around reducing the number of patients who should not be in hospital, and she considered that the risk needed to be higher than a nine. The visitors' carpark was not considered to be appropriate at sixteen.

David Sharif asked if the closure of 130 West would be appropriate for a Lessons Learned piece and Amanda responded that it would indeed be beneficial to relook at how the EQIA had been completed.

Dr Kate Wood rejoined the meeting at 12.05pm

Dr Kate Wood agreed there was a need for a review of the EQIA and it should have been included within the paper that she had asked for a three or six month review. She updated that a review of the EQIA around the closure of 130 West had been completed and it appeared that some of the mitigating actions had not been put in place as originally advised, and this had been escalated.

Julie Beilby was pleased to see that the process was being developed but referred to Amanda Stanford's earlier point about the car parking charges and could not understand how this risk was deemed higher than others that seemed more appropriate. Dr Kate Wood explained that the equality was applicable because this had impacted on many people.

David Sulch pointed out that the Committee had not seen any EQIAs for a good while and was not aware that Audit Yorkshire had undertaken a review which showed that the organisation was not complying with its EQIA requirements. Dr Kate Wood agreed with this observation and updated that she understood this matter had been discussed at the Audit, Risk & Governance Committees-in-Common.

ACTION: The Committee to consider how to improve links of communication between other CiCs to ensure issues are escalated and addressed

David also considered that the EQIA process perhaps needed some focus, considering the discussion around the visitors' car park.

Assurance on the EQIA process was noted as limited.

Dr Kate Wood left the meeting at 12.14pm

The meeting resumed normal running order

Clinical Effectiveness

4.6 Clinical Effectiveness Report (including clinical audit, NICE compliance & deviations, PROMS etc)

Richard Dickinson reported ongoing backlogs in clinical audit and NICE guidance compliance, with overdue items across Care Groups. There was a clear need for an improvement plan with clear trajectories to address the backlogs. A clinical effectiveness group met frequently but the engagement from Care Groups was still inconsistent, and Richard Dickinson suggested that clinical effectiveness could become part of the performance reviews. A reduction in the ratings was assumed to be because of using the SNAP scoring matrix rather than a reflection of service quality.

Amanda Stanford was of the view that an improvement plan needed to be presented to the Committee for assurance showing the improvement trajectory and which clearly showed the processes in place.

Assurance was noted as limited.

David Sharif asked for the clarity on what action would be needed to improve this rating and David Sulch responded that the Committee would need to see evidence of an improvement plan on performance with target dates. Matt Powls added that the structure of the performance meeting could be revisited to enable discussions around this.

ACTION: Matt Powls to look at the structure of the Care Group performance meetings to encompass clinical effectiveness

ACTION: An improvement plan to be brought to a future meeting

5. HIGHLIGHT REPORTS

5.1 Patient Safety and Learning Group

5.2 Patient Experience Group

5.3 Maternity and Neonatal Assurance Group

5.4 Risk and Compliance

These were all noted.

David Sharif referred to the External Agency Visits in that the organisation's position on this was causing some concern and it may need the Care Groups to accept some accountability. Michela Littlewood added that there was some work underway to look at the large number of actions, close them where appropriate or add them to the risk register.

6. ITEMS FOR INFORMATION

6.1 Draft workplan – discussed at a meeting on 24 October 2025 and to be redrafted and reviewed at the November time out session

Rebecca Thompson shared that she would work with Jo Palmer in redrafting the document in readiness for presentation at the time out session.

7. ANY OTHER BUSINESS

7.1 Any Other Urgent Business

Amanda Stanford advised that the CQC ED inspection draft report had been received earlier than expected, which indicated that the four areas of 'inadequacy' had moved up to 'requiring improvement'. This was being addressed, and the draft was due for return to CQC on 3 November 2025. The formal report would be presented to the Committee at a future date.

ACTION: Final CQC ED inspection report to be presented to the Committee at a future date once available

8. MATTERS TO BE REFERRED BY THE COMMITTEES

8.1 Matters to be referred to other Board Committees

There were no matters referred.

8.2 Matters to be escalated to the Trust Boards including any proposed changes to the BAFs

- ED risks being triangulated with the complaints and incidents at the PSLG but any harms to be escalated to this Committee
- Ulysses incident reporting system is now harmonised across the Group
- The CiC had received assurance that a robust system is in place and that oversight of the mitigations and management of the risks was still required
- All Chiefs of Service now have sight of the list of Never Events in order to encourage organisational ownership
- The CiC was advised that the Group currently has 350 open complaints and were advised of plans to address these
- CPE screening was taking place on admission
- The CiC had positive assurance around the SHMI at NLaG being at a stable position with improvement at HUTH
- Improved process with Mental Capacity by way of digitalised forms, but clinical engagement and leadership support still needed to ensure legal compliance
- Assurance on EQIA was limited
- Assurance on Clinical Effectiveness was limited and the CiC had requested an improvement plan
- Maternity & Neonatal workforce business cases not being approved at Board were posing a risk to MIS Y7 and the lifting of the Section 31 notice, but were to be represented to the Board on 13 November 2025
- The CiC noted the improving trajectory on CPE

David Sulch thanked Amanda Stanford for her hard work since joining the Group and for her invaluable contribution to the work of the Committee and wished her well in her secondment to the ICB.

9. DATE OF THE NEXT MEETING

The next meeting of the Quality & Safety Committees-in-Common will be a time out session on Thursday 27 November 2025, at 9.00am-2.00pm, in the Conference Room at Goole & District Hospital

The Chair closed the meeting at 12.28pm.

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

Name	Title	2025 / 2026											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y		Y	Y					
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y		Y	Y					
Tony Curry	Non-Executive Director (HUTH)	N	Y	Y	Y		Y	Y					
Julie Beilby	Non-Executive Director (NLaG)	N	Y	Y	Y		Y	Y					
Dr Kate Wood	Group Chief Medical Officer	Y	D	Y	Y		D	Y					
Amanda Stanford	Group Chief Nurse	D					Y	Y					
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	Y	Y	Y		D	Y					
Rebecca Crashley	Group Deputy Director of Assurance	Y	Y	Y	Y		Y	Y					
Yvonne McGrath	Group Director of Midwifery	N	N	Y	Y		Y	D					
Matt Powls	Interim Group Chief Delivery Officer							Y					
Michela Littlewood	Associate Director of Quality Governance (HUTH)	Y	Y	Y	Y		N	Y					
Richard Dickinson	Associate Director of Quality Governance (NLaG)	Y	Y	Y	Y		Y	Y					
Kevin Allen	Governor Observor	N	D	Y	Y		Y	D					
OTHER BOARD ATTENDEES													
Murray MacDonald	Interim Group Chairman	N	N	Y	N		N	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)019

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 February 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Results of Audit, Risk and Governance Committees-in-Common Annual Self-Assessment Exercise 2026**
Executive Summary	The annual self-assessment exercise has been conducted by the Audit, Risk and Governance Committees-in-Common (ARG CiC). The combined self-assessment document from January 2025 was reviewed initially by Sally Stevenson and updated accordingly, using the updated 2024 HFMA NHS Audit Committee Handbook checklist at that time, which included eight new questions. As with previous years, the updated document for 2026 was circulated via email to the following for initial review and comment as appropriate: • Simon Parkes – NED / ARG CiC Chair (NLAG) • Jane Hawkard – NED / ARG CiC Chair (HUTH) • Tony Curry – NED / ARG CiC Member (HUTH) • Helen Wright – NED / ARG CiC Member (HUTH) • Gill Ponder – NED / ARG CiC Member (NLAG) • Julie Beilby – NED / ARG CiC Member (NLAG) • Emma Sayner – Group Chief Financial Officer (from Dec24) • David Sharif – Group Director of Assurance • Brian Clerkin / Helen Dodds – SumerNI (NLAG External Audit) • James Collins / Louise Stables – Forvis Mazars (HUTH External Audit) • Neil Thomas / Harriet Fisher / Louise Kay – KPMG (Group Internal Auditor) A number of comments were subsequently received and incorporated into the attached document. The ARG CiC considered the need for some additional actions in relation to the agreement of management actions arising from Internal Audit reviews and those agreed actions subsequently going overdue, and these are set out in the response to question 4.5 **The Trust Boards-in-Common are asked to note the results of the latest self-assessment exercise performed by the Audit, Risk and Governance Committees-in-Common in January 2026.**
Background Information and/or Supporting Document(s) (if applicable)	Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024) – self-assessment checklist template.

Prior Approval Process	Audit, Risk and Governance Committees-in-Common – 22 January 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

Audit, Risk and Governance Committees-in-Common

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook (2024) - 22 January 2026

Area/ Question	Yes	No	Comments/Action
1. Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?	√		New Membership and Terms of Reference (ToR) produced for the introduction of Committees-in-Common (CiC) in January 2024, signed off by the Trust Boards-in-Common in December 2023. Minor revisions made to the Audit, Risk and Governance Committees-in-Common (ARG CiC) ToR during 2024 (to reflect new HFMA NHS Audit Committee Handbook (2024) and general CiC ToR changes), approved by the Trust Boards-in-Common in August 2024. Last minor revisions made in January 2025, approved by the Boards-in-Common in February 2025. Due to be considered at the January 2026 ARG CiC meeting as part of this self-assessment exercise.
1.2 Are the terms of reference reviewed annually?	√		Part of the ARG CiC's annual work plan, and also adjusted as necessary in the intervening period. See above details also.
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The ARG CiC's ToR specifically refers to how it integrates with other Board sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the ARG CiC, and identifying any issues that the ARG CiC feel further assurance is required on. Additionally, there is formal ARG CiC member representation on each of the Board sub-committees. Each CiC also has a standing agenda item to refer matters to Board / CiC's enabling each CiC to formally record their risk referral across the Group's governance.
1.4 Are committee members independent of the management team?	√		The ARG CiC membership comprises three Non-Executive Directors from each Trust, six in total.
1.5 Does at least one committee member have a financial background?	√		Yes, more than one.
1.6 Are all executive officers that you would expect to attend present at meetings?	√		Yes, Group Chief Financial Officer and Group Director of Assurance are in attendance at each meeting. Other executive officers attend as required. Attendance schedule produced and accompanies each set of minutes. Annual

Area/ Question	Yes	No	Comments/Action
			attendance schedule produced for the Trust's Annual Reports. ToR include Group CEO and Group Chairman invited to attend as required / requested by the ARG CiC and attend at least once a year for the annual accounts and reports review meeting.
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to the Trust Boards-in-Common. The Chairs of ARG CiC present a highlight report at Trust Boards-in-Common (as do all other sub-committee Chairs). Highlight reports also submitted to the NLAG Council of Governors for oversight and scrutiny.
1.8 Does the committee prepare an annual report on its work and performance for the governing body?	√		ARG CiC Annual Report submitted to the Trust Boards-in-Common, and Council of Governors (NLAG only), for information.
1.9 Has the committee established a plan of matters to be dealt with across the year?	√		New ARG CiC workplan developed for the introduction of Committees-in-Common in January 2024 by conducting a review of the two Trust's existing Audit Committee workplans with relevant Executive and Non-Executive Officers and arriving at a combined one aligned with its ToR. Signed off by the Board in December 2023. Adjustments made in line with revisions to ToR. Subject to annual review and adjustment as necessary in the intervening period. Workplan submitted to each meeting of the ARG CiC for information. To be reviewed as part of the self-assessment exercise at the January 2026 ARG CiC meeting.
1.10 Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ARG CiC ToR – five clear working days prior to each meeting (effective from June 2024 – previously seven calendar days before).
1.11 Has the committee been quorate for each meeting this year?	√		Five scheduled ARG CiC meetings during 2025 (Jan / Apr / Jun (audited accounts / reports only) / Jul / Nov) and all were quorate.
1.12 Is there a succession plan in place for the chair of the audit committee?	√		Normal recruitment process for Non-Executive Directors and part of appraisal process with Group Chair. With the benefit of the CiC approach, the ARG CiC has two Chairs present at each meeting. There are also two nominated vice chairs in place. The Group has good responses to all NED vacancies. Through having two members of the ARG Committee at each Trust with financial backgrounds gives assurance regarding succession planning. As we increasingly work as a Group structure for the HHP we will work with the Trust Boards-in-Common and the NLAG Governors to agree a sustainable

Area/ Question	Yes	No	Comments/Action
			group model for membership of the ARG CiC including succession planning.
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?	√		The Group Chief Executive and Group Chief Financial Officer bring routine updates to the Boards-in-Common on ICS developments and risks. The Partnerships Strategy was approved by the Boards-in-Common in December 2025 and regular updates on partnership arrangements will be presented at the Boards-in-Common by the Group Chief Strategy, Partnerships and Digital Officer. The Strategic Programmes and Partnerships Committees-in-Common is responsible for assurance on partnership arrangements and reports into the Boards-in-Common.
2. Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?	√		April, July and November 2025 ARG CiC meetings. Included in each Internal Audit plan and reported to the ARG CiC. Low assurance was received in 2024/25 and action plans agreed which are being monitored by the ARG CiC. The issues are regularly reported to the Boards-in-Common, as concerns on lack of progress persists with regards to the risk register. The ARG CiC will continue to have a focus on this area to ensure improvements are made. At the Boards-in-Common meeting in December 2025 the Interim Group CEO agreed for further independent work to be undertaken on risks and in November 2025 the Boards-in-Common received a report on risks from The Value Circle. The ARG CiC considered any further action required to improve implementation of Internal Audit actions, including those around risk management. Please refer to Question 4.5 for further details.
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through Internal Audit annual review at each Trust. The ARG CiC received the Annual Review of the Adequacy and Effectiveness of the System for Devising and Monitoring the Board Assurance Framework (BAF) at its July 2025 meeting. The ARG CiC also receives a routine report on the Group BAF and Risk Register at each meeting (excluding the accounts only meeting) since October 2024. The BAF has been highlighted as an area of concern at the ARG CiC meetings, as progress to reduce risk to tolerable levels has been slow. The BAF recommendations were made and actions are being monitored at each ARG CiC.
2.3 Does the committee receive and review the evidence required to	√		The Quality and Safety CiC has responsibility for monitoring compliance with CQC requirements and

Area/ Question	Yes	No	Comments/Action
demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			action plans. The ARG CiC receives updates through minutes from Board sub-committees. The 2025/26 Internal Audit Plan includes a review of the processes to undertake and close CQC recommended actions. Due to be received at the ARG CiC meeting in January 2026 which includes a number of recommendations which will be required to be implemented. Completion of actions will be monitored by the Internal Auditors and routinely reported to ARG CiC meetings.
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?	√		The ARG CiC endorses the Annual Governance Statement (AGS) for each Trust before they are presented to the Trust Boards-in-Common each year. ARG CiC minutes will evidence this.
2.5 Has the committee reviewed key data against the data quality dimensions?	√		The Committee receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan. The Committee also receives updates in quality dimensions through receipt of the Highlight Reports from the Quality and Safety CiC and Workforce, Education and Culture CiC.
3. Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Accounts. The ARG CiC received the draft accounts for both Trusts in April 2025 for review prior to submission to the External Auditor and NHSE, and ARG CiC minutes will evidence this. The ARG CiC also received the audited accounts and annual reports for review and approval in June 2025, under formal delegated authority from the Trust Boards-in-Common. Trust Boards-in-Common and ARG CiC minutes will evidence this.
Does the committee specifically review: • changes in accounting policies • changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit	√		Facilitated as necessary through reports from Finance / External Auditor for each Trust and discussion at ARG CiC meetings. All items mentioned are reviewed by the Committee as part of the review of the annual accounts process, which are minuted.

Area/ Question	Yes	No	Comments/Action
• explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Part of the Annual Accounts meeting discussions at the ARG CiC meetings (June 2025 for both NLAG and HUTH) prior to submission to NHSE.
3.4 Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. The Audit Completion Report from the External Auditor for each Trust includes explanations for any areas of non-adjustment as appropriate.
4. Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit (IA) Charter included as an appendix to the annual internal audit plan presented to the ARG CiC in April each year. The new Group Internal Audit service provider (KPMG) included the charter with its draft plan submitted to the June 2025 ARG CiC meeting.
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual IA plans are normally approved at the beginning of each financial year. Any changes to the IA plan are documented and approved through IA progress reports to each ARG CiC meeting as necessary. A new Group Internal Audit service commenced on 1.4.25 with KPMG. A long list of items for the 2025/26 Internal Audit plan was received by the April 2025 ARG CiC meeting and the draft plan was received at the June 2025 ARG CiC meeting for approval. The 2026/27 Internal Audit plan is currently being discussed with Group Executive Officers and compiled for review and approval by the ARG CiC in due course.
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		2025/26 Group IA plan derived from discussions with Group Executive Officers, and further discussion at the Group Cabinet Risk and Assurance Committee (GRAC) on 7.4.25. Approved through the ARG CiC as stated above. Additionally, the ARG CiC may from time to time suggest items of concern for consideration of inclusion in the annual IA plan.
4.4 Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting – Group IA Progress Report produced. ARG CiC NEDs also receive the final version of all Internal Audit reports as they are received by the Group. Reports are discussed at each meeting of the ARG CiC as necessary and referred on to other CiC's as appropriate. All reports are also submitted

Area/ Question	Yes	No	Comments/Action
			to the monthly GRAC meetings, chaired by the Group CEO.
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting, as part of the routine report from the Group Internal Auditor. In 2025 the ARG CiC requested that any second request to alter the implementation date of agreed actions should be reported to the ARG CiC for approval. The ARG CiC has noted that a number of actions have not been completed by the agreed date and have asked for remedial recovery plans to be presented to the ARG CiC. This has particularly been the case in terms of DSPT recommended actions and has lead to a higher level of scrutiny at the ARG CiC in year, which continues. The ARG CiC considered any further action required to improve implementation of Internal Audit actions. It was agreed that KPMG would continue to follow-up routinely each month with action owners and they would also be more robust in their closing meetings when agreeing actions and associated timescales for implementation. Also, once the Internal Audit plan is agreed for 2026/27, all Director leads will be advised of expectations in relation to agreeing management actions arising from audits. In addition, a piece of work will be undertaken by the Group before 28.2.26 to review all overdue recommendations and determine, with those responsible for the actions, as to whether they still considered each of the overdue actions appropriate, necessary and important to the performance of the Group. Additionally, all those requesting extensions to agreed implementation dates will be written to by the Assistant Director of Finance – Compliance and Counter Fraud on behalf of the ARG CiC, and asked to justify their request for an extension. Further extension requests for the same action(s) would require the responsible Director Lead to attend the ARG CiC to discuss the need for a further extension.
4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARG CiC ToR.
4.7 Does the committee hold It periodic private discussions with the internal auditors?	√		Once a year or at any other meeting if requested in advance by the auditors. Most recently undertaken in June 2025.
4.8 Does the committee assess the performance of internal audit?	√		Each KPMG report provides a QR code for Group staff involved in the audit to provide feedback on their experience. A summary of the outcome of post-audit questionnaires, including the scores

Area/ Question	Yes	No	Comments/Action
			obtained and any significant feedback if there are negative scores, is included in the annual report. No formal internal review mechanism for consideration by the ARG CiC previously (similar to the one for External Audit) – but to be undertaken going forward. Not performed in 2025 due to the appointment of a new Group Internal Audit service provider (KPMG) from April 2025.
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Issues regarding this could be raised at the annual private meeting (most recently in June 2025) between the auditors and the ARG CiC members, or by calling an ad-hoc private meeting at any time or during ARG CiC meetings if such an issue arose. IA also meet with the ARG CiC Chairs prior to each meeting and this provides a further opportunity to raise any issues should it be required.
4.10 Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*? *(Note: this should now read….complies with the Global Internal Audit Standards (GIAS) and the Public Sector Application Note)*	√		KPMG's work is undertaken in line with their Internal Audit manual which ensures that all work is conducted in line with IA standards, quality review requirements and other internal KPMG requirements. KPMG's Internal Audit Manual is externally reviewed every five years are required by Global Internal Audit Standards. The last review was completed in December 2025 and the highest rating ('generally conforms') was achieved as part of this review.
4.11 Does the committee receive and review the head of internal audit's annual opinion? *(Note: this should now read..annual conclusion not annual opinion…as a result of the new GIAS)*	√		ARG CiC minutes will evidence this for each Trust.
5. External audit			
5.1 Are appropriate external audit procurement arrangements in place?	√		Yes, evaluation panel established as necessary. NLAG procurement process involves Council of Governors (CoG) representatives and CoG approval is required as a NHS Foundation Trust.
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARG CiC minutes will evidence this for each Trust.
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARG CiC minutes will evidence this for each Trust. The Audit Completion Report from each External Auditor covers the requirements of ISA 260.

Area/ Question	Yes	No	Comments/Action
5.4 Does the committee review the external auditor's value for money conclusion?	√		ARG CiC minutes will evidence this for each Trust.
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARG CiC ToR.
5.6 Does the committee hold periodic private discussions with the external auditors?	√		Once a year or at any other meeting if requested in advance by the auditors. Most recently undertaken in June 2025.
5.7 Does the committee assess the performance of external audit?	√		Formalised approach with a paper to the ARG CiC providing a formal annual evaluation of External Audit performance for each Trust. Last undertaken in November 2025. Issues in the intervening period would be addressed as necessary.
5.8 Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit planning / fee documentation from each Trust's External Auditor.
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work was in place for each Trust and subject to annual review up to January 2025. In January 2025 the two existing policies were combined into one Group policy and approved by the January 2025 ARG CiC meeting. HUTH's policy was already based on the NLAG policy, so the Group document simply required some minor adjustments to ensure clarify around reporting to the Council of Governors at NLAG. Next scheduled review at January 2026 meeting. Details of non-audit work included in the annual ISA260 report from each Trust's External Auditor. Value of non-audit work also identified separately in the annual accounts for each Trust.
6. Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality & Safety Committees-in-Common (Q&S CiC) are responsible for monitoring delivery of clinical audit activity. Q&S CiC Highlight reports and action logs received by the ARG CiC.
7. Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Group counter fraud work plan agreed by the Local Counter Fraud Specialist (LCFS) with Group Chief Financial Officer and received by the ARG CiC for review in April 2025.

Area/ Question	Yes	No	Comments/Action
7.2 Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Group counter fraud work plan informed by register of fraud risks, internal audit, Cabinet Office's National Fraud Initiative (NFI), NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA / Cabinet Office.
7.3 Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written Group counter fraud progress reports from the LCFS at each ARG CiC meeting. Group LCFS in attendance at each meeting, although in 2025 the LCFS retired and therefore progress reports were produced by the Assistant Director of Finance – Compliance and Counter Fraud whilst a new Group LCFS was recruited.
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		Any actions included in the LCFS progress update received at each ARG CiC meeting. ARG CiC minutes will evidence this where appropriate.
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ARG CiC ToR in relation to the LCFS.
7.6 Does the committee receive and review an annual report on counter fraud activity?	√		Yes, ARG CiC minutes will evidence this.
7.8 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG CiC minutes will evidence this where appropriate.

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)020

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th February 2026
Director Lead	Gill Ponder, Non-Executive Director (NLaG) / Chair of Performance, Estates and Finance Committees-in-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Tuesday 02nd December 2025 and Tuesday 06th January 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	Performance, Estates and Finance Committees-in-Common on 06th January and 03rd February 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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PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 2nd December 2025 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) – Chair
Helen Wright	Non-Executive Director (HUTH)
Matt Powls	Interim Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Dr Kate Wood	Group Chief Medical Officer
Jane Hawkard	Non-Executive Director (HUTH)
Simon Parkes	Non-Executive Director (NLaG)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Ivan McConnell	Group Director of Transformation
Philippa Russell	Deputy Group Chief Finance Officer
Adam Creeggan	Group Director of Performance
Tom Myers	Group Director of Estates
Jenn Orton	Operations Director for Theatres, Anaesthetics and Critical Care (item 3.2)
Catherine Sowerby	Senior General Manager for Patient Services (item 4.3)

Observers

Ian Reekie	Lead Public Governor (NLaG)
Julie Beilby	Non-Executive Director (NLaG)
Jackie Bene	The Value Circle

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. No apologies for absence were received.

1.2 Staff Charter and Values

Gill Ponder noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 04 November 2025 and Private Minutes from 04 November 2025

The minutes of the meeting held on 04 November 2025 and private minutes from 04 November 2025 were accepted as a true and accurate record.

1.5 Matters Arising

No items were raised.

1.6 Committee Effectiveness Outcome

David Sharif took the report as read and reminded the Committees-in-Common that the effectiveness review highlighted areas that required focus to provide greater effectiveness to the Committee. Recommendations included performance trajectories, greater involvement from Care Group Directors, and a better understanding around how the Group inject the health and inequalities agenda within this meeting.

Gill Ponder acknowledged that Care Group representation was starting to take place however, it was not feasible for all 14 Care Groups to attend each meeting.

Dr Kate Wood suggested that the CiC utilise every opportunity for Care Groups to attend this CiC to discuss their areas and proposed that Chiefs of Service and Care Group Directors should be provided the opportunity to attend.

Helen Wright proposed that any actions captured from the effectiveness outcome were captured in the action tracker and the CiC would continue to review them. She noted that several Care Groups were not performing in-line with expectations around cost improvement plans (CIPs) and run rates and proposed that in the first instance, work should take place with the underperforming Care Groups to observe their recovery plans.

Simon Parkes raised concerns around inviting underperforming Care Groups to this CiC and possibly undermining line management and accountability responsibilities. He recognised that the Group were required to change their

approach to make a difference however, there were not enough recommendations in the effectiveness report to provide the next steps required to make those improvements. It was noted, however, that the effectiveness review related to the running of the Committees-in-Common and that Group performance was the responsibility of the Group Chief Delivery Officer.

Matt Powls clarified that Care Groups reported to him for operational performance, as such he would also be held accountable by the CiC.

Emma Sayner noted that further work was required regarding how to better hold Care Groups and the Group accountable.

Action: A further meeting to be organised to discuss the effectiveness outcome further and agree definite steps to take in order to respond to that feedback.

Helen Wright recognised that the Chairs had been reporting to Boards-in-Common regarding their limited assurance around financial and operational performance and recovery plans. She suggested that the next highlight report and discussion at Boards-in-Common address what changes were required.

1.7 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
1.6	Review of Action Tracker	Tom Myers to provide a further update on Anti-Ligature risks when EFD risks are presented to PEF CiC in December 2025.	An Anti-Ligature policy and procedure was in place on the South Bank, work was ongoing to implement this on the North Bank and produce a Group policy. Work was taking place with Jo Ledger to determine what was required in green rooms to improve Anti-Ligature. **Carried forward to January 2026.**
4.3	Deep Dive: Elective Care	Matt Powls to present a paper at a future meeting that would provide assurance regarding the loss of capacity within Theatres.	A paper will be presented to PEF CiC in January 2026.
4.3	Deep Dive: Elective Care	Scott Fitzgerald-Becker to pull together a one page briefing around Breast on behalf of Matt Powls, and circulate to	Karena Groom circulated this to PEF CiC members outside of the meeting.

		the PEF CiC outside of the meeting.	Action closed.
4.6.1	Contract Approval: Cleaning Harmonisation - (HUTH)	Tom Myers to bring back a subsequent Cleaning Harmonisation (HUTH) contract paper to the next meeting.	Discussed within Agenda. Action closed.

2. MATTERS REFERRED

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

Gill Ponder shared that a referral was previously made to Workforce, Education and Culture (WEC) CiC regarding 24-hour care as it was felt that attendance of vital clinical staff was not being provided. Helen Wright updated that a response was received from WEC CiC and they referred this matter back to PEF CiC. She proposed for Matt Powls to understand what effective patient experience and quality service need to look like from an operational perspective and what needs to support that in terms of workforce. She suggested that once that was determined, further work would take place with the Workforce team to determine how to make that happen and look at how to facilitate that.

Action: Matt Powls to bring a position statement briefing back to this meeting to explain what effective patient experience and quality service needs to look like from an operational perspective and what needs to support that in terms of workforce.

Action: Karena Groom to organise a meeting for Helen Wright and Matt Powls to discuss 24-hour care.

Simon Parkes queried whether a reduction in formal meetings may be more effective and a better use of time to solve these ongoing challenges.

Julie Beilby mentioned that the concerns regarding the perceived lack of availability of core staff over weekends, holiday periods and overnight was highlighted to the Boards-in-Common to facilitate a different discussion across the cultural and operational aspects of this.

Simon Parkes emphasised the importance of being mindful when escalating matters to the Boards-in-Common and raised that it was crucial for the CiC to propose alternative solutions to issues.

3. RISK & ASSURANCE

3.1 Board Assurance Framework to include Risk Register Report

David Sharif took the report as read and updated that there were no changes made to the scores. He noted the ongoing development towards articulating a risk around the population objective. The paper proposed changing the risk appetite for the patient access objective and taking a more conservative view on

the risk appetite associated with meeting that objective. David Sharif acknowledged that several risks had not been updated for some time which attributed to the changeover in the Interim Group Chief Delivery Officer role. Following a discussion that took place at Group Executive yesterday, it was determined that greater clarity was required around how to apply a rating to the controls presented in the BAF, and work was ongoing to review this which would be shared in due course. It was likely that several controls listed as reasonable would be downgraded.

Helen Wright mentioned that discussions had taken place previously around how to renew the BAF, however the paper still felt static due to lack of ownership and the updates required to reflect current situations. She reminded that the CiC wanted to see a more detailed trajectory and how to achieve tolerable scores. David Sharif recognised that this was ever-evolving work and greater granularity was still required around the resolving implementation plan which would enable greater insight in the development of the actions that would make a significant impact in the risk trajectory. Work was ongoing and this would be made a priority for the next discussions with colleagues.

Jane Hawkard asked for an update on the strategic bed review, and further clarity around the Artificial Intelligence (AI) risk. She mentioned that the Group recently invested £4.5 million to improve performance however, an update on this and detail around other updates were absent from the paper. Adam Creeggan explained that this risk referred to Luna Rova. He highlighted that it was unlikely that the current implementation target of early February 2026 for Luna Rova would be achieved due to the significant technical challenges that required resolution. Commencement of Luna Rova would require manual work to transact the opportunities within the PTL and would be trialled for one year to determine the benefits.

Gill Ponder queried the definition of the patient access risk and noted that the gap to the tolerable score was currently understated. She felt that they were two different risks; a risk regarding being away from the tolerable score in delivering services to patients that met the constitutional standards, and a longer-term aspiration to be an outstanding organisation and be upper quartile where the tolerable risk score would be higher. This felt like something further downstream rather than meeting the immediate requirement to achieve the constitutional standards for patients, where the tolerable risk was much lower.

Jenn Orton joined the meeting at 09:44 hours.

Gill Ponder proposed a discussion at Boards-in-Common regarding re-reviewing the actual risks and whether they reflected the risks as they stood today. She also wondered whether the finance risk score should increase due to the current financial challenges and anticipated difficulty in closing the gap towards the end-

of-year planned position. Philippa Russell explained that when setting the risk rating a few months ago there was a debate around the definition of catastrophic and increasing the finance risk would put the Group into a catastrophic rating.

David Sharif provided an update on the risk register report. He highlighted that the paper suggested that 83 risks were due for review which was an end of month figure however, 13 actual outstanding risks were due for review which better reflected the underlying rate at which Care Groups and Corporate Directorates were reviewing their risks.

Helen Wright shared that the positive response to risk training was encouraging. Gill Ponder wondered whether the Group were focusing training rollout on the areas of highest risks as some Care Groups had significantly higher risks.

Action: David Sharif to review whether people with the greatest need were undertaking risk training and being given that opportunity in priority order.

3.2 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

KPMG Audit: Theatres Utilisation

Jenn Orton updated the 642 process was well-embedded on the South Bank however, significant work was required on the North Bank along with Waiting List Initiatives (WLIs) and approval processes. She explained that while an approval process was in place, work was ongoing to implement a Group-wide approval process. A Standard Operating Procedure (SOP) was associated with the approval process and work was taking place with Care Groups to ensure it was aligned across all 14 Care Groups. A SOP regarding the scheduling process was formulated to ensure all Care Groups were involved which was expected to be completed by the end of December 2025. An in-depth theatre utilisation analysis was ongoing to review timing discrepancies and efforts were underway to review every session with each clinician where they felt that there might be a discrepancy with their own timing. Jenn Orton shared that this work was about managing expectations of surgeons while ensuring that the data being captured was in line with what they believed was most effective. All protocols and initiatives were being reviewed. The cancellation avoidance team (CAT) was effective on the South Bank, this was being implemented on the North Bank and would be undertaken as part of the ongoing pre-assessment work. While the pre-assessment process on the South Bank was in line with the national standards it required digitalisation, however, whilst the process was digitalised on the North Bank, it did not meet the national standards. The pre-assessment process would be reviewed and improved over Q4 to align it with national standards. Work around cost avoidance calls would take place on the North Bank which would improve cancellation-on-day and patient experience.

Jane Hawkard noted that the paper did not mention improving performance and queried when the CiC would expect to see a shift in performance. Jenn Orton shared that KPIs against each element would be implemented and every element

would be benchmarked against national standards. She expected to see a shift over the next three months and a month-on-month reduction of cancellation-on-day patients and cancelled sessions, with an increase in patients pre-assessed before TCI (To Come In).

Helen Wright queried whether it was possible to put preventative controls in place and whether the Group could automate scheduling to a standard process. Jenn Orton explained that the 642 process was a national process which worked well. This was embedded on the South Bank and work commenced on 01 December 2025 to implement this on the North Bank. Scheduling, closing down of lists, and capped utilisation for booked patients would be key to this, with the exception of cancer lists. She anticipated that the scheduling would make a difference and the Group would make it clear to Care Groups that it was not acceptable to deviate away from a nationally-driven process.

Dr Kate Wood shared that she had written to all Consultants on the North Bank to explain the 642 process and inform them that the process was implemented, and their feedback would be gained at the next clinical policy group to ensure they have an opportunity to discuss this further and take the ownership of this.

Gill Ponder queried whether the actions on the action plan were on track from an assurance perspective. Jenn Orton confirmed that the actions were on track and being delivered within the timescales.

The Committees-In-Common agreed reasonable assurance.

Jenn Orton left the meeting at 10:03 hours.

3.3 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Finance Report: Month 7

Emma Sayner updated that month 7 continued to be challenging and mentioned that the Group was now £4.8 million away from plan which was disappointing however set in the context of the ongoing quality and performance challenges the Group faced. From November 2025 the Executive team have taken further action to positively affect run rates, these actions particularly linked to the ongoing work around extra-contractual pay elements, the use of WLIs, and work was ongoing with Care Groups. She anticipated further escalated controls as the Group moved towards the end of 2025/26. Poor decisions continued to be taken around the use of resources and work was ongoing with Chiefs of Service and Care Groups to address this. A meeting took place with the Improvement Team last week to review learning that could be taken from the North-East. All requests for Agency,

overtime and the grip and control on WLI would be monitored. Grip and control and affecting the run rate was a key focus. The Group would enter into oversight with the Integrated Care Board (ICB) and the Regional Team through double and triple-lock processes which were due to start next week. The Group received notification that they would not receive Q4 deficit support funding which equated to £7 million across the Group. The impact of not receiving the £7 million revenue resource was not reflected within the numbers and if the Group did not receive the allocation, the financial risk and final year position would be adversely affected as a direct consequence. The Estates, Facilities and Development (EFD) team were working to ensure that the Group spend the remaining Capital by the end of 2025/26. There was a risk linked to a portion of the constitutional standards Capital money and procurement processes, and work would take place to ensure balance between the procurement, financial, and operational risks. Work was ongoing with Matt Powls, Scott Fitzgerald-Becker and Adam Creeggan regarding the deployment of the constitutional standards of £4.5 million and that work would be shared with the CiC in due course.

Philippa Russell updated that a £0.6 million deficit was seen in month 7 which was £1.5 million adverse variance to plan however, included £4.7 million of non-recurrent balance sheet flexibility. The underlying position did not improve significantly in-month which was a concern. An in-month improvement was seen in five Care Groups however, a significant proportion of Care Groups were still overspending. The Group delivered £53.5 million of CIP delivery year-to-date however, were £12.1 million behind plan. From a forecast perspective, the adjusted run rate suggested a £53 million deficit by-year-end, which was a slight reduction in comparison to month 6 however, the recurrent underlying position continued to deteriorate. The risk adjusted forecast of £48 million was unchanged from last month and the Group expected to seek cash support in the last part of 2025/26 unless improvement was made.

Simon Parkes queried what actions the Group would take to ensure that accountability and performance aligned and suggested that a proposal to get costs under control be presented at the Boards-in-Common.

Emma Sayner shared that work was underway to update the NHSE cost control checklist, PA consulting work and the enhanced work around the extra-contractual and variable pay controls.

Action: Emma Sayner would provide an update around this work and the ongoing impact to Boards-in-Common in December 2025 through the standing agenda item on Public Purse.

Emma Sayner explained that the Group expected guidance around the process that would need to be undertaken if the Group were unable to achieve a break-even position by year-end. This was expected to be a challenging process and involve discussions with regional and National directors. The balance sheet was being monitored monthly and discussions were ongoing with Partners regarding opportunities for mutual aid.

Helen Wright raised concerns around the Group taking an overly tactical approach regarding the underlying performance and the risk of possibly undoing the positive work which would provide recurrent benefit into 2026/27. She was eager to hear further around the plans for substantive headcount reduction. Emma Sayner advised that the Group needed to take decisions on a case-by-case basis as they moved into 2026/27 to ensure prioritisation of resources and emphasised that re-sizing services would make better use of resources.

Philippa Russell provided an update regarding anticipated risks. The industrial action that took place in July 2025 had a cost-effect of almost £1 million, and a similar scale cost was expected following the industrial action that took place in November 2025. High-cost drugs was also a growing risk as the Group agreed to a share arrangement with the ICS in early 2025/26 which meant that the Group would not receive payment if growth was not made.

4.1.1 Update on Transformation Programme

Ivan McConnell updated that this work was complex from a strategic point of view and expected it to take time. The Group forecasted to achieve £109 million against a £130 million target. He emphasised that from an opportunity perspective, closing the gap was a challenge. Corporate services was £50k below plan at month 7, however forecasted to deliver the full 2025/26 surplus. Agency, extra contractual pay and CIP were behind plan. Care Groups were the biggest area of spend and every Care Group was now subject to intensive support work through bi-weekly Care Group meetings, discretionary spend and pay panels. With additional intensive support and strategic projects in place, work was underway to review barriers and enablers.

Work was ongoing to commence an Agenda for Change (AFC) recruitment freeze. Efforts were underway around stock control and stock management on the North Bank. The greatest challenge within Pathology was regarding whether to integrate SHYPS (Scarborough, Hull and York Pathology Service) and Pathlinks. Work was ongoing within Estates, Facilities and Development to review areas where the estate could be rationalised. Ivan McConnell reminded the CiC that a tight six-step gateway process was in place and it was crucial to accelerate from gateway 1 through to gateway 4. 16 meetings were taking place every 7 days with Care Groups, which was a big ask on operational colleagues in terms of grip and control. A corporate headcount reduction would require further review, especially as there was no redundancy budget option. Patient Services had implemented a vacancy freeze which was impacting clinical colleagues in outpatients. Digital plans were in place and further information would be shared at a future meeting.

Jane Hawkard asked to have oversight of an actions report detailing closing of the gap with a most-likely forecast.

Gill Ponder acknowledged that the Group were holding Care Groups to account with a good theoretical process, but that it was not delivering transformation and improvements in the run rate and underlying deficit. As a large portion of

overspend sits within the Care Groups, she proposed a more detailed focus on closing the gap be discussed at Boards-in-Common next week.

Simon Parkes queried how the Care Groups that were not delivering against plans were being held to account. Ivan McConnell shared that all Care Groups were asked to provide a recovery plan and regular meetings were taking place to hold Operations Directors and Care Groups accountable.

The Committees-in-Common agreed limited assurance, noting the continued worsening of the financial position, specifically not seeing the improvements that were required to be made in the run rate or underlying position. They recommended a closing the gap report be presented at Boards-in-Common to further identify what more could be done.

4.1.2 Operational Planning Update

Adam Creeggan updated that the first submission for the 2026/27 operational plan was due by 17 December 2025 and the full submission was due by 12 February 2026. He explained that it had been a difficult planning round to navigate through as national guidance was delivered within short timelines which required the Group to respond rapidly. Detailed discussions were due to take place at Senior Leadership Team (SLT) on 02 December 2025 and the Top 100 Leaders event on 03 December 2025 with a real focus on closing the significant gaps. A 5% growth in non-elective activity was projected for 2026/27, which had a consequence of suppressed elective inpatients due the increased non-elective work and uncertainty around the funding available for Independent Sector work. It was anticipated that the Group would be required to reduce headcount to achieve financial savings. Work would take place to utilise current capacities that were available to the Group. Adam Creeggan recognised that there was suboptimal utilisation of Urgent Treatment Centres (UTCs) due to hours running and percentage compliance which impacted ED compliance. He highlighted that pathways were not set up to optimise treatment of non-admitted patients and Dr Kate Wood was leading work to address this. The Group would focus on how to translate those clear requirements into delivery plans.

Catherine Sowerby joined the meeting at 11:10 hours.

Simon Parkes wondered how the Group would deliver the actions and recognised that this would be a challenge throughout the process.

Helen Wright suggested a focus on areas that were overpromised and underdelivered in 2025/26.

4.2 Group Performance Report (including Trajectories and Improvement Data)

Matt Powls took the report as read and apologised that the paper did not provide assurance around performance in totality, this would be amended. Work was ongoing to monitor the 65-week performance position, and a reduction was seen

in the risk of 65-week breaches between July and October 2025. NHSE were informed that it was unlikely for the Group to achieve the target of zero patients at 65 weeks by 21 December 2025 and agreed to extend the target to mid-to-late January 2026. Daily meetings were taking place with the Care Groups with a focus on 65-week performance.

Adam Creeggan shared that the Group saw a 7% increase in referrals which was attributed to the increase in the Patient Tracking List (PTL) at HUTH from July 2025 onwards. He raised concerns regarding the increased referrals received for urgent and suspected cancer patients which absorbed capacity allocated to routine long waiters and was exacerbated by an increase in non-elective patients which created pressure on diagnostic delivery. He acknowledged that these positions were contrasting and shared that the year-to-date activity delivery was above plan for elective work and diagnostic recovery. Work was underway with the Care Groups to review how to book and re-book the profile of patients which was a cultural challenge. There were 400 patients that required a date by the end of December 2025 to avoid a breach. Work was ongoing to allocate capacity to the longest waiting patients.

A reduction was seen in the numbers of cancer patients on the PTL and patients waiting over 64-days. There was a significant improvement in the 28-day Faster Diagnosis Standard (FDS) across the Group.

UEC performance was largely unchanged in comparison to previous months which was attributed to a continued increase in referrals. Work was underway to implement alternative pathways for non-admitted patients.

Helen Wright wondered when a different approach would be taken regarding Urgent Treatment Centres (UTC). Matt Powls shared that the ICB were looking to potentially run a UTC at HUTH for 24 hours and a business case was established. He would provide an update once this was shared.

Helen Wright further queried whether the Winter Plan was sufficient against current performance. Matt Powls explained that the Winter Plan was robust and risk review meetings would take place next week to review how to strengthen plans further. Dr Kate Wood mentioned that she was leading an internal review alongside the Executive team regarding the closure of Ward 130 to understand whether the mitigation that the Group had previously been reassured would be in place had come to fruition.

Gill Ponder wondered what additional actions the Group would undertake to improve diagnostic performance.

Matt Powls explained that NHSE had offered support with undertaking deep dives and where to drive performance improvement. Adam Creeggan acknowledged that the Group were undertaking more activity than originally planned whilst being under-resourced and further work would be explored as the Group continued their transformational journey.

The Committees-In-Common agreed limited assurance, noting that constitutional standards were still not being delivered, achieving zero 65-week waits had been delayed and areas where the Group were diverging from improvement trajectories. However, there were areas with some green shoots of improvement in Cancer performance.

4.3 Deep Dive: Outpatient Transformation

Ivan McConnell updated that a clinical task force was established with a focus on PIFU, follow ups, primary care, communications education, digital and clinical leadership. Doctor Dr was implemented on the North Bank which expected to provide benefits.

Catherine Sowerby shared that the investment in Doctor Dr had seen a reduction in appointment rates from 8% to 5.5/6% on the North Bank. A patient-led booking pilot was underway on the North Bank and plans were in place to implement that across the South Bank in 2026. A Groupwide contact centre was being developed which was well-received and expected to be implemented in early 2026. Work had commenced on the South Bank in line with the Electronic Patient Record (EPR) as patient records were removed from outpatient clinics to support getting clinicians ready for paperless clinics. A business case was approved which aimed to reduce admin duplication and work was underway to reduce manual tasks. There was a planned reduction in administration which expected to reduce staffing by 4% over the next two to three years, and the Group were cognisant that skill-levels would need to be improved through this process to support complex patients. Work continued around New Models of Care.

Ivan McConnell mentioned that the identified actions from the Top 100 Leaders session resulted in implementation of an Outpatient Clinical Taskforce which was chaired by Caroline Hibbert. 22% of appointments in 2024/25 were not given advanced notice which equated to £121 million in lost capacity and activity, a high number of those DNAs were within Midwifery at HUTH and work was ongoing to encourage attendance. Additional support would be provided from NHSE to analyse validation and follow ups.

Jane Hawkard noted that it would be helpful to see a ‘lessons learned’ report. She mentioned the backlog of letters and wondered why AI was not being utilised to support this. Ivan McConnell clarified that the governance structure that was previously in place did not work as well as anticipated. The Group needed to improve shadowing clinics and work was underway to do this which had started to yield results, NHSE support was also expected to support with this.

Catherine Sowerby shared that the backlog of letters was due to the need to deliver on the CIP which required a rigorous vacancy control process in place and had exacerbated the issue. Funding was secured to support that process and efforts was underway to clear that backlog.

Simon Parkes mentioned that the Group needed to find efficiency and improve productivity rather than throwing resource at challenges.

Gill Ponder acknowledged that this was an ongoing cultural challenge and the Group needed to be more efficient in utilising existing resources to support priority activities.

Dr Kate Wood clarified that it was crucial to dismantle an old process after the new process was working and provided assurance.

Helen Wright wondered how the Group accelerate on the transformation programmes across all areas and how to reallocate resource to focus on transformation.

Catherine Sowerby left the meeting at 11:59 hours.

4.4 Directorate of Estates, Facilities and Development Update - to include Risks (including HRI Tower Block Update)

Tom Myers updated that Capital was currently challenging. Additional funding was secured which would be utilised to support the Tower Block. £2.6 million of Estates Safety Funding was also secured. The Group submitted a bid for £16 million of Energy funding to support with car charging and solar works and were awaiting a response. The HUTH Overall programme was subject to confirmation on the return to constitutional standards funding and was delayed due to the increased scrutiny on the HRI Tower Block. Work had commenced to re-deploy Capital money and the Discharge Lounge at HRI was near completion. Efforts were underway to progress with the Lansdowne block and meetings were scheduled to ensure that Group were compliant with procurement.

Retail catering was out to tender for in-house services at HRI and Castle Hill Hospital (CHH) and the Group had received positive engagement from the market. Tom Myers outlined the status of three Private Finance Initiative (PFI) agreements which were in place at HUTH. He raised concerns regarding providers delaying necessary surveys until twelve months before handback, the Group were monitoring this and discussions were ongoing with NHSE and National Infrastructure and Service Transformation Authority (NISTA). Work was underway to address delivering this efficiently and ensuring all lifecycle works were completed and risks reduced.

The Committees-In-Common agreed significant assurance.

4.5 Contract Approvals

4.5.1 Contract Approval: HUTH Cleaning Service Contract

Tom Myers shared that the paper evaluated two options which were considered best value to progress with the extension of the OCS contract at HUTH: either transferring OCS staff into the Group or extending the OCS contract by 12 months. The exact contract value for OCS in 2026/27 was uncertain as it was dependent on AFC pay increases and inflation measured by the Retail Prices Index (RPI), neither of which were known at this time but would impact both options. Transferring OCS staff to the Group would incur increased pension

contribution costs. The risk of challenge from the market was deemed low providing that the Group were clear regarding future procurement plans.

Gill Ponder requested that the extension of the contract be underpinned by a clear plan with milestones and owners to ensure that the procurement process would be achieved without the need for any further contract extensions. Tom Myers confirmed that a programme management role was in place and a clear plan would be shared in due course.

The Committees-in-Common endorsed a 12-month extension of the contract for Boards-in-Common approval subject to a clear procurement plan.

4.6 Emerging Issues

Nothing to raise.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Unplanned Care Board Draft Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Emma Sayner provided a verbal update on ME2 Pathology. Work was ongoing which was a development led through Leicestershire that affected Pathlinks at NLaG. A programme of work was underway to amalgamate a network arrangement for pathology with a number of other organisations. An update would be presented to Group Executive and considered by PEF and Boards-in-Common in January 2026.

Jackie Bene provided feedback following her observation of the meeting. She recognised that challenges were taking place which led to good challenge and strong discussions around accountability, grip and transformation. There was positive discipline to determine assurance ratings. The CiC asked the right questions around the BAF and risk register. The performance report could be stronger and bring in more around workforce and quality to allow the Group better triangulation.

Simon Parkes proposed thinking about the structure of the PEF CiC agenda as the size of it did not allow enough time to resolve discussions.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None raised.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

The next meeting will take place on Tuesday 06th January 2026 via Microsoft Teams.

The meeting closed at 12:24 hours.

Cumulative Record of Attendance at PEF CiC 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug 05/08 07/08	Sep 02/09	Oct 30/09	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y
Helen Wright	Chair / Non-Executive Director (NED - HUTH)		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y
Emma Sayner	Group Chief Financial Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	D 02/09	Y 30/09	Y	Y
Jane Hawkard	NED (HUTH)		Y	Y	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	D	Y
Simon Parkes	NED (NLaG)		Y	Y	Y	Y	Y	Y	Y 05/08 N 07/08	N 02/09	Y 30/09	D	Y
Clive Walsh	Interim Site Chief Executive North		D	Y	Y	D	D						

Sarah Tedford	Interim Group Chief Delivery Officer		Y	D	D	Y	Y	Y	Y 05/08 D 07/08	Y 02/09	Y 30/09		
Matt Powls	Interim Group Chief Delivery Officer											Y	Y
Dr Kate Wood	Group Chief Medical Officer		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	D 30/09	Y	Y
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y
Andy Haywood	Group Digital Information Officer		N	N	N	N	N	N	N 05/08 N 07/08	N 02/09	N 30/09	N	N
David Sharif	Group Director of Assurance or deputy		Y	Y	Y	Y	D	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y
Philippa Russell	Deputy Director of Finance		Y	Y	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y
Ian Reekie	Governor Observer (NLaG)		D	Y	D	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	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

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 6th January 2026 at 09:00 to 12:30 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director (HUTH) – Chair
Gill Ponder	Non-Executive Director (NLaG)
Matt Powls	Interim Group Chief Delivery Officer
Emma Sayner	Group Chief Financial Officer
Dr Kate Wood	Group Chief Medical Officer
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance
Karena Groom	Interim Personal Assistant (Minute Taker)
Ivan McConnell	Group Director of Transformation
Philippa Russell	Deputy Group Chief Finance Officer
Tom Myers	Group Director of Estates
Ashy Shanker	Operations Director for Cancer Network (item 4.4)
Alex Best	Group Deputy Director of Capital Services
Hayley Briggs	Interim Operations Director for Theatres, Anaesthetics and Critical Care (item 4.3)
Murray MacDonald	Interim Group Chair

Observers

Ian Reekie	Lead Public Governor (NLaG)
Julie Beilby	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Ben Smith	Deputy Improvement Director for NHSE

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Helen Wright, welcomed those present to the meeting. Apologies for absence were noted for David Sharif, Group Director of Assurance.

1.2 Staff Charter and Values

Helen Wright noted the Staff Charter and Group Values and reminded everyone to follow and live these throughout the meeting.

1.3 Declarations of Interest

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

1.4 To approve the minutes of the meeting held on 02 December 2025 and Private minutes from 02 December 2025

The minutes of the meeting held on 02 December 2025 and private minutes from 02 December 2025 were accepted as a true and accurate record subject to the following amendment:

Page 10 of the minutes to state that 'Jane Hawkard asked to have oversight of an actions report detailing closing of the gap with a most-likely forecast'.

1.5 Matters Arising

No items were raised.

1.6 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
1.6	Review of Action Tracker	Tom Myers to provide a further update on Anti-Ligature risks when EFD risks are presented to PEF CiC in December 2025.	**Tom Myers will provide an update regarding third party properties in the next EFD general update. An update will be provided at the next meeting regarding a timescale for harmonising the Group anti-ligature policy.**
1.6	Committee Effectiveness Outcome	A further meeting to be organised to discuss the effectiveness outcome further and agree definite steps to take in	**Meeting scheduled for 12 January 2026. Carry forward to February.**

		order to respond to that feedback.	
2.1	Matters referred by the Trust Board(s) or other Board Committees - 24 hour care	Matt Powls to bring a position statement briefing back to this meeting to explain what effective patient experience and quality service need to look like from an operational perspective and what needs to support that in terms of workforce.	Work was ongoing around 24 hour working and a paper would be presented at the next meeting, detailing the difference that 24 hour working would make to ED. **Carry forward to February 2026**.
2.1.1	Matters referred by the Trust Board(s) or other Board Committees - 24 hour care	Karena Groom to organise a meeting for Helen Wright and Matt Powls to discuss 24-hour care.	The meeting took place on 17 December 2025. **Action closed.**
3.1	Board Assurance Framework to include Risk Register Report	David Sharif to review whether the people with the greatest needs were undertaking risk training and also being given that opportunity in priority order.	The CiC wished to see percentages regarding how many people had participated in the training versus how many had not, and what was being done to address this. **Carry forward to February 2026**.
4.1	Group Finance Report: Month 7	Emma Sayner to provide an update to Boards-in-Common in December 2025 on the work that was ongoing to analyse the NHSE cost control checklist, PA consulting work and the enhanced work around the extra-contractual and variable pay, and the ongoing impact.	This was covered in Emma's public purse paper at Boards-in-Common on 11 December 2025. **Action closed.**

2. MATTERS REFERRED

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

None to note.

3. RISK & ASSURANCE

3.1 Review of Relevant Internal & External Audit Report(s), Recommendation(s) & Assurances as appropriate

None to note.

3.2 Review of Relevant External Report(s), Recommendation(s) & Assurances as appropriate

None to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Finance Report: Month 8

Emma Sayner updated that a further deterioration was seen in the year-to-date (YTD) position. The Group were £7.9 million off-plan at month 8, in comparison to being £4.8 million off-plan at month 7. Efforts were underway to improve the year-end position. Small reductions had been seen in extra contractual pay due to the enhanced controls put in place in particular on agency. The cash position was currently being monitored and the Group acknowledged that Capital Spend provided the flexibility to pay suppliers in a timely manner. The Group would ensure that they were clear regarding the cash requirements in the final quarter of 2025/26. Work was underway with the Estates, Facilities and Development team to achieve delivery on the Capital plan.

Philippa Russell highlighted that the Industrial Action had resulted in an unplanned impact, particularly at HUTH. £1 million worth of pressure was seen in month 8 which provided a YTD pressure of £2 million. The Group expected that the industrial action that took place in December 2025 would have a further impact.

Gill Ponder wondered what further the Group could do to encourage awareness and understanding of the current financial situation. She recognised that significant efforts were underway to increase grip and control measures, hold Care Groups to account and reduce their ability to overspend however, the impact was not seen in the run rate. Emma Sayner mentioned that internal communication would be crucial and emphasised that the Group would accelerate the grip and control measures that were in place. Discussions had taken place with the National Team regarding how to encourage the Group to think differently as the Group had not yet seen ownership at the scale and pace that was required. Non-clinical spend had reduced due to the grip and control measures in place however, better value was not coming out of clinical spend and this needed to be a key focus.

Ivan McConnell explained that a greater focus was required to address ownership, consequences, culture and behaviours. The Group needed to think differently around resourcing, and he acknowledged that there did not appear to be consequences to actions.

Philippa Russell highlighted that grip and control measures continued to be increased and were not yet reflected in the month 8 or 9 positions. The double-lock process with the Integrated Care System (ICS) had inevitably created delays and the stronger approach to vacancy control was expected to make an impact.

Helen Wright emphasised that the Group needed to be clear that underlying performance was £27.8 million adverse to plan however, it was supported by non-recurrent support.

Forecast Outturn Protocol Amendment

Emma Sayner explained that the Group were required to submit a formal request to NHSE by 08 January 2026 in order to change the Group's month 9 forecast. The Board members had received high level details of the process and delegated authority had been agreed to PEF with a formal decision being considered at Boards-in-Common in February 2026. The proposed amended FOT is in line with the financial risk that PEF and Board have discussed in detail at each of the preceding meetings. The Group has received confirmation that they would not receive the Q4 deficit support funding which totalled circa £7 million which is considered as part of the detail being submitted to NHS England.

The Group received confirmation regarding what the forecast protocol change process looked like and they were confident that they delivered all requirements. Before being able to formally notify NHSE of the change of forecast, the Group were required to evidence the following:

- Board approved recovery plan.
- Grip and control checklist.
- Completion of the Well Led Finance toolkit self-assessment.
- Activation of double/triple lock.
- Establishment of Cash Committee, Discretionary Spend panel, and Vacancy Control panel.
- NHSE regional team and organisation Board to Board meetings.
- NHSE observing Finance and Audit CiCs.

Philippa Russell updated that discussions had taken place with NHSE regarding forecast movement. There was no significant change to the Board approved recovery action plan, however she recognised that there was challenge regarding delivering the plan. The grip and control checklist and well-led finance toolkit self-assessments were completed and shared with ICS colleagues to ensure they had oversight. The double-lock process was now in place with the ICS and the Group were required to submit requests for non-pay items over £50k, Agency Spend and non-clinical vacancies. However, this excluded clinical supplies and drugs. A Cash Committee had been established and the first meeting was due to take place next week. Any recommendations from the Cash Committee would be reported to this meeting through the finance reports.

Action: Philippa Russell to circulate the grip and control checklist and well-led finance toolkit self-assessments to PEF CiC members following this meeting for awareness and feedback.

Jane Hawkard shared that the Board approved recovery plan felt like a set of initiatives to bring the Group back on plan, rather than a formal recovery plan. Emma Sayner recognised that a formal recovery plan would look different to the work that had taken place however, the intervention taken around recovery had come through the enhanced grip and control mechanisms that were put in place. Given the significant patient safety, quality and performance challenges the Group faced, they had been more restricted on acting against financial recovery than might have been the case. She felt that the Group had done all they could to deliver as good a position as possible and positive feedback was received from external agencies and partners regarding the work they had undertaken.

Helen Wright asked whether the Care Groups that had overspent year-to-date were required to meet their targets in the year to go (YTG).

Emma Sayner confirmed this and emphasised that work was ongoing with the Care Groups to ensure they delivered their required targets. She shared that there were opportunities for financial support from partner organisations however, this would be a contingency option as those arrangements would be repayable which would put pressure on future financial years.

Helen Wright asked to see risks and opportunities documented within the next finance report. She wished to see the risks and opportunities in balance and more net opportunities rather than risk.

Gill Ponder shared concerns that the Group may assume that controls would cease in 2026/27 if an end-of-year reforecast was made with the goal of delivering it in Q4. She emphasised that it was crucial for the Group to be clear that this was a permanent and enduring regime until the Group achieved the required financial discipline. Ivan McConnell explained that the Group expected these controls to continue throughout 2026/27 and 2027/28 and work was underway around the communications process that was required to support that.

Action: Ivan McConnell to bring a Communications plan to the next meeting around encouraging financial discipline.

Helen Wright raised concerns that the Group would not transform services and performance due to so much of the efforts being focused around tactical intervention, and emphasised that things needed to be different from an operational and financial performance perspective.

Philippa Russell shared that it was crucial for the Care Groups to deliver their recovery action plans to ensure that the Group achieve their amended forecast.

Jane Hawkard asked for clarification around the month 9 forecast. Philippa Russell clarified that the month 9 forecast included the unidentified gap and the opportunity within the forecast. The Group assumed that the Cost Improvement Programme (CIP) plans would be delivered in Q4. Emma Sayner shared that a detailed breakdown of the month 9 forecast would be shared with the CiC members alongside circulation of the Well Led Finance toolkit self-assessment.

Murray MacDonald asked to see a simple statement regarding where the Group initially thought they would be in comparison to where they expect to be. He asked for this to be circulated prior to the deadline of 08 January 2026. Subject to the actions being taken PEF approved the submission to NHS England by 8 January 2026.

The Committees-in-Common agreed reasonable assurance, highlighting the need to be careful around the communications being shared. The money is the money and there cannot be a perception that support is readily available should targets not be delivered. Detailed work was being undertaken and there was confidence that the Group would achieve the amended forecast.

4.1.1 Update on Transformation Programme

Ivan McConnell updated that the Group were currently £17.4 million behind plan at month 8 which was mainly due to Workforce Spend. Care Group CIP delivery was £2 million behind plan at month 8. Corporate had forecasted £1.3 million surplus. National benchmarking highlighted between £7-12 million of Corporate opportunities and the Group would be required to focus on delivering £120 million of other resource in 2026/27. The Group delivered £103 million at month 8 against a target of £130 million. Key drivers of spend were Emergency Care Practitioner (ECP), Agency Spend and Care Group slippage. From a variable pay perspective, there was a slight decrease seen in Agency Spend. The main challenge within Corporate was the requirement to flip non-recurrent to recurrent pay. Implementation of substantive service change was expected to be a challenge and take a minimum of 12 months to implement. There would be a targeted focus around accelerating outpatient transformation and virtual hospitals in 2026/27. Work was underway to review unsustainable services, and the Group would review the admin and clerical resources in place from a Corporate and Care Group perspective. The Group were looking to expand Goole Hospital from an integrated model of care perspective and anticipated that this would provide significant opportunities for improvement, productivity and efficiency. He acknowledged process challenges that were taking place with systems and the ongoing cultural challenges around behaviour and ownership.

Jane Hawkard asked to see a plan regarding how to re-organise Care Group capacity.

Gill Ponder proposed that a workforce review take place to monitor what people are currently doing, look at opportunities to stop activities that were lower value, and redeploy some of that resource into areas of transformation and Project Management Office (PMO).

The Committees-in-Common agreed limited assurance, noting that although the Group were aware of the right things to do, they needed to ensure they were appropriately resourced. Work was ongoing however, the ability to scale and push forward strategic change required improvement.

4.2 Group Performance Report (including Elective Recovery Trajectories)

Matt Powls highlighted that there were challenges regarding 65 and 52-week performance. A significant reduction was seen in 65-week performance for January 2026, and work was ongoing to achieve zero patients waiting 65-weeks. 14 specialties required insourcing and outsourcing to improve the performance position. Several contracts were being established which totalled £2.85 million however, they were sitting with the Integrated Care Board (ICB) due to the double-lock process and discussions were ongoing with the ICB to address this. Work was underway to better utilise theatre capacity and improve 65-week performance.

Helen Wright queried if the Group were on track to deliver the target of 65-weeks at zero by mid-January. Matt Powls shared that the Group expected the performance position to improve however, they did not expect to achieve the target of 65-weeks at zero due to the double-lock process that was in place. NHSE had requested a narrative paper from the Group which would be submitted by the end of the week and interventions were expected following this.

Gill Ponder wondered why diagnostics performance had deteriorated despite having extra capacity from Community Diagnostic Centres (CDCs).
Matt Powls clarified that work was ongoing with a focus on CDCs.

Action: Matt Powls to provide an update on CDC capacity at the next meeting that explains how to make more benefit and get the most from CDCs.

Gill Ponder questioned why there was a significant amount of 'on the day' theatre cancellations due to no theatre time and wondered how the Group would address this and resolve late starts in theatres.
Matt Powls explained that work would commence to review total capacity and the Group would look at specialties that would not be impacted if capacity was given up in order to focus on challenged areas.

Jane Hawkard asked to see a set of targets to improve diagnostics, 62 days and faster diagnosis performance as a result of signing off the £4.2 million investment.

Action: Matt Powls to provide a report detailing the targets that the Group initially set to achieve to improve diagnostics, 62 days and faster diagnosis performance and whether they had been achieved.

<u>UEC</u>
Matt Powls explained the Group were currently experiencing significant pressures around urgent care and work was ongoing to improve flow.

Action: Matt Powls to provide a report specifically around UEC and the effectiveness of the Winter Plan.

Gill Ponder noted that Urgent Treatment Centre (UTC) performance at HUTH appeared to be further behind in comparison to UTC performance at NLaG and wondered if there was learning that could be shared. She queried why it was taking significant time to replicate HUTHs ambulance handover improvement times on the South Bank. Matt Powls explained that this was due to variances in the set-up and available space across both Organisations, and the South Bank did not currently

have space without the risk of overcrowding. A document had been produced and was in a draft-stage regarding how to operate more effectively and a meeting was scheduled to take place with NHSE and East Midlands Ambulance Service (YAS) regarding this. The document would be circulated and discussed with clinicians through the clinical policy group.

Gill Ponder asked whether the Group expected to meet the 78% target by the end of March 2026.

Action: Matt Powls to circulate an update prior to the next meeting, regarding delivery of the 78% target by the end of March 2026, how confident the Group were that they would achieve the target and what actions were in place.

The Committees-in-Common agreed limited assurance, due to not meeting operational performance standards. The Group were still experiencing pressures in ED and wondered whether the spend that was invested was driving improvement. They requested further assurance around achieving the 78% target by the end of March 2026, and asked for further information regarding CDC capacity and how to better use resources to support underperforming areas.

4.3 Theatre Capacity

Hayley Briggs and Ashy Shanker joined the meeting at 10:55 hours.

Hayley Briggs updated that capped utilisation at HUTH was maintained between 75-80% against a KPI target of 85%. Session utilisation reduced over the last few months and required further improvement. 50% of cancellations at HUTH were due to patient choice, and top reasons were Did Not Attend (DNA), patients changing their mind on the day, and Consultants deeming patients not suitable for the procedure on the day. NLaG capped utilisation was on an upward trend achieving 81% in December 2025. Session utilisation was consistently above 90%. 30% of cancellations at NLaG were due to patient choice, and top reasons were DNA, patients changing their mind on the day, and Consultants deeming patients not suitable for the procedure on the day. A Standby patient protocol was trialled in Orthopaedics at NLaG which reduced lost theatre time, and this protocol would be implemented across all Care Groups in February 2026. A Golden patient protocol focused on early indications of the first patient on theatre lists and getting that patient ready, and this protocol would be implemented across the Group in February 2026. There was a significant opportunity from a day case surgery perspective at Castle Hill Hospital (CHH) and work was ongoing to ensure that the systems and processes in place were aligned. The Group would prioritise pathways with the quickest wins, the least investment and impact required. From a theatre session perspective, morning and afternoon lists were operating as separate sessions and work was ongoing with Care Groups to implement all-day sessions. A gap analysis was undertaken to identify pathways that were not utilised adequately and work would commence to establish trajectories for each pathway. Transformational work was ongoing with Pre-Assessment on the North Bank regarding screening questionnaires that are sent out to patients and moving those to national best practice. The cancellation avoidance team was introduced at NLaG several years ago with the aim of reducing avoidable cancellations on the

day. It was revealed that interactions with patients pre-TCI (To Come In) improved attendance rates and a phased approach would commence to implement this at HUTH by the end of January/early February 2026. Work was ongoing with Care Groups to understand the baseline for each Care Group and what they were set up to deliver in comparison to what theatres were set up to deliver which would provide an opportunity to re-use sessions and meet demand. This work was expected to be completed by the end of January 2026.

Gill Ponder asked for an indication on when the Group expected to see improvements around theatre capacity.

Action: Hayley Briggs to provide a paper that detailed timescales of when the Group would expect to see improvements around theatre capacity. This will be presented at a future meeting.

Helen Wright asked to see a rolling forecast based on the activity for 2026/27 which details what the Group were expecting to achieve with the different levels of activity.

Helen Wright queried whether there was confidence that the Group could execute these plans. Hayley Briggs was confident that the Care Groups were engaging and that a robust governance structure was in place to monitor performance and delivery and escalate any challenges to Care Groups and Executive colleagues. She noted that clinical engagement was crucial, and the biggest challenges were ensuring that appropriate people were physically available, and the significant number of outstanding vacancies from a consultant medical workforce perspective.

The Committees-In-Common agreed reasonable assurance.

Hayley Briggs left the meeting at 11:19 hours.

4.4 Deep Dive: Cancer Performance

Ashy Shanker updated that steady improvement had been seen over the last few months in NLaG regarding the Faster Diagnosis Standard (FDS), 31-day and 62-day standards however, further improvement was required to meet the national targets for those standards. The Patient Tracking List (PTL) backlog had reduced for urgent suspected cancer patients. Whilst there was a slight improvement seen in performance at HUTH, a decline was seen in some areas of performance in December 2025. The Group were currently maintaining and improving performance slowly, and work was underway to further improve performance. The Group submitted a recovery trajectory plan in September/October 2025 with an aim of achieving the targets set through the operational planning process earlier in 2025/26, and a significant focus was required in January 2026 to ensure achieving these targets and improving FDS performance at HUTH. Areas of concern at HUTH were breast, gynaecology, lung, and colorectal surgery. Areas of concern at NLaG were colorectal surgery, gynaecology, lung and urology. These areas all required a greater focus to improve performance. She explained that histopathology turnaround times at NLaG were provided by Pathlinks and turnaround times at HUTH were provided by Scarborough, Hull and York

Pathology Service (SHYPS). The urgent and two-week-wait average turnaround time for Pathlinks was 7.8 days in comparison to an average turnaround time of 18-days for SHYPS, which was significant to the 28-day pathway for FDS. A strategic review of histopathology was underway, and the Group would address whether there was further scope for improvement. Histopathology at HUTH was an area of concern as SHYPS were currently undertaking a digitisation programme which would impact performance and efficiency, and the Group would address this with SHYPS.

Breast was an area of focus due to capacity challenges which were attributed to national capacity constraints in radiology. The Group expected that resolving the capacity challenges within breast would enable them to achieve the national FDS standard target. There was an 8% increase seen in breast referrals in October 2025 due to breast awareness month. Radiotherapy capacity was an ongoing challenge and a business case was underway which expected to reduce the number of long waiters. Work was ongoing to right-size the Endoscopy service at HUTH due to a gap in available endoscopists, and the Group would focus on outsourcing and increasing capacity in the meantime. Efforts were underway to recruit 5 Whole Time Equivalent (WTE) Lung Consultants at NLaG. The Group were informed that the Cancer Alliance team would not provide funding to support core capacity gaps in 2026/27, and support would only be provided to non-recurrent requirements including clearing backlogs and service improvement. Several groups and processes were now in place to monitor and improve the ongoing challenges within cancer performance following the National Cancer Clinical Director visit that took place in July 2025. Efforts were underway to harmonise the clinical harm process across the Group. The top 3 improvement actions included an operational review of histopathology on the North Bank, rightsizing business cases to reduce dependence on external funding, and Capital and equipment requests to be considered. Further improvement actions included commencement of cancer specific operational planning, implementing a cancer-specific efficiency dashboard, and exploring innovation and digitisation by utilising Artificial Intelligence (AI), streamlining Multi-disciplinary Teams (MDTs), and improving integration across the Group.

Alex Best joined the meeting at 11:35 hours.

Emma Sayner confirmed that the Capital and equipment requests were included in the year-to-date forecast. Work was ongoing around right-sizing business cases and all other improvement actions would be monitored.

Gill Ponder raised concerns regarding the number of patients waiting over 104-days and asked when the Group expected to see an improvement.
Ashy Shanker explained that ongoing complexities made it difficult to provide a finite timescale however, a robust process was in place every week to review the number of patients waiting 104-days and every tumour site across the Group was required to present plans regarding how to reduce the number of patients waiting 104-days and 62-days plus. Causative factors needed to be addressed to improve 104-day performance.

Jane Hawkard mentioned a plan that was previously presented at Boards-in-Common regarding improving FDS performance. She asked if the Group were on track to achieve the targets that were set out in that plan.
Ashy Shanker explained that there was an inherent risk from January to March 2026 for the Group to achieve the improved level of performance required within the plan and that action was required immediately to achieve the targets set for improving FDS performance by the end of March 2026.

Jane Hawkard queried what interventions were in place to improve the urgent and two week-wait average turnaround time of 18-days for SHYPS.
Ashy Shanker explained that SHYPS recently appointed a gynae-pathologist and were requested by the Group to outsource more RTT to alleviate capacity for cancer patients. However, improvements were yet to be seen following this. SHYPS were now engaging well through the cancer delivery group which was positive.

Action: Ashy Shanker to provide a paper that detailed the live cancer forecast, the trajectory from a do-nothing position, and what the top 3-5 initiatives would deliver in terms of performance improvement. This would be presented at a future meeting.

The Committees-In-Common agreed limited assurance due to not seeing sustainable improvements particularly on the North Bank. Green shoots were being seen in the Faster Diagnosis Standard at NLaG. Significant activity was ongoing and the CiC were aware of the key actions.

Ashy Shanker left the meeting at 11:45 hours.

4.5 Directorate of Estates, Facilities and Development Update (including HRI Tower Block Update)

Tom Myers updated that the Estate Safety Funding was allocated £71 million over the next 4 years; £25 million of that would be allocated to the Tower Block, a further £20 million would be allocated to support theatres and ventilation challenges ongoing at NLaG, and a business case would be submitted by 28 January 2026. The Group were still experiencing challenges around Capital spend and mitigations were in place to improve this.

The Committees-In-Common agreed significant assurance, noting that there was no new increased risk around the HRI Tower Block, the Group were awaiting confirmation of the potential £25 million support funding, and £8 million additional funding was secured which would ensure the Group were more energy-efficient.

4.5.1 Estates Return Information Collection (ERIC)

Tom Myers explained that the Group were required to submit an Estates Return Information Collection (ERIC) annually with the purpose of highlighting any potential unwarranted variation, and that it was not a detailed benchmark due to variances across Organisations. Discrepancies in car parking services were noted between the South Bank and North Bank, with security costings applying only to

the South Bank and work was ongoing with NHSE to address this. A Humber Health Partnership Peer Group had been established and would be utilised to highlight efficiencies. Energy was flagged as being high in the two lower quartiles however, the Group secured £8 million funding support which would be utilised to improve energy efficiency. Work would commence to determine how to reduce space to improve utilisation and efficiency.

Action: Karena Groom to update the workplan for regular ERIC updates and any actions taken would be shared within the main EFD report.

The Committees-In-Common agreed significant assurance, noting that the ERIC review was submitted and actions were being undertaken and monitored to deliver savings.

4.5.2 Capital Programme Summary

Alex Best updated that the HUTH programme was currently £35 million due to the increased decarbonisation funding that had been received. The commitment to date was £18.2 million and a further £8 million was awaiting approval. Spend was relatively low at £6.4 million. The NLaG programme was currently £50 million due to decarbonisation funding that had been received. The commitment to date was £31 million and a further £6.8 million was awaiting approval. Spend was approximately £12 million however, that was increasing rapidly month by month due to Public Sector Decarbonisation Scheme (PSDS) works. He shared that despite additional funding being a benefit to the Group, it increased pressure on the team significantly over the next three months to complete this programme.

4.6 Contract Approvals

4.6.1 Contract Approval: HRI Theatres 8 & 9 and Plant Room

Alex Best explained that 3 contract approvals required delegated approval and the Group were conscious of the short timescale to appoint contractors. The value of these works were approximately between £3 and £5 million and would require either Group CEO or Chairman approval, and approval from either PEF or Strategic Programmes and Partnerships CiCs. These contracts would subsequently come back to PEF CiC for retrospective approval in February 2026.

Theatres 8 and 9 were a continuation of the critical theatres that were currently being upgraded at Hull Royal Infirmary (HRI). The plant room served theatres 6-4 and would subsequently form part of the future Estate Safety Fund bids. Two tenders were returned on 17 December 2025 however, the Group were unable to fully evaluate those tenders over the Christmas period due to annual leave therefore several clarifications still required resolution. Both tenders were broadly in line with each other and the Group were seeking to appoint one of the contractors with the upper figure being £4.27 million in line with the Capital programme.

Gill Ponder asked whether the CiC were being asked to provide delegated authority to enter into a contract and explained that the papers did not contain adequate detail regarding value for money and the expected benefits that these

contracts would provide. It was agreed to schedule an extra-ordinary meeting in two weeks' time to discuss these contract approvals in further detail.

Action: Karena Groom to organise an extra-ordinary meeting for the CiC to discuss the 3 contract approvals in further detail, understand value for money and the expected benefits.

4.6.2 Contract Approval: Lansdowne Block

Tom Myers explained that establishment of the Lansdowne Block would enhance the efficiency of the Tower Block. The Group explored all options to deliver discharges at HRI and it was determined that the only way to establish the Lansdowne Block was to create an additional space.

Gill Ponder noted that the paper referred to £2.7 to £3 million worth of NLaG Capital development money however, the programme was at HRI.
Alex Best confirmed that it should refer to HUTH and apologised for the typing error within the paper.

Gill Ponder mentioned that the paper referred to an amount of £8.5 million which would require Boards-in-Common approval.
Alex Best explained that there was an intention to bypass Boards-in-Common by dividing up the scheme due to the design stage of the scheme and the Group were conscious of the short timescale required to commence the building.
Emma Sayner clarified that £8.3 million was approved as part of the overall Capital plan and the scheme was approved through the Boards-in-Common.

Action: Emma Sayner to check that there is evidence from a governance perspective that £8.3 million was approved at Boards-in-Common via the Capital plan.

Murray MacDonald requested a statement confirming that the contract complies with procurement regulations.

An extra-ordinary meeting will be scheduled to discuss this contract in detail, understand value for money and the expected benefits.

4.6.3 Contract Approval: SGH Theatres B and C

Gill Ponder requested for the revised paper clearly state that any theatre upgrades would bring ventilation up to the latest standards.

An extra-ordinary meeting will be scheduled to discuss this contract in detail, understand value for money and the expected benefits.

4.7 ME2 Pathology Update

Emma Sayner will provide an update regarding this as part of the extra-ordinary meeting.

4.8 Emerging Issues

Nothing to raise.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

This was shared for information.

5.2 Unplanned Care Board Draft Meeting Minutes

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Ben Smith provided feedback following his observation of the meeting, acknowledging that the meeting was well-organised, attended by appropriate people and that Non-Executives challenged Executive colleagues adequately. Discussions were honest and Executive colleagues were transparent regarding their performance areas. He suggested that root causes and challenges should be more explicit within the recovery actions and evidence presented. He praised the discussions that took place around improvement plans, and the challenges around clinical engagement and financial planning. Meeting papers were strong and detailed however, members were encouraged to highlight the risks, impacts and priorities more clearly within the papers.

Julie Beilby asked for the performance data to highlight any national outliers.

Jane Hawkard mentioned that during discussions around ownership, a clinical voice was crucial. Dr Kate Wood highlighted that opportunities for members to talk in the meeting can be affected due to conversations progressing and time pressures.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAF

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

The next meeting will take place on Tuesday 03rd February 2026 via Microsoft Teams.

The meeting closed at 12:25 hours.

Cumulative Record of Attendance at PEF CiC 2025/2026

Name	Title	2025/26											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	Y		
Helen Wright	Chair / Non-Executive Director (NED - HUTH)	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	Y		
Emma Sayner	Group Chief Financial Officer	Y	Y	Y	Y	Y 05/08 Y 07/08	D 02/09	Y 30/09	Y	Y	Y		
Jane Hawkard	NED (HUTH)	Y	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	D	Y	Y		
Simon Parkes	NED (NLaG)	Y	Y	Y	Y	Y 05/08 N 07/08	N 02/09	Y 30/09	D	Y	N		
Clive Walsh	Interim Site Chief Executive North	Y	D	D									
Sarah Tedford	Interim Group Chief Delivery Officer	D	Y	Y	Y	Y 05/08 D 07/08	Y 02/09	Y 30/09					
Matt Powls	Interim Group Chief Delivery Officer								Y	Y	Y		
Dr Kate Wood	Group Chief Medical Officer	Y	Y	Y	Y	Y 05/08 Y	Y 02/09	D 30/09	Y	Y	Y		

						07/08							
REQUIRED ATTENDEES													
Tom Myers	Group Director of Estates	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	Y		
Andy Haywood	Group Digital Information Officer	N	N	N	N	N 05/08 N 07/08	N 02/09	N 30/09	N	N	N		
David Sharif	Group Director of Assurance or deputy	Y	Y	D	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	D		
Philippa Russell	Deputy Group Chief Finance Officer	Y	Y	Y	Y	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	Y		
Ian Reekie	Governor Observer (NLaG)	D	Y	Y	D	Y 05/08 Y 07/08	Y 02/09	Y 30/09	Y	Y	Y		
ADDITIONAL ATTENDEES													
Murray MacDonald	Interim Group Chair										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)021

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Philippa Russell, Deputy Director of Finance
Title of Report	**Finance Report – Month 9**
Executive Summary	This report highlights the reported financial position of Month 9 of the 2025/26 reporting period.
Background Information and/or Supporting Document(s) (if applicable)	-
Prior Approval Process	-
Financial Implication(s) (if applicable)	Contained within the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Finance Report Month 9
December – 2025/26

Finance Overview

In-month I&E Performance – page 3

(£9.5m)

The Group reported an in-month deficit for month 9 of (£9.5m), (£10.4m) adverse to plan.

Year to Date I&E Performance – page 3

(£18.3m)

The Group reported a (£28.3m) year to date deficit for month 9, (£18.3m) adverse to plan. This also includes £19.9m of non-recurrent balance sheet support.

I&E Forecast Outturn – page 4

(£36.6m)

The Group is forecasting a deficit of (£37.7m) based on an adjusted straight-line projection. Mitigating actions are forecast to reduce the deficit leaving an unidentified gap of (£36.6m). This includes £6.1m NR income support for IA.

YTD Cost Improvement Plan – page 5 to 6

(£20.8m)

The Group has delivered £69.3m in CIP against a YTD target of £90.1m, (£20.8m) behind target. The Group are forecasting CIP delivery of £93.8m, (£36.2m) adverse to plan.

Underlying I&E – page 7

(£123.9m)

The Group's underlying position is estimated at a deficit of circa (£123.9m). Recurrent CIP and FYE of in year schemes will be the key variable to the Group's underlying position.

System Performance – page 8

(£12.0m)

The ICS reported a YTD deficit of (£53.8m), (£39.6m) adverse to plan at month 9. The ICS is forecasting a (£96.1m) deficit for the year.

Capital Expenditure – page 9

(£35.7m)

The Group has spent £38.6m on capital expenditure against a plan of £74.3m, (£35.7m) behind plan.

Balance Sheet & Cash – pages 10 to 11

£37.8m

The Group's cash balance at the end of month 9 was £37.8m. The Group is anticipating external cash support for March 2026 and is enacting the relevant draw down request requirements.

Elective Recovery Performance – page 12

(£5.6m)

The Group is currently under-performing against ERF baselines by (£5.6m). No additional income or penalties have been assumed year-to-date. This is currently under review by the ICB.

Temporary Staffing – pages 13 to 16

£0.0m

The Group has spent £50.8m on agency and bank pay YTD. This is (£0.3m) more than the same period in 2024/25.

Key Risks

- ❑ Continued high value of unidentified CIP and high-risk CIP opportunities.
- ❑ ERF under-performance claw back.
- ❑ Unfunded costs associated with delivery of Constitutional Standards improvement plan and Operational pressures.
- ❑ Unidentified stretch income target
- ❑ Slippage on Capital Expenditure profile
- ❑ Requirement for Revenue Cash Support.

Key Actions

- ❑ Reducing cost pressures: reliance on premium bank and agency; minimising escalation beds; and greater control of non-pay expenditure.
- ❑ Maximising planned care activity within core capacity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- ❑ Delivering a challenging CIP programme – conversion of non-recurrent savings into recurrent delivery schemes and identifying additional schemes to close the gap to target.
- ❑ Delivery of Care Group Recovery Action Plans.

Financial Performance Summary

The Group ended December with a year-to-date (YTD) deficit at month 9 of (£28.3m), (£18.3m) 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	75.6	75.3	(0.3)	678.9	681.8	2.9	47.0	46.1	(0.9)	420.2	419.1	(1.2)	122.6	121.3	(1.3)	1,099.1	1,100.9	1.8
Other Income	5.9	7.1	1.2	69.5	72.2	2.7	6.1	6.5	0.4	56.2	51.2	(5.0)	12.0	13.6	1.6	125.7	123.3	(2.4)
Total Operating Income	**81.5**	**82.4**	**0.9**	**748.4**	**754.0**	**5.6**	**53.1**	**52.6**	**(0.5)**	**476.4**	**470.2**	**(6.2)**	**134.6**	**134.9**	**0.4**	**1,224.8**	**1,224.2**	**(0.6)**
Pay Costs																		
Clinical Pay	(39.1)	(41.9)	(2.7)	(353.2)	(367.3)	(14.1)	(27.7)	(28.9)	(1.2)	(251.2)	(256.6)	(5.4)	(66.9)	(70.8)	(3.9)	(604.4)	(623.9)	(19.5)
Other Pay	(8.4)	(8.3)	0.0	(75.3)	(75.2)	0.2	(7.4)	(7.5)	(0.1)	(65.9)	(64.9)	1.0	(15.7)	(15.8)	(0.1)	(141.2)	(140.1)	1.2
Total Pay Costs	**(47.5)**	**(50.2)**	**(2.7)**	**(428.5)**	**(442.4)**	**(13.9)**	**(35.1)**	**(36.4)**	**(1.3)**	**(317.1)**	**(321.5)**	**(4.4)**	**(82.6)**	**(86.6)**	**(4.0)**	**(745.7)**	**(763.9)**	**(18.3)**
Clinical Non Pay	(18.1)	(20.3)	(2.2)	(164.2)	(173.6)	(9.4)	(6.6)	(8.5)	(1.9)	(64.6)	(69.6)	(5.0)	(24.7)	(28.8)	(4.1)	(228.8)	(243.1)	(14.3)
Other Non Pay	(11.4)	(13.7)	(2.3)	(109.6)	(106.8)	2.8	(6.8)	(7.1)	(0.3)	(62.3)	(59.2)	3.0	(18.2)	(20.8)	(2.6)	(171.9)	(166.0)	5.9
Total Non Pay Costs	**(29.6)**	**(34.0)**	**(4.5)**	**(273.8)**	**(280.3)**	**(6.5)**	**(13.4)**	**(15.5)**	**(2.2)**	**(126.9)**	**(128.8)**	**(1.9)**	**(42.9)**	**(49.6)**	**(6.6)**	**(400.7)**	**(409.1)**	**(8.5)**
Total Operating Expenditure	**(77.1)**	**(84.2)**	**(7.2)**	**(702.3)**	**(722.7)**	**(20.4)**	**(48.4)**	**(51.9)**	**(3.5)**	**(444.0)**	**(450.3)**	**(6.3)**	**(125.5)**	**(136.2)**	**(10.6)**	**(1,146.3)**	**(1,173.1)**	**(26.7)**
EBITDA	**4.4**	**(1.9)**	**(6.3)**	**46.1**	**31.2**	**(14.9)**	**4.7**	**0.7**	**(4.0)**	**32.4**	**19.9**	**(12.5)**	**9.1**	**(1.2)**	**(10.3)**	**78.5**	**51.1**	**(27.3)**
Depreciation	(2.5)	(2.5)	0.0	(22.3)	(22.1)	0.2	(2.2)	(1.8)	0.4	(19.0)	(17.0)	2.0	(4.7)	(4.3)	0.4	(41.3)	(39.1)	2.2
Non Operating Items	(1.4)	(1.4)	(0.0)	(12.6)	(12.3)	0.3	(0.7)	(0.5)	0.2	(6.0)	(5.3)	0.8	(2.1)	(1.9)	0.2	(18.6)	(17.5)	1.1
Surplus/(Deficit)	**0.5**	**(5.8)**	**(6.3)**	**11.2**	**(3.1)**	**(14.4)**	**1.8**	**(1.7)**	**(3.4)**	**7.3**	**(2.3)**	**(9.7)**	**2.3**	**(7.4)**	**(9.8)**	**18.6**	**(5.5)**	**(24.0)**
NHSE Allowable Adjustments	0.0	(0.5)	(0.5)	(15.1)	(14.6)	0.5	(1.5)	(1.6)	(0.1)	(13.5)	(8.3)	5.2	(1.5)	(2.1)	(0.6)	(28.6)	(22.8)	5.7
Adjusted Surplus / (Deficit)	**0.6**	**(6.3)**	**(6.9)**	**(3.9)**	**(17.7)**	**(13.8)**	**0.3**	**(3.2)**	**(3.5)**	**(6.1)**	**(10.6)**	**(4.5)**	**0.9**	**(9.5)**	**(10.4)**	**(10.0)**	**(28.3)**	**(18.3)**

- **The Group reported a (£9.5m) deficit in month, (£10.4m) adverse to plan. £19.9m of balance sheet has now been released year-to-date to support the Groups financial position.**
- The Group is behind on its CIP programme by (£20.8m). The programme has £42.7m of schemes rated as high risk or unidentified.
- The Group cash balance decreased by (£1.4m) in month to £37.8m (£16.7m HUTH / £21.1m NLAG). Both Trusts within the Group are anticipating external cash flow support for March and liaising with the ICB and NHSE to prepare for potential draw-down requests.
- The Group has formally enacted the forecast outturn change protocol and is forecasting a year-end deficit of £36.6m. This is £6.2m favourable than the (£42.8m) deficit submitted as part of the FOT protocol change agreed by the Board due to receipt of non recurrent Industrial Action income of £6.2m.

See Appendix A on Page 19 to 20 for Detailed I&E Position

Financial Performance – Forecast Outturn (FOT)

The Group is forecasting a deficit of (£37.7m) based on an adjusted straight-line projection. Seasonal variation and other mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£36.6m) across the Group.

A straight-line forecast based on the M1-9 deficit position would leave the group with a £37.7m deficit by year end. When adjusted for seasonality, expenditure that has not yet started and non recurrent benefits in the year-to-date position, this deficit increases to £44.6m.

To achieve the revised forecast out-turn deficit (£36.6m), (£42.8m) adjusted for £6.2m IA income support, the group will need to:

- Improve efficiency delivery of £1.4m in the final quarter.
- Identify a further £3.2m of non recurrent mitigation.
- Deliver recovery plans of at least £3.7m to offset the additional pressure in the run-rate due to Care Group overspends.
- Secure £6.8m of unidentified income.

Forecast Bridge (Group)	HUTH £'m	NLAG £'m	HHP £'m	M8 £'m	Movement £'m
YTD deficit (M9)	(17.7)	(10.6)	(28.3)	(18.8)	(9.5)
Straight line forecast	**(23.6)**	**(14.1)**	**(37.7)**	**(28.2)**	**(9.5)**
Seasonality	(3.6)	(0.8)	(4.4)	(5.3)	1.0
Industrial Action	0.7	0.3	1.0	1.0	(0.0)
Industrial Support	4.1	2.1	6.2		6.2
CDC	(0.8)	-	(0.8)	(1.0)	0.2
Daycase Unit	(0.4)	-	(0.4)	(0.5)	0.1
Expected changes to run-rate	(3.2)	1.6	(1.6)	(6.0)	4.4
Non Recurrent Flexibility in YTD position	(4.4)	(2.1)	(6.6)	(9.5)	3.0
Depreciation, Interest Received & PDC	-	(0.4)	(0.4)	(0.8)	0.4
Adjusted Run Rate	**(31.3)**	**(13.3)**	**(44.6)**	**(50.3)**	**5.7**
Forecast CIP delivery (improvement in run-rate)	2.3	(0.9)	1.4	12.9	(11.5)
Non recurrent mitigation	3.2	-	3.2	3.2	0.0
Care Group Recovery Plans	3.7	-	3.7	4.4	(0.7)
Income target	3.4	3.4	6.8	6.8	0.0
Unmitigated Gap	-	-	-	23.1	(23.1)
Forecast deficit	**(18.7)**	**(10.8)**	**(29.5)**	**0.0**	**(29.5)**
Loss of Deficit Support Funding (Q4)	(3.3)	(3.7)	(7.0)	-	(7.0)
Forecast deficit including DSF	**(22.0)**	**(14.5)**	**(36.6)**	**0.0**	**(36.6)**
Plan	**-**	**-**	**-**	**-**	**-**
Variance	**(18.7)**	**(10.8)**	**(29.5)**	**0.0**	**(29.5)**

Financial Performance – Forecast Outturn (FOT) - RISKS

The revised FOT deficit of (£36.6m) is not without risk. However, potential mitigations identified minimise the Group's exposure to further deterioration to the financial position in the final quarter of the year.

Updated Risk Position	Plan 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Forecast 31/03/2026 Year Ending £'000	Comments	Current risk status	Risk adjusted £'000	Risk adjusted £'000	Risk adjusted £'000
Risks and mitigations	Group	HUTH	NLAG	Group		RAG	Group	HUTH	NLAG
Forecast deficit	**0**	**(22,030)**	**(14,534)**	**(36,564)**			(36,564)	(22,030)	(14,534)
(Risks)/(Offsets to benefits):									
Additional cost risk - HCD growth (ICS block funded)	(5,000)	(3,000)	(1,000)	(4,000)	ICS Risk Share: Growth		(1,200)	(900)	(300)
Additional cost risk - CDC 15% cost reduction	(3,000)		0	0	ICS Risk Share: CDC		0	0	0
Additional Cost risk - emerging		(500)	(1,000)	(1,500)	CPE outbreak, Escalation beds, RTT and Cancer recovery		(800)	(250)	(550)
Additional Cost risk - Industrial Action		0	0	0	Assumes any further strike action is funded		0	0	0
Additional cost risk (NP inflation)	(3,500)	(500)	0	(500)	Inflationary pressures above CUF		(75)	(75)	0
Efficiency risk	(47,072)			0	Unidentified CIP included in forecast		0	0	0
Efficiency risk		(1,099)		(1,099)	Opportunity / Plans in Progress - Highest risk already included in forecast		(642)	(642)	0
Care Group Recovery		(3,692)		(3,692)	Care Group Recovery actions		(1,846)	(1,846)	0
Income risk	(13,950)	(3,400)	(3,400)	(6,800)	Income target - not yet identified (ICS Risk share)		(6,800)	(3,400)	(3,400)
Deficit Support Funding					Q4 included in forecast				
Income risk - IPT claw-back		(700)	0	(700)	IS spend with ICS relating to 24/25 IPT referrals		(350)	(350)	0
Mitigations/benefits:									
Additional cost control	7,050	3,000	1,500	4,500	Vacancy Control / Double Lock including potential slippage on IS spend. Bed pressures mitigated		2,200	1,500	700
Transformational / Pathway changes	8,000	0	0	0	Utilisation of additional capacity to facilitate repatriation of Independent Sector activity (subject to agreement of funding mechanism)		0	0	0
Non-recurrent mitigation (Flexibility)	10,400	1,481	700				1,528	1,128	400
Non-recurrent mitigation (other)		8,000	1,535	9,535	Potential support from system partners - **would impact on future years** / other income opportunities		7,985	6,700	1,285
Total Provider Net Risk	**(47,072)**	**(22,440)**	**(16,199)**	**(38,639)**			**(36,564)**	**(20,165)**	**(16,399)**

Financial Performance – CIP Delivery

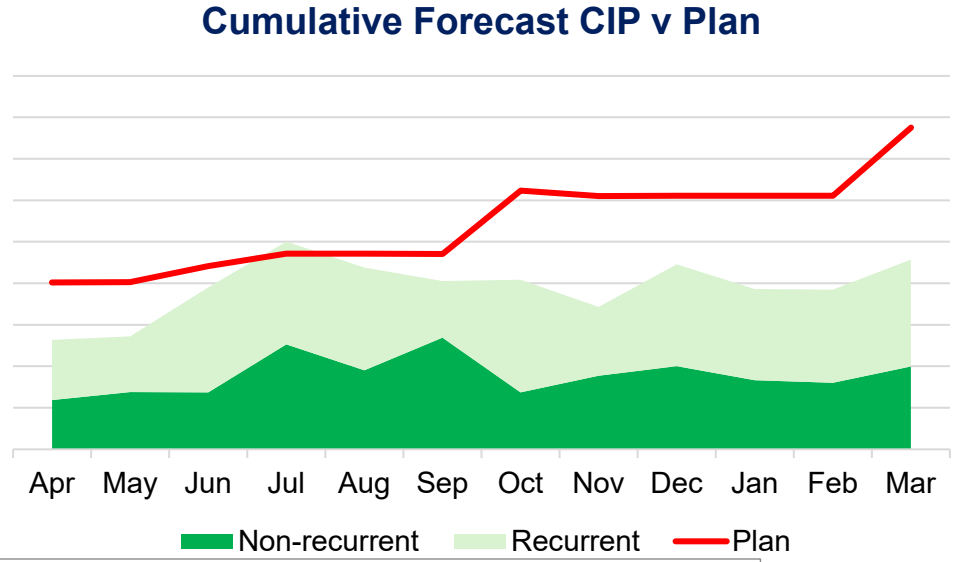
The Group has delivered £69.3m CIP year-to-date against a target of £90.1m, (£20.8m) adverse. The Group is forecasting CIP delivery of £93.8m (£36.2m) adverse to plan.

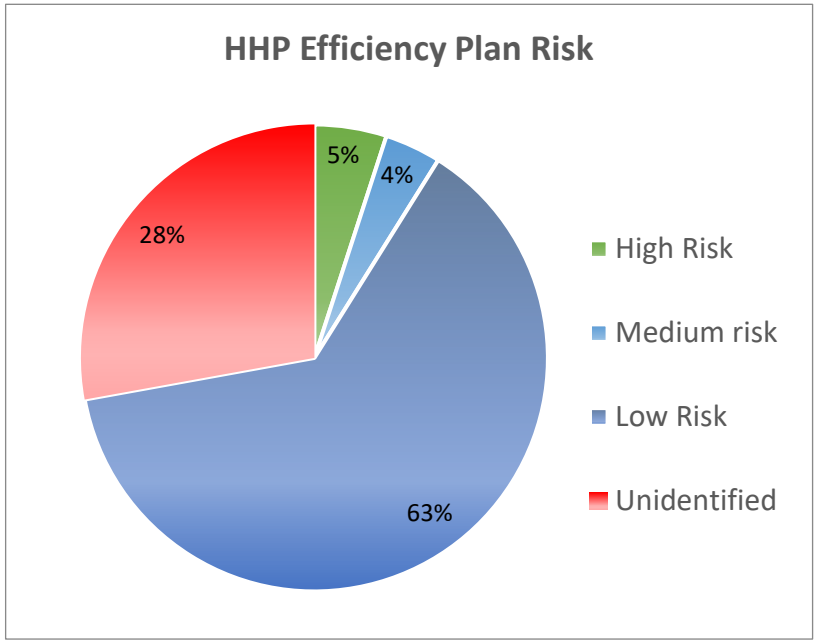
		HUTH						NLAG						HHP					
		Year to Date			Forecast Year-end			Year to Date			Forecast Year-end			Year to Date			Forecast Year-end		
£000		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Operations	Acute And Emergency Medicine	1,314	641	(673)	1,800	992	(808)	3,821	3,349	(472)	5,086	4,430	(656)	5,134	3,990	(1,145)	6,886	5,422	(1,463)
	Cancer Network	145	85	(60)	196	116	(80)	152	122	(29)	202	163	(39)	297	208	(89)	398	279	(119)
	Cardiovascular	1,120	1,987	867	1,491	2,535	1,045	419	490	70	490	582	92	1,539	2,477	938	1,981	3,117	1,136
	Chief Delivery Officer	29	41	12	38	59	21	27	141	114	37	155	118	56	182	126	75	214	139
	Community, Frailty & Therapy	1,001	636	(366)	1,324	976	(348)	2,067	1,964	(103)	2,620	2,638	18	3,068	2,600	(468)	3,944	3,614	(330)
	Digestive Diseases	632	108	(524)	848	193	(656)	2,161	2,132	(29)	2,750	2,654	(96)	2,794	2,240	(554)	3,598	2,847	(752)
	Family Services	2,492	1,750	(742)	3,066	2,362	(704)	2,497	2,163	(334)	3,132	2,903	(228)	4,989	3,913	(1,076)	6,197	5,266	(932)
	Head & Neck	1,364	1,771	407	1,765	2,091	326	886	1,031	145	1,098	1,254	156	2,250	2,802	552	2,863	3,345	482
	Major Trauma Network	153	68	(85)	160	76	(84)	(27)	0	27	(35)	0	35	126	68	(58)	126	76	(49)
	Neuroscience	1,341	838	(503)	1,649	1,143	(506)	382	375	(6)	500	490	(10)	1,722	1,213	(509)	2,149	1,633	(516)
	Pathology Network Group	459	277	(183)	588	374	(214)	1,816	1,488	(328)	2,347	1,948	(399)	2,276	1,765	(511)	2,936	2,323	(613)
	Patient Services	716	369	(347)	955	548	(407)	622	626	4	830	913	83	1,339	995	(344)	1,785	1,461	(324)
	Site Management & Discharge Teams	78	61	(17)	104	80	(24)	205	155	(50)	257	183	(74)	284	216	(68)	361	263	(98)
	Specialist Cancer And Support Services	5,678	5,211	(467)	7,626	6,881	(745)	1,824	2,028	204	2,481	2,809	328	7,502	7,239	(263)	10,107	9,690	(417)
	Specialist Medicine	1,540	1,029	(511)	1,985	1,316	(669)	816	790	(26)	1,041	971	(70)	2,356	1,819	(537)	3,026	2,287	(739)
	Specialist Surgery	1,314	1,108	(207)	1,694	1,438	(256)	928	845	(83)	1,140	1,158	18	2,242	1,953	(289)	2,834	2,596	(238)
	Theatres, Anaesthetics And Critical Care	2,361	2,495	133	3,071	3,469	399	1,325	1,039	(286)	1,845	1,493	(352)	3,687	3,534	(153)	4,915	4,962	47
Total Operations		**21,739**	**18,473**	**(3,266)**	**28,358**	**24,650**	**(3,709)**	**19,921**	**18,738**	**(1,183)**	**25,820**	**24,745**	**(1,075)**	**41,660**	**37,211**	**(4,449)**	**54,178**	**49,394**	**(4,784)**
Corporate	Chief Executive	39	32	(7)	52	41	(12)	34	26	(8)	46	39	(6)	74	58	(16)	98	80	(18)
	Chief Medical Officer	335	225	(110)	447	253	(194)	131	95	(35)	174	113	(61)	466	321	(145)	621	366	(255)
	Chief Nurse	331	533	201	442	637	195	291	525	235	388	652	264	622	1,058	436	829	1,289	460
	Director Of Assurance	8	0	(8)	11	0	(11)	34	7	(27)	46	12	(34)	43	7	(36)	57	12	(45)
	Director Of People	497	578	82	662	744	82	440	701	261	586	960	374	936	1,279	343	1,249	1,705	456
	Finance - E&F	2,654	3,142	487	3,555	4,128	573	1,819	1,215	(604)	2,428	1,727	(701)	4,473	4,356	(117)	5,983	5,854	(128)
	Finance - Finance	214	455	241	286	544	259	151	266	115	202	300	98	366	721	356	488	844	357
	Finance - Procurement	86	25	(61)	115	34	(82)	59	0	(59)	79	0	(79)	145	25	(120)	194	34	(160)
	Finance - S & P	279	441	163	371	552	181	178	400	222	237	523	286	456	841	384	609	1,075	467
	Strategy, Partnerships and Digital	377	445	68	510	585	75	455	750	295	607	962	355	832	1,195	363	1,117	1,548	431
Total Corporate		**4,821**	**5,876**	**1,055**	**6,451**	**7,518**	**1,067**	**3,592**	**3,985**	**393**	**4,792**	**5,288**	**496**	**8,413**	**9,861**	**1,448**	**11,243**	**12,806**	**1,564**
Total Allocated CIPCore Programme		**26,560**	**24,349**	**(2,211)**	**34,809**	**32,168**	**(2,641)**	**23,512**	**22,722**	**(790)**	**30,612**	**30,033**	**(579)**	**50,073**	**47,071**	**(3,001)**	**65,421**	**62,201**	**(3,220)**
Trustwide	Reserves	8,003	8,313	310	12,053	11,269	(784)	11,736	11,702	(33)	15,647	14,042	(1,605)	19,738	20,015	277	27,700	25,311	(2,389)
	Technical	473	514	41	630	671	41	349	349	0	466	466	0	822	863	41	1,096	1,137	41
	Unallocated	12,512	1,276	(11,235)	20,828	4,084	(16,744)	6,928	64	(6,864)	14,955	1,059	(13,896)	19,439	1,340	(18,099)	35,784	5,143	(30,641)
Total Technical & Unallocated		**20,987**	**10,103**	**(10,884)**	**33,511**	**16,024**	**(17,487)**	**19,013**	**12,116**	**(6,897)**	**31,068**	**15,567**	**(15,502)**	**39,999**	**22,218**	**(17,781)**	**64,579**	**31,591**	**(32,989)**
TOTAL		**47,547**	**34,452**	**(13,095)**	**68,320**	**48,192**	**(20,128)**	**42,525**	**34,838**	**(7,687)**	**61,680**	**45,599**	**(16,081)**	**90,072**	**69,290**	**(20,782)**	**130,000**	**93,791**	**(36,209)**

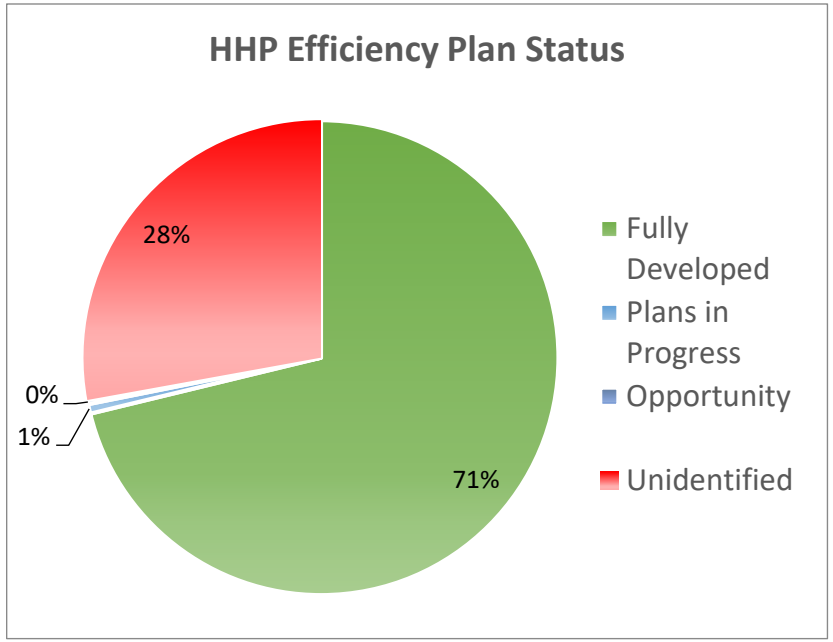
Financial Performance – CIP Planning Progress

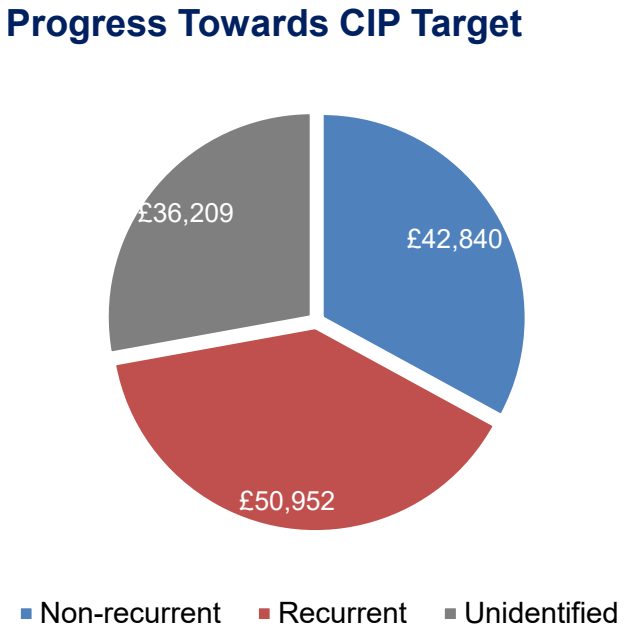
Efficiency Plan Status	HUTH	NLAG	HHP
Fully Developed	47,093	45,481	92,574
Plans in Progress	729	117	846
Opportunity	370	2	372
Unidentified	20,128	16,081	36,209
TOTAL	**68,320**	**61,680**	**130,000**

Efficiency Plan Risk	HUTH	NLAG	HHP
High Risk	6,156	340	6,496
Medium risk	3,861	1,219	5,080
Low Risk	38,174	44,041	82,215
Unidentified	20,128	16,081	36,209
TOTAL	**68,320**	**61,680**	**130,000**









Underlying Position

The Group's underlying financial position is estimated at a deficit of (£123.9m)

Bridging from the balanced planned for 2025-26 the below are the main drivers:

1. The Group is in receipt of specific Non-Recurrent Income support totalling (£30.6m).
2. Non-Recurrent Deficit funding received in 2025/26 of (£21.8m).
3. The Group has historically relied on Non-Recurrent savings delivery to achieve its financial targets. This is forecast to be (£32.0m) within the current year's savings plan. The Group must look to convert non-recurrent savings schemes into recurrent schemes where possible.
4. Non-recurrent industrial action income support net of costs of (£3.5m)
5. The in year CIP schemes have a potential FYE of £15.5m if delivered in full in year.
6. The Groups has been heavily reliant on Non-recurrent technical support in year of (£15.0

£million	NLAG	HUTH	HHP
2025/26 - Surplus/(Deficit) Plan	**(14.5)**	**(22.0)**	**(36.6)**
Non-recurrent Adjustments			
NR Additional Income Support	(5.0)	(25.6)	(30.6)
NR 25/26 Deficit Funding	(11.1)	(10.7)	(21.8)
NR Industrial Action	(1.4)	(2.0)	(3.5)
NR CIP (Forecast)	(16.9)	(15.2)	(32.0)
FYE 25/26 CIP	4.5	11.0	15.5
NR Flexibility	(5.7)	(9.2)	(15.0)
Underlying Deficit	**(50.2)**	**(73.7)**	**(123.9)**

System Financial Performance – December 2025

The ICS reported a YTD deficit of (£29.9m), (£12.0m) adverse to plan. The ICS is forecasting a break-even position as planned.

M9 Position

- ICB £43k overspend YTD, FOT £7.1m deficit relating entirely to non receipt of Q4 DSF funding.
- Providers £40m overspend YTD, FOT £89m deficit.
- The FOT deficit for the system would be a £76m deficit if DSF was received for Q4, (ICB Breakeven and Providers £76m deficit).
- Providers have enacted FOT protocols to submit deficit FOT position to NHSE.

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	(43)	(43)	(0.0%)	-	(7,076)	(7,076)	(0.1%)
Harrogate And District NHS Foundation Trust	(2,687)	(17,872)	(15,185)	(5.2%)	-	(20,000)	(20,000)	(5.2%)
Hull University Teaching Hospitals NHS Trust	(3,876)	(17,724)	(13,848)	(1.9%)	-	(22,030)	(22,030)	(2.3%)
Humber Teaching NHS Foundation Trust	(534)	2,467	3,001	1.5%	-	3,000	3,000	1.1%
Northern Lincolnshire And Goole NHS Foundation Trust	(6,122)	(10,580)	(4,458)	(1.0%)	-	(14,534)	(14,534)	(2.4%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(994)	(10,048)	(9,054)	(1.4%)	-	(35,444)	(35,444)	(4.0%)
ICS Total	(14,213)	(53,800)	(39,587)	(1.1%)	-	(96,084)	(96,084)	(2.0%)

System Revenue excluding Deficit Support Funding

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year £000	Forecast Year £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	(21,228)	(21,271)	(43)	(0.0%)	(28,304)	(28,304)	(0)	0.0%
Harrogate And District NHS Foundation Trust	(6,656)	(21,841)	(15,185)	(382.6%)	(5,297)	(23,969)	(18,672)	(352.5%)
Hull University Teaching Hospitals NHS Trust	(14,541)	(28,389)	(13,848)	(129.8%)	(14,233)	(32,695)	(18,462)	(129.7%)
Humber Teaching NHS Foundation Trust	(534)	2,467	3,001	0.0%	-	3,000	3,000	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(17,260)	(21,718)	(4,458)	(40.0%)	(14,856)	(25,672)	(10,816)	(72.8%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(13,407)	(22,461)	(9,054)	(72.9%)	(16,551)	(47,857)	(31,306)	(189.1%)
ICS Total	(73,626)	(113,213)	(39,587)	0.0%	(79,241)	(155,497)	(76,256)	2.4%

Capital Expenditure

The Group has spent £38.6m year to date on capital expenditure against a plan of £74.3m plan, (£35.7m) behind plan as we enter the final quarter of the year.

£million	NLAG Year to Date			HUTH Year to Date			HHP Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Estates Major Schemes									
Ward/Department Refurbishment/Development	2.0	0.8	(1.2)	2.6	1.7	(0.9)	4.6	2.5	(2.1)
Day Surgery CHH	0.0	0.0	0.0	4.8	1.1	(3.7)	4.8	1.1	(3.7)
Theatres & IRT	0.0	0.0	0.0	2.7	0.8	(1.9)	2.7	0.8	(1.9)
Community Diagnostic Centres	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estates Safety Funding	0.0	0.5	0.5	3.9	0.4	(3.5)	3.9	0.9	(3.0)
NEEF 4	0.0	0.0	0.0	6.1	0.3	(5.8)	6.1	0.3	(5.8)
Decarbonisation Funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Estates Major Schemes	**2.0**	**1.4**	**(0.6)**	**20.1**	**4.3**	**(15.8)**	**22.1**	**5.7**	**(16.4)**
Other Estates Schemes	0.1	0.0	(0.0)			0.0	0.1	0.0	(0.0)
IM&T Programme	1.6	0.7	(0.9)	0.9	0.9	0.0	2.5	1.6	(0.9)
EPR	4.9	0.7	(4.2)	0.0	0.9	0.9	4.9	1.6	(3.3)
Equipment Renewal	2.2	1.0	(1.1)	1.2	1.9	0.7	3.4	2.9	(0.4)
Facilities Maintenance	3.6	0.7	(2.9)	1.3	1.7	0.4	4.9	2.4	(2.5)
Other Capital Expenditure	16.5	9.1	(7.4)	19.8	15.3	(4.5)	36.3	24.4	(11.9)
Total Capital Programme	**30.8**	**13.6**	**(17.2)**	**43.3**	**25.0**	**(18.3)**	**74.1**	**38.6**	**(35.5)**
Funded By:									
Internally Generated	10.4	3.5	(6.9)	13.6	9.4	(4.2)	24.0	12.9	(11.1)
PDC Funded	4.0	1.1	(2.9)	15.0	0.0	(15.0)	19.0	1.1	(17.9)
Donated	15.2	8.9	(6.3)	0.9	2.2	1.3	16.1	11.1	(5.0)
IFRS16	1.2	0.1	(1.1)	14.0	13.4	(0.6)	15.2	13.5	(1.7)
Disposals - Net Book Value	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**30.8**	**13.6**	**(17.2)**	**43.5**	**25.0**	**(18.5)**	**74.3**	**38.6**	**(35.7)**

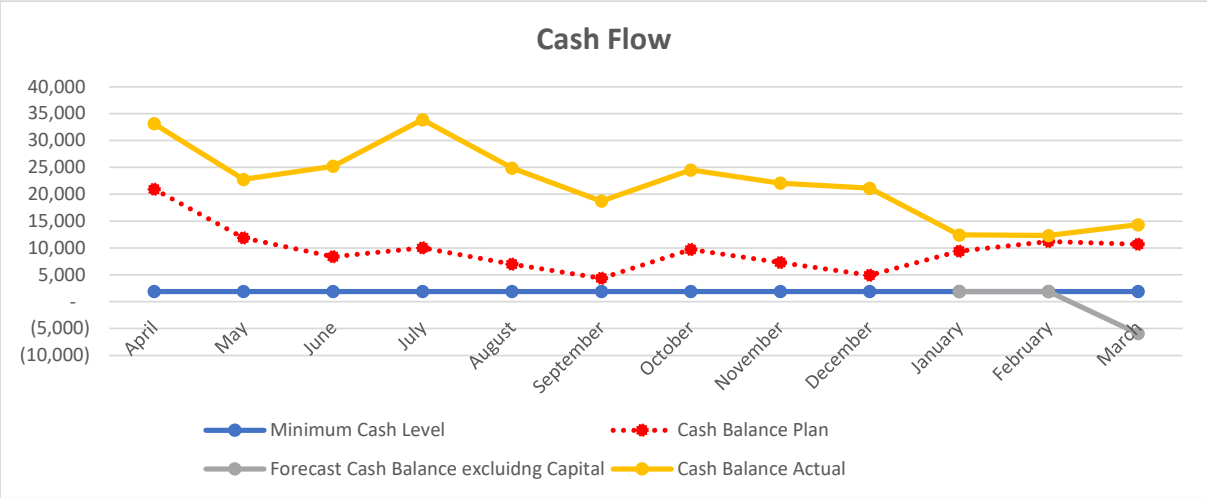
Balance Sheet

£ million	NLAG			HUTH			HHP		
	Actual	Actual	In month	Actual	Actual	In month	Actual	Actual	In month
	30-Nov-25	31-Dec-25	movement	30-Nov-25	31-Dec-25	movement	30-Nov-25	31-Dec-25	movement
Fixed Assets	296.2	297.3	1.1	487.3	488.4	1.1	783.5	785.7	2.2
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	5.0	5.7	0.7	19.6	18.5	(1.0)	24.6	24.2	(0.4)
Trade and Other Debtors	20.3	21.6	1.3	40.3	40.3	(0.0)	60.6	61.9	1.3
Cash	22.1	21.1	(0.9)	17.1	16.7	(0.5)	39.2	37.8	(1.4)
Total Current Assets	**47.4**	**48.4**	**1.0**	**77.0**	**75.4**	**(1.5)**	**124.3**	**123.8**	**(0.5)**
Current Liabilities									
Trade and Other Creditors	(42.3)	(50.3)	(8.0)	(68.2)	(63.1)	5.0	(110.5)	(113.5)	(3.0)
Accruals	(17.4)	(16.0)	1.4	(33.2)	(46.6)	(13.4)	(50.6)	(62.6)	(12.0)
Other Current Liabilities	(11.8)	(9.0)	2.8	(25.0)	(22.4)	2.6	(36.8)	(31.4)	5.4
Total Current Liabilities	**(71.6)**	**(75.4)**	**(3.8)**	**(126.4)**	**(132.2)**	**(5.8)**	**(198.0)**	**(207.6)**	**(9.6)**
Net Current Liabilities	**(24.2)**	**(27.0)**	**(2.8)**	**(49.4)**	**(56.8)**	**(7.4)**	**(73.6)**	**(83.7)**	**(10.1)**
Debtors Due > 1 Year	0.8	0.8	0.0	2.3	2.3	0.0	3.0	3.0	0.0
Creditors Due > 1 Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loans > 1 Year	(2.9)	(2.9)	0.0	(3.8)	(3.8)	0.0	(6.7)	(6.7)	0.0
Finance Lease Obligations > 1 Year	(7.4)	(7.3)	0.0	(72.0)	(71.5)	0.5	(79.4)	(78.9)	0.5
Provisions - Non Current	(3.6)	(3.6)	0.0	(2.3)	(2.3)	0.0	(5.9)	(5.9)	0.0
Total Assets/(Liabilities)	**258.9**	**257.2**	**(1.7)**	**362.7**	**356.9**	**(5.8)**	**621.6**	**614.1**	**(7.4)**
TOTAL CAPITAL & RESERVES	**258.9**	**257.2**	**(1.7)**	**362.7**	**356.9**	**(5.8)**	**621.6**	**614.1**	**(7.4)**

Cash Flow

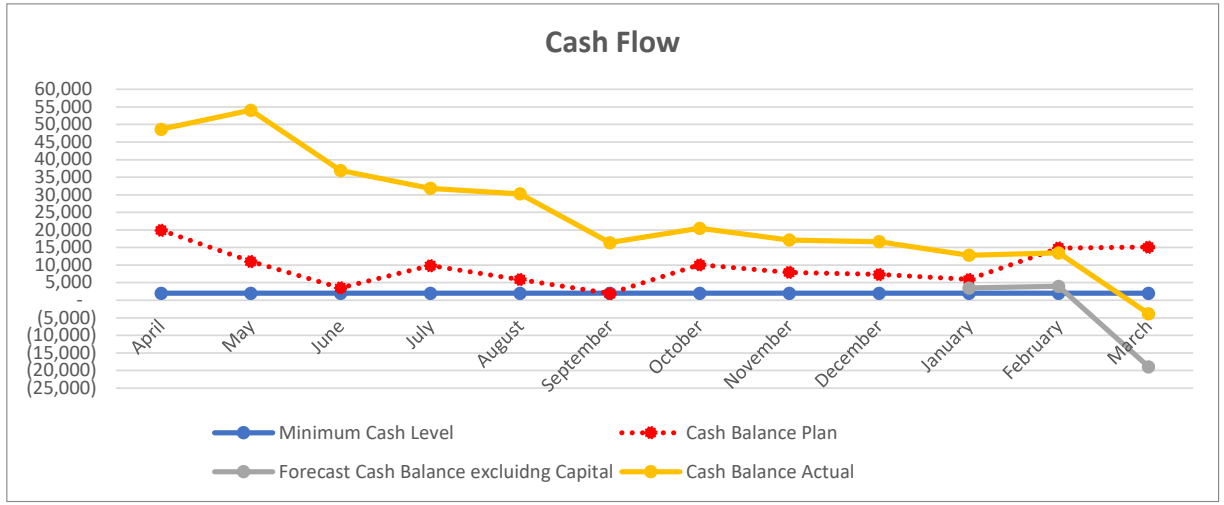
The Group's cash balance at the end of month 9 was £37.8m. The Group is anticipating external cash support for March 2026 and is enacting the relevant draw down request requirements.

NLAG



£000's	September	October	November	December	January	February	March
Minimum Cash Level	1,900	1,900	1,900	1,900	1,900	1,900	1,900
Cash Balance Plan	4,385	9,726	7,297	4,931	9,421	11,214	10,699
Forecast Cash Balance excluding Capital					1,900	1,900	(5,921)
Cash Balance Actual / Forecast	18,732	24,518	22,057	21,111	12,430	12,324	14,315

HUTH



£000's	September	October	November	December	January	February	March
Minimum Cash Level	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Cash Balance Plan	1,927	10,089	7,921	7,321	5,904	14,845	15,110
Forecast Cash Balance excluding Capital					3,466	3,964	(18,953)
Cash Balance Actual / Forecast	16,372	20,461	17,125	16,656	12,822	13,482	(3,825)

Elective Recovery

The Group is currently under-performing against ERF baselines by (£5.6m). No additional income or penalties have been assumed year-to-date.

	YTD											
£000's	HUTH				NLAG				HHP Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	118,907	112,476	(6,431)	95%	54,675	56,119	1,444	103%	173,582	168,595	(4,987)	97%
External Contracts	2,124	1,912	(212)	90%	7,416	8,219	803	111%	9,540	10,131	591	106%
Specialist	33,857	32,038	(1,819)	95%	1,343	1,942	599	145%	35,199	33,980	(1,219)	97%
Sub Total ERF	**154,888**	**146,426**	**(8,462)**	**94.5%**	**63,433**	**66,280**	**2,846**	**104.5%**	**218,321**	**212,706**	**(5,615)**	**97.4%**
A&G	2,851	2,851	0	N/A	690	689	(1)	N/A	3,540	3,539	(1)	N/A
Total	**157,739**	**149,277**	**(8,462)**	**94.5%**	**64,123**	**66,968**	**2,846**	**104.5%**	**221,861**	**216,245**	**(5,616)**	**97.4%**

	Forecast											
£000's	HUTH				NLAG				HHP Total			
	Target	Actual	Variance	%	Target	Actual	Variance	%	Target	Actual	Variance	%
H&NY Contracts	158,334	151,786	(6,548)	96%	72,803	74,676	1,873	103%	231,137	226,462	(4,675)	98%
External Contracts	2,832	2,548	(284)	90%	9,888	10,925	1,037	110%	12,720	13,473	753	106%
Specialist	45,142	42,918	(2,224)	95%	1,790	2,581	791	144%	46,932	45,499	(1,433)	97%
Sub Total ERF	**206,308**	**197,252**	**(9,056)**	**95.6%**	**84,481**	**88,175**	**3,700**	**104.4%**	**290,789**	**285,434**	**(5,356)**	**98.2%**
A&G	3,796	3,796	0	N/A	918	917	(1)	N/A	4,714	4,713	(1)	N/A
Total	**210,104**	**201,049**	**(9,056)**	**95.6%**	**85,400**	**89,093**	**3,699**	**104.4%**	**295,504**	**290,147**	**(5,357)**	**98.2%**

Temporary Staffing Summary

The Group has spent £50.8m on agency and bank YTD. This is (£0.3m) more than the same period in 2024/25 and remains below the NHSE Target of 3.2% of total pay expenditure at 2.7%.

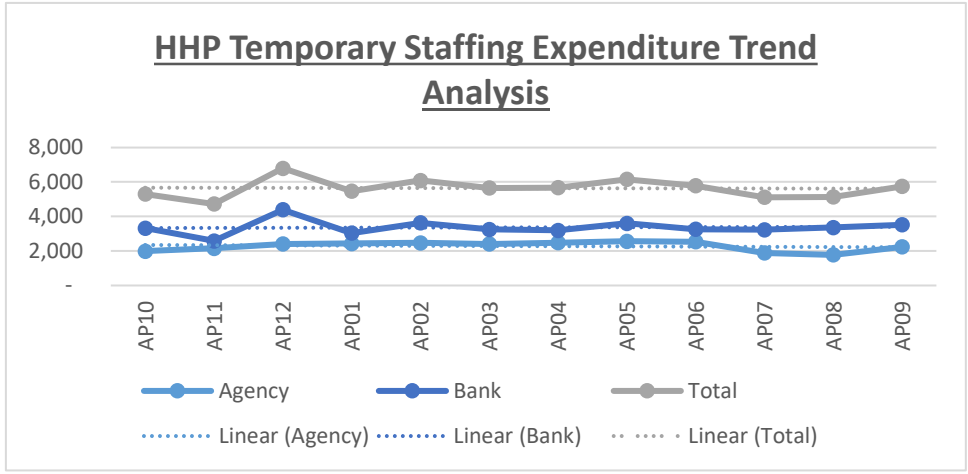
		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Type	Subjective Sub category	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Agency	Medical Staff	7,385	6,087	1,298	8,510	9,763	(1,253)	15,895	15,850	46
	Nursing Staff	210	1,194	(984)	2,330	2,209	121	2,540	3,403	(863)
	Scientific, Therapeutic & Technical Staff	507	136	371	1,118	1,264	(147)	1,625	1,401	224
	Admin & Clerical Staff	380	17	363	253	41	212	632	58	575
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	0	0	0	0	0	0	0	0	0
	Other Staff	0	38	(38)	3	3	0	3	40	(38)
Agency Total		**8,482**	**7,472**	**1,010**	**12,213**	**13,279**	**(1,067)**	**20,695**	**20,751**	**(56)**
Bank	Medical Staff	3,196	3,334	(138)	8,632	8,087	546	11,828	11,421	407
	Nursing Staff	4,121	3,259	862	9,110	9,460	(349)	13,231	12,718	513
	Scientific, Therapeutic & Technical Staff	418	509	(92)	979	1,068	(89)	1,397	1,578	(181)
	Admin & Clerical Staff	2	550	(547)	1,583	1,431	152	1,585	1,981	(396)
	Maintenance Staff	0	0	0	0	0	0	0	0	0
	Support Staff	43	112	(70)	1,745	2,261	(515)	1,788	2,373	(585)
	Other Staff	0	0	0	0	0	0	0	0	0
Bank Total		**7,779**	**7,764**	**15**	**22,050**	**22,307**	**(257)**	**29,829**	**30,071**	**(241)**
Grand Total		**16,261**	**15,236**	**1,026**	**34,263**	**35,586**	**(1,323)**	**50,524**	**50,822**	**(298)**

Agency Spend as % Total Pay (3.2% is the NHSE Target)	1.7%	4.1%	2.7%

Temporary Staffing Summary – Directorate / Care Group

The Group has spent £50.8m on all agency and bank pay YTD. This is (£0.3m) more than the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	**Care Group**	**2024/25**	**2025/26**	**Variance**	**2024/25**	**2025/26**	**Variance**	**2024/25**	**2025/26**	**Variance**
Operations	Acute and Emergency Medicine	3,507	3,332	175	9,891	11,028	(1,137)	13,399	14,360	(961)
	Cancer Network	0	38	(38)	31	57	(26)	31	95	(63)
	Cardiovascular	483	501	(18)	383	397	(14)	866	898	(32)
	Chief Delivery Officer	0	0	0	0	0	(0)	0	0	(0)
	Community, Frailty & Therapy	1,632	2,043	(411)	2,785	2,721	65	4,417	4,764	(346)
	Digestive Diseases	846	548	298	1,647	2,169	(522)	2,494	2,717	(224)
	Family Services	1,546	1,011	535	3,841	3,757	84	5,387	4,768	619
	Head & Neck	867	999	(132)	1,627	1,609	18	2,494	2,608	(114)
	Major Trauma Network	43	62	(19)	169		169	212	62	149
	Neuroscience	908	521	386	861	1,096	(235)	1,769	1,617	152
	Pathology Network Group	20	6	14	850	766	84	869	771	98
	Patient Services	72	436	(364)	1,002	797	204	1,073	1,233	(160)
	Site Management & Discharge teams	62	361	(299)	234	210	24	296	571	(275)
	Specialist Cancer and Support Services	2,322	1,981	341	1,826	2,209	(383)	4,148	4,190	(42)
	Specialist Medicine	823	472	351	2,099	2,599	(500)	2,922	3,071	(149)
	Specialist Surgery	876	835	41	2,015	1,546	469	2,891	2,381	509
	Theatres, Anaesthetics and Critical Care	2,057	1,772	285	2,664	2,332	333	4,721	4,104	617
Total Operations		**16,062**	**14,917**	**1,145**	**31,926**	**33,293**	**(1,367)**	**47,989**	**48,211**	**(222)**
Corporate	Corporate Directorates	367	278	89	2,256	2,579	(323)	2,622	2,857	(235)
Total Corporate		**367**	**278**	**89**	**2,256**	**2,579**	**(323)**	**2,622**	**2,857**	**(235)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(167)	40	(208)	80	(323)	404	(87)	(283)	196
	Reserves	0	0	0	0	37	(37)	0	37	(37)
Total Central Income, Reserves & Technical		**(167)**	**40**	**(208)**	**80**	**(286)**	**367**	**(87)**	**(246)**	**159**
Surplus / (Deficit)		**16,261**	**15,236**	**1,026**	**34,263**	**35,586**	**(1,323)**	**50,524**	**50,822**	**(298)**

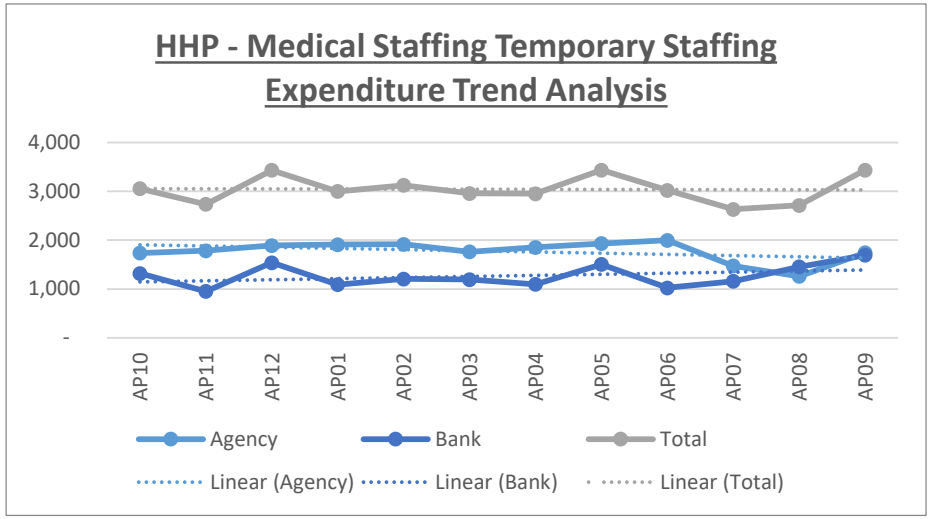


Type	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09
Agency	1,980	2,147	2,403	2,433	2,465	2,405	2,478	2,558	2,527	1,884	1,771	2,231
Bank	3,322	2,579	4,391	3,035	3,627	3,249	3,195	3,598	3,259	3,232	3,363	3,513
Total	**5,302**	**4,726**	**6,794**	**5,468**	**6,092**	**5,654**	**5,673**	**6,156**	**5,786**	**5,116**	**5,134**	**5,744**

Temporary Staffing Summary – Medical Staffing

The Group has spent £27.3m on Medical Staffing agency and bank pay YTD. This is £0.5m less than the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			HHP Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	2,773	2,275	498	6,374	7,095	(721)	9,147	9,370	(224)
	Cancer Network	0	0	0	0	0	0	0	0	0
	Cardiovascular	213	291	(78)	38	69	(32)	251	360	(109)
	Chief Delivery Officer	0	0	0	0	0	0	0	0	0
	Community, Frailty & Therapy	709	962	(253)	1,022	1,156	(135)	1,731	2,119	(388)
	Digestive Diseases	332	162	170	755	1,222	(467)	1,086	1,384	(298)
	Family Services	1,150	641	509	1,498	1,480	18	2,649	2,121	528
	Head & Neck	815	934	(119)	1,370	1,233	137	2,184	2,167	18
	Major Trauma Network	8	19	(11)	0	0	0	8	19	(11)
	Neuroscience	632	333	299	454	516	(62)	1,086	850	236
	Pathology Network Group	1	0	1	423	330	93	424	330	94
	Patient Services	0	0	0	0	0	0	0	0	0
	Site Management & Discharge teams	10	5	4	0	0	0	10	5	4
	Specialist Cancer and Support Services	1,104	1,177	(73)	680	643	37	1,784	1,820	(36)
	Specialist Medicine	353	210	142	1,144	1,581	(436)	1,497	1,791	(294)
	Specialist Surgery	487	638	(150)	1,631	1,174	457	2,118	1,811	307
	Theatres, Anaesthetics and Critical Care	2,001	1,719	282	1,769	1,787	(18)	3,770	3,506	264
Total Operations		**10,587**	**9,368**	**1,220**	**17,158**	**18,286**	**(1,129)**	**27,745**	**27,654**	**91**
Corporate	Corporate Directorates	5	16	(11)		0	0	5	16	(11)
Total Corporate		**5**	**16**	**(11)**	**0**	**0**	**0**	**5**	**16**	**(11)**
Central Income, Reserves & Technical	Central Income	0	0	0	0	0	0	0	0	0
	Central Technical	(11)	37	(48)	(15)	(437)	422	(26)	(400)	374
	Reserves	0	0	0	0	0	0	0	0	0
Total Central Income, Reserves & Technical		**(11)**	**37**	**(48)**	**(15)**	**(437)**	**422**	**(26)**	**(400)**	**374**
Surplus / (Deficit)		**10,581**	**9,421**	**1,160**	**17,142**	**17,849**	**(707)**	**27,723**	**27,270**	**453**

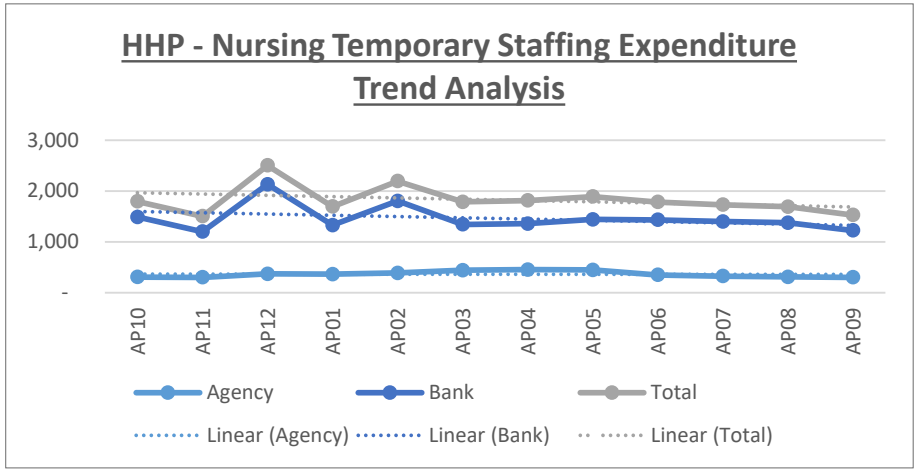


Type	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09
Agency	1,737	1,783	1,892	1,911	1,917	1,763	1,854	1,930	1,998	1,472	1,260	1,743
Bank	1,319	952	1,540	1,089	1,208	1,194	1,097	1,505	1,024	1,158	1,454	1,692
Total	**3,056**	**2,735**	**3,432**	**3,000**	**3,125**	**2,957**	**2,951**	**3,435**	**3,022**	**2,631**	**2,714**	**3,435**

Temporary Staffing Summary - Nursing

The Group has spent £16.1m on Nursing agency and bank pay YTD. This is (£0.4m) more than the same period in 2024/25.

		HUTH (£000s)			NLAG (£000's)			Group Total (£000's)		
Directorate	Care Group	2024/25	2025/26	Variance	2024/25	2025/26	Variance	2024/25	2025/26	Variance
Operations	Acute and Emergency Medicine	732	1,057	(325)	3,382	3,795	(413)	4,114	4,852	(738)
	Cancer Network	0	0	0	8	0	8	8	0	8
	Cardiovascular	170	194	(24)	224	289	(65)	394	483	(89)
	Chief Delivery Officer	0		0	0	0	0	0	0	0
	Community, Frailty & Therapy	694	926	(232)	1,343	1,239	104	2,037	2,165	(128)
	Digestive Diseases	515	386	129	884	947	(63)	1,399	1,333	66
	Family Services	395	368	27	2,278	2,273	5	2,673	2,641	33
	Head & Neck	52	32	20	50	24	26	102	56	46
	Major Trauma Network	35	43	(8)	159	0	159	193	43	150
	Neuroscience	275	187	89	381	529	(148)	657	716	(59)
	Pathology Network Group	1	0	1	0	0	0	1	0	1
	Patient Services	8	5	4	193	60	133	201	65	137
	Site Management & Discharge teams	53	347	(294)	229	203	26	281	549	(268)
	Specialist Cancer and Support Services	664	384	280	154	165	(10)	818	548	270
	Specialist Medicine	469	261	208	917	999	(82)	1,386	1,260	126
	Specialist Surgery	389	192	196	366	372	(6)	755	564	191
	Theatres, Anaesthetics and Critical Care	56	53	3	781	494	288	837	547	291
Total Operations		**4,508**	**4,434**	**75**	**11,350**	**11,389**	**(39)**	**15,858**	**15,823**	**35**
Corporate	Corporate Directorates	7	26	(18)	69	96	(27)	76	121	(45)
Total Corporate		**7**	**26**	**(18)**	**69**	**96**	**(27)**	**76**	**121**	**(45)**
Central Income,	Central Income	0	0	0	0	0	0	0	0	0
Reserves &	Central Technical	(185)	(6)	(178)	21	147	(125)	(163)	140	(304)
Technical	Reserves	0	0	0	0	37	(37)	0	37	(37)
Total Central Income, Reserves & Technical		**(185)**	**(6)**	**(178)**	**21**	**184**	**(162)**	**(163)**	**177**	**(341)**
Surplus / (Deficit)		**4,331**	**4,453**	**(122)**	**11,440**	**11,668**	**(228)**	**15,771**	**16,121**	**(350)**



Type	AP10	AP11	AP12	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09
Agency	309	304	372	366	391	444	456	450	352	328	313	303
Bank	1,489	1,201	2,134	1,330	1,806	1,345	1,358	1,442	1,433	1,402	1,378	1,225
Total	**1,797**	**1,505**	**2,505**	**1,696**	**2,196**	**1,789**	**1,814**	**1,892**	**1,785**	**1,730**	**1,691**	**1,528**

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	75.6	75.3	(0.3)	678.9	681.8	2.9	47.0	46.1	(0.9)	420.2	419.1	(1.2)	122.6	121.3	(1.3)	1,099.1	1,100.9	1.8
Other Income	5.9	7.1	1.2	69.5	72.2	2.7	6.1	6.5	0.4	56.2	51.2	(5.0)	12.0	13.6	1.6	125.7	123.3	(2.4)
Total Operating Income	**81.5**	**82.4**	**0.9**	**748.4**	**754.0**	**5.6**	**53.1**	**52.6**	**(0.5)**	**476.4**	**470.2**	**(6.2)**	**134.6**	**134.9**	**0.4**	**1,224.8**	**1,224.2**	**(0.6)**
Pay Costs																		
Medical Staff	(17.4)	(18.7)	(1.3)	(157.1)	(163.5)	(6.4)	(9.8)	(11.0)	(1.2)	(90.1)	(94.0)	(4.0)	(27.1)	(29.7)	(2.5)	(247.1)	(257.5)	(10.4)
Nursing Staff	(15.5)	(16.2)	(0.7)	(134.3)	(140.4)	(6.1)	(12.9)	(12.6)	0.3	(115.9)	(115.5)	0.4	(28.4)	(28.8)	(0.4)	(250.2)	(255.9)	(5.7)
Scientific Therapeutic & Technical Staff	(6.3)	(7.0)	(0.7)	(61.8)	(63.4)	(1.6)	(5.0)	(5.3)	(0.3)	(45.3)	(47.1)	(1.8)	(11.3)	(12.3)	(1.0)	(107.1)	(110.4)	(3.3)
Total Clincial Pay	**(39.1)**	**(41.9)**	**(2.7)**	**(353.2)**	**(367.3)**	**(14.1)**	**(27.7)**	**(28.9)**	**(1.2)**	**(251.2)**	**(256.6)**	**(5.4)**	**(66.9)**	**(70.8)**	**(3.9)**	**(604.4)**	**(623.9)**	**(19.5)**
Admin & Clerical Staff	(6.2)	(6.2)	(0.0)	(55.8)	(56.1)	(0.3)	(5.4)	(5.5)	(0.1)	(48.1)	(47.2)	0.9	(11.6)	(11.7)	(0.1)	(103.9)	(103.3)	0.6
Maintenance Staff	(0.3)	(0.3)	0.0	(2.9)	(2.7)	0.2	(0.2)	(0.2)	(0.0)	(1.6)	(1.5)	0.1	(0.5)	(0.5)	0.0	(4.6)	(4.2)	0.3
Support Staff	(1.7)	(1.6)	0.0	(14.9)	(14.5)	0.4	(1.6)	(1.7)	(0.0)	(14.8)	(14.8)	0.0	(3.3)	(3.3)	0.0	(29.7)	(29.3)	0.4
Other Staff	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	(0.0)
Apprentice Levy	(0.2)	(0.2)	(0.0)	(1.6)	(1.7)	(0.2)	(0.1)	(0.1)	(0.0)	(1.3)	(1.3)	0.0	(0.3)	(0.3)	(0.0)	(2.9)	(3.0)	(0.1)
Total Other Pay	**(8.4)**	**(8.3)**	**0.0**	**(75.3)**	**(75.2)**	**0.2**	**(7.4)**	**(7.5)**	**(0.1)**	**(65.9)**	**(64.9)**	**1.0**	**(15.7)**	**(15.8)**	**(0.1)**	**(141.2)**	**(140.1)**	**1.2**
Total Pay Costs	**(47.5)**	**(50.2)**	**(2.7)**	**(428.5)**	**(442.4)**	**(13.9)**	**(35.1)**	**(36.4)**	**(1.3)**	**(317.1)**	**(321.5)**	**(4.4)**	**(82.6)**	**(86.6)**	**(4.0)**	**(745.7)**	**(763.9)**	**(18.3)**
Drugs	(10.8)	(11.5)	(0.7)	(97.9)	(102.2)	(4.4)	(2.6)	(3.8)	(1.2)	(28.7)	(30.9)	(2.3)	(13.4)	(15.3)	(1.9)	(126.6)	(133.2)	(6.6)
Clinical Supplies & Services	(7.4)	(8.8)	(1.4)	(66.3)	(71.3)	(5.0)	(4.0)	(4.7)	(0.7)	(35.9)	(38.6)	(2.7)	(11.3)	(13.5)	(2.2)	(102.3)	(109.9)	(7.7)
Total Clinical Non Pay	**(18.1)**	**(20.3)**	**(2.2)**	**(164.2)**	**(173.6)**	**(9.4)**	**(6.6)**	**(8.5)**	**(1.9)**	**(64.6)**	**(69.6)**	**(5.0)**	**(24.7)**	**(28.8)**	**(4.1)**	**(228.8)**	**(243.1)**	**(14.3)**
General Supplies & Services	(2.0)	(2.4)	(0.4)	(17.1)	(17.0)	0.1	(0.5)	(0.8)	(0.3)	(4.7)	(6.5)	(1.8)	(2.5)	(3.2)	(0.7)	(21.8)	(23.5)	(1.8)
Establishment Expenses	(0.5)	(0.6)	(0.1)	(4.7)	(4.8)	(0.1)	(0.7)	(0.6)	0.1	(6.2)	(5.4)	0.7	(1.2)	(1.2)	0.0	(10.9)	(10.3)	0.6
Other Establishment Costs	(2.4)	(2.5)	(0.1)	(21.8)	(21.8)	(0.0)	(1.5)	(1.5)	(0.0)	(13.4)	(13.3)	0.1	(3.9)	(4.0)	(0.1)	(35.2)	(35.1)	0.1
Premises and Fixed Plant	(2.6)	(3.1)	(0.5)	(27.2)	(25.1)	2.1	(2.2)	(2.2)	(0.0)	(19.4)	(17.7)	1.7	(4.8)	(5.3)	(0.5)	(46.5)	(42.8)	3.7
Purchase of Healthcare Services	(3.3)	(4.0)	(0.7)	(33.1)	(32.0)	1.1	(1.6)	(1.5)	0.1	(15.2)	(12.6)	2.5	(4.9)	(5.5)	(0.6)	(48.2)	(44.6)	3.6
Miscellaneous Expenditure	(0.0)	(0.1)	(0.1)	(0.1)	(0.5)	(0.4)	(0.1)	(0.1)	(0.0)	(0.9)	(1.1)	(0.2)	(0.1)	(0.2)	(0.1)	(1.0)	(1.6)	(0.6)
Education Expenditure	(0.6)	(1.0)	(0.4)	(5.6)	(5.5)	0.2	(0.1)	(0.3)	(0.1)	(2.3)	(2.2)	0.1	(0.7)	(1.3)	(0.6)	(7.9)	(7.6)	0.3
Consultancy Expenditure	(0.0)	0.0	0.0	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.3)	(0.4)	(0.1)	(0.0)	(0.0)	(0.0)	(0.3)	(0.5)	(0.2)
Total Other Non Pay	**(11.4)**	**(13.7)**	**(2.3)**	**(109.6)**	**(106.8)**	**2.8**	**(6.8)**	**(7.1)**	**(0.3)**	**(62.3)**	**(59.2)**	**3.0**	**(18.2)**	**(20.8)**	**(2.6)**	**(171.9)**	**(166.0)**	**5.9**
Total Non Pay Costs	**(29.6)**	**(34.0)**	**(4.5)**	**(273.8)**	**(280.3)**	**(6.5)**	**(13.4)**	**(15.5)**	**(2.2)**	**(126.9)**	**(128.8)**	**(1.9)**	**(42.9)**	**(49.6)**	**(6.6)**	**(400.7)**	**(409.1)**	**(8.5)**
Total Operating Expenditure	**(77.1)**	**(84.2)**	**(7.2)**	**(702.3)**	**(722.7)**	**(20.4)**	**(48.4)**	**(51.9)**	**(3.5)**	**(444.0)**	**(450.3)**	**(6.3)**	**(125.5)**	**(136.2)**	**(10.6)**	**(1,146.3)**	**(1,173.1)**	**(26.7)**
EBITDA	**4.4**	**(1.9)**	**(6.3)**	**46.1**	**31.2**	**(14.9)**	**4.7**	**0.7**	**(4.0)**	**32.4**	**19.9**	**(12.5)**	**9.1**	**(1.2)**	**(10.3)**	**78.5**	**51.1**	**(27.3)**
Depreciation	(2.5)	(2.5)	0.0	(22.3)	(22.1)	0.2	(2.2)	(1.8)	0.4	(19.0)	(17.0)	2.0	(4.7)	(4.3)	0.4	(41.3)	(39.1)	2.2
Non Operating Items	(1.4)	(1.4)	(0.0)	(12.6)	(12.3)	0.3	(0.7)	(0.5)	0.2	(6.0)	(5.3)	0.8	(2.1)	(1.9)	0.2	(18.6)	(17.5)	1.1
Surplus/(Deficit)	**0.5**	**(5.8)**	**(6.3)**	**11.2**	**(3.1)**	**(14.4)**	**1.8**	**(1.7)**	**(3.4)**	**7.3**	**(2.3)**	**(9.7)**	**2.3**	**(7.4)**	**(9.8)**	**18.6**	**(5.5)**	**(24.0)**
NHSE Allowable Adjustments	0.0	(0.5)	(0.5)	(15.1)	(14.6)	0.5	(1.5)	(1.6)	(0.1)	(13.5)	(8.3)	5.2	(1.5)	(2.1)	(0.6)	(28.6)	(22.8)	5.7
Adjusted Surplus / (Deficit)	**0.6**	**(6.3)**	**(6.9)**	**(3.9)**	**(17.7)**	**(13.8)**	**0.3**	**(3.2)**	**(3.5)**	**(6.1)**	**(10.6)**	**(4.5)**	**0.9**	**(9.5)**	**(10.4)**	**(10.0)**	**(28.3)**	**(18.3)**

Appendix A – Trust I&E & Divisional Budgetary Performance (2)

		HUTH (£m)						NLAG (£m)						HHP (£m)					
		CM			YTD			CM			YTD			CM			YTD		
Directorate	Care Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Operations	Acute and Emergency Medicine	(3.3)	(4.0)	(0.7)	(30.1)	(33.3)	(3.1)	(5.7)	(5.9)	(0.1)	(51.3)	(52.3)	(1.0)	(9.1)	(9.9)	(0.8)	(81.4)	(85.6)	(4.1)
	Cancer Network	(0.4)	(0.4)	0.1	(4.0)	(3.9)	0.1	(0.3)	(0.4)	(0.1)	(2.4)	(2.4)	0.1	(0.7)	(0.7)	0.0	(6.4)	(6.3)	0.1
	Cardiovascular	(3.4)	(4.0)	(0.6)	(31.9)	(32.0)	(0.1)	(0.9)	(0.9)	0.0	(8.4)	(8.1)	0.2	(4.4)	(4.9)	(0.5)	(40.3)	(40.1)	0.1
	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(0.7)	(0.7)	(0.0)	(0.1)	(0.1)	(0.0)	(0.7)	(0.6)	0.1	(0.2)	(0.2)	(0.0)	(1.4)	(1.3)	0.1
	Community, Frailty & Therapy	(3.6)	(3.8)	(0.2)	(31.9)	(33.5)	(1.6)	(4.2)	(4.2)	0.0	(36.3)	(36.6)	(0.3)	(7.8)	(8.0)	(0.2)	(68.2)	(70.1)	(1.9)
	Digestive Diseases	(2.9)	(3.3)	(0.4)	(26.1)	(29.0)	(2.9)	(2.6)	(2.6)	(0.1)	(22.8)	(22.9)	(0.1)	(5.4)	(5.9)	(0.4)	(48.9)	(51.9)	(3.0)
	Family Services	(4.8)	(5.3)	(0.5)	(42.4)	(45.9)	(3.5)	(4.5)	(4.6)	(0.1)	(39.6)	(41.2)	(1.6)	(9.3)	(9.9)	(0.6)	(82.0)	(87.1)	(5.1)
	Head & Neck	(3.5)	(3.6)	(0.0)	(31.6)	(32.3)	(0.7)	(1.4)	(1.5)	(0.2)	(12.1)	(12.6)	(0.5)	(4.9)	(5.1)	(0.2)	(43.7)	(44.9)	(1.2)
	Major Trauma Network	(0.3)	(0.3)	(0.0)	(2.5)	(2.6)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.3)	(0.4)	(0.1)	(2.6)	(2.7)	(0.1)
	Neuroscience	(2.3)	(2.7)	(0.3)	(20.8)	(22.1)	(1.3)	(0.8)	(0.9)	(0.1)	(7.5)	(7.9)	(0.4)	(3.2)	(3.6)	(0.4)	(28.2)	(30.0)	(1.8)
	Pathology Network Group	(2.1)	(2.2)	(0.1)	(17.6)	(18.3)	(0.7)	(2.2)	(2.2)	(0.0)	(19.1)	(19.1)	(0.1)	(4.3)	(4.4)	(0.1)	(36.6)	(37.4)	(0.8)
	Patient Services	(2.2)	(2.1)	0.1	(19.8)	(19.8)	0.0	(1.7)	(1.7)	0.1	(15.2)	(14.9)	0.3	(4.0)	(3.8)	0.2	(35.0)	(34.7)	0.3
	Site Management & Discharge teams	(0.3)	(0.3)	(0.1)	(2.4)	(2.9)	(0.4)	(0.4)	(0.4)	(0.0)	(3.1)	(3.2)	(0.1)	(0.6)	(0.7)	(0.1)	(5.5)	(6.1)	(0.5)
	Specialist Cancer and Support Services	(18.0)	(18.5)	(0.5)	(162.2)	(163.6)	(1.4)	(6.1)	(6.2)	(0.1)	(54.8)	(54.6)	0.3	(24.1)	(24.7)	(0.6)	(217.0)	(218.1)	(1.1)
	Specialist Medicine	(3.9)	(4.3)	(0.4)	(34.5)	(35.7)	(1.3)	(2.0)	(2.1)	(0.1)	(17.6)	(18.0)	(0.4)	(5.8)	(6.3)	(0.5)	(52.1)	(53.7)	(1.6)
	Specialist Surgery	(3.8)	(3.8)	0.0	(32.0)	(33.7)	(1.6)	(1.9)	(2.0)	(0.1)	(16.1)	(16.6)	(0.4)	(5.7)	(5.8)	(0.1)	(48.2)	(50.2)	(2.0)
	Theatres, Anaesthetics and Critical Care	(7.4)	(7.5)	(0.1)	(66.3)	(67.8)	(1.5)	(4.1)	(4.6)	(0.4)	(37.9)	(38.8)	(0.9)	(11.5)	(12.0)	(0.5)	(104.2)	(106.6)	(2.4)
Total Operations		**(62.4)**	**(66.1)**	**(3.7)**	**(556.9)**	**(576.9)**	**(20.0)**	**(38.9)**	**(40.2)**	**(1.2)**	**(345.0)**	**(349.9)**	**(4.9)**	**(101.3)**	**(106.2)**	**(4.9)**	**(901.9)**	**(926.8)**	**(25.0)**
Corporate	Chief Executive	(0.1)	(0.2)	(0.0)	(1.1)	(1.4)	(0.3)	(0.1)	(0.2)	(0.1)	(1.0)	(1.3)	(0.3)	(0.2)	(0.3)	(0.1)	(2.1)	(2.7)	(0.6)
	Chief Medical Officer	(0.6)	(0.5)	0.1	(4.1)	(3.8)	0.2	(0.6)	(0.6)	0.0	(6.0)	(5.9)	0.0	(1.2)	(1.1)	0.1	(10.0)	(9.7)	0.3
	Chief Nurse Office	(3.0)	(3.2)	(0.2)	(26.9)	(27.6)	(0.7)	(2.2)	(2.2)	0.0	(20.2)	(19.8)	0.4	(5.2)	(5.4)	(0.2)	(47.1)	(47.4)	(0.4)
	Director of Assurance	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)	(0.0)	(0.1)	(0.1)	0.0	(0.6)	(0.6)	0.0	(0.1)	(0.1)	0.0	(0.8)	(0.8)	(0.0)
	Director of People	(0.9)	(0.9)	0.0	(8.0)	(7.6)	0.4	(0.8)	(0.8)	0.0	(7.4)	(7.1)	0.2	(1.7)	(1.7)	0.0	(15.3)	(14.7)	0.6
	Director of Finance, Estates & Facilities	(6.2)	(6.6)	(0.4)	(56.7)	(54.7)	2.0	(4.2)	(4.6)	(0.3)	(37.7)	(38.9)	(1.2)	(10.4)	(11.2)	(0.8)	(94.4)	(93.6)	0.8
	Strategy and Partnerships	(0.9)	(0.8)	0.1	(8.0)	(7.9)	0.1	(0.7)	(0.7)	0.0	(6.6)	(6.3)	0.3	(1.7)	(1.5)	0.2	(14.6)	(14.2)	0.4
Total Corporate		**(11.7)**	**(12.1)**	**(0.4)**	**(104.8)**	**(103.2)**	**1.6**	**(8.8)**	**(9.2)**	**(0.3)**	**(79.5)**	**(80.0)**	**(0.5)**	**(20.5)**	**(21.2)**	**(0.8)**	**(184.3)**	**(183.2)**	**1.1**
Central Income, Reserves & Technical	Central Income	76.4	76.3	(0.1)	703.4	700.4	(2.9)	48.6	47.5	(1.1)	435.5	433.2	(2.3)	125.0	123.8	(1.2)	1,138.8	1,133.6	(5.2)
	Central Technical	(3.5)	(3.9)	(0.4)	(34.2)	(23.4)	10.8	(1.2)	0.1	1.3	(9.9)	(5.2)	4.7	(4.7)	(3.8)	0.9	(44.1)	(28.6)	15.5
	Reserves	1.7	0.0	(1.6)	3.7	(0.1)	(3.8)	2.2	0.0	(2.1)	6.3	(0.4)	(6.7)	3.8	0.1	(3.8)	10.0	(0.5)	(10.5)
Total Central Income, Reserves & Technical		**74.6**	**72.4**	**(2.2)**	**672.9**	**677.0**	**4.1**	**49.6**	**47.7**	**(1.9)**	**431.8**	**427.6**	**(4.2)**	**124.1**	**120.0**	**(4.1)**	**1,104.7**	**1,104.6**	**(0.1)**
Surplus / (Deficit)		**0.5**	**(5.8)**	**(6.3)**	**11.2**	**(3.1)**	**(14.4)**	**1.8**	**(1.7)**	**(3.4)**	**7.3**	**(2.3)**	**(9.7)**	**2.3**	**(7.4)**	**(9.8)**	**18.6**	**(5.5)**	**(24.0)**
Adjustments to adjusted financial performance		0.0	(0.5)	(0.5)	(15.1)	(14.6)	0.5	(1.5)	(1.6)	(0.1)	(13.5)	(8.3)	5.2	(1.5)	(2.1)	(0.6)	(28.6)	(22.8)	5.7
Adjusted financial performance Surplus / (Deficit)		**0.6**	**(6.3)**	**(6.9)**	**(3.9)**	**(17.7)**	**(13.8)**	**0.3**	**(3.2)**	**(3.5)**	**(6.1)**	**(10.6)**	**(4.5)**	**0.9**	**(9.5)**	**(10.4)**	**(10.0)**	**(28.3)**	**(18.3)**

NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)022

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 12th February 2026
Director Lead	Tony Curry, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common Julie Beilby, Non-Executive Director and Chair of Workforce, Education and Culture Committees-in-Common
Contact Officer / Author	Karena Groom, Interim Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on Wednesday 26th November and Wednesday 17th December 2025.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	**The minutes attached are for information.**
Prior Approval Process	Workforce, Education and Culture Committees-In-Common held on Wednesday 17th December 2025 and Wednesday 28th January 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, 26th November 2025 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) – Chair
Julie Beilby	Non-Executive Director (NLaG)
Simon Nearney	Group Chief People Officer
Heather McNair	Interim Group Chief Nurse
Andy Gratrix	Group Associate Chief Medical Officer (attending for Group Chief Medical Officer)
Sue Liburd	Non-Executive Director (NLaG)
Laura Treadgold	Non-Executive Director (HUTH)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Lucy Vere	Group Director of Learning and Organisational Development
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement
Helen Knowles	Director of People Services (item 4.5)
Katie Firth	Head of Undergraduate Medical Education (HUTH) (item 4.3)
Kathryn Hallam	Head of Undergraduate Medical Education (NLaG) (item 4.3)
Dr Wajiha Arshad	Guardian of Safe Working (HUTH) (item 4.4.1)
Dr Elizabeth Evans	Guardian of Safe Working (NLaG) (item 4.4.2)

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 were noted for Dr Kate Wood, Group Chief Medical Officer, Peter

Sedman, Deputy Group Chief Medical Officer, and David Sulch, Non-Executive Director (HUTH).

Tony Curry shared that the Non-Executive Directors were required to join an urgent meeting at 10:00 hours for 30 minutes. He proposed that the CiC take a break at that point and reconvene at 10:30 hours.

1.2 **Staff Charter and Values**

Tony Curry noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meeting held on 24th October 2025**

The minutes of the meeting held on 24th October 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to note.

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

Updates to the Action Tracker were provided within the agenda items.

Sue Liburd joined the meeting at 09:08 hours.

1.7 **Review of Effectiveness**

David Sharif mentioned that the Group conducted an Effectiveness review annually across the Committees-in-Common. A link to the survey would be circulated to the CiC members outside of this meeting and the results of the Effectiveness review would be presented at the next meeting.

1.8 **Urgent and Emerging Issues**

Simon Nearney updated that the resident doctors Industrial Action had now ended without upset. Elective activity was maintained at 95% and disruption was kept to a minimum. The IA will cost the group, but exact costs were not known at this time. Performance and patient flow improved as Consultants were making decisions. Caroline Hibbert was undertaking a review to establish what could be retained as the industrial action ends and the Group revert to business-as-usual.

The dispute with the NLaG LNC regarding on-call payments was now resolved. Further discussions had taken place with HUTH LNC colleagues to ensure harmonisation and they agreed to the offer of the new on-call rate. The Group would write to the Consultants, LNCs and Chiefs of Service to confirm this and the new on-call rate would be implemented from 01 December 2025.

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 Frameworks: including Risk Register Report

David Sharif took the report as read. He shared that there were 4 actions with a current score of 20 and the aim was to reduce that score to a tolerable score of 8. The Value Circle had undertaken a risk stocktake and presented their findings to Boards-in-Common which identified several substantive risks regarding leadership, workforce and culture. David Sharif emphasised the importance of reflecting on those risks to achieve the overarching strategic objective.

Julie Beilby raised that the lack of stability within the senior leadership team had an impact on the whole Group however, it was not captured overtly within the risks. Simon Nearney proposed changing the Group Senior Management team rating from reasonable to limited.

Lucy Vere mentioned that as several meetings within her team were exec-led, the current challenges within the senior leadership team had impacted and delayed progressing those meetings. Mandatory learning was harmonised and the next stage was to review subject areas with the mandatory learning oversight group to manage the risks. The structure was in place and the first meeting scheduled for December 2025/early January 2026.

David Sharif assured the CiC that he would make it clear in the report that the stability of the leadership team controls would be rated as limited. He mentioned the vacancy control panel and emphasised the objective of reducing the headcount within the Group in 2025/26 which was challenging.

Simon Nearney emphasised the importance of being vigilant regarding headcount. He shared that the Group submitted a plan to NHSE for 2025/26 that would increase the headcount and were on track to deliver £115 million against a £130 million target. Corporate Services were required to reduce by £6.7 million this year and this would be delivered. He emphasised that the key objective was to reduce the budget but sometimes the headcount may not reduce as you deliver the saving and maintain the service by skill mixing or reduce variable pay but increase substantive staff. The main driver was to live financially within the Group's means.

Heather McNair queried why the biannual safer staffing paper was given limited assurance. She mentioned that the safer staffing assurance visit took place recently from NHSE and they provided the Group significant assurance within their report. Simon Nearney suggested amending the assurance to reasonable once the CiC has sight of that report. Heather McNair would bring that report to the next meeting.

Action: Heather McNair to bring the feedback report from the safer staffing assurance visit to the next meeting.

Tony Curry acknowledged the current challenges around reporting of Whole Time Equivalent (WTE) numbers. He noted that there was a planned increase in WTE in 2025/26 however, there was also an unplanned increase which raised concerns regarding how numbers were being monitored and reported. Greater visibility was required around how those numbers were devised.

David Sharif clarified that the ratings that were provided as part of the controls assurances were Executive-led and rounded judgements that were conducted based on the available evidence through reports, exceptions or incidents to indicate that control systems were not working as well as expected. The Group was moving towards a more direct-evidence basis which was expected to take time to instigate through the system.

Helen Knowles joined the meeting at 09:34 hours.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s), as appropriate**

None to note.

3.3 **Review of Relevant External Reports, Recommendations & Assurances as appropriate**

None to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Resident Doctor 10 Point Plan**

Simon Nearney shared that NHSE had written to every organisation in August 2025 to launch the Resident Doctor 10 point plan with the aim of improving the working lives of resident doctors. He was identified as the executive lead and was working closely with Dr Kate Wood through the oversight group that she chaired which also included the work to improve GMC survey results. Becky Lavelle (NLaG) and Alex Abel (HUTH) were identified as the resident doctor leads, and the infrastructure was in place with the Group now focusing efforts on the 10 point plan. Work was required alongside NHSE and the Deanery to improve timescales of supplying rota schedules. It was determined that resident doctors should not be experiencing issues with payroll errors, and the Head of Payroll was working with the National Group to understand what the Group were required to do differently. Work was ongoing to ensure that resident doctors were not required to refresh statutory mandatory training and allow resident doctors transferring into the Group to bring forward their mandatory training. This was now in place. Efforts would continue to encourage resident doctors to submit exception reports. Work would take place to raise awareness of the wellbeing support that was already in place for resident doctors. A process was in place to ensure that employment checks were not repeated for resident doctors moving across the Group however, further work was required with other organisations to streamline employment checks for resident doctors rotating from other organisations. Other matters such as car parking, rest spaces and hot food were being reviewed and changes had been made to pay resident doctors some of their expenses before they attended

training. Regular updates would be presented to this meeting.

Sue Liburd queried whether the Oversight Delivery Group was structured enough to capture insights quickly.
Simon Nearney explained that there was a three-tier structure in place which allows for flexible and responsive action:

- The Resident Doctors Forum, which provides resident doctors an opportunity to raise concerns and what was working well on a monthly basis.
- A 10 Point Plan meeting, with Resident Doctor Leads to get into the specifics of the plan.
- An Overview Group chaired by Dr Kate Wood which reviewed the 10 point plan agenda and wider GMC staff survey issues.

Becky Lavelle and Alex Abel are positive advocates for resident doctors, they were involved in the action plan and had the confidence to raise any concerns immediately. Simon confirmed that there were no significant risks.

Julie Beilby noted appendix 1 within the report regarding access to mess facilities and queried whether this would be addressed in the Q4 programme of the people strategy. Simon Nearney confirmed this and shared that work would take place to review the mess facilities which would support health and wellbeing. Funding was received from the Wishh Charity which would be utilised to develop the rest rooms at HUTH.

Paul Bunyan highlighted that the Group were seeking to address challenges that were not directly related to the 10 point plan but would still improve the working lives of resident doctors.

Lucy Vere shared that a pilot was underway on the North Bank to recruit an assistant psychologist based within medical education and this was funded from the medical education budget. A review meeting would take place, and Lucy Vere would meet with Paul Bunyan and Andy Gratrix to understand the implications and engagement progress. Further feedback would be provided to this meeting in due course as part of the 10 point plan update.

Tony Curry mentioned that it would be helpful to understand the position in terms of achieving the ambitions of the plan as it was not clear within the report.
Simon Nearney explained that efforts were underway to understand what was most important for resident doctors and as the Group moved forward they would be able to report this.

4.2 **Apprenticeship Levy Annual Report 2024/25 (progress since March 2025)**

Lucy Vere updated that £1.8 million was invested in apprenticeship levy spending in 2025/26, which was a 14% increase in comparison to 2024/25. This was positive considering the ongoing challenges within recruitment and a key factor was the level 7 spend which would be eradicated. The Group were actively exploring how maintain the level of spend and it was confirmed that Advanced Care Planning (ACPs) could now be included within that spend. Work was ongoing regarding level 6 enhanced care apprenticeships which would significantly support that.

The proportion of apprentices under 20 remained low with 28% at HUTH and 2% at NLaG. Lucy Vere acknowledged that HUTH onboarded a significant volume of external new starters however, NLaG utilised internal staff for nursing apprenticeships, and a widening participation engagement would take place. Following resignation of the Head of Learning at NLaG, a Group Head of Learning would be appointed and Anne Burdis was appointed as the Group Widening Participation Manager. Efforts were underway to build on T-levels, project search and explore traineeships. A graduate engineering scheme was sponsored by NHSE which would support Medical Physics to prosper and develop their succession plan. Work was ongoing to support hard to recruit areas and recruitment into mammography had been successful. The Group continued to support with levy transfers through a structured process, working closely with the ICB to ensure that the Group were targeting appropriate areas.

Sue Liburd queried whether the Group would significantly benefit from the refocus on funding for junior and younger people. Lucy Vere explained that this would provide greater flexibility, and funding would support the Group to create more talent pipelines for existing staff and support them with further or higher education.

Sue Liburd wondered whether there was more that the Group could do to support the challenges with apprenticeships around retention and completion rates. Lucy Vere explained that further work would take place to understand the reasons and whether there was a continual theme across the Group.

Julie Beilby wondered whether there was a mandatory requirement for the frequency of reporting. Lucy Vere proposed providing an update alongside the learning report and an annual report would be provided in April at the end of each financial year.

Action: Karena Groom to amend the workplan for the annual levy report to come back in April 2026.

David Sharif asked for clarification around expiring refunds. Lucy Vere clarified that some expiring refunds would return to the treasury for NLaG, however HUTH did not have any expiring refunds.

The Committees-in-Common agreed reasonable assurance.

The meeting paused at 10:01 hours and would reconvene at 10:30 hours.

4.3 **Undergraduate Medical Education Annual Report – HUTH and NLaG**

Katie Firth and Kathryn Hallam joined the meeting at 10:29 hours.
Dr Wajiha Arshad joined the meeting at 10:38 hours.

Katie Firth shared that the Boards-in-Common had requested for a combined report and this was the first combined Undergraduate Medical Education report that was produced. Leadership roles at HUTH had been redefined and there was greater targeted leadership for key areas into specific years. The recruitment of an Innovation, Research and Technology Lead was expected to support students undertaking CIP projects, clinical teaching fellows and the workforce team to develop research in partnership with the Group. Formal student feedback was sparse due to the summer break. Student support mechanisms were robust and

the new attendance monitoring would improve visibility for rotating students. Work was ongoing with Legal and Access teams to define a process for supervised activities. An accommodation phase-out plan had commenced which was expected to provide additional saving in the tariff. Challenges were ongoing regarding space due to an increase seen in students over the past 5 years and work was taking place to look at alternative spaces off-site, which would redirect tariff to those areas however work would take place to assess need and space within the Group versus the requirement for teaching. She emphasised the need for clarity around tariff spend. Work was ongoing to define the current processes around tariff spend and further conversations would take place with clinical groups to define the current position.

Kathryn Hallam provided an update for NLaG. Challenges were ongoing due to moving services and student perceptions however, virtual cross-site meetings and teaching were being implemented to support this. 60% of fellows were former Hull York Medical School (HYMS) and Sheffield students and recruitment retention was a key focus for medical students. Challenges were ongoing regarding service changes and inadequate space, as student numbers had increased over 80% across the Group. There were no current plans for student expansion due to the lack of training posts within Undergraduate Medical Education. A Sheffield monitoring visit would take place on Monday 02 December 2025. Work was ongoing with Finance colleagues to assess teaching arrangements and costs to ensure that tariff funding was utilised to support tutors and tutor time.

Laura Treadgold mentioned the significant number of sessions that were cancelled in Children's and Women's Health and wondered the cause of this, whether the sessions were being repeated and whether students were losing out as a consequence. Kathryn Hallam clarified that this was being monitored however, the Group were unsure why Children's and Women's Health was an outlier and work was ongoing to understand why.

Laura Treadgold raised concerns and asked for further clarification around the reported increased number of trainees from all professions on wards which reduced the quality of student experience and had an impact on their willingness to attend. Katie Firth clarified that this was ongoing within areas around Women's Health and the level of supervision was required to be higher however the Group did not have oversight of nursing or midwifery students and further work was required to identify this. Laura suggested that a discussion take place with nursing colleagues regarding how to solve this. Katie Firth shared that she would identify key members to start those discussions.

Dr Elizabeth Evans joined the meeting at 10:46 hours.

Tony Curry acknowledged that understanding the use of tariff spend was previously discussed and on the Committees' radar.

Katie Firth and Kathryn Hallam left the meeting at 10:58 hours.

The Committees-in-Common agreed reasonable assurance.

4.4 **Guardian of Safe Working Hours Quarter 2 Report – HUTH and NLaG**

4.4.1 **Guardian of Safe Working Hours Quarter 2 Report – HUTH**

Dr Wajiha Arshad shared that 170 exception reports were raised in Q2 predominantly due to hours worked. Resident doctors were engaging with the new exception reporting system and positive feedback was received regarding the streamlining of the system. There was a significant number of fines received, attributing to historical challenges ongoing in Paediatric surgery and totalling almost £12k. A retrospective analysis revealed that Paediatric Surgery had incurred £117k in fines since August 2022 and a business case was in place to potentially reduce additional hours and future fines.

The Committees-in-Common agreed reasonable assurance.

4.4.2 **Guardian of Safe Working Hours Quarter 2 Report – NLaG**

Dr Elizabeth Evans shared that a significant increase was seen in the exception reports received in Q2, highlighting that this was prior to implementation of the new exception reporting system. She acknowledged that efforts were previously made to encourage new starters to report however, the recent increase in exception reports was unexpected. Reasons for reporting were due to short overruns and hours. Previous funding challenges had resolved, and no fines were incurred.

Sue Liburd queried the reasons for concerns being continuously raised in the resident doctor's forum. Dr Elizabeth Evans acknowledged that cultural behaviours within Medicine contributed to the inability of resolving challenges however, challenges were predominantly due to insufficient staffing on the wards. Dr Nick Cross and Dr Caroline Hibbert had commenced a staffing review of the medical establishment within medicine across the Group.

Julie Beilby mentioned that a paper around Theatre Utilisation was presented to Audit, Risk and Governance CiC which indicated that there was capacity within theatre utilisation however, that did not correlate with the reported theatre overruns within this paper. Dr Elizabeth Evans explained that the reported theatre overruns were not genuine, and in fact were reported by numerous resident doctors whose work schedules finished an hour before the theatre lists ended. She expected that this challenge would resolve and assured the CiC that work would continue to monitor this. Julie Beilby suggested providing this clarity within the paper.

Tony Curry acknowledged that admin and allocation of PA support appeared to be different across the Group. Andy Gratrix explained that clarity around PAs, ownership, educational supervision and whether every resident doctor had an allocated educational supervisor was not clear at NLaG and work was ongoing to understand this.

Andy Gratrix shared that the Director of Medical Education at NLaG had resigned their post and would terminate at the end of December 2025. A Partnership Group Director of Medical Education was appointed in the meantime and site-specific Directors of Medical Education would be advertised in due course.

The Committees-in-Common agreed reasonable assurance.

Dr Wajiha Arshad and Dr Elizabeth Evans left the meeting at 11:15 hours.

4.5 **Medical and Dental Job Planning – Monthly Update**

Helen Knowles took the paper as read and updated that as of 18 November 2025 compliance was 77% and had increased by 13% in comparison to the previous report in October 2025. The compliance rate to date was 79.6% and continued to increase. Dr Kate Wood and Peter Sedman were overseeing consistency panels to encourage achievement of the 95% compliance by the end of March 2026. Peter Sedman was having discussions with Chiefs of Service and Clinical Directors of Care Groups that were not making progress to see what support could be provided.

Julie Beilby noted that she was pleased to see significant progress that was made and wished to see the report come back to the CiC for assurance possibly in January 2026 to ensure that the Group were focused on achieving 95% compliance by the end of March 2026.

Tony Curry queried whether the Group were in danger of passing any of the planning cycles by with incomplete information and wondered whether job planning was required to support other processes. Helen Knowles shared that discussions were now taking place around team job planning and capacity, to encourage Care Groups to think about how the capacity within job plans impacts on the demand.

Heather McNair mentioned that it was crucial to understand whether job plans were signed off, the quality of the job plan, and whether it linked to capacity and demand. Helen Knowles shared that efforts were underway with a focus on capacity and demand.

Laura Treadgold queried how job planning collaborated with clinical academics. Helen Knowles explained that academics were included within job planning compliance. Job plans had a first and second level sign off however, she was unsure around the link between job planning and academic managers.

The Committees-in-Common took the report for information and agreed to take the next report for assurance.

4.6 **Organisational Development Update**

Lucy Vere took the report as read and explained that the OD (Organisational Development) team had developed a ‘stepped intervention model’ to define the types of requests received, input required, and the service provided. Moderate support was the most common request. Family Services, Community, Frailty and Therapy, Specialist Therapy and TACC were the biggest requestors across the board. 84 requests were made since January 2025, with 42 completed and 26 currently in progress. Maternity continued to be a top priority, and the new leadership structure supported changing the approach to maternity workforce culture. ‘Systemic Set Change Approach’ was a new structured approach in place which had a positive impact on providing clarity around the targets in place. The reporting tool provided the Group support with identifying hot spot areas for focus. 48 Maternity incivility reports were raised in 2024/25 and key themes for reporting were around undermining and intimidation, predominantly taking place on the Labour Ward and Rowan Ward. The ‘Tea Trolley’ approach for addressing challenges had a positive impact on encouraging people with the ‘Freedom to Speak Up’. Work was ongoing to support and strengthen skillset training in the form of leadership essentials, REACT mental health training, PMA training and

restorative approaches training. Efforts were underway to support leaders in moving to a coaching approach through PMA sessions, leadership supervision and coaching. There was clear governance in place through systemic team coaching, perinatal workforce culture group and the Midwifery and Neonatal Group meetings. Progress was seen within Cardiology at HUTH as the level of interventions had decreased from level 5 to level 4.

Preliminary National Staff Survey results revealed that consistent improvements were made in staff engagement, morale and 'we are a team' scores. Lucy Vere shared that a restorative practice session that was organised to support two individuals within Theatres had a positive impact and restored their working relationship. The OD team would continue to develop the OD stepped intervention model, measuring impact through the Kirkpatick Model with a focus on levels 3 and 4. Work would take place with the Improvement Team to ensure the Group were aligning with organisational priorities.

Sue Liburd asked how confident the team were that their interventions could be sustained. Lucy Vere shared confidence around level 5 and level 4 interventions however, a full evaluation was required to understand what was working versus what was not. She anticipated that the Improvement Team would provide different priorities for the OD team and work was currently taking place to explore how to offer a wider prospectus of working in priority areas.

4.7 **Nursing & Midwifery Bands 4 – 9 National Profile Review**

Heather McNair shared that the Group were asked to look at a job evaluation process for bands 4-9 nurses to ensure that there was consistency across banding and job profiles. This work was now underway and there was a predominant focus on Nursing & Midwifery in the initial period of this work as they represented 28% of the workforce. She anticipated challenges due to the significant amount of work that was expected to take place and shared that she would Chair the Regional Group to ensure that there was consistency across local colleagues. The RCN (Royal College of Nursing) had launched a campaign to suggest that band 5 nurses should progress to a band 6 however, this was unaffordable for the NHS and counterproposals would be submitted.

The Committees-in-Common accepted the report for information.

4.8 **Safer Nurse Staffing Establishment Review**

Heather McNair updated that costings were absent from this paper and therefore it was withdrawn. Discussions had taken place at Group Executive on 25 November 2025 and it was agreed that a different approach would be taken. She proposed that the subsequent paper would have areas of focus around areas of non-compliance within national standards and CQC and the current general nurse staffing position, acknowledging that data around specialist nurses and outpatients was absent from the paper. Heather McNair highlighted that there was a significantly greater proportion of registered nurses on the South Bank in comparison to the North Bank and it was crucial to understand the consequences and what that means to the quality of care on the wards.

Julie Beilby emphasised the importance of not accepting any staffing reports outside of the planning cycle to ensure that the Group were not looking at asks in

isolation of the bigger picture. She noted that it was particularly important that the Group have a grip on growth and aspirations across the whole, rather than specific areas.

Heather McNair highlighted that a staffing paper would be submitted in due course as it was a requirement for the Boards-in-Common to see figures twice-yearly.

5. ITEMS FOR INFORMATION

5.1 Workplan

This was shared for information.

5.2 Q2 Communications Activity Report 2025/26

This was shared for information.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Nothing to raise.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note.

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- No issues during the resident doctors industrial action.
- The NLaG LNC dispute was resolved.
- Guardian of Safe Working Hours HUTH revealed that there were significant issues regarding Paediatrics surgery, high fines business case was in process
- Limited assurance was agreed for the Guardian of Safe Working Hours NLaG report due to issues raised and it not being on track.
- Reasonable assurance was agreed for the Apprenticeship Levy Annual Report due to unspent apprenticeship levy.
- Medical and dental job planning was 79% which had increased and the CiC asked for a focus on capacity and demand going forward.
- Conversations had begun regarding the resident doctors 10 Point Plan.
- Undergraduate Medical Education was pressured due to the number of students and cancelled clinics, which was being monitored.
- The review around tariff spend was ongoing.
- The bands 4-9 Nursing and Midwifery review had started.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 17th December 2025 at 9am till 12:30pm, via Microsoft Teams

The Committee Chair closed the meeting at 11:52 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y	Y	Y	Y	Y	
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Amanda Stanford	Group Chief Nurse	Y	Y	Y	D				D	Y	D		
Heather McNair	Interim Group Chief Nurse					Y	D	Y				Y	
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y	Y	D	Y	D	
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	D	
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y	Y	Y	Y	Y	Y	Y	

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 17th December 2025 at 09:00 to 12:30
Via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) – Chair
Julie Beilby	Non-Executive Director (NLaG)
Simon Nearney	Group Chief People Officer
Heather McNair	Interim Group Chief Nurse
Dr Kate Wood	Group Chief Medical Officer
David Sulch	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Laura Treadgold	Non-Executive Director (HUTH)

In Attendance:

Rebecca Crashley	Deputy Director of Assurance (HUTH)
Karena Groom	Interim Personal Assistant (Minute Taker)
David Sharif	Group Director of Assurance
Lucy Vere	Group Director of Learning and Organisational Development
Paul Bunyan	Director of Planning, Recruitment, Wellbeing and Improvement

Observers:

Ian Reekie	Governor Observer
Amanda Callow	The Value Circle

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. No apologies of absence were noted. Dr Kate Wood shared that she needed to step out of the meeting to attend another meeting from 10:00 hours.

1.2 Staff Charter and Values

Tony Curry noted the Staff Charter and Group Values and reminded everyone to follow these within the meeting.

1.3 **Declarations of Interest**

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

1.4 **To approve the minutes of the meeting held on 26th November 2025**

The minutes of the meeting held on 26th November 2025 were accepted as a true and accurate record.

1.5 **Matters Arising**

None to note.

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

Updates to the Action Tracker were provided within the agenda items.

1.7 **Committee Effectiveness Outcome**

David Sharif provided an update and shared that 5 out of 11 members had completed the effectiveness survey. Feedback was mainly positive and no significant issues were raised regarding the operation of the committee. Several areas were highlighted for further consideration and actions were proposed regarding greater alignment in the work carried out and the Group strategic objectives. Feedback indicated that Chiefs of Service should be invited to future meetings and highlighted that the CiC could not identify that they had received assurance updates regarding the development of emerging innovative roles and the understanding of the workforce implications arising from service transformation.

Julie Beilby suggested inviting accountable officers to future meetings to discuss any areas of concern that the CiC had.

Julie Beilby raised concerns regarding confusion over where transformational change was being reported and she questioned whether the development of emerging innovative roles fit within the transformation portfolio. Simon Nearney recognised that the central resources available to support transformational change was currently challenged. He shared that operational planning work was currently underway, and that outpatients and medical productivity were key drivers to encourage transformational change in 2026/27. The outpatients service required a re-design and it was the responsibility of the Performance, Estates and Finance (PEF) CiC to review the structure and re-design at a first instance. Once approved, the Workforce, Education and Culture (WEC) CiC would review any staffing issues. This would be clarified in the Terms of Reference.

Action: David Sharif to update the WEC CiC Terms of Reference to clarify that transformation was the responsibility of the Performance, Estates and Finance (PEF) CiC, and WEC CiC would review any staffing issues following.

Tony Curry queried whether there was guidance which explored what transformation would include regarding service, staffing and financial implications. Simon Nearney shared that the Trust Strategy was recently developed regarding transformation and digital. He acknowledged the current Group priority of focusing on finance, constitutional standards and well-being, and noted that work was ongoing regarding outpatients and productivity.

Sue Liburd queried whether inviting accountable officers to this meeting was a decision for the CiC to make or whether Lyn Simpson and Executive colleagues were required to make a decision regarding the most suitable people to present particular themes at future meetings. David Sharif clarified that the entire Committees-in-Common had the authority to invite who they deemed appropriate to meetings to provide assurance.

1.8 **Urgent and Emerging Issues**

Simon Nearney updated that the Flu staff vaccination take up rate was 50% across the Group.

Julie Beilby asked what the national average vaccination rates were. Simon Nearney shared that the Group was just below the medium in comparison to other organisations.

Julie Beilby queried whether the Group were considering using face masks. Heather McNair shared that the Regional NHSE team had asked the Group to review whether staff working with Flu patients were vaccinated, and work was currently ongoing to review this. The Group would ensure that face masks were available however this would not be mandated.

Paul Bunyan shared that Flu vaccination performance had improved. The Group were 1% away from achieving the NHSE target (5% more staff than in 2024/25) and expected to achieve this by the end of December 2025.

Dr Kate Wood provided an update regarding the resident doctors strike that had commenced today. She emphasised that planning would continue as usual with prioritisation of emergency cover followed by planned care. The Group forecasted to deliver as much planned activity as possible. Simon Nearney shared that the Group were currently maintaining 95% elective activity during the industrial action and activity would be kept under review.

Dr Kate Wood reminded the CiC of challenges in June 2025 regarding the General Medical Council (GMC) national training survey at NLaG. She shared that the Group received a letter from the GMC which explained that the Gastroenterology Service at NLaG was now under enhanced monitoring. George Abouda, the Chief of Service for Gastroenterology was providing excellent engagement to support with the ongoing changes and work was underway to implement structural changes for Post Graduate Medical Education.

Action: Karena Groom to update the workplan for a quarterly GMC update to come to the meeting in February 2026. The CiC would then assess the frequency that was required.

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 **Registered Nursing & Midwifery Staffing - HUTH and NLaG**

Heather McNair updated that the recommendations to the Safer Nursing Care Tool (SNCT) were unchanged since the previous report. The risks remained lower at NLaG, in comparison to HUTH where the risk was still at 20. The significant turnover in unregistered workforce required further consideration regarding whether the Group were not preparing them appropriately before they started. A Safer Staffing investment paper would be presented to the next meeting regarding mitigating these risks. She explained that the CiC were asked to provide assurance on the totality of the process, not the actual staffing levels.

David Sulch mentioned temporary staff expenditure and queried whether the Group were spending up to establishment or beyond establishment. Heather McNair clarified that the Group were spending over establishment and explained that this was attributed to areas that required attention and did not have capacity to accommodate the acuity of the patients, particularly relating to unregistered staff. She noted the significant utilisation of security staff and highlighted a requirement for appropriately trained staff to de-escalate cognitively impaired patients.

David Sulch noted that HUTH was fully established for registered nursing but faced significant risks regarding care hours however, NLaG was not fully established and did not face such risks. He wondered whether it was possible to move the vacant posts from the NLaG to HUTH. Heather McNair agreed that this would be an ideal solution to share that risk across the sites however, the Group Chief Financial Officer had previously clarified that this was not constitutionally possible as the Group did not hold a shared budget.

Sue Liburd wondered about the Groups level of confidence in the effectiveness of the SNCT. Heather McNair clarified that work was required to understand the tool further, however it was ascertained that the tool was being used appropriately and there was not another nationally credited tool that the Group could currently use. She suggested that it would be useful to review model hospital data in comparison

to other Organisations and triangulate whether their quality outcomes were more effective.

Sue Liburd queried when the Group would harmonise data regarding shift fill rates.

Action: Heather McNair was unsure if work was ongoing around shift fill rates and would review this further.

Julie Beilby noted that the Group had recently agreed significant growth in maternity services and asked if that investment was reflected in the paper. Heather McNair clarified that it was not reflected in the paper as maternity used a different tool.

Julie Beilby shared that a discussion took place outside of this meeting to determine whether there were similar tools available to calculate staffing needs in other areas and it was determined that there were not. Heather McNair highlighted that the SNCT solely captured registered and unregistered nurses which was not a true picture of the care that was being delivered as other health professionals are in the clinical areas such as Allied Healthcare Professionals (AHPs), however Care Hours Per Patient Day (CHPPD) was calculated at 23.59.

Julie Beilby queried the reporting timelines and processes, noting page 4 of the report which mentioned that 4 papers were produced and included recommendations for investment based on priority need after review of the SNCT finding. This would be presented to Group Executive and then subsequently presented to Boards-in-Common in December 2025. Heather McNair explained that the report was previously withdrawn as it was not explicit enough regarding the investment. The report would be presented to Group Executive and WEC CiC in January 2026, and then subsequently presented to Boards-in-Common.

Tony Curry acknowledged the unregistered turnover of 25% across the Group and wondered whether the Group understood why a significant number of people were leaving the organisation. Paul Bunyan shared that exit interviews revealed that pay and culture were the top reasons for people leaving the Group and work would take place to address this.

Lucy Vere shared that projects were in place to address development from roles into other roles and ensure that people felt that they had a career pathway within the Group. Work was ongoing to encourage further external recruitment into traineeships.

Dr Kate Wood left the meeting at 10:00 hours.

The Committees-in-Common agreed reasonable assurance.

4.2 **Workforce Integrated Performance Report**

Paul Bunyan took the report as read and mentioned that as the report was re-written in line with accessibility standards, this unfortunately reduced the readability of the paper and would be improved for the next report. A decrease was seen in agency spend in line with the 30% reduction target set by NHSE. The latest data which was not included in the paper, revealed a reduction in agency spend across Medical and Dental, Nursing and Midwifery and AHPs for the second month,

however the Group spent more in other variable pay areas. The Group currently forecasted to achieve a reduction in agency spend of 10 to 12%. Bank Spend was performing well against the 10% reduction target set by the NHSE. It was established that extra contractual pay was not factored into bank and agency spend, and that Waiting List Initiatives (WLIs) and overtime were hidden costs within that. Paul Bunyan advised that full variable spend data would be included in future reports. A reduction was seen in Agency Spend which was attributed to the improved vacancy position and strengthened grip and control from an Executive and Care Group level. The Group expected to see an increased vacancy position as they entered the vacancy freeze, particularly for corporate roles. Turnover continued to perform well however, the Group expected to see an increase in turnover due to the vacancy freeze.

An increase was seen in the shortlisting position and time taken to inform people following interview. These increases in KPI average were as a result of specific HR cases associated to the recruitment process. Work continues to improve the performance position as part of normal efficiency processes.

Data revealed an increase in the sickness position which was mainly due to Flu and other respiratory illnesses associated with the time of the year, this was likely to be the case for a number of months. Psychological-related sickness had reduced due to interventions from the health and well-being practitioners and well-being initiatives that were in place across the Group. The Human Resources Business Partner (HRBP) team were focusing on long-term sickness specifically relating to stress, anxiety, and depression. Programmes of support were in place for people returning to the workplace, which was having a positive impact.

Julie Beilby noted that it was disappointing that such intensive grip and control mechanisms were required to get spending under control which reflected a poor cultural understanding of the Groups financial position.

Julie Beilby asked if there was a sense of whether anxiety, stress, and depression sickness was primarily due to work or home life. Paul Bunyan clarified that it was a 50% balance between work-related and home-life however, the Group understood that they could impact both elements.

Sue Liburd mentioned the consultant vacancies and wondered whether the Group were expediting the recruitment of the 13 out of 18 consultants awaiting start dates in the Group. Paul Bunyan explained that the Group were undertaking a technical recruitment process to ensure that checks and clearance were completed in a timely manner and continuous line management engagement was being provided to support the consultants.

David Sulch queried what portion of agency spend was related to poor grip and control and wondered whether the Group were employing the appropriate people. Paul Bunyan shared that Care Groups were now risk-assessing whether gaps were required to be filled, which would improve their grip and control.

Tony Curry wondered whether the Group expected any challenges in achieving the agency spend target due to the consultant vacancy rate. Paul Bunyan explained that the Group anticipated that this would always be a challenge as there was a national expectation that organisations would always have a degree of agency

spend. He shared that work was ongoing to improve the advertising process and the Group had seen an increase in the number of applicants.

Simon Nearney shared that NHSE operational planning states that agency spend should be zero by the end of March 2029. He raised concerns that the Group would not expect to deliver this due to the consultant vacancy position however, the Group would not be an outlier due to a national shortage for medical consultants.

The Committees-in-Common agreed reasonable assurance.

4.3 **2026/27 Operational Workforce Plan – Draft 1**

Paul Bunyan shared that the report provided an overview of NHSEs request for the Group to produce a 5-year report with expectations of achieving a 30% reduction in agency spend, 10% reduction in bank spend, 95% Job Planning compliance, and to reduce sickness down to 4.1%. The Group anticipated that there may be a greater expectation to deliver a higher degree of headcount reduction than currently accounted for within the plan, however they did not currently have the detail required to be able to make those workforce assumptions. An executive-level conversation was required to determine how far corporate headcount could be reduced whilst still running effective and efficient services that did not impact adversely upon frontline clinical services. The plan outlined a required headcount reduction for 150 Whole Time Equivalents (WTEs) from support functions and expected to save £7.5 million in one financial year. This included all corporate areas, and planning would commence to determine how to deliver this. Simon Nearney stated that corporate services had delivered £3m+ in 204/25 and is forecasting to deliver £11.2m this year, so taking another c£10m from services would be extremely difficult. Paul Bunyan explained that 2024/25 model hospital data was included within the paper which was not the most current data however, it showed that the Group were in the upper quartile in terms of value for money for people and finance directorates. The national data was also used to benchmark the Group against sickness, job planning and temporary staffing metrics. The model hospital data portrayed HUTH as a higher performing organisation and NLaG a lower performing organisation against those metrics.

The highest level of Capital investment within the operational workforce plan related to the Electronic Patient Record (EPR) project. This was temporary resource of approximately 180 WTE over a 2-year period, and did not affect the revenue position. Paul Bunyan explained that the Group were asked through guidance to include this resource in the plan however, it falsely inflated the staff-in-post position and would be withdrawn at the end of the project. The second submission of the plan was due by February 2026, and the final position was due to be submitted by March 2026. Delivery of the plan would commence from 01 April 2026.

Julie Beilby acknowledged that the plan did not align with the latest version of the Cost Improvement Programme (CIP) and asked if there was an opportunity to present a revised version of the operational workforce plan at the next meeting. Paul Bunyan confirmed that a revised version of this report would be presented at the next meeting and would detail the current progress on the workforce plan however, he acknowledged that it would be a working progress prior to the second

submission. Overall the Group staff in post (WTE) would reduce for 2026/27 and beyond.

Simon Nearney shared that the operational workforce plan would be presented to Boards-in-Common in January and February 2026 to review the activity, finances and workforce within the plan.

Action: A revised report to be presented at January's meeting detailing current progress on the workforce plan.

Julie Beilby queried whether the figures on page 15 within the paper reflected the investment choices that were made regarding maternity services. Paul Bunyan shared that they were factored in and he anticipated that the phasing may change.

Sue Liburd emphasised the importance of being sensitive regarding the language and reporting around the reduction in headcount.

Simon Nearney recognised that reducing the headcount in corporate services would have an impact on the Group and work would take place to determine what the impact would be. Communications regarding the vacancy freeze would be published today and he was cognisant of the need to be sensitive when publishing information around the headcount reduction.

Paul Bunyan highlighted that there were no current plans for redundancy, however this would be discussed. He raised concerns regarding a possible vacancy freeze extension and anticipated that this would cause burnout and increased sickness.

Heather McNair suggested that the Group carefully considered the consequences of decisions taken to reduce corporate statutory services and ensure that robust Equality Impact Assessments (EQIAs) are undertaken.

The Committees-in-Common took the report for information.

4.4 **Equality, Diversity & Inclusion Annual Report - 2024/25**

Lucy Vere updated that the establishment of a Group Equality, Diversity and Inclusion (EDI) Steering Group had enhanced governance and oversight of the EDI agenda. Revised Terms of Reference and the creation of staff and patient working groups would ensure a more effective and inclusive approach, with quarterly meetings set to begin in January 2026. She mentioned that further work was required to strengthen action plans and inclusive recruitment across the Group, acknowledging that challenges were ongoing regarding discrimination and bullying. Senior engagement and leadership consistency was crucial and further discussions were required to further support EDI. Efforts were underway to strengthen staff networks on the South Bank. The recent focus on zero tolerance had resulted in the piloting of a new Standard Operating Procedure (SOP) which would support staff to escalate events of racism and provide the Group with an opportunity to ask people to be treated elsewhere. This was currently being trialled on 2 wards across both sites.

Helen Knowles joined the meeting at 11:00 hours.

Julie Beilby asked for further clarity regarding the restructure within the Learning and Organisational Development (OD) team and the expected impact that it would have on capacity. Lucy Vere explained that the OD team now held 1 Group Head of OD, in comparison to the previous 2 heads of OD for both sites. Capacity had reduced however, work was underway to establish an OD manager and an OD practitioner, and connected work would take place with the internationally educated nurse leads across the Group to co-ordinate and consolidate OD work.

Julie Beilby wondered whether she, as a champion for disability, and Sue Liburd, as a champion for diversity, should undertake meetings with Network Leads to strengthen engagement and support the ongoing work around EDI. Lucy Vere welcomed a discussion regarding this and highlighted that there was a lack of diversity and decision-making at a senior level. She addressed that 20% of workforce were from a Black, Asian and Minority Ethnic (BAME) background, and raised concerns that current cultural behaviours did not make people feel welcome.

Sue Liburd queried whether the OD team expected to see positive changes in the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reporting in 2026. Lucy Vere shared that she was optimistic that the reporting would improve as CPD reporting on the North Bank and career reporting on the South Bank had improved following targeted work. She shared that there was currently less confidence regarding bullying, harassment and discrimination due to ongoing challenges and further discussions would take place to address this. The number of staff supporting disciplinary cases on the North Bank was positive and the Group aimed to replicate this on the South Bank.

David Sharif proposed that he would work alongside Lucy Vere to clarify the support that Non-Executive Directors would provide to Network Leads. He asked for further clarification regarding an inactive Women's Network that was operating on the South Bank. Lucy Vere explained that she would review this with the OD team and raised concerns that the development of another network would impact the capacity of the OD team.

Action: Lucy Vere to provide David Sharif with a further update regarding the inactive Women's Network on the South Bank.

Dr Kate Wood re-joined the meeting at 11:10 hours.

The Committees-in-Common took the report for information.

4.6 *The Agenda was taken out of order at this point.*

Outcome of External Visit - Nurse Staffing

Heather McNair took the report as read and explained that the Regional NHSE team had undertaken an external visit to review the Groups process around the use of the SNCT. Although NHSE agreed significant assurance around the process, recommendations were provided regarding workforce safeguard standards and actions were underway. She highlighted action number 6 within the appendix of the paper which related to the Nursing Medical Director providing assurance that there was safer staffing within the Group, and she acknowledged the absence of a formal tool for doctors to use for this. Heather McNair shared that the SNCT identified an inadequate number of registered nurses and health care

assistants on the North Bank, and was given a risk score of 20. She suggested a discussion take place with David Sharif regarding the assurance statement.

Julie Beilby acknowledged that the use of security and patient watch was identified as an area of significant spend, and noted that there was a risk on the risk register regarding a suicide risk associated with breaking windows. She wondered whether the mitigation for high-risk patients to call security was appropriate and referred to a previous discussion regarding the corporate restraint policy which required review and further restraint training was required however, the restraint training could not be provided to security staff. This raised concerns around the use of security staff on patient watch and Julie Beilby raised this with Matt Powls outside of the meeting. Heather McNair shared that security staff had a different external training regime and the Group were unable to impose on their training. She explained that the restraint training had not yet been rolled out adequately for all healthcare assistants.

Action: Heather McNair to review and provide an update position regarding restraint training.

The Committees-in-Common agreed reasonable assurance.

4.7 **Resident Doctor 10 Point Plan**

Helen Knowles took the report as read and highlighted that the Group were required to complete a further assessment in conjunction with resident doctor leads which was submitted last week per the national requirements. Work was underway to establish a survey based on the 10-point plan and the survey was expected to launch in January 2026. There was a current focus on the February 2026 rotation however, the Group were experiencing challenges regarding receiving information from the Deanery in a timely manner prior to deadlines. Work was underway to ensure that resident doctors would not have to repeat their mandatory and statutory training however, the Group were experiencing challenges regarding rotating doctors' electronic records not being up to date.

Simon Nearney shared that the Group had a good working relationship with the resident doctor leads and positive joint-work was taking place. He raised that there were ongoing challenges regarding annual leave and rest rooms, and work was ongoing to address this.

David Sulch wondered whether there was a responsibility from the resident doctors to inform organisations regarding training they had undertaken. Helen Knowles agreed that there was an onus on resident doctors however, training should be logged on the NHS Electronic Staff Record (ESR) to allow Organisations to transfer that information across. She noted that there was also a responsibility for the Group to ensure that information was up to date.

The Committees-in-Common took the report for information.

4.5 *The Agenda returned to the correct order.*

Medical and Dental Job Planning – Monthly Update

Dr Kate Wood updated that a marginal increase was seen in job planning compliance and was currently at 81% since the previous report. The Group continued to meet with Care Groups on a regular basis to challenge and monitor their compliance position against the target of achieving 95% compliance by March 2026. The next report would provide a granular breakdown regarding required additional support. Neurosciences and Family Services compliance required further improvement. Trauma, Anaesthetics and Critical Care (TACC) had undertaken positive improvement work and Care Groups were continuing to engage.

Laura Treadgold noted that section 3.2 of the report appeared to show that compliance had declined. Dr Kate Wood explained that this was due to both a recruitment element and doctors not having a job plan in place due to time expired. She acknowledged that job plans were only in place for 12 months and some job plans would have fallen out of compliance.

The Committees-in-Common took the report for information and agreed to take the next report for assurance.

5. ITEMS FOR INFORMATION

5.1 Workplan

This was shared for information.

5.2 Minutes of Workforce Transformation Group

This was shared for information.

Julie Beilby noted page 4 of the Workforce Transformation Group minutes which referred to flexible working and stated that 'permanent home base working would not be allowed'. She wondered whether the mention of flexible working should be amended to state that it was 'not normally allowed'. Simon Nearney acknowledged that there was always an exceptional case and the minutes would be amended to reflect this.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Nothing to raise.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

None to note.

7.1 Matters to be Referred to other Board Committees

None to note.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Effectiveness Review - Transformation was discussed and it was agreed that transformation sat with PEF CiC and that WEC CiC would review any staffing issues following. This would be clarified in the Terms of Reference.
- Flu vaccination rates were 50% across the Group.
- Resident Doctors Industrial Action had commenced today. Planning processes were in place as usual and would cover as much activity as possible, dependent on the pressures in ED.
- The Group had received the 2026/27 Operational Workplan and delivery of the plan was expected to commence from 01 April 2026.
- A marginal increase was seen in Medical and Dental Job Planning compliance and the Group continued to meet with Care Groups to support achieving the 95% target by March 2026.
- Significant assurance was given to the Nurse Staffing processes following the external visit however, a number of recommendations were required to be worked through.
- The Resident Doctor 10-point plan was underway and working well so far.
- The GMC National Training Survey – Gastroenterology at NLaG were under enhanced monitoring and quarterly updates would be received.
- Nursing and Midwifery Staffing – HUTH establishment risks were discussed and turnover in the first year of employment. Culture and pay were the main factors and were addressed.
- Equality and Diversity – The importance of Executive and NED involvement was discussed. NED champion support would be formalised.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Wednesday 28th January 2026 at 9am till 12:30pm, via Microsoft Teams

The Committee Chair closed the meeting at 11:51 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2025/2026

Name	Title	2025											
		Jan	Feb	Mar	Apr	May	June	Jul	Au	Sep	Oct	Nov	Dec
CORE MEMBERS													
Julie Beilby	Non-Executive Director (NLaG) / Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tony Curry	Non-Executive Director (HUTH) / Chair	Y	D	Y	D	Y	D	Y	Y	Y	Y	Y	Y
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Amanda Stanford	Group Chief Nurse	Y	Y	Y	D				D	Y	D		
Heather McNair	Interim Group Chief Nurse					Y	D	Y				Y	Y
Kate Wood	Group Chief Medical Officer	D	D	Y	Y	D	Y	Y	Y	D	Y	D	Y
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	D	Y
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y
Laura Treadgold	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y	Y	Y	Y	Y	Y	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)023

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	12 February 2026
Director Lead	Jane Hawkard, Non-Executive Director / Chair of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Jane Hawkard
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – November 2025 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 12 November 2025, approved at the ARG CiC meeting on 22 January 2026.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 12 November 2025
Prior Approval Process	ARG CiC meeting – 22 January 2026
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday 12 November 2025 at 9.00am to 12.30pm via Microsoft Teams

For the purpose of transacting the business set out below:

Present:
Core Members:

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

In Attendance:

David Sharif	Group Director of Assurance
Philippa Russell	Deputy Group Chief Financial Officer
Sally Stevenson	Assistant Director of Finance – Compliance and Counter Fraud
Helen Dodds	Sumer NI – External Audit NLaG
James Collins	Forvis Mazars – External Audit HUTH
Harriet Fisher	Senior Manager, KPMG – Group Internal Audit
Louise Kay	Manager, KPMG – Group Internal Audit
Matt Overton	Group Operations Director (item 9.1)
Edd James	Procurement Director (item 9.2)
Daryl Cheetham	Local Counter Fraud Specialist (LCFS) (from item 4.2)
Mike Bateson	NLaG Governor Observer
Jenny Sharp	NHS England Observer
Tony Bruce	The Value Circle Observer
Jo Palmer	PA to Committees-in-Common (Minutes)

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

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

1. Welcome and Apologies for Absence

Simon Parkes, NLaG ARG CiC Chair welcomed those present to the meeting, including observers Jenny Sharp from NHS England (NHSE), and Tony Bruce from The Value Circle who were undertaking a governance review at the Group. Apologies for absence were received from Jane Hawkard, HUTH ARG CiC Chair / Non-Executive Director (NED), Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer and Brian Clerkin, Managing Director (Sumer NI) – External Audit NLaG. It was noted that the new Group LCFS, Daryl Cheetham, was delayed arriving in the meeting due to IT issues.

2. Declarations of Interest

Simon Parkes asked for any declarations of interest and none were made.

3. To approve the minutes of the meetings held on 31 July 2025

3.1 Public Minutes – 31 July 2025

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

3.2 Private Minutes – 31 July 2025

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

4. Matters Arising and Review of ARG CiC Action Tracker

4.1 Public Action Tracker

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

- July 2024 item 17.3 - action closed.
- April 2025 item 11.2 – in progress.
- April 2025 item 11.3 – awaiting a further response from Humberside Police.
- April 2025 item 13.1 – the reference to secondary employment within the PADR document will not feature in the new Group document. Simon Parkes asked for further discussion on this under item 9.8. This action closed and a new action opened.
- June 2025 item 5.2(a) – policy now approved and action closed.
- July 2025 item 4 – update to be provided within item 9.8 on the agenda.
- July 2025 item 7.1 – David Sharif to provide an update at item 7.1.
- July 2025 item 9.7 –CiC cover sheet amended / circulated – action closed.
- July 2025 item 9.12 – Simon Parkes asked that this was discussed later in the meeting. Gill Ponder to raise under the relevant agenda item (9.13).

All other actions were either confirmed as on the agenda, closed or due at a later ARG CiC meeting. Simon Parkes commented that there had been good progress in the majority of the actions but one or two had missed their due dates, and it may be necessary to relook at all completion dates to ensure they are consistent with Group priorities and amend where necessary to ensure they are realistic in terms of priorities.

Daryl Cheetham arrived in the meeting.

4.2 Private Action Tracker

Refer to private minutes.

5. NLaG External Audit (Sumer NI)

5.1 Routine Update

Helen Dodds advised that they were still unable to formally issue the audit certificate for 2024/25 as an update from the National Audit Office (NAO) on NHS group

consolidation was still awaited, but confirmed they would issue it as soon as they were able to.

Post meeting note: The NLaG Audit Certificate for 2024/25 was received by the Trust from Sumer NI via email on 12 December 2025.

Initial planning work for 2025/26 had commenced and progress following the planning meeting with management scheduled for 27 November 2025 would be shared at the January 2026 meeting in the form of their draft audit plan for 2025/26, following which they would move to undertaking their interim audit work using the same timetable as last year.

Helen Dodds advised that NHSE were looking to bring forward some of the accounts submission dates this year by a couple of days, but this was yet to be formally confirmed. No dates were known for the annual report deadline as yet.

Simon Parkes found it unacceptable that the 2024/25 audit certificate was still not able to be issued, but there had been an ask for earlier submission dates for 2025/26 despite this. Philippa Russell agreed and commented that this is able to be fed back into the national conversation. Sally Stevenson pointed out that the ARG CiC meeting dates for April and June 2026 may need to be adjusted to align with the revised submission dates once confirmed.

Action: Sally Stevenson

Post meeting note: NHSE issued details of revised submission dates for the 2025/26 audited accounts and as a result the June 2026 ARG CiC meeting was brought forward slightly to allow for the earlier NHSE submission date. Revised diary invites circulated to all involved.

5.2 Annual Review of NLaG External Auditor Performance / Additional Fees

The annual evaluation did not identify any areas of concern with regard to the performance of Sumer NI over the last year (their third year of engagement) and no additional fees were levied. There were no questions from the ARG CiC.

6. HUTH External Audit (Forvis Mazars)

6.1 Routine Update

James Collins advised, as per the earlier Sumer NI update, the same situation applied in respect of issuing the 2024/25 audit certificate for HUTH.

James Collins confirmed that planning work would commence in December 2025 with potentially the draft Audit Strategy Memorandum (ASM) coming out in January 2026. James Collins advised that he was not aware of any significant changes for 2025/26, adding that could change at the last minute though.

6.2 Annual Review of HUTH External Auditor Performance / Additional Fees

The annual evaluation did not identify any areas of concern with regard to the performance of Forvis Mazars over the last year (their first year of a new contract with HUTH). Additional fees of £7k plus VAT had been levied as part of the 2024/25 year

end audit work, the details of which were reported to the July 2025 ARG CiC meeting. There were no questions from the ARG CiC.

7. Group Internal Audit (KPMG)

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

Harriet Fisher reported a positive first half year review working with HHP with good engagement and developing good relationships. Two finalised reports were being presented to the ARG CiC, namely Theatre Utilisation and AI Benchmarking, as well as an update on the position with Internal Audit management actions.

Louise Kay advised that a week after the report had been produced for the ARG CiC papers the tracking system was now showing twenty-five actions having been implemented, with sixteen overdue and was pleased to say that it was an improving picture, partly due to the reallocation of actions to more appropriate owners. Louise Kay envisaged that as staff became familiar with the Jira tracking system, this would improve further by the new year. To facilitate this, KPMG will issue reminders at the beginning of the month of any actions that are overdue and also a reminder on actions that are becoming due, to ensure actions are updated on a timely basis.

Tony Curry was reassured to hear of the good progress but asked as incomers whether KPMG were satisfied that the Group had a firm control on management actions, in view of the escalation of actions up to Executive level because of no named senior management lead. Tony Curry also asked whether the deadlines were realistic and whether the process was reassessed. Harriet Fisher responded that there was a real focus on actions at Executive level and the new system would greatly help the process, particularly the forward view. At a recent Group Cabinet Risk & Assurance Committee (GRAC) that Harriet Fisher had been at, it was agreed that the process would become part of regular conversations with teams and discussion took place on how to make the process as user-friendly as possible with information at user's finger tips. Re-evaluation of the actions was also the subject of discussion at GRAC, and Harriet Fisher considered that it was a maturity journey that needed to be continued and added that they had not been worried by anything they had seen in terms of approaches.

Simon Parkes asked David Sharif to respond to the comment around looking again at management actions in the context of the turnaround plan and making sure management time was focussed on the right things that were most likely to lead to improvements in the Group's performance. Simon Parkes added that he had not been pleased with the report when he had seen it at the pre-meet with the Auditors and had written to the Acting Group CEO to ask for support in improving the position and stressed that although there had been improvement, it needed to be sustained. Simon Parkes stated he had considered the possibility of inviting owners of actions that had not progressed to the ARG CiC meeting in the future to explain their position, but the Acting Group CEO did not feel such action was necessary at this stage.
David Sharif spoke in terms of Executive prioritisation of agenda items and shared that the Executive group had recently met and the Acting Group CEO had presented a further development of the improvement plan with a focus on management basics. David Sharif considered that it would help Executive colleagues deal with actions accordingly, as many of the recommendations were around basic matters. David

Sharif considered that the timescales were realistic and balanced in level of priority but did recognise that the majority of those that had slipped, were relating to basic issues that were easily resolvable. David Sharif indicated that the Executive team would support the efforts of KPMG by also following up actions accordingly, adding they expected that some of the recommendations likely to come from KPMG would be more evidence based and therefore easier to fulfil. Simon Parkes accepted this but pointed out that it had always been for managers to be clear with the auditors on the action and what evidence was required.

Gill Ponder was also concerned with the report, considering the considerable progress that had been made previously, but was pleased to hear that it had improved since the ARG CiC report was produced and that there was now the expectation of evidence that an action had been completed. Focus, however, now needed to be given to areas where the implementation date had been moved on and needed attention from Executives where the date had been extended more than once. Simon Parkes agreed with this and was of the view that when a second extension to a date is sought, this is formally requested by attendance at the ARG CiC meeting with an explanation as to why the extension is needed. Simon Parkes to write to the Group CEO in this regard and report back at the next meeting.

Action: Simon Parkes

Julie Beilby was also concerned with the report but pleased to hear the latest update that there had been positive progress, adding that it was disappointing there was a need for intervention by the ARG Chair and Acting Group CEO, particularly in view of the actions involving basic management tasks, but welcomed continued improvement in this area. Julie Bielby referred to action 8 around the implementation of a comprehensive governance framework and in acknowledging the presence of The Value Circle observer at the meeting, hoped that the work would be dovetailed and the appropriate deadline date given. Simon Parkes anticipated that David Sharif would be reflecting on the governance framework once the findings of The Value Circle review were available. David Sharif considered that the original action was now closed and Simon Parkes asked that this be brought back to a future meeting for a reflection discussion, once The Value Circle report was available.

Action: David Sharif

Helen Wright welcomed the report and referred to action 6 and was concerned that budgets had still not been signed off despite time being spent in the Performance, Estates & Finance (PEF) CiC meeting reviewing Care Group ownership of financials and cost improvements plans (CIPs), adding it was difficult to hold them to account if budgets had not been signed off. Helen Wright questioned what the scale of this was and Philippa Russell responded that this was by exception with the vast majority signed off and just three outstanding which had been chased for. Helen Wright suggested this was a piece of learning for next year, as she was conscious that timings had been improved and wanted to ensure there was no repeated delays next year.

Helen Wright also asked if there had been any progress with the possibility of introducing Risk Champions since the presentation at the last meeting. David Sharif responded that he had made the suggestion to adopt a more positive language and approach to risk management training and this was evident, but the term of ‘Risk Champion’ had not landed and recognised that it was part of a cultural change in perception of risk management.

Simon Parkes emphasised that efforts should continue in holding people to account and hoped to see a much-improved position with Internal Audit management actions at the next meeting, particularly as there was a view that it may be due to familiarity with the new Jira system to some extent and any initial teething issues should have passed by January 2026. Progress needed to be sustained, and given that the opportunity to revisit actions to determine whether they were priority actions in the current context had been given and confirmed as actions that need dealing with, the ARG CiC would continue to hold people to account for lack of action on them.

The two reports on AI Benchmarking ('no assurance' rating) and Theatre Utilisation were outlined by Louise Kay. 'Partial assurance with improvements required' was given for the Theatre Utilisation review. KPMG found that, despite the established planning processes currently in place, in line with the 6-4-2 model, including regular meetings, escalation frameworks, etc. to optimise scheduling there were still some issues around inconsistently documenting the need for and approving waiting list initiatives (WLIs). There was also frequent over-scheduling of theatre sessions which led to underperformance against utilisation targets. There were limitations around the oversight and performance management of the sessions and in relation to NLaG, a lack of system integration between the theatre management system and the timetabling system which could lead to two sources of the truth.

Gill Ponder advised colleagues that theatre utilisation and productivity was a high priority at the PEF CiC and the Care Groups were due to attend the December 2025 meeting to speak on the actions they were taking, in response to this report. The management of late starts on a theatre session and the discipline needed to ensure theatre sessions started on time to avoid running out of time and cancelling patients, was also on the December 2025 PEF CiC agenda. Simon Parkes commented that this demonstrated that the ARG CiC didn't need to discuss all issues arising from Internal Audit reports, it did however need to be assured that such issues were picked up appropriately at other CiC meetings as part of the governance process, which was clearly the case with this one.

Matt Overton joined the meeting.

Tony Curry questioned whether the issues on WLI had been apparent to management before this audit had taken place, considering the current climate of cost control and queried how management were dealing with and escalating the situation on the day, and whether information was available to management to indicate the improvements needed. Harriet Fisher replied that she understood that management were aware of the issues outlined in the report, but wanted an external review on how things could be improved and the appropriate risk identified, with an opportunity for KPMG to suggest alternatives around theatre utilisation and provide a baseline with actions to improve. Tony Curry acknowledged this but stated that WLIs had been discussed frequently at various Committees-in-Common and was obviously high-profile therefore the management of the WLIs should really be business as usual rather than waiting for Internal Audit to undertake a review to tell the organisation what its opportunities are.

Simon Parkes clarified that management did identify this as an area of weakness within the Group and there were differences between the North and South banks and it was difficult to get agreement about productivity. The matter had been raised several times at the PEF CiC, and it was for colleagues to consider how best to oversee management action and feedback to the CiC.

Helen Wright noted that the theatre transformation team were doing what they could on limited resources and was reassured to see that the KPMG report had not included excessively long target dates.

Gill Ponder was of the view that management were not only aware but were taking action in some areas, citing an example at NLaG, and was hopeful that the KPMG report would assist in overcoming barriers within Care Groups where theatres had met resistance on certain actions. Philippa Russell added that there were deep dives underway into WLIs being led by Ivan McConnell, and the Executive team had been meeting with Care Groups individually, so were not waiting for the KPMG report but would take on board KPMG's recommendations to assist with this process.

Edd James joined the meeting.

Louise Kay outlined the AI benchmarking report which involved KPMG surveying 22 Trusts to assess where AI development and deployment maturity was at, and advised that there were no formal actions raised but piece uses in place at other Trusts were included in the report. HHP were typical of most Trusts i.e. in the early stages of developing a structured approach to deploying AI in its processes. KPMG had instigated an introduction to colleagues at another Trust with the aim of learning how to use the apprenticeship levy to upskill its workforce in AI. Simon Parkes considered this report was helpful advice and would support transformation and anticipated that the relevant Committees-in-Common would pick this up accordingly to be assured that the development of AI was a serious element to the transformation programme.

Tony Curry was supportive of the report and questioned whether there was a process in place in terms of how it was developed going forward around a strategy and who within HHP would pick this up and move it along. Tony Curry also emphasised that data quality was essential to the development and deployment of AI and queried who had a hold of it. Simon Parkes summarised that the report gave HHP the ability to ask better questions when looking at transformation programmes, adding that this was something he would expect to see running through Ivan McConnells work.

8. Counter Fraud – Group

8.1 Group LCFS Progress Report

Daryl Cheetham was experiencing IT issues with his microphone and unable to be heard. Sally Stevenson therefore gave a brief update on Daryl Cheetham's previous law enforcement background and that he had been talking to numerous key contacts within the Group since commencing in post and confirmed that he had recently completed his NHS Counter Fraud Authority Investigator training and was now actively looking at fraud referrals.

Gill Ponder referred to the graph on page 9 of the annual report (item 8.2) and noted the large imbalance between NLaG and HUTH on the amount of compliance days available to work on counter fraud within strategic governance work. Sally Stevenson replied that historically a large amount of work had been undertaken at NLaG on the National Fraud Initiative (NFI) exercise data matches which sees benefits for the organisation, with that NFI work now also taking place at HUTH.

Helen Wright referred to the significant number of referrals / investigations and commented that most seem to result in management / HR intervention and therefore would be keen to understand what proportion of investigations would be expected to move to full criminal investigation, to be assured that the organisation was not being too soft and was taking all appropriate action. Sally Stevenson responded that each referral received was considered on its own merits and whether it was appropriate and proportionate to pursue a criminal investigation, and often it was more appropriate to deal with it internally. Sally Stevenson added that it was well known that there is a significant backlog of cases in the courts and when cases are submitted to the Crown Prosecution Service (CPS) they will sometimes get knocked back but when they do take them it can take up to three years, sometimes longer, to reach court. Sally Stevenson stated that if a referral was not suitable for criminal prosecution then it would be considered for a disciplinary sanction, adding that was borne out by the number of disciplinary sanctions reported in the annual report at item 8.2. Helen Wright acknowledged there was a thorough review undertaken, but just for context wanted to understand how the Group benchmarked against others in terms of criminal prosecutions.

Action: Sally Stevenson

Simon Parkes concurred with the view of proportionality for the CPS taking cases, and the expectation that internal disciplinary processes would likely be more appropriate, and was of the view that the ARG CiC had reasonable assurance that the fraud investigation processes were working correctly.

8.2 Group Annual LCFS Report 2024/25

Discussed with item 8.1.

9. Management Reports for Assurance

9.1 Group EPRR Regulatory Report

Matt Overton referenced the annual assurance process for the national EPRR core standards and reported NLaG at 94% (previously 90%) substantial compliance and HUTH at 90% (previously 69%) substantial compliance. These levels were vastly improved to where they were previously and had formed part of the strategic objectives to get these levels increased and this had been achieved one year early. The aim was now to sustain these levels and continue to address the remaining partially compliant core standards.

Julie Beilby was pleased to see the good progress made but was concerned about the risk scenario around the denial of access to systems and the risk of losing all the IT despite having a backup in place, referring to the recent critical incident at another Trust implementing their Electronic Patient Record (EPR). Julie Beilby asked for further reassurance on work done to mitigate the risk and Matt Overton shared this concern acknowledging it was a heightened risk for all organisations including healthcare. Matt Overton advised that a lot of work had been undertaken by Andy Haywood and the Digital team on strengthening resilience in this regard, working with the Integrated Care Board (ICB) and NHSE in regional workshops to look at how organisations would all work together with mutual aid. Individual Trusts were working together to ensure a structured approach in supporting each other, should one Trust's

systems fail. Matt Overton anticipated for next year's work programme, that it would be included within the exercises to test business continuity plans.

Simon Parkes noted the good progress made, particularly at HUTH, and standards had been reached sooner than planned, so thanked everyone involved. Simon Parkes asked if the Group was responsive to the current climate and could respond appropriately, enabling preparedness for potential emergencies. Matt Overton replied that the Group had moved to a more consequence-based methodology for its impact assessment approach and this was used to structure the exercises on a worst-case scenario basis to identify gaps in capabilities. Matt Overton also informed the Committees as to the practical work being done in conjunction with the EPR team, Fire Safety and Estates teams, e.g. practical testing of equipment and timings and additional information that can go into the evacuation plan to support decision making in a real life incident.

Tony Curry commented that he thought that computer disaster recovery was a much bigger issue and Matt Overton advised that Tony Deal, Group Chief Technology Officer, was leading a piece of work around digital resilience, engaging with external partners and had had sight of all the business continuity plans and no concerns had been raised to date.

Simon Parkes recognised the continued concern particularly over denial of access to systems and the need to be particularly focussed on this due to the ever present and changing threats. Simon Parkes clarified that assurance was received on the responsiveness of EPR processes, and in particular the work done on the Tower Block to test and provide updates on evacuation and other processes for it.

The ARG CiC recommended the approval of the plan by the Boards-in-Common.

Matt Overton left the meeting at 10.24am.

9.2 Group Procurement Update inc. Waiving of Standing Orders

Julie Beilby was pleased to note the report, as when she first joined the Group was concerned that there did not appear to be grip and control on procurement, adding that there was still work to do but that significant progress was being made. There were no further comments or questions from the ARG CiC.

Edd James left the meeting at 10.26am.

9.3 Group Board Assurance Framework

David Sharif advised that the scores remained unchanged and that unfortunately an update around patient access was cancelled due to other priority handovers at the time. In terms of the risk appetite around patient access, it had been discussed and determined that it should be more of a cautious risk appetite that is assigned to the strategic risk around patient access and future reports would reflect this, should this update be acceptable to the ARG CiC . David Sharif also considered that with the recent changes to the Trust Boards-in-Common agenda, there was now an opportunity to use the BAF even more and he planned to write to Committees-in-Common Chairs to request that, as part of the agenda set process, there is reference

to the BAF as well as the workplan, to be assured on items outside of the workplan to support assurance up to the Trust Boards-in-Common.

Helen Wright referred to the conversation on partnerships within the new Strategic Programmes & Partnerships Committees-in-Common and the query around the risk score, the latest being twelve and the belief that partnerships was not getting enough coverage, even though there was a strategy document it was very much still in the early stages. Helen Wright commented that there was a need to leverage the advantage that can come from working through partnerships, but noted that partnerships was not on the agenda for the new CiC. As a result Helen Wright and Gill Ponder had pushed to get an update on partnerships on to the agenda.

Helen Wright's second query was on how to make the BAF more of a live document as it felt very static, and this had been discussed at the PEF CiC. Helen Wright was keen to know if people where genuinely engaging with it, and what was updated in it since it had last been seen as it appeared to contain the same information each time.

Gill Ponder commented on the tolerable risk score for patient access being too high in her view. However, the risk appetite scores had been agreed by the Boards-in-Common, therefore there was a need to ensure that any change to the Group's risk appetite that the Boards-in-Common were engaged in that. Gill Ponder questioned whether there was now the need for another risk appetite session at the Boards-in-Common meeting to review the risk appetite and see if it has changed over the period since the last discussion. David Sharif replied that he would address this, given the proposal from Executives for the risk appetite to change from transformation to patient safety and proposed a broader discussion around risk appetite at the Boards-in-Common.

In response to Helen Wright's query, David Sharif replied that colleagues were engaged in updating the BAF but considered that more could be done around the agenda set process to focus more on how actions were being deployed.

Gill Ponder referred back to the ARG CiC action log containing a link to some score cards to be used for triangulation and stated she was not aware that the score cards existed. Secondly, when clicking the link, the score cards were very detailed and suggested it may be helpful for NEDs particularly to have a briefing on the score cards to aid their understanding of how they could best be used. Gill Ponder clarified that this didn't mean they had not been triangulating, just that this data represented another opportunity to do so. Simon Parkes asked if David Sharif would take the action to discuss with the Group Chair as to whether a future development day could include a briefing on the score cards, given their importance in triangulation.

Action: David Sharif

Simon Parkes indicated that he would consult the Quality & Safety Committees-in-Common Chairs to ensure they are focussed on this patient access discussion to enable the Boards-in-Common to consider the risk appetite, having been fully briefed on the quality and safety aspects.

Action: Simon Parkes

Simon Parkes reflected that when talking about risk appetite some of the risks were not making sufficient improvement and there was a need to become a little less patient

in order to get people engaged to have improved performance on a sustainable basis. Simon Parkes commented that there was a need to use the improved version of the BAF to be more demanding as an Executive and Non-Executive team. In particular, the patient safety risk of 20 was a serious concern and there needed to be a detailed discussion at the Boards-in-Common around receiving assurance that there had been sufficient progress. Simon Parkes stated that he would write to the Chairs of the other Committees-in-Common to ensure that risks were being escalated appropriately to enable a meaningful Boards-in-Common discussion, adding that the Boards-in-Common were aware of this, having discussed it previously, but that there was a need to get an understanding of how the Group were going go to close the gap to make progress. David Sharif welcomed this move.

Action: Simon Parkes

Assurance was considered as remaining at 'limited, despite some improvement in engagement, but until such time as there was evidence that the BAF process was working effectively and the purpose was strengthened it would remain limited.

9.4 Group Risk Register

David Sharif updated that there were currently 683 risks across the Group, 101 of which were considered high risk with a score of 15+. Thirteen were overdue for review (which was a lower number than previously seen), however seven of which were high risk, and there were ongoing safety concerns being raised in relation to the high risks.

Gill Ponder stated that in the move to a new common system, she hoped that it would show not only the level of risk but also what the risk appetite score was or what it could be because of the mitigating actions. An indication of the target score for the year would also be useful and Gill Ponder considered that the narrative should be reviewed and kept as up to date as possible. David Sharif agreed there was a need for improvement and work had been undertaken with the Executive team to improve the quality of the narrative, adding that it was a real challenge and advised he was of the view that there needed to be more involvement by the Executive team in the high-level risks. Discussion at the Risk and Compliance meetings and a review of the risk management training was expected to improve engagement with the process.

Gill Ponder added that there needed to be clear accountability for managing and mitigating risks and this should be embedded into job descriptions along with all the management basics so that people understand their personal role in reducing risks. David Sharif advised that the training is in two parts, one element being the basics of good risk management and the second being the training on the system. David Sharif also clarified that the scores shown were the post mitigated ones. Gill Ponder commented that if they were the post mitigation scores then the mitigating actions were the wrong actions.

Helen Wright stated that it was an on-going concern and Executive ownership was needed, in addition there was lots of unhelpful detail without clear mitigations. Helen Wright suggested execution of a focus on the top ten risks by Executives and discussion in the relevant Committees-in-Common as to what further action was required, and endorsed the need for a further discussion at the Boards-in-Common.

Julie Beilby advised of staff speaking to the Freedom to Speak Up Guardian to escalate risks as they felt that they were not being listened to by their manager, rather

than the risks appearing on the risk register being acted on appropriately by the relevant owners, adding that this was a clear example of how the culture needed to change around risk management. Simon Parkes agreed and commented that this was being seen in the results of the staff survey in terms of staff not feeling heard.

Simon Parkes concluded that the risk register currently contained far too much as a result of people putting things on it to remove their responsibility for managing their risks. Furthermore, there was missing information (e.g. no risk handler, no risk owner) from some risks shown and questioned how progress could be achieved with such missing information and not knowing who needed to be held to account. Simon Parkes stated that this now needed to be escalated to the Boards-in-Common as a very significant issue because of the on-going lack of any assurance on the management of risks on the risk register, including high-level risks.

Tony Curry fully supported this action and considered there needed to be a further look at the top ten priorities for Executives.

Simon Parkes reflected that there was a need for a greater amount of effort being put in on the management side and therefore more resource in this area to make the progress needed, and this would need a discussion at the Boards-in-Common.

9.5 Annual Review of Adequacy & Effectiveness of System for Management and Monitoring of Risk (inc. ICS Risks) – Group

Simon Parkes referred to the overdue recommendations and anticipated that this may be partly related to resource issues. The Committees-in Common were not assured on the adequacy of the arrangements for risk management within the organisation, and this would be the escalation given to the Boards-in-Common as discussed earlier

9.6 Annual Review of Risk Management Strategy

Gill Ponder advised that she had provided some detailed comments offline when the initial draft was circulated for comment. Gill Ponder commented that there appeared to be issues with the operational teams in understanding how to manage risks and did not envisage that a 27 page detailed document would be read. If the culture was expected to change, the strategy needed to be produced on one or two pages to help people clearly understand how to change their processes.

Simon Parkes acknowledged that there was a need for a strategy to cover a lot of areas, and the document did that, however he agreed that it needed to be simpler for staff to understand and suggested the Boards-in-Common look at performance, risk, etc. and the expectation of the right behaviours throughout the organisation and would speak with the Acting Group Chairman to request this and asked David Sharif to also give this some thought.

Action: Simon Parkes / David Sharif

David Sharif agreed to develop a simple one to page document and bring it back to the next meeting. The Committee therefore approved the Risk Management Strategy 2025-2028 subject to a simplified document also being produced.

Action: David Sharif

The meeting paused for a ten minute break at this point.

9.7 Review of Losses and Compensations – Group

Philippa Russell highlighted the pharmacy losses as quite significant, equating to around £232K for HUTH. However, it accounted to only 0.3% of year to date expenditure on drugs, but it was definitely an opportunity to improve the stock management of drugs. This had not been reported on at HUTH prior to the organisation moving to a Group structure.

Julie Beilby supported the focus on the HUTH pharmacy losses and the opportunities it presented, as it linked to wider stock control issues that was discussed in various Committees-in-Common meetings. Julie Beilby also referred to the payments made in respect of the complaints process as part of the review of the complaints process in improving the response rate and learning from it.

Gill Ponder referred to the NLaG overseas visitors debts written off as unrecoverable which were later paid and queried whether debts were written off too quickly. Gill Ponder also highlighted that too many patients were suffering the indignity of loss of dentures, more so at HUTH, and stressed that she would like to see some continued focus in terms of reducing the impact on patients as well as the obvious cost of loss of personal possessions.

Harriet Fisher advised that she would share the results of a benchmarking exercise undertaken by KPMG on pharmacy losses for another client who had concerns around such losses. Harriet Fisher to supply to Philippa Russell after the meeting.

Action: Harriet Fisher

Simon Parkes commented that the value of losses of patient's personal effects may be negligible but the impact of those patients affected was enormous and the Group needed to get it right, adding that an audit carried out on it did see substantial improvement but this needed to be seen across the Group.

Simon Parkes accepted that the pharmacy losses was a small percentage of overall expenditure but observed that small amounts of money all contributed to the savings that the Group were required to make, noting the difficult conversations around savings at the Boards-in-Common. Simon Parkes was pleased that this area was being given attention and should be highlighted to the Boards-in-Common.

Philippa Russell agreed to review the overseas visitors write-off process in light of Gill Ponders comments. Sally Stevenson advised that the payments could be linked to people making visa applications to the Home Office and clearing an outstanding NHS debt in the process. Simon Parkes asked that Philippa Russell provide some assurance around the robustness of the write off process for the next meeting.

Action: Philippa Russell

9.8 Review of Standards of Business Conduct Declarations – Group

David Sharif reported ongoing low compliance rates with the declarations across the Group, despite a now unified policy since September 2025, albeit two different approaches still. David Sharif referred to putting a business case together to support a Group wide system, but in the current financial climate considered that this would

not be successful. Therefore, a three point plan had been devised to implement over the next three to four months to attempt to improve the culture of making declarations.

Julie Beilby stressed it was a basic task that required completion as necessary and added that she was unsure of any consequences of not providing a return, including a nil return. Julie Beilby also referred to issues of having two different systems, but noted that there was now one policy and people just needed to comply, and also queried whether investment in one common system would really improve anything or whether it was more about mindset. David Sharif advised that the plan to change the system had been exhausted for the time being, and he was proposing a series of actions to improve reporting and bring it to the fore of the organisation.

Simon Parkes stated that it was unacceptable, not where the Group needed to be and left the organisation vulnerable to public scrutiny. The Group would also be unable to support colleagues who may come under pressure because of the lack of a register that there was any confidence in that conflicts were being properly managed, etc. Simon Parkes stated that managers should be held accountable and driving the correct behaviours, including through the performance appraisal process and referred back to the earlier action point about it being removed from the appraisal documentation. Simon Parkes advised that he would write to the Group Chief People Officer and the Acting Group CEO to highlight the Committee's frustration with non-compliance of the business conduct policy.

Action: Simon Parkes

Julie Beilby commented that in relation to job planning, the WEC CiC had instilled a discipline with regular monitoring and required that management responsibilities be clear, and it had really helped drive some good progress and suggested David Sharif may want to consider that with Simon Nearney, as well as some consequences for non-compliance.

Simon Parkes concluded the discussion by stating it was about the ARG CiC supporting David Sharif with the issue by saying that this position could not continue, and there was now clarity about what needed to be done to get a trajectory for improvement in the same way that WEC CiC had done for other matters.

Sue Meakin joined the meeting at this point

9.9 Document Control Report – Group

David Sharif updated that the organisation remained static at around 90% in terms of compliance, even during the churn of the move to a Group structure and the Care Groups being established it remained around 90%, but wanted to see it higher. Some areas were up at 98% but others were becoming outliers with quite a number of overdue documents. The Performance & Accountability (P&A) sessions with the Care Groups was the appropriate forum to enable a change in behaviour and David Sharif sensed an increased awareness of why it was so important.

Gill Ponder noted the improvement but voiced her concern about the number of high risk documents that were overdue and questioned whether the focus should be on these, with a strict view that this was not acceptable due to the potential impact on patients.

Helen Wright asked whether there was a clear trajectory on improvement for overdue documents and David Sharif responded that Care Groups were asked at the P&A sessions when they expected to be compliant, although advised that the usual response was 'by the next meeting' which was not then achieved. David Sharif agreed that he would take on board the point around having a more risk stratified approach to the problem.

Simon Parkes thanked everyone involved for their work around this area, adding however that there was clearly scope for further improvement as the process was not entirely effective. It was highlighted that, again, there were gaps in the names of staff who were responsible and this needed rectifying to be able to progress and hold staff accountable. It was important to address this in appraisals so that the expectations were clear. Simon Parkes also emphasised that the documents needed reviewing at the very least, and only needed to be changed if necessary, and it was confirmation of the review that was recorded. Again, it was simply a matter of getting the basics right. David Sharif clarified that although the report appendix did not show it, the document owner was known for every document on the register.

9.10 Charitable Funds Governance Arrangements Update - *Deferred*

As Emma Sayner had sent her apologies to the meeting and this was due to be a verbal update, it was agreed for this item to be deferred until the next meeting.

10. Policies for Review / Approval

There were none.

11. ARG CiC Governance Items

It was noted that the January 2026 meeting would also be via MS Teams as part of the three-month trial, enabling Executives and Non-Executives to make more efficient use of their time.

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

12.1 Performance, Estates & Finance CiC
12.2 Capital & Major Projects CiC / Strategic Programmes & Partnerships CiC (from Oct 25)
12.3 Quality & Safety CiC
12.4 Workforce, Education & Culture CiC
12.5 The Health Tree Foundation Committee – NLaG

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

13. Private Agenda Items

Item 13.1 was minuted as a private agenda item.

14. Any Other Urgent Business

There was no urgent business to discuss.

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

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

- Group EPRR Report – endorsed the report and recommended approval by the Boards-in-Common.
- Group BAF – limited assurance remained, due to not seeing progress expected.
- Group Risk Register – no assurance, as process of risk management not working in the way it needed to work.
- Group Losses and Compensations Report – value of HUTH Pharmacy stock write-offs highlighted, but pleased to note actions being taken to focus on opportunities.

16. Matters to Highlight to other Trust Board CiCs

The following items of business were agreed to be highlighted to other CiCs:

- Group BAF – ARG CiC Chair to confirm with Q&S CiC Chairs that they have patient access risk issue on their agenda.
- Group BAF – ARG CiC Chair to write to other CiC Chairs to ensure escalating risk items from their CiC to the Boards-in-Common where key risks are adrift from the risk appetite.

17. ARG CiC Workplan – for information only

The Workplan had been circulated for information and Simon Parkes asked if anyone had any comments or issues to raise with it. There were none raised.

18. Review of the Meeting

Simon Parkes encouraged feedback from colleagues on the meeting either at that point or afterwards. Simon Parkes offered his own reflections that the ARG CiC were aware of several issues that had been around for quite a while and more tangible progress on these was required and as a result the ARG CiC had been a little tougher on its expectations during the meeting and hoped that the focus was on issues which would support the improved performance of the Group. It was noted that the observers to the meeting did not have the back story to some of the issues discussed during the meeting.

Jenny Sharp thanked the ARG CiC for the opportunity to join and observe the meeting, adding that NHSE were not looking for different behaviours or actions, it just gave NHSE the opportunity to lift the lid on things a little more from a largely financial perspective particularly in terms of grip and control. Jenny Sharp acknowledged that it was a challenging time for the Group. Jenny Sharp advised that the point of observing was not to offer any formal written feedback, but offered an informal conversation to Committee Chairs after such observations to update on how NHSE considered the organisation was taking control of its position and to update on whether there was

effective challenge from Non-Executive Directors. Simon Parkes thanked Jenny Sharp for her comments, advising that he would take up the offer of informal feedback.

Tony Bruce advised that he was there from a developmental perspective, so any feedback was offered in that way. His summary points included papers going out on time; agenda sometimes stated 'for assurance' but papers stated ' to note'; papers had been read; the meeting went at a good pace with time being spent where it needed to be; lots of constructive challenge, positive engagement and discussion between all present; sometimes needed to express clarity on assurance taken from papers and confirm actions going to be taken; confirm level of assurance for each item; strong improvement culture; did not shy away from difficult conversations; maybe needed to be more impatient sooner (but acknowledged he only had three months of minutes to form a view), a couple of paper introductions were a little lengthy; and the meeting was chaired well. Tony Bruce concluded that overall there was lots to be positive about.

David Sharif offered his observations, stating that he felt that he had been respectfully challenged on difficult issues in his papers and added that he had also been asked to present papers which he had not written, so needed to reflect on this.

Simon Parkes thanked Tony Bruce and David Sharif for their very helpful feedback, which he would reflect on.

19. DATE AND TIME OF THE NEXT MEETING

The next meeting of the Audit, Risk and Governance Committees-in-Common will be held on Thursday 22 January 2026 at 9am to12.30pm via MS Teams.

The ARG CiC Chair closed the meeting at 12.35pm.

Schedule of Attendance at ARG CiC Meetings 2025/26

Member / Attendee	Apr-25	Jun25 Audited Accounts	Jul-25	Nov25	Jan-26	Total
Members - NLAG:						
Simon Parkes – NED / ARG CiC Chair	Y	Y	Y	Y		4/4
Gill Ponder – NED	Y	N	Y	Y		3/4
Julie Beilby – NED (from Jan 25)	Y	Y	Y	Y		4/4
Members - HUTH:						
Jane Hawkard – NED / ARG CiC Chair	Y	Y	Y	N		3/4
Tony Curry – NED	Y	N	Y	Y		3/4
Helen Wright – NED (from Jun 24)	Y	Y	Y	Y		4/4
Regular Attendees:						
Emma Sayner – Group CFO (from Jan 25)	Y	Y	Y	N		3/4
David Sharif – Group Director of Assurance	Y	Y	Y	Y		4/4
Rebecca Thompson – Deputy Director of Assurance - HUTH	Y	N	N			1/3
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y		4/4
Daryl Cheetham – Local Counter Fraud Specialist				Y		1/1
External Audit - NLAG (Sumer NI)	Y	Y	Y	Y		4/4
External Audit – HUTH (Forvis Mazars)	Y	Y	Y	Y		4/4
Internal Audit - NLAG (Audit Yorkshire)	Y	Y				2/2
Internal Audit – HUTH – (RSM)	Y	Y				2/2
Internal Audit – Group (KPMG)	Y	Y	Y	Y		4/4
Sue Meakin - Group DPO / IG Lead	Y	N[1]	Y	Y		3/3
Mike Bateson - NLAG Governor Observer	Y	Y	Y	Y		4/4
Ad-hoc Attendees:						
Asst. DoF – Planning & Control (Nicola Parker)	Y	Y	-	-		2
HUTH Vice Chair (Murray MacDonald)	Y	-	-	-		1
Acting Group Chief Executive (Amanda Stanford)	Y	Y	-			2
Group Chief Strategy & Partnerships Officer (Ivan McConnell)	Y	-	-	-		1
Group Chair (Sean Lyons)	-	Y[2]	-			1

Ad-hoc Attendees continued….:						
Group Deputy Director of Communications (Adrian Beddow)	-	Y	-	-		1
Associate Director of Quality Governance (Richard Dickinson)	-	-	Y	-		1
Operations Director – Group Emergency Planning (Matt Overton)	-	-	Y	Y		2
Group Head of Legal (Gerard Curran)	-	-	Y	-		1
Group Chief Technology Officer (Tony Deal)	-	-	Y	-		1
Group IT Security Manager (Manoj Konanki)	-	-	Y	-		1
Director of Procurement (Edd James)	-	-	-	Y		1
NHS England Observer (Jenny Sharp)	-	-	-	Y		1
The Value Circle Observer (Tony Bruce)	-	-	-	Y		1

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

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(26)024

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 12 February 2026**
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	Neil Gammon, Chair Health Tree Foundation Trustees' Committee
Title of Report	Health Tree Foundation Trustees' Committee Highlight Report
Executive Summary	To provide a 6 monthly highlight report for the Health Tree Foundation
Background Information and/or Supporting Document(s) (if applicable)	**N/A**
Prior Approval Process	**The Health Tree Foundation Trustees' Committee**
Financial Implication(s) (if applicable)	None to NLAG
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ✓ Information ☐ Assurance ☐ Other – please detail below:

Current Income and Spend Position

As at 31 December 2025, planned income of £543k was only £329k. Like many charities currently, fund-raising income was less than expected and this was also true for both legacies and donations from individuals. Trustees reviewed HTF's plans and noted that despite much endeavour and including some novel ideas, it had not been possible to reach targets.

Expenditure for the same period was £431k versus a budget plan of £828k. This was due to an underspend of £100k on fulfilling the Fairchild Legacy at SGH, which will be achieved in time; together with various delays in approvals prior to placing orders.

The above resulted in a FY25/26 Year to Date financial KPI of £0.54 of every £1 of income fulfilling the charity's objects, against a target of £0.75.

Delays in Approval for Wishes

As mentioned above, delays in approvals for larger items of expenditure, such as the purchase of pieces of equipment, are causing problems. Several different internal, and some external, approvals are routinely required, for very sound reasons. Not only can such delays impact the patient benefit but HTF has experienced equipment quotations expiring, resulting in subsequent increased costs. Trustees would like to emphasise the importance of dealing with such requests in a timely manner.

Corporate Tiered Relationships

The HTF Team have introduced a refreshed corporate partnership offer, tiered according to the financial sponsorship level. Keepmoat Homes Limited are one of the first businesses to sign up for this.

Contract Expiry

The current contract with The HEY Smile Foundation to manage DPOW's Charitable Funds expires on 30 June 2026. The Invitation to Tender for the next period, following Trustee approval, was issued on 20 January 2026. The tender closes on 27 February 2026 and evaluation will take place week commencing 2 March 2026.

Approval of Wishes

At their meeting on 15 January 2026, Trustees approved a “Wish” for 2 portable ultrasound machines for ENT at DPOW and SGH. They also approved a “Wish” to have The Pink Rose Suite at DPOW’s nursing corridor redecorated and flooring replacement in the corridor and all clinical rooms.

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)025

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2026
Director Lead	**Emma Sayner, Group Chief Financial Officer**
Contact Officer / Author	Chris Fry, Associate Director, Performance & Insights
Title of Report	Group Performance Report – NlaG & HUTH
Executive Summary	**Key messages:** • Significant challenges relating to patient access • Group Trusts are in national Tier 1 oversight for UEC, Cancer, Diagnostics and RTT (NLAG only) • An Operational Improvement Plan and associated in year recovery trajectories has not delivered necessary capacity • Delivery against both original 25/26 Operating Plan and in-year recover trajectories for UEC and RTT are detailed in the paper. • Format changed for accessibility requirements December 2025.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Site Directors of Operational Transformation
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:

Integrated Performance Report

MONTH 9: December 2025 Performance

November 2025 for Cancer data
Produced January 2026

Table of Contents

1. Executive Summary 5

2. Pathway Summary – Benchmark Report – Elective Care 6

2. Pathway Benchmarking & Trend – Elective Care 7

3. Referral to Treatment - HUTH 8

4. Referral to Treatment - NLAG 9

5. Referral to Treatment – 65w Waits - HUTH 10

6. Referral to Treatment – 65w Waits - NLAG 11

7. Referral to Treatment – Data Quality - HUTH 12

8. Referral to Treatment – Data Quality - NLAG 13

9. Cancelled Operations - HUTH 14

10. Cancelled Operations - NLAG 15

11. Capped Theatre Utilisation - HUTH 16

12. Capped Theatre Utilisation - NLAG 17

13. Pathway Summary – Benchmark Report – Diagnostics 18

14. Pathway Benchmarking & Trend – Diagnostics 19

15. Diagnostic 6 Week Standard - HUTH 20

16. Diagnostic 6 Week Standard - NLAG 21

17. Pathway Summary – Benchmark Report – Cancer Waiting Times 22

18. Pathway Benchmarking & Trending – Cancer Waiting Times 23

19. 62 Day Cancer Performance - HUTH 24

20. 62 Day Cancer Performance - NLAG 25
21. 28 Day Faster Diagnosis Standard - HUTH 26
22. 28 Day Faster Diagnosis Standard - NLAG 27
23. Pathway Summary – Benchmark Report – Unscheduled Care 28
24. Pathway Benchmarking & Trending – Unscheduled Care 29
25. Emergency Care Standards – 4 hour Performance - HUTH 30
26. Emergency Care Standards – 4 hour Performance - NLAG 31
27. Core Objective 1 – Mean Time to Treatment 32
28. Core Objective 2 – Non-Admitted Total Time in Department 33
29. Core Objective 3 – Total Time in Department (Patients >= 65 years) 34
30. A&E Attendances – All Types 35
31. A&E Attendances – Type 1 Attendances 36
32. A&E Attendances – Type 3 Attendances 37
33. Ambulance Handovers >60 minutes - HUTH 38
34. Ambulance Handovers >60 minutes - NLAG 39
35. Activity ..... Error! Bookmark not defined.
36. Financial Activity Summary - HUTH 44
37. Financial Activity Summary - NLAG 44

1. Executive Summary

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

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**December 2025** **0** **0** **112** **3,072**	**December 2025** **0** **0** **42** **915**	• Increase in 65w breaches for NLAG (+13) and decrease at HUTH (-22) on previous month • Decrease in 52w breaches for NLAG (-73) and decrease at HUTH (-219) on previous month • Slight decrease in total waiting list size at both HUTH and static at NLAG
Diagnostic 6w Performance	**December 2025** **40.2%**	**December 2025** **46.5%**	• Deterioration in performance for both HUTH and NLAG compared to previous month
Cancer 62-day Performance (all sources)	**November 2025** **57.4%**	**November 2025** **70.5%**	• Both Trusts are in Tier 1 for Cancer delivery, working with NE&Y Regional Office on recovery assurance • 62-day performance at HUTH improved to 57.4%. • 62-day performance at NLaG improved to 70.5% • Delays in the front of pathway (outpatient and diagnostics) driving increases in the total volume of patients waiting for Cancer assessment or treatment. The >104-day Urgent Suspected Cancer backlog remains a challenge at 25 in NLAG and 136 in HUTH.
ED: 4-hour standard (Type 1 & 3)	**December 2025** **60.1%** **Trust compliance inclusive of on-campus UTCs**	**December 2025** **64.8%** **Trust compliance inclusive of on-campus UTCs**	• HUTH A&E 4 Hour standard (all types) was 60.1% in December 2025 (plan 73.6%). Type 1 performance of 47.1% was below the 25/26 operating plan target of 63.3%. Type 3 performance (HRI UTC) was 91.6% against the 95% target. Type 1 attendances were above plan, Type 3 attendance volumes were below plan. • NLaG combined type 1 and 3 performance was 64.8% against a target of 76.8%. Type 1 performance = 41.5% (Target 61.9%) and Type 3 performance = 99.4% (Target 99%). Type 1 and Type 3 attendances were below planned levels for December 2025.

2. Pathway Summary – Benchmark Report – Elective Care

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

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT - Patients waiting 18 weeks or less	Nov 25	-	55.96%			16
RTT 52 Week Breach	Nov 25	0	3,291			4
RTT 65 Week Breach	Nov 25	-	134			9
RTT 95th Percentile Admitted Waiting Time	Nov 25	18.0	63.1			26
RTT 95th Percentile Non-Admitted Waiting Time	Nov 25	18.0	57.1			19
RTT Admitted Treatment Within 18 Weeks	Nov 25	90.0%	55.7%			46
RTT Average (Median) Admitted Waiting Time	Nov 25	9.0	14.8			44
RTT Average (Median) Non-Admitted Waiting Time	Nov 25	5.0	8.4			60
RTT Average Wait for Incomplete	Nov 25	7.00	15.28			17
RTT Incomplete 92nd Percentile	Nov 25	-	44.6			8
RTT Incomplete Pathways With a DTA	Nov 25	25.0%	17.8%			33
RTT Non-Admitted Treatment Within 18 Weeks	Nov 25	95.0%	65.1%			50
RTT Total Clock Starts	Nov 25	-	17,872			87
RTT Total Clock Stops	Nov 25	-	18,185			91
RTT Total Incompletes	Nov 25	-	80,790			13

NLAG

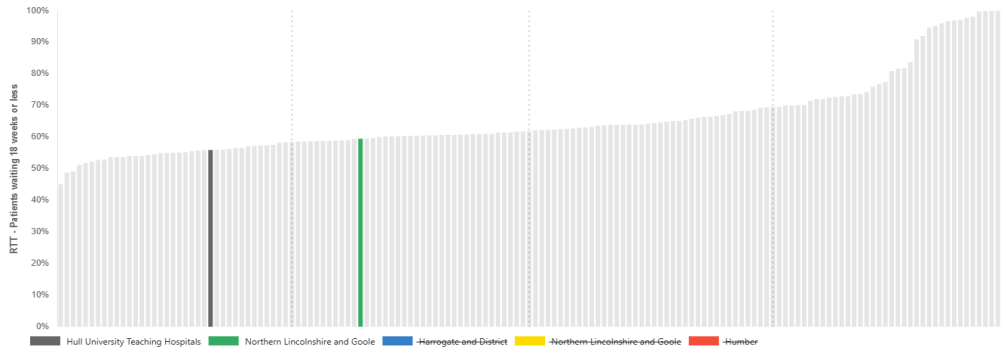
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT - Patients waiting 18 weeks or less	Nov 25	-	59.49%			32
RTT 52 Week Breach	Nov 25	0	988			42
RTT 65 Week Breach	Nov 25	-	29			34
RTT 95th Percentile Admitted Waiting Time	Nov 25	18.0	59.2			57
RTT 95th Percentile Non-Admitted Waiting Time	Nov 25	18.0	53.1			42
RTT Admitted Treatment Within 18 Weeks	Nov 25	90.0%	52.6%			36
RTT Average (Median) Admitted Waiting Time	Nov 25	9.0	16.6			36
RTT Average (Median) Non-Admitted Waiting Time	Nov 25	5.0	9.1			53
RTT Average Wait for Incomplete	Nov 25	7.00	13.55			39
RTT Incomplete 92nd Percentile	Nov 25	-	41.9			28
RTT Incomplete Pathways With a DTA	Nov 25	25.0%	15.7%			45
RTT Non-Admitted Treatment Within 18 Weeks	Nov 25	95.0%	64.4%			46
RTT Total Clock Starts	Nov 25	-	8,972			49
RTT Total Clock Stops	Nov 25	-	8,561			55
RTT Total Incompletes	Nov 25	-	39,296			49

2. Pathway Benchmarking & Trend – Elective Care

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

RTT – Incomplete Standard

Ranking Chart



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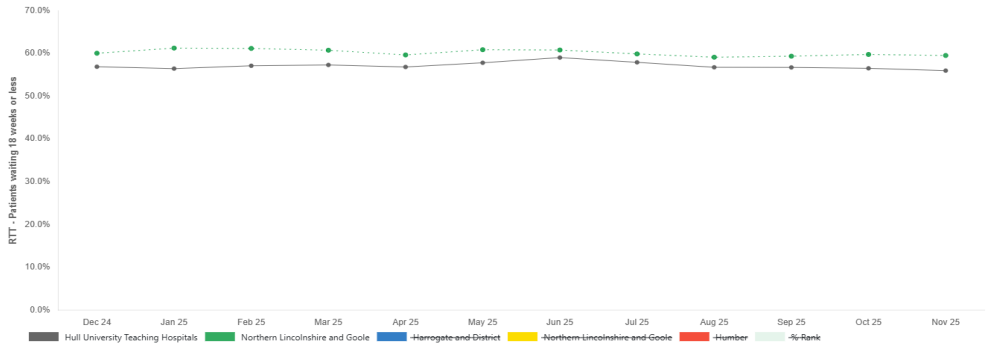
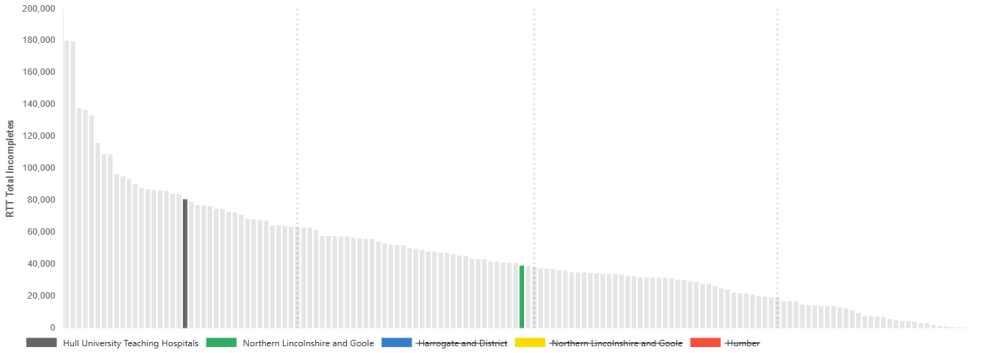
Trend Chart



RTT – Total Waiting List Volume

Ranking Chart



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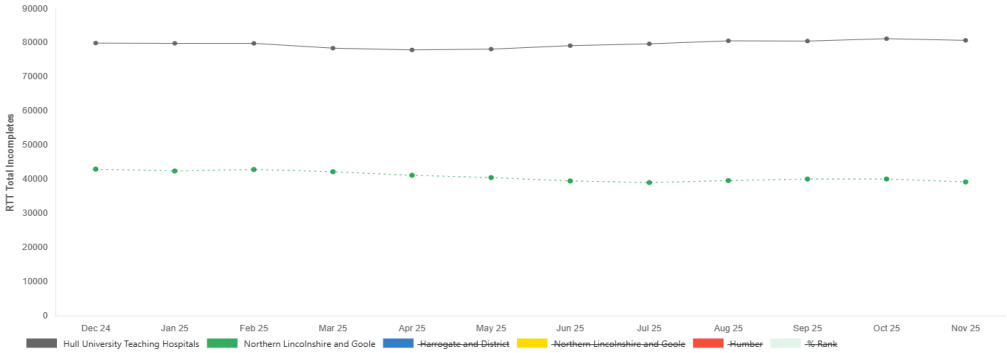
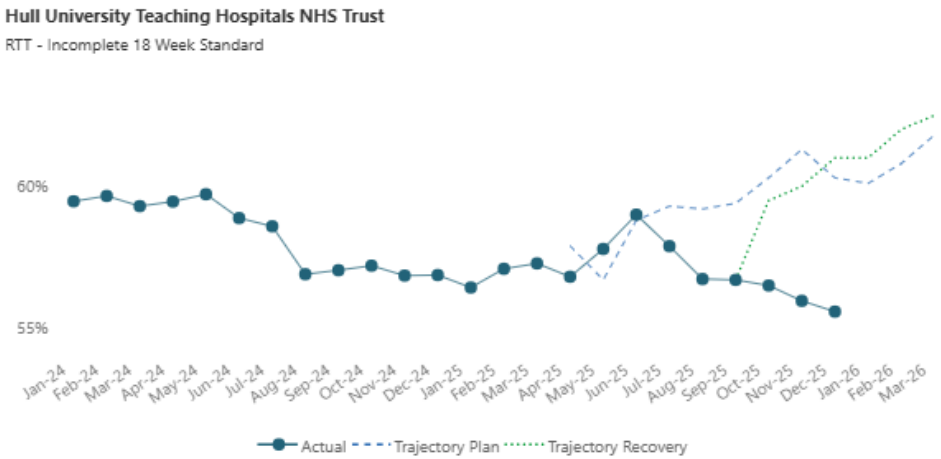
Trend Chart



3. Referral to Treatment - HUTH

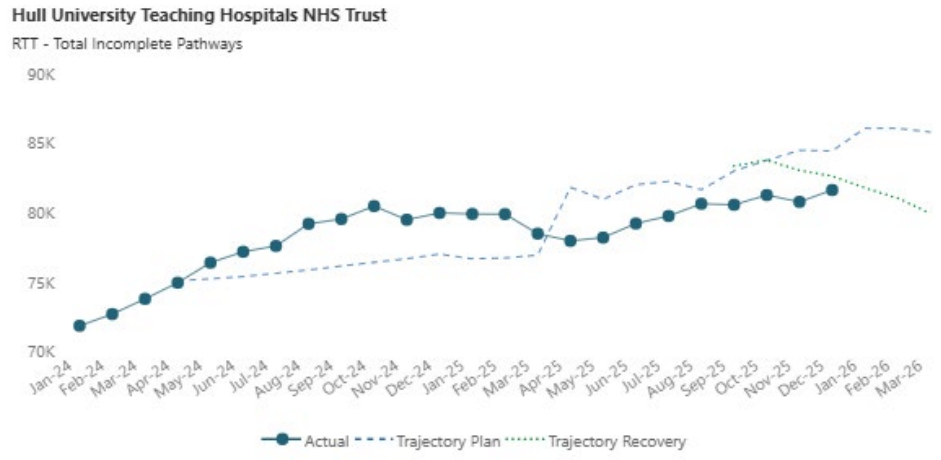
Compliance



Key Themes

- The total waiting list volume increased slightly to 82,638 but is below the trajectory due to enhanced in year validation volumes.
- December RTT performance of 55.6% which is a slight deterioration on the previous month and 5.4% below the recovery trajectory.
- Referrals are down 0.5% up on last year, and below the 3% planning assumption.
- 58% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Dermatology, Ophthalmology, Neurology, Gynaecology and Gastroenterology
- Average wait for incomplete pathway is 15 weeks but remains broadly stable.

Critical Enabler



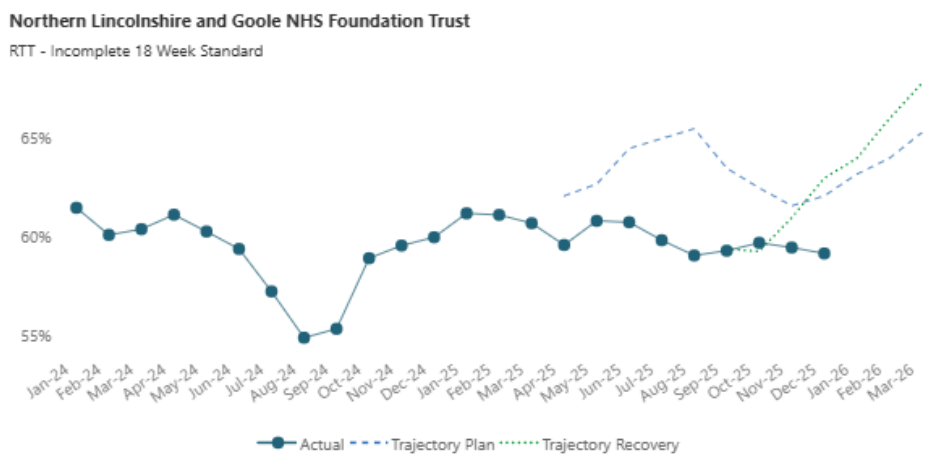
Actions

Critical actions being progressed through RTT Delivery Group:

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

4. Referral to Treatment - NLAG

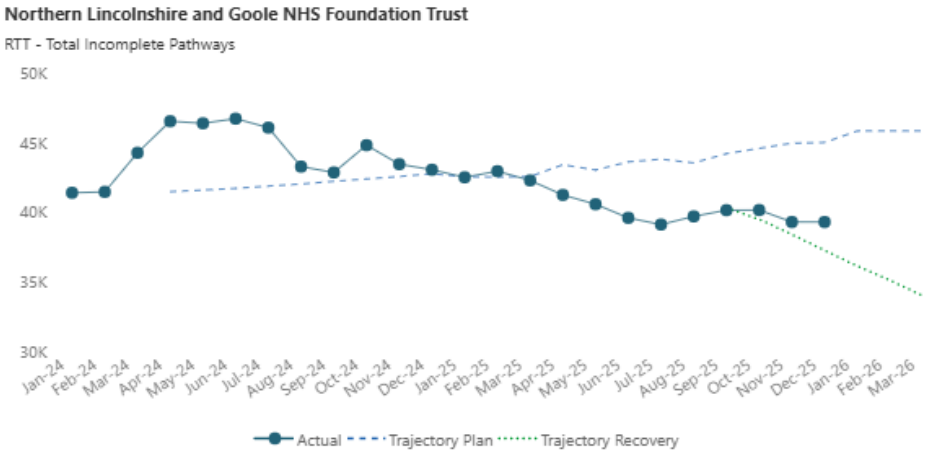
Compliance



Key Themes

- November performance of 59.2% which is 3.8% below the recovery trajectory.
- Since the correction of ASI reporting in April 2024 the RTT waiting list volume has subsequently been reduced to 39,294 and is significantly below the 25/26 planned trajectory.

Critical Enabler



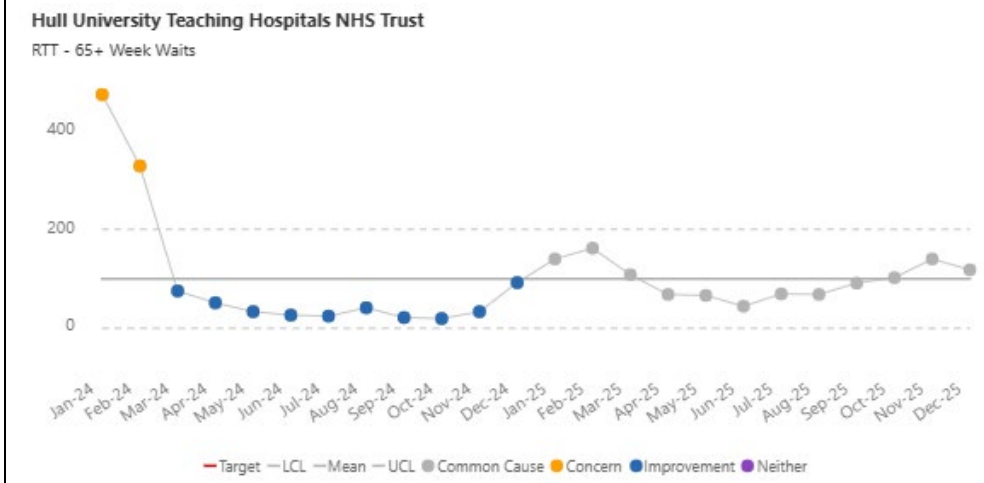
Actions

Critical actions being progressed through RTT Delivery Group:

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

5. Referral to Treatment – 65w Waits - HUTH

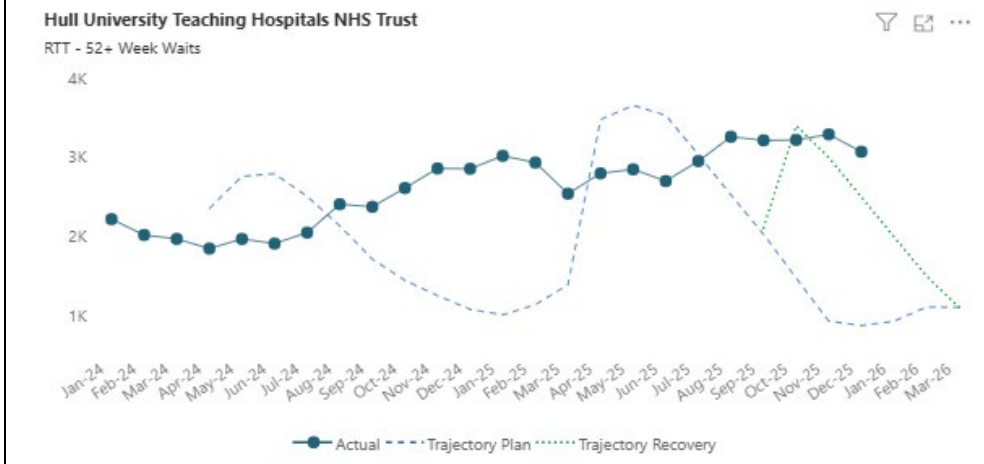
Compliance



Key Themes

- 112 patients exceeded 65 weeks at the end of December which is a decrease of 22 on the previous month
- Risks relating to delivery: -
  - ENT – additional weekend audiology and outpatient capacity is being delivered through DMC. Additional weekend theatre lists in place from December with HEYAS.
  - Plastic Surgery – additional sessional requirement to support delayed DIEPs
  - Breast Surgery – gender surgery – acknowledgement from NHSE and Spec Comm that due to increased referral demand no performance sanctions on long wait breaches
  - Delays in offering admission dates leading to unreasonable offers and patient choice breaches.
- 3.8% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year 2024. The 25/26 planning requirement is to achieve no more than 1% waiting over 52 weeks by March 26.

Critical Enabler



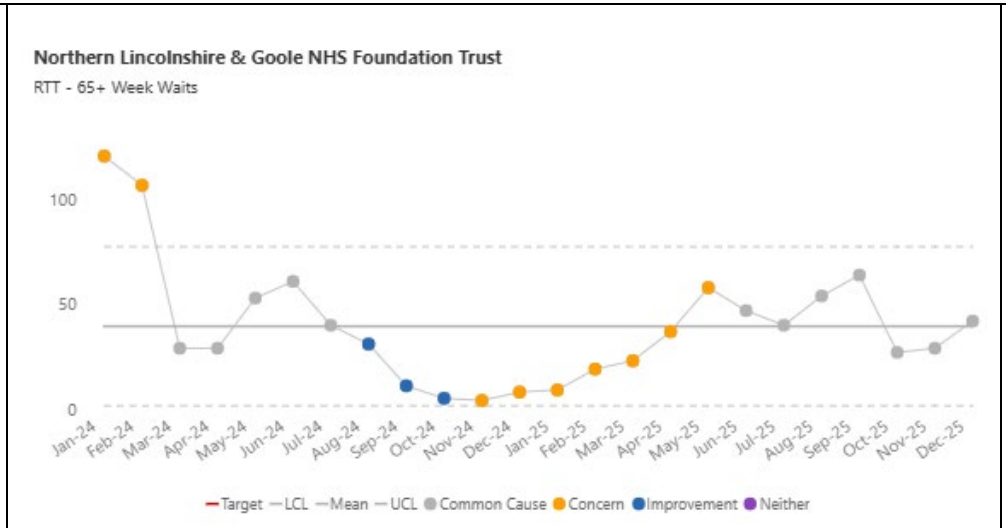
Actions

Critical actions being delivered through the RTT Delivery Group

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

6. Referral to Treatment – 65w Waits - NLAG

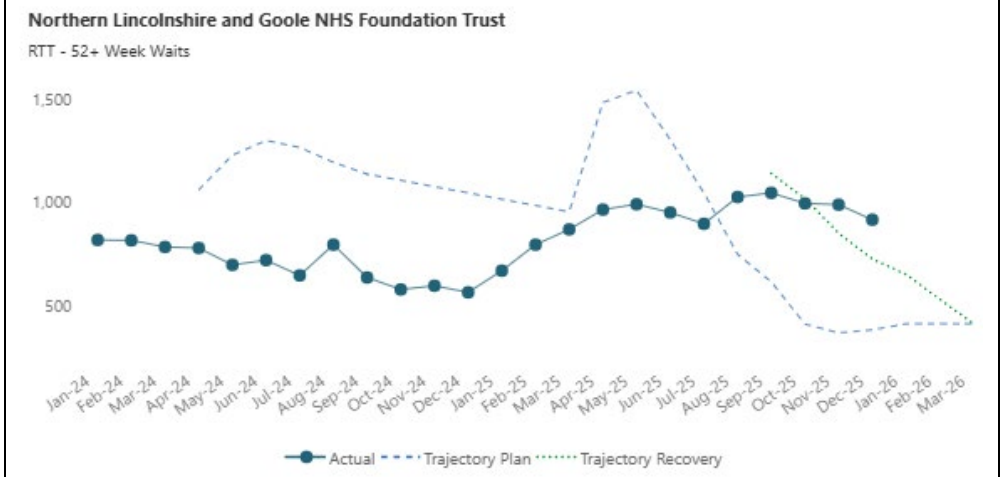
Compliance



Key Themes

- 42 breaches >65 weeks at the end of December which was an increase of 13 on the previous month.
- 2.3% of the PTL is over 52 weeks which is a slight reduction on the previous month.

Critical Enabler



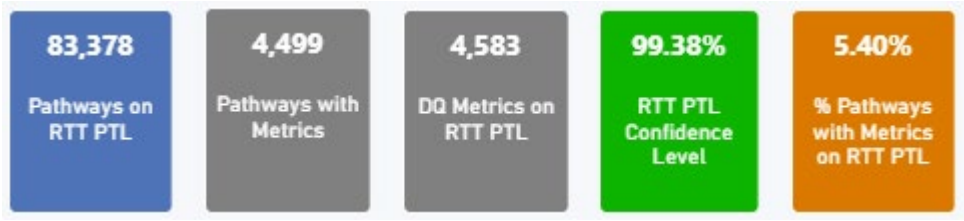
Actions

Critical actions being delivered through the RTT Delivery Group

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

7. Referral to Treatment – Data Quality - HUTH

Compliance



Key Themes

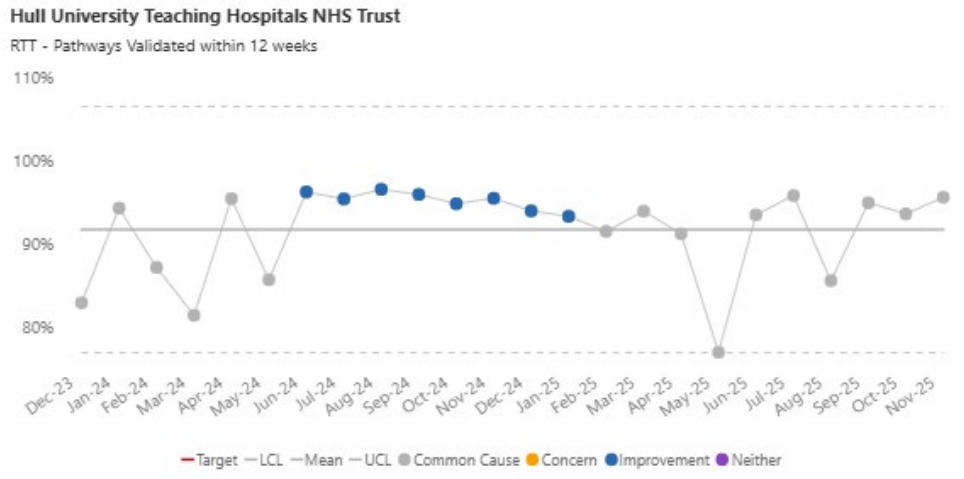
It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

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

95.6% pathways have been validated every 12 weeks.

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

Critical Enabler



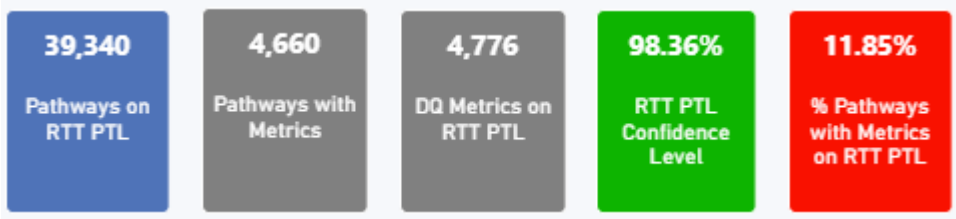
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment
- Deployment of LUNA ROVA proof of concept trial to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- The Q4 Validation Sprint is ongoing. Additional national income at £33 per clock of the baseline waiting list.

8. Referral to Treatment – Data Quality - NLAG

Compliance



Key Themes

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

- LUNA data quality is showing a confidence rate to 98.36%.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks. Current performance is at 90.%

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

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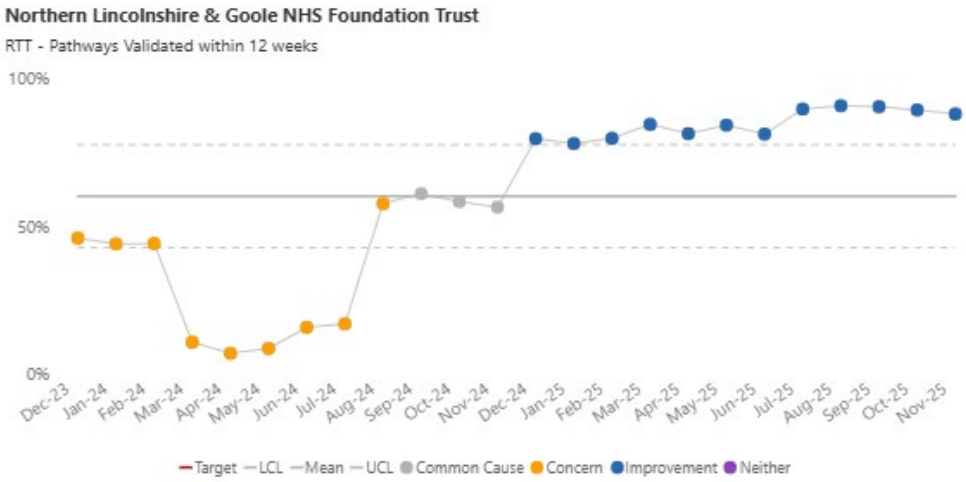
Critical Enabler

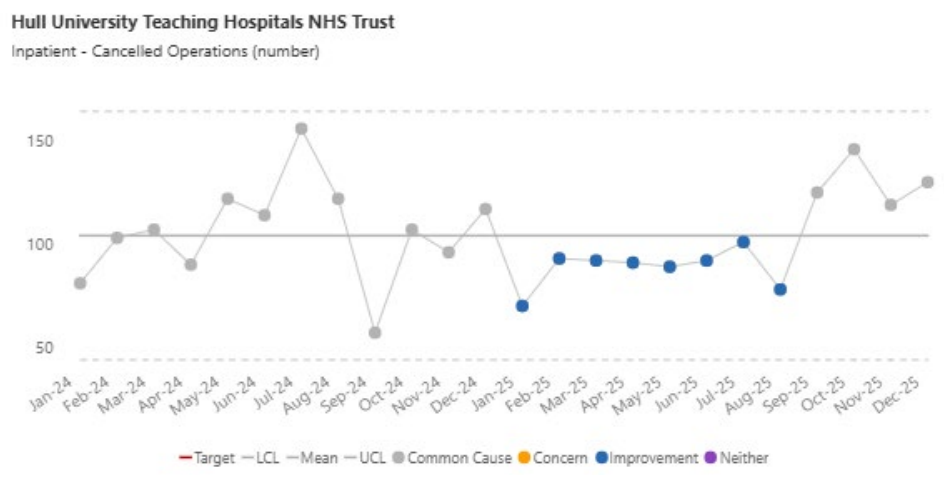


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments.
- Deployment of LUNA ROVA proof of concept trial to support the national drive to deliver a minimum 65% incomplete standard by March 2026.
- The Q4 Validation Sprint is ongoing. Additional national income at £33 per clock of the baseline waiting list.

9. Cancelled Operations - HUTH

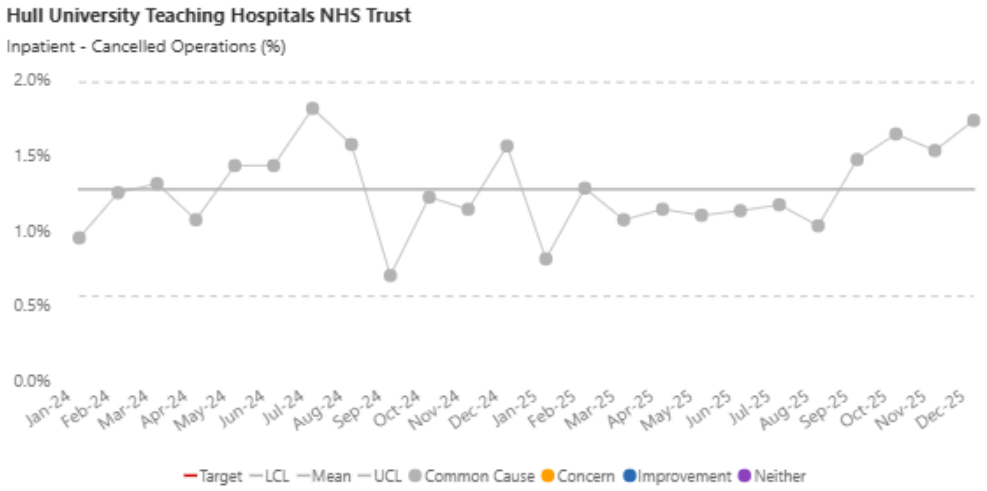
Compliance



Key Themes

- In December there were 130 cancelled operations on the day for non-clinical reasons equating to 1.7% of elective activity.
- The largest reasons were –
  - No Theatre Time - 42
  - Emergency case - 19
  - Surgeon unavailable - 16
- The main specialties incurring cancellations on the day were –
  - Interventional Radiology – 19
  - Pain Management – 19
  - Upper GI Surgery - 16
  - Gynaecology - 15

Critical Enabler

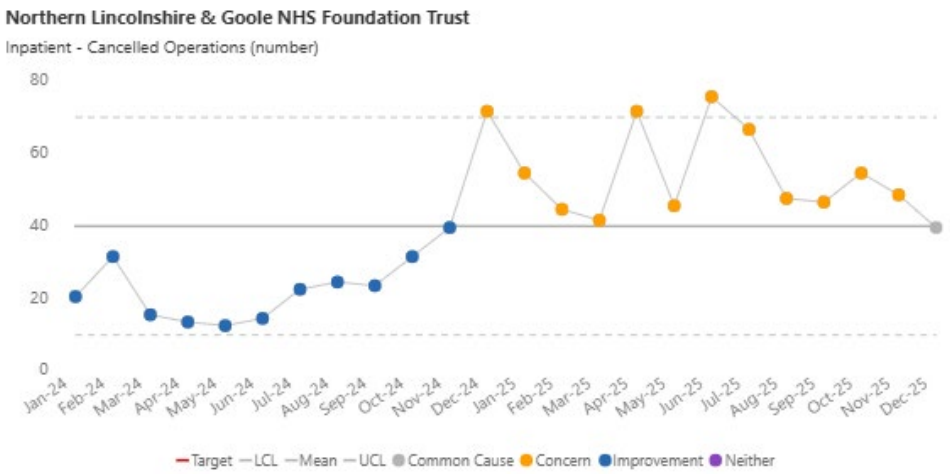


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focused operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 pre-op.

10. Cancelled Operations - NLAG

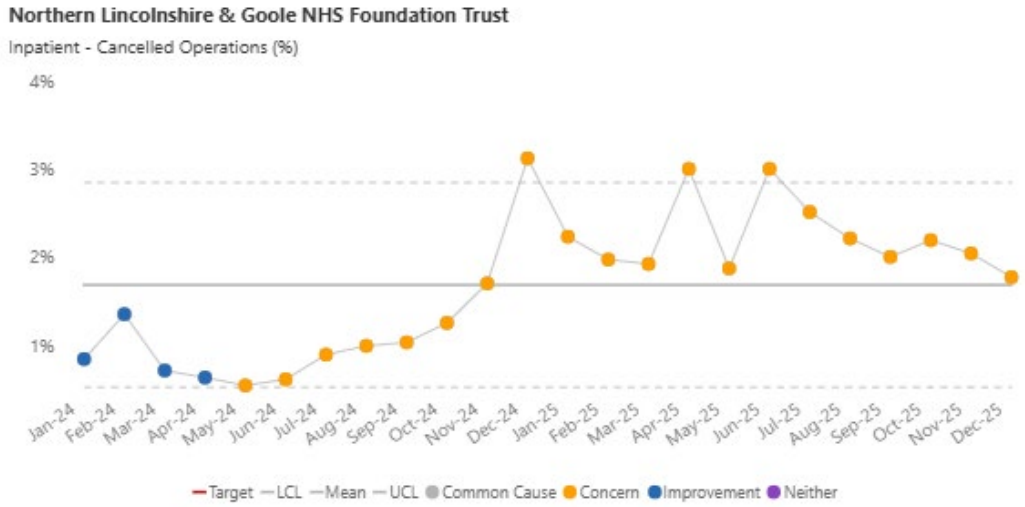
Compliance



Key Themes

- December cancellation volumes totalled 39 equating to 1.8% of elective activity
- The largest reasons were –
  - List overrun – 11
  - Surgery deferred - 6
  - Equipment failure – 6
- The main specialties incurring cancellations on the day were –
  - Ophthalmology – 8
  - T&O – 7
  - Gynaecology – 7
  - General Surgery – 7

Critical Enabler

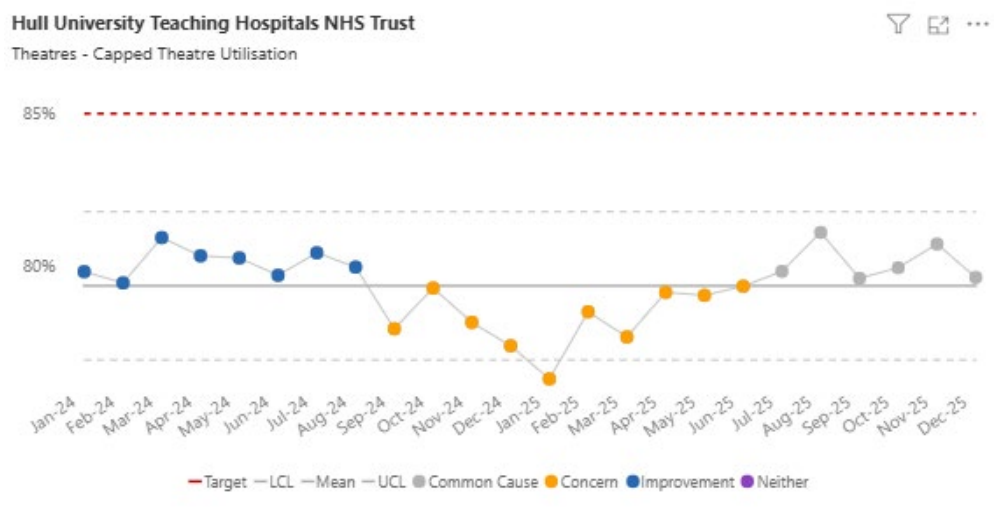


Actions

- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.
- Standing down or lifting sessions SOP completed and deployed.
- Working with NHSE/GIRFT on improvement recommendations
- Enhanced BIU support to report national data set and eliminate DQ issues.

11. Capped Theatre Utilisation - HUTH

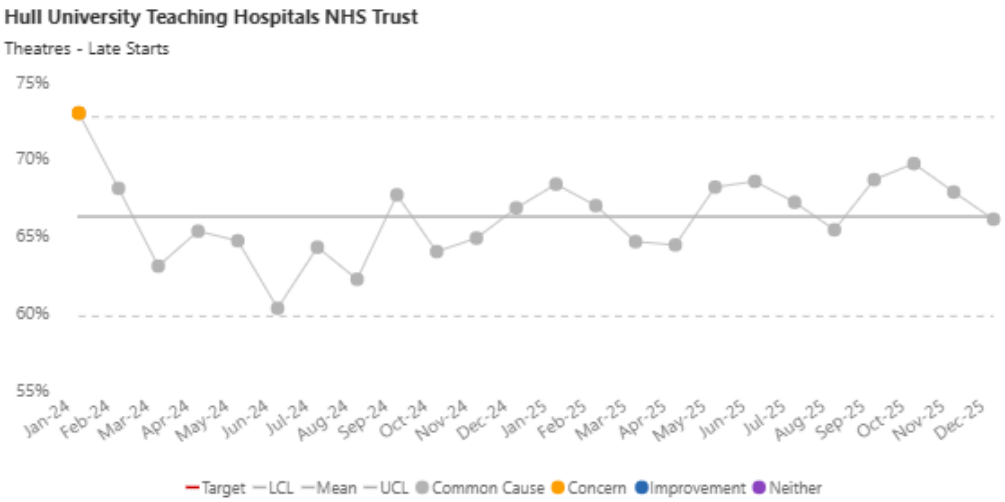
Compliance



Key Themes

- Internal reporting at 79.6% for capped theatre utilisation for December.
- Day Case capped theatre utilisation is at 76.9% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- Utilisation deterioration linked to increase in late starts to 66.1% (methodology 0 minutes = late start)

Critical Enabler

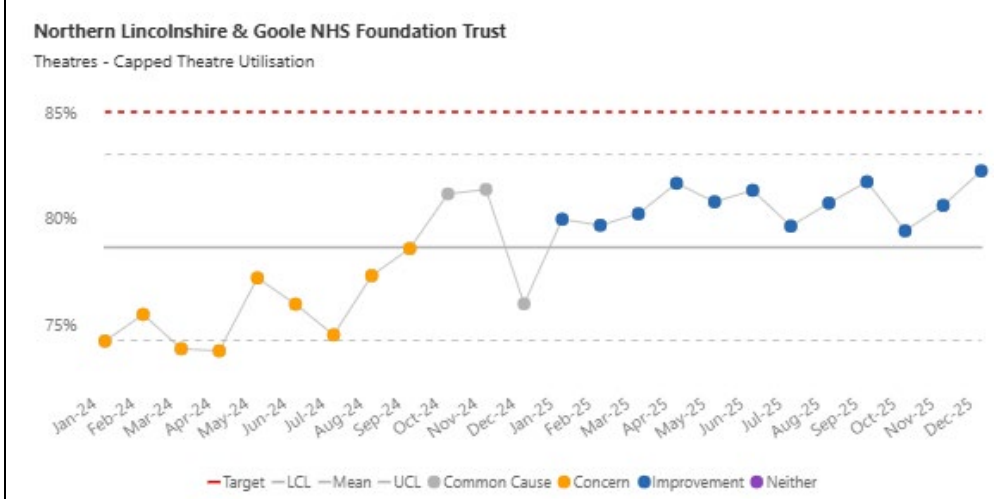


Actions

- Improve recording of day case touch points in ORMIS
- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

12. Capped Theatre Utilisation - NLAG

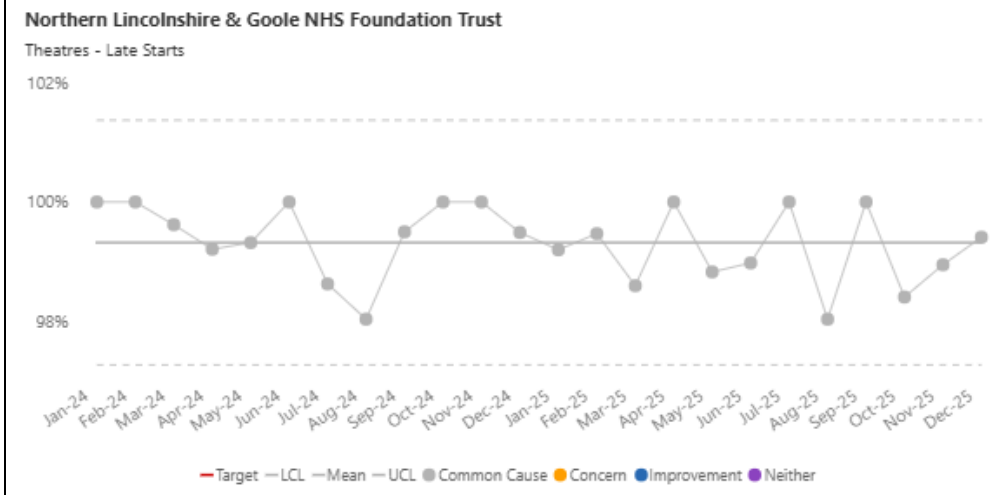
Compliance



Key Themes

- Internal reporting shows performance at 82.2%.
- Theatre late starts issue at NLAG with 98.9% of sessions starting late in November on the zero-minute measure.

Critical Enabler



Actions

- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments. Detail of this plan relayed to Committee in Common in the 'Elective Deep Dive' paper.

13. Pathway Summary – Benchmark Report – Diagnostics

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

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Oct 25	5.00%	31.21%			40
Barium Enema	Oct 25	5.00%	2.13%			38
Colonoscopy	Oct 25	5.00%	43.42%			14
Computed Tomography	Oct 25	5.00%	26.79%			6
Cystoscopy	Oct 25	5.00%	20.13%			47
DEXA Scan	Oct 25	5.00%	47.51%			6
Diagnostic activity levels - Audiology Assessments	Oct 25	-	1,019			77
Diagnostic activity levels - Barium Enema	Oct 25	-	56			81
Diagnostic activity levels - Colonoscopy	Oct 25	-	354			52
Diagnostic activity levels - CT	Oct 25	-	7,093			74
Diagnostic activity levels - Cystoscopy	Oct 25	-	494			89
Diagnostic activity levels - Dexa Scan	Oct 25	-	414			71
Diagnostic activity levels - Echocardiography	Oct 25	-	561			30
Diagnostic activity levels - Endoscopy	Oct 25	-	1,549			76
Diagnostic activity levels - Flexi Sigmoidoscopy	Oct 25	-	130			70
Diagnostic activity levels - Gastroscopy	Oct 25	-	571			76
Diagnostic activity levels - Imaging	Oct 25	-	15,550			65
Diagnostic activity levels - Non Obstetric Ultrasound	Oct 25	-	4,748			57
Diagnostic activity levels - Total	Oct 25	-	19,313			65
Diagnostic activity levels - Urodynamics	Oct 25	-	65			82
Diagnostics - 6 Week Standard	Oct 25	5.00%	31.32%			19
Diagnostics - 6 Week Standard Reversed	Oct 25	95.00%	68.68%			19
DM01 Waiting <13 Weeks	Oct 25	100.00%	88.04%			19
Echocardiography	Oct 25	5.00%	62.20%			6
Gastroscopy	Oct 25	5.00%	24.38%			34
Magnetic Resonance Imaging	Oct 25	5.00%	6.48%			49
Neurophysiology	Oct 25	5.00%	43.43%			24
Non-obstetric Ultrasound	Oct 25	5.00%	16.83%			33
Urodynamics	Oct 25	5.00%	26.25%			56

NLAG

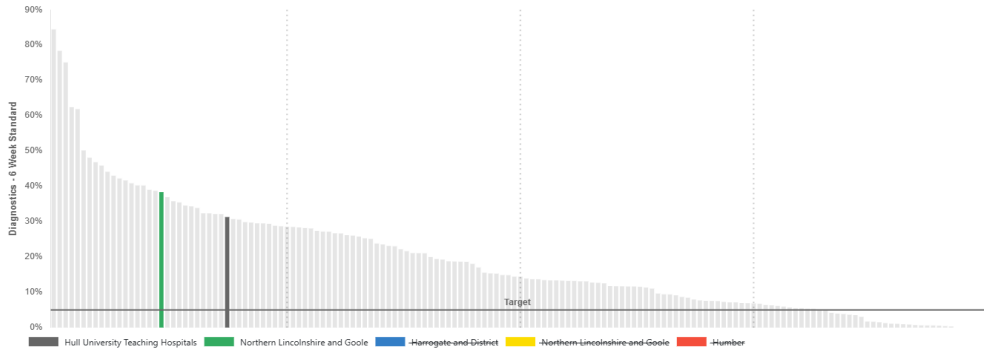
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Oct 25	5.00%	61.29%			15
Barium Enema	Oct 25	5.00%	2.35%			36
Colonoscopy	Oct 25	5.00%	44.39%			11
Computed Tomography	Oct 25	5.00%	1.81%			56
Cystoscopy	Oct 25	5.00%	7.45%			70
DEXA Scan	Oct 25	5.00%	21.55%			14
Diagnostic activity levels - Audiology Assessments	Oct 25	-	621			55
Diagnostic activity levels - Barium Enema	Oct 25	-	178			97
Diagnostic activity levels - Colonoscopy	Oct 25	-	139			29
Diagnostic activity levels - CT	Oct 25	-	11,686			95
Diagnostic activity levels - Cystoscopy	Oct 25	-	366			78
Diagnostic activity levels - Dexa Scan	Oct 25	-	373			63
Diagnostic activity levels - Echocardiography	Oct 25	-	1,113			58
Diagnostic activity levels - Endoscopy	Oct 25	-	764			37
Diagnostic activity levels - Flexi Sigmoidoscopy	Oct 25	-	87			51
Diagnostic activity levels - Gastroscopy	Oct 25	-	172			29
Diagnostic activity levels - Imaging	Oct 25	-	22,545			88
Diagnostic activity levels - Non Obstetric Ultrasound	Oct 25	-	5,509			63
Diagnostic activity levels - Total	Oct 25	-	25,530			86
Diagnostic activity levels - Urodynamics	Oct 25	-	135			92
Diagnostics - 6 Week Standard	Oct 25	5.00%	38.37%			12
Diagnostics - 6 Week Standard Reversed	Oct 25	95.00%	61.63%			12
DM01 Waiting <13 Weeks	Oct 25	100.00%	91.42%			30
Echocardiography	Oct 25	5.00%	8.37%			58
Gastroscopy	Oct 25	5.00%	42.11%			10
Magnetic Resonance Imaging	Oct 25	5.00%	43.39%			4
Neurophysiology	Oct 25	5.00%	49.45%			18
Non-obstetric Ultrasound	Oct 25	5.00%	38.33%			9
Urodynamics	Oct 25	5.00%	4.55%			81

14. Pathway Benchmarking & Trend – Diagnostics

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

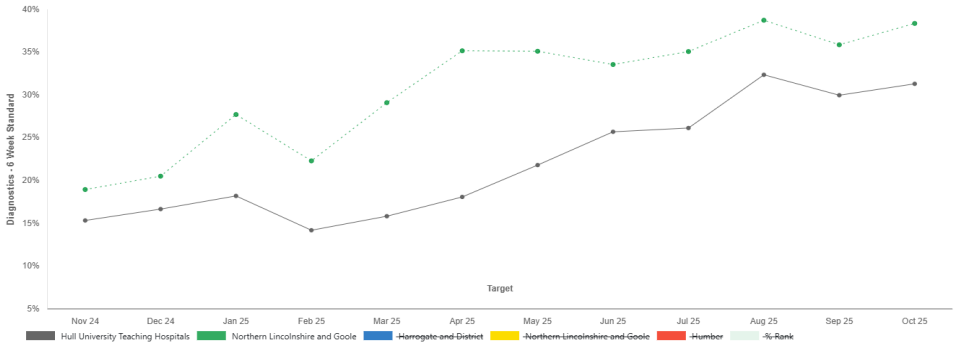
Diagnostics – 6 week Performance Standard

Ranking Chart



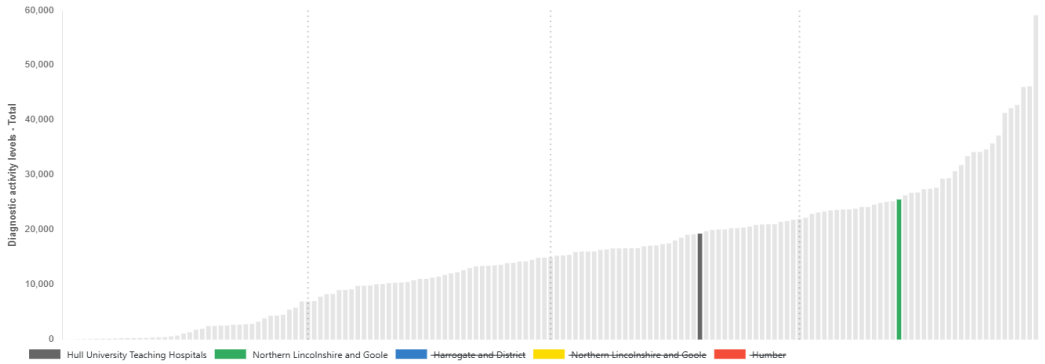
Rank 127 of 156 selected

Trend Chart



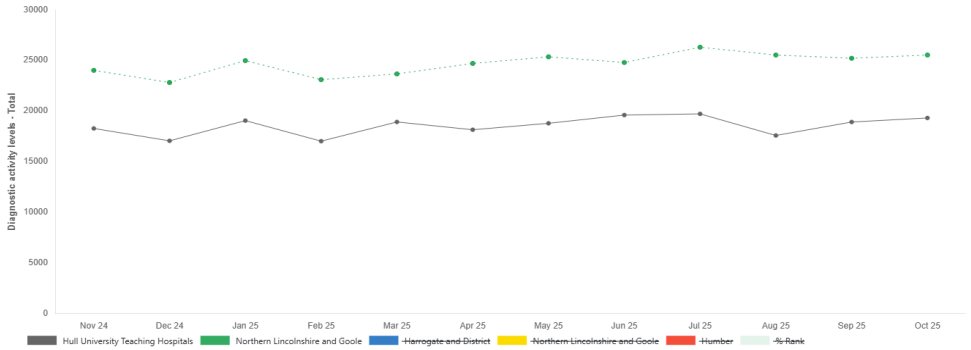
Diagnostics – Activity

Ranking Chart



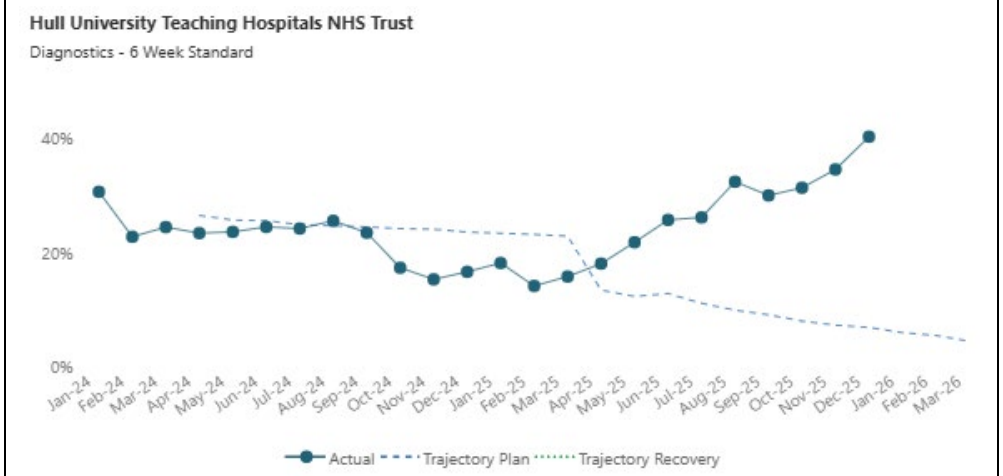
Rank 55 of 157 selected

Trend Chart



15. Diagnostic 6 Week Standard - HUTH

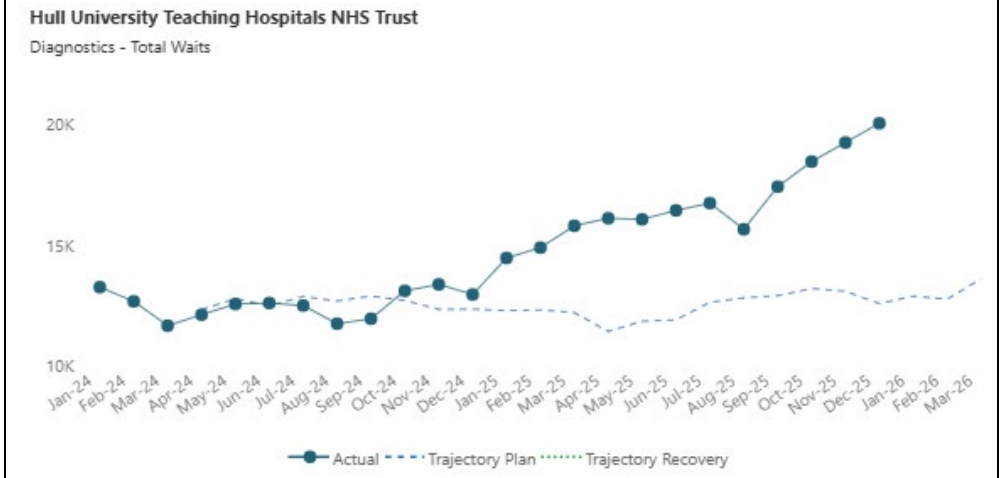
Compliance



Key Themes

- December saw a 5.7% deterioration in performance to 40.2%.
- The largest decreases in performance were seen in Urodynamics, Gastroscopy, Echo, MRI and NOUS.
- Continuing demand pressures in Colonoscopy, DEXA and Sleep Studies
- Total waits continue an increasing theme most notably in MRI, NOUS, Flexi, Gastroscopy, DEXA and Echo.

Critical Enabler



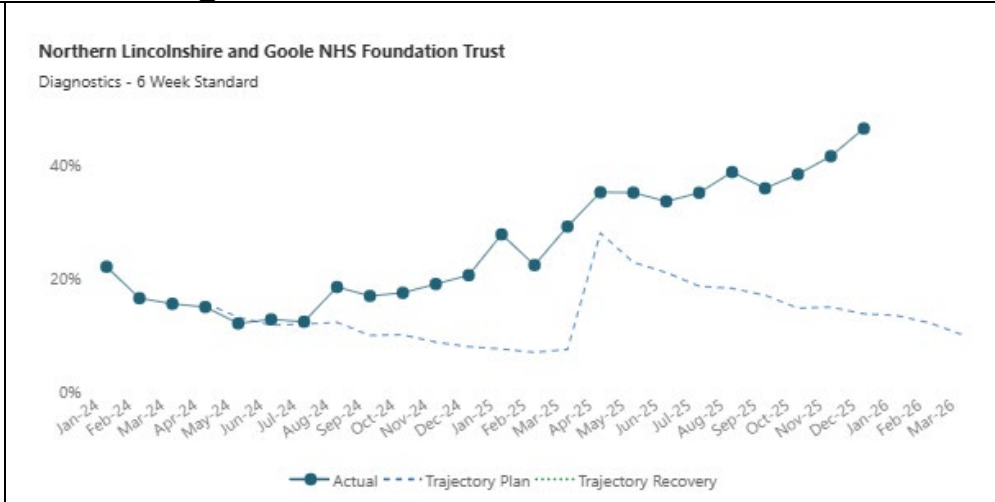
Actions

Critical actions being progressed through Diagnostic Delivery Group:

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

16. Diagnostic 6 Week Standard - NLAG

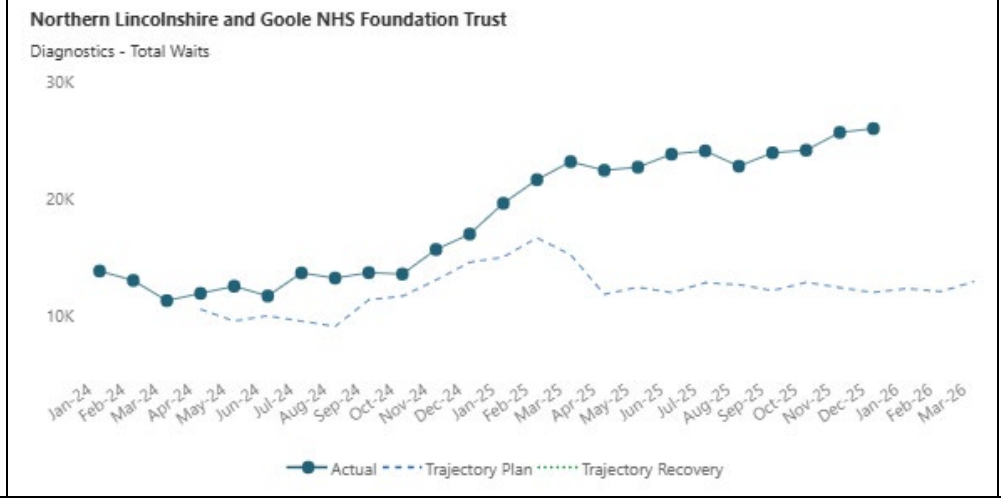
Compliance



Key Themes

- December performance saw a 4.9% deterioration at 46.4%.
- All modalities saw a deterioration in performance in December with the main increases seen in Urodynamics, Gastroscopy, Flexi and Neurophysiology.
- Continuing pressures are seen in Audiology, Colonoscopy, MRI and NOUS.
- DEXA has seen significant improvement from October and remains just below 10% which is a greatly improved position.
- Total Waits show an increasing position most notably in MRI, NOUS, Colonoscopy, Flexi and Gastroscopy.

Critical Enabler



Actions

Critical actions being progressed through Diagnostic Delivery Group:

- Neurophysiology contract mobilisation commenced in October.
- Weekend waiting list initiatives for Stress Echo and develop sonographer-led service.
- Operational Improvement Plan launched creating enhanced elective capacity and utilisation efficacy to deliver in-year end elective commitments.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 2 Week Wait	Nov 25	93.00%	70.23%			23
Cancer - 2 Week Wait Breast Symptomatic	Nov 25	93.0%	8.6%			12
Cancer - 31 Day All Stages	Nov 25	96.0%	74.0%			1
Cancer - 31 Day First Treatment	Nov 25	96.00%	80.34%			1
Cancer - 31 Day Subsequent Treatment	Nov 25	96.0%	67.3%			3
Cancer - 31 Day Subsequent Treatment - Drugs	Nov 25	96.0%	96.9%			15
Cancer - 31 Day Subsequent Treatment - Radiotherapy	Nov 25	96.0%	53.4%			7
Cancer - 62 Day Consultant Upgrade	Nov 25	85.0%	65.1%			4
Cancer - 62 Day Screening	Nov 25	90.0%	68.2%			48
Cancer - 62 Day Urgent Suspected	Nov 25	85.00%	49.71%			15
Cancer - Patients treated within 62 of referral	Nov 25	75.00%	57.44%			9
Cancer - Urgent referrals diagnosis within 4 weeks	Nov 25	80.0%	60.2%			4
Summary Hospital Mortality Indicator - Cancer of bronchus; lung	Aug 25	1.00	1.04			49

NLAG

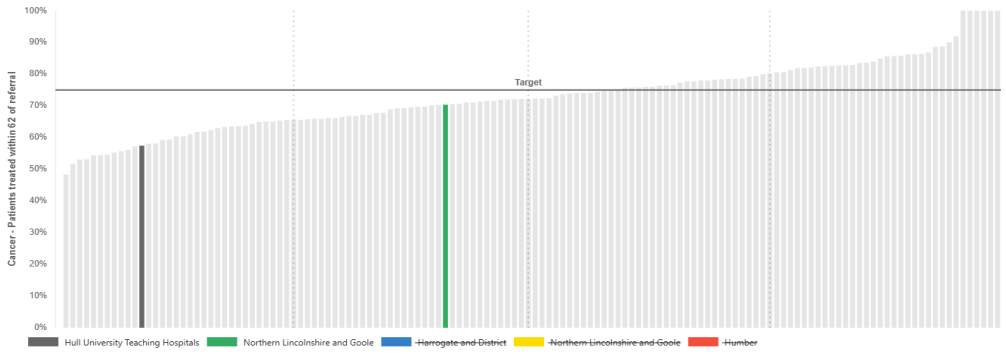
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 2 Week Wait	Nov 25	93.00%	95.82%			88
Cancer - 2 Week Wait Breast Symptomatic	Nov 25	93.0%	88.9%			69
Cancer - 31 Day All Stages	Nov 25	96.0%	97.3%			75
Cancer - 31 Day First Treatment	Nov 25	96.00%	97.27%			71
Cancer - 31 Day Subsequent Treatment	Nov 25	96.0%	97.2%			59
Cancer - 31 Day Subsequent Treatment - Drugs	Nov 25	96.0%	98.1%			21
Cancer - 62 Day Consultant Upgrade	Nov 25	85.0%	89.0%			76
Cancer - 62 Day Screening	Nov 25	90.0%	50.0%			21
Cancer - 62 Day Urgent Suspected	Nov 25	85.00%	58.50%			28
Cancer - Patients treated within 62 of referral	Nov 25	75.00%	70.36%			41
Cancer - Urgent referrals diagnosis within 4 weeks	Nov 25	80.0%	75.6%			32
Summary Hospital Mortality Indicator - Cancer of bronchus; lung	Aug 25	1.00	1.16			26

18. Pathway Benchmarking & Trending – Cancer Waiting Times

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

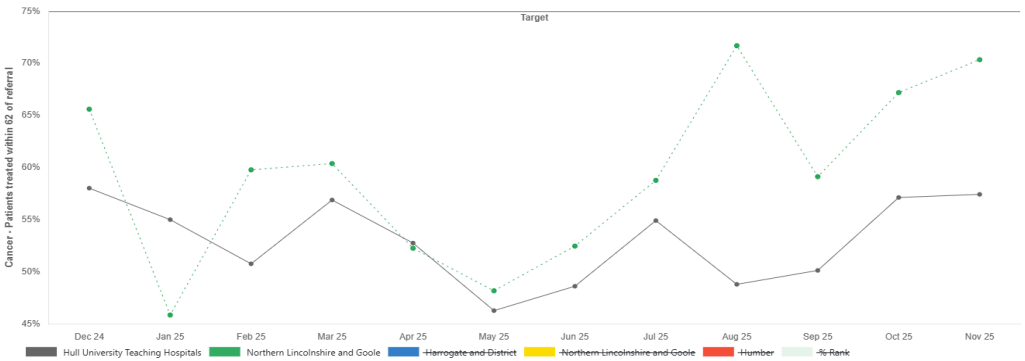
62 Day Performance

Ranking Chart



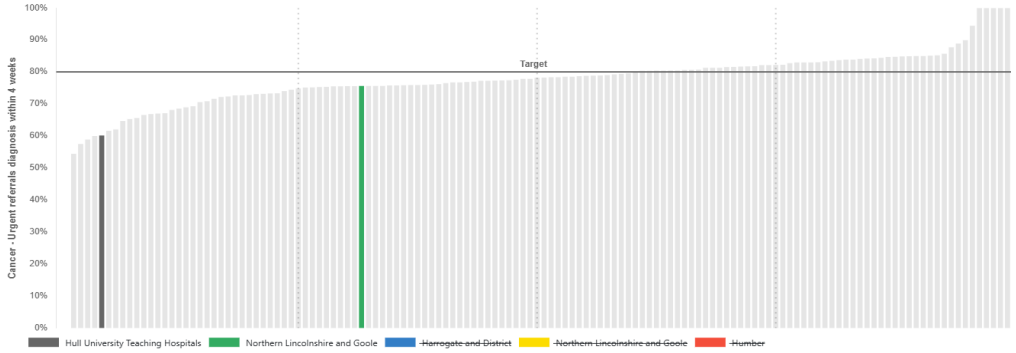
Rank 125 of 137 selected

Trending Chart



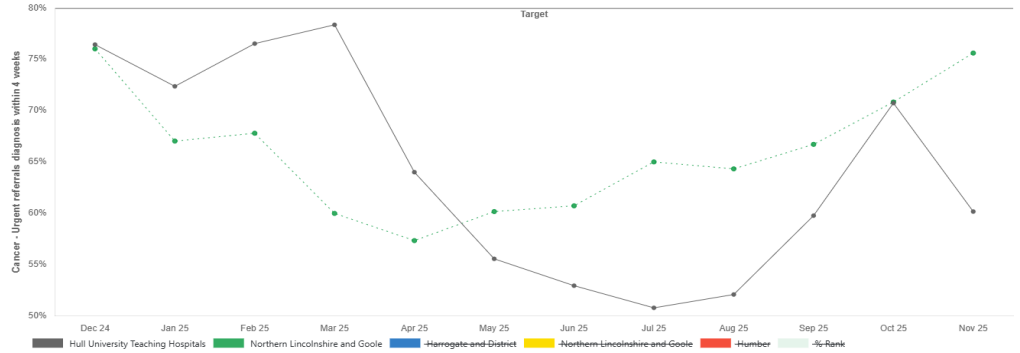
Faster Diagnosis Performance

Ranking Chart



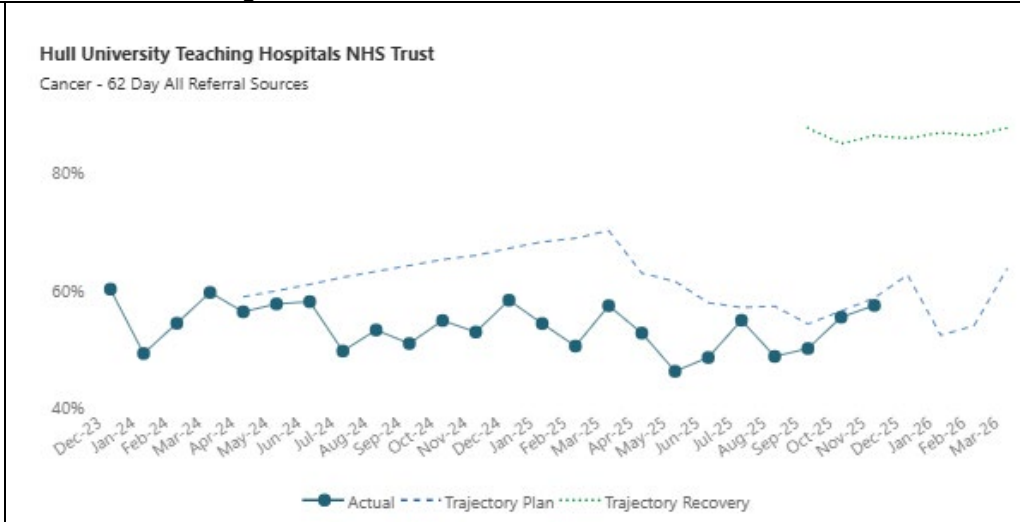
Rank 130 of 136 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

Compliance

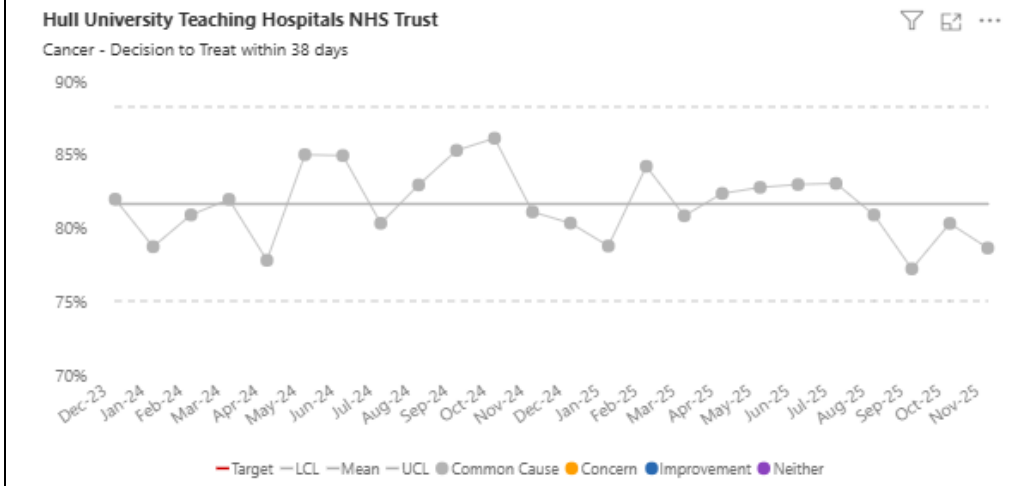


Key Themes

- November performance of 57.4.% shows an improvement on the previous month but remains within normal variation.
- Breast – 1st outpatient radiology capacity constraints
- Colorectal- Significant endoscopy capacity constraints, high Histopathology turnaround times(TAT), endoscopy equipment
- Gynaecology- Long Histopathology TAT , late IPTs and theatre capacity constraints; high levels of sickness
- Head and Neck- Surgical capacity constraints - thyroid
- Lung- Capacity in Radiotherapy and late IPTs
- Urology – Robotic surgery capacity constraints, loss of IS capacity

  Significant deterioration of first appointment within 2 weeks is impacting on 62 day and 28-day FDS delivery.

Critical Enabler

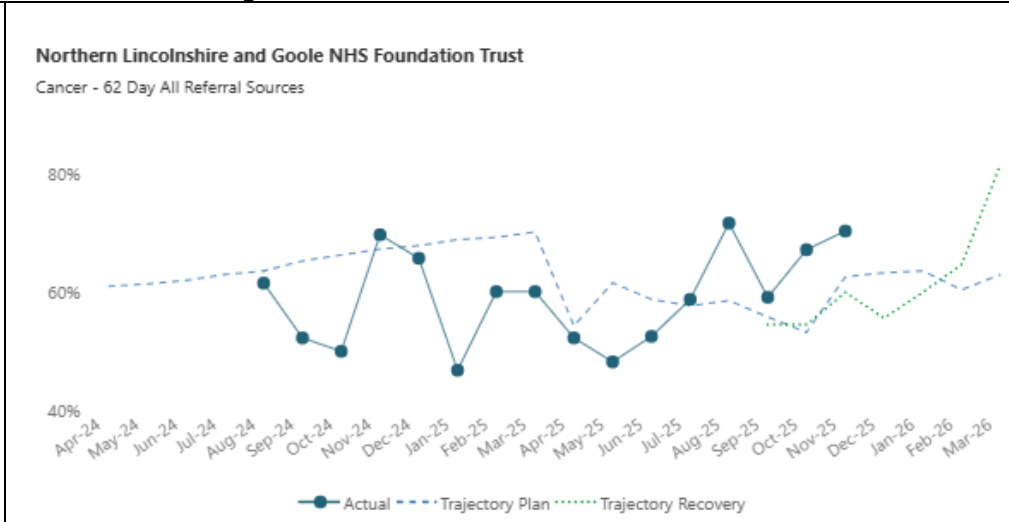


Actions

- Breast – Radiology recovery plan implemented . Additional weekend clinics and insourcing in place, but not enough to meet trajectories.
- Histopathology SHYPS performance and improvement review progressing.
- Gynaecology –Demand and capacity paper submitted, awaiting outcome. Clinical lead to review and address MDT inefficiencies and late IPTs. Funding secured to hold 1 x extra list per month for remainder of financial year (approx. 12 additional sessions).
- Lung –Business Case for additional Thoracic Surgeon declined by executive team , productivity challenged. Case to be resubmitted.
- Urology – Cancer Alliance funding secured for additional weekend theatre lists, not a sustainable solution. Robotic theatre capacity remains a bottleneck .
- New fortnightly Service improvement and performance monitoring meetings in place
- Improvement trajectories in place for all tumour sites

20. 62 Day Cancer Performance - NLAG

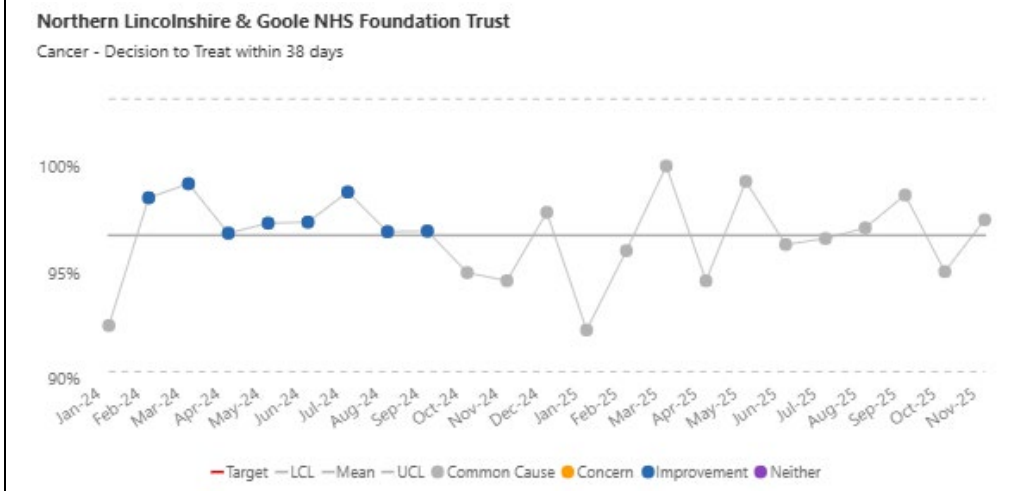
Compliance



Key Themes

- November performance of 70.5% shows a significant improvement and performance is above trajectory.
- Breast- Consultant vacancies, radiology capacity constraints, sickness and leave resulting in pathway delays
- Colorectal- Endoscopy capacity constraints, demand and capacity analysis progressing
- Gynaecology- Rightsizing business case submitted, awaiting decision. This will confirm gynae oncology theatre requirements at NLAG. C&D work also to review hysteroscopy and USC capacity for 1st OPA
- Head & Neck- Thyroid and Max Fax capacity constraints
- Lung- clinical vacancies, Oncology capacity constraints
- Urology- Haematuria STT pathway introduced using CDC capacity. Will enable CT to be undertaken prior to cystoscopy, within the CDC. This will enable diagnosis to be given to patient at the time of the cystoscopy.

Critical Enabler

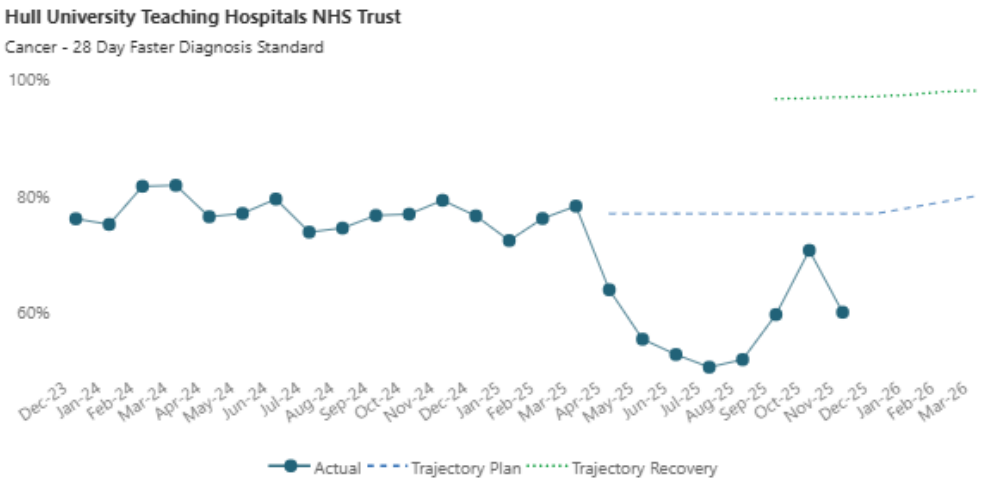


Actions

- Breast – Consultants x 2 WTE recruitment underway, with OD support. Radiology recovery plan in place, with additional weekend clinics and insourcing .
- Colorectal – Cancer Alliance funded WLIs in place. Weekly monitoring of the PTL with navigators and trackers .
- Gynaecology – Capacity and demand work undertaken. Cancer Alliance funded WLIs in place to mitigate.
- Lung – Continuous advertisement for recruitment to 5 x WTE posts, locums in place
- Urology – Weekend theatres and in week additional theatre sessions in place funded by Cancer Alliance
- Improvement trajectories in place for all tumour sites.

21. 28 Day Faster Diagnosis Standard - HUTH

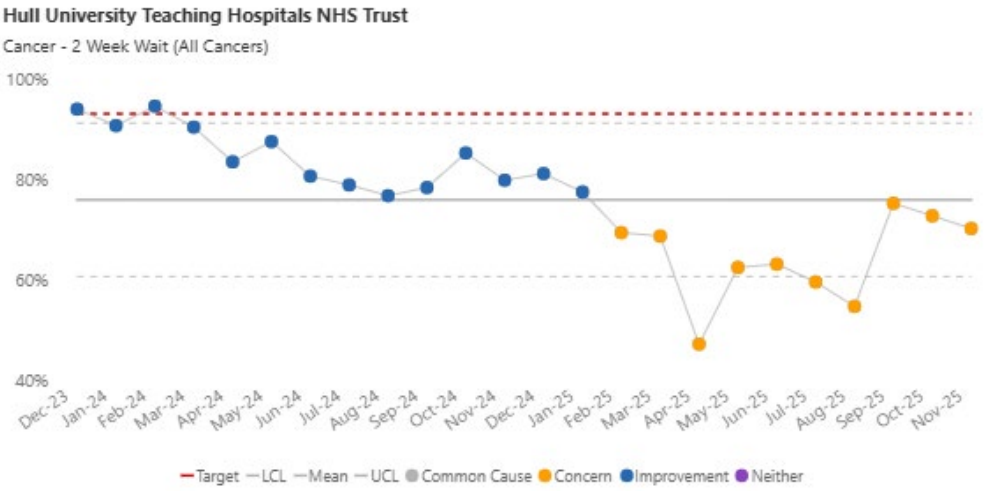
Compliance



Key Themes

- November performance 60.2%, which is a significant deterioration from previous month.
- Histopathology turnaround times are significantly high approx. 22 days on average.
- Breast; significant delays due to radiologist capacity constraints
- Colorectal; loss of CNS through Alliance funding has reduced capacity for triage, bowel screening Endoscopy capacity shortfall for accredited endoscopists, CT Colon radiologist capacity with current waits up to 4 weeks
- Gynaecology; outpatient capacity and US capacity, diagnostic histology turnaround times up to 3 weeks
- Head & Neck; significant delays with first outpatient consultant capacity
- Skin; significant delays with first outpatient consultant capacity
- Urology: Development of One Stop Prostate Pathway.

Critical Enabler

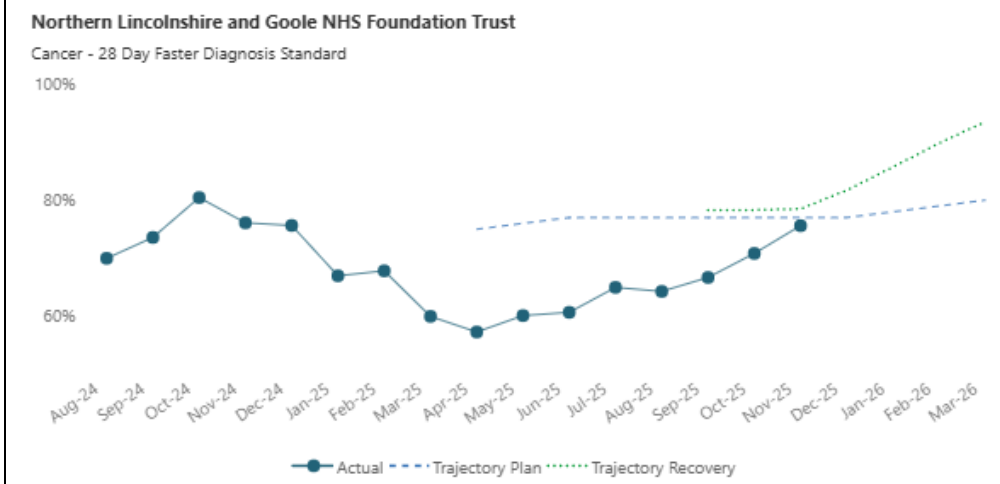


Actions

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

22. 28 Day Faster Diagnosis Standard - NLAG

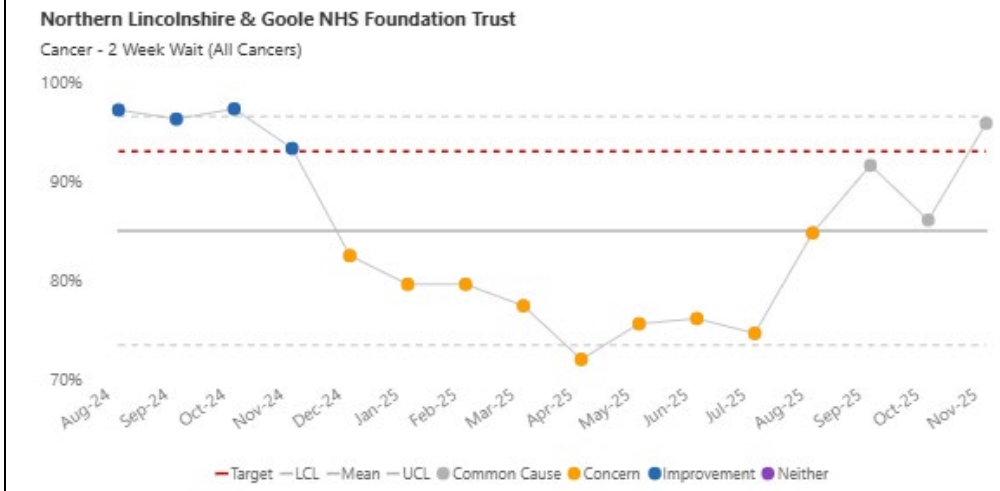
Compliance



Key Themes

- November performance 74.9%, which is an improvement on the previous month.
- Breast- first outpatient capacity constraints, Radiology
- Colorectal- endoscopy core capacity constraints, screening continued delays due to patient choice
- Lung- Due to vacancies, locums in place to cover inpatient activity and allow the substantive consultants to focus on outpatient activity.
- Urology- increase in referrals and demand for prostate biopsies

Critical Enabler



Actions

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

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
ED - Attendances All Types	Dec 25	-	14,458			46
ED - Attendances managed within 4 hours	Dec 25	78.00%	60.13%			9
ED - Attendances managed within 4 hours (Type 1)	Dec 25	78.0%	47.1%			26
ED - Attendances managed within 4 hours (Type 2 or 3)	Dec 25	95.0%	91.6%			20
ED - Attendances over 12 hours in department	Nov 25	-	13.0%			29
ED - Attendances Type 1	Dec 25	-	10,230			44
ED - Attendances Type 3	Dec 25	-	4,228			44
ED - Conversion Rate	Dec 25	25.0%	27.2%			10
ED - DTA to Admission >12 Hours	Dec 25	0.0%	16.2%			28
ED - DTA to Admission >12 Hours#	Dec 25	0.0	635.0			21
ED - DTA to Admission >4 Hours	Dec 25	10.00%	40.43%			32
ED - Left Department Before Being Seen	Nov 25	5.00%	8.96%			7
ED - Reattendance Rate	Nov 25	5.0%	9.7%			30
ED - Time to Initial Assessment	Nov 25	15.0	18.0			11
ED - Time to Treatment	Nov 25	60.0	80.0			40
ED - Total Time in A&E	Nov 25	160.0	266.0			0
ED - Total Time in A&E (Admitted)	Nov 25	180.0	285.0			54
ED - Total Time in A&E (Non-Admitted)	Nov 25	140.0	257.0			1
Emergency Admissions Type 1	Dec 25	-	3,928			21
Emergency Admissions via A&E	Dec 25	-	3,928			23
Other Emergency Admissions	Dec 25	-	2,264			11
Total Emergency Admissions	Dec 25	-	6,192			15

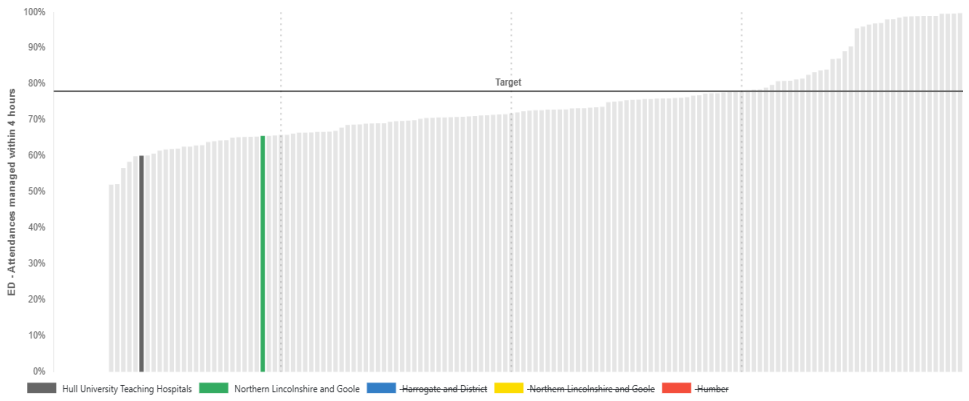
NLAG

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
ED - Attendances All Types	Dec 25	-	16,824			38
ED - Attendances managed within 4 hours	Dec 25	78.00%	65.64%			23
ED - Attendances managed within 4 hours (Type 1)	Dec 25	78.0%	41.3%			20
ED - Attendances managed within 4 hours (Type 2 or 3)	Dec 25	95.0%	99.4%			79
ED - Attendances over 12 hours in department	Nov 25	-	17.2%			8
ED - Attendances Type 1	Dec 25	-	9,775			47
ED - Attendances Type 3	Dec 25	-	7,049			29
ED - Conversion Rate	Dec 25	25.0%	32.4%			1
ED - DTA to Admission >12 Hours	Dec 25	0.0%	16.0%			29
ED - DTA to Admission >12 Hours#	Dec 25	0.0	871.0			9
ED - DTA to Admission >4 Hours	Dec 25	10.00%	28.60%			52
ED - Left Department Before Being Seen	Nov 25	5.00%	2.70%			83
ED - Reattendance Rate	Nov 25	5.0%	9.5%			38
ED - Time to Initial Assessment	Nov 25	15.0	24.0			4
ED - Time to Treatment	Nov 25	60.0	68.0			56
ED - Total Time in A&E	Nov 25	160.0	169.0			62
ED - Total Time in A&E (Admitted)	Nov 25	180.0	436.0			24
ED - Total Time in A&E (Non-Admitted)	Nov 25	140.0	131.0			79
Emergency Admissions Type 1	Dec 25	-	5,444			7
Emergency Admissions via A&E	Dec 25	-	5,444			7
Friends & Family A&E Score	Oct 25	85%	75%			32
Other Emergency Admissions	Dec 25	-	394			60
Total Emergency Admissions	Dec 25	-	5,838			19

24. Pathway Benchmarking & Trending – Unscheduled Care

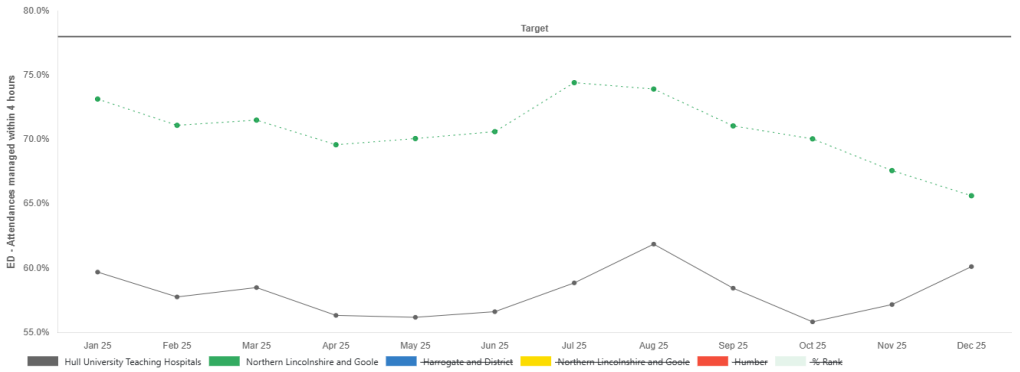
A&E - 4 Hour Performance

Ranking Chart



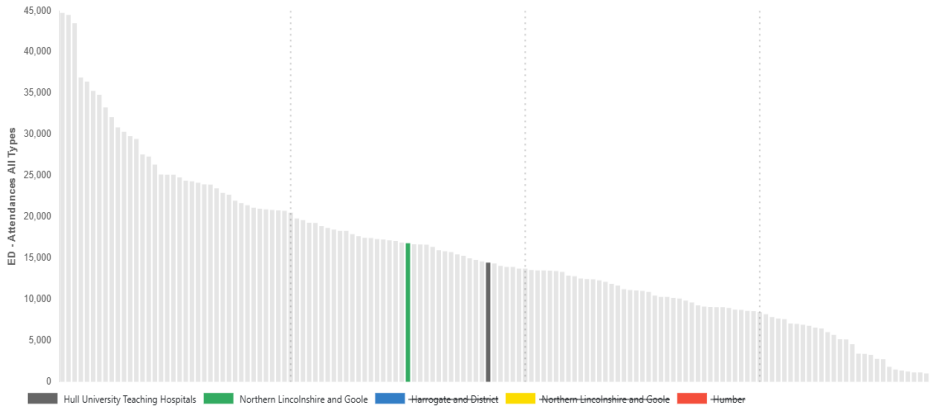
Rank 136 of 150 selected

Trending Chart



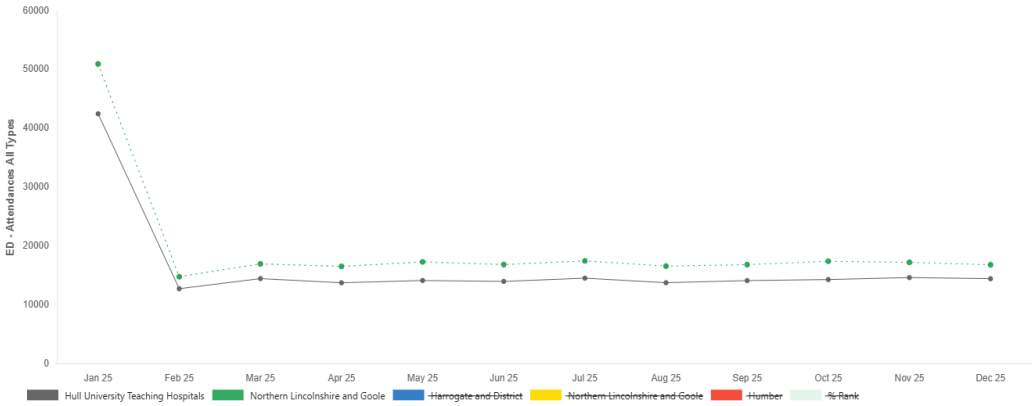
A&E – Attendances

Ranking Chart



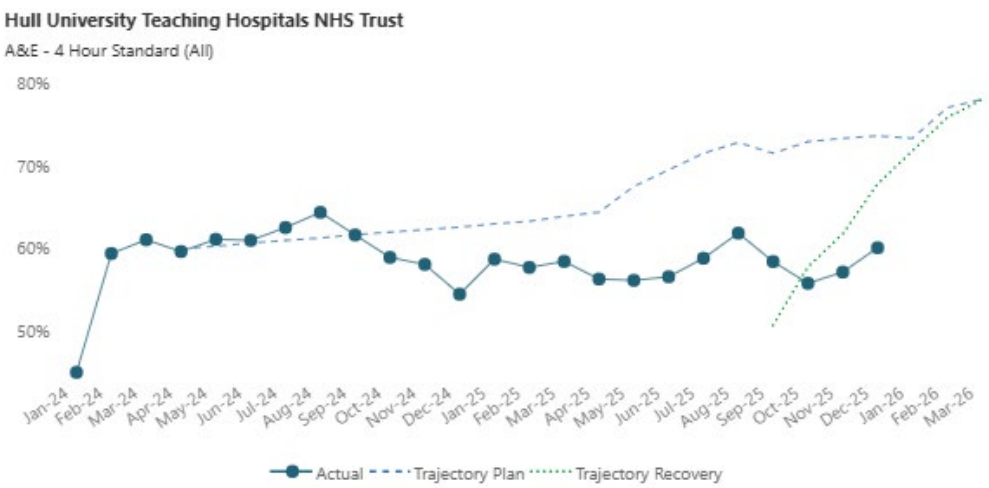
Rank 81 of 150 selected

Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

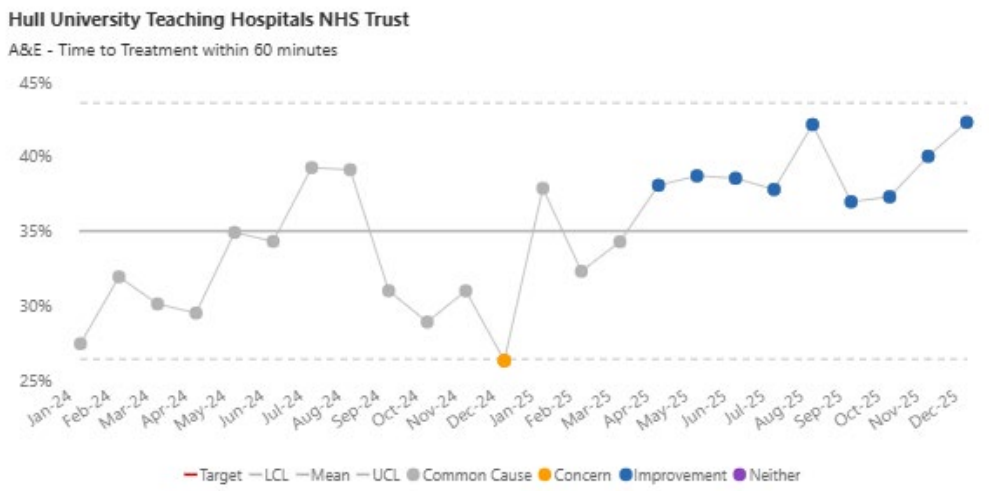
Compliance



Key Themes

- A&E 4 Hour standard (all types) remains challenged with performance of 60.1% in December 2025 behind the 25/26 Operating Plan (73.6%) and the in-year recovery plan of 67.8%.
- Type 1 performance of 47.1% was below the 25/26 operating plan target of 63.3%. Attendances were above plan.
- Type 3 performance (HRI UTC) was 91.6% against the 95% target. Attendances at the UTC were below planned levels in December.
- The percentage of patients seen by a clinician within 60 minutes of arrival totalled 42.3%, an improvement on the previous month's position

Critical Enabler

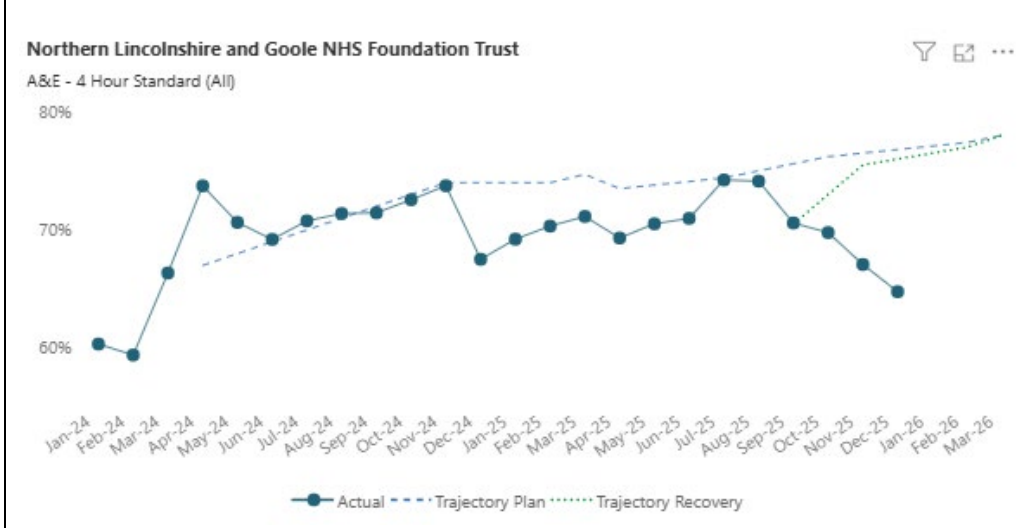


Actions

- Flow out of the department is a challenge, particularly if patients require side rooms. Close monitoring of 12 hours is being presented to Senior Leaders to increase awareness and ownership by Clinical Care Groups
- Working closely with Place partners aiming to increase UTC operating hours until 2am during winter to increase capacity
- Work ongoing with Yorkshire Ambulance Service to develop a falls care home pathway to avoid ED attendance where appropriate
- Plan to utilise H1 during winter pressures to reduce non admitted breaches.
- The Group has reiterated its commitment to 78% delivery by March 2026 for both sites via the action programme agreed via national Tiering.

26. Emergency Care Standards – 4 hour Performance - NLAG

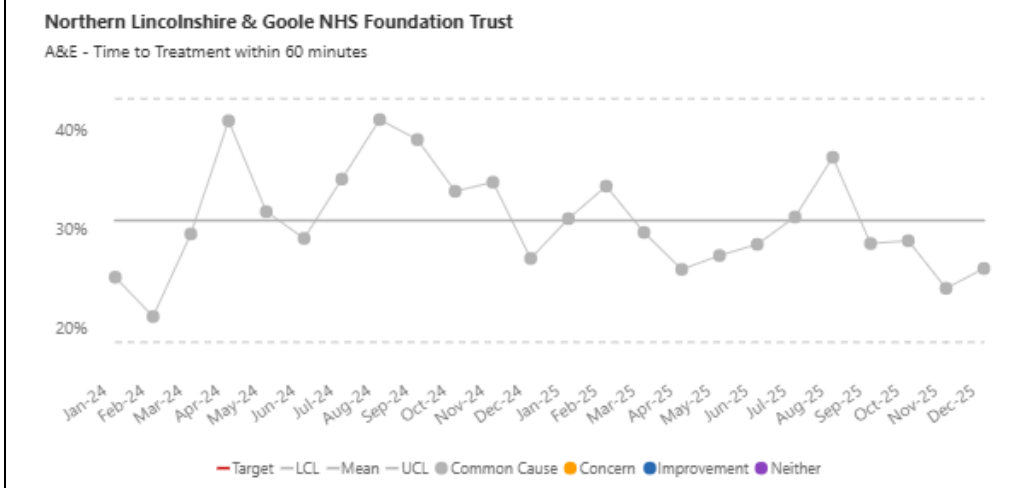
Compliance



Key Themes

- A&E 4 Hour standard (all types) performance was 64.8% in December 2025, which was behind the 25/26 Operating Plan (76.8%) and the in-year recovery plan of 76%.
- Type 1 performance of 41.5% was below plan at 61.9%. Attendances were in below plan.
- Type 3 performance of 99.4% which was in line with plan of 99%. Attendances were below plan
- Time to treatment within 60 minutes was 26% in December, an improvement on the previous month

Critical Enabler



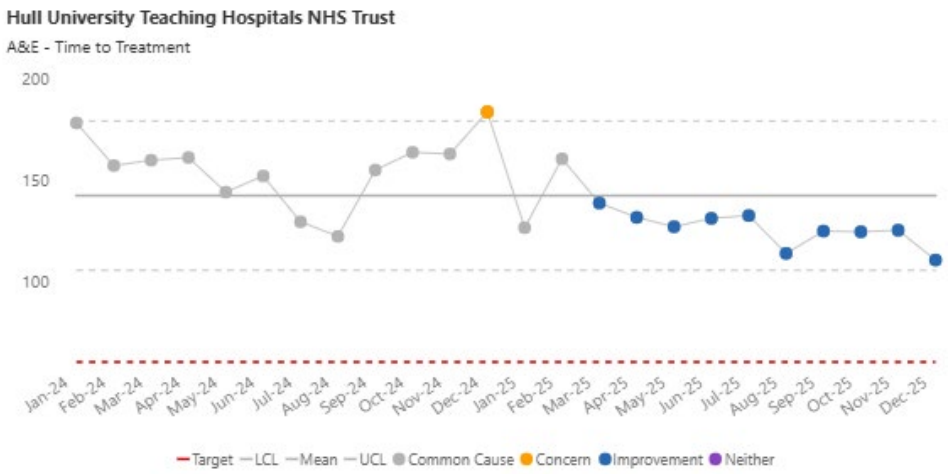
Actions

DPOW & SGH

- The Continuous Flow model was introduced in September in line with the new GIM model
- Expanding CDU pathways to increase utilisation of area
- Introduced new Gynaecology SDEC pathway at SGH to ensure patients treated in right environment, this also increases capacity in medical SDEC
- The Group has reiterated its commitment to 78% delivery by March 2026 for both sites via the action programme agreed via national Tiering

27. Core Objective 1 – Mean Time to Treatment

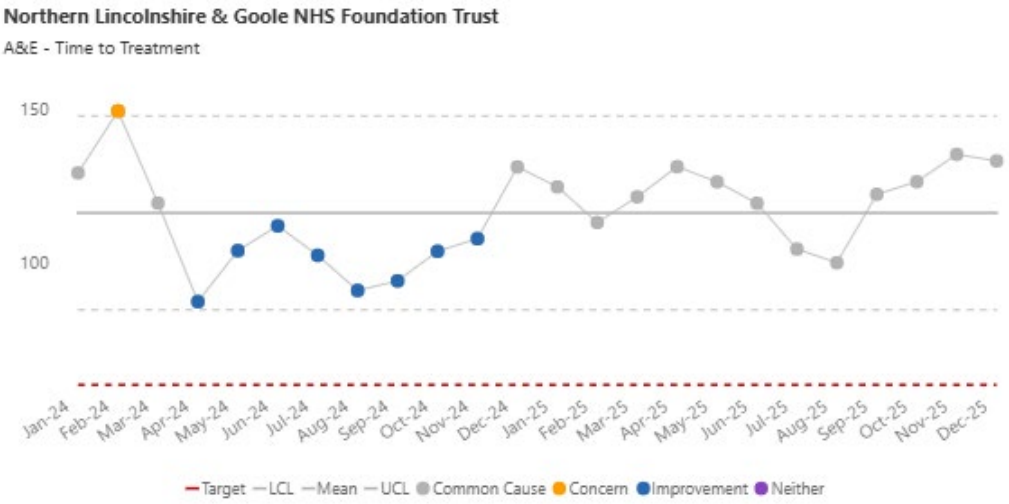
Compliance



Key Themes

- The Group established an operating target of 60 minutes for time to first clinician (time to treatment)
- HUTH performance in December was 110 minutes.
- NLaG performance was 133 minutes

Compliance

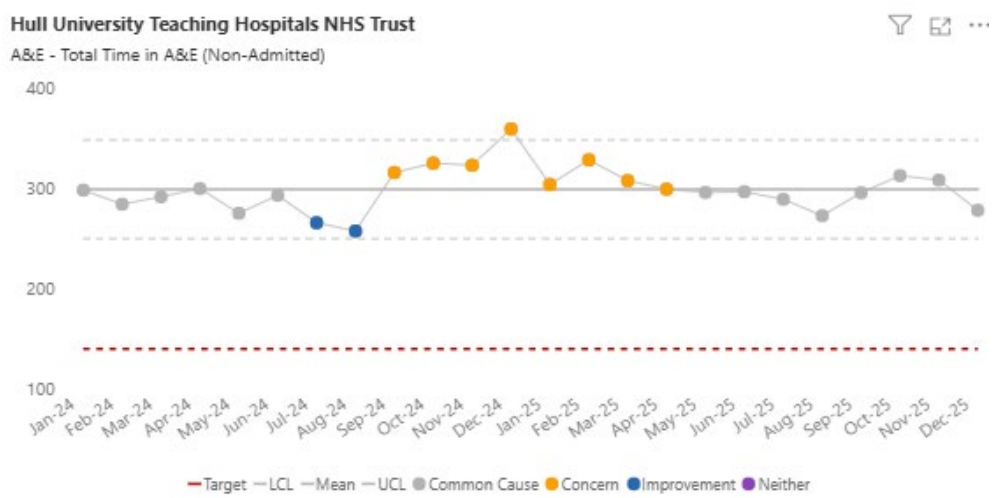


Actions

- Ongoing monitoring and focus on time first seen by doctor in department
- HUTH – Rapid Assessment now taking place in ECA & Majors.
- HUTH – consultant cover 24 hours Mon – Thurs. When team is fully established this will cover the 7 days.
- NLAG GIM ward and medical staff proposal agreed, launched in September.
- HUTH GIM consultation now complete, awaiting outcome

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

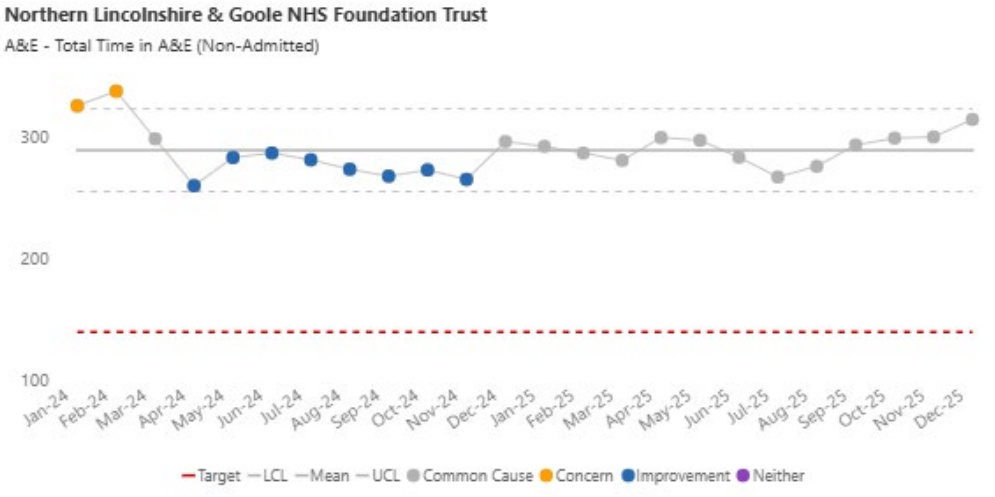
Compliance



Key Themes

- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED
- HUTH's performance improved in December 2025 at 278 minutes average
- NLaG has performed consistently in 265-300 mins range since late Spring 2024. December 2025 performance saw a deterioration at 314 mins

Compliance

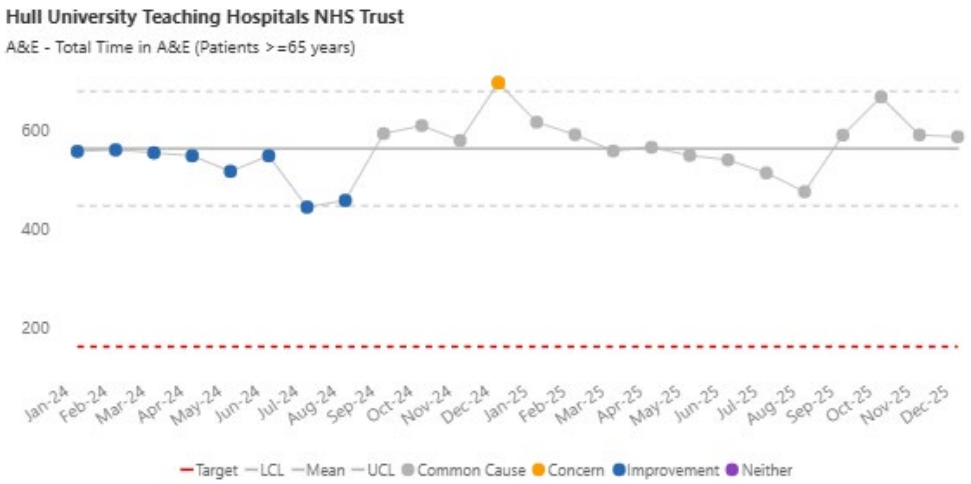


Actions

- Plan being worked up for H1 to support non admitted breaches for winter
- Challenge remains with limited flow, and discharges compound this issue. Raised with clinical colleagues at SLT to agree way forward and ownership

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

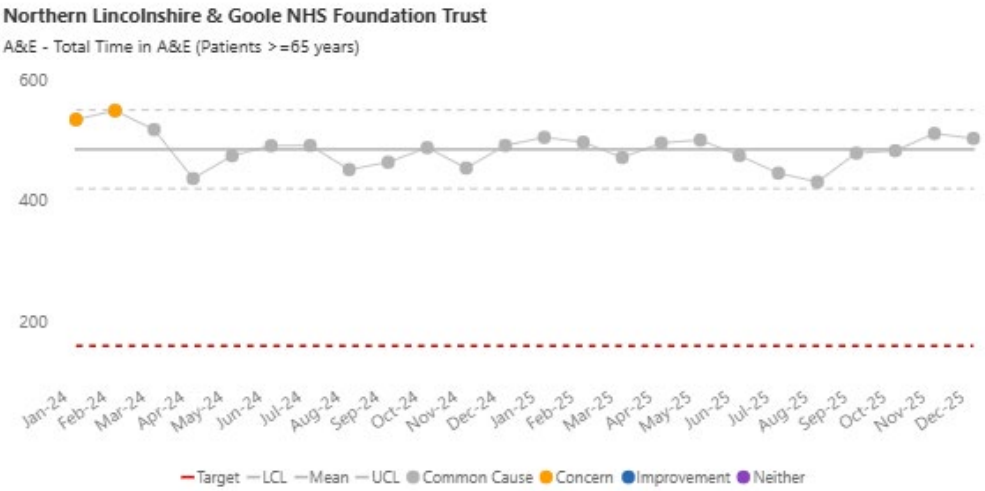
Compliance



Key Themes

- The Group established a target of 160 minutes for total time in the ED for patients aged 65 years and over
- The mean for HUTH was 586 minutes in December, an improvement on the November position.
- NLaG saw an improvement in waiting times in December at 502 minutes

Compliance

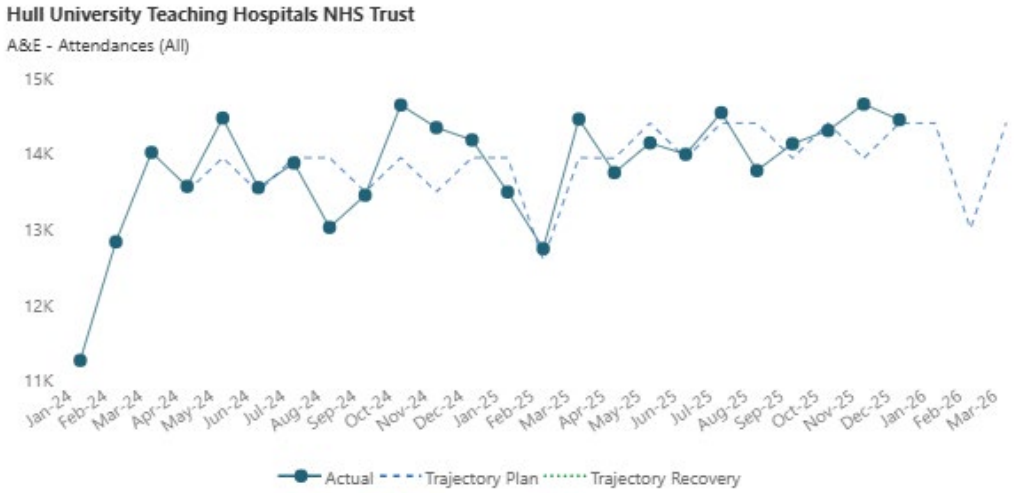


Action

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

30. A&E Attendances – All Types

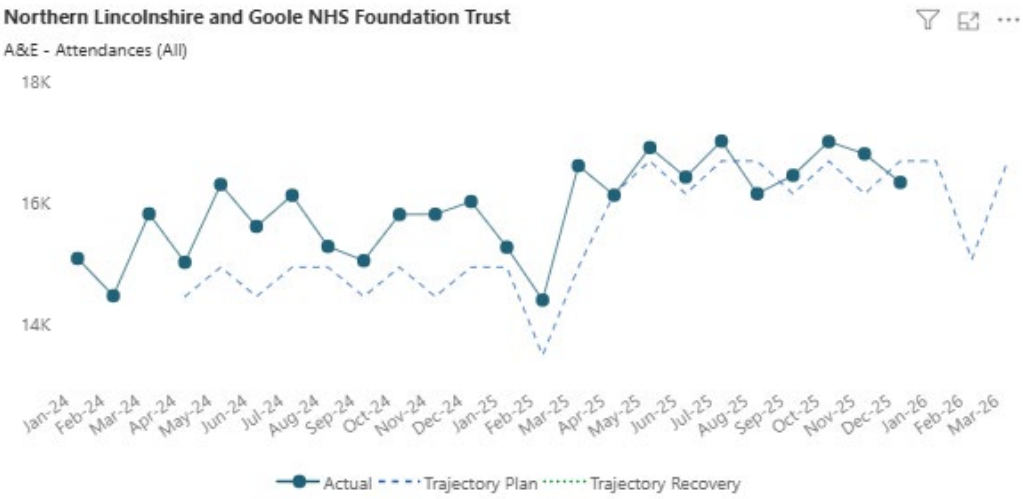
Compliance



Key Themes

- HUTH December 2025 – 14,452 total attendances comprising 10,224 Type 1 (above plan) and 4,228 Type 3 (below plan)
- NLaG December 2025 – 16,345 total attendances comprising 9,775 Type 1 (below plan) and 6,570 Type 3 (below plan)

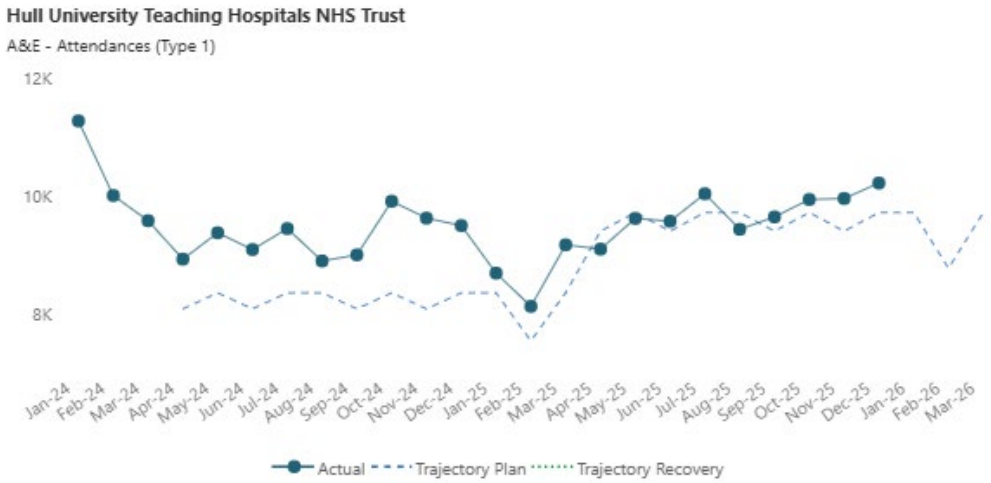
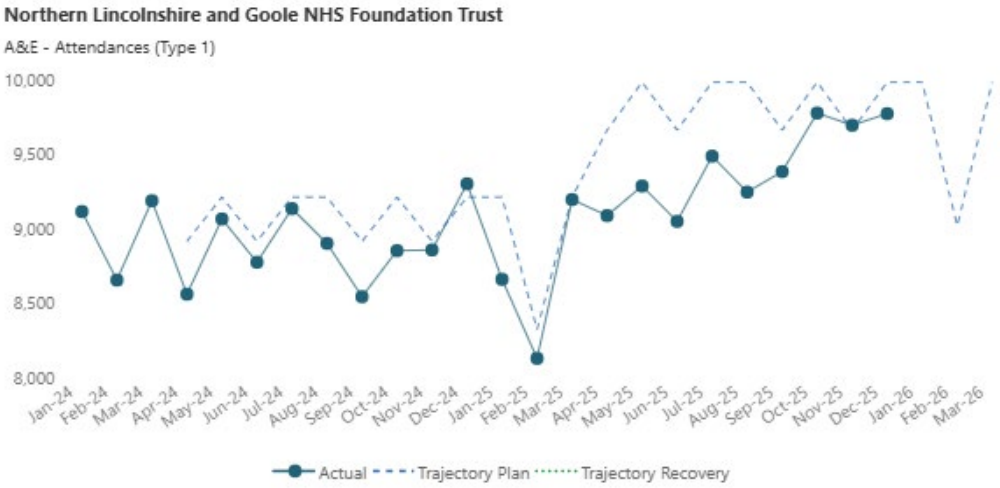
Compliance



Actions

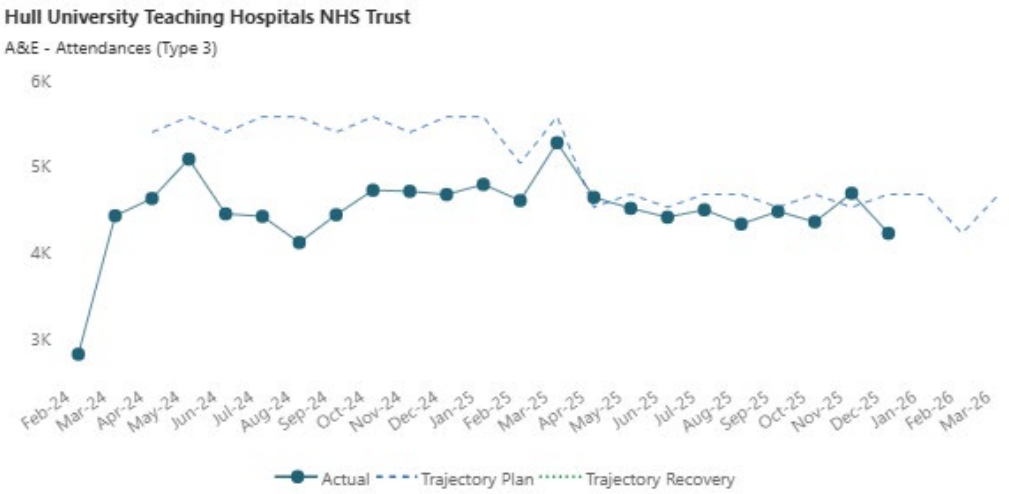
- Work taking place with system partners and Place to ensure pathways in place for community providers.
- Working with Yorkshire Ambulance Service on a Head Injury Pathway for Care Home patients.

31. A&E Attendances – Type 1 Attendances

Compliance		**Key Themes** • HUTH Type 1 attendances – December actuals were 10,224, above plan by 297.
Compliance		• NLaG Type 1 attendances in December were 9,775 vs plan of 9,987 (212 below plan)

32. A&E Attendances – Type 3 Attendances

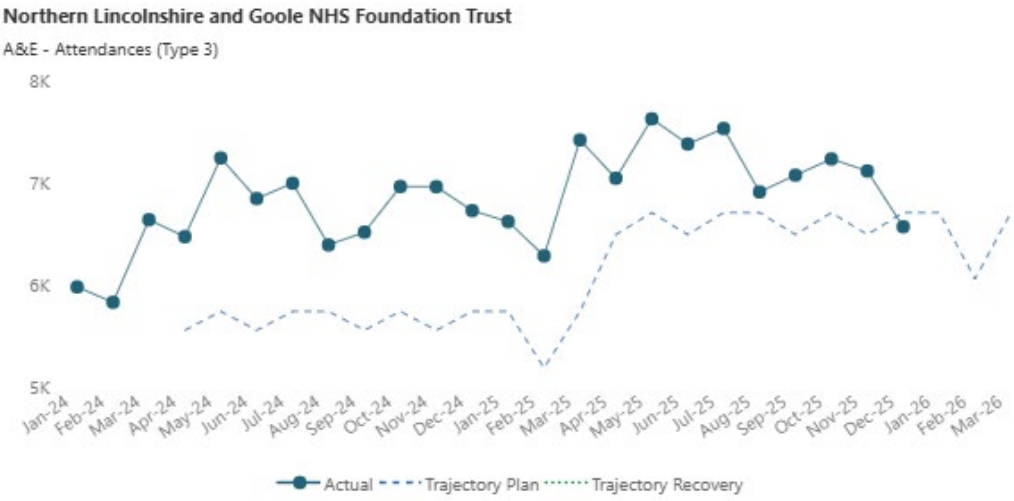
Compliance



Key Themes

- HUTH Type 3 attendances at HRI – 4,228 seen in December vs plan of 4,681 (453 below plan)

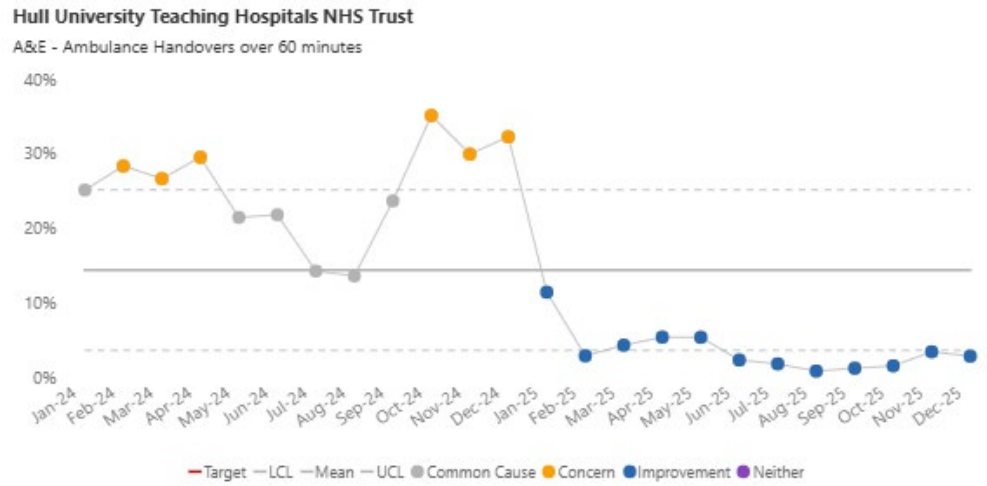
Compliance



- NLaG Type 3 attendances were 6,570 vs plan of 6,709 (139 below plan).

33. Ambulance Handovers >60 minutes - HUTH

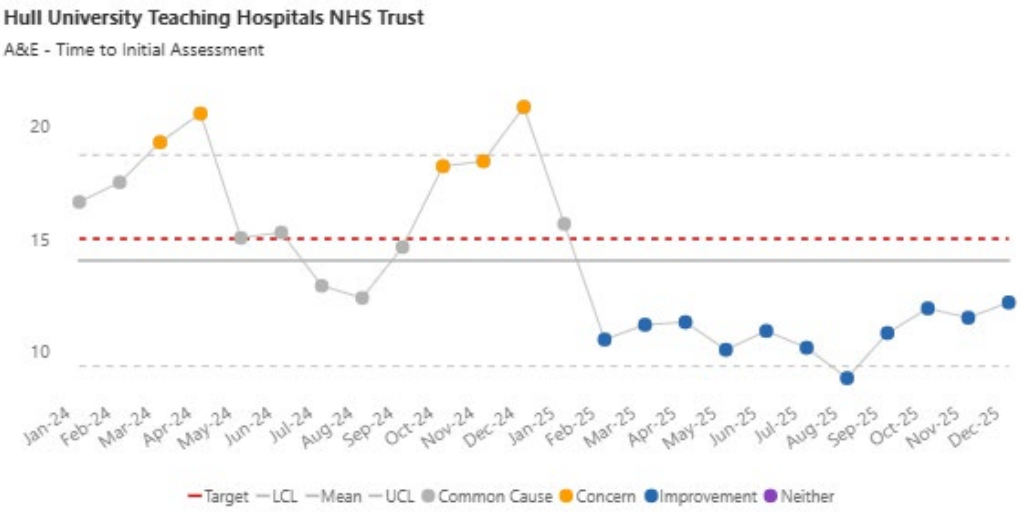
Compliance



Key Themes

- Significant sustained improvement on ambulance handover since the joint work with YAS in December 2024
- Average ambulance handover time in December was 24 minutes
- Total ambulance conveyances in December were 4,573
- Time to initial assessment 12 minutes

Critical Enabler

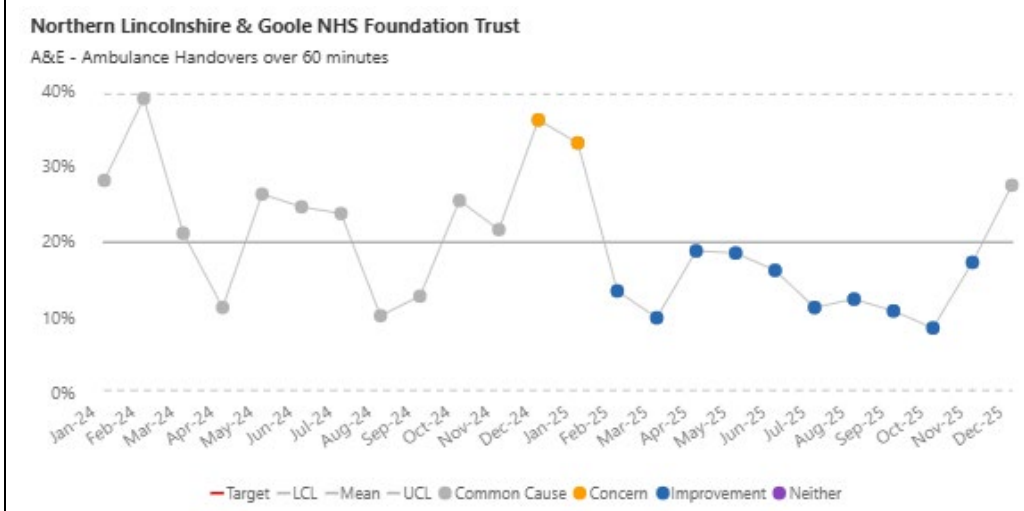


Actions

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

34. Ambulance Handovers >60 minutes - NLAG

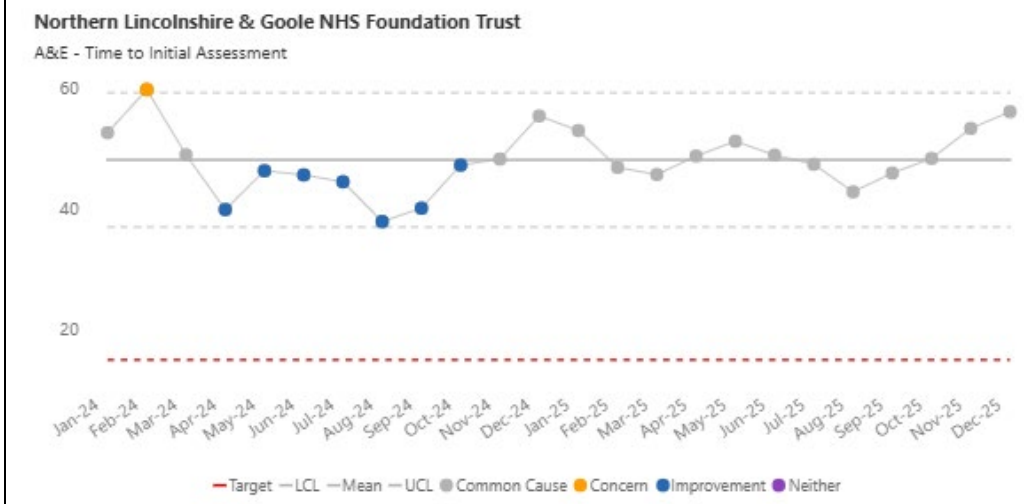
Compliance



Key Themes

- Performance in percentage of ambulance handovers >60 minutes has decreased in December 2025 = 27.5%
- Time to initial assessment was 56 minutes against target of 15 minutes
- Average ambulance handover time in December was 51 minutes
- Total ambulance conveyances were 3,608.

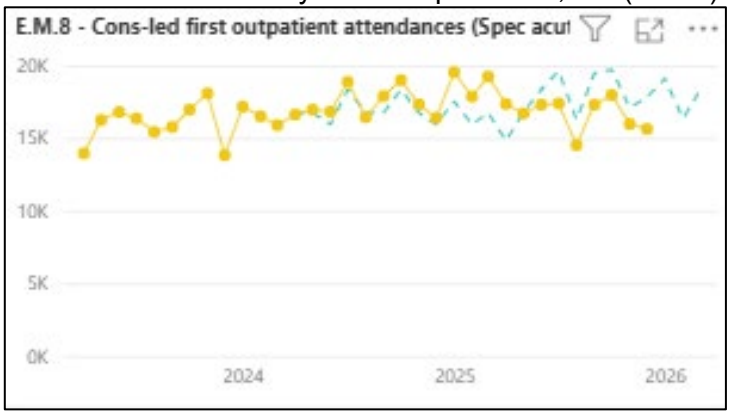
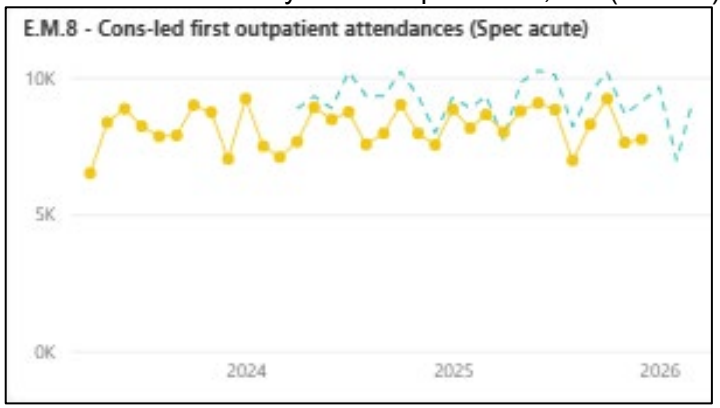
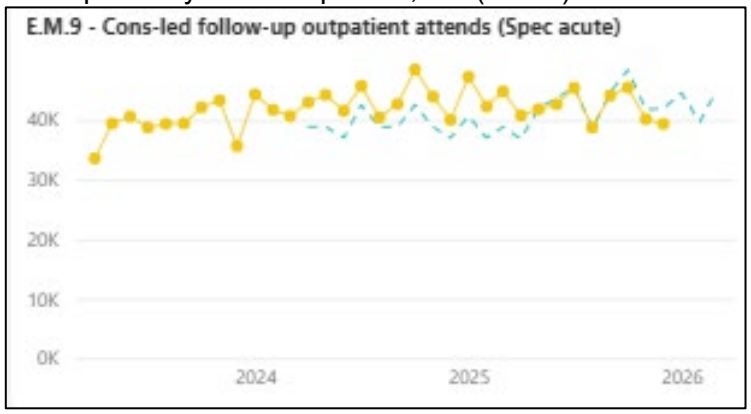
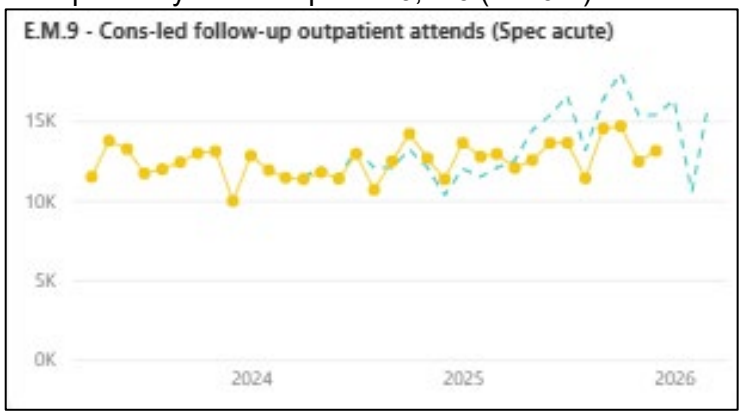
Critical Enabler



Actions

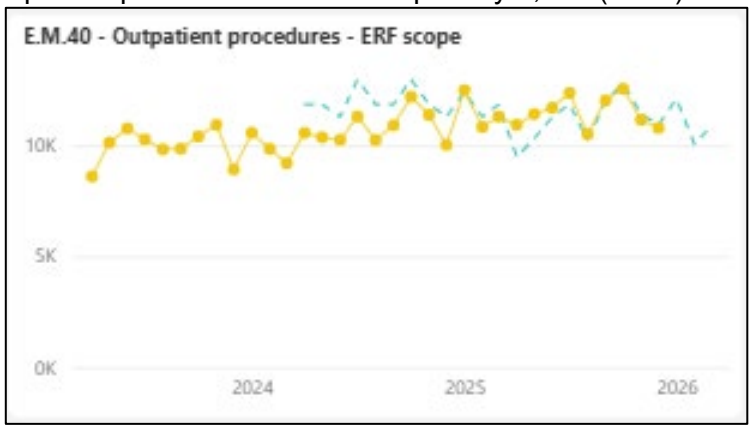
- Relaunched handover processes with ED and EMAS team which is working well.
- Daily 2 hourly monitoring and escalation are in place to maintain ambulance performance.
- Discuss and agree new pathways with EMAS sharing lessons learnt from work undertaken with YAS.

35. Activity

HUTH (Month 9)	NLAG (Month 9)
New Outpatient Attendances vs Plan	**New Outpatient Attendances vs Plan**
YTD New consultant-led activity is below plan at -9,799 (-6.1%).	YTD New consultant-led activity is below plan at -8,981 (-10.8%).
	
Follow up Outpatient Attendances vs Plan	**Follow up Outpatient Attendances vs Plan**
YTD Follow up activity is below plan -4,850 (-1.3%)	YTD Follow up activity is below plan -19,146 (-14.0%).
	

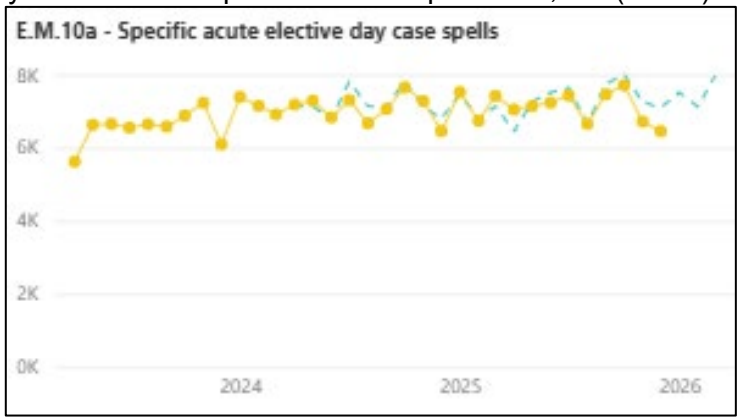
Outpatient Procedures vs Plan

YTD Outpatient procedures are above plan by 3,125 (3.1%).



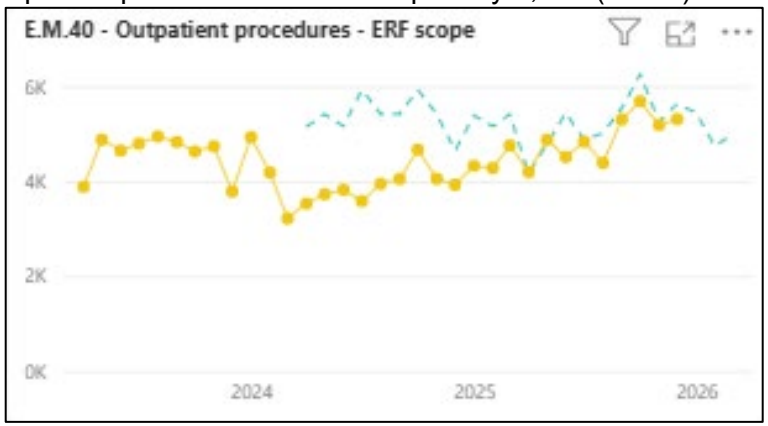
Day Case Admissions vs Plan

YTD Day case elective spells are below plan at -1,766 (-2.7%)



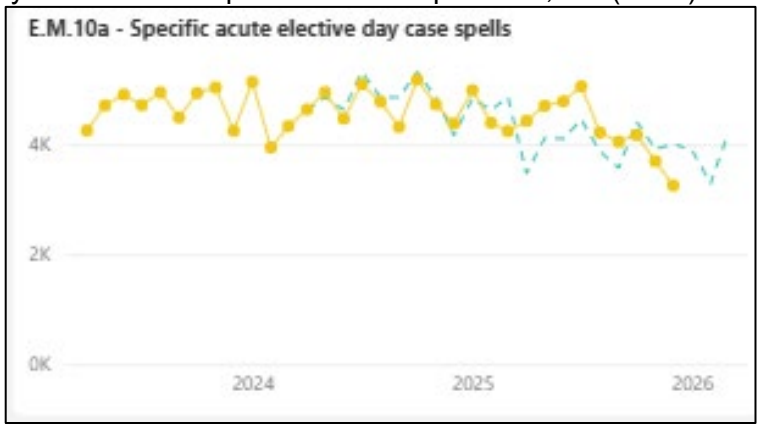
Outpatient Procedures vs Plan

YTD Outpatient procedures are below plan by 2,674 (-5.7%).



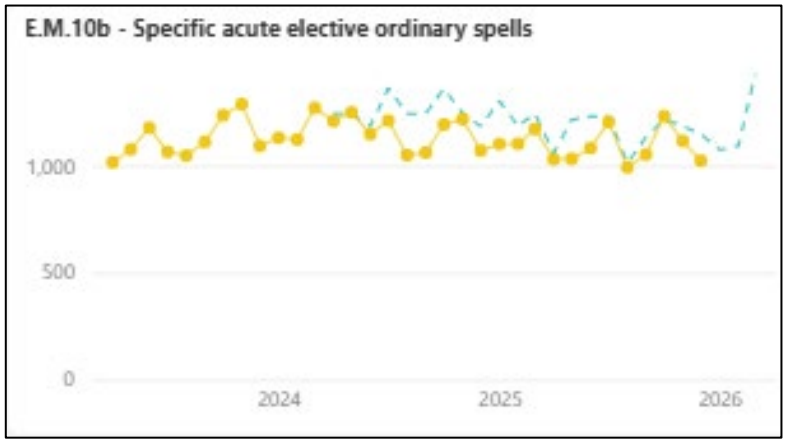
Day Case Admissions vs Plan

YTD Day case elective spells are above plan at 2,434 (6.8%)



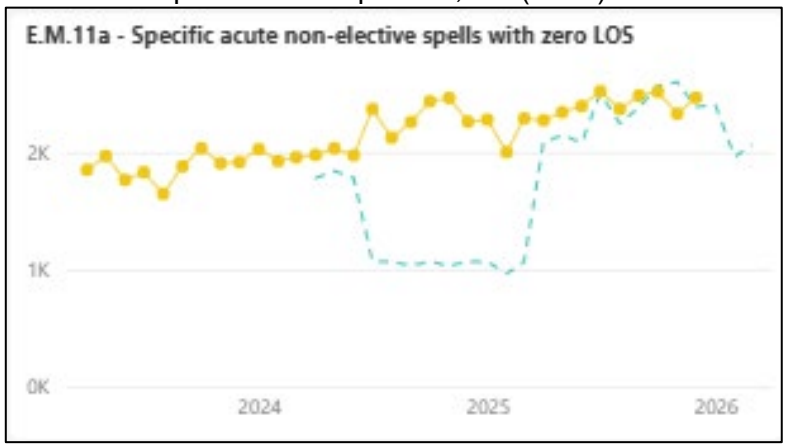
Elective Admissions vs Plan

YTD Inpatient spells are below plan at -668 (-6.4%)



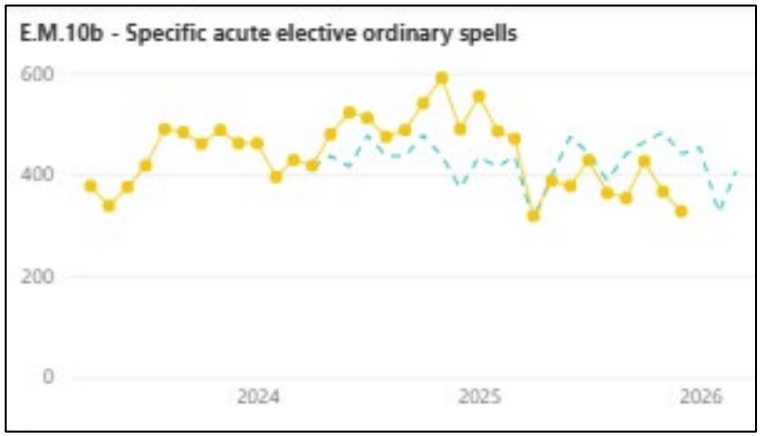
Non-Elective Admissions vs Plan

YTD non-elective spells are over plan +1,788 (3.4%)



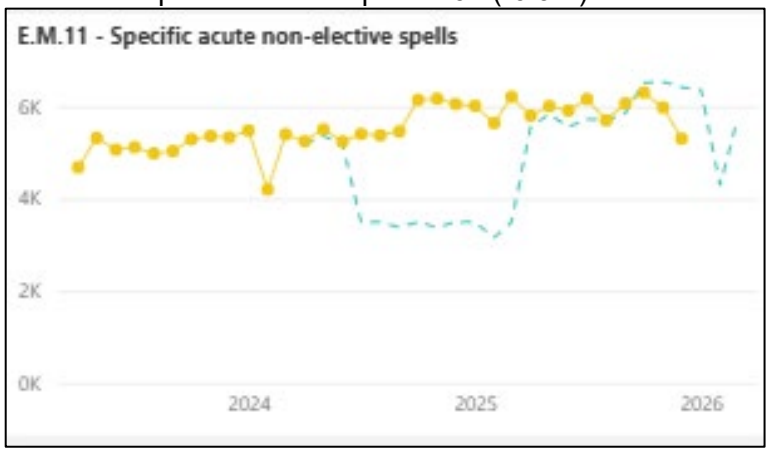
Elective Admissions vs Plan

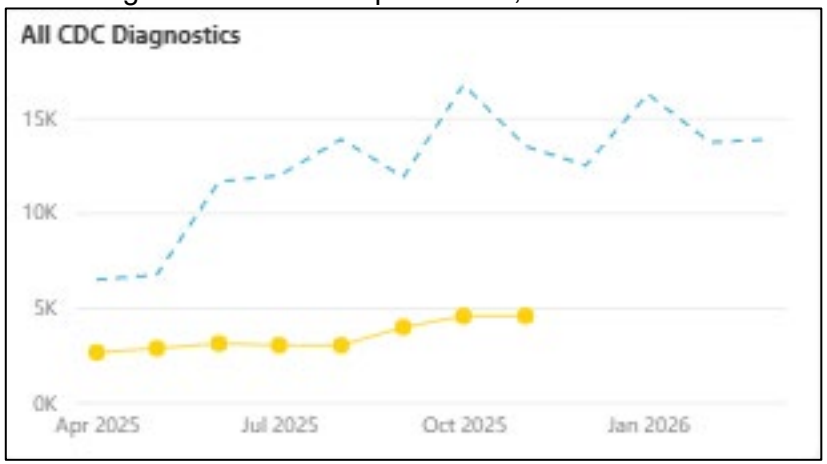
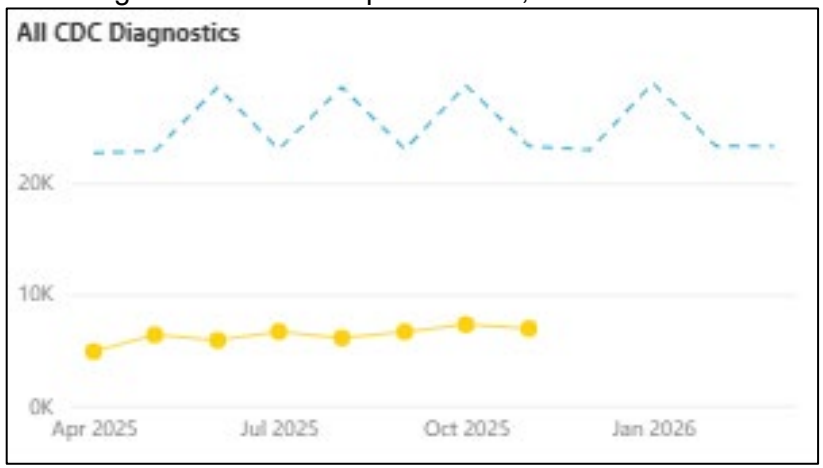
YTD Inpatient spells are below plan at -491 (-12.8%)



Non-Elective Admissions vs Plan

YTD non-elective spells are below plan -464 (-0.9%)



All CDC Diagnostics	All CDC Diagnostics
YTD CDC diagnostics are below plan at -77,585 	YTD CDC diagnostics are below plan at -173,196 

36. Financial Activity Summary - HUTH

HUTH 2025/26 Elective Recovery Activity M9

	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
Daycase	66,314	63,097	-3,217	51,066,006	47,493,945	-3,572,061
Elective	14,377	13,336	-1,041	57,093,798	51,542,851	-5,550,947
Outpatient New Attendance	150,580	144,903	-5,677	30,404,868	28,952,929	-1,451,939
Outpatient New Procedure	27,625	29,425	1,800	5,195,267	5,583,413	388,146
Outpatient Follow Up Procedure	86,523	89,863	3,340	9,435,621	9,482,539	46,917
	345,420	340,624	-4,796	153,195,561	143,055,677	-10,139,885

Data includes 852 uncoded October spells priced at Average Tariff by Specialty

37. Financial Activity Summary - NLAG

NLAG 2025/26 Elective Recovery Activity M9

	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
Daycase	35,547	38,798	3,251	£ 24,880,159	£ 27,445,675	£ 2,565,516
Elective	4,480	3,815	-665	£ 17,405,415	£ 15,791,604	-£ 1,613,811
Outpatient New Attendance	58,296	56,599	-1,697	£ 12,140,884	£ 11,716,181	-£ 424,703
Outpatient New Procedure	18,940	16,267	-2,673	£ 3,875,409	£ 3,186,849	-£ 688,560
Outpatient Follow Up Procedure	30,697	35,591	4,894	£ 4,093,647	£ 6,398,794	£ 2,305,148
	147,960	151,070	3,110	62,395,514	64,539,103	2,143,590

Data includes 2044 uncoded December spells priced at Average Tariff by Specialty

To Note

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

Quality Performance Metrics

NHS
Humber Health
Partnership

December 2025

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

The IPR is now published following development with the Information Team, building a refreshed reporting tool for the Group. There are some datasets being worked on as DQ issues identified through deployment. Most of the report used BI data from Information Services. A glossary is provided on the last slide.

	HUTH	NLAG
Highlights	• HUTH is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0199 . This is lower than last month's value of 1.0324. • The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 100.5, improved from 101.9. • P. Aeruginosa and Klebsiella rates are below trajectory.	• NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of 1.0297. This is higher than last month's value of 1.0235. • There has been a statistically significant improvement with successive reduction in the HSMR over the past fifteen months, now remains under 100 for 19 months, and at 92.2 improved from 93.5. • All current safety alerts are managed within the timeframe.

Lowlights	• Duty of candour compliance is lower than target. Some care groups have systems in place and are working effectively, while others are developing their processes.
	• There were no Never Events identified in December 2025, but there have been 7 cases in the rolling 12 months.
	• Safety Alert for Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls is overdue. (all others are in progress and within timeframes)
	• For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher-than-expected SHMI for:
	  • Septicaemia
	• Pressure Ulcer rates are higher for the last 3 months, and this is being investigated.
	• Patient complaint rate of completion within timescales remains below target consistently.
	• The FFT data collection has been interrupted with the contract ending and a new process being introduced. There has been no A&E FFT collected for 4 months, and a digital collection solution is being implemented currently to remedy.
	• MRSA bacteraemia rates are over the target for the year.
	• VTE data remains below the 95% target overall and at 14 hours from admission.
		• Duty of candour compliance is not as timely as it should be, although tracked and monitored, with an updated mandatory field structure to enable closure introduced from October across the group.
		• There was one never events in December, with 6 in the rolling 12 months.
		• For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher-than-expected SHMI for:
		  • Septicaemia
		• Patient complaint rate of completion within timescales remains below target consistently.
		• C.difficile rates, E-coli and P Aeruginosa bacteraemia are over the annual target
		• MRSA bacteraemia rates are over the annual target.
		• VTE data remains below the 95% target overall and at 14 hours from admission.

Quality IPR dashboard (Safe)

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Falls - Moderate and above (per 1,000 bed days)	Dec-25		0.22		
Falls - per 1,000 bed days	Dec-25		8.36		
Falls - Serious harm or death	Dec-25		5		
Falls - Serious harm or death (per 1,000 bed days)	Dec-25		0.15		
Falls - Total incidents	Dec-25		271		
Medication Incidents	Dec-25		127		
Medication Incidents - Moderate harm	Dec-25		4		
Medication Incidents - per 1,000 bed days	Dec-25		3.92		
Medication Incidents - Serious harm	Dec-25		1		
Mixed Sex Accommodation Breaches	Dec-25		0		
Patient Incidents	Dec-25		2,015		
Patient Safety Incidents - % Harmful	Dec-25		3.2%		
Patient Safety Incidents - Fatal	Dec-25		8		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Sep-25		0.00		
Patient Safety Incidents - Investigations (PSIIs)	Sep-25		3		
Patient Safety Incidents - Low harm	Dec-25		485		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Dec-25		1.97		
Patient Safety Incidents - Moderate harm	Dec-25		51		
Patient Safety Incidents - No harm	Dec-25		1,466		
Patient Safety Incidents - Severe harm	Dec-25		5		
Pressure Ulcers - Category 1	Dec-25		13		
Pressure Ulcers - Category 2	Dec-25		45		
Pressure Ulcers - Category 3	Dec-25		2		
Pressure Ulcers - Category 4	Dec-25		0		
Pressure Ulcers - Device related	Dec-25		19		
Pressure Ulcers - Hospital acquired	Dec-25		132		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Dec-25		4.07		
Pressure Ulcers - Hospital acquired moderate and above (p...	Dec-25		0.37		
Pressure Ulcers - Suspected deep tissue injury	Dec-25		34		
Pressure Ulcers - Total community acquired	Dec-25		0		
Pressure Ulcers - Unstageable	Dec-25		10		
VTE Risk Assessment	Dec-25	≥ 95.0%	92.3%		
VTE Risk Assessment 14 Hour Standard	Nov-25	≥ 95.0%	90.4%		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Falls - Moderate and above (per 1,000 bed days)	Dec-25		0.19		
Falls - per 1,000 bed days	Dec-25		6.49		
Falls - Serious harm or death	Dec-25		3		
Falls - Serious harm or death (per 1,000 bed days)	Dec-25		0.14		
Falls - Total incidents	Dec-25		136		
Medication Incidents	Dec-25		76		
Medication Incidents - Moderate harm	Dec-25		1		
Medication Incidents - per 1,000 bed days	Dec-25		3.63		
Medication Incidents - Serious harm	Dec-25		0		
Mixed Sex Accommodation Breaches	Dec-25		17		
Patient Incidents	Dec-25		1,495		
Patient Safety Incidents - % Harmful	Dec-25		3.2%		
Patient Safety Incidents - Fatal	Dec-25		3		
Patient Safety Incidents - Investigation rate (per 1,000 bed ...	Dec-25		0.05		
Patient Safety Incidents - Investigations (PSIIs)	Dec-25		1		
Patient Safety Incidents - Low harm	Dec-25		477		
Patient Safety Incidents - Moderate and above (per 1,000 b...	Dec-25		2.29		
Patient Safety Incidents - Moderate harm	Dec-25		41		
Patient Safety Incidents - No harm	Dec-25		970		
Patient Safety Incidents - Severe harm	Dec-25		4		
Pressure Ulcers - Category 1	Dec-25		15		
Pressure Ulcers - Category 2	Dec-25		101		
Pressure Ulcers - Category 3	Dec-25		10		
Pressure Ulcers - Category 4	Dec-25		1		
Pressure Ulcers - Device related	Dec-25		16		
Pressure Ulcers - Hospital acquired	Dec-25		210		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	Dec-25		10.02		
Pressure Ulcers - Hospital acquired moderate and above (p...	Dec-25		1.24		
Pressure Ulcers - Suspected deep tissue injury	Dec-25		45		
Pressure Ulcers - Total community acquired	Dec-25		0		
Pressure Ulcers - Unstageable	Dec-25		15		
VTE Risk Assessment	Dec-25	≥ 95.0%	95.7%		
VTE Risk Assessment 14 Hour Standard	Nov-25	≥ 95.0%	87.8%		

Quality IPR dashboard (Mortality)

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Dec-25		3.2%		
Mortality - HSMR	Sep-25	≤ 100.0	100.5		
Mortality - SHMI	Aug-25	≤ 1.0	1.020		
Mortality - Still Births (per 1,000 births)	Dec-25		5.128		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Mortality - Crude Mortality (non-elective)	Dec-25		2.3%		
Mortality - HSMR	Sep-25	≤ 100.0	92.2		
Mortality - SHMI	Aug-25	≤ 1.0	1.030		
Mortality - Still Births (per 1,000 births)	Dec-25		0.000		

Quality IPR dashboard (Patient Experience)

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Dec-25	≥ 85.0%	28.8%		
Complaints - 60 day compliance	Dec-25	≥ 85.0%	52.0%		
Complaints - Average response time	Dec-25	≤ 40	77		
Complaints - Received	Dec-25		36		
Complaints - Received (per 1,000 bed days)	Dec-25		1.11		
Complaints - Reopened	Dec-25		0		
Friends & Family - A&E Score	Nov-25	≥ 85.0%	0.0%		
Friends & Family - Antenatal Score	Nov-25	≥ 95.0%	0.0%		
Friends & Family - Birth Score	Nov-25	≥ 95.0%	0.0%		
Friends & Family - Inpatient Score	Nov-25	≥ 95.0%	97.2%		
Friends & Family - Outpatient Score	Nov-25	≥ 95.0%	96.7%		
Friends & Family - Postnatal Score	Nov-25	≥ 95.0%	0.0%		
PALS - Complaints	Dec-25	≤ 1	241		
PALS - Complaints compliance within 5 working days	Dec-25		42.0%		
PALS - Compliments	Sep-25		0		
PHSO Referrals	Sep-25		0		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
Complaints - 40 day compliance	Dec-25	≥ 85.0%	46.4%		
Complaints - 60 day compliance	Dec-25	≥ 85.0%	67.9%		
Complaints - Average response time	Dec-25	≤ 40	44		
Complaints - Received	Dec-25		19		
Complaints - Received (per 1,000 bed days)	Dec-25		0.91		
Complaints - Reopened	Dec-25		0		
Friends & Family - A&E Score	Nov-25	≥ 85.0%	75.6%		
Friends & Family - Antenatal Score	Nov-25	≥ 95.0%	76.2%		
Friends & Family - Birth Score	Nov-25	≥ 95.0%	87.5%		
Friends & Family - Community Score	Nov-25	≥ 95.0%	99.4%		
Friends & Family - Inpatient Score	Nov-25	≥ 95.0%	97.5%		
Friends & Family - Outpatient Score	Nov-25	≥ 95.0%	95.9%		
Friends & Family - Postnatal Community Score	Nov-25	≥ 95.0%	100.0%		
Friends & Family - Postnatal Score	Nov-25	≥ 95.0%	92.9%		
PALS - Complaints	Dec-25	≤ 1	240		
PALS - Complaints compliance within 5 working days	Dec-25		57.3%		

Quality IPR dashboard (Infection Prevention)

Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | EasySPC Spotlight | Data Table | Metadata

Framework: NOF | PEF | Quality

Metric Group: A&E | Cancer | Complaints | Diagnostic | FFT | Finance | Infections | Inpatients | Mortality | Outpatient | RTT | Safe

Trust | Group

Hull University Teaching Hospitals NHS Trust

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

Metric	Month	Target	Result	Var	Asr
CQC Inpatient Survey Satisfaction Mean Score	Nov-25		8.2		
CQC Safe Inspection Score	Nov-25		1.0		
Infections - C.Difficile	Oct-25		6		
Infections - C.Difficile (Cumulative)	Oct-25		52		
Infections - C.Difficile (per 1,000 bed days)	Oct-25		0.16		
Infections - E.Coli	Oct-25		17		
Infections - E.Coli (Cumulative)	Oct-25		145		
Infections - E.Coli (per 1,000 bed days)	Oct-25		0.44		
Infections - Klebsiella	Oct-25		7		
Infections - Klebsiella (Cumulative)	Oct-25		42		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Oct-25		0.18		
Infections - MRSA	Oct-25		0		
Infections - MRSA (Cumulative)	Oct-25		3		
Infections - MRSA (per 1,000 bed days)	Oct-25		0.00		
Infections - MSSA	Oct-25		12		
Infections - MSSA (Cumulative)	Oct-25		54		
Infections - MSSA (per 1,000 bed days)	Oct-25		0.31		
Infections - Pseudomonas aeruginosa	Oct-25		6		
Infections - Pseudomonas aeruginosa (Cumulative)	Oct-25		20		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Oct-25		0.16		

Northern Lincolnshire and Goole NHS Foundation Trust

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

Metric	Month	Target	Result	Var	Asr
CQC Inpatient Survey Satisfaction Mean Score	Nov-25		8.1		
CQC Safe Inspection Score	Nov-25		2.0		
Infections - C.Difficile	Oct-25		6		
Infections - C.Difficile (Cumulative)	Oct-25		25		
Infections - C.Difficile (per 1,000 bed days)	Oct-25		0.29		
Infections - E.Coli	Oct-25		32		
Infections - E.Coli (Cumulative)	Oct-25		173		
Infections - E.Coli (per 1,000 bed days)	Oct-25		1.55		
Infections - Klebsiella	Oct-25		12		
Infections - Klebsiella (Cumulative)	Oct-25		76		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	Oct-25		0.58		
Infections - MRSA	Oct-25		1		
Infections - MRSA (Cumulative)	Oct-25		2		
Infections - MRSA (per 1,000 bed days)	Oct-25		0.05		
Infections - MSSA	Oct-25		9		
Infections - MSSA (Cumulative)	Oct-25		48		
Infections - MSSA (per 1,000 bed days)	Oct-25		0.43		
Infections - Pseudomonas aeruginosa	Oct-25		3		
Infections - Pseudomonas aeruginosa (Cumulative)	Oct-25		22		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,0...	Oct-25		0.15		

Duty of Candour

HUTH

	No of PS Incidents for DoC			Completed DoC in Writing			Compliance rate			
HUTH	**Oct-25**	**Nov-25**	**Dec-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Total**
Acute And Emergency Medicine	5	5	15	2	1	2	40%	20%	13%	20%
Cardiovascular	5	2	2	4	0	1	80%	0%	50%	56%
Community, Frailty & Therapy Services	1	2	2	0	1	1	0%	50%	50%	40%
Digestive Diseases	3	2	5	1	2	1	33%	100%	20%	40%
Family Services	4	8	4	4	8	2	100%	100%	50%	88%
Head And Neck	4	1	2	4	1	2	100%	100%	100%	100%
Major Trauma	4	0	1	3	0	1	75%	NA	100%	80%
Neuroscience	0	1	4	0	0	3	NA	0%	75%	60%
Pathology Network	0	1	0	0	0	0	NA	0%	NA	0%
Patient Services	1	0	3	1	0	1	100%	NA	33%	50%
Specialist Cancer And Support Services	1	3	5	1	1	2	100%	33%	40%	44%
Specialist Medicine	2	1	3	1	1	1	50%	100%	33%	50%
Specialist Surgery	3	2	0	1	2	0	33%	100%	NA	60%
Theatres, Anaesthetics And Critical Care	2	1	2	1	0	1	50%	0%	50%	40%
Total	***35***	***29***	***48***	***23***	***17***	***18***	***66%***	***59%***	***38%***	***52%***

NLAG

	No of PS Incidents for DoC			Completed DoC in Writing			Compliance rate			
NLAG	**Oct-25**	**Nov-25**	**Dec-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Total**
Acute And Emergency Medicine	2	8	4	2	8	4	100%	100%	100%	100%
Cardiovascular	0	1	2	0	1	0	NA	100%	0%	33%
Chief Nurse	0	1	0	0	1	0	NA	100%	NA	100%
Community, Frailty & Therapy Services	23	21	20	23	21	17	100%	100%	85%	95%
Digestive Diseases	2	4	9	2	3	2	100%	75%	22%	47%
Family Services	8	6	1	6	6	1	75%	100%	100%	87%
Head And Neck	1	1	0	1	1	0	100%	100%	NA	100%
Neuroscience	1	1	1	1	1	0	100%	100%	0%	67%
Pathology Network	0	0	0	0	0	0	NA	NA	NA	NA
Patient Services	0	1	0	0	0	0	NA	0%	NA	0%
Site Management And Discharge Teams	1	0	2	0	0	0	0%	NA	0%	0%
Specialist Cancer And Support Services	2	0	1	0	1	1	0%	NA	100%	67%
Specialist Medicine	1	0	1	1	0	0	100%	NA	0%	50%
Specialist Surgery	4	1	1	4	0	1	100%	0%	100%	83%
Theatres, Anaesthetics And Critical Care	1	1	3	1	1	1	100%	100%	33%	60%
Total	***46***	***46***	***46***	***41***	***44***	***27***	***89%***	***96%***	***59%***	***81%***

There is a 10 working day target for completing written DoC and an improvement plan to achieve completion and improve timeliness with achievement expected by February's reporting cycle.

HUTH

There is some improvement in completion of written DoC, with the greatest challenges of volume and lower compliance performance in AEM.

Key themes

Key points identified with compliance are:

- the change in process to provide written DoC
- Implementation of Ulysses as new system to adjust to, although exceeding Datix performance now.
- Documentation of all steps taken including the assurance of letters uploaded onto the database.
- Ownership by departments and Care Groups.

Actions taken

- Validation of appropriate completion when closed by the Head of Patient Safety.
- ADQG review of incidents and suggest resolution plans shared to prompt action.

NLAG

Key themes

Key points identified with compliance are the process change from using the questionnaire tool, to the fields being part of the manager form from October 2025.

There is improved completion and compliance at NLAG in October and November, with some lag seen for December, but confident that this will improve as previous months.

Group Actions being taken to improve:

- Ulysses closure requirement ensures DoC section of the manager forms is completed.
- Dashboard on Ulysses provides realtime data.
- Care Group weekly performance reporting through the weekly monitoring report and ADQG reminders to all care groups.
- Sharing of good practice.
- Further training for teams that require support.

Never Events

HUTH

- There have been 7 Never Events in HUTH in the rolling 12 months with the last in November 2025.

NLAG

- There have been 6 Never Events in NLAG in the rolling 12 months with the last case identified in December 2025, as follows:

DPOW - Retained swab – breast surgery 3/12/2025, identified and removed on 29/12/2025.

What happened:

- Right Pintuition guided therapeutic mammoplasty + SNB.
- The patient had two surgical sites, the breast and axilla, with the axilla site having a swab placed intentionally during surgery, with intent to remove at the point of wound closure.
- The count was perceived to be correct by the scrub practitioner and the circulating practitioner.
- The patient attended with appearance of a seroma in the axilla on 2 occasions and the second of these, the gauze swab was identified in the wound. Removed using local anaesthetic. DoC and apology provided.
- Patient wound improving and no infection indications.

Immediate Response Meeting and AAR

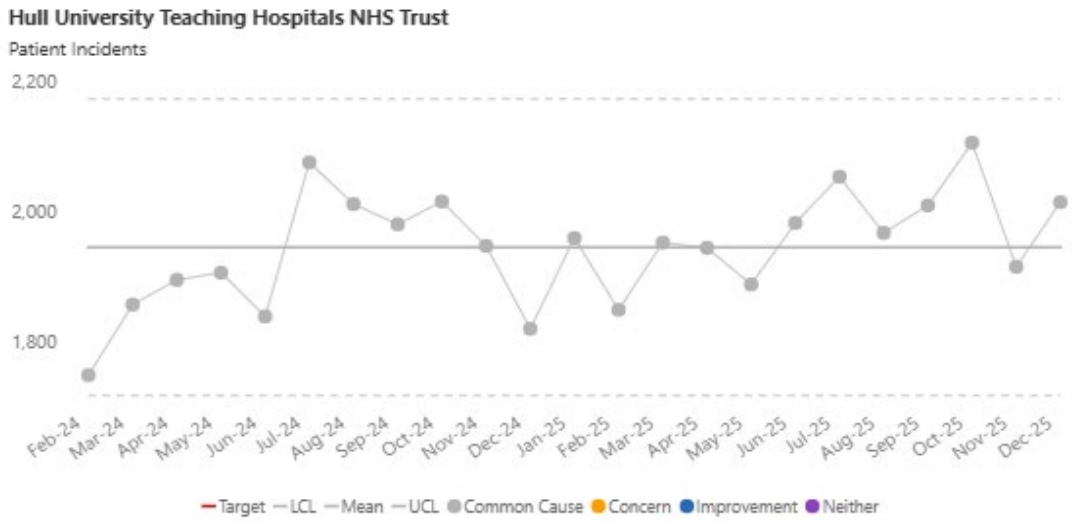
- Work system
    - Distractions from patient who was first on the list when they returned to the ward, telephone calls into theatre.
    - Surgical assistant not rostered, with alternate cover obtained partly. Scrub practitioner assisted with retraction during the procedure.
    - Introduction of the revised NatSSIPS2 checklist on this day – no direct impact (count steps have not changed) but first time use in practice on this day.
- Learning from those involved
    - The timing of the final count, particularly with having two wounds. The scrub practitioner stated that they would do a count during both closures, the last wound being the final count.
    - The surgeon recognised the depth of the axilla cavity took the whole swab, so would ensure they leave the swab partially outside the incision until the wound closure, which generated discussion about using a different pack or swab size to suit the size of the cavity and enable it to be visible outside the wound.

Group wide actions

- Safer Surgery and Interventions Group is meeting monthly, with focus on practice across interventional procedures in and outside the operating theatre.
- Introduction of a compliant NatSSIPs2 checklist in critical care and theatres for central line insertion, with a New document in December 2025.
- The remaining specialty and procedure specific NatSSIPs2 SOP and checklists are being updated
- Introduction of culture reporting tools
- Promotion of the FTSU role
- Use of the NHSE Being fair tools for all staff directly involved
- Thematic review of Never Event learning points.
- Surgical Safety and professional standards in the operating theatre environment are in development.
- Observational audits undertaken by Chief Nurse and Quality Governance teams.
- Revision of the audit tools to align to the checklists for both documentation and observation tools.
- Recognition of some education and implementation of change improvements being taken forward with clinical education teams.

Patient Safety Incident (PSI) reporting

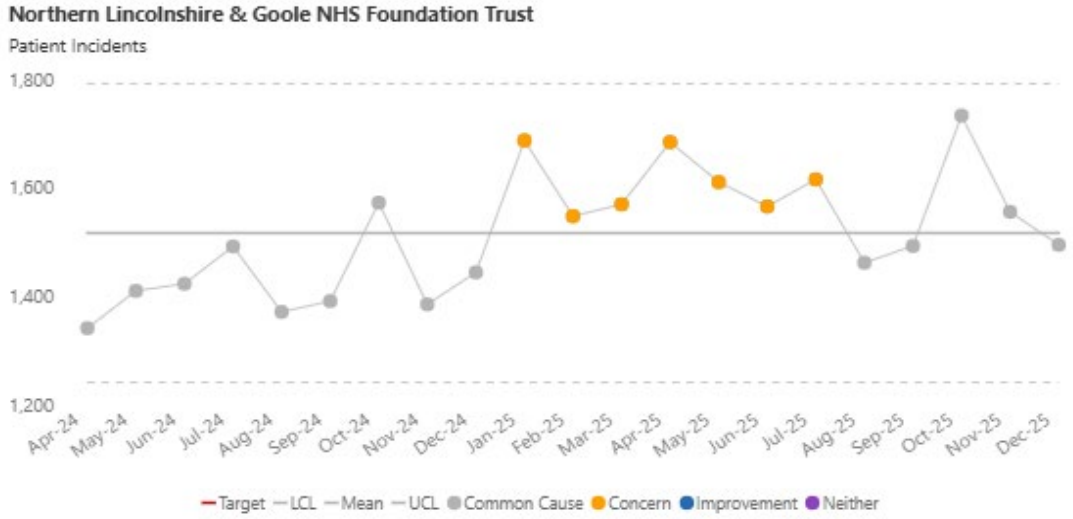
HUTH



Key themes

- Normal variation seen in this chart
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Benchmarking data is limited currently due to NRLS changes to LFPSE and the transition period, is now in the pipeline from national team updates for coming months.

NLAG

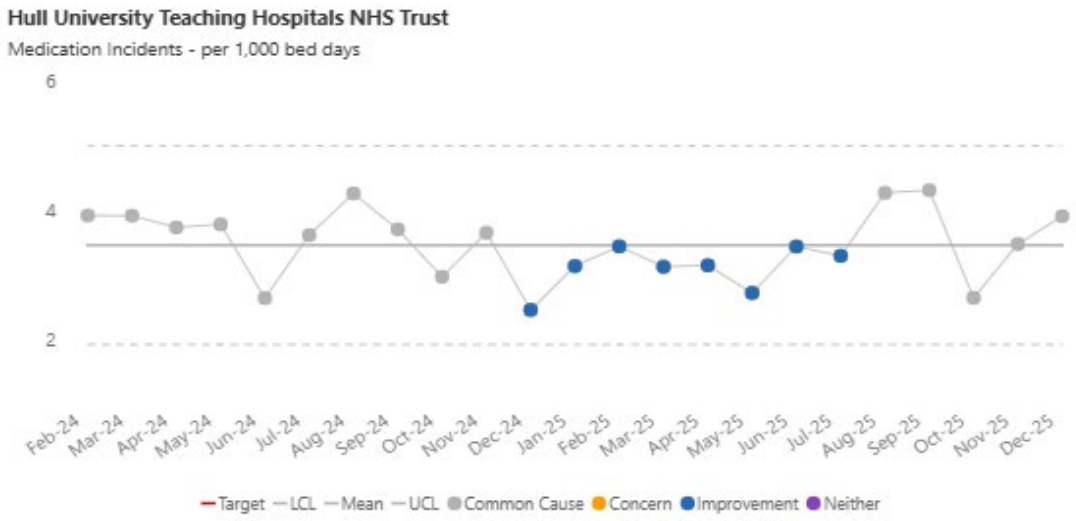


Key themes

- The rate of reporting shows a return to normal variation of reporting after a rise from January to July 2025, which correlates with no harm reporting rates that had also increased.

Patient Safety Incident (PSI) – Medication incidents per 1000 bed days

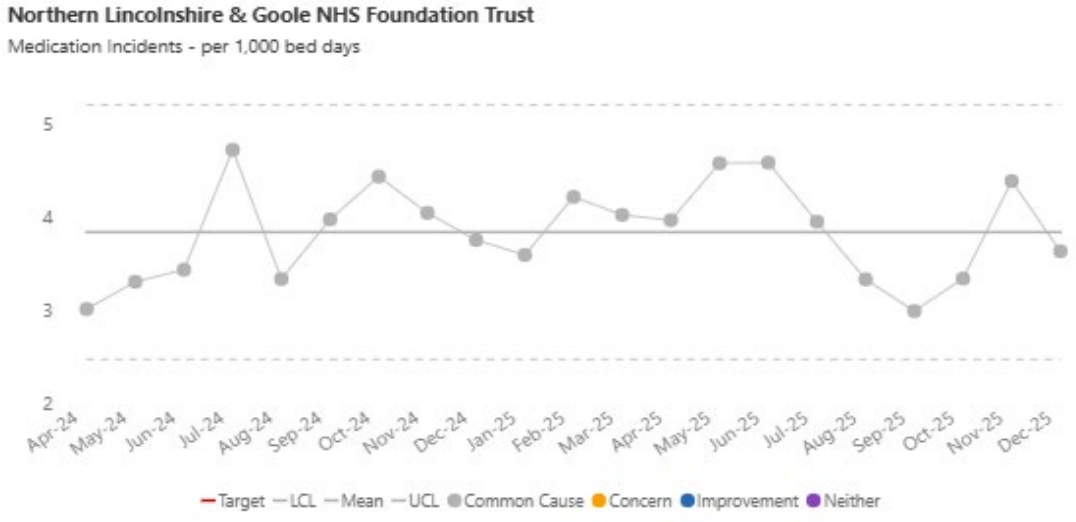
HUTH



Key themes

- Normal variation seen ion the chart.

NLAG



Key themes

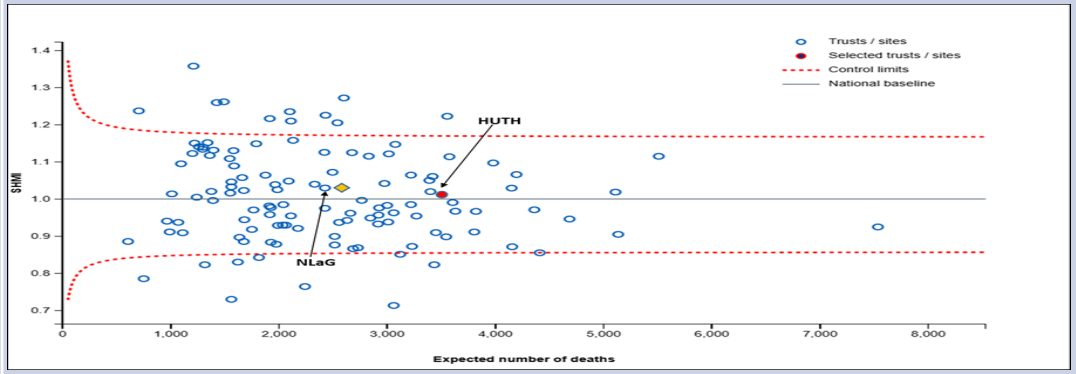
- Normal variation is seen on the chart.

Patient Safety Alerts

HUTH	**Overdue – 1 alert:** • Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. Closure report and evidence collation has 2 actions that lack evidence for: Action 3 - Inventory/database of assets (incomplete ~90% capture on Tagnos system) and Action 4 - subcontracted maintenance process oversight. Escalation for resolution with Estates and Clinical Engineering. • Estates and Clinical Engineering are working together to ensure there is a solution to ensure a full inventory and maintenance tracking database is in place, replicating the NLAG database and Clinical Engineering accountability. A paper is being prepared for presentation to the Executive team. **Current open Alerts (HUTH Specific)** • NatPSA/2026/001/DHSC - Steriflex® No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags. Due by 6/2/2026 and being assessed for relevance to the Trust.
Group	**Current open Alerts:** • NatPSA/2025/005/NHSPS - Harm from delayed administration of rasburicase for tumour lysis syndrome due by 9 March 2026. • NatPSA/2025/006/NHSPS - Harm from incorrect recording of a penicillin allergy as a penicillamine allergy, due by 20 November 2026. • NatPSA/2025/008/NHSPS - Risk associated with adult breathing circuits lacking a patent exhalation route. Due on 12 June 2026. **Completed Alerts:** • NatPSA/2025/007/DHSC - Supply of Licensed and Unlicensed Epidural Infusion Bags issued 2 December and due by 12 December 2025.
NLAG	**Overdue:** • None

Mortality - SHMI

Benchmark

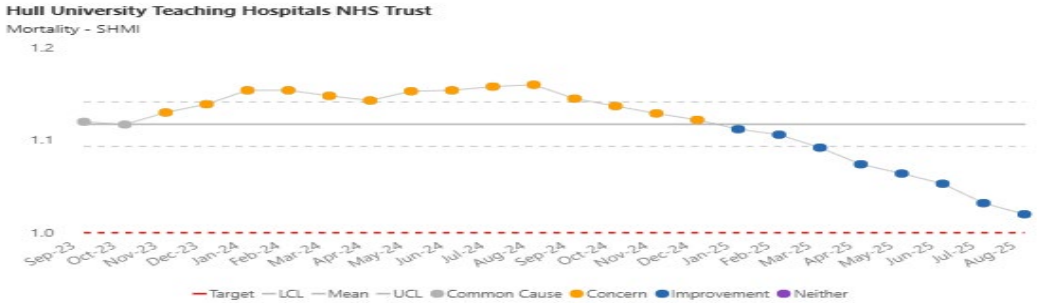


SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings..

The latest SHMI values for each site are:

- Castle Hill – 0.9739; 'as expected' (previously 0.9911 and 'as expected')
- Hull – 1.0412; 'as expected' (previously 1.0514 and 'as expected')
- Grimsby – 0.9976; 'as expected' (previously 0.9864 and 'as expected')
- Scunthorpe – 1.0703; 'as expected' (previously 1.0688 and 'as expected')
- Goole – insufficient activity for SHMI to be calculated

HUTH



Key themes

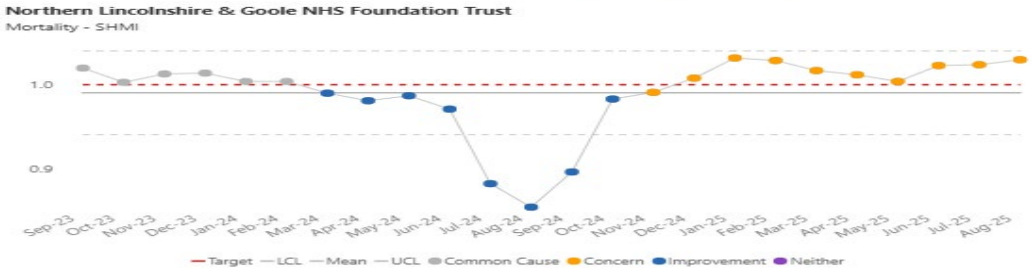
- **HUTH** is identified as having a 'as expected' SHMI, with an overall SHMI of **1.0199** . This is lower than last month's value of 1.0324.

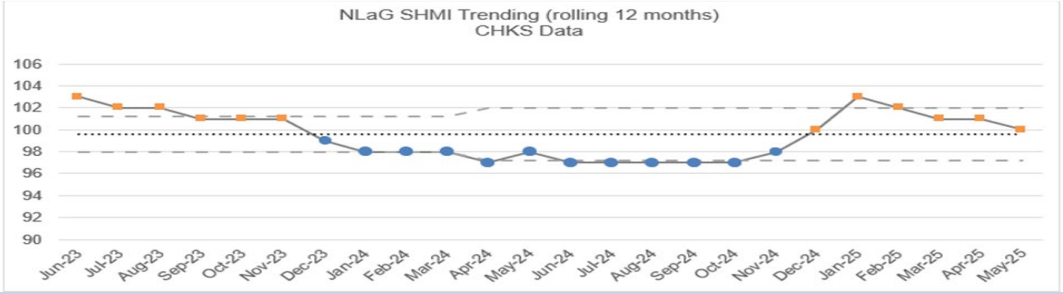
For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher than expected SHMI for:

- Septicaemia

.

NLAG





Key themes

- **NLaG** is identified as having a 'as expected' SHMI, with an overall SHMI of **1.0297**. This is higher than last month's value of 1.0235.

For the conditions for which SHMI is calculated by NHS Digital – NLAG is identified as having a having a higher than expected SHMI for:

- Septicaemia

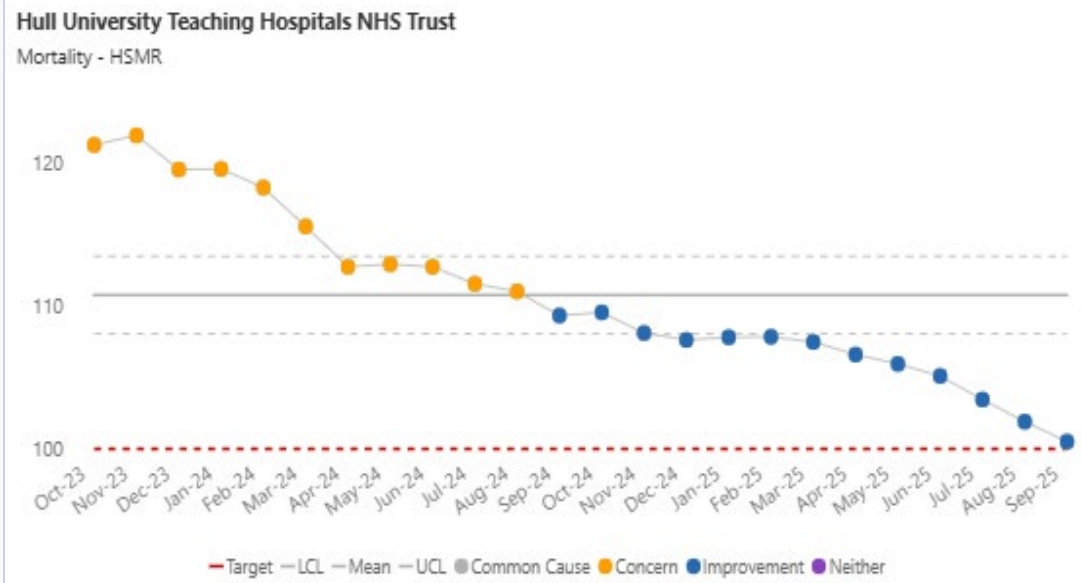
NLAG has a data issue shown in July-September 2024, which may be rectified once processed by NHS Digital. An additional chart is provided from CHKS providing charts reflecting the difference between the national published data and the SUS data complete data set.

Actions being taken to improve across the Group:

- Septicaemia is a Quality priority for the Group and remains an area of focus through the Mortality Improvement Group.
- Mortality Improvement Group workplan and oversight of workstreams to investigate causes of concern in the data.
- Learning from deaths reporting arrangements each quarter.

Mortality - HSMR

HUTH

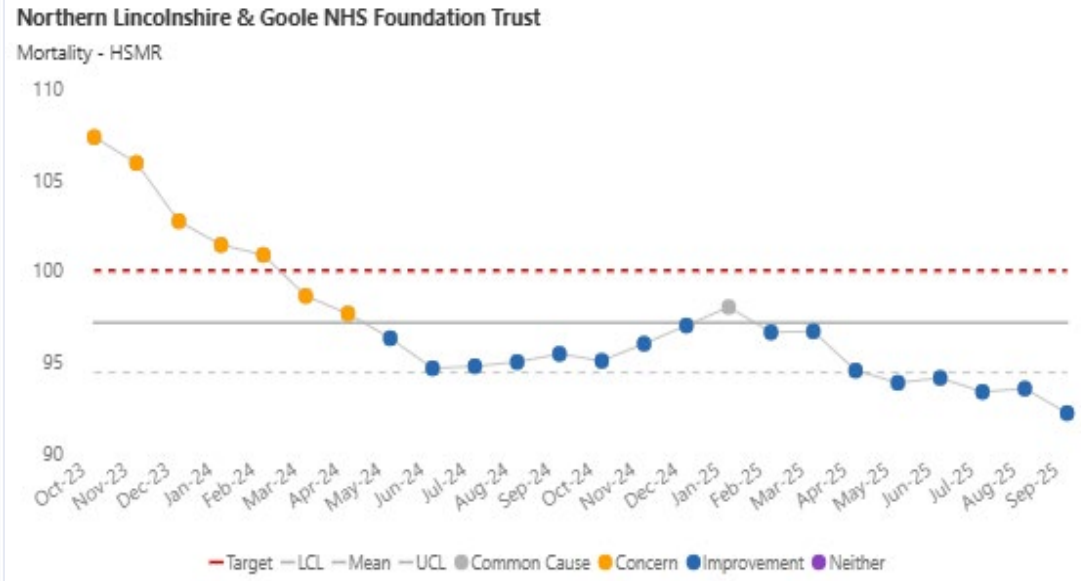


HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

The HSMR is improving and the downward trend tracks more recent data than SHMI, with a ratio of 100.5.

NLAG



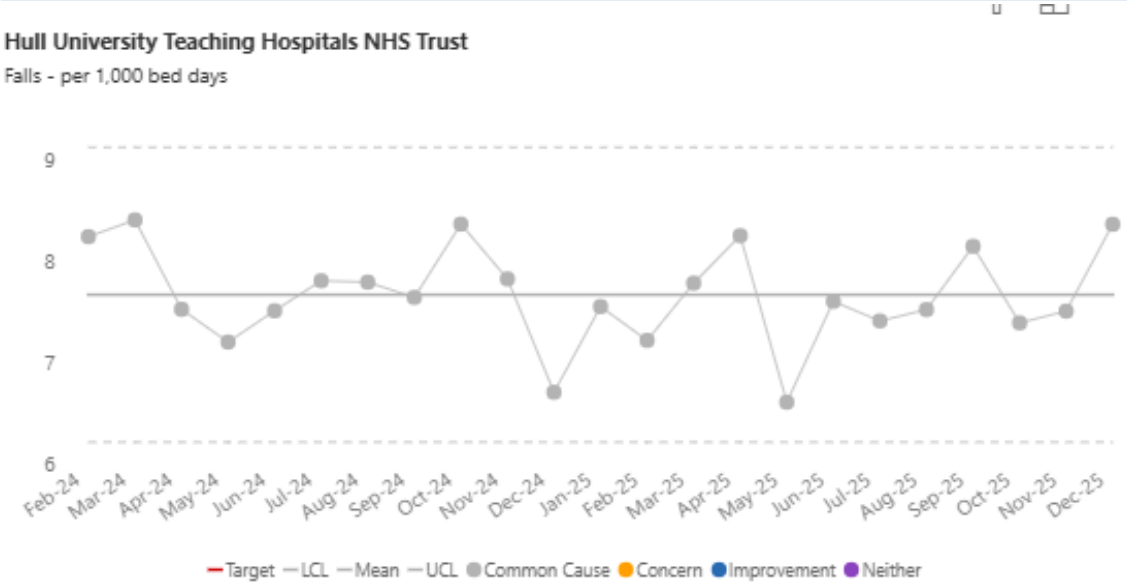
Key themes

There has been a statistically significant improvement with successive reduction in the HSMR over the past fifteen months, now remains under 100 for 19 months, and at 92.2.

Actions are included in the same way for the SHMI description, and HSMR is used as part of the analysis of the mortality data, recognising a different methodology and risk adjustment is applied.

Falls

HUTH

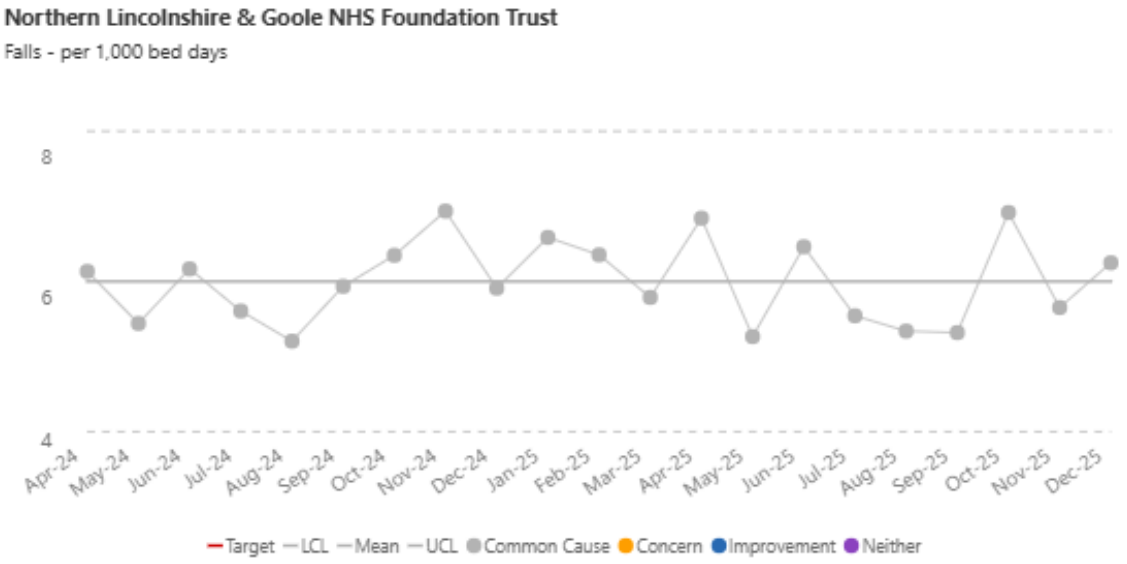


Key themes

HUTH – The Falls Improvement Programme has been successful in driving a reduction in the number of falls across the Trust, through the appointment of key leads, focus on risk assessments and environment and learning from incidents.

There is common cause variation in the rate of falls per 1000 bed days.

NLAG



Key themes

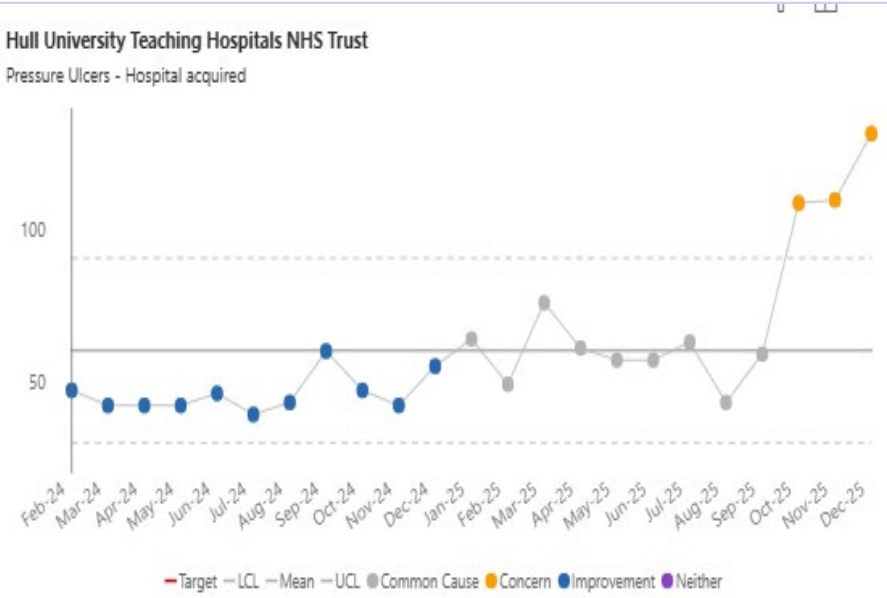
NLAG Falls rate data shows common cause variation.

Actions being taken to improve across the Group:

- A strategic action plan has been in place in NLAG and is being reviewed for the group context.
- Falls team review all repeated fall cases.
- Weekly review of all falls incidents
- Escalation of concerns, including fatal outcomes are reported to the Weekly Learning Response Panel

Pressure Ulcers

HUTH



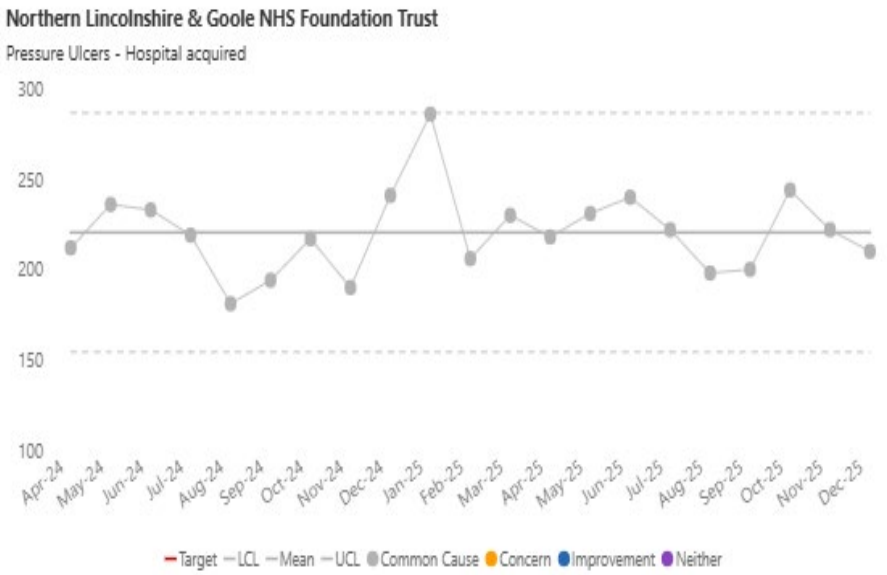
Key themes

- There is an increase in the rate of hospital acquired pressure ulcers for October, November and December 2025, which is seen for the last month usually and then reduces as reviews of incidents are made over the following month. The rate does trigger as a moderate increase on the rate per 1000 bed days.

Actions being taken to improve across the Group:

- Groupwide Pressure Ulcer Group has been established
- Strategic Action Plan is in development
- Weekly Pressure Ulcer Incident review process.

NLAG

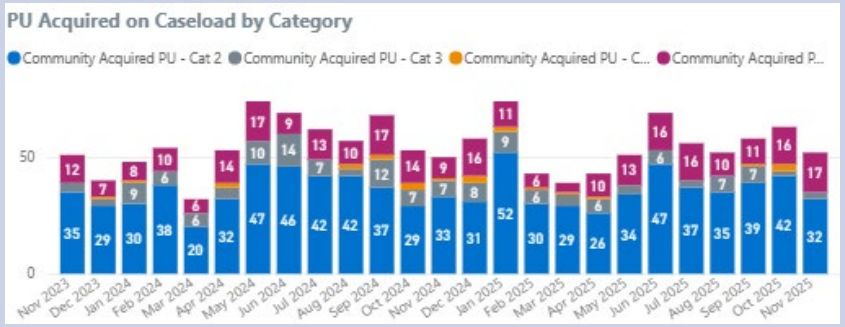


Key themes

- The NLAG BI report data is provided for Community which includes Category 2, 3 and 4 pressure ulcers and unstageable. Cat 1 cases are not included in the community bar chart.
- The Hospital Acquired data is inclusive of in-hospital and on caseload for community of all categories and appears static.
- There is no per 100 bed days data available for NLAG at this time.
- BI updates are being worked through with Information team.

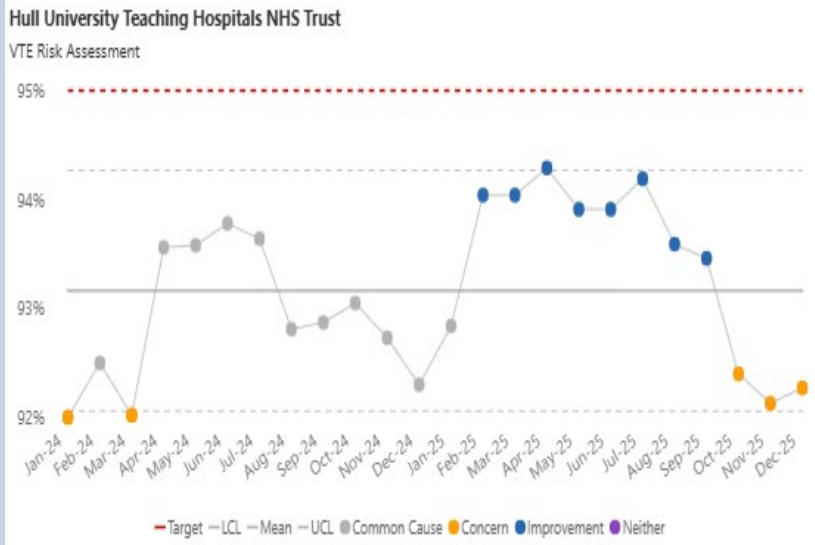
NLAG Community actions

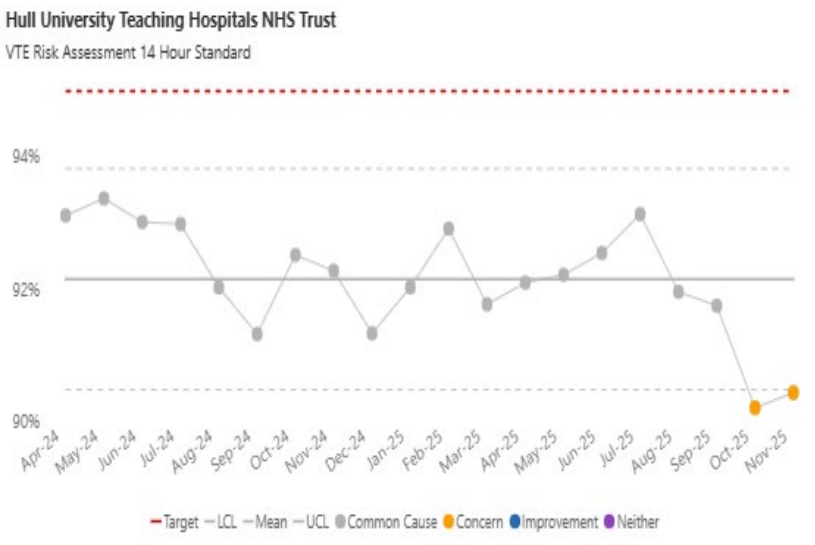
- NL Community team have a weekly pressure ulcer group to review and monitor incidents.



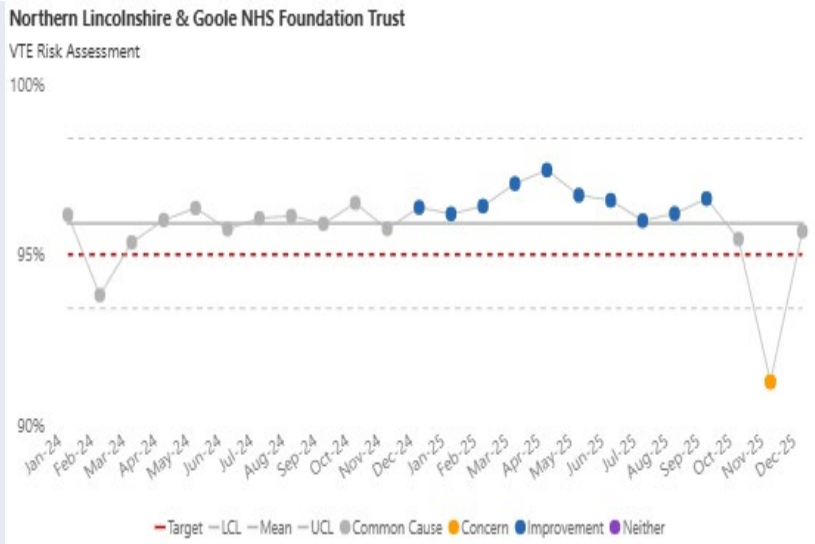
VTE Risk assessment rate

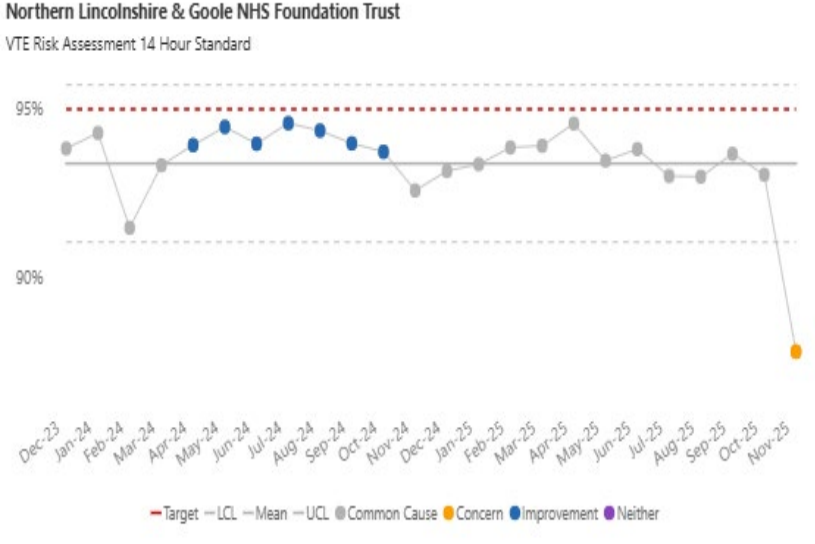
HUTH





NLAG





Key themes

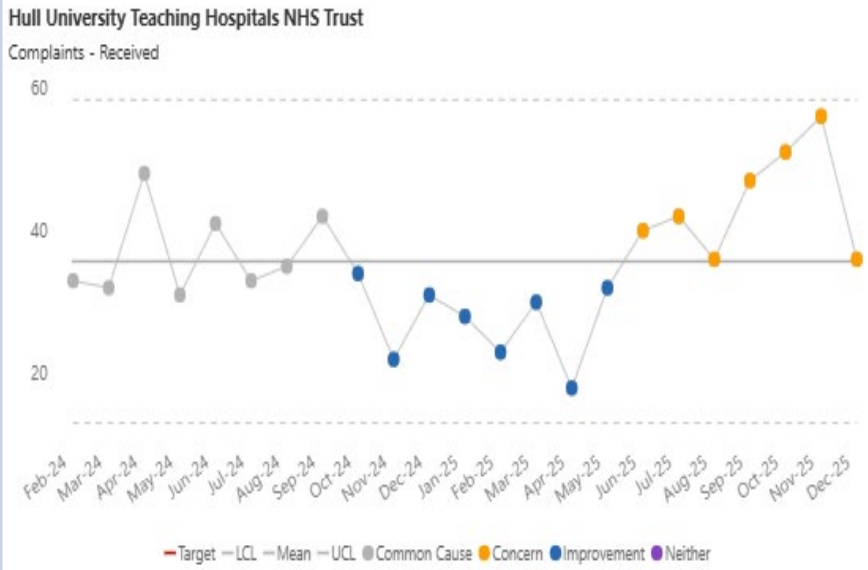
- VTE risk assessment compliance has been measured historically, which is the chart to the left, is within one day of admission.
- With the renewal of the quarterly national data submissions in 2024, the guidance is clear that providers should submit data reflecting the percentage of assessments completed within 14 hours of admission, recognising this is the specified time to start pharmacological thromboprophylaxis should the assessment reflect this. This is illustrated on the charts to the right.
- HUTH data demonstrate that the 95% target is not achieved for these measures..
- NLAG data has shown some improved performance with the last few months data have been reported as improved overall.

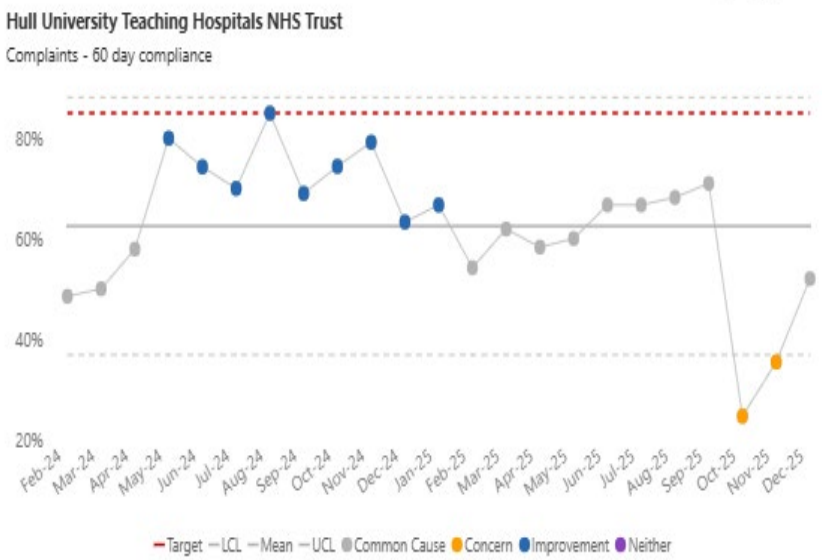
Actions being taken to improve:

- Care Group data is available to provide focus on the relevant teams to address their performance and will be used in the Performance Review meetings and at the Patient Safety and Learning Group as part of Care Group Highlight reports.

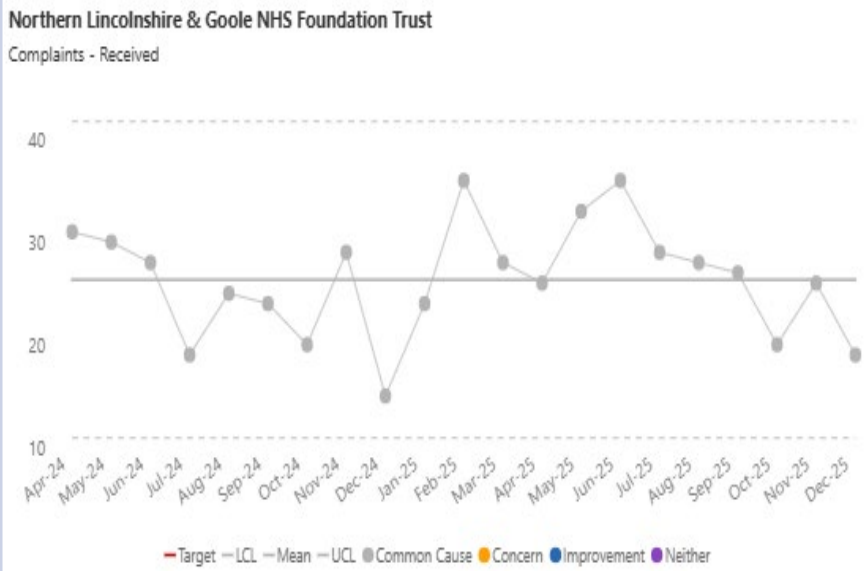
Patient Experience: Complaints – received and compliance with KPIs

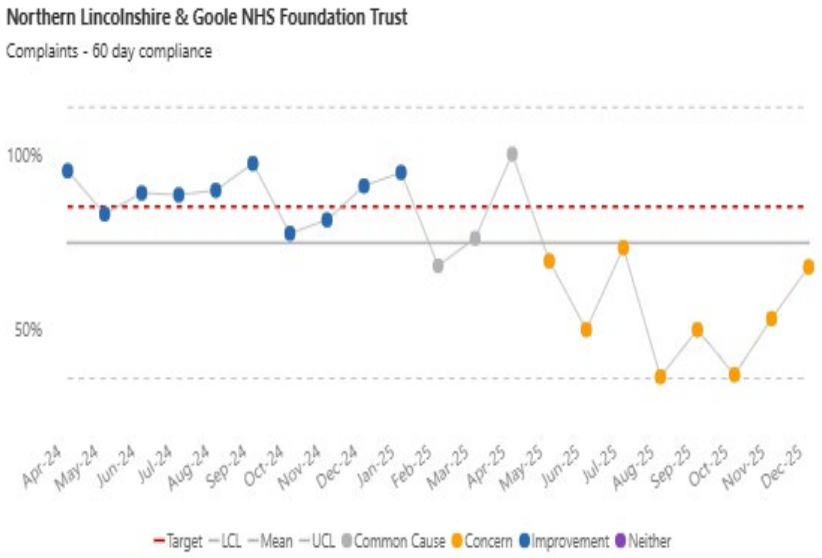
HUTH





NLAG





Key themes

- HUTH complaints shows a moderate increase in complaints, associated with an increase with Acute and Emergency Medicine and Neuroscience Specialist care groups over the Q3 2025/26 periods.
- Previously there has been a reduced rate from November 2024 –August 2025 at HUTH.
- Compliance with timescales remains below the 85% target performance has deteriorated below the further and is a group wide similar issue.

Actions to improve:

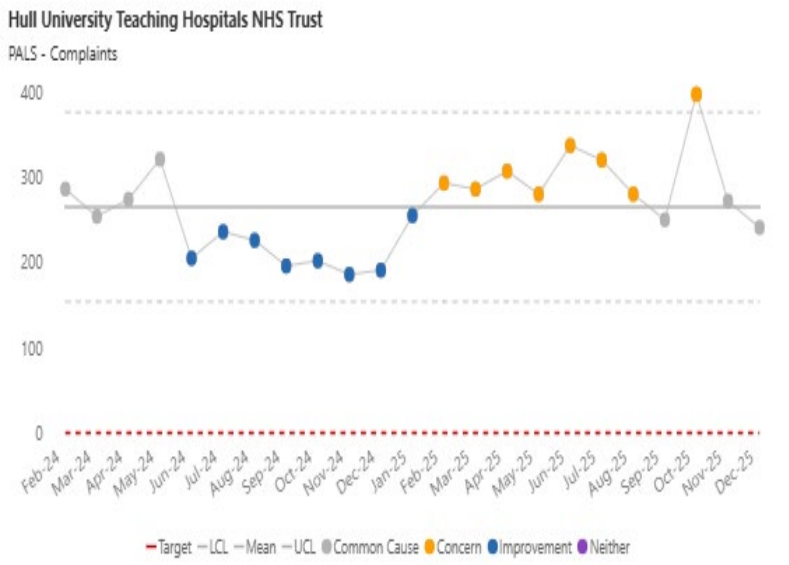
- Central team are aiming to work across the group, following the NLAG investigation and response model.
- Reporting of Care Group performance
- Weekly meetings with Care Group and Central team case handlers.
- Care Group Performance Meeting with Site Nurse Director
- QI programme in development for reducing the number of complaints by acting on the learning gained from complaint themes, with Care Group accountability for their improvement plans
- Complaint sign off process has streamlined to reduce barriers of the number of steps in the process.

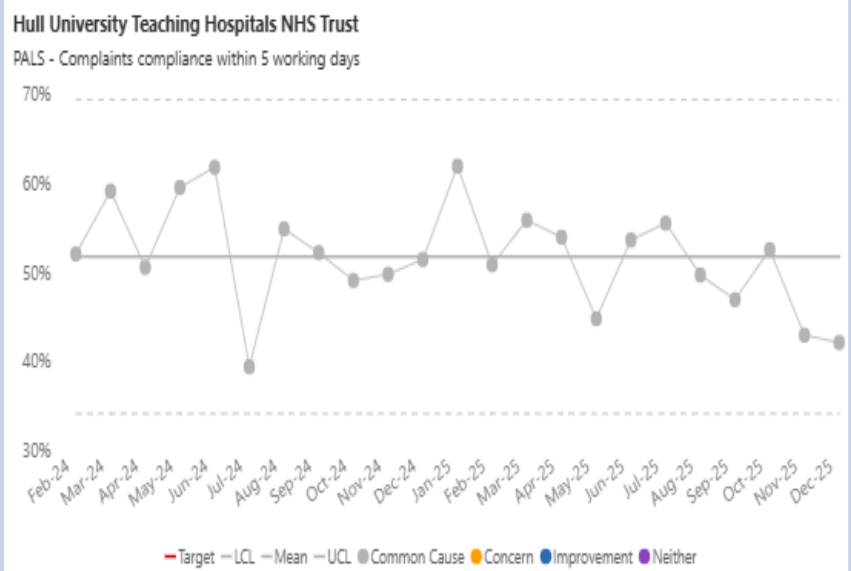
Key themes

- The rate of complaints received showing normal variation patterns.
- The NLAG performance has deteriorated below the standard, and is a group wide similar issue. A targeted approach to support timely completion and sign off continues.

PALS – received and response times

HUTH

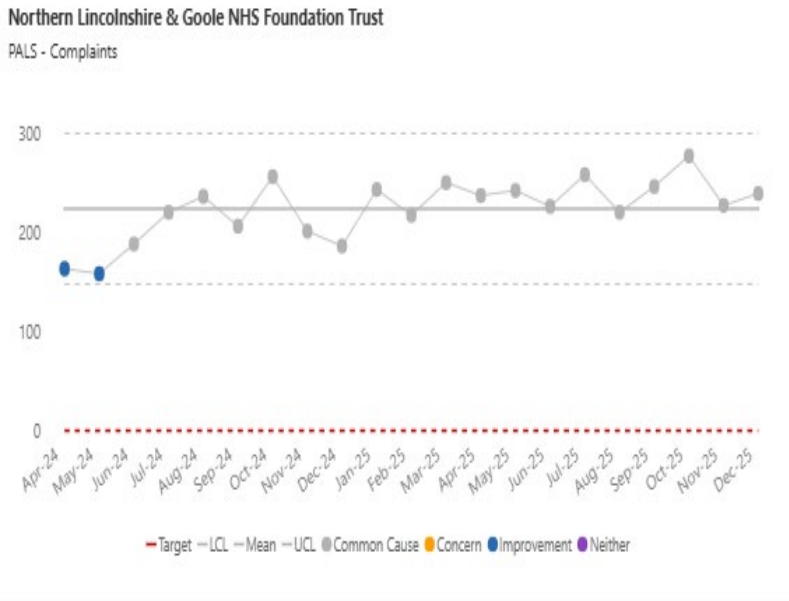


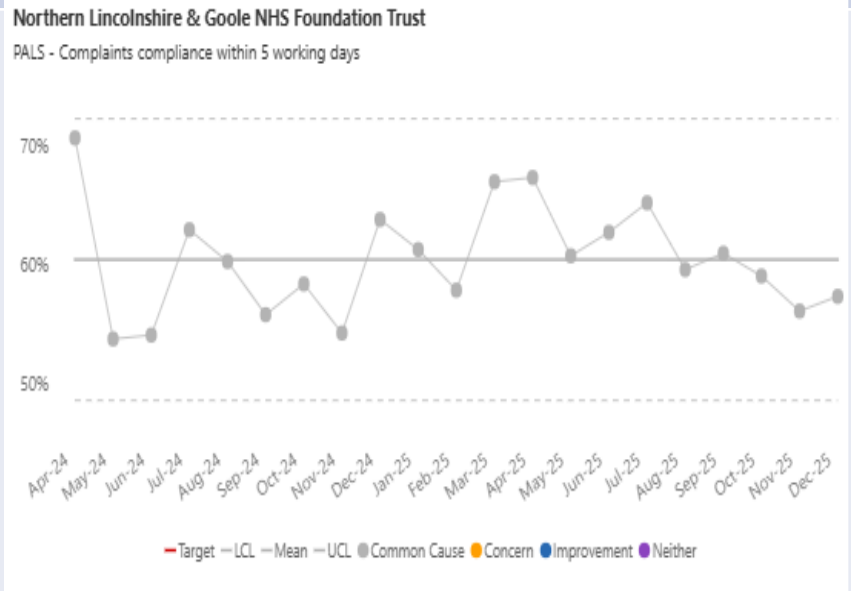


Key themes

- There is an increase in the rate of PALS from February to August 2025 and October 2025 which has returned to normal variation.
- There is no specific correlating increase for a care group. The Patient Experience Quarterly report provides further details.
- There is a 42% completion of PALS concerns within 5 days.

NLAG



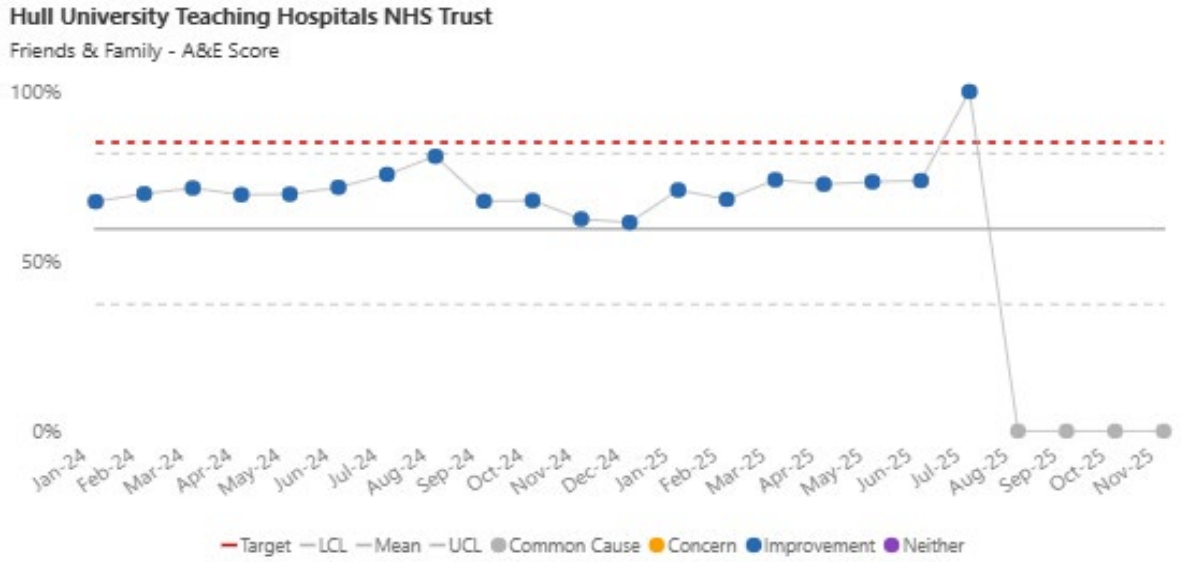


Key themes

- There is normal variation in the rate of PALS contacts.
- There is a 57.3% completion of PALS concerns within 5 days.

Patient Experience – Friends and Family Test A&E

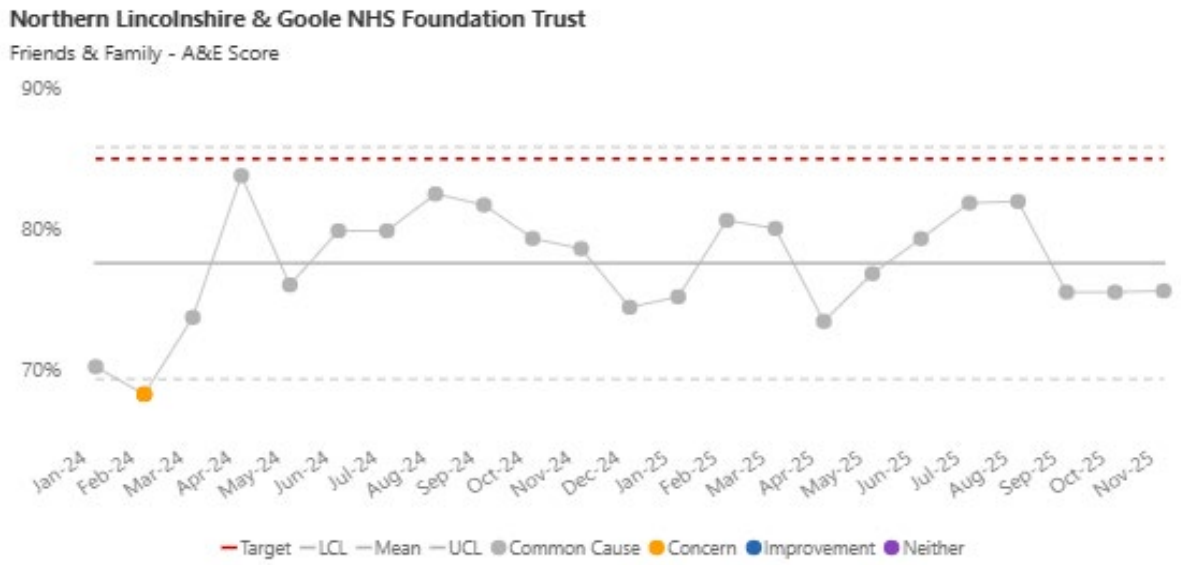
HUTH



Key themes

- Collection of FFT for HUTH is under review due to contract end date. Solutions being sought for process moving forward. No FFT data has been collected for 4 months. NHS England aware and being updated with resolution plan. An electronic solution is being implemented.

NLAG



Key themes

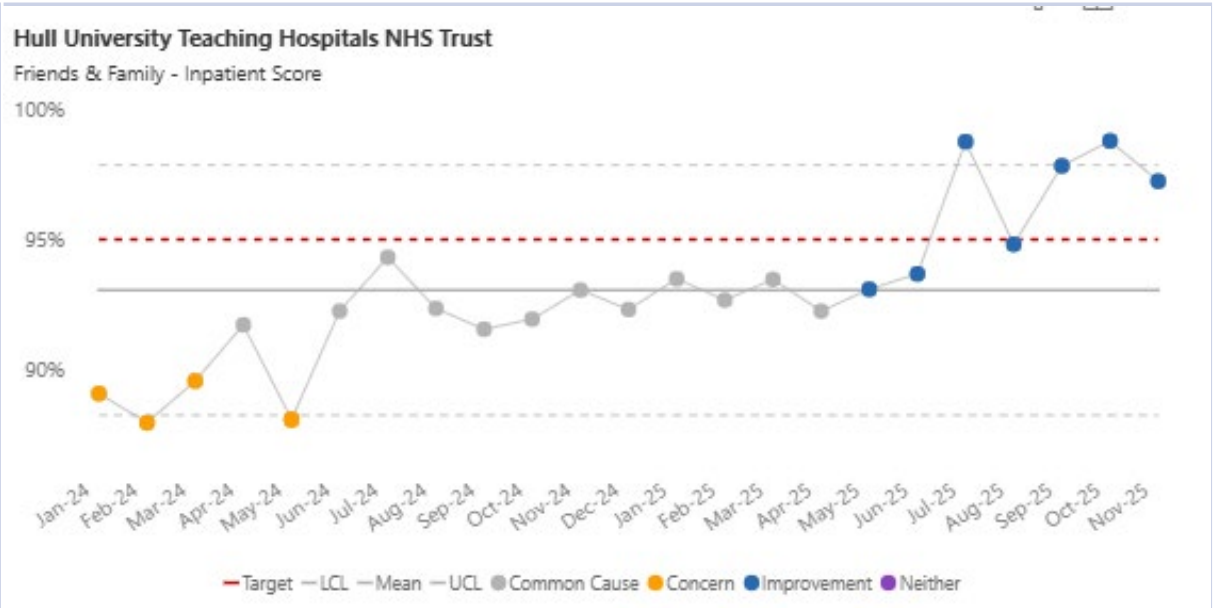
- Normal variation patterns observed for the recent period.
- Remains below the target.

Actions being taken to improve across the Group:

- Performance data available in the Care Group
- Initiatives to improve timely ambulance handover delays
- Initiatives to support patients despite crowding in the EDs.

Patient Experience – Friends and Family Test Inpatient and daycase

HUTH



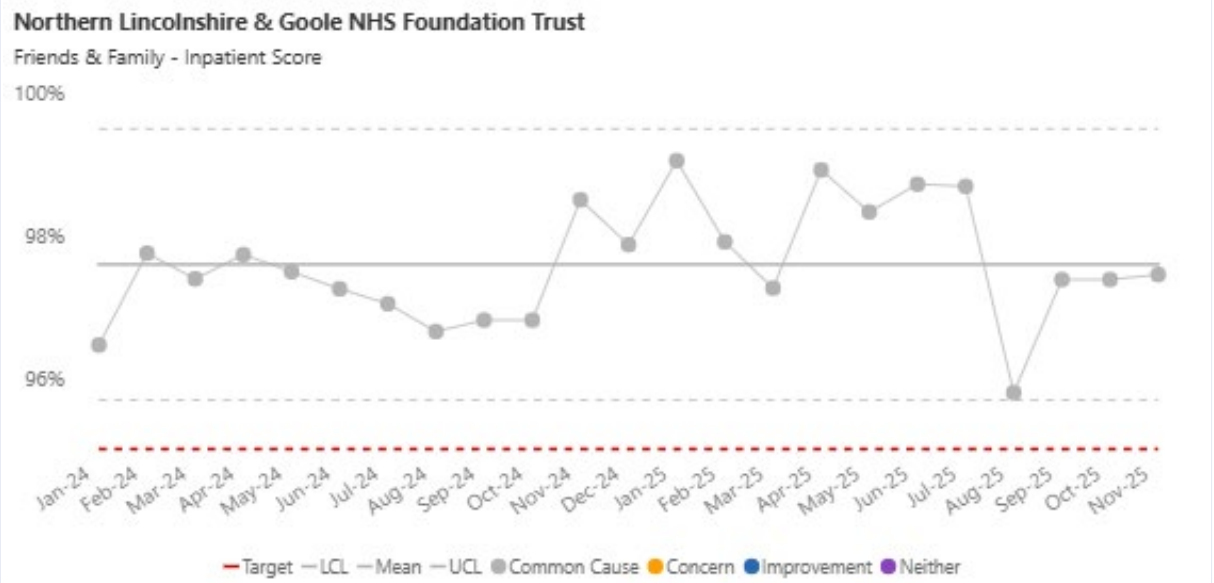
Key themes

- Data collection method changed due to contract end. Digital form being introduced.
- A smaller number of forms are being undertaken, with a higher score, which is not directly comparable to the previous data.

Actions to improve:

- Negative responses are disseminated to care groups for learning which is a key focus of improvement across the themes of staff attitude, communication and environment.
- Care Group performance monitoring.

NLAG

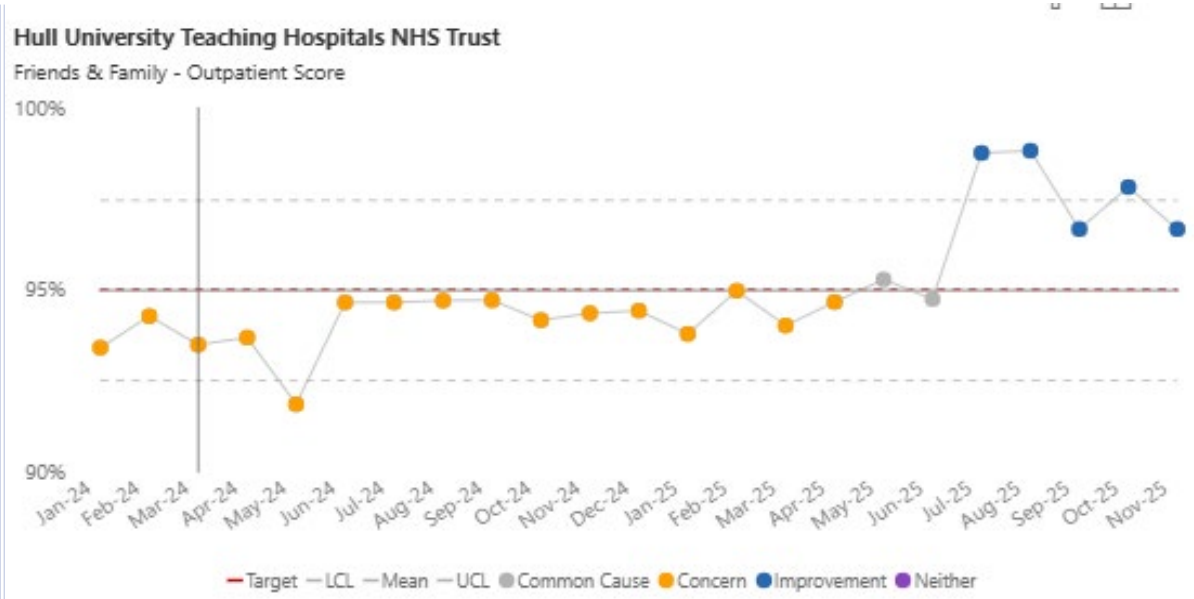


Key themes

- Consistency in achievement of the 95% target.

Patient Experience – Friends and Family Test Outpatient

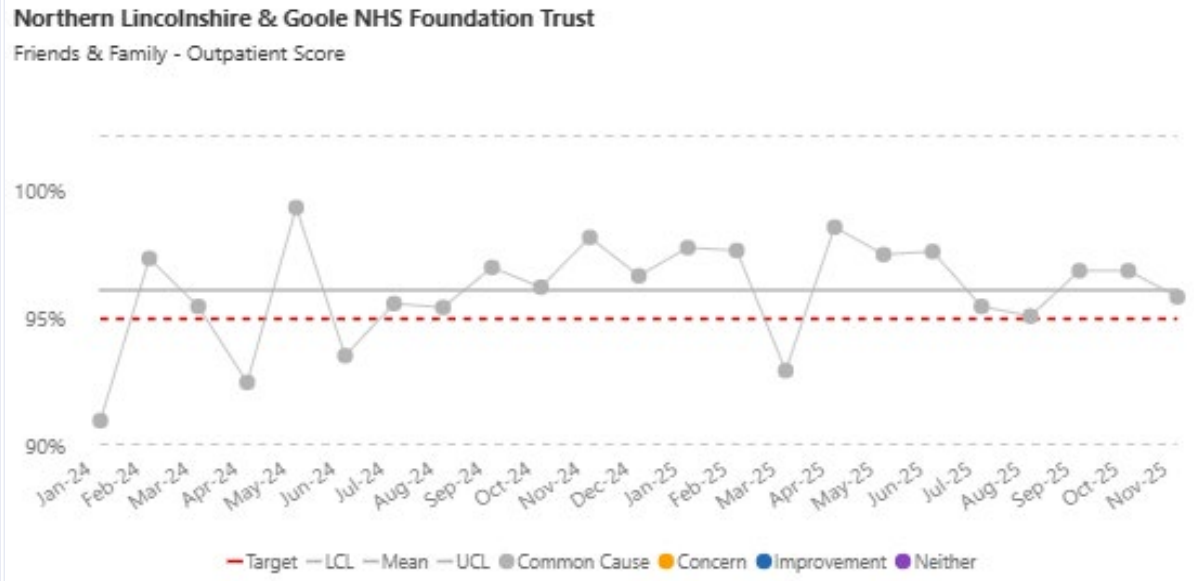
HUTH



Key themes

- Data collection method changed due to contract end. Digital form being introduced.

NLAG

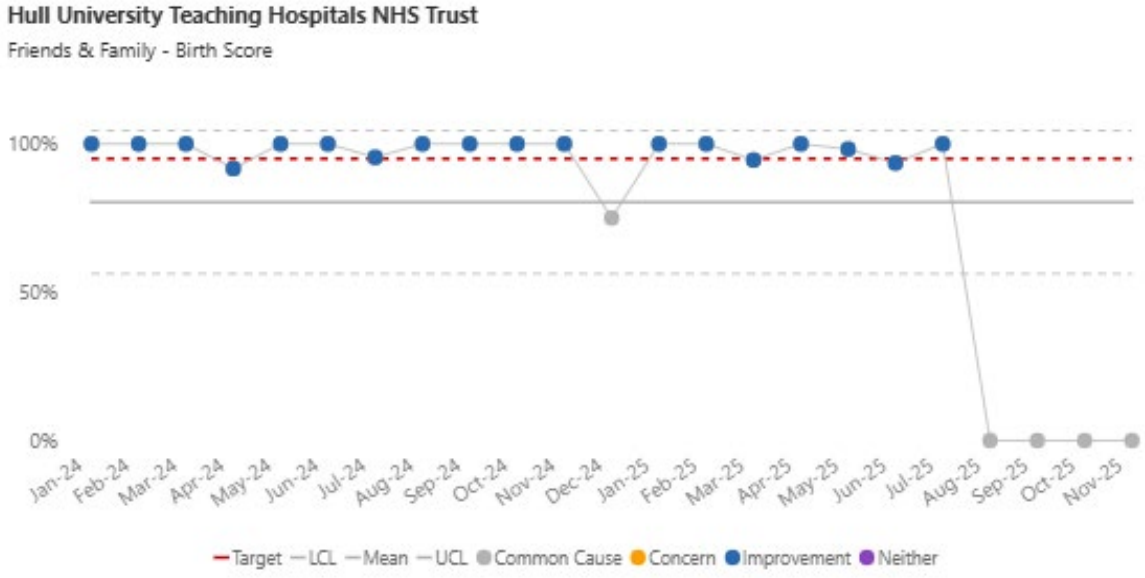


Key themes

- Previously sustained achievement over the target of 95%.

Patient Experience – Friends and Family Test Maternity (Birth)

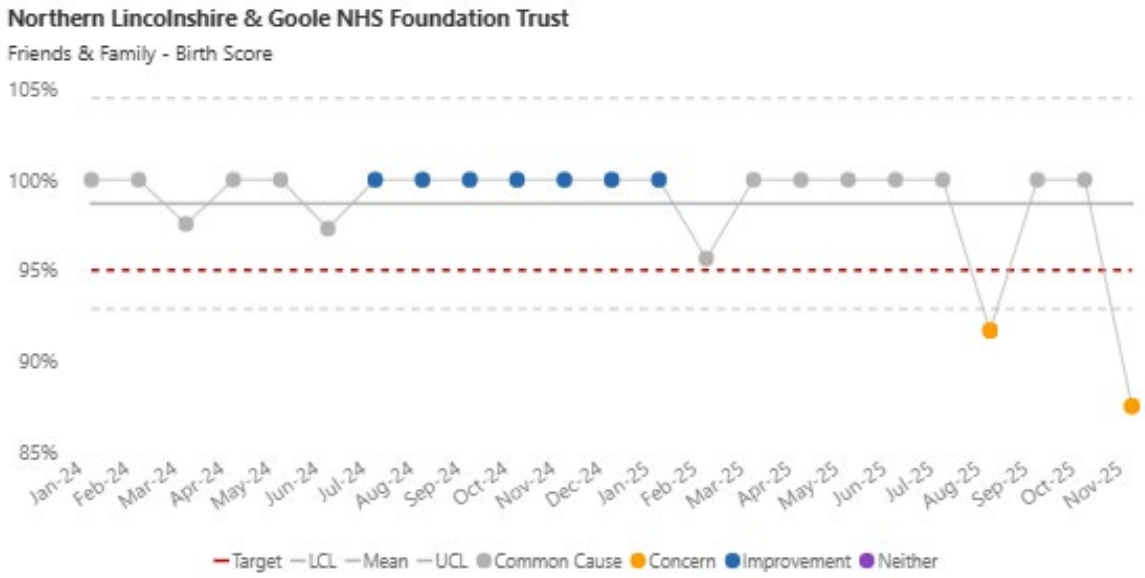
HUTH



Key themes

- Some positive results following a dip of performance in December 2024, with a rate of 100% in August.

NLAG

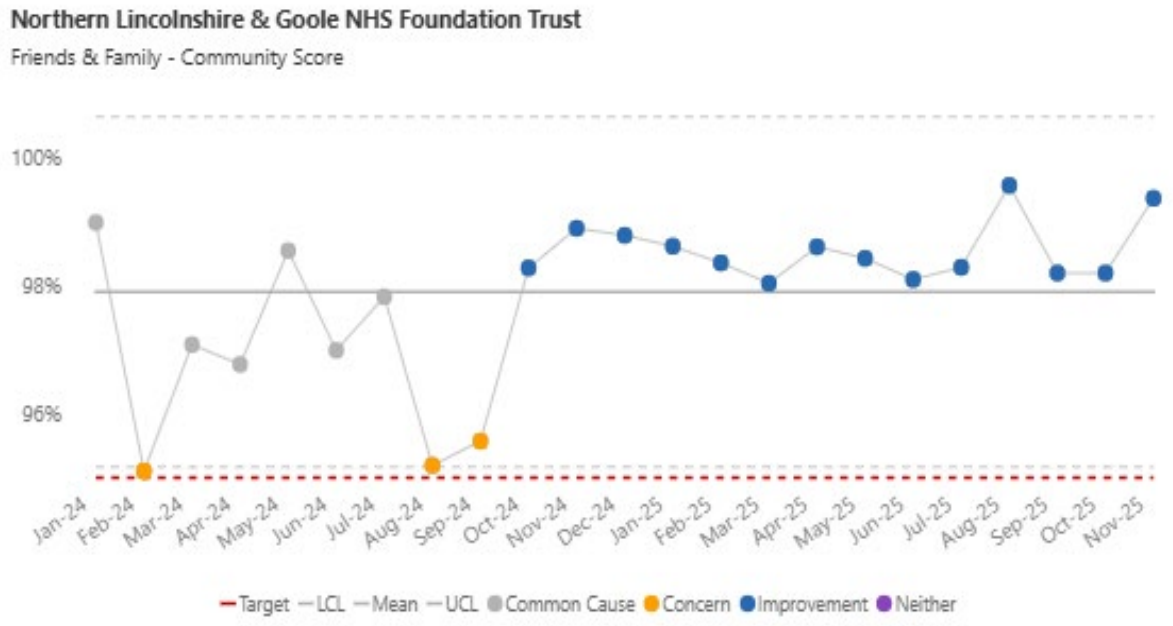


Key themes

- Sustained positive results are seen, remaining above the target and at 100% with the exception of February and August 2025..

Patient Experience – Friends and Family Test Community (NLAG only)

NLAG

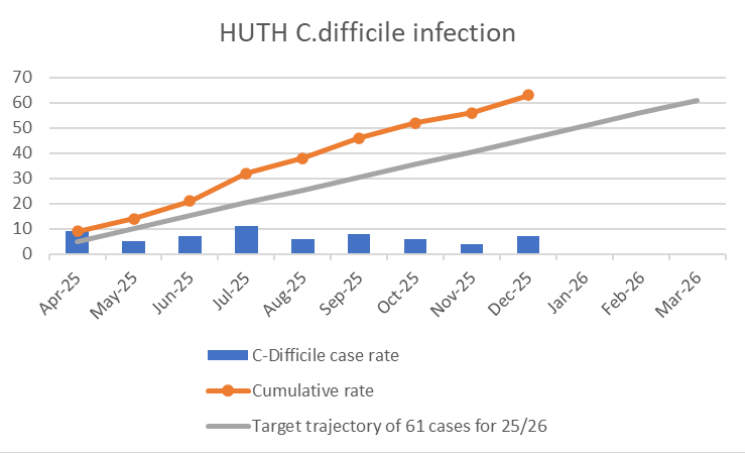


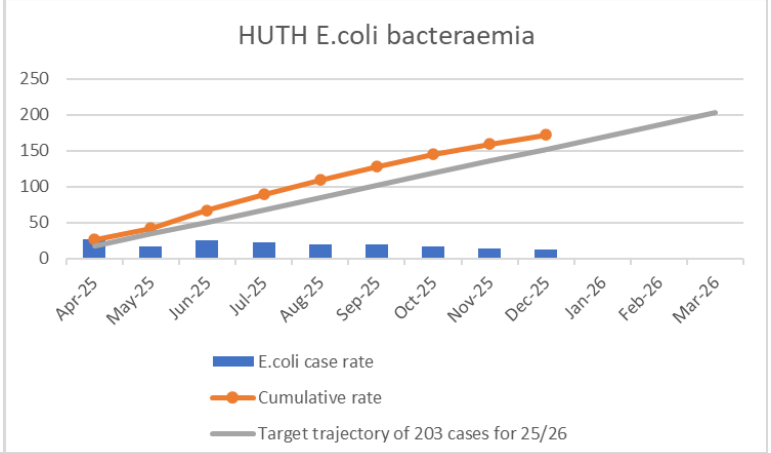
Key themes

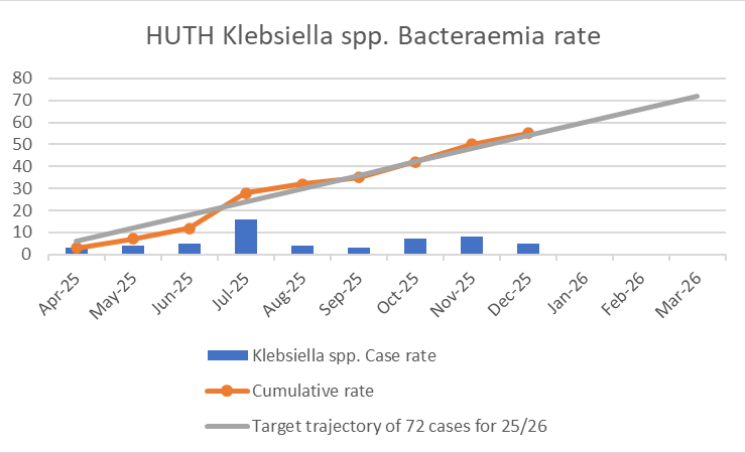
- Normal variation pattern is found and the Trust is consistently achieving the 95%.

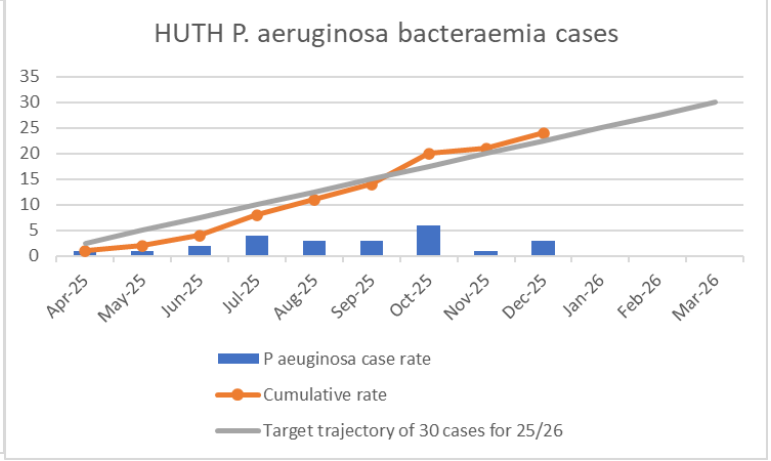
Infection Control - HUTH

Humber Health Partnership









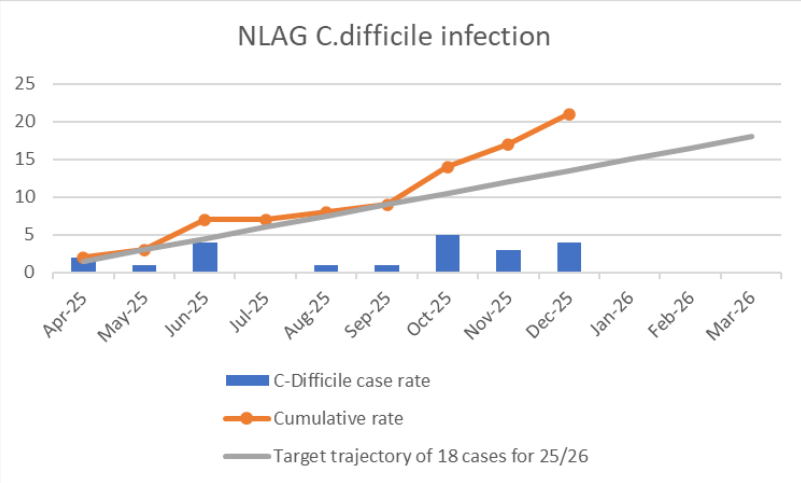
Alert organism	2025/26 Target	M9	YTD rate	Trajectory RAG
C. Difficile	61	7	63	
E. Coli	203	13	172	
P. Aeruginosa	30	3	24	
Klebsiella spp.	72	5	55	
MRSA bacteraemia	0	0	4	
MSSA bacteraemia	No target	5	66	NA
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				

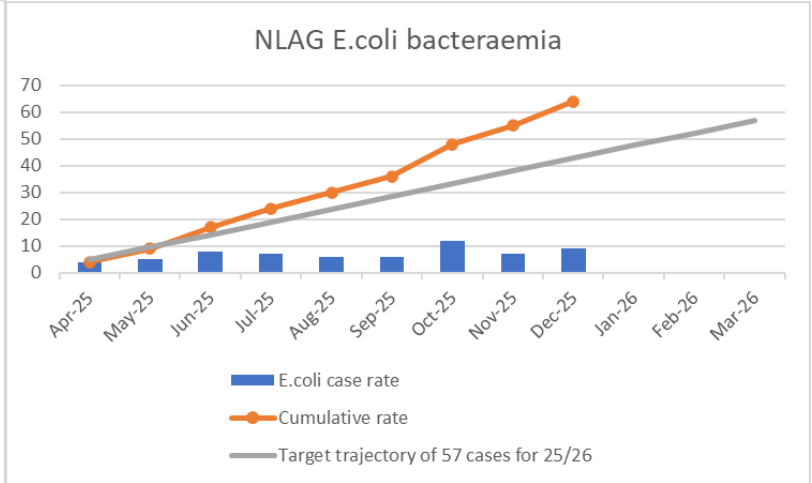
The latest data is refreshed when validated and approved from 15th of the month, so this charting shows the December 2025 position.

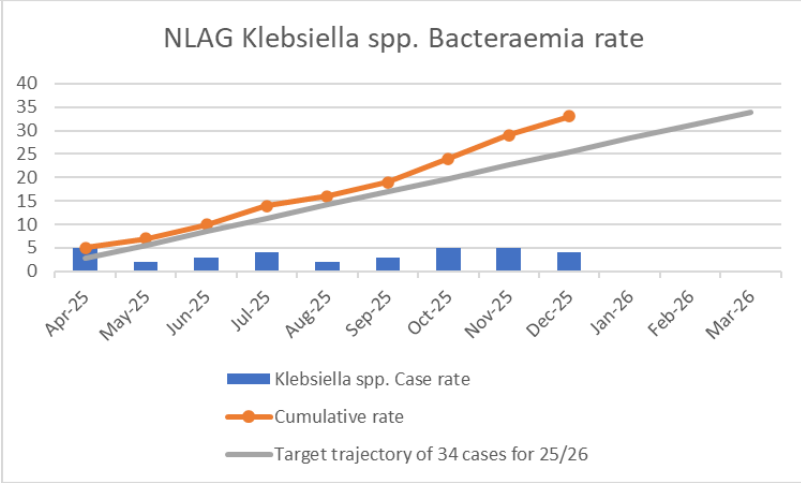
- C.difficile and MRSA rate are over the annual target.
- E-coli, Klebsiella and P Aeruginosa are over the trajectory and within the annual target.
- MSSA rates show normal variation (see charts on following pages)

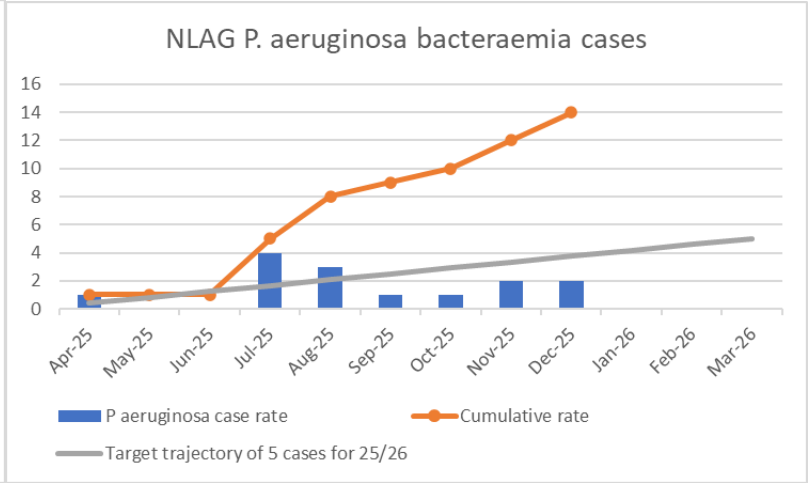
Infection Control - NLAG

Humber Health Partnership









Alert organism	2025/26 Target	M9	YTD rate	Trajectory RAG
C. Difficile	18	4	20	
E. Coli	57	3	54	
P. Aeruginosa	5	2	12	
Klebsiella spp.	34	2	22	
MRSA bacteraemia	0	0	3	
MSSA bacteraemia	No target	2	19	NA

Key: Red – over annual target; Amber - over trajectory; Green – within trajectory

The latest data is refreshed when validated and approved from 15th of the month.

- C.difficile, E.coli and P.Aeruginosa are over trajectory, and over the annual target.
- Klebsiellais over trajectory for the year with 2 cases this month
- MSSA rates remain within normal variation patterns
- There have been 3 MRSA cases this year.

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HUTH Care Group Figures & Thresholds

HCAI ORGANISM HUTH	MRSA BSI		MSSA BSI		ECOLI BSI		KLEBSIELLA BSI		PSEUDOMONAS BSI		CDI (Clostridioides difficile)	
CARE GROUP	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA
MAJOR TRAUMA	0	0	2	0	3	0	3	0	0	0	3	0
CARDIOVASCULAR	2	0	4	4	4	2	0	0	0	0	1	0
THEATRE, ANEASTHETIC & CRITICAL CARE	0	0	5	0	4	3	3	1	2	0	2	0
DIGESTIVE DISEASES	0	0	5	0	29	7	10	6	3	3	9	1
SPECIALIST SURGERY	0	1	3	3	2	8	0	1	0	1	4	1
FAMILY SERVICES	0	0	2	0	3	1	0	1	0	0	0	1
HEAD & NECK	0	0	0	1	0	1	1	0	0	0	1	0
SPECIALIST CANCER & SUPPORT	0	0	15	3	16	23	7	6	4	5	12	5
ACUTE & EMERGENCY MEDICINE	1	0	2	1	9	11	3	5	0	1	8	3
SPECIALIST MEDICINE	0	0	6	1	14	6	2	1	1	0	7	4
COMMUNITY FRAILTY & THERAPY	0	0	5	1	13	5	2	1	3	2	5	2
NEUROSCIENCES	0	0	1	2	5	3	4	0	0	0	3	0
TOTAL TO DATE	4		65		172		57		25		72	
THRESHOLD HUTH FY 2025/26	ZERO		NONE		203		72		30		61	

Areas with two or more organisms of concern

- Digestive Diseases Care Group
- Specialist Cancer Care Group
- Acute and Emergency Medicine Care Group North
- Community, Frailty and Therapy Care Group
- Specialist Medicine Care Group

Humber Health Partnership

NLAG Care Group Figures & Thresholds

HCAI ORGANISM NLAG	MRSA BSI		MSSA BSI		ECOLI BSI		KLEBSIELLA BSI		PSEUDOMONAS BSI		CDI (Clostridioides difficile)	
CARE GROUP	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA	HOHA	COHA
MAJOR TRAUMA	0	0	0	0	0	0	0	0	0	0	0	0
CARDIOVASCULAR	1	0	2	0	0	0	0	0	0	0	1	0
THEATRE, ANEASTHETIC & CRITICAL CARE	0	0	0	0	4	0	3	0	1	0	1	0
DIGESTIVE DISEASES	0	0	4	0	10	1	10	0	3	0	3	1
SPECIALIST SURGERY	0	0	1	0	1	0	1	0	0	0	1	0
FAMILY SERVICES	0	0	1	0	2	0	1	0	0	0	0	0
HEAD & NECK	0	0	0	0	0	0	0	0	0	0	0	0
SPECIALIST CANCER & SUPPORT	0	0	0	0	0	0	0	0	0	0	0	0
ACUTE & EMERGENCY MEDICINE	1	0	4	3	6	32	4	8	0	5	5	3
SPECIALIST MEDICINE	0	0	5	0	4	0	2	0	3	0	4	1
COMMUNITY FRAILTY & THERAPY	0	0	2	0	1	1	3	0	0	0	3	0
NEUROSCIENCES	0	0	1	0	4	0	1	0	2	0	0	0
TOTAL TO DATE	2		23		66		33		14		23	
THRESHOLD NLAG FY 2025/26	ZERO		NONE		57		34		5		18	

Areas with two or more organisms of concern

- Acute and Emergency Medicine Care Group South
- Specialist Medicine Care Group
- Digestive Diseases Care Group

Specialist Cancer & Clinical Support

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
SPECIALIST CANCER & SUPPORT	0	0	15	3	16	23	7	6	4	5	12	5
THRESHOLD	0		0		203		72		30		61	

Areas of concern:

- MSSA BSI – 18/65 (27.6%) Trust cases apportioned to SCCS
- CDI – 17/72 (23.6%) Trust cases apportioned to SCCS
- Ecoli BSI – 39/182 (21.4%) Trust cases apportioned to SCCS

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Specialist Cancer & Clinical Support

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	100%	49%	93.5%	94%	92%

Themes:

- Reduced compliance in correct PPE (83%)
- Adherence to Uniform policy (68%)
- Bare below the elbow (68%)
- Stored equipment not labelled clean, dirty equipment in clinical areas

Specialist Medicine

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
SPECIALIST MEDICINE	0	0	6	1	14	6	2	1	1	0	7	4
THRESHOLD	0		0		203		72		30		61	

Areas of concern:

- MSSA BSI – 7/65 (10.7%) Trust cases apportioned to SM
- CDI – 11/72 (15.2%) Trust cases apportioned to SM
- Ecoli BSI – 20/182 (10.9%) Trust cases apportioned to SM

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Specialist Medicine

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	100%	67%	89%	85%	74%

Themes:

- Reduced compliance in correct PPE (80%)
- Adherence to Uniform policy (80%)
- Bare below the elbow (68%)
- Dirty utility / dirty equipment (40%)
- COSHH cupboard unlocked / items not stored correctly (80%)

Digestive Diseases

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
DIGESTIVE DISEASES	0	0	5	0	29	7	10	6	4	5	9	1
THRESHOLD	0		0		203		72		30		61	

Areas of concern:

- MSSA BSI – 5/65 (7.6%) Trust cases apportioned to DD
- CDI – 10/72 (13.8%) Trust cases apportioned to DD
- Ecoli BSI – 36/182 (19.7%) Trust cases apportioned to DD

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Digestive Diseases

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	100%	76%	97%	90%	72%

Themes:

- Adherence to Uniform policy (83%)
- Bare below the elbow (83%)
- Stored equipment not labelled clean, dirty equipment in clinical areas

Acute and Emergency Medicine North

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
ACUTE & EMERGENCY MEDICINE NORTH	1	0	2	1	9	11	3	5	0	1	8	3
THRESHOLD	0		0		203		72		30		61	

- **Areas of concern:**

- MRSA BSI – 1/4 (25%) Trust cases apportioned to AEM North
- CDI – 11/72 (15.2%) Trust cases apportioned to AEM North
- Ecoli BSI – 20/182 (10.9%) Trust cases apportioned to AEM North

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Acute and Emergency Medicine North

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles.

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	100%	71%	90%	90%	77%

- Themes:
- Reduced compliance in stored equipment not labelled clean (75%)
- Dirty utility room / equipment not tidy and clean (75%)
- Sharps bin not labelled / over filled (50%)
- Catheter bags placed inappropriately (75%)

Acute and Emergency Medicine South

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
ACUTE & EMERGENCY MEDICINE SOUTH	1	0	4	3	6	32	4	8	0	5	5	3
THRESHOLD	0		0		57		34		5		18	

- **Areas of concern:**
- MRSA BSI – 1/2 (50%) Trust cases apportioned to AEM South
- CDI – 8/23 (34.7%) Trust cases apportioned to AEM South
- Ecoli BSI – 38/66 (57.5%) Trust cases apportioned to AEM South
- klebsiella BSI - 12/33 (36%) Trust cases apportioned to AEM South
- Pseudomonas BSI - 5/14 (35.7%) Trust cases apportioned to AEM South

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Acute and Emergency Medicine South

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	90.8%	45% (NLAG data not Care Group specific)*	90.8%	76.5%	42%

*NLAG data is currently being reviewed to align with HUTH process as per AMS workstream

- Themes:
- Equipment is clean and stored appropriately with 'I am clean' stickers
- Patients cared for in isolation with correct isolation procedures
- Sluice is not stored/ kept clean and tidy, commodes stained
- Boxes stored on floor
- Blood culture contaminants ^ - currently being reviewed as part of QIP programme

Community, Frailty and Therapy

Humber Health Partnership

- Positive Cases: April 25 - December 25

HCAI ORGANISM HUTH	MRSA BSI HOHA	 COHA	MSSA BSI HOHA	 COHA	ECOLI BSI HOHA	 COHA	KLEBSIELLA BSI HOHA	 COHA	PSEUDOMONAS BSI HOHA	 COHA	CDI (Clostridioides difficile) HOHA	 COHA
COMMUNITY, FRAILTY AND THERAPY	0	0	5	1	13	5	2	1	3	2	5	2
THRESHOLD	0		0		203		72		30		61	

Areas of concern:

- MSSA BSI – 6/65 (9.2%) Trust cases apportioned to CFT
- CDI – 7/72 (9.7%) Trust cases apportioned to CFT
- Ecoli BSI – 18/182 (9.8%) Trust cases apportioned to CFT

- **Future Aim:** To achieve a **10%** reduction in relation to each of the above identified reportable organisms from the current baseline over the next 12 months

Community, Frailty & Therapy

Humber Health Partnership

- Compliance and Assurance Rates with Current Audit Cycles

	Hand Hygiene	AMS	Points Prevalence	Enhanced Audit	Training Compliance
Threshold / target	96%	70%	90%	96%	85%
Actual	100%	79%	89%	94%	75%

Themes:

- Reduced compliance in Correct PPE (87.5%)
- Adherence to Uniform policy (87.5%)
- Bare below the elbow (68%)
- Sharps bins not labelled / overfilled (62.5%)
- Dirty equipment in clinical areas (87.5%)

Immediate Actions to be taken at Care Group Level

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- Continued Deep Dive reviews of IPC incidents at Care Group Level
- Increased frequency of hand hygiene and IPC audits at ward level with real time feed back to teams
- Introduction of ward level compliance dashboards, reviewed weekly by care group leadership teams
- Targeted education sessions for wards/departments with repeated non-compliance
- Strengthen escalation process for persistent non-compliance to care group triumvirate
- Monthly review of training compliance across of staff groups
- Regular review and escalation of estate and infrastructure constraints effecting environmental controls
- Strengthened role of IPC link staff within Care Groups
- Daily Review of Isolation Capacity
- IPC Nurse Assigned to Care Groups to support the implementation of above initiatives

Strategic Actions:

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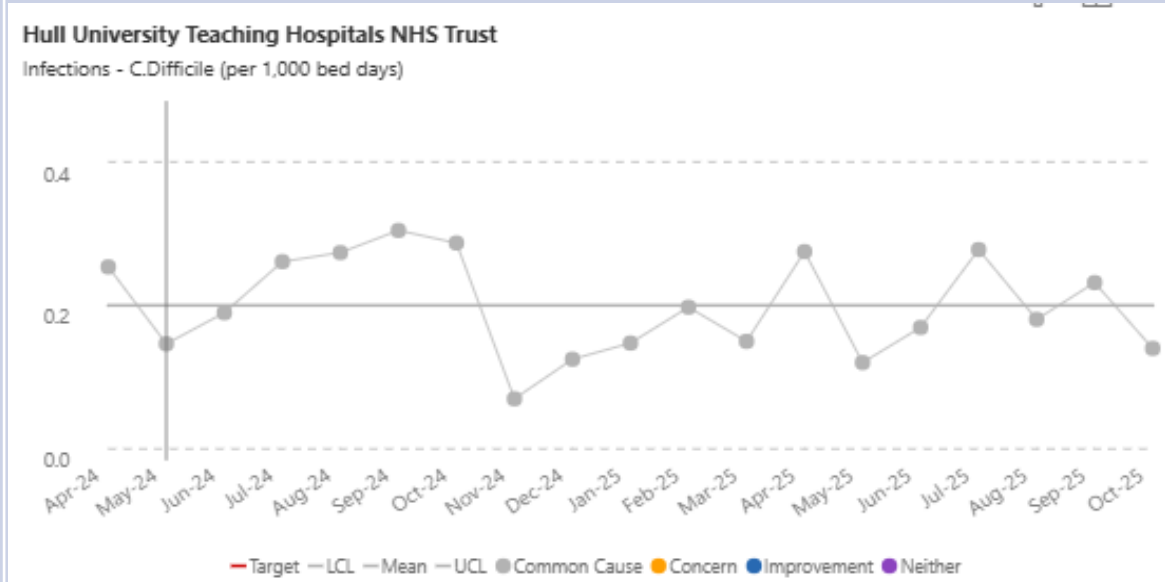
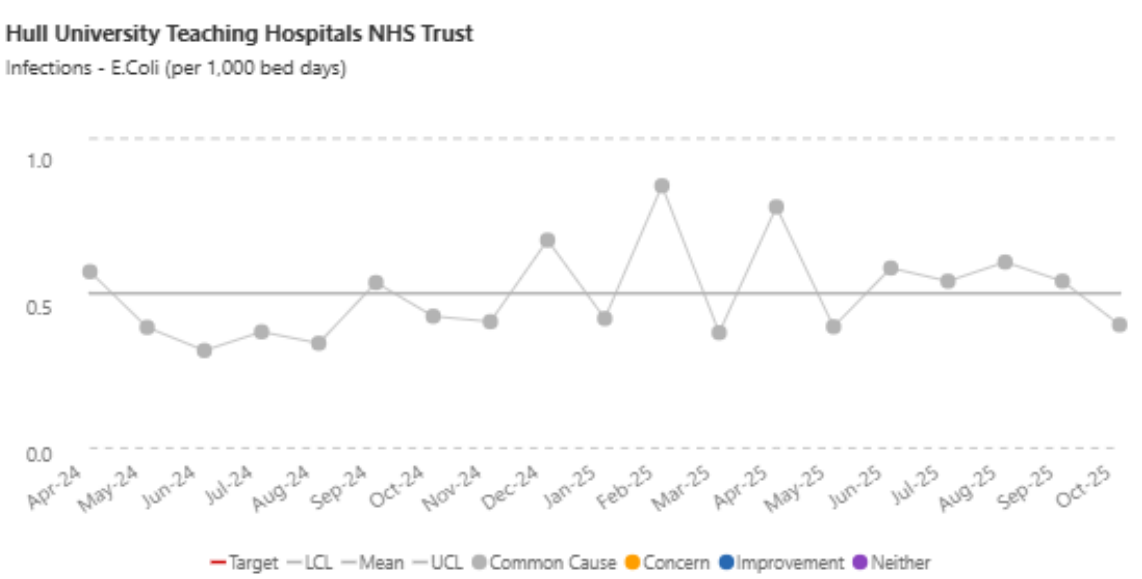
- Launch of `Back to Basics` Safety Campaign
- Standardisation of training and education across the group for IPC
- Implementation of competency assessment framework for all clinical staff
- System wide QIP to support the reduction of urinary catheter acquired infections
- Group AMS action plan focusing on correct antibiotic usage, IV to Oral switch, watch / reserve agents focusing on selecting the right drug, dose and duration
- Implementation of `Putting Patients First` ward/department accreditation programme
- Development of Vascular Device QIP
- CDI (Clostridioides difficile) Deep Dive

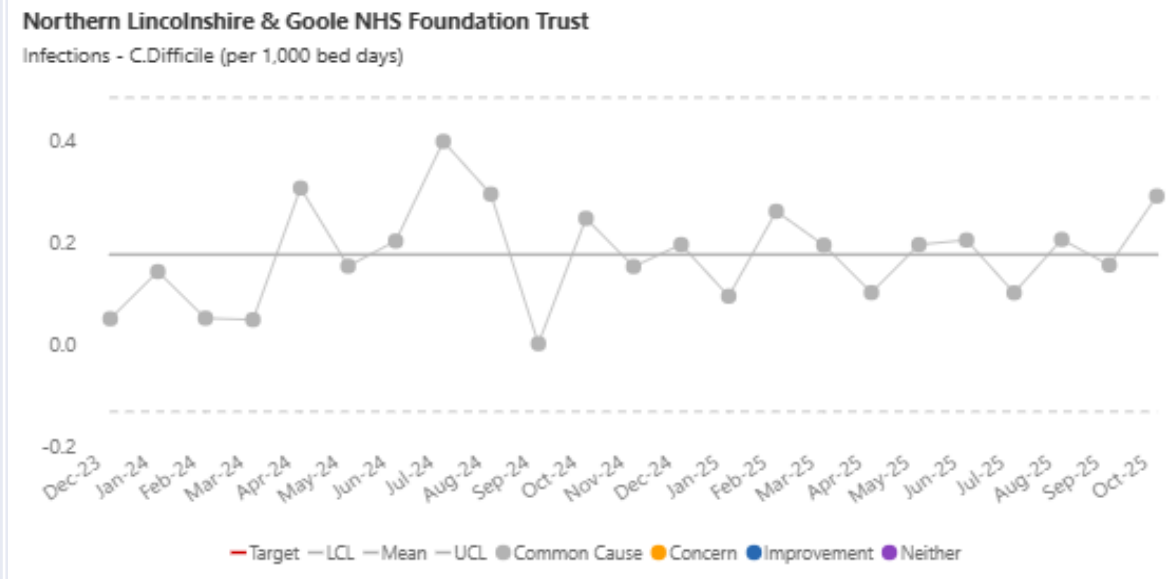
Infection control rates per 1000 bed days – C-difficile and E.Coli bateraemia

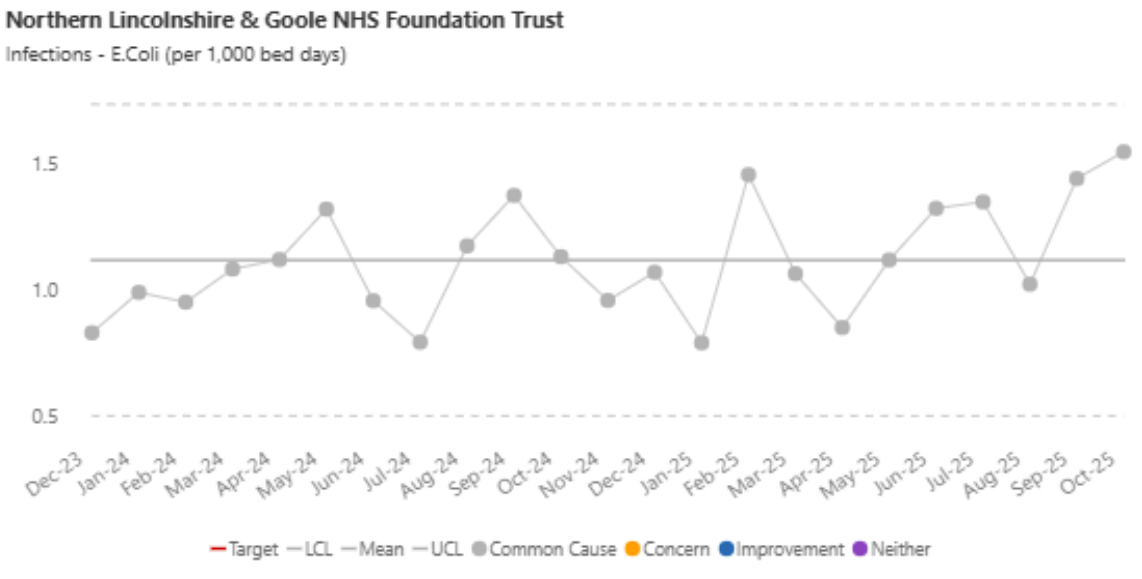
HUTH





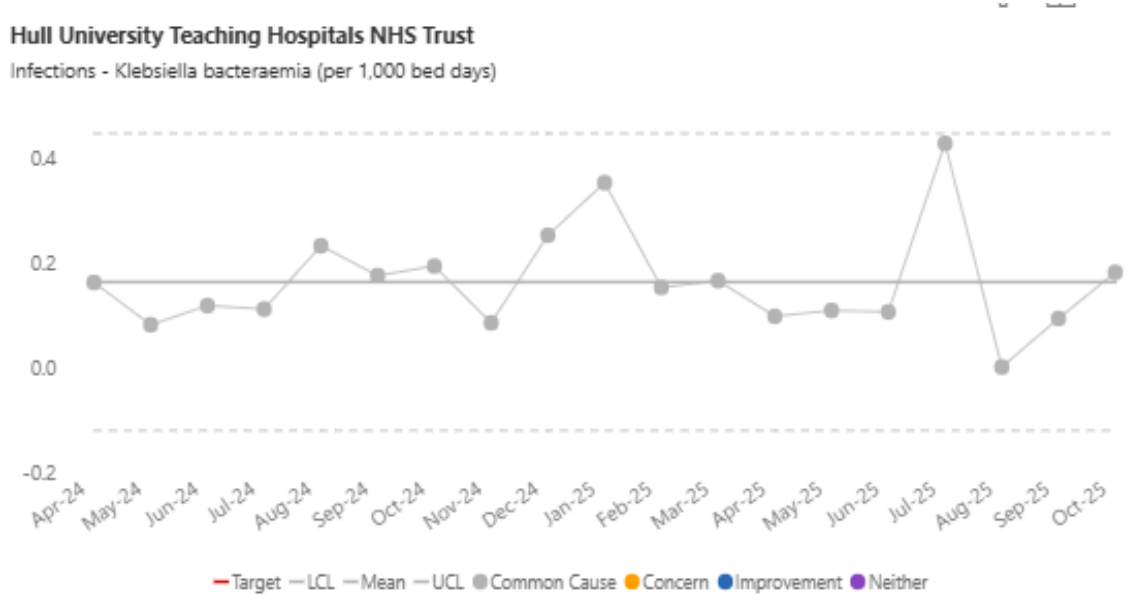
NLAG

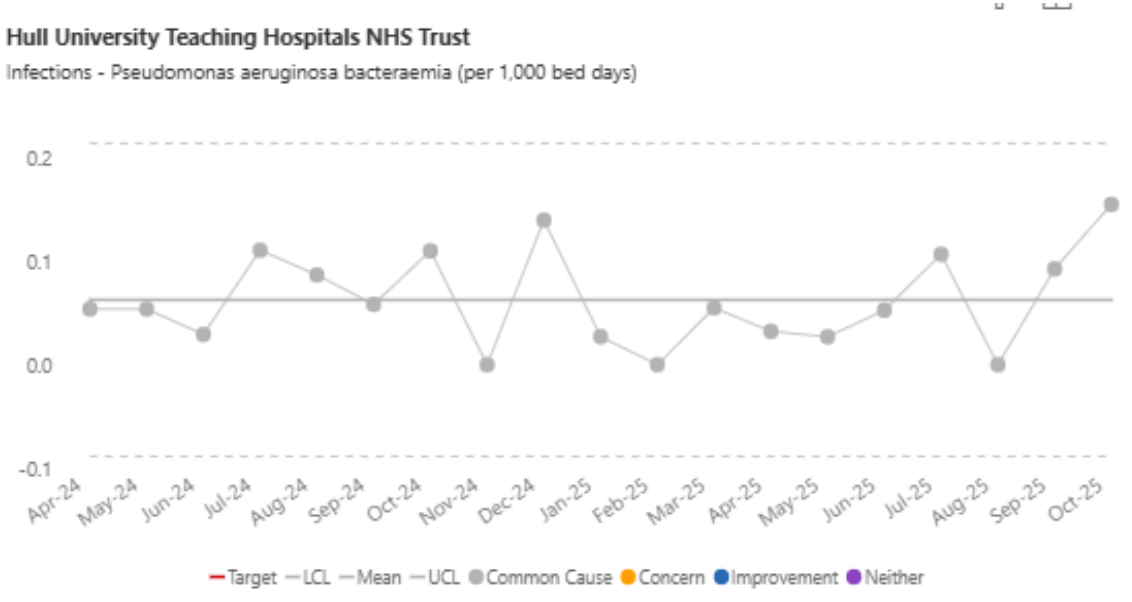




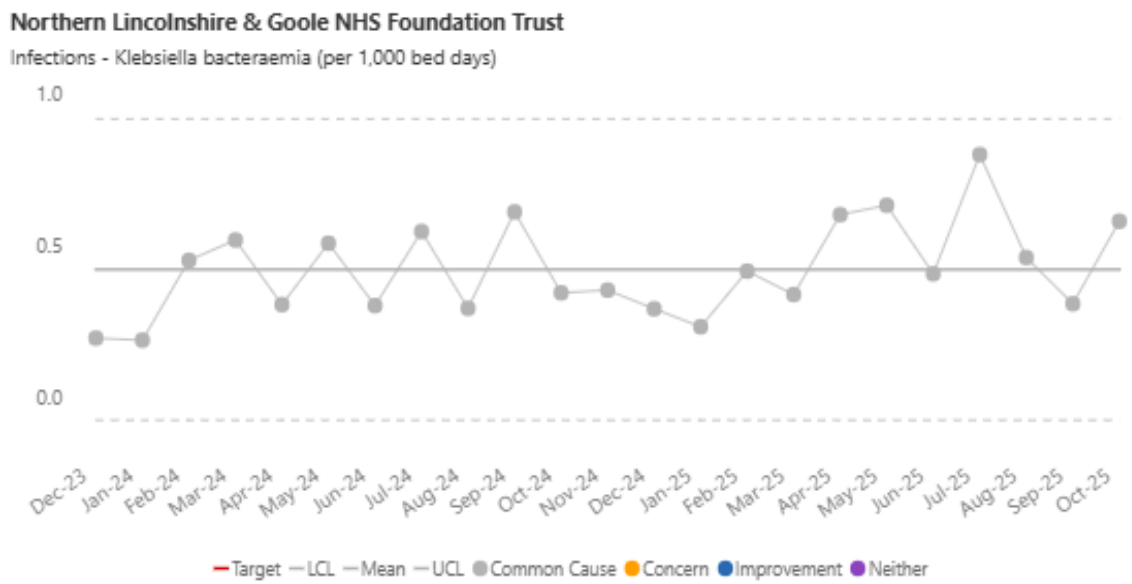
Infection control rates per 1000 bed days – Klebsiella and Pseudomonas aeruginosa bacteraemia

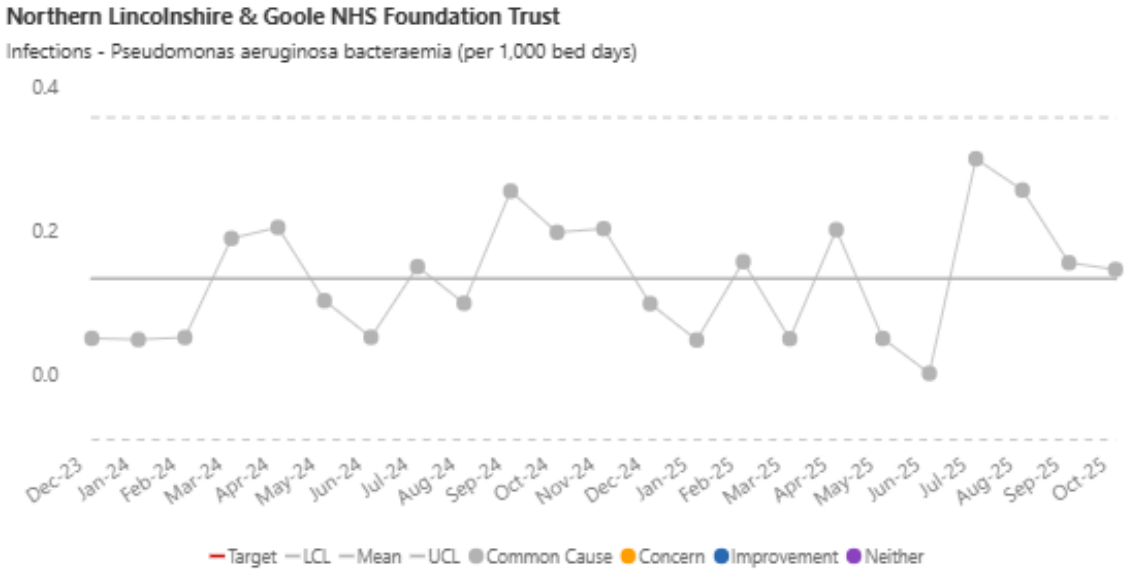
HUTH





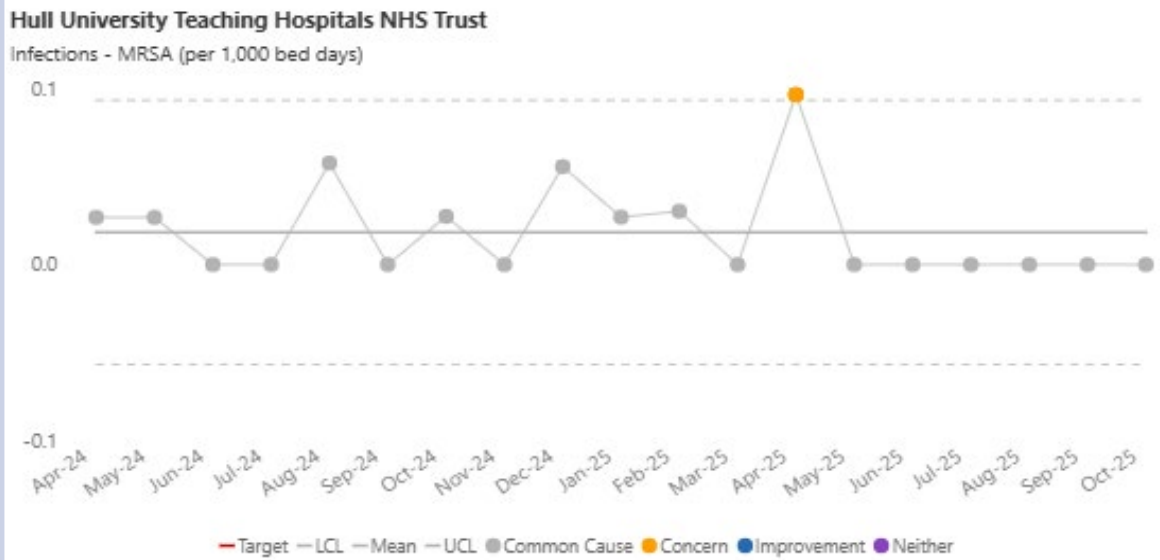
NLAG

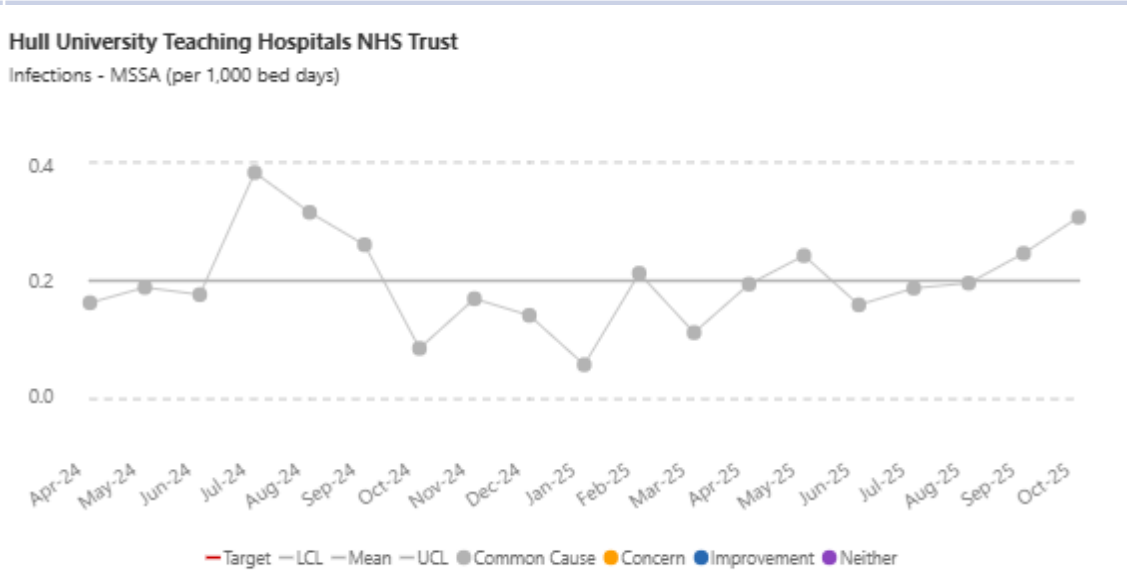




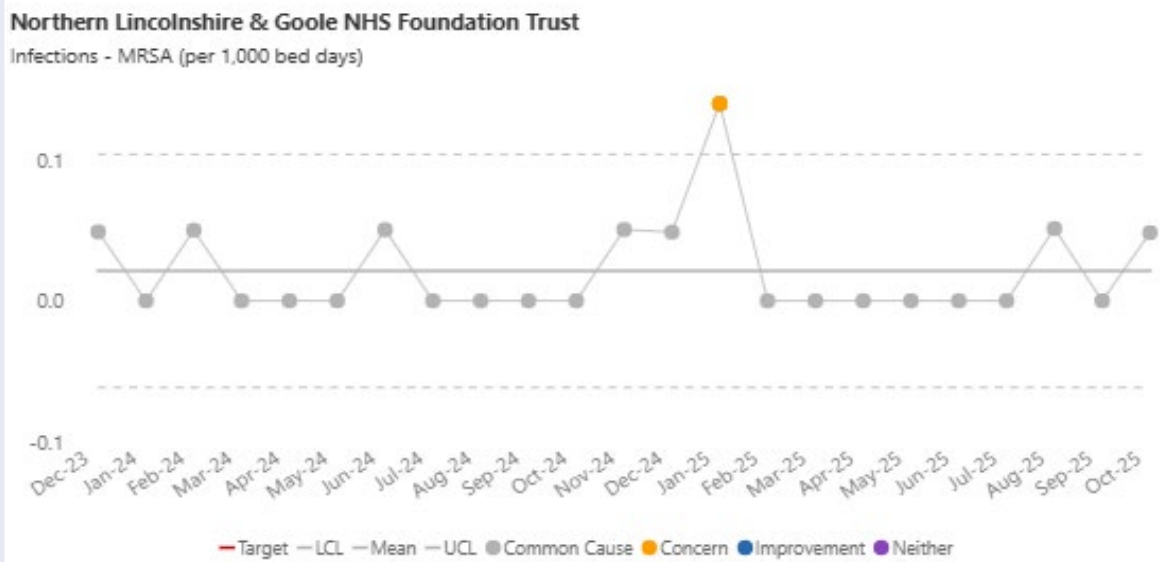
Infection control rates per 1000 bed days – MRSA and MSSA bateraemia

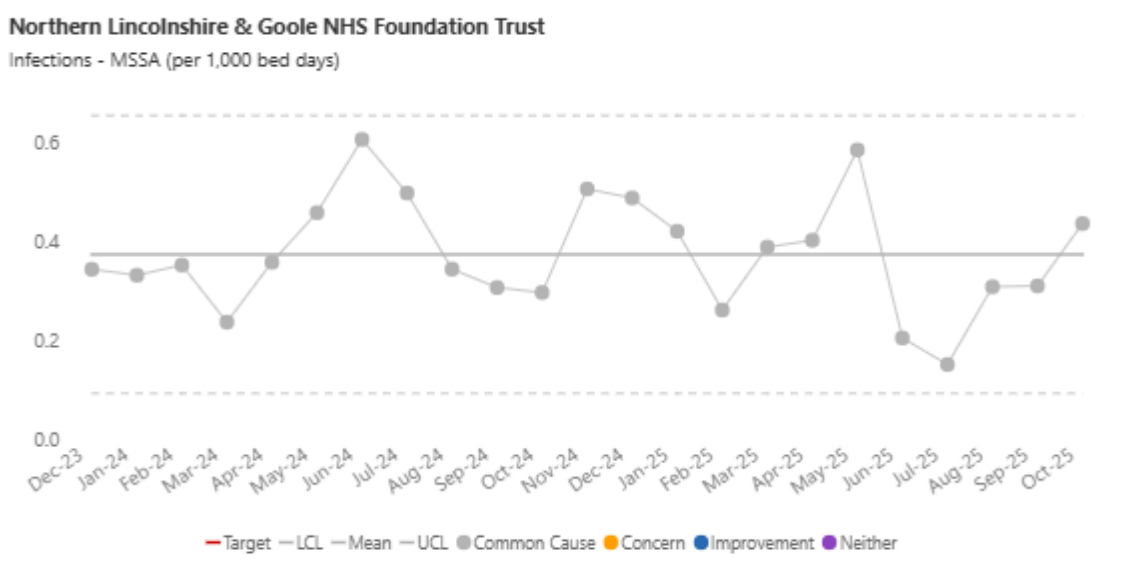
HUTH





NLAG





Glossary

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- C.difficile – clostridium difficile is a type of bacteria that can cause bowel infection
- CCS – Clinical Classification Software
- CHH – Castle Hill Hospital
- COPD – Chronic Obstructive Pulmonary Disease
- CQC – Care Quality Commission
- CT – Computerised Tomography scan, using x-ray techniques to build detailed images.
- CVP – Central Venous Pressure lines are used to monitor haemodynamic status in critically unwell patients and can also be used to provide medicines into the large veins returning blood to the heart.
- DPOW – Diana Princess of Wales Hospital, Grimsby
- E.coli – Escherichia coli are a group of bacteria that are found in the gut of nearly all people, and can cause infections if gets into new areas, such as wounds, urinary catheter sites and can cause blood stream infections.
- ED/ A&E – Emergency Department
- FFT – Friends and Family Test
- GDH – Goole District Hospital
- HHP – Humber Health Partnership
- HSMR – Hospital Standardised Mortality Ratio, a measure to assess the in-hospital death rate
- HRI – Hull Royal Infirmary
- HUTH – Hull University Teaching Hospitals NHST
- ICB – Integrated Care Board
- IPC – Infection prevention and control
- Klebsiella – Klebsiella Pneumoniae are normally harmless bacteria that are found in the gut and can cause infections in the blood stream and pneumonia.
- LFPSE – Learning from Patient Safety Events is a national database that provider organisations automatically submit patient safety incidents to from their incident reporting systems.
- MRSA – Methicillin-resistant Staphylococcus aureus, which is resistant to the normal treatments for staphylococcus infections and can be difficult to treat in wound and blood stream infections.
- Never Event/NE – Considered to be wholly preventable due to safety measures available from national safety notices and defined by the Never Event List provided by NHS England.
- NLAG – Northern Lincolnshire and Goole NHSFT
- NPSA – National Patient Safety Alert
- NRFIT – An injection connection device to specifically reduce risk of error for spine and other anaesthetic blocks.
- PALS – Patient Advice and Liaison Service
- PIR – Post Infection Review
- Pressure Ulcer/PU – Tissue damage from pressure from prolonged pressure from sitting, laying or devices causing ulceration.
- PSI – Patient Safety Incident
- PSII – Patient Safety Incident Investigation, a detailed investigation as part of the response to an incident where there may be significant learning.
- RAG – Red, Amber, Green colour coded ranking, worst to best,
- RCEM – Royal College of Emergency Medicine
- SGH – Scunthorpe General Hospital
- SHMI – Summary Hospital-level Mortality Indicator, a measure to assess the in-hospital and for 30 days following discharge death rate.
- VTE – Venous thromboembolism, linked with risk assessment and prophylaxis.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Meeting name	Trust Boards-in-Common
Meeting date	12 February 2026
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q3 current risks and scores: 1. People – 20 (8 points from its tolerable score) 2. Performance, Patients Access – 20 (11 points from the tolerable score) 3. Patients, Safety – 20 (11 points from the tolerable score) 4. Pioneer – 12 (matching tolerable score) 5. Partnerships – 12 (matching tolerable score) 6. Public Purse – 20 (8 points from the tolerable score) – this was previously a score of 16 and reflects the ongoing run-rate and potential impact on the year-end position of the Group. 7. Population – TBC BAF Risk Patients Access was reviewed at Performance, Estates and Finance CIC and it was agreed that the risk description and the tolerable risk score should be updated. Details of this is highlighted at Slide 25 of the pack.

A narrative for the Population risk has been developed and its controls, assurances and actions will be developed through the same process:

We aim to help those with the greatest needs and help everyone to live well. However, if we fail to work with partners to tackle inequity in care delivery, listen to the patient's voice and choice, and embed new models of care, we will not address growing demand and improve the life chances of those living in the most deprived communities.

For all Group risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders.

This edition introduces the use of a green flag to indicate where controls or assurances have been added. The number of controls and assurances without an indication of their strength continues to reduce with each review.

There are actions underway addressing all the listed BAF risks and a further separate paper contains a number of proposals for the BAF. Members are invited to consider the current risk score factors and

Recommendations:

The Boards-in-Common are asked to:

- Note and review the BAF risks, and specifically the increase in score to the Public Purse risk
- Note Slide 25 and the changes to the risk description of Patient – Access and the tolerable score

Background information and/or Supporting Document(s) (if applicable)	All BAF risks are updated following discussion between the Executive Team and the Group Director of Assurance.	
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.	
Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns	
Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group	
Recommended action(s) required	☑ Approval ☐ Discussion ☐ Assurance	☑ Information ☐ Review ☐ Other

Board Assurance Framework

Humber Health Partnership

Purpose of the report

The purpose of the report is to update the Committee regarding the Group's strategic culture and leadership risk. The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for the finance risk:

- The risk description;
- The risk owner/s;
- The current risk score (and whether a change from the previous report);
- The target score (the maximum acceptable);
- The optimum score; and
- The risk appetite category.

The subsequent pages additionally set out, by each risk (over three pages each):

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information) with a circle indicated for each of the risk scores; current, tolerable and target.

#2

- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Summary

NHS Humber Health Partnership

The following table summarises the 6 strategic risks facing the Group and the key aspects including their current score with current mitigations towards the target score. There are 4 risks scoring 15 or over. The risks coloured red indicate those risks scoring above the maximum score set by the appetite score.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk	Last reviewed
1	People	WEC	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.	Simon Nearney, Group Chief People Officer	20		23/09/2025	Balanced	12	8	21/01/2026
2	Patients - Access	PEF	We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.	Matt Powls, Interim Group Chief Delivery Officer	20	0	24/01/2025	Cautious	16	4	18/12/2025
3	Patients - Safety	QS	We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.	Kate Wood, Group Chief Medical Officer, Matt Powls, Interim Group Chief Delivery Officer	20		26/01/2026	Cautious	9	4	26/01/2026
4	Pioneers	QS	We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, Kate Wood, Group Chief Medical Officer	12		05/09/2025	Open	12	4	02/12/2025
5	Partnerships	SPP	We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.	Lyn Simpson, Interim Group Chief Executive Officer, Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	12		28/04/2025	Balanced	12	4	09/10/2025
8	Public Purse	PEF	We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.	Emma Sayner, Group Chief Financial Officer	20	4	27/01/2026	Open	12	9	27/01/2026

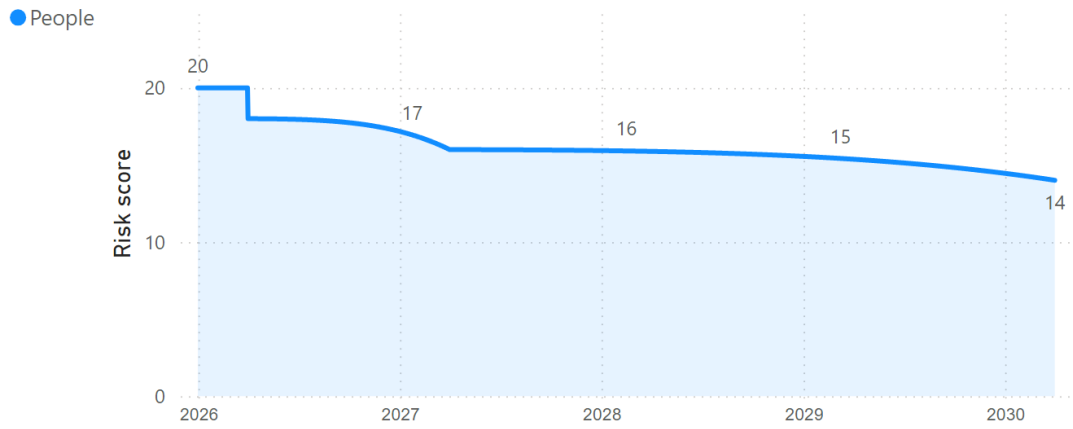
1. People

The strategic risk affecting our objective, 'People' is led by Simon Nearney, Group Chief People Officer and reported to the Workforce, Education and Culture Committees-in-Common. Under the risk category of People, the risk's current score is 20 and its score last changed on 23/09/2025. The actions were last reviewed on 21 January 2026. In full, the risk is:

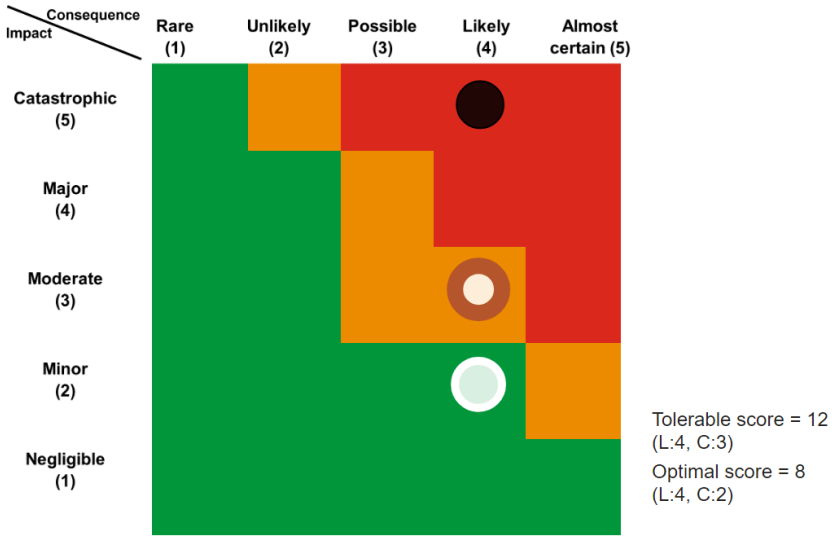
We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.

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

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



Current score and risk appetite



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

Optimal score = 8 (L:4, C:2)

Risk appetite statement (Balanced)

Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

1. People

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

Control	Rating
Annual Care Group Workforce plans	Limited
Care Group Performance and Accountability	Limited
CESR Programme	Significant
Clinical Poiicy Group (CPG)	Limited
Cultural transformation programme	Limited
EDI Steering Group	Reasonable
E-Rostering for clinical staff	Reasonable
Executive Team	Limited
Group Leadership Strategy	Limited
Group People Strategy 2025-28	Reasonable
International recruitment drives	Reasonable
Medical Workforce Strategy 2025-28	Limited
Required Learning Steering Group	Reasonable
Resident Doctor 10 Point Plan Oversight Delivery Group	Reasonable
Senior Leadership Team (SLT)	Limited
Talent management team for international recruitment	Limited
Vacancy Control Panel	Reasonable
Workforce Transformation Group	Reasonable

Gaps in control (and Action ID)	6	7	8	69	Total
Hard to recruit roles in medical specialities		✓	✓		2
Instability among Board-level leadership					1
Low clinical engagement across specialities and Group					1
Management and Leadership consistency in delivering the People Promise to staff			✓		1
Sufficient attraction, to recruit and retain staff to work in the area		✓	✓	✓	3
Total	1	2	2	2	1	8

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

Source	Assurance	Rating
Internal	Bi-annual Safer Staffing Report	Limited
Internal	Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	Reasonable
Internal	Educational Governance for Undergraduate Medical Education and Physician Associate Education	Reasonable
External	External Safer Staffing report on application of model	Reasonable
Internal	Guardian of Safe Working Hours Report (HUTH)	Reasonable
Internal	Guardian of Safe Working Hours Report (NLAG)	Limited
Internal	Integrated Performance Report	Reasonable
Internal	Job Planning compliance rate	Reasonable
Internal	Mandatory training levels	Limited
Internal	Never events	Limited
Internal	Organisational Development Updates	Reasonable
External	Staff survey and quarterly pulse surveys	Limited
External	Workforce Report to Pay and Agency meetings	Reasonable
External	WRES / WDES reports	Limited
Internal	XXX - Apprenticeship Levy Annual Report	Reasonable

Assurance gaps (and Action ID)	7	Total
Frequent culture and staff experience measures	✓	1
Lack of assurance re short term additional hours / overtime from Care Groups	✓	1
Manual triangulation of KPIs across Care Groups, Corporate and locations	✓	1
Plans to address ageing workforce profile	✓	1
Poor levels of mandatory training compliance		1
Total	4	1	5

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

1. People

NHS Humber Health Partnership

The table below details the 4 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
6	Recruitment drives using the Group values to attract high calibre candidates - focussed on medical staff and other key areas	31/03/26	01/04/26	Focus currently on medical staff.	21/01/26	Simon Nearney, Group Chief People Officer	Significant
7	Cultural Transformation action plan development	31/03/26	01/04/30	People First programme to evolve and support Safety agenda	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable
8	Group Leadership network and training programme	30/12/25	01/04/27	New leadership programme for the Group ongoing (bitesize programme). Putting People First in Q2 phase. Focus required on strengthening performance management and transformation whilst balancing support to staff where required.	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable
69	Development of Executive Team programme of development	31/03/27	31/03/27	Draft plan agreed	21/01/26	Simon Nearney, Group Chief People Officer	Limited

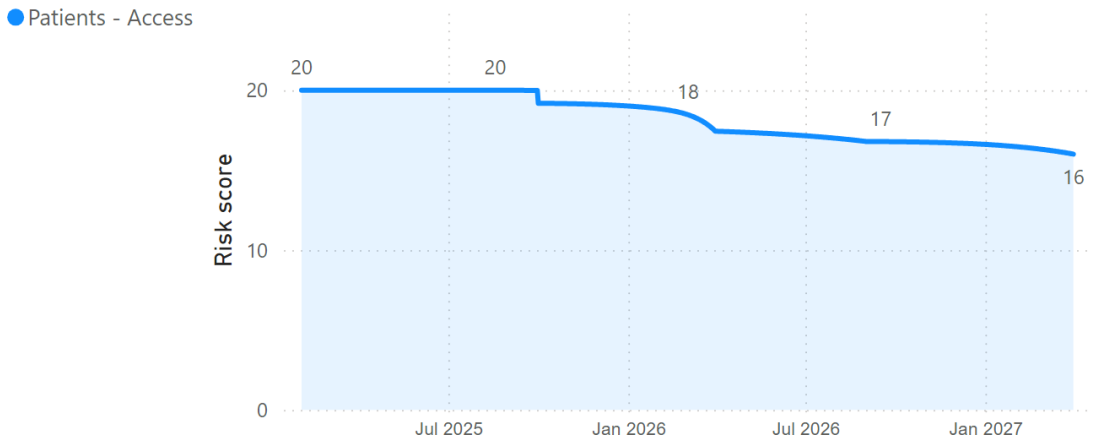
2. Patients - Access

The strategic risk affecting our objective, 'Patients - Access' is led by Matt Powls, Interim Group Chief Delivery Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Patients - Access, the risk's current score is 20 and its score last changed on 24/01/2025. The actions were last reviewed on 18 December 2025. In full, the risk is:

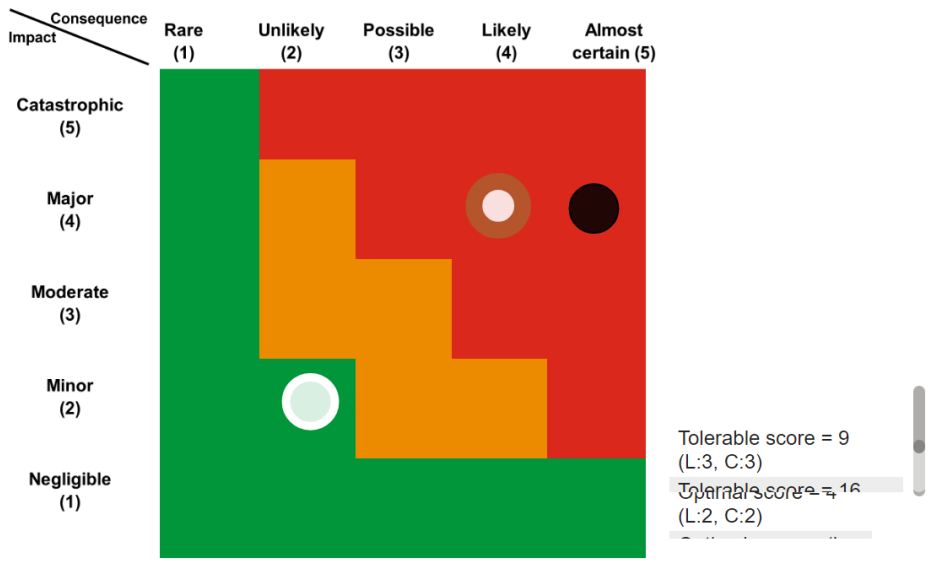
We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.

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

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



Current score and risk appetite



Risk appetite statement (Cautious)

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

2. Patients - Access

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

Control	Rating
Care Group Performance and Accountability	Limited
Daily / weekly PTL meetings (cancer and elective)	Significant
Financial Planning Improvement Board	Limited
Flow programme	Limited
National performance framework for support and scrutiny	Reasonable
Operating plan 2025-26	Limited
Planned Care Board	Limited
Tier 1 review processes - UEC, Cancer, Elective and Diagnostics	Reasonable
Unplanned Care Board	Limited

Gaps in control (and Action ID)	37	68	Total
Challenge in resolving numerous national expectations / targets with available finance, space and resources, degrading or overriding control	✓		1
Inert behaviour towards addressing system solutions by ICB	✓		1
Lack of positive medical engagment in delivery	✓		1
Lack of sufficient capacity to identify and implement service improvement gains from exemplar sites or best practice	✓		1
Weak culture of improvement/change management and siloed working	✓	✓	2
Total	3	2	1	6

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

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

Assurance gaps (and Action ID)	20	42	53	Total
Absence of a sophisticated demand and capacity (bed) model that supports scenario analysis and planning	✓		✓	2
Absence of routine data quality monitoring and patient record validation		✓		1
Total	1	1	1	3

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

2. Patients - Access

NHS Humber Health Partnership

The table below details the 5 actions underway to reduce the current risk score of 20. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
20	Strategic Bed Review (based on optimum LoS)	31/01/25	01/09/26	Being developed by BI team in conjunction with clinical and operational colleagues	18/12/25	Adam Creeggan, Group Director of Performance, Matt Powls, Interim Group Chief Delivery Officer	Reasonable
37	Developing skills and capability of Care Group leadership to support D&C planning and associated operational tasks	31/03/26	01/04/27	B7 to 8b ops courses made available but yet to identify recurrent resources to support	18/12/25	Simon Nearney, Group Chief People Officer, Matt Powls, Interim Group Chief Delivery Officer	Limited
42	External PTL validation exercise (using AI) to help cleanse PTL and ensure future booking capacity is optimised	30/09/25	01/10/25	Lunar Rover being implemented and benefits still to be realised	18/12/25	Adam Creeggan, Group Director of Performance	Limited
53	Develop and embed Care Group integrated plans aligning expendture, activity and workforce	31/05/25	31/03/26	Set clear and individual objectives across domains of finance, activity and workforce	18/12/25	Emma Sayner, Group Chief Financial Officer, Matt Powls, Interim Group Chief Delivery Officer	Reasonable
68	Separation and clarification of north and south operations where structural change is not required e.g. bed meetings	31/12/25	31/03/26	Weekly PTL meetings in place and reinvigorated	18/12/25	Matt Powls, Interim Group Chief Delivery Officer	Reasonable

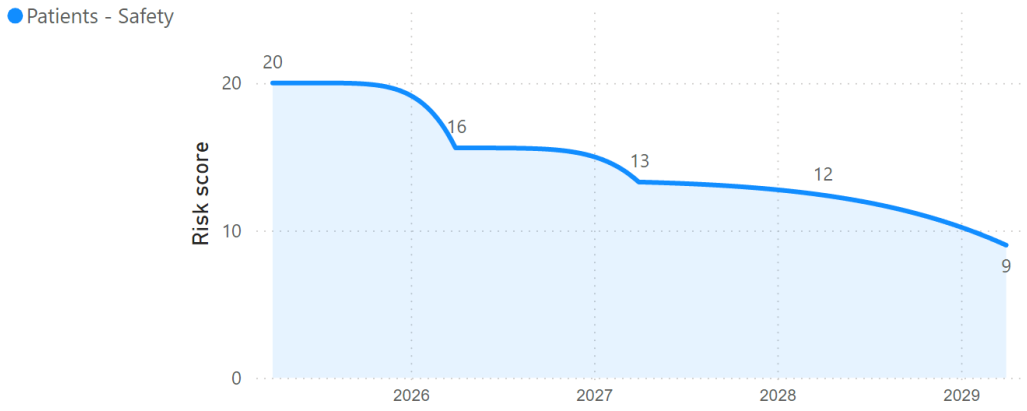
3. Patients - Safety

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

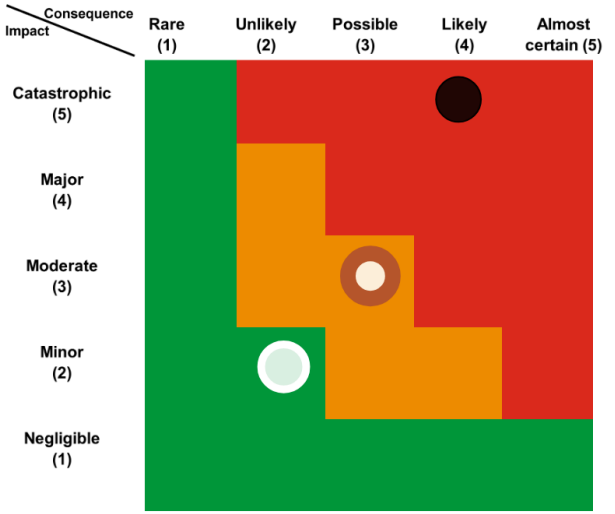
We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Cautious)

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

3. Patients - Safety

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

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

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

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

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

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

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

3. Patients - Safety

NHS Humber Health Partnership

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

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

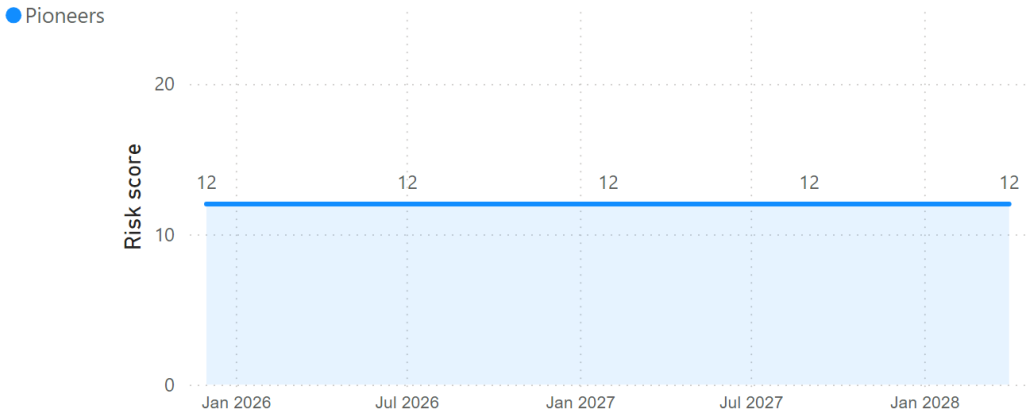
4. Pioneers

The strategic risk affecting our objective, 'Pioneers' is led by Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer; Kate Wood, Group Chief Medical Officer and reported to the Quality and Safety Committees-in-Common. Under the risk category of Pioneers, the risk's current score is 12 and its score last changed on 05/09/2025. The actions were last reviewed on 02 December 2025. In full, the risk is:

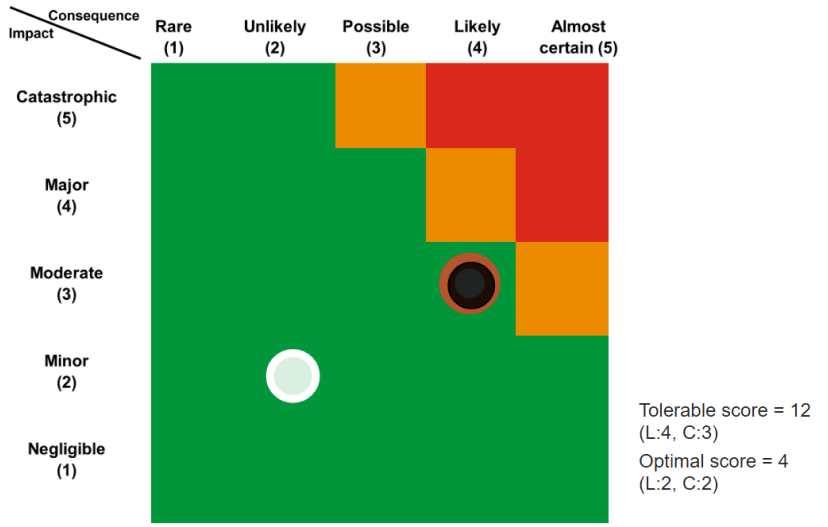
We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.

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

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



Current score and risk appetite



Risk appetite statement (Open)

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

4. Pioneers

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

Control	Rating
Available research service capacity eg labs	Limited
Business cases for investment / disinvestment decisions	Limited
Digital governance group	Reasonable
Digital Strategy	Significant
EPR Programme Board	Reasonable
Financial clarity over existing research resources	Reasonable
Financial management education for directors and budget holders	Reasonable
Financial Strategy	Limited
Full EPR Business Case	Limited
ICB / CAP Digital Governance	Limited
Innovation infrastructure	Limited
Long term Financial Model	Limited
Outline EPR Business case	Significant
Protected time	Limited
Research and innovation strategy	Significant
Research Committee	Reasonable
Senior digital leadership team	Reasonable
Senior research team	Reasonable

Gaps in control (and Action ID)	56	57	64	65	66	70	Total
Insufficient capacity within research team for expansion	✓						1
Lack of comprehensive digital asset register				✓			1
Lack of comprehensive oversight of all digital investment and management			✓	✓			2
Lack of innovation infrastructure		✓					1
Out of date Long Term Financial Model inc investments					✓		1
Research resources being part of CIP	✓						1
Weak commercial and contractual grip and control	✓						1
Weak culture of improvement/change management and siloed working	✓	✓	✓		✓	✓	5
Total	2	2	2	2	2	1	13

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

Source	Assurance	Rating
External	DSPT IA led	Limited
External	External agency visit and inspection reports	Limited
External	External support to the EPR programme	Reasonable
External	North Yorkshire and Humber Research Delivery Network reports	Reasonable
External	Numerous research publications	Reasonable
Internal	Self-assessment of CAF	Reasonable

Assurance gaps (and Action ID)	56	57	Total
Gaps in financial tracking and funding	✓		1
Lack of available protected time for research	✓		1
Lack of skilled resources to develop innovation	✓	✓	2
Poor framework to assess digital procurement performance and security	✓		1
Weak understanding and resources from ICB and broader external relationships	✓		1
Total	3	2	1	6

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

4. Pioneers

NHS Humber Health Partnership

The table below details the 6 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
56	Launch and continuous support via Comms to Partnership over R&I strategy	31/03/26	31/03/28	Post Board approval, discussing with Comms launch support	05/09/25	Kate Wood, Group Chief Medical Officer	Reasonable
57	Pilot Innovation Hub (12 month period)	31/05/26	31/05/26	Project manager appointed (and a lead professor), started Nov 2025	02/12/25	Kate Wood, Group Chief Medical Officer	Reasonable
64	Digital Foundations Business case	30/11/25	30/09/26	financial profile piece - no template readily available for 5 year investment	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Limited
65	Centralisation of digital resource, governance and oversight, including a single group-wide asset register	31/03/26	31/03/27	Paper to Execs (Sep)	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Limited
66	EPR Full Business case production	28/02/26	31/03/28	Progressing well	05/09/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Reasonable
70	Development of LISA	31/03/27	31/03/28	Part of the Improvement Plan	21/01/26	Simon Nearney, Group Chief People Officer	Significant

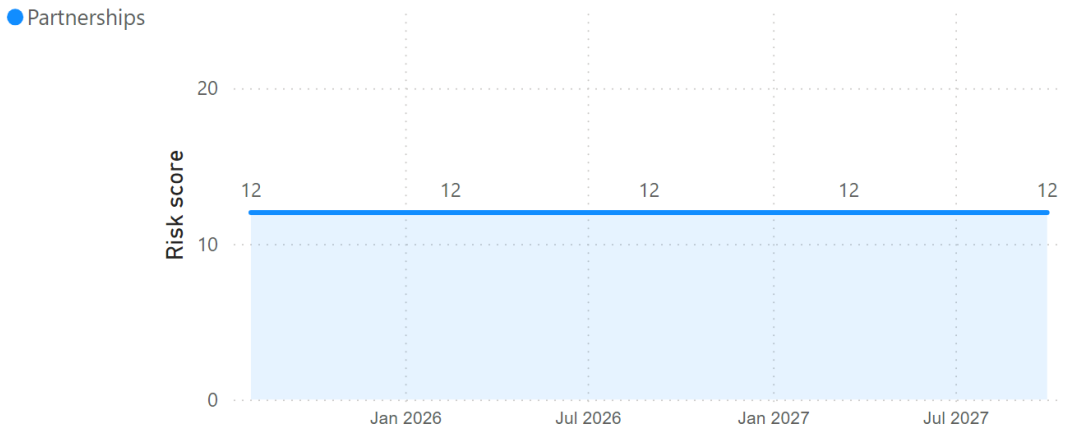
5. Partnerships

The strategic risk affecting our objective, 'Partners' is led by Lyn Simpson, Interim Group Chief Executive Officer; Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer and reported to the Strategic Programmes and Partnerships Committees-in-Common. Under the risk category of Partnerships, the risk's current score is 12 and its score last changed on 28/04/2025. The actions were last reviewed on 09 October 2025. In full, the risk is:

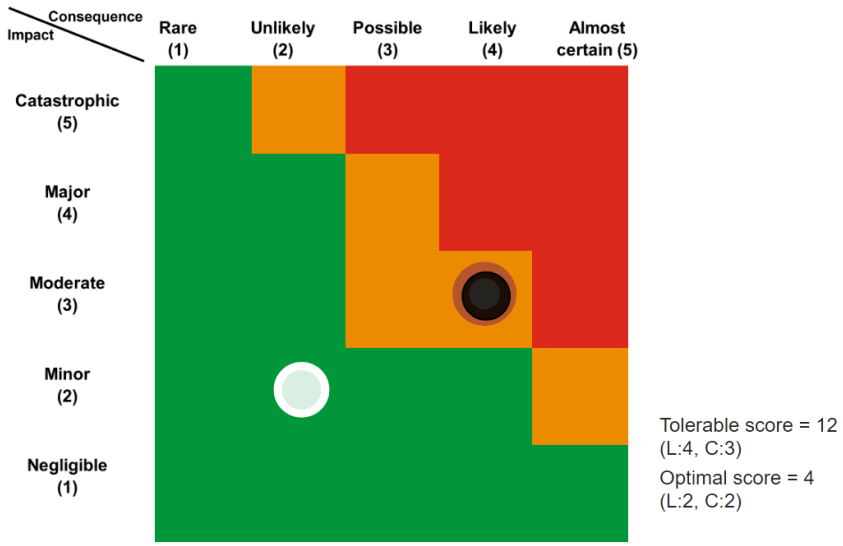
We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our offer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.

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

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



Current score and risk appetite



Risk appetite statement (Balanced)

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

5. Partnerships

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

Control	Rating
Goole service review	Reasonable
Health and Overview Scrutiny Committees	Reasonable
Humber and North Yorkshire Collaboration of Acute Providers	Limited
Integrated Care Board	Limited
Place Boards	Limited

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	✓	1
Lack of continuous leadership plus inconsistent engagement across region	✓	1
Lack of ICB partnership strategy and identification of common opportunities and priorities	✓	1
Lack of integrated CAP strategy despite workplan (limited progress)	✓	1
Low system wide infrastructure to implement Goole plan	✓	1
Variable quality of engagement with Place Boards	✓	1
Total	**4**	**6**

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

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

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	✓	1
Weak partnership approach embedded in Group strategies	✓	1
Total	**2**	**2**

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

5. Partnerships

NHS Humber Health Partnership

The table below details the 2 actions underway to reduce the current risk score of 12. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
32	Develop and publish partnership strategy	31/07/25	30/09/27	On course for completion, undergoing futher review to ensure alignment with the Ten Year Plan	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer	Significant
59	Align partership reporting to governance arrangements internally	30/09/25	31/03/26	Changes to Committees in Common, Capital and Major Projects to become Strategic Partnerships and Programmes - will ensure greater visibility of partnerships working going forward	09/10/25	Andy Haywood, Group Chief Strategy, Partnerships and Digital Officer, David Sharif, Group Director of Assurance	Reasonable

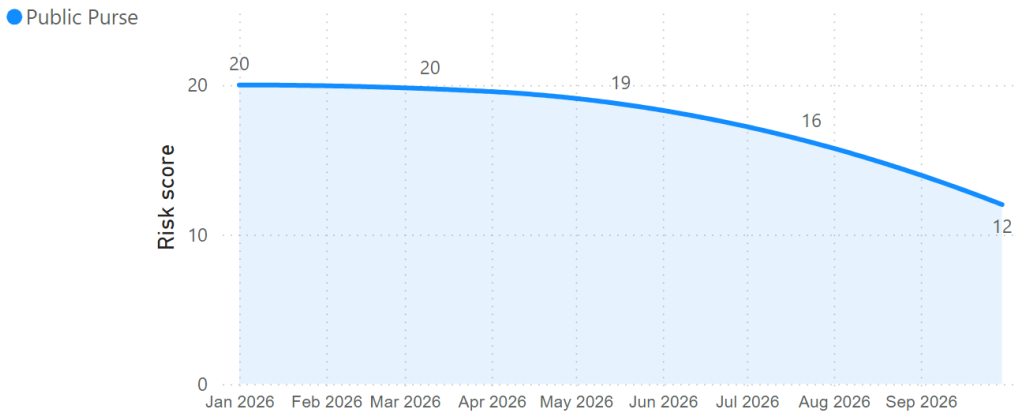
6. Public Purse

The strategic risk affecting our objective, 'Public purse' is led by Emma Sayner, Group Chief Financial Officer and reported to the Performance, Estates and Finance Committees-in-Common. Under the risk category of Public Purse, the risk's current score is 16 and its score last changed on 27/01/2026. The actions were last reviewed on 27 January 2026. In full, the risk is:

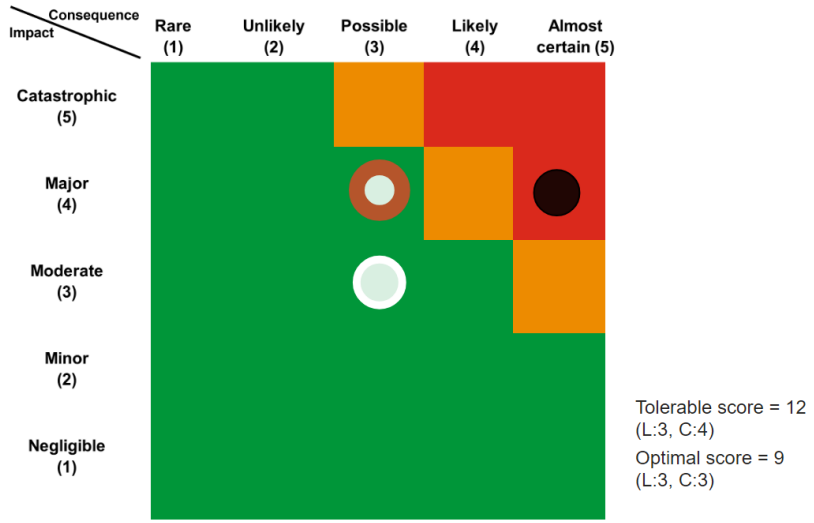
We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

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

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



Current score and risk appetite



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

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

Risk appetite statement (Open)

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

6. Public Purse

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

Control	Rating
Agency Approval Panel	Reasonable
Board capability and education	Reasonable
Budgetary control system	Reasonable
Business cases for investment / disinvestment decisions	Limited
Care Group Performance and Accountability	Limited
Cash management controls	Significant
Cost Improvement Programme	Limited
Financial management education for directors and budget holders	Reasonable
Financial Planning Improvement Board	Limited
Financial Strategy	Limited
High functioning Finance department advice and guidance	Reasonable
ICS finance model	Reasonable
Long term Financial Model	Limited

Gaps in control (and Action ID)	22	33	35	36	Total
Absence of comprehensive Estates Strategy / 10-year plan	✓				1
Absence of Group Clinical Strategy	✓				1
Absence of Group Finance Strategy founded on clinical and estates strategies		✓			1
Fragmented systems and processes for financial control, planning and safety					1
Instability among Board-level leadership					1
Lack of accountability and consequence for non-delivery					1
Lack of understanding of current financial pressure and need to live within means			✓	✓	2
Out of date Long Term Financial Model inc investments		✓			1
Sustainable PMO / CIP Engine room capability to deliver transformation and financial savings	✓				1
Weak culture of improvement/change management and siloed working			✓	✓	2
Total	6	1	1	2	2	12

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

Source	Assurance	Rating
Internal	2025-26 Operational Plan Assurance Statement	Limited
Internal	Budget control reports	Reasonable
Internal	Exception reporting on Standing Financial Instructions and Standing Orders compliance	Reasonable
Internal	FPIB and PMO reporting on transformation and run-rate	Limited
External	Internal audit review of key financial systems	Reasonable
Internal	In-year operational plan progress	Limited
External	NHSE external assurance reviews	Reasonable
Internal	Service Line Reporting	Limited
Internal	Vacancy control and Discretionary Spend Panel	Reasonable
Internal	Workforce planning updates	Reasonable

Assurance gaps (and Action ID)	Total
SLR not fully developed and embedded	✓	1
Total	1	1

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

6. Public Purse

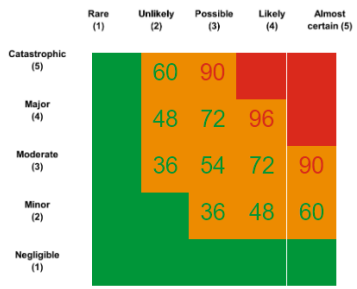
NHS Humber Health Partnership

The table below details the 6 actions underway to reduce the current risk score of 16. The completion date is the estimated date for the action to be substantively ended or become a business as usual activity. The benefits date is the point at which there is no more risk reduction anticipated from the action. A closed action may continue to contribute to a risk score reduction, hence its inclusion here where appropriate. Where a primary action is true, it contributes to the risk reduction trajectory shown earlier.

ID	Action	Completion date	Benefits date	Update	Last updated	Action owner/s	Delivery assurance
22	Develop a five-year long term financial model and strategy	31/03/27	31/03/27	Linked to Operational Plan (three-year plan provides financial model) and Finance strategy development. Planning to form part of the Stabilisation / Transitional Plan development.	27/01/26	Emma Sayner, Group Chief Financial Officer	Reasonable
33	Business Case Compliance and Recommending Groups to engage and prioritise clinical and operational future developments	31/12/25	30/09/26	Both now fully operational. Review of progress to be undertaken in six months	27/01/26	Emma Sayner, Group Chief Financial Officer	Significant
35	Utilise the Care Group Performance and Accountability Groups to focus and deliver on transformation and accountability	31/03/26	31/03/27	Pending ValueCircle assessment, likely area to strengthen	27/01/26	Matt Powls, Interim Group Chief Delivery Officer	Limited
36	Develop a positive challenge culture within Finance e.g. to query why we do things and where we need add value	31/03/26	30/09/26	Directorate team meeting used to feedback issues and take group-wide actions	27/01/26	Emma Sayner, Group Chief Financial Officer	Reasonable
62	Workforce pay and agency control programme	31/03/26	31/03/26	Triple lock in place plus internal arrangements established to approve pay spend.	27/01/26	Emma Sayner, Group Chief Financial Officer, Simon Nearney, Group Chief People Officer	Limited
63	Corporate services efficiency programme	31/03/26	31/03/26	Progress becoming more complex and lengthy. People Services reducing staff (thereby giving leaders less capacity to transform)	21/01/26	Simon Nearney, Group Chief People Officer	Reasonable

Risk Appetite Statement

Risk category	Current risk appetite level	Risk appetite statement
Clinical Quality and Safety	Cautious	Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.
Financial / Value for Money	Open	Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.
Partnership	Balanced	Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.
Transformation delivery	Open	Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.
Workforce	Balanced	Our staff are the most important ingredient to deliver safe and effective care to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity,



Board Assurance Framework
Next steps and recommendations

Next steps

Audit, Risk and Governance Committees-in-Common received a detailed presentation on 24 April 2025 on the status and actions being taken to strengthen the Group's risk management system. This included a proposed format for future risk reporting to the Board (in support of the BAF) and to CiCs. This will include the development of a commentary on the high-scoring Group-wide risks. The advent of the single group-wide risk register will support this development in future reporting.

The management of the high-level risks will continue to be assessed through the Care Groups, corporate Directorates and the Risk and Compliance Group and the escalation processes in place. The Risk and Compliance Group will inform group-wide risks to the Group Risk and Assurance Committee before their adoption by corporate leads.

The Executive Team will continue to review their strategic risks between CICs and the Group Cabinet Risk and Assurance Committee will recommend any changes to risk ratings or BAF risks to the CICs. Final decisions will be made at the Boards-in-Common.

Recommendations

The Boards-in-Common are asked to:

- Note and review the BAF risks, and specifically the increase in score to the Public Purse risk
- Note Slide 25 and the changes to the risk description of Patient – Access and the risk appetite

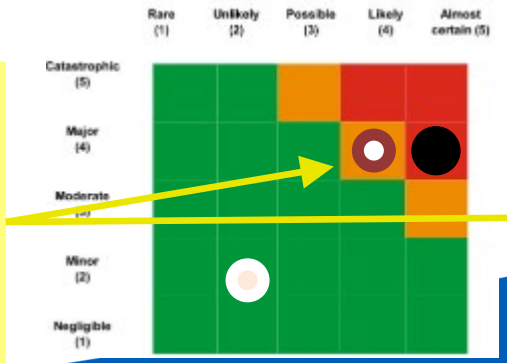
Appendix 1: Patient – Access

On 12 December, Boards-in-Common approved the change of the risk appetite for the Patient Access risk from being open (16) to becoming cautious (9) as shown below. This means that the tolerable score is 11 points below the actual risk score.

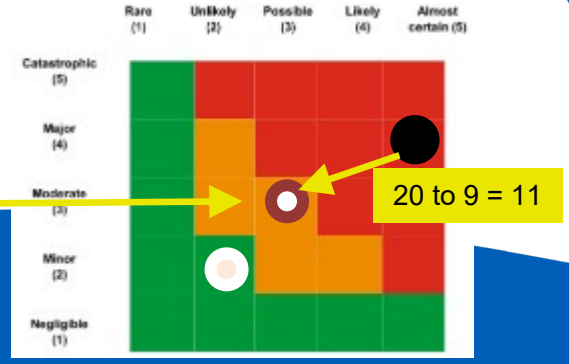
Patients – Access risk: The Chairs of Performance, Estates and Finance CIC also requested a change to the risk description as they believe that achieving the upper quartile in the current climate is unrealistic.
The following was proposed: *We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to care they need, when they need it.*

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

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



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



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)039

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	12 February 2026
Director Lead	Emma Sayner, Group Chief Financial Officer David Sharif, Group Director of Assurance
Contact Officer / Author	Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Audit, Risk and Governance Committees-in-Common Terms of Reference – NLAG and HUTH**
Executive Summary	The annual review of the Audit, Risk and Governance Committees-in-Common (ARG CiC) Membership and Terms of Reference (ToR) is scheduled for January each year on its annual work plan. The ARG CiC's ToR were last updated for minor amendments in January 2025, which were subsequently approved at the February 2025 Trust Boards-in-Common meeting. As a result of this latest review a limited number of minor changes were proposed and approved by the ARG CiC at its meeting on 22 January 2026 and are tracked for ease of reference on the attached. **The Trust Boards-in-Common are asked to approve the proposed changes to the Audit, Risk and Governance Committees-in-Common Terms of Reference for both organisations.**
Background Information and/or Supporting Document(s) (if applicable)	Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024)
Prior Approval Process	ARG CiC meeting – 22 January 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:

Northern Lincolnshire and Goole NHS Foundation Trust

Group Corporate Assurance Directorate

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	GT011
Version:	1.2
This version issued:	~~07/03/25~~
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	~~13/02/25~~
Approving body:	Trust Boards-in-Common
Date for review:	January, 2027~~6~~
Owner:	~~Sean Lyons,~~ Group Chair
Document type:	Terms of Reference
Number of pages:	18 (including front sheet)
Author / Contact:	Emma Sayner, Group Chief Financial Officer / David Sharif, Group Director of Assurance

NHS Humber Health Partnership (Hull University Teaching Hospitals NHS Trust & Northern Lincolnshire and Goole NHS Foundation Trust) actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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

United by Compassion:
Driving for Excellence

1.0 Purpose

1.1 The role of the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Audit, Risk & Governance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Audit, Risk & Governance Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The **Audit, Risk & Governance Committee-in-Common** is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee. The committee is also authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

3.0 Accountability & Reporting Arrangements

3.1 The **Audit, Risk & Governance Committee-in-Common** is accountable to the NLaG Trust Board and shall report to the board on how it discharges its responsibilities.

3.2 The minutes of each meeting shall be submitted to the next meeting for formal approval as a true record of that meeting. The approved minutes will be submitted to the next meeting of the board for information.

3.3 The **Audit, Risk & Governance Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting highlighting issues that require disclosure to the board or require executive action.

3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

3.5 The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

3.6 The committee's annual report and workplan will also be submitted to the Council of Governors for information.

4.0 Responsibilities

4.1 The specific duties & responsibilities of the committee are categorised as follows:

4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Test.

- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets Global Internal Audit Standards (GIAS, effective from 9.1.2025) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, which is consistent with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- Reviewing the Internal Auditor's annual report before its submission to the Board.

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with GIAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate).

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

4.5 Financial Reporting

4.5.1 The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

4.5.2 The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.5.3 The committee shall review the annual report and financial statements before submission to the board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

4.6 Risk Management

4.6.1 The committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies.
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks.
- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.
- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties, and as such the ~~Audit C~~committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the ~~Audit C~~committee will need and where these will come from.

4.7 The Board will however retain the responsibility for routinely reviewing specific risks.

4.8 Counter Fraud

4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. These may include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management. The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common

- Workforce, Education & Culture Committees-in-Common
- Health Tree Foundation Trustees' Committee
- ~~Capital & Major Projects~~Strategic Programmes & Partnerships Committees-in-Common
- Remuneration Committee – Annual Summary report only
- ~~Ethics Committee (when in operation)~~

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust board or other groups within NLAG, as appropriate.

4.12 Summary Scope

4.12.1 In summary, ~~to~~the committee will cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Charitable Funds governance arrangements
- Counter Fraud
- Data Quality
- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control
- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation
- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience. One of the members will be nominated as vice chair of the committee.

5.1.2 The Cchair of the Trust and the Group Chief Executive shall not be members of the committee. However, they may be invited to attend a meeting by the committee Chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.2.3 An invitation to join the committee as an attendee in an observer capacity with will be extended to a governor.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable.

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their item(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year, members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and ~~jointly~~ alternate in chairing the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between NLaG and HUTH, both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of ~~one or~~ both Non-Executive Director chairs, one of the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will ~~jointly~~ chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members. Associate Non-Executive Directors will not form part of the quorum.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions (dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

7.0 Equality Act (2010)

7.1 NHS Humber Health Partnership is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

7.2 The Partnership is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

7.3 The Partnership aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

7.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

8.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this terms of reference, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to either of the Freedom to Speak Up Policies and Procedures. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact either of the Trust's Freedom to Speak Up Guardian in confidence by email to huth.ftsuguardian@nhs.net and nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with either Trusts' Freedom to Speak Up Guardians or with one of the Associate Guardians can be found on the Trusts' intranet sites.

The electronic master copy of this document is held by Document Control, Group Directorate of Corporate Assurance, NHS Humber Health Partnership.

Appendix A

HFMA NHS Audit Committee Handbook Extract (2024)

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?			
1.2 Are the terms of reference reviewed annually?			
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?			
1.4 Are committee members independent of the management team?			
1.5 Does at least one committee member have a financial background?			
1.6 Are all executive officers that you would expect to attend present at meetings?			~~New question 2024~~
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
1.8 Does the committee prepare an annual report on its work and performance for the governing body?			
1.9 Has the committee established a plan of matters to be dealt with across the year?			

1.10 Are committee papers distributed in sufficient time for members to give them due consideration?			
1.11 Has the committee been quorate for each meeting this year?			
1.12 Is there a succession plan in place for the chair of the audit committee?			~~New question 2024~~
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?			~~New question 2024~~
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?			~~New question 2024~~
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?			
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?			
2.5 Has the committee reviewed key data against the data quality dimensions?			
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?			
3.2 Does the committee specifically review: • changes in accounting policies			

• changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?			
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?			
4.4 Does the committee receive periodic progress reports from the head of internal audit?			
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?			

4.7 Does the committee hold periodic private discussions with the internal auditors?			~~New question 2024~~
4.8 Does the committee assess the performance of internal audit?			~~New question 2024~~
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
4.10 Has the committee evaluated whether internal audit complies with the *Public sector internal audit standards*?			
4.11 Does the committee receive and review the head of internal audit's annual opinion?			
5.0 External audit			
5.1 Are appropriate external audit procurement arrangements in place?			~~New question 2024~~
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?			
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
5.4 Does the committee review the external auditor's value for money conclusion?			
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?			~~New question 2024~~
5.6 Does the committee hold periodic private discussions with the external auditors?			
5.7 Does the committee assess the performance of external audit?			
5.8 Does the committee require assurance from external audit about its policies for ensuring independence?			
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			

6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

Hull University Teaching Hospitals NHS Trust

Group Corporate Assurance Directorate

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	GT012
Version:	1.2
This version issued:	
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	~~13/02/25~~
Approving body:	Trust Boards-in-Common
Date for review:	January, 202~~6~~7
Owner:	~~Sean Lyons,~~ Group Chair
Document type:	Terms of Reference
Number of pages:	18 (including front sheet)
Author / Contact:	Emma Sayner, Group Chief Financial Officer / David Sharif, Group Director of Assurance

NHS Humber Health Partnership (Hull University Teaching Hospitals NHS Trust & Northern Lincolnshire and Goole NHS Foundation Trust) actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

1.0 Purpose

1.1 The role of the Hull University Teaching Hospitals NHS Trust (HUTH **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Audit, Risk & Governance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Audit, Risk & Governance Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The **Audit, Risk & Governance Committee-in-Common** is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee. The committee is also authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

3.0 Accountability & Reporting Arrangements

3.1 The **Audit, Risk & Governance Committee-in-Common** is accountable to the HUTH Trust Board and shall report to the board on how it discharges its responsibilities.

3.2 The minutes of each meeting shall be submitted to the next meeting for formal approval as a true record of that meeting. The approved minutes will be submitted to the next meeting of the board for information.

3.3 The **Audit, Risk & Governance Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting highlighting issues that require disclosure to the board or require executive action.

3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

3.5 The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

4.0 Responsibilities

4.1 The specific duties & responsibilities of the committee are categorised as follows:

4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.

- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Person Test.

- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets Global Internal Audit Standards (GIAS, effective from 9.1.2025) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, which is consistent with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- Reviewing the Internal Auditor's annual report.

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with GIAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Recommending to the Trust Board the appointment of the External Auditor. The committee will act as the Auditor Panel, as per the Trust's Standing Financial Instructions. The Auditor Panel's function is to oversee the selection and appointment of the External Auditor by agreeing and overseeing a robust procurement process, making a recommendation to the Board and ensuring any conflicts of interest are dealt with effectively. It will also advise the Board on any decision involving the removal or resignation of the External Auditor.

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

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- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.
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4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation . These may include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management . The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common

- Workforce, Education & Culture Committees-in-Common
- ~~Health Tree Foundation Trustees'~~Charitable Funds Committee
- ~~Capital & Major Projects~~Strategic Programmes & Partnerships Committees-in-Common
- Remuneration Committees-in-Common – Annual Summary report only
- ~~Ethics Committee (when in operation)~~

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust Board or other groups within HUTH, as appropriate.

4.12 Summary Scope

4.12.1 In summary, ~~to~~ the committee will cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Charitable Funds governance arrangements
- Counter Fraud
- Data Quality
- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control
- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation
- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience. One of the members will be nominated as vice chair of the committee.

5.1.2 The Cchair of the Trust and the Group Chief Executive shall not be members of the committee. However, they may be invited to attend a meeting by the committee chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable.

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their items(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and ~~jointly~~ alternate in chairing the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between HUTH and NLaG both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of ~~one or~~ both Non-Executive Director chairs, one of the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will ~~jointly~~ chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions (dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will see to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No later papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the ‘action tracker’ of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action ‘lead’ and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

7.0 Equality Act (2010)

7.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

7.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

7.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

7.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

8.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with these terms of reference, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Freedom to Speak Up Policy for the NHS (DCP126) which has been adopted by the Trust in line with national guidance. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg-tr.ftsuguardian@nhs.net or telephone 07892764607. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

The electronic master copy of this document is held by Document Control, Group Directorate of Corporate Assurance, NL&G NHS Foundation Trust.

Appendix A

HFMA NHS Audit Committee Handbook Extract (2024)

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?			
1.2 Are the terms of reference reviewed annually?			
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?			
1.4 Are committee members independent of the management team?			
1.5 Does at least one committee member have a financial background?			
1.6 Are all executive officers that you would expect to attend present at meetings?			~~New question 2024~~
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
1.8 Does the committee prepare an annual report on its work and performance for the governing body?			
1.9 Has the committee established a plan of matters to be dealt with across the year?			

1.10 Are committee papers distributed in sufficient time for members to give them due consideration?			
1.11 Has the committee been quorate for each meeting this year?			
1.12 Is there a succession plan in place for the chair of the audit committee?			~~New question 2024~~
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?			~~New question 2024~~
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?			~~New question 2024~~
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?			
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?			
2.5 Has the committee reviewed key data against the data quality dimensions?			
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?			
3.2 Does the committee specifically review: • changes in accounting policies			

• changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?			
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?			
4.4 Does the committee receive periodic progress reports from the head of internal audit?			
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?			

4.7 Does the committee hold periodic private discussions with the internal auditors?			~~New question 2024~~
4.8 Does the committee assess the performance of internal audit?			~~New question 2024~~
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
4.10 Has the committee evaluated whether internal audit complies with the *Public sector internal audit standards*?			
4.11 Does the committee receive and review the head of internal audit's annual opinion?			
5.0 External audit			
5.1 Are appropriate external audit procurement arrangements in place?			~~New question 2024~~
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?			
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
5.4 Does the committee review the external auditor's value for money conclusion?			
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?			~~New question 2024~~
5.6 Does the committee hold periodic private discussions with the external auditors?			
5.7 Does the committee assess the performance of external audit?			
5.8 Does the committee require assurance from external audit about its policies for ensuring independence?			
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			

6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			